Universal access to reproductive healthcare

Senate Inquiry submission

MSI AUSTRALIA

Acknowledgement

MSI Australia acknowledges the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

Publication details

Published by
MSI Australia (MSI Reproductive Choices)
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Contents

Executive Summary

After two decades of legislative and policy reform, and two years of acute pressure on health systems, it is timely that the Australian Government is reviewing universal access to reproductive health services.

As the only national non-profit provider of sexual and reproductive healthcare, we make the following key recommendations:

1. Short term, provide universal access to sexual and reproductive healthcare
    - 1.1 Fund critical healthcare access gaps
    - 1.2 Immediately boost workforce capacity
    - 1.3 Reduce abortion related costs
2. Longer term, strategise for sexual and reproductive health
    - 2.1 Resource a national taskforce on abortion care
    - 2.2 Mental healthcare reviews
    - 2.3 Legislation and policy reviews
3. Prevent reproductive coercion, abuse and violence
    - 3.1 Truth telling, redress and research
    - 3.2 Centre First Nations leadership and innovation
    - 3.3 Professional training and community education

We look forward to working with the Australian Government and other key stakeholders to reshape sexual and reproductive health access and enable bodily autonomy for all.

Background

On 28 September 2022, the Senate referred an inquiry into the universal access to reproductive healthcare to the Senate Community Affairs References Committee for inquiry and report by 31 March 2023.

There is a current consultation on the inquiry. We appreciate the opportunity for individuals and organisations having the opportunity to provide a submission.

We support submissions made by partner organisations and alliances that provide all options sexual and reproductive healthcare. We appreciate that many individual doctors, nurses and midwives at MSI Australia and beyond have taken the time to share their expertise through individual submissions to this inquiry.

We highlight the importance of submissions made by Aboriginal Community Controlled Health Organisations, the Australian Indigenous Doctors Association, the Congress of Aboriginal and Torres Strait Islander Midwives, the First Peoples Disability Network (FPDN), the Multicultural Centre for Women's Health, the LGBTI Health Alliance, Intersex Human Rights Australia and Women With Disabilities Australia (WWDA).

To contain this submission to the suggested five pages, we have focused not on the Terms of Reference structure and instead, on a list of comprehensive recommendations. We would welcome any opportunity to expand on these further throughout and beyond the inquiry process.

We consent to this submission being published on the inquiry website and shared publicly online. We would welcome an opportunity to speak at a public hearing.

MSI Australia

As an independent, non-profit organisation, MSI Australia (formerly Marie Stopes Australia) is Australia's only national accredited provider of abortion, contraception and vasectomy services, and the country's longest running provider of teleabortion.

For individuals looking to control their sexual and reproductive health and choices safely, we are the fiercely pro-choice, non-judgemental, holistic health provider. Our clinical expertise, supported client journey, and values-led approach combine to deliver safer clinical outcomes and client wellbeing.

We published a white paper on reproductive coercion in 2018 called 'Hidden Forces: Reproductive Coercion in contexts of domestic violence'. [1] This was reviewed with recommendations updated in a Second Edition published in 2020.

[1] MSI Australia (2022), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, both editions available at https://www.msiaustralia.org.au/reproductive-coercion/

We work alongside MS Health, a non-profit pharmaceutical provider of medical abortion medication that sits within the MSI Reproductive Choices International umbrella. MS Health has made a separate submission to this inquiry.

Our services

At MSI Australia we provide the following services:

- Contraceptive options counselling, including vasectomy counselling
- Pregnancy options counselling, including abortion, adoption, care, kinship care and parenting
- Various aspects of nurse care including blood tests, ultrasounds and safety planning
- STI tests and cervical screening
- Contraceptive care, including Long Acting Reversible Contraception (LARC)
- Vasectomy care
- Tubal ligation care
- Medical abortion care (in person in clinic)
- Teleabortion, or medical abortion via telehealth (at our virtual clinic)
- Surgical abortion care up to 24 weeks and 6 days gestation
- Aftercare, including low-sensitivity urine pregnancy tests where relevant
- Australian Choice Fund bursaries, philanthropic bursaries to subsidise part of or all of contraception or abortion funding gaps[2]

Some of these services are face to face, others are online and some are a hybrid depending on the needs of clients and availability of clinical staff. Information on sexual and reproductive health access, equity and agency in Australia is available in the resources section of our website.[3]

This submission is made from the perspective of being a service provider of these particular services. We acknowledge that other aspects of the terms of reference, such as maternal health, also require further investment to enable equity and universality.

[2] MSI Australia (2022), Australian Choice Fund at https://www.msiaustralia.org.au/donate//
[3] MSI Australia (2022), Policy Brief section of Resource Library at https://www.msiaustralia.org.au/resources/document-library/

Recommendations

Sexual and reproductive health access is critical for population health. When left untreated, sexual and reproductive health concerns can have chronic physical, mental, and social health impacts.[4]

Universal access to sexual and reproductive health would have immediate and intergenerational benefits. This is supported by the National Women's Health Strategy (2020-2030) in which sexual and reproductive health equity is an indicator of success.[5]

Recommendation 1: Short term, provide universal access to sexual and reproductive healthcare

Recommendation 1.1 Fund critical healthcare access gaps

Fund the out-of-pocket costs that consumers face, to enable free access to medical abortion, surgical abortion and contraceptive methods including LARC, vasectomy and tubal ligation. Ensure access for all people in Australia, including temporary visa holders.

1.1.1 Activity funds allocated to States and Territories should be administered in a way that can enable sexual and reproductive health equity. These activity funds should support all health regions to provide abortion and all contraception options, including vasectomy, tubal ligation, and options counselling, at no out-of-pocket cost.

1.1.2 Health regions which do not provide these services within their own facilities need a transparent mechanism for reallocating activity funds to provide short term access elsewhere, with a plan to increase capacity within their own hospitals in the coming decade. Patient travel schemes need to be reviewed and increased to ensure that all those who must travel to access care, including their support people and any dependants, are safe, accommodated and supported at all times.

1.1.3 Where publicly funded health or hospital services delay or refuse provision of sexual and reproductive healthcare, funding pathways should be established with additional service providers to cover any fee gaps and provide no cost access for residents within the hospital catchment area. These funding pathways could be contracted using numerous approaches, such as the

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[4] Isobel, S., Goodyear, M., Furness, T. and Foster, K., 2019. Preventing intergenerational trauma transmission: A critical interpretive synthesis. *Journal of clinical nursing*, *28*(7-8), pp.1100-1113.
Kendall, S., Lighton, S., Sherwood, J., Baldry, E. and Sullivan, E.A., 2020. Incarcerated aboriginal women's experiences of accessing healthcare and the limitations of the 'equal treatment' principle. *International Journal for Equity in Health*, *19*, pp.1-14.
Menzies, K., 2019. Understanding the Australian Aboriginal experience of collective, historical and intergenerational trauma. *International Social Work*, *62*(6), pp.1522-1534.

[5] Australian Government Department of Health, National Women's Health Strategy (2020-2030), at https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

Western Australia model straight from WA Health to service providers, or the Tasmania model via women's health services to service providers. These models must only ever be short and medium term approaches until another longer term solution is embedded within the public hospital system.

1.1.4 Provide flexible funding to support engagement in rituals related to pregnancy loss and grief, including specific cultural rites, cremation and other related costs. These should be applicable to any pregnancy loss including abortion, miscarriage and stillbirth. Flexible Funds should enable self-determination such as being contracted via Aboriginal Community Controlled Health Organisations, disability organisations and migrant and refugee women's health services. This should be a short or medium term approach until a long-term solution that recognises cultural wellbeing as a health indicator is embedded across health finance systems.

Recommendation 1.2 Immediately boost workforce capacity

Boost health workforce capacity immediately, including:

1.2.1 Provide incentives for prescribers and dispensers of medical abortion in order to increase telehealth access throughout rural, regional and remote areas of Australia.[6] This is particularly relevant for South Australia during the post-abortion decriminalisation reform process.

1.2.2 Provide incentives to increase medical abortion accessibility, including for GPs (General Practitioner) to become certified prescribers and invest in reforms for nurse-led medical abortion care.[7]

1.2.3 Invest in a bilingual, bicultural sexual and reproductive health workforce that is professionally recognised and appropriately remunerated.[8]

1.2.4 Where scope of clinical practice has been extended during the pandemic, provide financial incentives to support new and emerging practitioners to gain greater sexual and reproductive health experience, including travel and accommodation to gain this experience in rural and remote areas.

1.2.5 Overseas-trained doctors should have temporary exemptions to Section 19AB of the Australian Government Health Insurance Act 1973, in order to increase clinical capacity for the provision of sexual and reproductive healthcare.

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[6] Fix, L., Seymour, J. W., Sandhu, M. V., Melville, C., Mazza, D., & Thompson, T. A. (2020). At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations. *BMJ Sexual & Reproductive Health*, *46*(3), 172-176.

[7] MSI Australia (2021), Nurse led medical termination of pregnancy in Australia at https://www.msiaustralia.org.au/nurse-led-care/

[8] Dr Regina Torres Quiazon (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/defining-universal-access-by-dr-regina-torres-quiazon-the-road-to-abortion-equity-8eeb0ffb5876?source=friends_link&sk=8b3e7ffc532baf2fdcff7fd274222a0d

1.2.6 Resource community-controlled health initiatives and services that co-design innovation in sexual and reproductive healthcare and health information. In particular, collaborate with organisations led by and for Aboriginal and Torres Strait Islander communities, people with disability, LGBTIQ+ populations, migrant and refugee communities and sex workers.[9]

Recommendation 1.3 Reduce abortion related costs

Boost public health initiatives that will reduce abortion related costs and prevent delayed access to care, including:

1.3.1 All emergency departments should provide all emergency contraceptive options, including various emergency contraceptive pills and the copper intrauterine device (IUD). Compliance should be monitored alongside other national and State/Territory standards for emergency care.

1.3.2 Emergency contraception pill prescription and dispensation limitations should be reduced to ensure that pharmacists cannot discriminate against young people, that more than one pill can be accessed at a time, can be collected on behalf of another person, and that they can be stored at home in case of future need to access to emergency contraception. Services such as Headspace in which GP (General Practitioner) and nurse services are co-located should be supported to deliver this time sensitive care.

1.3.3 Resource a national nurse triage, information, referral and advice organisation (such as existing contractor Healthdirect Australia and their National Health Service Directory) to provide streamlined pathways to sexual and reproductive health providers including all options providers of pregnancy and contraceptive choices counselling, ultrasound care, abortion care and contraceptive care.[10]

1.3.4 Resource a national organisation with mental health expertise (such as existing contractors 1800RESPECT and Headspace) to provide all options and non-judgemental pregnancy and contraceptive choices counselling, including safety planning and ongoing support in response to cases of reproductive coercion and abuse.

1.3.5 Support programs, initiatives and services that offer discreet and free public access to pregnancy tests, cervical and STI screening, condoms, dental dams and menstrual health products.

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[9] Delaram Ansari (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-delaram-ansari-the-road-to-abortion-equity-f32c3d0a18ae?source=friends_link&sk=170619e3f1a08e197f5e96ecc90a8749

[10] Healthdirect (2022), Health Service Finder, which includes sexual health services but does not yet have a category for abortion or contraception providers: https://www.healthdirect.gov.au/australian-health-services

Recommendation 2: Longer term, strategise for sexual and reproductive health

Recommendation 2.1 Resource a national taskforce on abortion care

The National Women's Health Strategy's commitment to universal access to sexual and reproductive health care, needs a comprehensive plan.[11] To create this, we need a national taskforce to review abortion care.[12] It could be a working group of the recently formed National Women's Health Advisory Council, or a separate body also linked to the National Women's Health Strategy. Alongside all recommendations, the taskforce should consider how to:

2.1.1 Work through a holistic scope of abortion equity, including intersecting areas of prevention such as universal access to vasectomy. Develop a collaborative action plan for how the Australian Government will achieve equitable access to abortion by 2030, a key measure of success in the *National Women's Health Strategy (2020-2030).*

2.1.2 Any health or hospital services that have access to public funds should:

- At a bare minimum, provide high obstetric risk abortions, and develop organisational policy that affirms LARC and abortion care as Category 1 essential healthcare.[13]
- Standardise procedures for optional referral to internal or external contraceptive choices counselling or pregnancy choices counselling, such as trained employee social workers or nurses, or an external publicly funded contractor.
- Standardise contraceptive options provided at time of abortion and live birth.[14]
- Develop organisational policy and procedures to operationalise conscientious objection with documented referral pathways and clinical risk mitigation plan.
- Where any aspect of sexual and reproductive health provision is limited, report annually on a capacity building plan to develop organisational policy, boost workforce and develop sexual and reproductive health infrastructure. There should be a goal to have the

[11] Fair Agenda, Australian Women's Health Network, Children by Choice and MSI Australia (2022), Achieving Equal Access: Abortion care in Australia November 2022 at www.abortionaccessnow.org.au or https://www.msiaustralia.org.au/resources/document-library/

[12] Dr Ahmad Syahir Mohd Soffi (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-dr-syahir-soffi-the-road-to-abortion-equity-52b053211160?source=friends_link&sk=cf7c798173db1cc3f336cfc71083ef96

[13] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2020, 'COVID-19 Access to reproductive health services' at https://ranzcog.edu.au/news/covid-19-access-to-reproductive-health-services.

[14] Makins, A., Arulkumaran, S., FIGO Contraception and Family Planning Committee, Sheffield, J., Townsend, J., Ten Hoope-Bender, P., Elliott, M., Starrs, A., Serour, G., Askew, I. and Musinguzi, J., 2020. The negative impact of COVID-19 on contraception and sexual and reproductive health: Could immediate postpartum LARCs be the solution? *International Journal of Gynecology & Obstetrics*.

capacity to provide high risk and complex aspects of surgical abortion care by 2040.

2.1.3 Ensure sexual and reproductive health projects, clinical governance committees and programs are resourced to incorporate consumer perspectives that inform design, quality improvement and evaluation processes.

2.1.4 Invest in academic research partnerships that will increase evidence and understanding of sexual and reproductive health equity and access, in order to evolve current models of sexual and reproductive healthcare, extend care provision and increase workforce capacity, and improve health consumer experiences. Research should consider quality and safe models of care that are used globally to address health inequity, such as nurse-led medical abortion and manual vacuum aspiration (MVA). Academic partnerships should plan to integrate new knowledge into enhancing clinical models of care, health finance structures, and various programs and schemes including philanthropic that enhance access.[15]

2.1.5 Develop a national data set for induced abortions alongside a review of the World Health Organisation's (WHO) International Classification of Diseases (ICD) coding.[16] Resource national data collection mechanisms that enable health consumer anonymity. Ensure that all medical and surgical abortion providers are resourced to actively contribute. Include population health factors in reporting such as gender, intersex variation, disability, visa/residency status, country of birth, year of arrival in Australia, and request for an interpreter.

2.1.6 Commission research into the impact of reproductive health help seeking on engagement in the labour force, and to evaluate existing reproductive health leave policies. Use this research process to inform public consultation which can garner community action and leadership.[17]

Recommendation 2.2 Mental healthcare reviews

2.2.1 All people in Australia, including women and pregnant people, their partners and support people, need access to non-judgemental and all-options

[15] Cohen, M.A., Powell, A.M., Coleman, J.S., Keller, J.M., Livingston, A. and Anderson, J.R., 2020. Special Ambulatory Gynecologic Considerations in the Era of COVID-19 and Implications for Future Practice. *American Journal of Obstetrics and Gynecology*.

[16] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

[17] Dr Romy Listo (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-dr-romy-listo-the-road-to-abortion-equity-e29acc27fc81?source=friends_link&sk=8e13be8a496a64e4fef8f3a5fdeb061a

pregnancy choices counselling. All options include abortion, adoption, care, kinship care and parenting.

2.2.2 Embed pregnancy options counselling in all public health and hospital services, which could be done via acute mental health, social work and allied health staff. These services should ensure that any person wishing to discuss their pregnancy options can do so within the hospital setting rather than requiring referral to an external provider, which risks delaying access to care, and unnecessarily separates physical and mental health aspects of pregnancy options care.

2.2.3 Pregnancy related counselling must be embedded in all public funded health pathways and public funded hospital provision, including all aspects of pregnancy including pregnancy options decision making, perinatal mood disorders, family adjustment, grief and loss and bereavement support.

2.2.4 Any additional government funding for pregnancy counselling should prioritise all options, non-judgemental counselling and providers that employ qualified psychologists, counsellors and social workers trained in this approach.

2.2.5 Pregnancy choices counselling providers should be required to disclose to clients if they do not support all pregnancy options, and if they are not a member of a relevant professional or regulatory body. This should be communicated clearly on their website, disclosure statements and via any referral networks

2.2.6 Providers who choose not to provide all options pregnancy counselling services should be subject to the same duty of care as medical practitioners who are conscientious objectors.

2.2.7 A review of best practice organisational approaches to supporting the health and wellbeing of the sexual and reproductive healthcare workforce. This will ensure future retention and stability of this specialist workforce.[18]

Recommendation 2.3 Legislation and policy reviews

2.3.1 The *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)* need to be adequately resourced, implemented and monitored to ensure key measures of success are achieved, including equitable access to sexual and reproductive healthcare.

2.3.2 All states and territories should design and resource sexual and reproductive health strategies that link to the *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)*. State and Territory strategies should address the domains identified in the 2014

[18] Dr Lydia Mainey (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-dr-lydia-mainey-the-road-to-abortion-equity-3641d6ea3651?source=friends_link&sk=33dc056f068afdf68664434fc3104821

Melbourne Proclamation that honours Australia's commitment to the Sustainable Development Goals.[19]

2.3.3 Enable further abortion law reform to harmonise legislation, deregulate and progress evidence-based practice, including nurse led care.[20] Shift the details of how abortion can be provided from law into clinical frameworks which promote continual improvement for cultural safety, quality and efficacy.

2.3.4 Resource Pharmaceutical Benefits Scheme and Therapeutic Goods Administration reviews to address sexual and reproductive health inequities including review of access to contraceptive rings, copper intrauterine devices, and the extension of gestational access to medical abortion to at least 70 days.[21]

2.3.5 Enact Medicare Benefits Schedule reviews including:

- Extend Medicare to all migrants, irrespective of visa category.[22]
- Ensure primary care MBS (Medicare Benefits Schedule) rebates are increased to remove the gap currently covered by health consumers, healthcare providers and philanthropists.
- Extend scope of health professionals including Registered Nurses and Midwife Practitioners for things like telehealth consults, ultrasound provision, and contraceptive implant insertion and removal.
- Permanent item numbers for all providers of sexual and reproductive care via telehealth, including item numbers for contraceptive counselling, genetic counselling and medical abortion access.[23]

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[19] Sexual Health Victoria (2022), 2014 Melbourne Proclamation at https://shvic.org.au/assets/resources/150501Melbourne-Proclamation-2014-FINAL.pdf

[20] MSI Australia (2022), Nurse led medical termination of pregnancy in Australia at https://www.msiaustralia.org.au/nurse-led-care/
MSI Australia (2022) Abortion access scorecard at https://www.msiaustralia.org.au/abortion-access-scorecard/

[21] Kapp, N., Eckersberger, E., Lavelanet, A. and Rodriguez, M.I., 2019. Medical abortion in the late first trimester: a systematic review. Contraception, 99(2), pp.77-86.
US Food and Drug Administration 2020, 'Mifeprex (mifepristone) Information'; at https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

[22] Dr Regina Torres Quiazon (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/defining-universal-access-by-dr-regina-torres-quiazon-the-road-to-abortion-equity-8eeb0ffb5876?source=friends_link&sk=8b3e7ffc532baf2fdcff7fd274222a0d and MCWH (2022) Universal Access to Reproductive Health Senate Inquiry Submission

[23] Mazza, Danielle, Seema Deb, and Asvini Subasinghe. "Telehealth: an opportunity to increase access to early medical abortion for Australian women." *The Medical Journal of Australia* 213, no. 7 (2020): 298-299.
Human Genetics Society of Australasia (2022), Submission to the Commonwealth Department of Health MBS Review Advisory Committee: Provision of Services by FHGSA Registered Clinical Genetic Counsellors at https://consultations.health.gov.au/medicare-reviews-unit/medicare-benefits-

- Consideration of how the MBS can be used alongside activity funding to enable choice of and universal access to contraception, surgical abortion and medical abortion in all States and Territories.

2.3.6 Protect intersex rights by actioning the 2021 Australian Human Rights Commission report on recommendations for better practice.[24] This includes legal protections, resourcing for independent psychosocial support, rights-affirming guidelines, education to address stigma, and community-led research.[25]

2.3.7 Remove waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed which is due to expire in June 2024, and within the Minister for Health's power to remove (as outlined in Schedule 4d).[26]

2.3.8 Sexual and reproductive healthcare provision and access must be adequately covered within State and Territory pandemic management plans, to ensure continued and safe access to services in current and future pandemics.

2.3.9 All accredited sexual and reproductive healthcare providers, including private and community health providers, need access to the National Medical Stockpile for relevant PPE (Personal Protective Equipment) and medications.

2.3.10 Tertiary education policy should ensure mandatory inclusion of sexual and reproductive health education in undergraduate degrees and postgraduate training programs including medicine, midwifery, nursing, general practice and obstetrics and gynaecology, psychiatry, psychology and social work.[27]

2.3.11 Ensure education policy includes the provision of age-appropriate, culturally safe, community centred, relationships and sexuality education for people of all ages and all genders as a mechanism to support preventative health measures.

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schedule-mbs-review-advisory-com/supporting_documents/HGSA%20Submission%20for%20MRAC%20Review.pdf

[24] Australian Human Rights Commission (2022), Ensuring health and bodily integrity at https://humanrights.gov.au/intersex-report-2021

[25] Morgan Carpenter (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-morgan-carpenter-the-road-to-abortion-equity-a13b7af294ac?source=friends_link&sk=41d8b38c87553246440b3c5eaf323bb4

[26] Dr Regina Torres Quiazon (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/defining-universal-access-by-dr-regina-torres-quiazon-the-road-to-abortion-equity-8eeb0ffb5876?source=friends_link&sk=8b3e7ffc532baf2fdcff7fd274222a0d and MCWH (2022) Universal Access to Reproductive Health Senate Inquiry Submission

[27] Swathy Santhakumar (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-swathy-santhakumar-the-road-to-abortion-equity-b4ba95895906?source=friends_link&sk=aec49cae5b5e32caa1787583069525e6

2.3.12 International aid and development policy and related funding must be protected and increased to support countries to achieve self-determination in sexual and reproductive healthcare now and into the future. [28]

Recommendation 3: Prevent reproductive coercion, abuse and violence

Recommendation 3.1 Truth telling, redress and research

3.1.1 Formally acknowledge Australia's history of reproductive coercion, abuse and violence. This includes forced contraception, abortion and sterilisation related to institutional and systemic racism in Australia since invasion.[29]

3.1.2 Enable spaces for victim-survivors of reproductive violence to share their stories and be heard. Commission a national inquiry into reproductive violence for people with disabilities starting with the removal of babies and children from parents with disabilities and forced sterilisation.[30]

3.1.3 Offer a national redress scheme for victim survivors of various forms of sexual and reproductive violence, which is inclusive of and addresses both Aboriginal and Torres Strait Islander women and other communities of disabled women who have intersecting and overlapping identities.[31]

3.1.4 The *National Women's Health Strategy (2020-2030)* lists reduction in reproductive coercion as a key measure of success. This requires investment in data collection, academic research, ongoing monitoring and evidence publication.[32]

3.1.5 Invest in further research to explore, document and build evidence on[33]:

- Intersections of sexual and reproductive health stigma, social isolation, reproductive abuse, coercion and violence.

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[28] Howes, S. 2020, 'COVID-19: Implications for Australian Aid' viewed at DevPolicyBlog https://devpolicy.org/covid19-implications-for-australian-aid-20200327/
Khoo, E.J. and Lantos, J.D., 2020. Lessons learned from the COVID-19 pandemic. *Acta Paediatrica*.

[29] MSI Australia (2022), Apology for forced medical procedures linked to colonisation and racism in Australia at https://www.msiaustralia.org.au/apology-for-forced-medical-procedures-linked-to-colonisation-and-racism-in-australia/

[30] Margherita Dall'Occo-Vaccaro (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-margherita-dallocco-vaccaro-the-road-to-abortion-equity-dfb3ee4e8aed?source=friends_link&sk=ac0410c90263d5e3ae83ea780e2a6c2c

[31] Margherita Dall'Occo-Vaccaro (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-margherita-dallocco-vaccaro-the-road-to-abortion-equity-dfb3ee4e8aed?source=friends_link&sk=ac0410c90263d5e3ae83ea780e2a6c2c

[32] Australian Government Department of Health, National Women's Health Strategy (2020-2030), at https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

[33] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/
Sheeran, N., Vallury, K., Sharman, L. S., Corbin, B., Douglas, H., Bernardino, B., ... & Tarzia, L. (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 1-10.

- Escalation of reproductive coercion as a risk factor and indicator of violence including non-fatal strangulation and homicide, for women and pregnant people.
- Qualitative research on the diversity of lived experiences of reproductive coercion, including non-carceral responses and alternative forms of reproductive justice for victim-survivors.
- Prevalence, including ongoing reviews and development of the Australian Bureau of Statistics (ABS) Personal Safety Survey.

3.1.6 Support reproductive justice programs, initiatives and services that are led by community-controlled organisations including by those that have experienced historic reproductive violence in Australia including communities that are Aboriginal and Torres Strait Islander, migrant and refugee, disabled, LGBTIQ+, sex workers and/or incarcerated.[34]

Recommendation 3.2 Centre First Nations leadership and innovation

3.2.1 Implement all 54 recommendations of the Bringing Them Home Report[35] and the Pathways Forward from the Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report.[36]

3.2.2 Resource community-controlled research to collate and share evidence on what reproductive justice means today, and how self-determination of sexual and reproductive health, including contraception and abortion care, can be regained and maintained.[37]

3.2.3 Support programs, initiatives and services that can expand models of sexual and reproductive healthcare on Country, including pregnancy loss

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[34] Brenna Bernardino (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-brenna-bernardino-the-road-to-abortion-equity-101a7341959a?source=friends_link&sk=06e63b899af6b1be33ccb2b0a38c2e46
Margherita Dall'Occo-Vaccaro (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-margherita-dallocco-vaccaro-the-road-to-abortion-equity-dfb3ee4e8aed?source=friends_link&sk=ac0410c90263d5e3ae83ea780e2a6c2c

[35] Commonwealth of Australia (1997) Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families at https://humanrights.gov.au/our-work/bringing-them-home-report-1997.

[36] Australian Human Rights Commission (2020), Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future at https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/wiyi-yani-u-thangani

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intersections of abortion care, miscarriage and stillbirth, alongside other pregnancy outcomes such as kinship care and parenting.[38]

3.2.4 Support programs, initiatives and services that can expand models of Aboriginal and Torres Strait Islander community-controlled comprehensive sexuality education. This should be considered at all ages, inside early childhood and school settings and beyond through tertiary education settings, workplaces and community centres.[39]

Recommendation 3.3 Professional training and community education

3.3.1 Resource academic research partnerships to increase evidence and understanding of reproductive coercion prevention and response mechanisms. Build on these partnerships to develop communities of practice throughout Australia.[40]

3.3.2 Embed pre-service and in-service healthcare professionals' training and education on abortion and contraceptive access and care in all primary care, allied and mental health professional degrees, including identifying and responding to reproductive coercion.[41]

3.3.3 Provide training and support for family, domestic and sexual violence professionals to promote early intervention and response to reproductive coercion, while offering consumers free contraceptives, pregnancy tests, emergency contraceptive pills and menstrual products at refuges and community centres.[42]

3.3.4 Invest in age-appropriate, culturally safe, community centred, reproductive coercion prevention activities and programs, including relationships and sexuality education. Nationally accredited relationships and sexuality education in a variety of learning modalities facilitated in places such as early learning centres, maternity services, schools, universities, workplaces, disability and aged care facilities. It must embed aspects of menarche and menopause, and a range of content relevant to digital cultures and online relationships.

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[38] Brenna Bernardino (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-brenna-bernardino-the-road-to-abortion-equity-101a7341959a?source=friends_link&sk=06e63b899af6b1be33ccb2b0a38c2e46

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[40] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

[41] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

[42] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

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