Abortion legislation – proposal for reform in Western Australia

Consultation submission

December 2022

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, present and emerging. 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

1. Executive Summary

MSI Australia has operated within WA for the past two decades, first with face to face clinics, then expanding to telehealth, and now with a hybrid virtual care model.

We welcome the WA Government's review of abortion law. Alongside updating and harmonising health law, we suggest reviewing, resourcing and evolving models of care to enable universal access.

In this submission we have summarised some key areas of knowledge and demographic data, and have provided the following recommendations.

Recommendation 1: Strategise for sexual and reproductive health

a) Remove all references to abortion in the *WA Criminal Code Act 1913*.

b) Reform sections of the *Health (Miscellaneous Provisions) Act 1911*:

- Amend 334(2). Enable clear legal duties on health practitioners to disclose their objection and treat their patients with dignity and respect. Require health practitioners to refer, or transfer the care of, the patient to a health practitioner or service that is known to not have a conscientious objection as quickly as possible. Require health practitioners to perform, or assist in, the abortion in cases of medical emergency where an abortion is necessary to save a person's life or prevent serious harm.
- Remove 334(5)-(6) content related to gestational limits, as these should instead be addressed in WA Health clinical guidelines which can be continuously reviewed and updated alongside the evolving evidence base.
- Remove 334(7) content related to medical panels and ministerial approvals, as these should instead be addressed in WA Health clinical guidelines which can be continuously reviewed and updated alongside the evolving evidence base.
- Consider other areas of the Act that could be reviewed and harmonised including the removal of sections 334(8)-(11) which refers to minors.

c) Ensure that throughout health law and subsequent policy and regulations, that an abortion may be provided in any circumstance of informed consent, as with any other medical procedure.

d) Enable further abortion law reform to enable evidence based practice and ensure longevity of access, such law that enables various aspects of nurse led abortion care.

e) Design and resource a WA Sexual and Reproductive Health Action Plan that can link to WA Women's and Men's Health and Wellbeing Policies, including:

- Develop communities of practice on abortion access and care.

- Support the review of clinical guidelines that can renew alongside evolving models of abortion care.
- Provide incentives for health professionals to train as surgical and medical abortion care providers, such as supporting GP's in regional and remote areas to become medical abortion prescribers.
- Provide incentives for interpreters and translators to train and work in specialise areas of sexual and reproductive healthcare, particularly those from emerging language groups.
- Develop WA content within national referral services such as Healthdirect[1] to provide information, referral and advice on sexual and reproductive health services providers and health options.
- Invest in academic research partnerships that will increase evidence and share knowledge on sexual and reproductive health access in WA.

Recommendation 2: Provide universal access to sexual and reproductive healthcare

a) Fund the out of pocket costs that health consumers face state-wide. Enable free access to medical abortion, surgical abortion and contraceptive methods including Long Acting Reversible Contraception (LARC), vasectomy and tubal ligation. Ensure access for temporary visa holders.

b) Resource community designed outreach and mobile services within regional and remote Aboriginal and Torres Strait Islander communities.

c) Provide financial support for rituals related to grief and loss, including specific cultural rituals, cremation and other related costs with provision for kinship family to participate.

d) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, emergency contraception, condoms, dental dams and menstrual health products.

e) Collaborate with the Commonwealth to continue Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) reviews on sexual and reproductive health related rebates, including the Copper IUD and hormonal contraceptive ring. Consider how these funds could be better utilised in collaboration with State activity funds to maximise access and equity.

[1] Healthdirect (2022), service finder viewed on 15 December 2022 at https://www.healthdirect.gov.au/australian-health-services

Recommendation 3: Prevent reproductive coercion and violence

a) Invest in age-appropriate, culturally safe, community centred reproductive coercion prevention activities and programs, including relationships and sexuality education throughout the lifespan.

b) Embed pre-service and in-service healthcare professional training and education on abortion care, including identifying and responding to reproductive coercion. Provide training and support for family, domestic and sexual violence services to promote early intervention and prevention responses to reproductive coercion.

c) Fund academic research partnerships to increase evidence and understanding of reproductive coercion in WA.

We appreciate the WA Government's commitment to health access, and look forward to continued collaboration for sexual and reproductive health equity across metropolitan, regional and remote areas.

2. Background

The WA Government's inquiry into abortion legislation is timely. Having moved most of abortion care into health law in 1998, WA was ahead of other Australian states and territories in recognising reproductive rights. Since then, every other state and territory has undertaken significant reforms and in terms of abortion law, WA has shifted from being one of the most progressive to the least progressive jurisdiction.

The McGowan Government's move to legislate safe access zones last year was a welcome shift, creating a 150 metre buffer zone around abortion clinics where harassment and intimidation of clients and staff is now prohibited. This became a national milestone for health justice, as Australia now fulfils our international human rights commitments on legislating safe access zones.

In recent years there have been broad social normalisation of reproductive rights, a series of legislative and policy reforms, and a growing evidence base that sexual and reproductive healthcare is evolving. It is an opportune time for WA to undertake a review of abortion law, to align with other jurisdictions and future proof essential healthcare access by removing all references to abortion within the criminal code.

This paper is a consultation submission written in direct response to the questions listed in the public consultation discussion paper.[2] It can be published online and shared publicly.

Alongside this submission, we endorse the submission by the Human Rights Law Centre which provides further detail on legislative reforms.

2.1 MSI Australia

As an independent, nonprofit 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.

The MSI Perth clinic was established in 2001, following on from another clinical provider that operated in the same premises. The Western Australian (WA) Government has been consistently supportive of our presence.

The WA Government resources high-level facility costs by sponsoring clinic infrastructure and supporting service delivery within select catchment areas. MSI Australia manages all other operational aspects of service delivery. Clinic demand is greater than clinic capacity.

[2] https://consultation.health.wa.gov.au/pahd-ocho-alr/abortion-laws/

We work alongside MS Health, a non-profit pharmaceutical provider of medical abortion medication that sits within the MSI Reproductive Choices International umbrella. Further information on MS Health is available at www.mshealth.org.au.

At MSI Australia we provide the following services to WA residents:

- Contraceptive options counselling, including vasectomy counselling
- Pregnancy options counselling, including: abortion, adoption, care, kinship care and parenting
- Various aspects of nurse-led care including blood tests, ultrasounds and safety planning
- STI tests and cervical screening
- Low-sensitivity urine pregnancy tests
- Contraceptive care, including Long Acting Reversible Contraception (LARC)
- Vasectomy care
- Medical abortion care (in clinic)
- Medical abortion care (via telehealth)
- Surgical abortion care up to 19 weeks and 6 days pregnancy gestation, depending on clinician availability
- Surgical abortion care 20 weeks and beyond in pregnancy gestation, travelling interstate, to a combination of the MSI Melbourne or Brisbane clinics, or referral to another service provider such as the SA Health Pregnancy Advisory Centre
- Aftercare 24 hours a day, 7 days per week
- Australian Choice Fund bursaries, philanthropic bursaries to subsidise part of, or all, of a contraception or abortion funding gap

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.

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

Our sister services in WA include Sexual Health Quarters and women’s health services. They have a range of reproductive choices services and programs, including relationships and sexuality education, parenting support and advocacy for reproductive health leave.

2.2 Pregnancy options counselling

Most pregnancies may have all five pregnancy options: abortion, adoption, care, kinship care or parenting. Other pregnancies have fewer options, which depend on the woman or pregnant persons, health, relationships and personal circumstances. Some pregnancies will end with miscarriage.

Pregnancy options counselling is a model of non-directive decision-making counselling. This model supports women and pregnant people as they make a decision about their pregnancy. It's a conversation where all pregnancy outcomes are discussed including abortion, adoption, care, kinship care or parenting. The counsellor supports and listens to concerns without encouraging one option over another. While some people choose to seek advice from their partner, friends or family, others might feel that they can't do so for a variety of reasons. These could include conflict over the decision, fear of abuse and violence, a lack of friends and family close by, or fear of being judged or shamed.

At MSI in WA we also offer contraceptive choices counselling, which may be part of abortion care or part of a separate contraceptive service provision. This is a particularly important service for people considering tubal ligation or vasectomy, given they are making a permanent choice with a potential for later regret.

2.3 Medical abortion

Medical abortion is a safe and effective method of terminating a pregnancy up to 9 weeks (63 days) gestation using medication rather than a procedure. Overall, medical abortion is a low risk non-surgical option for early termination with a high success rate, up to 98%.

Medical abortion is a two-stage process. The first stage involves taking a tablet that blocks the hormone necessary for the pregnancy to continue and prepares the uterus for the second stage of the procedure. This is followed 24-48 hours later by a second medication that causes the contents of the uterus to be expelled.

Medical abortion care can be accessed face to face at the MSI Perth Clinic and a number of local GP prescriber sites. On 30 June 2022, across WA, there were 275 active prescribers (doctors) who have completed a free 2 hour online training course with MS Health. 68% were in metropolitan areas, 19% in regional areas and 13% in remote areas of WA.

On 30 June 2022, there were 397 dispensers (pharmacists) across the State.[3] 63% were in metropolitan areas, 21% in regional areas and 15% in remote areas of WA. Pharmacists are also required to complete a free 2-hour online training course with

[3] MS Health (2022), July Update, Melbourne, Australia: MSI Reproductive Choices at https://www.mshealth.com.au/publications/

MS Health, however MS Health has recently lodged a proposal with the Therapeutic Goods Administrator (TGA) to remove this requirement for pharmacists.

Medical abortion via telehealth is a safe, quality and private method of abortion access.[4] During the course of the COVID-19 pandemic, client preferences in WA shifted and are now trending towards medical termination via telehealth.

MSI Australia's national teleabortion service is partially staffed from the MSI Perth Clinic, servicing thousands of people each year with online bookings, nurse and doctor consults, medication courier system and a 24-hour aftercare phone line.[5] Alongside MSI's teleabortion service, GP providers of medical abortion are increasingly offering telehealth options as part of their everyday services.

2.4 Surgical abortion

Surgical abortion is a safe and straightforward day-surgery procedure that is most commonly performed in the first trimester (up to 12–14 weeks' gestation). Beyond 16 weeks our patient pathways ensure clients receive a greater level of care to account for increased complexity, including ultrasounds, blood tests and a specialised assessment prior to procedure.

Surgical abortion in the first trimester is a low-risk procedure with a high success rate of greater than 98%. A doctor uses gentle suction to remove the pregnancy from the uterus. The procedure takes between 5–15 minutes and is usually performed under intravenous sedation. Local anaesthetic can be used if preferred and/or when intravenous sedation is not clinically suitable.

For people who wish to prevent or delay pregnancy following their abortion, a surgical abortion is an opportune time to have a LARC fitted. For example, an IUD can be inserted within the same episode of twilight medication or local anaesthetic. We offer all surgical abortion clients free insertion of a LARC providing they bring the device or cover the device cost. At the MSI Perth Clinic over 1 in 4 (26%) people choose to have a LARC inserted following a surgical abortion.

LARC is also available separate from a surgical abortion as a standalone service, either at our clinics or from Sexual Health Quarters, from most gynaecology specialists including Gynaecological clinics, and some GPs.

2.5 Demographics of abortion access

In order to provide insight into abortion access, we have analysed a range of client data to look at key demographic information. Given patterns changing during the pandemic, we analysed clinic data and produced average values from 2018 to 2021.

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[4] 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.

[5] MSI Australia (2022), Teleabortion, at https://www.mariestopes.org.au/abortion/home-abortion/

The average age of a person accessing abortion in the MSI Perth Clinic during that time was 30 years old. The youngest person in the past five years has been 13 years of age, and the oldest person has been 50 years of age.

Most (99%) of people living in the WA who contact MSI Australia will access an abortion in the Perth Clinic. For the 1% who travel interstate, the majority travel to VIC or QLD and a minority travel to the ACT or NSW. Of people who access surgical or medical abortion at the MSI Perth Clinic:

- At least 4% of people are First Nations people, which is the same as the average in MSI clinics nationally.
- The majority (90%) of people live in metropolitan areas, with the remaining (10%) living in regional and remote areas.
- Unfortunately, data regarding a range of disability is only available in hardcopy clinic files. They cannot be analysed without further resources.
- One in three (37%) people are born outside of Australia.
- Almost one in ten (8%) people do not have access to Medicare.
- Almost one in ten (8%) people prefer a language other than English.
- One in twenty (5%) people who request an interpreter to be present, do not have an interpreter available in their preferred language during abortion related consultations.

It is particularly hard to find interpreters in WA for abortion and contraceptive care, and near impossible for any minority or emerging language groups. This is a critical situation which potentially places women and pregnant people at risk – medically and due to their psychosocial circumstances.

2.6 Policy context

The United Nations Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have enshrined sexual and reproductive care within women's right to health. [6] As a signatory to CEDAW, the Australian Government is therefore obliged to respect, protect and fulfil sexual and reproductive health and rights.

Australia has a patchwork of health laws and health policies across federal, state, territory and local governments. Observations on Australia's periodic CEDAW report recommend that Australia harmonise abortion-related legislation across jurisdictions

[6] Office of the United Nations High Commissioner (2020), Sexual and Reproductive Health and Rights, viewed on 27 July 2020 at <https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.asp>

to increase health access and equity.[7] Until abortion law is harmonised, women and pregnant people will continue to travel between jurisdictions in order to access healthcare and Australia's human rights record in abortion care will remain opaque.

The National Women's Health Strategy commits to equitable access to pregnancy termination services and strives for universal access by 2030. Alongside the National Preventative Health Strategy, we have a sound national policy model to support further policy development and implementation in WA.

Nurse led abortion care

We note that an MS Health application is currently with Therapeutics Goods Administrator (TGA) to amend the risk management plan for medical abortion medication. One of the proposed amendments removes reference to medical practitioner, which would effectively redistribute power from the Commonwealth to states and territories to govern which health professionals can provide abortion care.

In early 2022, MSI Australia published the second edition of a paper which conducted a legislative scan of nurse-led abortion care in Australia, which contains further detail on the shift towards nurse-led care.[8] The lawful performance of abortions in Western Australia is specifically limited to medical practitioners.[9] Further, an unlawful abortion performed by anyone other than a medical practitioner is a crime.[10]

Nurse practitioners, nursing and midwifery colleges and professional bodies would need to be involved in expanding pre-service and in-service training, clinical guidance, governance and regulation.

Continuity of care would be relatively seamless given there are maternal and child health/mental health referral pathways already funded across and within the primary, secondary and tertiary health sectors.

2.7 Legislative context

Comparison with other Australian Jurisdictions

In 2022 MSI Australia released an Abortion Access Scorecard which outlined and simplified legislative barriers across jurisdictions.[11] Each legislative area of abortion is ranked according to most accessible legislative framework (green tick), somewhat

[7] Committee on the Elimination of Discrimination against Women (2018), CEDAW/C/AUS/CO/8: Concluding observations on the 8th periodic report of Australia viewed on 27 July 2020 at < https://digitallibrary.un.org/record/1641944?ln=en>.
[8] MSI Australia (2022), Nurse Led Medical Termination of Pregnancy In Australia, available at https://www.mariestopes.org.au/advocacy-policy/nurse-led-care/
[9] Criminal Code Act Compilation Act 1913 (WA) s 199.
[10] Ibid s 199(2).
[11] MSI Australia (2022), Abortion Access Scorecard, available at https://www.mariestopes.org.au/advocacy-policy/abortion-access-scorecard-australia/

accessible legislative framework (orange tick) or least accessible legislative framework (red cross). Green points to no remaining legislative barriers.

Importantly, legislative barriers are only one piece of the abortion access puzzle – alongside regulations, resourcing, health literacy and community empowerment.

When abortion was criminalised, a high level of regulation was understandable. Now that abortion is recognised as healthcare including mental healthcare, governance of abortion care must be led by clinicians rather than politicians.

All areas of healthcare, including abortion care, changes rapidly alongside new and emerging evidence, health system structures, and workforce capacity development. For these reasons, it is clinical guidelines and standards that must provide guidance for abortion care, rather than legislation. Clinical guidelines are led by relevant colleges, informed by current evidence, and considered at length by clinical leaders and other health sector experts. Likewise clinical standards are set by healthcare agencies, such as the Australian Commission on Safety and Quality in Care.

Abortion care can be provided with a red, or red and orange scorecard. However, complexities and contradictions across jurisdictions create significant administrative and clinical care obstacles for our clinics and for people who are required to physically travel between them. Ideally, as a long term goal, there would be harmonisation of law across Australia to enable consistent provision of this essential healthcare.

WA is in prime position for legislative reform.[12]

Area of abortion law	**WA**	**Ideal situation to enable abortion access, equity and agency**
Abortion provided by one doctor	✗	More than one doctor is required for abortion care, plus for cases beyond 20 weeks in pregnancy gestation a Ministerial Panel is involved. Ideally only one doctor would be required to provide abortion care.
Doctors can provide abortions without risk of criminalisation	✓	Yes, doctors do not need to fear about being criminalised for their healthcare provision.
Nurses, Midwives and Aboriginal and Torres Strait Islander workers can provide medical abortions without risk of criminalisation	✗	All references to abortion must be removed from criminal codes. This includes someone being coerced towards an abortion.

[12] MSI Australia (2022), Abortion Law in Australia, WA section at https://www.msiaustralia.org.au/advocacy-policy/abortion-law-in-australia/

Support people can assist someone to access abortion without risk of criminalisation	✗	Reproductive coercion instead needs to be addressed through prevention mechanisms such as: ✓ relationships and sexuality education throughout the lifespan, ✓ parenting programs and support, perinatal mental health care ✓ community based prevention programs to end gender-based violence, ✓ data collection, research investment and the building evidence base, ✓ monitoring and review of clinical standards to be evidence informed, and ✓ clinical governance to prevent and mitigate risk of adverse events.
Safe Access Zones are legislated	✓	Safe access zones are legislated at 150 metres around clinics.
Counselling referrals are optional and not mandated	✗	Pregnancy options counselling should be optional and provided as part of clinical care. As with other healthcare services, psychosocial care should be considered as integral to long term health outcomes for all individuals. Women and pregnant people should be able to choose to speak with a counsellor to discuss all options (abortion, adoption, care, kinship care and parenting), at any point in their pregnancy. Counselling models should be informed by recovery based, trauma-informed systems thinking, rather than a deficit lens.
Abortion access free from judgement and justification	✓	Abortion access should be free from judgement, including the need to provide justification for a very personal choice. Aspects of the current law including mandated counselling, complexities in

		the criminal code and conscientious objection enables space for judgement and discrimination.
Abortion evidence base is supported with data collection and publication	✓	WA has better data collection and sharing methods than some other jurisdictions. WA should be contributing towards a national evidence base on abortion, supported by resourcing to enable data collection, analysis and publication to inform future policy and practice development. National data on abortion access, should not require any publication of client names, address, or any other identifying factors.
Conscientious objection is legislated with a referral	✗	No healthcare worker in WA has a legal duty to provide abortion access to someone who wants an abortion. Where someone does contentiously object, we suggest mandating a referral to an actual abortion provider who can and will provide the service.

3. Response to Discussion Paper

3.1 Pregnancy Options Counselling Mandates

Regulatory options in relation to informed consent and mandatory counselling requirements

> *Option 1: No change. Retain the existing provisions requiring mandatory counselling in order to obtain informed consent for abortion, as per the Act.*
>
> *Option 2: Remove existing legislated provisions requiring mandatory counselling in in order to obtain informed consent. Medical practitioners would continue to be required to obtain informed consent in line with existing standards of care and professional obligations.*

Free, non-directive, pregnancy option counselling would continue to be available to people wishing to access this service. The Department's WA Health Consent to Treatment Policy outlines the minimum mandatory requirements for health professionals in obtaining a patient's consent to treatment.

We support Option 2 to remove existing legislated provisions requiring mandatory counselling in order to obtain informed consent. Medical practitioners would continue to obtain informed consent in line with existing standards of care and professional obligations.

3.2 Number of doctors required to perform an abortion

Regulatory options in relation to the requirement for two medical practitioners to be involved before a woman can have an abortion

> *Option 1: No change: Retain the existing provisions requiring two medical practitioners to be involved before a woman can have an abortion.*
>
> *Option 2: Amend provisions to allow only one health practitioner to be involved (excludes late abortions).*

We support Option 2 given that only one health practitioner is required. Ideally, this would apply at any gestation. Doctors follow practice guidelines and codes of conduct, so will always consult with Medical Directors or other health practitioners when required.

3.3 Conscientious objection and access to care

Regulatory options in relation to conscientious objection

> *Option 1: Retain current provision allowing a person, hospital, health institution or other institution to conscientiously object to providing abortion care, without any requirement to refer the patient to a practitioner who is willing and able to provide abortion care.*

Option 2: Provide updated provisions to allow health practitioners to conscientiously object with clear and unambiguous directions to refer the patient to another health practitioner who is willing and able to provide abortion care.

This provision would not allow a health practitioner or institution to invoke conscientious objection if the abortion is required to manage an emergency health care event.

We support option 2, to allow health practitioners to conscientiously object with clear and unambiguous directions to refer the patient to another health practitioner who is willing and able to provide abortion care. Access is far more than a referral onwards; the client must be able to access the additional healthcare provider without judgement and other barriers such as travel or cost.

3.4 Gestational limits

Regulatory options in relation to gestational limit for additional requirements

Option 1: No change. Retain additional requirements from 20 weeks gestation.

Option 2: Increase the gestational age at which additional requirements will apply from 20 weeks to 24-weeks gestation.

We support Option 2: Increase the gestational age at which additional requirements will apply from 20 weeks to 24-weeks gestation. Ideally there would be no need for 'gestational limits' at all, as any considerations for complex cases would be navigated by clients in consultation with their health practitioner.

From these two options, the second is more suitable as it would align WA with other jurisdictions and prevent the need to travel between states and territories. If any lower than 24 weeks gestation, clients would still choose to travel interstate to access care.

3.5 External judgement of complex cases with a Ministerial Panel

Regulatory options in relation to a Ministerial Panel

Option 1: No change. Retain the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e. late abortions).

Option 2: Remove the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e. late abortions) but require an additional medical practitioner to be consulted.

We support Option 2. The Ministerial Panel is a structure that can be problematic, traumatising and patronising for clients. It causes delays while people wait for a resolution, meaning that people access abortion care at a later gestation.

Delayed access to abortion care increases clinical complexity and subsequently increases clinical risk. It also increases social, emotional, cultural and financial stress on clients and their communities, meaning that some women and pregnant people fly interstate to avoid facing this process.

3.6 Health service regulations for clinical care

Regulatory options in relation to health service approval to perform late abortions

> *Option 1: No change. Retain the requirement for Ministerial approval for a health service to perform late abortions.*
>
> *Option 2: Remove the requirement for Ministerial approval for a health service to perform late abortions.*

We support Option 2, remove the requirement for Ministerial approval for a health service to perform late abortions. These services already have other regulatory requirements in order for accreditation.

If the intention of this clause is to support access to quality and safe care, then WA Health could consider resourcing an abortion information, referral and advice service. This could be via an existing provider with established infrastructure such as Healthdirect.

It should also be a priority for health consumer advisory bodies to ensure that when health consumers search for a provider they search for a high standard of care, including safety and quality. For example, health consumers can consider adverse event rates in comparison to national averages.

3.7 Other comments

3.7.1 The Choice Fund

As a non-profit healthcare provider, we provide bursaries to clients who are experiencing financial hardship. We do this by combining philanthropic donations together with any surplus from other sexual and reproductive health services where clients have paid the full-fee. Known as the ‘Safe Abortion and Contraception Choice Fund’, the Choice Fund is for women and pregnant people in Australia who are experiencing financial hardship in addition to other barriers.

Every fortnight we receive at least one Choice Fund request for the MSI Perth Clinic. People’s situations are complex. Their pregnancies are planned and unplanned. They are First Nations women and pregnant people, migrants and refugees, many of whom are on temporary visas, they are women with disabilities, they are survivors of violence, they are LGBTIQ+ and experiencing or at risk of homelessness.

They are all people who are experiencing hardship, who:

- meet stringent financial hardship criteria

- can’t access abortion at their public hospital
- don’t have private health insurance or there is a waiting period on claims
- where it is safe to, have approached friends and family for financial support but still have a fee gap
- want a healthcare procedure which necessarily increases in price and clinical complexity with every week that passes

In every one of these cases, it is philanthropists who donate to the Australian Choice Fund who fill the gap.

In the past three years, the Choice Fund has funded in excess of $1 million worth of contraception and abortion services nationally, for women and pregnant people experiencing financial hardship. During the Covid19 pandemic, the number of regular Choice Fund donors, philanthropists and the size of their donations has dramatically reduced. For the first time in many years, MSI Australia has had to turn away women experiencing financial hardship who cannot afford to access their choice of healthcare.

Abortion service gaps and subsequent Choice Fund demand is particularly high for people who hold temporary visas. For example, international students are not entitled to Medicare and must have Overseas Student Health Cover (OSHC) for the duration of their stay in Australia. OSHC does not cover pregnancy-related conditions in the first 12 months of arrival in Australia unless the pregnancy is linked to an emergency situation. This means that if an international student, or the partner of an international student, experiences an unplanned pregnancy within the first 12 months of arrival in Australia, they may be faced with limited reproductive choices while simultaneously experiencing financial and resettlement difficulties.

There are also considerations that preclude some groups from seeking emotional support from family. In turn, this can lead to poorer health outcomes due to ongoing isolation, disengagement from employment and education, and relationship breakdown.

3.7.2 Abortion cost

In Australia, the cost of an abortion can be free, or ranging up to $8,000 depending on funding structures. Every abortion provider has different prices, and some outsource parts of the service. MSI Australia delivers a holistic service and as many costs as possible are included in the one fee, including ultrasound (if relevant), counselling sessions, nurse consultation, doctor consultation, anaesthetist (if relevant), and 24-hour aftercare following. Prices at the MSI Perth and telehealth clinics are publicly available at the online ‘cost estimate checker’.[13]

[13] Visit: https://www.mariestopes.org.au/bookings/find-a-service/

Abortion cost varies greatly depending on personal situation:

- Pregnancy gestation: care changes significantly by pregnancy gestation, increasing in complexity as the pregnancy progresses. For example, some abortions can be at home, while others need to be in a day hospital. Some abortions can be without any anaesthetic, while others need to be under twilight medication.
- Abortion care method: In WA, there are two methods of abortion, medical abortion with tablets, and surgical abortion using electrical or manual vacuum aspiration. Some people have a choice between methods, others do not because of factors that relate to disability, chronic health issues or other personal health circumstances.
- Mental health needs: some people want pregnancy options counselling prior to making a decision about or continuing one of their five pregnancy options - abortion, adoption, care, kinship care and parenting. They may also need general counselling support, particularly for those seeking abortion care they can feel disenfranchised about the lack of community respect or support for their choice. Many clients have pre-existing mental health concerns, including those related to childhood trauma and abuse. Pregnancy and/or the nature of the abortion process can be triggering for many clients who may then require referral to community-based support services.
- Any complex health needs: for example if the person has a disability or a chronic illness, or if their body is a particular weight, they may need a different form of anaesthetic, procedure or recovery set up.

Abortion care is diverse, just like people's bodies and lives. There is no standard cost for surgical abortion, because how, why and where abortion is provided will change depending on the client's personal needs and situation.

Indirect costs that contribute to abortion inequity

Indirect costs that we see abortion clients in the WA experience include:

- identifying a support person, which in the case of abortion requires disclosing a very personal choice and responding to any reactions or judgement.
- taking time off work, for the person seeking care and their support person.
- finding childcare for existing children in order to travel, attend counselling and clinic appointments, and have appropriate rest in the recovery period.
- sourcing carer support to assist with other carer roles including people with disability and elders.
- travel regionally or interstate, long drives or flights, with a support person.

- if someone cannot stay at home following the procedure, for example they need to travel, or are at risk of violence, they may need to source a hotel or stay with a family or friend during the recovery period.
- costs of other related health needs such as contraceptive devices or products, menstrual pads, wheat hot packs, plastic sheets, paracetamol and various other pain relief needs.
- psychosocial costs of a potentially challenging life choice, or the circumstances around the clinical health provision such as cost of living, housing or work instability, risk of violence and reproductive coercion.
- impact on the health and wellbeing of children and partners when a parent/spouse is experiencing traumatic loss, has trouble coping, financial stress.
- cultural or religious practices; during their time in the health system and beyond, when accessing abortion, a person may also need to participate in grief and loss rituals, including ceremony and cremation.
- potential implications for long term employment, visas status, educational rankings and other lifelong considerations.

A common thread of all these points is abortion stigma. It is why people do not often disclose their experience with their employers, education institutions, families or broader communities.

The presence of abortion stigma can lead to hesitation in seeking a support person, asking for help, booking a counselling appointment or asking for time off work – delaying access to care while the abortion service required increases in cost and clinical complexity.

3.7.3 Reproductive coercion

Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health and is a form of violence[14]. It includes:

- sabotage of another person's contraception
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy
- forcing someone into sterilisation, or preventing them from accessing their choice of vasectomy or tubal ligation; and

[14] MSI Australia (2020), Hidden Forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/

- any other behaviour that interferes with the autonomy of a person to make decisions about their sexual and reproductive health.

Reproductive coercion can be experienced by trans and non-binary people, and people of all genders. Women experience intimate partner violence at higher rates than men, including reproductive coercion. Women and pregnant people attempting to access abortion can be at higher risk of violence than the general population.[15]

Reproductive coercion can be particularly complex for First Nations women, migrant and refugee women, women with disability, sex workers and people who are incarcerated. The violence they endure may be more severe and prolonged and they often experience structural and interpersonal barriers to accessing support services.[16]

Recent research using pregnancy choices counselling data demonstrates that in Australia, 15% of people experience reproductive coercion and abuse when considering their pregnancy options.[17]

Informed consent and person-centred care are central to our service provision. We use sensitive enquiry to identify points in someone's abortion care journey where we can enquire about harm, including coercion, abuse and violence. The way that questions are phrased, asked and expanded will be responsive to the unique social, cultural and emotional needs of the person in front of us on the day.

Sensitive enquiry enables us to prevent and respond to reproductive coercion in clinical settings. It supports us to tailor personalised care for each unique person. Only when care is holistically seen as physical, mental, cultural, environmental and social can we properly embed sensitive enquiry.

For people who present with experience of coercion and violence, our administrative, counselling, nursing and clinical staff move through stages of identification, risk analysis, support, safety planning, documentation and referral.

Any future moves to criminalise reproductive coercion should be mindful of the risk of creating additional barriers for disclosure between a client and their healthcare professional. This includes disruptions to sensitive enquiry and informed consent, where clients need space to share any personal or child safety concerns. Ideally reproductive coercion would be addressed through prevention and early intervention, including relationships and sexuality education throughout the lifespan.

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[15] Hall, M., Chappell, L.C., Parnell, B.L., Seed, P.T., & Bewley, S. (2014). Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis. PLoS Medicine, 11 (1), e1001581.

[16] https://www.anrows.org.au/publication/promoting-community-led-responses-to-violence-against-immigrant-and-refugee-women-in-metropolitan-and-regional-australia-the-aspire-project-state-of-knowledge-paper/

[17] Sheeran, N., et al (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 1-10.

4. Recommendations

Legislative reforms in recent years have recognised the importance of healthcare access, bodily autonomy, and diversity within relationships and families. It is now time for WA to invest in abortion access. We suggest the following:

Recommendation 1: Strategise for sexual and reproductive health

f) Remove all references to abortion in the *WA Criminal Code Act 1913*.

g) Reform sections of the *Health (Miscellaneous Provisions) Act 1911*:

- Amend 334(2). Enable clear legal duties on health practitioners to disclose their objection and treat their patients with dignity and respect. Require health practitioners to refer, or transfer the care of, the patient to a health practitioner or service that is known to not have a conscientious objection as quickly as possible. Require health practitioners to perform, or assist in, the abortion in cases of medical emergency where an abortion is necessary to save a person's life or prevent serious harm.
- Remove 334(5)-(6) content related to gestational limits, as these should instead be addressed in WA Health clinical guidelines which can be continuously reviewed and updated alongside the evolving evidence base.
- Remove 334(7) content related to medical panels and ministerial approvals, as these should instead be addressed in WA Health clinical guidelines which can be continuously reviewed and updated alongside the evolving evidence base.
- Consider other areas of the Act that could be reviewed and harmonised including the removal of sections 334(8)-(11) which refers to minors.

h) Ensure that throughout health law and subsequent policy and regulations, that an abortion may be provided in any circumstance of informed consent, as with any other medical procedure.

i) Enable further abortion law reform to enable evidence based practice and ensure longevity of access, such law that enables various aspects of nurse led abortion care.

j) Design and resource a WA Sexual and Reproductive Health Action Plan that can link to WA Women's and Men's Health and Wellbeing Policies, including:

- Develop communities of practice on abortion access and care.
- Support the review of clinical guidelines that can renew alongside evolving models of abortion care.

- Provide incentives for health professionals to train as surgical and medical abortion care providers, such as supporting GP's in regional and remote areas to become medical abortion prescribers.
- Provide incentives for interpreters and translators to train and work in specialise areas of sexual and reproductive healthcare, particularly those from emerging language groups.
- Develop WA content within national referral services such as Healthdirect[18] to provide information, referral and advice on sexual and reproductive health services providers and health options.
- Invest in academic research partnerships that will increase evidence and share knowledge on sexual and reproductive health access in WA.

Recommendation 2: Provide universal access to sexual and reproductive healthcare

f) Fund the out of pocket costs that health consumers face state-wide. Enable free access to medical abortion, surgical abortion and contraceptive methods including Long Acting Reversible Contraception (LARC), vasectomy and tubal ligation. Ensure access for temporary visa holders.

g) Resource community designed outreach and mobile services within regional and remote Aboriginal and Torres Strait Islander communities.

h) Provide financial support for rituals related to grief and loss, including specific cultural rituals, cremation and other related costs with provision for kinship family to participate.

i) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, emergency contraception, condoms, dental dams and menstrual health products.

j) Collaborate with the Commonwealth to continue Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) reviews on sexual and reproductive health related rebates, including the Copper IUD and hormonal contraceptive ring. Consider how these funds could be better utilised in collaboration with State activity funds to maximise access and equity.

[18] Healthdirect (2022), service finder viewed on 15 December 2022 at https://www.healthdirect.gov.au/australian-health-services

Recommendation 3: Prevent reproductive coercion and violence

d) Invest in age-appropriate, culturally safe, community centred reproductive coercion prevention activities and programs, including relationships and sexuality education throughout the lifespan.

e) Embed pre-service and in-service healthcare professional training and education on abortion care, including identifying and responding to reproductive coercion. Provide training and support for family, domestic and sexual violence services to promote early intervention and prevention responses to reproductive coercion.

f) Fund academic research partnerships to increase evidence and understanding of reproductive coercion in WA.

We appreciate the WA Government's commitment to health access, and look forward to continued collaboration for sexual and reproductive health equity across metropolitan, regional and remote areas.

Further information and feedback

If you would like to know more about the work that we do at MSI Australia (formerly Marie Stopes Australia), you can follow us on social media or get in touch via the following channels.

Twitter: @MSI_Australia

Facebook: @AustraliaMSI

Instagram: MSIAustralia_

Website: msiaustralia.org.au

You can also support access to sexual and reproductive healthcare by making a tax deductible donation @ https://www.msiaustralia.org.au/donate/