Queensland Women's Health Strategy

Consultation paper response

January 2023

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.

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Contents

1. Executive Summary

MSI Australia has operated within Queensland for the past two decades, first with a face to face clinic, then expanding to telehealth, and now with a hybrid virtual care model. In this submission we have summarised some key areas of practice knowledge and demographic data, and have the following recommendations:

a) Design and resource a Queensland Sexual and Reproductive Health Strategy which includes universal access to abortion and contraception, including non-Medicare card holders. Link measurable indicators in the *National Women's Health Strategy (2020-2030)*.[1]

b) Commission a Queensland abortion access taskforce, which can develop a comprehensive plan for addressing abortion inequity in Queensland, including workforce capacity, health infrastructure and access to health information, advice and referral. Involve health consumer leaders, community groups, health leaders, GPs, specialists, social workers, mental health workers and clinical providers of surgical abortion care.

c) Health regions which do not provide abortion and contraception 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.

d) Review and upgrade all facilities that provide surgical abortion care to ensure that all people, including people with diverse health needs, people who need interpreters, people with disability and those who are in prison or institutionalised, can access quality and culturally safe abortion care. Consider how this can align with opportunities for strategic health infrastructure expansion to improve broader health outcomes for all.

e) 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 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. Even if

[1] Queensland Health (2023), Sexual Health Strategy, https://www.health.qld.gov.au/public-health/topics/sexual-health/strategy

this model was in place, Queensland Health, at a minimum, should be providing increased services for high-risk clients and the higher gestations and feticide through maternal fetal medicine specialists.

f) 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 and hospital systems.

g) Support programs, initiatives and services that can expand models of sexual and reproductive healthcare on Country, including pregnancy loss intersections of abortion care, miscarriage and stillbirth, alongside other pregnancy outcomes such as kinship care and parenting.[2]

h) 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.

i) Ensure the continuation and growth of the women's health services network through a funded peak body specific to women's health, which would have an ongoing population health benefits.[3]

j) Develop and strengthen links with Healthdirect, which has formalised agreements to provide nurse triage, women's health information, advice and support to every Australian State and Territory, other than Queensland.[4] This should complement existing service provision within Queensland, aid health consumer pathways and prevent duplication.

k) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, cervical and STI screening, condoms, dental dams and menstrual health products.

[2] 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

[3] Australian Women's Health Network (2023), Why Women's Health at https://awhn.org.au/why-womens-health/

[4] Healthdirect (2023) at https://www.healthdirect.gov.au/

l) Consider and embed recommendations from the 2021 Australian Human Rights Commission report on ensuring health and bodily integrity for intersex people.[5]

m) Enable further abortion policy reform to harmonise legislation, deregulate and progress evidence-based practice, including nurse led care and medical abortion access. [6] Work with other Australian jurisdictions on these changes, in a move towards nationwide and cross-border abortion access and equity.

n) Resource state-wide abortion and contraception 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.

o) Invest in academic research partnerships that will increase evidence and understanding of sexual and reproductive health, in order to:

- evolve current models of sexual and reproductive healthcare,
- inform future models of universal access,
- continually review clinical guidelines,
- inform pre-service and in-service clinical education and training,
- extend care provision and increase workforce capacity,
- prevent reproductive coercion,
- improve health consumer leadership, pathways and experiences, and
- contribute to sexuality education and community health literacy.

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. Academic partnerships should include plans to integrate new knowledge into enhancing clinical models of care, health finance structures, and various programs and schemes that enhance access.[7]

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[5] Australian Human Rights Commission (2022), Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics at https://humanrights.gov.au/intersex-report-2021
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

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

[7] 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*.

2. Background

The Queensland Women's Health Strategy consultation is timely. 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.

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.

The MSI Queensland clinic was established in 2011, following on from another clinical provider that operated in the same space. Since that time, the Queensland Government has been consistently supportive of our presence.

Government partnerships

The Queensland Government resources partial cost of abortion and contraception provision in select areas of Queensland. This is administered through a combination of activity and block funds. In these cases, MSI has direct contracts or agreements with 12 of the 16 health and hospital services that have opted-in to partial resourcing of abortion care. While it is promising these contracts exist, key challenges remain:

- **They rely upon MSI Australia subsidising abortion cost:** No contract or agreement covers the actual cost of abortion provision in that region, meaning that MSI Australia needs to subsidise abortion delivery costs from other service areas.
- **They are not universal:** Some contracting health and hospital services will only provide funds for Healthcare Card holders, rather than people experiencing financial hardship or other situational factors.
- **They are limited to people who can prove financial hardship:** These arrangements are for people experiencing financial hardship only, meaning that the client needs to prove that they are experiencing financial hardship by sharing details of their personal finances. Some contracts require identification of other situational factors such as experiencing family or domestic violence.
- **They are enhancing workforce skill gaps:** The funding model means that as local health and hospital services upskill, local GP and specialist clinics can take on medical abortion cases and less complex abortion procedures. They continue to refer most complex and later gestation cases to MSI Australia. Increasing public health capacity is not just about volume of services, it is

about education and training to ensure highly skilled clinicians can provide quality care to those most at risk within our communities.

- **They are inconsistent:** Agreements are under constant review and renegotiation, require extensive administration, each differ slightly, and do not exist in all health and hospital regions.

MSI Australia manages all operational aspects of service delivery. Our surgical abortion services have outgrown the current service location at Bowen Hills. Not only are facilities outdated, clinic demand is greater than clinic capacity.

Community partnerships

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.

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.

We are a member of the Women's Health Services Alliance Queensland (WHSA). Our sister services and organisations in the region include Queensland Sexual Health Society, True Relationships and Reproductive Health, Queensland Council for LGBTI Health, Children by Choice, and various Young Parents Programs.

These services have a range of reproductive choices services and programs, including relationships and sexuality education, reproductive coercion prevention, parenting support and advocacy for childcare subsidies. We support their submissions in this inquiry.

Services available

At MSI Australia we provide the following services to people in Queensland:

- 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
- Medical abortion care (in person in clinic)
- Teleabortion, or medical abortion via telehealth (at our virtual clinic)
- Surgical abortion care up to 22 weeks pregnancy 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[8]

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. In other jurisdictions we also provide tubal ligation care however our MSI Brisbane clinic would require an upgrade in order to do so.

Information on sexual and reproductive health access, equity and agency in Australia is available in the resources section of our website.[9]

This submission has been authored from the perspective of being a service provider of these particular services, therefore highlighting challenges and solutions experienced within contraceptive care and abortion care provision. We acknowledge that other aspects of the consultation, such as maternal health, also require further strategy and investment for equity.

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

3. Response to consultation

Question 1: What, if any, would be the key barriers you have experienced, or seen, for women and girls accessing health services?

Abortion cost

In Queensland the cost of 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 Queensland Clinics are publicly available at the online 'cost estimate checker'.[10]

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: Our clinics have two methods of abortion, medical abortion, which is abortion with a series of tablets; or surgical abortion, which uses either electric 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. Some women and pregnant people request joint counselling so that a partner or significant other has an opportunity to be heard. The primary client remains the woman or pregnant person.
- 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.

[10] Visit: https://www.msiaustralia.org.au/bookings/find-a-service/

Abortion provision can be 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 Queensland 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 child care 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, long drives or flights, particularly in the Torres Strait, 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
- during the COVID-19 pandemic, there have been additional psychosocial costs linked to lockdowns particularly when people needed permits to travel interstate and were required to quarantine/ receive healthcare in isolation.
- 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

The common thread of all of 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.

A lack of day hospital facilities that can provide surgical abortion access

Sexual and reproductive health service infrastructure throughout Queensland is long overdue for an upgrade in all three areas of systems, people and processes.

MSI Brisbane Clinic is a key surgical site, but services have outgrown the current Bowen Hills location. This means that clinic demand is often greater than clinic capacity, creating waitlists. The clinic requires an upgrade for:

- **Complex abortion and contraceptive care:** the current clinic cannot meet emerging standards or accreditation requirements for tubal ligation and would ideally have an upgrade to the procedure room.
- **Care for people with disability:** the current clinic is lacking appropriate lift access and other accessible design features such as appropriate clearances in the hallway and door functionality which would improve workflow. It is overdue for an upgrade to improve functionality for a range of disability needs to support disabled clients and clinic staff.
- **Care for people who are criminalised or institutionalised:** there is not the space or functionality to enable holistic care for women and pregnant people who are escorted to the clinic under state custody. Subsequently personnel, such as prison guards, share space with numerous clients, in addition to the client they are escorting. All people, including those who face incarceration, need quality and compassionate access to healthcare.
- **Care for people with specific personal or cultural needs:** there is minimal space in the clinics for prayer or ritual. Some people also choose to bury fetal remains, others choose cremation, which rely upon the client having access to funds and resources.

To address these issues, the MSI Brisbane Clinic requires an upgrade including renewed lift access, a discreet space for situations where additional client privacy is required, for example, a larger surgery room, upgraded beds and other equipment. All of these are essential to successful NSQHS Standards Accreditation including Infection prevention and control and AS 4187 compliance requirements to ensure quality and safety in care.[11]

[11] National Commission on Safety and Quality in Healthcare (2023), National Safety and Quality Health Service Standards at https://www.safetyandquality.gov.au/standards/nsqhs-standards/assessment-nsqhs-standards

Reproductive coercion

Abortion access is not an indicator of agency. Agency to choose to have abortion or contraception, depends on risk of 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[12]. 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
- 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.[13]

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.[14]
Recent research using pregnancy choices counselling data demonstrates that in Australia, 15% of people experience reproductive coercion and abuse when considering their pregnancy options.[15]

Reproductive coercion includes preventing someone from accessing their choice of contraception or abortion. A child or an additional child, to an abusive partner creates yet another link with lifelong risk and other implications. Sexual and reproductive

[12] 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/
[13] 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.
[14] 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/
[15] Sheeran, N., et al (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 1-10.

healthcare not only prevents the risk of harm; it is a point of early intervention and prevention.

Reproductive coercion extends to all pregnancy outcomes. For example, adoption requires consent from all parents on the birth certificate. In an abusive relationship, this can result in child safety services involvement or a residency or access dispute.

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.

Clinic staff have access to a national psychosocial support team that can assist with pathways. Qualified social workers and a psychologist with specialist skills in sexual and reproductive health staff this psychosocial support team. All MSI Australia clients have access to this service for counselling support, which operates without any government funding. Alongside this there are a number of private, public and non-profit providers of pregnancy counselling in Queensland.

Any 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. Ideally reproductive coercion would be addressed through prevention and early intervention, including relationships and sexuality education for all ages and genders.

Question 2: What, if any do you think are the main enablers that would support women and girls to access health services and increase equity?

Timely and low or no cost access to 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 Brisbane, Woolloongabba or Gold Coast Clinics, women's health centres, family planning clinics, select health and hospital Services and a number of local GP prescriber sites. There are currently 781 active prescribers (doctors) and 1191 dispensers (pharmacists) across the Queensland.[16]

Medical abortion via telehealth is a safe, quality and private method of abortion access.[17] In recent years client preferences in Queensland shifted and are now trending towards medical termination via telehealth.

MSI Australia's national teleabortion service is partially staffed from the MSI Queensland Clinics, servicing thousands of Queenslanders each year with online bookings, nurse and doctor consults, medication courier system and a 24 hour aftercare phone line.[18] Alongside MSI's teleabortion service, GP providers of medical abortion across Australia are increasingly offering national telehealth options as part of their everyday services.

Timely and low or no cost access to 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). Termination of pregnancy after 14 weeks gestation, is legal however is less accessible due to clinical complexity and often requires travelling to interstate clinics.

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 suction is manual or electric, depending on pregnancy gestation and other situational factors. 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.

Surgical abortion can be accessed at the MSI Brisbane Clinic, at various private providers and at select health and hospital services. Health and hospital access is more likely in specific circumstances, usually most likely if the pregnancy involves a fetal anomaly.

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[16] MS Health (2023), January Update, Melbourne, Australia: MSI Reproductive Choices at https://www.mshealth.com.au/publications/

[17] 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.

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

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 surgical abortion client's free insertion of a LARC providing they cover the device cost. At the MSI Queensland Clinics, one in twenty (5%) 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 True, from most gynaecology specialists including health and hospital services, and some GPs.

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.

We received 2 to 5 Choice Fund requests a week from people living in Queensland. 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 in a public hospital
- don’t have private health insurance or there is a waiting period on claims
- have approached friends and family for financial support but still have a fee gap
- want a healthcare procedure that 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.

Abortion service gaps are 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 cultural considerations that preclude some groups from seeking emotional support from family. In turn this can lead to poorer health outcomes due to ongoing isolation and disengagement.

Question 3: From your experiences, please indicate Queensland Health services that you believe need more support to improve health equity for women and girls.

Contraceptive care

All people in Queensland should have universal access to contraceptive choices, including long acting reversible contraception and tubal ligation.

In order to provide insight into contraception access, we have analysed a range of client data to look at key demographic information.[19]

The average age of a person accessing contraception at MSI Queensland Clinics is 31 years old. The youngest person in the past five years has been 15 years of age, and the oldest person has been 62 years of age.

Most (99%) of people who contact MSI in Queensland will access contraception without travel interstate. Of people who access contraception at MSI Queensland Clinics:

- At least 1% of people are First Nations people.
- The majority (88%) of people live in metropolitan areas, with the remaining (12%) living in regional areas.
- Of those who travel interstate to Queensland to access contraception, the majority (65%) are residents living in New South Wales.
- Unfortunately, data regarding a range of disability is only available in hardcopy clinic files. They cannot be analysed without further resources.
- One in three (31%) people are born outside of Australia.
- One in sixteen (6%) people do not have access to Medicare.
- One in thirty (3%) people prefer a language other than English.

It is particularly hard to find interpreters for abortion and contraceptive care, and near impossible for any minority or emerging language groups.

[19] This dataset references 2018 – 2021 clients at MSI clinics across Queensland, including telehealth clinics.

Abortion care

All people in Queensland should have universal access to abortion care, and the choice between medical and surgical abortion methods.

In order to provide insight into abortion access, we have analysed a range of client data to look at key demographic information.[20]

The average age of a person accessing abortion at MSI Queensland Clinics is 29 years old. The youngest person in the past five years has been 14 years of age, and the oldest person has been 52 years of age.

The majority of (99%) of people who contact MSI in Queensland will access an abortion without travelling interstate. Of those who travelled interstate from Queensland, most travelled to Victoria (47%) and New South Wales (31%). Of people who access abortion at MSI Queensland Clinics:

- At least 4% of people are First Nations people.
- The majority (75%) of people live in metropolitan areas, with the remaining (25%) living in regional areas or overseas.
- Of those who travel interstate to Queensland to access abortion, the majority (76%) are residents living in New South Wales.
- Unfortunately, data regarding a range of disability is only available in hardcopy clinic files. They cannot be analysed without further resources.
- One in three (31%) people are born outside of Australia.
- One in eleven (9%) people do not have access to Medicare.
- Over one in twenty (6%) people prefer a language other than English.

It is particularly hard to find interpreters for abortion care, and near impossible for any minority or emerging language groups.

Question 4: From your experiences, please indicate activities outside of direct health service delivery that you believe would have the largest impact on improving health services for women and girls.

We are a member of Queensland Women's Health Network. They provided opportunities for collaboration, capacity building and in the past have used their magazine as a health literacy resource in clinics. Funding for the network ended in 2022, leaving Queensland without a peak body that specialises in women's health. Local, targeted, community based, trauma informed women's health and wellbeing services most use a social determinants of health approach to provide counselling,

[20] This dataset references 2018 – 2021 clients at MSI clinics across Queensland, including telehealth clinics.

group work and community connection to enable the strengthening of health seeking behaviours. They can be publicly or privately funded, or a combination of both. Ensuring the continuation and growth of the women's health service network, and a peak body, would have an ongoing population health benefits.[21]

Ensure education policy, programs and curriculum 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.

Continue to embed pre-service and in-service professional training and education on abortion access and care, including identifying and responding to reproductive coercion, within the health system and beyond. Continue to provide training and support for family, domestic and sexual violence services to promote early intervention and response to reproductive coercion.

Question 5: Have we got the potential core driver, elements and focus areas for a Queensland women's health strategy right?

The National Women's Health Strategy commits to equitable access to sexual and reproductive health services and aims for universal access by 2030. Alongside the National Preventative Health Strategy, we have a sound national policy model to guide the Queensland Women's Health Strategy.

It would be timely to ensure this Strategy:

- Reasserts and affirms the commitment to universal access to reproductive health by 2030, as outlined in the National Women's Health Strategy.
- At the very least makes mention of the prevention of reproductive coercion and abuse as a women's health issue, linking to the National Women's Health Strategy success measure of a reduction in prevalence of reproductive coercion.
- Incorporates all determinants of health, including political, cultural and economic, extending on descriptors in the National Preventative Health Strategy.

[21] Australian Women's Health Network (2023), Why Women's Health at https://awhn.org.au/why-womens-health/

Question 6: Are there any programs and services that could be enhanced?

Legislative reforms in recent years have recognised the importance of gender equity, healthcare access, and diversity within relationships and families.

It is now time for the Queensland Government to embed programs and services within health and education systems that increase abortion access. Where possible they should be integrated within Health and hospital services. We provide the following recommendations:

a) Design and resource a Queensland Sexual and Reproductive Health Strategy which includes universal access to abortion and contraception, including non-Medicare card holders. Link measurable indicators in the *National Women's Health Strategy (2020-2030)*.[22]

b) Commission a Queensland abortion access taskforce, which can develop a comprehensive plan for addressing abortion inequity in Queensland, including workforce capacity, health infrastructure and access to health information, advice and referral. Involve health consumer leaders, community groups, health leaders, GPs, specialists, social workers, mental health workers and clinical providers of surgical abortion care.

c) Health regions which do not provide abortion and contraception 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.

d) Review and upgrade all facilities that provide surgical abortion care to ensure that all people, including people with diverse health needs, people who need interpreters, people with disability and those who are in prison or institutionalised, can access quality and culturally safe abortion care. Consider how this can align with opportunities for strategic health infrastructure expansion to improve broader health outcomes for all.

e) 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 Western Australia model straight from WA Health to service providers, or the

[22] Queensland Health (2023), Sexual Health Strategy, https://www.health.qld.gov.au/public-health/topics/sexual-health/strategy

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. Even if this model was in place, Queensland Health, at a minimum, should be providing increased services for high-risk clients and the higher gestations and feticide through maternal fetal medicine specialists.

f) 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 and hospital systems.

g) Support programs, initiatives and services that can expand models of sexual and reproductive healthcare on Country, including pregnancy loss intersections of abortion care, miscarriage and stillbirth, alongside other pregnancy outcomes such as kinship care and parenting.[23]

h) 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.

i) Ensure the continuation and growth of the women's health services network through a funded peak body specific to women's health, which would have an ongoing population health benefits.[24]

j) Develop and strengthen links with Healthdirect, which has formalised agreements to provide nurse triage, women's health information, advice and support to every Australian State and Territory, other than Queensland.[25] This should complement existing service provision within Queensland, aid health consumer pathways and prevent duplication.

[23] 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

[24] Australian Women's Health Network (2023), Why Women's Health at https://awhn.org.au/why-womens-health/

[25] Healthdirect (2023) at https://www.healthdirect.gov.au/

k) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, cervical and STI screening, condoms, dental dams and menstrual health products.

l) Consider and embed recommendations from the 2021 Australian Human Rights Commission report on ensuring health and bodily integrity for intersex people.[26]

m) Enable further abortion policy reform to harmonise legislation, deregulate and progress evidence-based practice, including nurse led care and medical abortion access.[27] Work with other Australian jurisdictions on these changes, in a move towards nationwide and cross-border abortion access and equity.

n) Resource state-wide abortion and contraception 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.

o) Invest in academic research partnerships that will increase evidence and understanding of sexual and reproductive health, in order to:

- evolve current models of sexual and reproductive healthcare,
- inform future models of universal access,
- continually review clinical guidelines,
- inform pre-service and in-service clinical education and training,
- extend care provision and increase workforce capacity,
- prevent reproductive coercion,
- improve health consumer leadership, health pathways and experiences, and
- contribute to sexuality education and community health literacy.

Research should consider quality and safe models of care that are used globally to address health inequity, such as nurse-led medical abortion and

[26] Australian Human Rights Commission (2022), Ensuring health and bodily integrity: towards a human rights approach for people born with variations in sex characteristics at https://humanrights.gov.au/intersex-report-2021
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
[27] MSI Australia (2022), Nurse led medical termination of pregnancy in Australia at https://www.msiaustralia.org.au/nurse-led-care/

manual vacuum aspiration. Academic partnerships should include plans to integrate new knowledge into enhancing clinical models of care, health finance structures, and various programs and schemes that enhance access.[28]

Question 7: What have we missed?

The Queensland Women's Health Strategy should make links between gender equity, women's health and abortion access. When left untreated, sexual and reproductive health concerns can have chronic physical, mental, and social health impacts.[29] Queensland Government investment in sexual and reproductive health will have immediate and intergenerational benefits.

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

[28] 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*.

[29] 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.

Further information and feedback

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