

## SETTING THE AGENDA

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Children by Choice submission to the  
Australian Labor Party's national gender equality consultation  
August 2017



## ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, deliver sexual and reproductive health education sessions in schools and youth centres, and offer training for GPs and other health and community professionals on unplanned pregnancy options.

We also advocate for improvements to law and policy that would increase women's access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to reproductive and sexual health.

We support around 2000 clients a year through our counselling service, ranging in age from under 14 to over 50. Our Annual Reports are available on our website at [www.childrenbychoice.org.au](http://www.childrenbychoice.org.au).

## ABOUT THIS SUBMISSION

Children by Choice welcomes the Australian Labor Party's consultation on the way forward in addressing gender inequality.

While the focus of our service delivery is sexual and reproductive health (in particular pregnancy options and access to services), we operate from a social determinants of health framework. This recognises that many underlying factors, such as housing, employment, and education contribute to health outcomes.<sup>1</sup> As part of our work supporting women experiencing unplanned pregnancy, we discuss many of these issues with our clients, and some issues – in particular, violence – have a significant impact on women's reproductive health and choices.

We believe that any measures taken to improve gender equality in Australia are positive ones and should be supported. However, the focus of the majority of our submission is on safety, and health and wellbeing.

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<sup>1</sup> See for example *Development of a New National Women's Health Policy Consultation Discussion Paper 2009* Department of Health and Ageing, Commonwealth Government Canberra p14-15.

## RECOMMENDATIONS

### Enhancing women's safety:

1. Explicit recognition of reproductive coercion as a form of violence in federal domestic violence programs and policies.
2. Introduction of a Medicare item number for domestic and family violence screening, with training for GPs around best practice screening and responding to disclosure (similar to the current measures in place around pregnancy counselling).
3. Guaranteed long term secure funding for domestic violence shelters across the country.
4. Guaranteed long term secure funding for community legal services, including women's legal services whose clients in the majority are seeking support around intimate partner violence.
5. A dedicated national helpline that runs 24 hours a day, 7 days a week, staffed by qualified nurses and counsellors, for survivors of sexual and domestic violence and their support people.
6. Any federal funds allocated to safety planning for women and children living with violence to be explicitly allowed to be used for reproductive health services, including STI screening, pregnancy testing, provision of Long Term Reversible Contraceptives or pregnancy termination.

### Reproductive health:

7. Develop and implement a comprehensive, well-funded National Strategy on Sexual and Reproductive Health, as recommended by the Public Health Association of Australia, Sexual Health and Family Planning Australia (now the Family Planning Alliance of Australia), and the Australian Reproductive Health Alliance.
8. Work to improve the uptake of long acting reversible contraceptives in Australia, including examining some of the following mechanisms to do so:
  - a. Increasing the Medicare benefit schedule for LARC insertion, particularly item 35503 for IUD insertion;
  - b. Incentivising GP referral to sexual health practitioners for the purposes of LARC consultation and provision, for example through the Practice Incentives Program (PIP);
  - c. Providing free or low cost LARCs to disadvantaged women and people with uteruses, in the form of a Centrelink payment for reproductive health services available periodically (similar to the crisis payments currently available) or by linking payments to Medicare cards for eligible patients;
  - d. Allowing trained Nurse Practitioners, nurses and midwives to access Medicare item numbers for LARC insertion; and
  - e. Including the non-hormonal IUD on the PBS as a device.

9. Legislate for transparency in advertising for pregnancy counselling services at a federal level.
10. Work with state and territory governments to introduce a national notification scheme for termination of pregnancy, where de-identified patient data is collected on every termination, to allow us to track rates and trends in order to enhance service planning and policy responsiveness.
11. Consult with the sector around the use of Medicare rebates for pregnancy termination, and the possibility of introducing a new item number either specifically for medication termination or for surgical termination of pregnancy.
12. Work with state and territory governments to support the decriminalisation of abortion in all Australian jurisdictions and to eliminate inequity of access to termination services.
13. Increase the Medicare rebates currently used for surgical pregnancy termination, specifically item numbers 35643 and 16525.
14. Work with organisations providing Emergency Relief to expand the use of ER for medical expenses, including emergency contraception or pregnancy termination.

### **Sexuality education:**

15. Ensure the Australian Curriculum for Health and Physical Education is uniformly delivered across schools regardless of jurisdiction.

### **International aid funding and gender equity:**

16. Join the international coalition of countries pledging additional funds to sexual and reproductive health programs in developing countries to fill the gap left by the reinstatement of the United States' Mexico City Policy.
17. Reinstate 2012 levels of funding for reproductive health in our Overseas Development Assistance budget.
18. Commit to a long-term funding increase in Australia's aid program which has dedicated gender equality targets and includes guaranteed designated funding for reproductive health programs in developing countries to improve the health outcomes for women and girls – including the provision of unbiased and evidence base information and services relating to contraception, pregnancy and maternity care, birthing, and pregnancy termination, according to the laws of the country in which programs are being delivered.

## EVIDENCE: ENHANCING WOMEN'S SAFETY

The ALP is of course aware of the enormous impact of violence on the lives of Australian women. This is well established and has been the subject of several state and federal inquiries: for example, the 2015 'Not Now, Not Ever' report and recommendations of the Special Taskforce headed up by Dame Quentin Bryce on domestic violence here in Queensland, and the 2016 Victorian Royal Commission into Family Violence.

While we welcome these approaches at state level – particularly the Victorian government's funded response to the Royal Commission recommendations in this year's state budget – there are also measures which can be taken and supported federally.

Given our clients' experiences of violence, the intersection between domestic and sexual violence, and the relationship between domestic violence and reproductive health, are very important issues be addressed.

National data exists to show one in three women has experienced physical violence and one in five has experienced sexual violence.<sup>2</sup>

Many sexual assaults take place within current relationships or are perpetrated by ex-partners, and yet sexual violence is often ignored in discussions around Intimate Partner Violence (IPV) or domestic violence. A state of knowledge paper by Australia's National Research Organisation for Women's Safety reports that one in six women has experienced sexual or physical violence from a current or former partner.<sup>3</sup> Our work here at Children by Choice further confirms this correlation between domestic and sexual violence, with our own service data showing that for the three years to 30 June 2017, over 8 per cent of the work of our counselling team was with women reporting both sexual and domestic violence.<sup>4</sup>

The relationship between domestic violence and poor reproductive health outcomes is well established. The World Health Organization reports that IPV may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, pregnancy complications<sup>5</sup> and gynaecological problems<sup>3</sup>. Further, IPV has been shown to impact on other factors, including lack of autonomy and hardships associated with seeking care.<sup>3</sup> Evidence shows that many women face increased risk of intimate partner abuse during pregnancy,<sup>6</sup> and unintended pregnancy and termination of pregnancy is experienced more commonly for women in abusive relationships.<sup>3,7</sup> Some studies show that unintended pregnancies

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<sup>2</sup> See the Our Watch website for an overview of Australian data around violence against women and children: <http://www.ourwatch.org.au/Understanding-Violence/Facts-and-figures>

<sup>3</sup> ML On, J Ayre, K Webster, & L Moon (2016) *Examination of the health outcomes of intimate partner violence against women: State of knowledge paper*. Alexandria: Australia's National Research Organisation for Women's Safety Limited.

<sup>4</sup> Our Annual Reports are available at our website at <https://www.childrenbychoice.org.au/aboutus/annualreports>.

<sup>5</sup> C Garcia-Moreno, A Guedes and W Knerr (2012) *Understanding and addressing violence against women: Intimate partner violence* World Health Organisation Department of Reproductive Health. Available online at [http://apps.who.int/iris/bitstream/10665/77432/1/WHO\\_RHR\\_12.36\\_eng.pdf/](http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf/).

<sup>6</sup> K Chibber et al, 'The Role of Intimate Partners in Women's Reasons for Seeking Abortion' (2014) 24(1) *Women's Health Issues* e131; Lynn Meuleners et al, 'Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence: A population based study in Western Australia, 2002-2008' (2011) 11(70) *BMC Pregnancy and Childbirth*.

<sup>7</sup> E Miller, B Jordan, R Levenson and J Silverman, 'Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy' (2010) 81 *Contraception* 457; Available online at <https://www.arhp.org/publications-and-resources/contraception-journal/june-2010>.

are up to two or three times more likely to be associated with intimate partner violence than planned pregnancies.<sup>8</sup>

Data also shows that using medical contraception to control fertility is often complicated for women in abusive relationships.<sup>9</sup>

Reproductive coercion may be one mechanism that helps to explain the known association between intimate partner violence and unintended pregnancy. Reproductive coercion refers to a range of male partner pregnancy-controlling behaviours which interfere with reproductive autonomy and deny a woman's decision-making and access to options. These behaviours can include birth control sabotage (where contraception is deliberately thrown away or tampered with), threats and use of physical violence if a woman insists on condoms or other forms of contraception, emotional blackmail coercing a woman to have sex or to fall pregnant, or to have an abortion as a sign of her love and fidelity, as well as forced sex and rape.

**RECOMMENDATION 1: Explicit recognition of reproductive coercion as a form of violence in federal domestic violence programs and policies.**

**RECOMMENDATION 2: Introduction of a Medicare item number for domestic and family violence screening, with training for GPs around best practice screening and responding to disclosure (similar to the current measures in place around pregnancy counselling).**

In some cases, multiple forms of violence are used by a woman's partner in the context of their relationship.

It is important to note that some women in violent relationships may experience coerced abortion; although there is some available evidence relating to poor mental health outcomes for women in these circumstances,<sup>10</sup> there is little data on the prevalence of coerced abortion in Australia, and what exists is largely anecdotal. However, we are currently working on a project in this area, funded by a philanthropic grant, which involves working with Queensland abortion providers to implement universal screening for violence and coercion among their patients.

Universal screening is an evidenced based practice, which increases women's safety by providing women with awareness of IPV resources, and promotes self-efficacy to uptake harm reducing behaviours<sup>8</sup>. Understanding the rationale for screening for violence and coercion and the unique position abortion care settings are in to screen is explored by Bacchus, Mezey and Bewley (2006) study:

*Pregnancy may act as an impetus to end an abusive relationship, or inform a decision to access an abortion, when a woman is concerned about the possibility of violence being witnessed or directed towards the resultant child, as well as solidifying an ongoing relationship with the perpetrator as co-parents. Women in these circumstances may be*

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<sup>8</sup> E Miller, R Decker, H McCauley, D Tancredi, R Levenson, J Waldman, P Schoenwald and J Silverman 'Pregnancy coercion, intimate partner violence and unintended pregnancy' *Contraception* 2010 Volume 81 Issue 4. Online at [http://www.contraceptionjournal.org/article/S0010-7824\(09\)00522-8/abstract](http://www.contraceptionjournal.org/article/S0010-7824(09)00522-8/abstract).

<sup>9</sup> C Williams, U Larsen, and L McCloskey, 'Intimate Partner Violence and Women's Contraceptive Use' (2008) 14 *Violence Against Women* 1382. Online at <http://vaw.sagepub.com/content/14/12/1382.abstract>.

<sup>10</sup> American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the Task Force on Mental Health and Abortion*. Washington, DC. Available online at <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>

*highly motivated to take action on a range of issues at the time of presentation for an abortion.*<sup>11</sup>

Our project has been enthusiastically welcomed by abortion providers, and we envisage that this is a program which could be rolled out across other jurisdictions in the future if additional funding and support could be found.

**RECOMMENDATION 3: Guaranteed long term secure funding for domestic violence shelters across the country.**

**RECOMMENDATION 4: Guaranteed long term secure funding for community legal services, including women's legal services whose clients in the majority are seeking support around intimate partner violence.**

**RECOMMENDATION 5: A dedicated national helpline that runs 24 hours a day, 7 days a week, staffed by qualified nurses and counsellors, for survivors of sexual and domestic violence and their support people.**

**RECOMMENDATION 6: Any federal funds allocated to safety planning for women and children living with violence to be explicitly allowed to be used for reproductive health services, including STI screening, pregnancy testing, provision of Long Term Reversible Contraceptives or pregnancy termination.**

## EVIDENCE: REPRODUCTIVE HEALTH

Reproductive and sexual health is not addressed as a whole by cohesive national policy, and is instead the subject of numerous state and federal policies and programs addressing particular aspects of this area of health - for example, some states and territories have specific STI strategies or Indigenous sexual health strategies while others do not. The approach is piecemeal and this area of health would be much better served by a national sexual and reproductive health strategy as proposed by an alliance of sector peak bodies in 2008.<sup>12</sup>

**RECOMMENDATION 7: Develop and implement a comprehensive, well-funded National Strategy on Sexual and Reproductive Health, as recommended by the Public Health Association of Australia, Sexual Health and Family Planning Australia (now the Family Planning Alliance of Australia), and the Australian Reproductive Health Alliance.**

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<sup>11</sup> B Bacchus, G Mezey, & S Bewley (2004) 'A Qualitative Exploration of the Nature of Domestic Violence in Pregnancy' *Violence Against Women*, 12(6), 588.

<sup>12</sup> O'Rourke 2008 Time for a national sexual and reproductive health strategy for Australia: Background paper Published by Public Health Association of Australia, Sexual Health and Family Planning Australia (now Family Planning Alliance of Australia), and the Australian Reproductive Health Alliance, February 2008. The call to action from this paper is available online at <http://familyplanningallianceaustralia.org.au/wp-content/uploads/2015/09/Time-for-a-national-srh-strategy-call-to-action.pdf>.

Methods of long acting reversible contraception (LARC) are now available in Australia and have much higher efficacy rates than the pill or condoms,<sup>13</sup> but rates of uptake are lower than in other developed countries:<sup>14</sup>

*Similar to other developed countries, two-thirds of Australian women of reproductive age use contraception and up to 85% of women have ever used contraception. Oral contraception use was most common (27 to 34%), followed by condom use (20 to 23%), vasectomy (8.5 to 12%) and tubal ligation (4.1 to 8.6%). Very few women used long acting reversible contraception (LARCs) with injectable contraception accounting for 0.9 to 2.1% of contraceptive use with similar proportions of use for the implant (1.1 to 3.6%) and intrauterine contraceptive methods (IUDs) (1.2 to 3.2%). Conversely, use of oral contraception and sterilisation was more common in Australia than in other developed countries, but use of IUDs was much less common.<sup>15</sup>*

High upfront costs for insertion and limited numbers of trained clinical providers may be two factors which limit the uptake of intrauterine and implant methods for Australian women. Expanding access to these methods of contraception by making them more available and affordable would greatly assist in lowering the rate of unplanned pregnancy in Australia.

**RECOMMENDATION 8: Work to improve the uptake of long acting reversible contraceptives in Australia, including examining some of the following mechanisms to do so:**

- a. Increasing the Medicare benefit schedule for LARC insertion, particularly item 35503 for IUD insertion;**
- b. Incentivising GP referral to sexual health practitioners for the purposes of LARC consultation and provision, for example through the Practice Incentives Program (PIP);**
- c. Providing free or low cost LARCs to disadvantaged women and people with uteruses, in the form of a Centrelink payment for reproductive health services available periodically (similar to the crisis payments currently available) or by linking payments to Medicare cards for eligible patients;**
- d. Allowing trained Nurse Practitioners, nurses and midwives to access Medicare item numbers for LARC insertion; and**
- e. Including the non-hormonal IUD on the PBS as a device.**

No contraception method is 100% effective. While some methods may technically be 98-99% effective, the effectiveness of methods like the pill and condoms are reduced when allowing for human error - what's referred to as 'typical use' is often lower than 'perfect use'.<sup>10</sup> Even when used correctly and consistently, contraceptive methods can fail: the World Health Organisation estimates that if every couple used contraception perfectly every single time they had sex, there would still be

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<sup>13</sup> *Contraceptive efficacy* Family Planning Queensland (True) fact sheet, July 2013. Available online at <http://www.true.org.au/Reproductive-health/Health-information/contraception>

<sup>14</sup> D Mazza, C Harrison, A Taft, B Brijnath, H Britt, M Hobbs, K Stewart, S Hussainy 'Current contraceptive management in Australian general practice: an analysis of BEACH data' *Medical Journal of Australia* 2012; 197 (2): 110-114. Available online at <https://www.mja.com.au/journal/2012/197/2/current-contraceptive-management-australian-general-practice-analysis-beach-data>.

<sup>15</sup> Family Planning NSW. *Reproductive and sexual health in Australia*. Ashfield, Sydney: FPNSW, 2013. Available online at [http://familyplanningallianceaustralia.org.au/wp-content/uploads/2015/09/rshinaust\\_book\\_webedition\\_1.pdf](http://familyplanningallianceaustralia.org.au/wp-content/uploads/2015/09/rshinaust_book_webedition_1.pdf).



six million unplanned pregnancies each year worldwide.<sup>16</sup> Abstinence is usually not a realistic contraception option for most people across their entire reproductive lifespan.

While no national data collection on pregnancy or pregnancy outcomes exists, it is estimated that almost half of all pregnancies in Australia are unplanned.<sup>11</sup> One study conducted in 2006 found that:

*Parenting was the most, and adoption the least, popular choice for resolving an unplanned pregnancy. The majority of women (56%) resolved their unplanned pregnancy by choosing to parent. The next largest group (29%) chose abortion, while just 2% chose adoption. Thirteen percent (13%) of women miscarried.<sup>17</sup>*

Individuals experience an unplanned pregnancy differently. For some, the decision to continue or terminate a pregnancy is not a difficult one, while for others it may be more demanding, or represent a crisis point in their lives. Many women and pregnant people discuss their decision with their partner or someone else close to them. Not all women want or need counselling – the 2006 study found that three quarters of women who'd experienced an unplanned pregnancy did not want to speak to a counsellor<sup>19</sup> – but for those who do, the availability of independent and unbiased counselling and information is essential.

Because many Australian pregnancy counselling services are run on a not-for-profit basis (often by faith-based groups or their affiliates) and offer services for free or by donation, they are not subject to the trade practices legislation that regulates misinformation and false advertising. According to the federal parliament website:

*A service that provides counselling or information without charge is not deemed to be engaged in a commercial transaction or an act of trade and so is exempt from operating within the confines of the Trade Practices Act 1974. Section 52 of this Act states:*

*A corporation shall not, in trade or commerce, engage in conduct that is misleading or deceptive or is likely to mislead or deceive.*

*Consequently there is no legislative basis for ensuring that free-of-charge pregnancy counselling providers both do not engage in advertising that may be perceived as deceptive or misleading or that they provide key information which may be sought by potential clients.<sup>18</sup>*

This creates an environment where services claiming to give information on abortion and respect women's choices are not compelled to reveal anti-choice bias or policy. Unfortunately this allows these organisations to provide inaccurate and sometimes intentionally-misleading information on abortion and its availability to women experiencing an unplanned or unwanted pregnancy.

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<sup>16</sup> *Safe Abortion: Technical and Policy Guidance for Health Systems* World Health Organisation, Geneva 2003 p12. Available online at [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/en/](http://www.who.int/reproductivehealth/publications/unsafe_abortion/en/).

<sup>17</sup> J Michelson 'What women want when faced with an unplanned pregnancy' *Sexual Health* 4(4) 297 - 297. Published by CSIRO, November 2007, available online at <http://www.publish.csiro.au/sh/SHv4n4Ab33>.

<sup>18</sup> *Transparent advertising and notification of pregnancy counselling services Bill 2005*: overview of the Inquiry by the Senate Community Affairs Legislation Committee is available on the federal parliament website at [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/pregnancy\\_counselling/report/c01](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pregnancy_counselling/report/c01)

Legislative requirements for truth in advertising for pregnancy counselling services would still allow those services to counsel as they choose, while at the same time protecting the rights of pregnant people to contact a service which aligns with their own values and not be subjected to distressing or misleading information about their choices.

**RECOMMENDATION 9: Legislate for transparency in advertising for pregnancy counselling services at a federal level.**

No national data collection on abortion in Australia takes place. Using Medicare to estimate numbers of terminations is problematic given that:

- The Medicare item numbers used for surgical termination of pregnancy procedures are also used in treating other gynaecological conditions;
- Public hospital procedures are not processed using Medicare (not a large problem statistically in Queensland as the state health department estimates that only around 1% of our terminations are performed in public hospitals, but a bigger issue when looking at nation-wide abortion data for Australia);
- Some patients choose not to claim the Medicare rebate available because of concerns around privacy, repercussions from violent partner/s, and/or the belief it may prejudice current or future health care providers with an opposition to abortion; and
- Medication abortion is not covered by Medicare.

Medications used for early medical termination of pregnancy are listed on the Pharmaceutical Benefits Scheme so some information about dispensed doses is available at a national level. There are however limitations with this data when looking at the state-based distribution statistics; in Queensland, for example, the data is artificially inflated because one large pharmacy group supplies prescription medicines used for medical abortion to service providers in other states, whilst processing the PBS prescriptions in Queensland.

Given these shortcomings, using Medicare data alone can be very misleading.

Because of these data limitations, national estimates are difficult to compile and must be academically calculated. This is most often done using a combination of Medicare data, public hospital morbidity data, and private health insurance claims. The most recent estimate was calculated in 2005, before medication abortion was available in Australia.

In Australia it is estimated that more than 80,000 women a year will access health care services for the purpose of pregnancy termination.<sup>19, 20</sup> It is also estimated that more than one in four Australian women will experience abortion in their lifetime.<sup>21</sup>

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<sup>19</sup> A Pratt, A Biggs, L Buckmaster *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection* Parliament of Australia Parliamentary Library, Social Policy Section. 14 February 2001, p2.

<sup>20</sup> A Chan, L Sage 'Estimating Australia's abortion rates 1985-2003' *Medical Journal of Australia* 2005; 182 (9): 447-452. Available online at <https://www.mja.com.au/journal/2005/182/9/estimating-australia-s-abortion-rates-1985-2003>.

<sup>21</sup> W Scheil, K Jolly, J Scott, B Catchside, L Sage, R Kennare *Pregnancy Outcome in South Australia 2014*. Pregnancy Outcome Unit, SA Health, Government of South Australia, Adelaide 2016 p57. Reports from the Pregnancy Outcome Unit are available to read online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>.

Without national data to draw upon, statistics from South Australia are often extrapolated to give national estimates.

Western Australia and South Australia are the only two states to routinely collect and publish data on pregnancy termination, and they both report that over 90% of pregnancy terminations in Australia occur in the first 14 weeks.<sup>22 23</sup>

**RECOMMENDATION 10: Work with state and territory governments to introduce a national notification scheme for termination of pregnancy, where de-identified patient data is collected on every termination, to allow us to track rates and trends in order to enhance service planning and policy responsiveness.**

**RECOMMENDATION 11: Consult with the sector around the use of Medicare rebates for pregnancy termination.**

Despite the prevalence of abortion in Australia, it remains the subject of criminal law in most states and territories, although in differing degrees and to differing gestational limits:

**Queensland & New South Wales:** Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.

**Australian Capital Territory:** Legal, must be provided by medical doctor. Exclusion zones may be set at the discretion of the ACT Health Minister.

**Victoria:** Legal to 24 weeks. Legal post-24 weeks with two doctors' approval. Illegal to protest within 150m of an abortion service.

**South Australia:** Legal if two doctors agree that a woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Unlawful abortion a crime.

**Tasmania:** Legal to 16 weeks. Legal post-16 weeks with two doctors' approval. Illegal to protest within 150m of an abortion service.

**Western Australia:** Legal to 20 weeks, some restrictions particularly for under 16s. Very restricted after 20 weeks.

**Northern Territory:** Legal to 14 weeks with one doctor's approval, and at 14 - 23 weeks with an additional doctor. Not legal after 23 weeks unless it is performed to save a pregnant person's life. Illegal to protest within 150m of an abortion service.<sup>24</sup>

Such a diversity of different laws creates vast inequities in access to services.

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<sup>22</sup> J Straton, K Godman, V Gee, & Q Hu (2006) *Induced abortion in Western Australia 1999-2005*. Report of the WA Abortion Notification System. Department of Health. Perth, Western Australia. Available online at [https://www.health.wa.gov.au/publications/documents/AbortionReport1999-2005FINAL\(4\).pdf](https://www.health.wa.gov.au/publications/documents/AbortionReport1999-2005FINAL(4).pdf).

<sup>23</sup> The reports of the Pregnancy Outcome Unit of SA Health, in the Government of South Australia, are available online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>.

<sup>24</sup> More details on abortion law and practice across Australian jurisdictions are available on our website: <https://www.childrenbychoice.org.au/factsandfigures/australianabortionlawandpractice>

Adding to confusion is the fact that some regulatory frameworks which impact on the provision of abortion are governed at the federal level – for example, Medicare rebates for surgical pregnancy termination services, and the licensing and distribution of abortion medications overseen by the Therapeutic Goods Administration and the Pharmaceutical Benefits Scheme.

In most states, abortion services are provided in private clinics only, so patients will pay some out-of-pocket expenses. Although there is a Medicare rebate available for surgical pregnancy termination it falls far short of covering the cost of provision of service, including meeting licensing, accreditation, quality control and nursing staff costs (and as it is also used for non-termination procedures, it provides no statistical information on termination rates). No Medicare item number is currently available for use in medication abortion consultation, provision and/or follow up.

**RECOMMENDATION 12: Work with state and territory governments to support the decriminalisation of abortion in all Australian jurisdictions and to eliminate inequity of access to termination services.**

Therefore, the majority of women accessing termination of pregnancy face significant out-of-pocket costs.<sup>25</sup>

In parts of Queensland, the cost of a termination has quadrupled since 2000, and while private clinics offer very safe and high quality services, increasing numbers of women are struggling to pay for a procedure. Costs are higher in clinics based in regional and northern areas of Queensland, and women from rural and remote town and communities often face additional costs and barriers due to travel and accommodation; only two surgical providers and a handful of medication abortion services operate north of the Sunshine Coast. A small number of GPs across the state provide medication abortion to nine weeks gestation; this has made a difference for some women but considerable barriers to access remain.<sup>26</sup>

Medication abortion in Queensland costs \$350-\$800 upfront. Surgical services have out-of-pocket upfront costs of \$400 to over \$3000, depending on location and gestation.<sup>27</sup>

**RECOMMENDATION 13: Increase the Medicare rebates currently used for surgical pregnancy termination, specifically item numbers 35643 and 16525.**

Women on low fixed incomes find meeting these costs within the short time frame increasingly difficult. Many women who are dependent on Centrelink and family assistance payments already struggle to financially provide for existing children and family members. Many are in transient housing due to domestic violence or poverty, and some already have children who have been removed from their care by state child protection agencies.

Children by Choice and some other organisations provide financial assistance for contraceptive and abortion access for disadvantaged Queenslanders, including through an accredited No Interest Loan

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<sup>25</sup> For full information on the cost of abortion in Queensland, visit our website: <http://childrenbychoice.org.au/if-youre-pregnant/im-considering-an-abortion/termination-costs-in-queensland>

<sup>26</sup> All surgical abortion providers and known medication abortion providers in Queensland are listed on our website at <https://www.childrenbychoice.org.au/forwomen/abortion/clinicsqld>.

<sup>27</sup> An overview of abortion costs in Queensland is available on our website at <https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>.

Scheme. In 2015-17 we provided over \$225,000 in assistance for contraceptive and abortion access for Queenslanders. Almost half of this went to victims of domestic and/or sexual violence who were unable to access an abortion in their public hospital.<sup>28</sup>

There is no federal support scheme of the same nature and approaches to this area of need are ad hoc and largely dependent on individual service staff or board members.

Emergency Relief (ER)<sup>29</sup> funds provided by the federal government's Department of Social Services through community organisations and non-profits around Australia are discretionary and therefore depend on the policies and positions of the organisations administering them. Few organisations make ER available for medical expenses, and many organisations with ER funding are faith-based and therefore ideologically opposed to providing financial assistance for contraceptive or abortion access.

**RECOMMENDATION 14: Work with organisations providing Emergency Relief to expand the use of ER for medical expenses, including emergency contraception or pregnancy termination.**

## SEXUALITY EDUCATION

The instances of unplanned pregnancy, STI rates, unwanted sex and sexual violence all have the capacity to be reduced through a focus on preventative measures and education.

Despite its inclusion in the national curriculum, delivery of sexuality and relationships education in Australian schools remains inconsistent and largely impacted by the attitudes of parents and teachers at individual schools.

In 2015, the Young Women's Advisory Group of the Equality Rights Alliance surveyed young women across Australia on their experiences of sexuality education. They also held three focus groups in two jurisdictions. They found that

*'While participants ... reported receiving sexuality and relationships education on similar topics, the tone, depth and perspective varied considerably. Common topics included puberty and anatomy, basic contraception, and pregnancy and childbirth, but discussions around complex issues including consent, healthy relationships and drugs and alcohol were uncommon. The age at which participants received their first class also varied from year 5 to year 9.'*

In addition, participants in all three focus groups

*'reported that they did not feel adequately informed to manage their sexual health, or their sexual relationships, after participating in sex education at school. Across the focus groups, it was clear that young peoples' experience of sex education at*

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<sup>28</sup> Details of our financial assistance program are available on our website at <https://www.childrenbychoice.org.au/aboutus/annualreports>.

<sup>29</sup> Information on the Emergency Relief program, including a directory of service providers, is available on the Department of Social Services website at <https://www.dss.gov.au/our-responsibilities/communities-and-vulnerable-people/programs-services/emergency-relief>.

*school varied considerably, and depended upon the nature of the school, the teacher as well as individual circumstances.<sup>30</sup>*

The Young Women's Advisory Group (YWAG) goes on to make recommendations around 8 core components which should be embedded in age-appropriate, evidence-based sexuality education in Australian schools: informed consent, positive and respectful relationships, a healthy and informed approach to sex, gender and sexual diversity, relationships and technology, bodies, reproductive health, and sexual health.

Sexuality and reproductive health education should be delivered uniformly across schools and jurisdictions, and include not only biological aspects but non-biological factors such as healthy relationships, consent, and negotiating sex and contraceptive use with a partner. Education in this field needs to be gender sensitive and inclusive of differences, such as children and young people who are gender diverse or considering same sex attraction. The curriculum should focus on the characteristics of respectful, safe, healthy relationships which are above religious and culturally prescriptive views on the nature of a family.

As part of our education and training program we provide sexuality education to young people – mostly in youth services or alternative education programs to those who are disengaged from mainstream schooling. We would note the stereotyping of women's reproductive roles and sexuality, and the need to address self-esteem and risk taking behaviour as well as biology, as being particularly important to address in inclusive and respectful sex education.

**RECOMMENDATION 15: Ensure the Australian Curriculum for Health and Physical Education is uniformly delivered across schools regardless of jurisdiction.**

## INTERNATIONAL AID FUNDING AND GENDER EQUITY

Earlier this year one of the first official acts of new United States president Donald Trump was to reinstate the Mexico City Policy on foreign aid, otherwise known as the 'global gag rule':

*'Foreign organizations that take US family planning money can't use any money, from any other donor, on abortion-related services. It's a restriction on how they use their other, non-US government money, and it applies to providing abortions or giving any information about abortion, including medical advice or referrals — even in countries where abortion is legal.'*

In real terms, this is expected to actually increase the worldwide abortion rate - by an estimated 2.2 million abortions globally each year, 2.1 million of which will be unsafe. Unsafe abortion is the cause of around 13% of maternal mortality rates worldwide. As Buzzfeed reported:

*'A 20-country study by the Stanford University School of Medicine, published by the WHO in 2011,<sup>31</sup> found that abortion rates actually went up 40% the last time the gag rule was in place, under President George W. Bush. In countries most heavily affected by the policy,*

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<sup>30</sup> Let's Talk, the report of the national survey of young women on sexuality education, and the companion report, A Whole Generation Out Of Date: Young People's Stories of Sex Education, are available online at <http://reports.equalityrightsalliance.org.au/ywag/lets-talk/>.

<sup>31</sup> E Bendavid, P Avila, G Miller 2011 'United States aid policy and induced abortion in sub-Saharan Africa' *Bulletin of the World Health Organization* 2011;89:873-880C. Available online at <http://www.who.int/bulletin/volumes/89/12/11-091660/en/>.

*contraceptive use dropped, and a woman's odds of having an unsafe abortion were more than two times higher after the policy went into effect.'*<sup>32</sup>

While we recognise that the Labor Party has publically opposed the reintroduction of this policy by the United States and called on the federal government to lobby for its repeal, we remain concerned that several countries including Canada, Sweden and Finland have announced reproductive health aid funding to cover the shortfall created by the reinstatement of the global gag rule, but so far Australia has declined to do the same.

We are further concerned about the low level of funding Australia dedicates to sexual and reproductive health as part of our foreign aid budget, and that recent reports state that funding for family planning in the Overseas Development Assistance (ODA) budget has been halved in just four years, from \$46m in 2012-13 to \$23m in 2015-16.<sup>33</sup>

Lack of development funding for reproductive health creates significant barriers to access for services in developing countries and places vulnerable women and girls at risk of poorer health outcomes across their lifecourse.

**RECOMMENDATION 16: Join the international coalition of countries pledging additional funds to sexual and reproductive health programs in developing countries to fill the gap left by the reinstatement of the United States' global gag rule.**

**RECOMMENDATION 17: Reinstate 2012 levels of funding for reproductive health in our Overseas Development Assistance budget.**

**RECOMMENDATION 18: Commit to a long-term funding increase in Australia's aid program which has dedicated gender equality targets and includes guaranteed designated funding for reproductive health programs in developing countries to improve the health outcomes for women and girls – including the provision of unbiased and evidence base information and services relating to contraception, pregnancy and maternity care, birthing, and pregnancy termination, according to the laws of the country in which programs are being delivered.**

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<sup>32</sup> J Moore 'Here's how Trump's anti-abortion rule will affect women worldwide' BuzzFeed News, 24 January 2017. Online at [https://www.buzzfeed.com/jinamoore/trump-just-slapped-an-anti-abortion-rule-on-foreign-aid?utm\\_term=.abBvAOdeO&bfbmain#.mvQNxdApd](https://www.buzzfeed.com/jinamoore/trump-just-slapped-an-anti-abortion-rule-on-foreign-aid?utm_term=.abBvAOdeO&bfbmain#.mvQNxdApd).

<sup>33</sup> See for example R Hirini 'Australia's foreign aid funding for family planning cut in half' SBS News, 6 July 2017. Online at <http://www.sbs.com.au/news/article/2017/07/05/australians-foreign-aid-funding-family-planning-cut-half>.