LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into abortion and reproductive choice in the ACT)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 28 OCTOBER 2022

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Secretary to the committee:
Dr A Chynoweth (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 9.30 am.

TANNAHILL, MR GREG

THE CHAIR: I declare open this public hearing, and I welcome everybody who is present today. My name is Johnathan Davis. I am the Chair of the ACT Legislative Assembly Standing Committee on Health and Community Wellbeing, and this is our first and only public hearing of our inquiry into abortion and reproductive choice in the ACT.

Before we begin, on behalf of the committee, I would like to acknowledge that we meet on the lands of the Ngunnawal people. I pay our respects to elders past, present and emerging, and the continuing culture and contribution they make to life in this city and our region.

This is a very important inquiry. The committee has received 51 submissions. Some of those submissions are from individuals who provided emotional and concerning recollections of their experiences in accessing some medical services. The committee is incredibly grateful to these people for sharing their personal experiences with us, and we trust that it will inform our work.

I would also like to indicate that it is likely that local media will be in the room today or showcasing some of the *Hansard*. If anyone has any issues or concerns with this, please see the committee secretary to indicate these concerns.

I remind everybody appearing today that their comments are on the public record and are broadcast and webstreamed live. Please feel free to speak without any reprisal or intimidation, but please also exercise caution in your comments so that individuals are not adversely affected or identified.

If anybody would like counselling or support as a result of appearing today or watching proceedings, please make yourself known to the committee secretary, who can provide you with names and contact details of appropriate support services. You are also welcome to contact the committee secretary after today for this information, if you wish.

Today the committee will hear from 13 witnesses: Mr Greg Tannahill, Ms Rylee Schuhmacher, a panel of local GPs, the ACT Council of Social Service, the ACT Right to Life Association, the Catholic Archdiocese of Canberra and Goulburn, Marie Stopes International Australia, the ACT Human Rights Commission, the ACT Minister for Health, the Australian National University's Law Reform and Social Justice Research Hub, the Women's Centre for Health Matters, Sexual Health and Family Planning ACT, and the ACT Youth Advisory Council.

On the first occasion that a witness speaks, please note for the record that you have read and understood the privilege statement provided on the pink laminated card that is on the table. Again, these proceedings will be recorded and transcribed by Hansard and published. The proceedings are also being broadcast and webstreamed live.

We will move to our first witness today, Mr Greg Tannahill. On behalf of the

committee, thank you for appearing today, Mr Tannahill, and for your written submission to the inquiry. Can I ask that you provide us with the capacity in which you appear, and acknowledge the privilege statement?

Mr Tannahill: Certainly. Good morning, Mr Davis, Dr Paterson and Mr Milligan. My name is Greg Tannahill and my pronouns are he/him. I am appearing as a private citizen. I have read and acknowledge the privilege statement. I acknowledge we are meeting on the lands of the Ngunnawal people and pay respects to elders past, present and emerging. Would the committee like me to speak or would the committee like to ask me questions?

THE CHAIR: Mr Tannahill, you are more than welcome to make an opening statement before we move to questions, so take it away.

Mr Tannahill: All right. In brief, my written submission detailed my experience in supporting a woman who chose not to be named, who I have referred to as X, in accessing a termination and dealing with some complications arising from that termination, and our experience with Calvary hospital. I would like to say again, in terms of all of the individual people that we dealt with at Calvary Hospital, it was exceptional health care. I have no complaints to make about anyone at Calvary hospital.

My feelings arising out of that are that it continues to be problematic that the ACT's public hospital is run by a religious organisation with a religious mission. If we were tendering for that service today, we probably would not make the same decision. Abortion has been legal in the ACT for 20 years. It is settled law, and I think it is a public policy problem to have our only public hospital being run by an organisation that fundamentally does not agree with that.

In talking to the woman I referred to as X prior to coming here, she had some additional notes about her experience that she has passed on to me. With the committee's permission, I would like to read them onto the record.

THE CHAIR: Please.

Mr Tannahill: This is in her voice. It is quite short. I can provide a copy of this to the committee secretary, if you would benefit from that. She said:

> It is frustrating to feel that, as a woman, when I speak on reproductive issues, people do not listen, often including doctors and treatment providers. It is problematic that the only provider of termination services in the ACT is the Marie Stopes organisation, which is a fine organisation, but exercising your rights requires having choice and options. There should be a wider range of providers.
>
> It is not acceptable that in accessing Marie Stopes, clients need to be coded in and go through security measures because of the constant safety threats to the clinic. People need to be able to access their rights openly and without fear, and the government needs to build that environment.
>
> Stigmatisation of pregnancy termination means that it is difficult to speak with

> friends, co-workers and others about a difficult, traumatic and life affecting decision process. The pressures at every level around a stigmatised and security conscious environment work together to prevent patients getting the level of care and quality that they deserve, including difficulties for those organisations in attracting and retaining staff, engaging security, social stigmas for the people who are working there et cetera.
>
> I had a bad experience and I could have had a better experience had this procedure had the same level of normalisation and support as every other medical procedure we engage with as humans. I think it is difficult for practitioners and providers to discuss with women how serious the procedure is and its real risks and benefits when we are in a stigmatised environment where we are also having to defend the right to access it in the first place.

Specifically, what she is referring to there is when she was inquiring about the procedure. In the early stages she was asked whether she wanted pain medication and pain management. She asked, "Well, how bad is it going to be?" She was told, "It's not that bad." She had very significant pain during the termination—agonising—and when she eventually sought care for that, they said, "Yes, it was always going to be very painful."

She feels that it is difficult for doctors to discuss the intensity of the procedure when they are having to say that it is an okay procedure to have in the first place, but there is a worry about warning people off something that still is in their best interests, simply because they cannot give the full information.

Those are the additional things she wanted me to share that were above and beyond what I have already put in my submission to the committee. I think that covers the points I was making. Obviously, they are in more detail in my written submission. If you would like to ask me any questions, I am happy to answer them.

THE CHAIR: Thank you, Mr Tannahill. As the chair, I will start with the first question; then we will move down the panel. Your submission largely focuses on the experience of X at the Calvary hospital.

Mr Tannahill: Yes.

THE CHAIR: In your submission, you say:

> It is operated by The Little Company of Mary, a Catholic organisation with an explicitly religious mission … it holds a religious objection to certain forms of healthcare …

Do you believe ACT ratepayers should be subsidising health care provided by a religious organisation?

Mr Tannahill: Religious organisations deliver a range of health care around Australia, and the majority of it is of a very high quality and completely unproblematic. But in this specific situation, there is a problem, yes; particularly when it is our only public hospital. If an organisation is receiving public money to provide public health care, including such things as emergency care, I do not think there should be a right to conscientious objection in that situation. If they wish to exercise that right, they can

work in private practice.

THE CHAIR: What would you say if somebody said, "A healthcare consumer has the option to go to the Canberra Hospital instead, an ACT government-run public hospital"?

Mr Tannahill: The care that we needed was emergency care. It was intense pain. We did not know the reason. An ambulance was involved. We live on the north side of town, so that naturally took us to Calvary. We did not have an option of turning the ambulance around because we wanted to go to Canberra Hospital. We needed emergency care. We were in that position; we wanted to be a public patient.

In the context of the way that the ACT legislation works, it is not an elective operative procedure; it is a fundamental right that people have in the ACT. We need to make sure that, wherever that care is being accessed, and accessed urgently, the standard of care is the same and the principles governing that care are the same.

MR MILLIGAN: Did you—did they—receive care at Calvary hospital?

Mr Tannahill: We did.

MR MILLIGAN: Was there any restriction or—

Mr Tannahill: As mentioned, the care we received was excellent. With respect to what we actually got, we have no complaints. It was in the context of knowing that the Little Company of Mary fundamentally does not support or agree with abortion, and that individual people working there may be working there for a range of reasons but may hold those same beliefs. Even if we got the best care, we may be judged, and that there may be a moral feeling around that; and that if we did get advice, that advice might not be advice as to the best health options. That advice might not be the same advice that we would get somewhere else, and we would have no way of knowing that.

It is at a higher level. The individuals that we were treated by were wonderful; we got the care that we needed. It was a much more stressful experience in accessing that care and a much more worrying experience in accessing that care than it would have been if the hospital had been in fully public hands.

MR MILLIGAN: What was that stress? What was that specifically?

Mr Tannahill: We had not done our research on a whole bunch of things before we called an ambulance. We were aware that Calvary hospital was run by the Little Company of Mary and what the beliefs of that organisation were. We were asking, on our way in, "Will they even treat us? If we say these are complications arising from a termination, will they say, 'We don't do that here, go somewhere else'"? That is not what they said and it is not what I think they would say, but it was a worry.

In terms of triaging, in terms of priority, we wondered whether we would be triaged appropriately or whether we would get a nurse saying, "She shouldn't have had a termination in the first place; she can wait behind these patients."

MR MILLIGAN: But none of that happened, though.

Mr Tannahill: I mean—

MR MILLIGAN: There was a perception that—

Mr Tannahill: Yes, it was a perception. The care that we got was good. I do not know what the individuals involved were thinking or doing, but I have no complaints to make about the care that we got or the individuals we dealt with.

MR MILLIGAN: It is just the perception; it is the worry that you might be judged, based on who runs that hospital.

Mr Tannahill: That worry was not, I think, an unrealistic worry. The worry had real-world consequences in terms of the experience that we had. It does not arise from the specific actions of the people that we dealt with. If we had been able to go to Canberra Hospital, it would have been a much less stressful experience, except for the fact that it would have taken longer to get to et cetera. Being a public hospital, we had a right to go there.

MR MILLIGAN: It sounds like the service that you received—and I know you said this in your submission—was highly professional.

Mr Tannahill: Once again, highly professional; yes.

DR PATERSON: I would like to say thank you very much for being here today to represent the woman that you are representing, and thank her very much for sharing her story. We need to hear the voices of people with lived experience. We are very grateful for her voice today. Can you speak to the level of stigma that you feel or that you are here today—

Mr Tannahill: Around the experience generally?

DR PATERSON: Yes.

Mr Tannahill: The woman I am talking about was uncomfortable to present to the committee. At the time that the submissions process opened, the committee was made up of three men. There was not a very clearly marked process for anonymous submissions, how that information would be used or the opportunity to appear in camera. There was the possibility that the hearing today would be protested outside, that it might be necessary to move through protesters to get here, or that there might be people present in the room who were aggressive in holding the other opinion. All of that is stressful in itself.

On top of that, knowing that it was a public hearing, X did not want co-workers knowing about the experience. One of the issues feeding into the decision to get a termination was worry about how it would impact mental health. There is some mental health stigma involved there as well. She did not want it to be something for co-workers to discuss. She has a difficult relationship with some members of her

family and did not want to have the conversation about having a termination with members of her family—none of their business. She did not want to be facing questions that might perhaps be hostile or might be well intentioned but provocative. She did not want to be in tears while giving evidence.

For all of those reasons, she was very hesitant to put anything in here, but also very keen for her experience to be heard and shared. I said, "I have some thoughts as well; why don't I put my thoughts and then add your words, and I will put in a submission on my behalf?"

Stigma can range from actively hostile people through to thinking, "People are forming an opinion about me; they may never share that opinion with me, but they have formed an opinion about me on something that is none of their business." The reaction by some people to "I've had a termination" is very different to "I broke a bone and I went to the hospital" or even "I had to have my gall bladder removed". It is medical treatment often made on very necessary health grounds, and it is ultimately no-one's business but that of the person having it. But that is not quite the way our society treats it. Despite having been legal in the ACT and, I think, as a matter of political reality, unlikely to change in the near future, it is treated quite differently.

DR PATERSON: What do you think we could be doing to reduce the stigma in the community and to have this issue treated as a healthcare issue, so that women can choose to talk about it or not, and not be judged?

Mr Tannahill: The submission I have already made covered some of my thoughts. As X said, a greater range of options in treatment providers would go a long way. A consistent approach across the health system would go a long way. Some of the steps already announced by the government in terms of paying for terminations and so forth are excellent steps, and steps taken under previous governments to implement protest-free zones and so forth have also been very sensible and appear to be working out very well.

While acknowledging that there is still a quite wide and honest difference of opinion in the community about this—it is not a fringe thing—at the same time it needs to be taken off the table as a debate. The matter is settled in the ACT, and it is the process of having the debate itself that makes it harder. Beyond that, I do not have ideas. That is not to say there are not other people who will have good ideas.

THE CHAIR: I have a question based on Mr Milligan's earlier questioning, particularly around accessing emergency health care at Calvary. You are aware that that hospital is run by the Little Company of Mary. You are aware of the faith-based way that that organisation operates. If you—or X, for that matter—were to access health care in a non-emergency situation where you had more freedom and choice, would choosing a healthcare provider that did not have a religious affiliation or affinity have been a deciding factor in who you chose to access health care from?

Mr Tannahill: X makes a little more money than me and has more choices, therefore. Personally, I would generally be choosing the public option, out of necessity. Having more money gives you more options. In this particular situation of a termination, I am pretty sure, speaking on behalf of X—I have not put the particular question—that X

would have chosen anywhere not religious over somewhere religious for every stage of the care.

One of the most important things was knowing that everyone she interacted with was going to treat it as a perfectly okay option, alongside all of the other options that might include no termination, and give her the best advice on what her options were, what the impacts of those options would be and what she might experience in accessing them. She wanted good information that she could rely on, and that required talking to people with, as far as possible, a neutral outlook.

Even in that, it would have been nicer to have more people with a neutral outlook, even in talking to Marie Stopes, which is a fine organisation, but a fine organisation dedicated to the provision of a particular service. To some extent, that is not the place she would have wanted to get her first information from. It would have been an additional source, in amongst being able to go to a GP and have a frank conversation with a GP, knowing everything was on the table, in addition to being able to go, perhaps, to SHFPACT and have a conversation there, and know that she was aware of what all the options are, what it would be like to take those options and what the consequences could be. Anywhere that was not a religious organisation would have been the first port of call.

THE CHAIR: In a utopian world where money does not matter—and, of course, it does, but let us pretend for a moment that it does not—as someone that lives on the north side and your public hospital is operated by the Little Company of Mary, what would perfect emergency health care in the situation that you have described in your submission look like?

Mr Tannahill: "Utopian" is a big question, but it certainly would look like exactly the same as you would get anywhere else in the ACT. You would not have to pick and choose where you are getting your emergency care. You would not have a preferred emergency care provider because you know that you are getting the highest possible standard of care wherever you go. You are getting the highest possible standard of care and you are getting the same approach to it. Your doctors are on the same page, and the advice you get from one doctor will be the advice you get from another doctor because it is the best and correct advice.

As mentioned, some years back there was an attempt to buy out the Calvary hospital; events intervened and that did not happen. I think that would have been a wonderful outcome for the ACT to be full owners of that organisation, bought out on reasonable terms. It does not look like that will happen any time in the near future. Certainly, the establishment of the University of Canberra Public Hospital has gone some way to mitigating some of the effects there, but in this particular situation that has not been the solution so far. In a utopian world, I would love to see it in government hands. That is my answer.

THE CHAIR: Not to put too fine a point on it, if the Little Company of Mary were to approach the ACT government with an offer to purchase the Calvary hospital—

Mr Tannahill: Absolutely not, no. I would be very surprised, if a tender was being run today to run a public hospital in the ACT, if the Little Company of Mary would

get a look in. They would be invited to submit a tender, I hope, and put in a good offer; at the end of the day, I think that their religious mission is incompatible with the way that we would do that today.

THE CHAIR: I think I framed that incorrectly. Should the Little Company of Mary make an offer to the ACT government to purchase Calvary, would you be in support of that?

Mr Tannahill: To sell, yes. The budget is not infinite, but I would very much like to see that happen.

DR PATERSON: There is the issue of support for women who have had a termination, and you mentioned in the submission mental health issues and the weight of the decision to have a termination. What are your thoughts, particularly on women who are going through this on their own? What supports should we have in the community in that situation?

Mr Tannahill: At a large scale, I do not think it is a secret that there could be a lot more funding for mental health throughout the ACT. There are blockages in terms of practitioners, funding and a range of other things. Again, in an ideal world, everyone who has had a termination would have a right to some free counselling following that, and it should be something which exists independently of their employer assistance program or anything else. I think it is very valuable, even for people who are feeling fine, to be able to go along to a counsellor and talk through that experience. Everyone should see a psych once a year, at the very least, to check in. The reality of whether that could be provided is difficult, but I would always say: please put more funding into mental health. I think that is my answer to that.

DR PATERSON: One of the submissions—and it is in line with what you have been saying—suggests a recommendation to insert a requirement into the Health Act for conscientious objectors to provide a referral to an equivalent service. Do you have any thoughts on that?

Mr Tannahill: I saw that Fiona Patten has put in a bill to the Victorian parliament recently to that effect. I do not comment about whether the specific provisions of the bill achieve the intended effect, but I support the principle. I think it is important, in organisations that are being publicly funded to provide an essential public health service, that those conscientious objection provisions do not necessarily apply. They are being funded to provide a service and, if they cannot provide the service to the same standard as a non-religious organisation, they should not be funded. Again, I am casting no aspersions on particular people; it is about the organisational level.

THE CHAIR: Thank you, Mr Tannahill. On behalf of the committee, we very much appreciate your appearance today.

Mr Tannahill: Thank you for your inquiry.

THE CHAIR: When available, a proof transcript will be forwarded to you, to provide an opportunity to check the transcript and identify any transcription errors. If you undertook to provide any further information or if you think of something after having

further conversations, particularly with X, feel free to provide those to the committee secretary in the coming days—ideally within the next week, to be included in the committee's report. Otherwise, thank you so much for appearing today.

Mr Tannahill: Thank you.

Short suspension.

SCHUHMACHER, MS RYLEE

THE CHAIR: Our next witness appearing today is Ms Rylee Schuhmacher. On behalf of the committee, I thank you for appearing today and for your written submission to our inquiry. I remind you of the protections and obligations that are afforded by parliamentary privilege when appearing today, and draw your attention to the privilege statement on the pink laminated card that is on the table.

I remind all witnesses today to feel free to speak without any fear of reprisal or intimidation; also, please exercise caution in your comments so that individuals are not adversely identified or impacted. Of course, please make yourself known to the committee secretary after today, if there is any additional support that the Assembly can provide to you, having made your submission to today's inquiry.

Ms Schuhmacher, would you mind stating the capacity in which you appear and acknowledge the privilege statement?

Ms Schuhmacher: I am appearing in my capacity as an individual Canberran, and I have read and understood the privilege statement.

THE CHAIR: Would you like to provide a brief opening statement?

Ms Schuhmacher: Yes. I would like to thank the committee for inviting me to give evidence. I am honoured and really flattered to have been invited to give evidence. I have seen the witness list and some of the other submissions, and I know there are a lot of people on it who are doing a lot of really important work and have really important stories to tell in the space of reproductive care, reproductive choice and sexual health. My experience, which has only been as an individual, has been, fortunately, relatively limited. I am honoured to be here.

I would also like to thank Dr Cristy Clark at the University of Canberra. She convened a unit on human rights law over the winter term this year, in which students engaged in a mock inquiry, much like this one. Undertaking that unit was critical to giving me the skills and confidence to both prepare a written submission and appear before you today.

I will tell you a little bit about myself. I am an international student at the University of Canberra. I have called Canberra home for 4½ years, on a handful of temporary visas. What started off as a four-month exchange turned into four years because I fell in love with Canberra.

I am originally from Canada. In Canada, I spent a period of time working as a peer outreach worker at the Battleford sexual health centre, which was a really great job. I spent a lot of time educating other young people on sexual health, reproductive choice and the importance of safe sex.

That being said, by having that experience and knowledge in a professional context, it did not stop me making some decisions in my personal life several years later that were very "do as I say and not as I do", and I do not think that the 17-year-old me

would be terribly proud of this. It was the aftermath of those bad decisions that formed the basis for this submission.

On 15 February 2020, only a few weeks after starting university again, I had unprotected sex with someone on a night out. It was somebody I had previously been sexually intimate with. I had just started using a new form of birth control, the contraceptive ring, a few months prior. I was incredibly intoxicated and I wound up leaving the contraceptive ring on his bedside table. I then realised, the next morning, hungover, and thought, "Oh God."

A series of mistakes were made and all of them added up to a weeks-long pregnancy scare. I knew pretty much immediately that I was not interested in keeping that pregnancy if it happened to be the case. I was not in a place mentally, physically or financially to bring a child into this world. I did not want the degree I had just started and spent a huge amount of money on to be derailed by a pregnancy. The man I had unprotected sex with was not someone I particularly liked or trusted. With a lot of therapy in the following year, I would come to understand that our relationship dynamic was one that was emotionally abusive towards me.

In between taking pregnancy tests and monitoring for symptoms of pregnancy, I spent a significant amount of my first month back at university researching my options for accessing an abortion and how much it would cost. The information I found, as I outlined in my submission, was often confusing and contradictory. Ultimately, it all added up to the same conclusion—that my access to abortion was likely to be dependent on my ability to pay a large sum of money out of pocket for the procedure, which was not something I was in a place to afford.

Regardless of my immigration status, I do not think the punishment for a regrettable sexual decision on a night out should ever be having to pay either thousands of dollars for abortion care or being forced to carry a pregnancy to term, which I did not want.

I have always been ardently pro-choice, and I knew very quickly that I would personally be choosing an abortion. That being said, if I had determined that I wanted to keep my pregnancy, I would have run into many of the same difficulties, if not more.

Finally, three weeks after it was meant to, my period arrived. It was the first time I have ever felt joy in having a period.

I know that my experience as an international student is not unique. I am not appearing in a capacity representing them, but while working in student services at the University of Canberra I have helped multiple international students to put their studies on hold due to a pregnancy so that they can go back to their home countries and access reproductive care because they do not know how to navigate our healthcare system.

As more international students and more temporary workers move back into our territory following the pandemic, the issues of reproductive care and access to reproductive choice for those Canberrans will only become more important to be addressed.

I am aware that, ultimately, a lot of the issues I highlighted in my written submission are for the federal government to address, as the regulators of OSHC and OVHC—overseas student health cover and overseas visitor health cover. If this were a federal government hearing, I would also implore the consideration of better regulation of overseas visitor health cover, which is the equivalent insurance for temporary workers. It is much more expensive for much less care compared to OSHC. Hopefully, with the budget earlier this week having a focus on attracting new Australians, it is safe for the federal government to address these issues.

In terms of what the ACT government can address, I would recommend addressing and filling gaps left by the current federal regime by way of information and by way of funding. I would also like to draw attention to the submission by MSI Australia. In particular, they noted similar issues to me in terms of some of the gaps with OSHC, particularly the 12-month waiting period.

They also noted the existence of a reproductive choice fund for those who are experiencing financial hardship, and noted that a large number of people accessing the fund are those on temporary visas. To me that drew two conclusions. First, it was confirmation that my experience was not unique; and, second, regret that I did not know the option existed when I was going through my pregnancy scare, along with uncertainty as to whether I would have been eligible—hard-up enough to meet what they described as stringent financial hardship requirements.

I would like the ACT government to make abortion free for all Canberrans, rendering the use of an access fund less important than it currently is. It ties in to my recommendations around having access to funding to fill gaps that are left by state or federal policies at this point. I also think that, even with free abortion, considering how isolated a lot of immigrants and those residing temporarily can be, having access to post-abortion care and support is of really special importance to that demographic, and something that could be addressed by financial support.

I also want to expand on something that I briefly mentioned in my submission, which was asking the government to consider subsidising the provision of contraceptives, particularly long-acting reversible contraceptives—LARCs—outside the context of abortion care, which is something that I believe the ACT government is currently committed to doing. They are relatively cheap through Medicare; you can get them on the PBS. The PBS rate is $40 or so. But if you are not eligible for that, there is a pretty significant up-front cost, although it is cheaper over time than using an oral pill, for example.

I do not believe any territory or state-level governments have looked into providing them for free to residents, anywhere that I can think of. There is promising evidence from this level of government internationally, as well as school and health districts in the United States who offer it to high school students as an option, and where it does a lot to prevent unplanned pregnancy. Access to abortion is critically important, but I also share the belief that abortion should be safe, legal and rare, and that includes making reliable methods of birth control and information about birth control accessible to everyone.

That is the conclusion of my opening statement. I welcome any questions from the committee.

THE CHAIR: Thank you, Ms Schuhmacher. I am sure I speak for everybody on the committee when I thank you so much for being so frank in your opening statement. It certainly helps the committee in our deliberations to have a really honest conversation. I was alarmed by one thing that you said in your opening statement, and I would appreciate some elaboration, about other international students that you had met or worked with at the University of Canberra who needed to go to their home country in order to access reproductive health care. First of all, how regularly did that happen? Second of all, do you believe that the ACT government's decision to subsidise the cost of reproductive health care and abortion now will lower or eliminate that happening in the future?

Ms Schuhmacher: Again I do not speak on behalf of the University of Canberra to any extent. I worked as a student services officer for the last year, at the start of both semesters. I could not speak about how long it was happening to everyone, but I would have probably two to four people come up every semester with that issue of needing to go on an intermission to go home or go on an intermission to otherwise access reproductive care. They were all casual conversations. I would not be able to provide hard data on that.

I do think that subsidising the cost is a significant part of it. It is also about subsidising the cost or having the option for those who want to give birth and want to stay in Australia as well. My mum was a teen mum and went through high school while pregnant with me. Certainly, if you are willing to do it, you can go through your studies while nursing a baby. I think that is not something people are aware of as an option or as an option that they can afford. Subsidising is a part of it, but there is also education on the healthcare system and how they can best access the reproductive care that they need, whether that is pregnancy care or an abortion.

THE CHAIR: On the information sharing, obviously, it is a relatively new announcement from the ACT government that they will cover the cost of abortions. Do you believe that that is well promoted and well understood by the student population at UC and throughout your social circles? Do you believe your peers would know that they could access that fund if they needed it?

Ms Schuhmacher: The fund in terms of the ACT government covering legal abortions free?

THE CHAIR: Yes.

Ms Schuhmacher: I do not know that my social circle is terribly representative of the general Canberra population, but I would say that there is a decent amount of awareness of it. Again, looking at the international student demographic, of which I am a bit of an outlier, being from a predominantly English-speaking country and a country very familiar to Australia, I would worry that there is some degree of a knowledge gap there. It could be better promoted to international students and to people who are not native Canberrans and/or from a relatively similar county.

THE CHAIR: Quite practically, how do you think the ACT government could ensure that international students in particular, but the student population more broadly, had access to that information?

Ms Schuhmacher: I think there are certainly ways. Off the top of my head, the university does a lot to communicate with international students. So maybe tying into those organisations. There is a support organisation for international students at UC and an international students society, so it could tie into those organisations and get them to spread the word. I think having information about it available in different languages is also something that is really helpful. As someone who speaks mostly English, and very little French, it is not something that is terribly applicable to me, but it is something that I think would be helpful for a lot of other students. I think it is about linking in with communities and consulting with communities themselves on that. Again, I am not representative of most international students in Canberra.

THE CHAIR: Thank you so much.

DR PATERSON: I would like to say thank you so much for being really brave today and telling your story. I really admire you. I was wondering if you could speak to the experience of being a student here, without family members around you or friends to support you. A lot of students may be in that situation. What sorts of services or supports do you think could be offered through universities more broadly that are not already?

Ms Schuhmacher: That is a really good question. Something that comes to mind for me, not in the realm of abortion, is that I have to get dental surgery later this year and I do not have family in Australia. So I very much have to try and schedule it for a time when one of my friends—I have really, really great friends in this country now, bless their souls—is free to pick me up from the dentist and to take care of me for a few days while I recover from that.

A surgical abortion procedure has relatively low downtime but is something that still requires after care and requires, I think, support. I have been the support person for people accessing abortion who did not want to tell their parents back home, and that is something a lot of international students do lack. I was speaking with someone who used to work as a doula, talking about the support they give to new mothers. I know there are things like abortion doulas as well that provide and care and that post-abortion support for people. I think it would be really something for the ACT government to kind of explore.

It is not something I am incredibly familiar with, but I think also counselling services could be supported. I listened to the end of the submission previously, where it talked about counselling services. The University of Canberra has a counselling service. I understand that the ANU also does. They are not the best resourced at times in terms of waiting periods. There is very high demand. Counsellors are really great and try their best, but there is really high demand, so maybe giving them a degree of priority counselling or some access to counselling outside of that, whether that is through the university or through some other organisation.

DR PATERSON: Thank you very much.

MR MILLIGAN: You have already spoken briefly on what information is available from our ACT healthcare system. Can you elaborate a little more on that? What should the government be working towards to provide this information for international students, and is that information available in the different languages required for the students that are here?

Ms Schuhmacher: I think translation, as I was talking to Johnathan about, is particularly important. I know I cited a couple of examples. I cannot remember exactly what it is called, but the New South Wales government page for international students accessing health care is worth looking at. It is a really good example of information that is laid out in a way that is very clear and in plain English, and translated into multiple languages.

It answers a lot of questions that you or I might think are a bit silly, but if you are an international student in Australia for the first time you might not know at what stage do you go to the emergency room? At what stage do you go to a doctor? Where do you go to access what care? You might inherently know if you have grown up in Australia, but you might not know that if you are coming from a country with a healthcare system that does not look like ours. In particular, when looking at like social stigma around abortion in other countries, having that information spelled out is really, really important.

THE CHAIR: I want to pick up on the last point that you made in your opening submission, where you said your view is that abortion should be safe, legal and rare. I want to focus on the rare point, because I think you have touched really nicely on access to birth control. Do you believe that the ACT government and the community organisations the ACT government funds provide access to birth control at an adequate rate in Canberra? Would you know where to get it free or subsidised, for example?

Ms Schuhmacher: I would not have a clue. No, I would not have a clue. Actually, that does bring to mind something: potentially you could look at doing that at a walk-in centre. They do prescriptions for other things. I know that in Canada they have moved towards allowing pharmacists to prescribe the pill. If you have gone to the pharmacist with a prescription from your doctor, you can get them to re-prescribe. I think those are also options to explore, but I would have not a clue as to where to get birth control at a free or subsidised level. I have always paid out of pocket for it, even when not necessarily able to afford it.

THE CHAIR: I will ask a very ignorant question that I should know but do not. In terms of the healthcare provision on the University of Canberra campus, as a student at UC are there healthcare providers on campus?

Ms Schuhmacher: Yes.

THE CHAIR: And do they provide reproductive choice information, birth control et cetera, that you are aware of?

Ms Schuhmacher: The actual birth control would be free, particularly to international

students. I think it is UC Medical and Counselling and the national health club. Probably because they operate at ANU, they are the two providers I know of who direct bill to Overseas Student Health Cover, which means you do not pay anything out of pocket whatsoever to see a doctor at either of those two organisations. I think both of them do a pretty good job of providing information about sexual health and about reproductive choice and birth control.

THE CHAIR: Given your previous professional experience, I am going to ask a question you have probably heard before that sounds spicy and does not reflect my politics, but I trust you will know how to answer it. What would you say to someone who says, "Well, condoms are readily available. You can get a condom almost anywhere; therefore birth control is accessible"? What would you say to the critics who say that that is free and equitable access to birth control, when you talk about other options?

Ms Schuhmacher: There are a huge range of things on that. I think everyone knows someone or most likely has had an experience where they have gone to have sex with them and he has said, "Well, it feels funny on my dick," to put it very bluntly.

THE CHAIR: I appreciate you being frank.

Ms Schuhmacher: Everyone has been subject to that degree of pressure, as a woman. It is not something that people always know how to react to. I worked in sexual health for years. I am generally the type of person who insists that the partner has a condom. I am generally the type of person who insists on carrying condoms for my own safety. That did not mean that I made the right decision while I was several drinks in. I do not think the punishment for making the wrong decision, several drinks in at Mooseheads, should be having to spend thousands of dollars on an abortion.

I think condoms are a good method. They are also the only method that prevents sexually transmitted infections, but they are not the be-all and end-all. Nor are they as effective as other methods of birth control. There is always going to be the failure of improper use, and there is always going to be the guy thinking that his dick is too big to wear a condom.

THE CHAIR: I am not usually speechless, Ms Schuhmacher. Thank you very much for a *Hansard* first.

Ms Schuhmacher: I didn't think about that!

THE CHAIR: Not to put too fine a point on it—yes, Dr Paterson, that joke was on purpose—do you believe, then, that the state has a responsibility to provide free and equitable access to all forms of birth control, based on the consumer's choice?

Ms Schuhmacher: I think it is something that certainly needs to be looked into. I think there should be increased equitable access to all forms of birth control, for sure. I would not say you should be looking to grab birth control pills in the same way you can grab a pack of condoms from a bowl in the health centre. But I think it is something that needs to be looked at in terms of ensuring people have full reproductive choice. I also think, going back to what I said, condoms are a form of

birth control. It is dependent on the male partner or the penis-having partner, who is not the person who is going to have the pregnancy, using it correctly, not stealthing you and not pressuring you into not using it, whereas birth control is something that puts that choice back into the hands of the person who is going to have to bear the pregnancy.

THE CHAIR: Thank you very much.

DR PATERSON: In terms of your experience as a student, working in student services and engaging with other international students from many different countries, are there any specific issues that have come up, to your knowledge, either religious or culturally based issues or limitations to people accessing abortion or reproductive health care in the ACT that potentially the government could work to address?

Ms Schuhmacher: That is definitely not something I would claim to be an expert on. Again, I am aware that I am white, from Canada and speak English as a first language, so I am not representative of the international student demographic as a whole. That being said, I am from a province back home in Canada that is very culturally pro-life and that was something I had to work through. Again, I would advise consulting with people that have lived experience in that field.

I know I had to work through my own shame associated with abortion as a teenager, and I think that is something to note if you are coming to Australia for the first time, and coming to Canberra for the first time, too. In terms of social issues, Canberra is an incredibly progressive state. That was something that, coming from somewhere like Saskatchewan in Canada, felt very freeing to me and felt very nice. It was a huge adjustment even being from Canada, which is incredibly, incredibly pro-choice as a country. I think there is definitely a lot to work through, but I cannot speak to much more than my personal experience there.

DR PATERSON: Thank you.

THE CHAIR: Is there anything more that you think the committee needs to deliberate on or the ACT government needs to deliberate on in terms of providing access to not just birth control but information in the broader community? You have the unique perspective of somebody who seems to culturally align with the Canberrans, but you are able to contrast and compare the ACT to back home. You have spoken a little bit about back home, but what was the most obvious and missing thing in how we talk about sexual health and reproductive choice in Canberra, as someone relatively new here?

Ms Shuhmacher: I think mostly just information on access, which is, again, something I talked a lot about in my written submission. Culturally, we talk a lot about not just sexual health but LGBT identities and women's rights and racial justice—stuff like that. But I think when it comes down to actual day-to-day information on those things or how to access support for those things, that is not always the most clear. I do not know if that makes sense, but it is kind of a case of: "Yes, we are pro-choice; we are funding free abortions and everyone has the right to get an abortion," but if you go to the website there is one page and the information is not super clear.

We had the highest yes vote in the country. We have the gay crosswalks, for example. But if you have experienced LGBTQ discrimination, do you know immediately where to turn or is there information available on immediately where to turn? I would not immediately know, as a queer woman. The gaps are mostly in the actual logistics of accessing the things that the ACT government sometimes espouses as values or that Canberra sometimes espouses as progressive social values, if that makes sense.

THE CHAIR: That makes perfect sense. In terms of that barrier to accessing information, is the barrier logistical? Is it that great Canberra problem where all the information is in a two-kilometre radius of this building or it is that it is not accessible on digital platforms, or it is but it is just not on the digital platforms that young people are using?

Ms Schuhmacher: I think it is a bit of all three and definitely within a two-kilometre radius of this building. You can now get tested for chlamydia and gonorrhoea at the walk-in centres, which is a really great initiative, but I remember someone saying, "But you can go to Sexual Health and Family Planning ACT and get tested for free if you meet these demographics or you can go to the Sexual Health Centre and get tested for free." For one, you have to get there, which, if you are living in the suburbs, is not always easy to do. Secondly, you have to know that that is available and meet those demographics.

So I think part of it is logistics, like you said; I think some of it is just the quality of the information on where to access it. Taking, for example, the abortion page, if you want to access a medication abortion—I think there is a written submission focused on this as well from someone else; I cannot remember exactly who—there is no public list of who provides medication abortions. You can call Sexual Health and Family Planning ACT and they, I believe, can refer you to a provider who can, but that is still an extra step if you are wanting to access a medication abortion, rather than being able to google it and find someone who is offering that service

THE CHAIR: To be specific, because it helps the committee in making recommendations to government, would you recommend that the government then stand up, monitor and update a list of providers?

Ms Schuhmacher: I think either the government should do that or another organisation should do that but with ACT government support. There might be community organisations better placed to do that. Either way, it should be something that is public facing and not something that you have to make a phone call for or jump through hoops to obtain. Similarly, with abortion care itself, it is, I think, listed that you can go to Marie Stopes or to Queanbeyan—I have got a blank on the name of the provider—for a surgical abortion. That is listed, but, again, I think it is mostly about having that information.

Another thing about information is costs. I noted in my submission that Marie Stopes do not list the cost of an abortion for someone who is not on Medicare on their website. You can call them; they have a hotline and they will tell you. They will price everything out for you over the phone, but it is not public-facing information, which gives you another hoop to jump through while you are managing studies, while you

are managing the fact that you are pregnant—all those things. Again, it is the same with the costs for reproductive care, if you are choosing to give birth.

THE CHAIR: That makes sense. Thank you very much.

DR PATERSON: My question is with respect to stigma. I really admire your leadership in speaking here today. Can you speak to the thought processes that you went through to come and speak here and how, as a community, we may support more women to feel comfortable to talk about this issue, if they choose to or not?

Ms Schuhmacher: Yes. I do not want to, again, deflect by saying that I am not a good demographic representation. I don't know, man. I was born without some degree of shame that I think a lot of people have built in. I never had that quite socially drilled into me, growing up. I watched some of the hearings into period product access, prior to coming here, just to get a feel for what an actual committee hearing would be like. I think it was really, really nice and inspiring. I think the first one I watched was the one from the CFMEU, where she spoke very openly about having to carry a pad in her pocket. I thought that was something that was really brave and really good to share.

I know I have also gotten up here and been like: "Hey, I left my contraceptive ring on someone's bedside table." I think it is mostly about giving people space where they are not going to be judged for it and also just having those conversations openly in your daily life. I somehow never had the shame around sexual health drilled into me as a kid, which meant that I was always the sexual health friend. Any time my friends got a boyfriend in high school, I was like: "Hey, so are you going on the pill? Do you have access to condoms? How far have you gone? I thought you would be aware that you could get an STI or you could get pregnant from that. Please be careful. The pull-out method is not that effective."

I was always that kid and I think that was something a lot of people reacted to a little bit strangely, but I think the more you are having those conversations in your day-to-day life—and not just in your day-to day life but publicly—is important. I note that Tara Cheyne speaking up in the Assembly about having chlamydia was really inspiring to me. I think that sets the precedent that I can come here and talk about condom use in the same way. But having those conversations and just normalising those conversations is the biggest thing that I have found reduces stigma.

DR PATERSON: Do you think education plays a role in that? You do sound like a very informed friend and a good friend to have, and you have an impressive knowledge of sexual and reproductive health. Do you think we need more education in schools or through the community to improve that?

Ms Schuhmacher: Yes. I think that is definitely a part of it. Now that I am thinking about it, I think a large part of it is generational. I know I am technically a mature-aged student at 24, so I am meeting people who are 18 and 19 who have so much less shame in talking about their sex lives and talking about their sexual choices compared to my generation even, which is weird because it is only a few years.

I think that is the proliferation of the internet. I very much went down a rabbit hole of

watching sex ed videos as a teenager and became very knowledgeable on that subject. I think education is a part of it, but I think also just generally reducing the shame around talking about the subjects. I think education is a huge thing. I did not feel that having to tell people to go on the pill if they were having unprotected sex or to use a condom if they did not know someone's sexual history and did not trust them was revolutionary knowledge. It is knowledge that I clearly do not put into practice in my everyday life, but I did not think that was groundbreaking knowledge. But to a lot of my friends it always was. It was something that they did not think applied to them. I think a lot of people think it does not happen to you, which is not great. So I think education is a big part of that.

My education in terms of schooling was very strange, in the sense that I went from a public school, where it was talked about quite openly, to a Catholic school, where I had Catholic sex ed, which involved, basically: "Condoms don't work. You will get pregnant. You will get AIDS and you will die immediately from AIDS." We watched a video from the eighties of HIV patients dying, which was not great. It was a very weird 180, I think, in terms of education. I would think having the knowledge and speaking about it openly and giving people accurate information is certainly the better approach. I think education is important. Sorry; I am rambling on.

DR PATERSON: Perfect. Thank you.

THE CHAIR: No rambling at all. Ms Schuhmacher, we thank you very much for your appearance at today's hearing. A copy of the proof transcript will be sent to you in a couple of days, which you can read and clarify whether there were any omissions or errors in taking your evidence today. I personally, and on behalf of the committee—and the Hansard staff that probably have just won a bet—very much thank you for your appearance at today's hearing and for your submission. I trust and hope that this will not be the last time the Assembly hears from you and your expertise. So thank you very much.

Ms Schuhmacher: Thank you guys so much for hearing me.

DORRINGTON, DR MELANIE, General Practitioner and member, Deep End GPs
ROBERTSON, DR TANYA, General Practitioner and member, Deep End GPs

THE CHAIR: Good morning, Dr Dorrington and Dr Robertson. Thank you so much for appearing today and for your written submissions to our inquiry. I remind you of the protections and obligations that are afforded by parliamentary privilege and draw your attention to the privilege statement on the table. Before we begin, would you both be willing to state the capacity in which you appear and acknowledge that you have read and understood that privilege statement?

Dr Dorrington: I am here representing myself, as a community member and GP, and also as a member of the Deep End GPs of Canberra. I have read the privilege statement.

THE CHAIR: Thank you.

Dr Robertson: Good morning. I am a local GP. I am here representing myself and also the Deep End GP group, which Melanie and I are both members of.

THE CHAIR: Tremendous. Thank you both so much. Would you like to begin with a brief opening statement?

Dr Dorrington: Thank you.

THE CHAIR: Please. Thank you so much.

Dr Dorrington: Good morning, honourable members and others. Before I begin, I would like to acknowledge the traditional owners of the land on which we meet today, the Ngunnawal and Ngambri peoples. I apologise if I pronounced that incorrectly. I pay my respects to their elders past, present and emerging, as well as to any Aboriginal or Torres Strait Islander peoples here today.

I want to acknowledge that our First Nations peoples have additional barriers and face additional issues in relation to reproductive autonomy, from the impact of intergenerational trauma of stolen generations, institutional child abuse, rape of First Nations women, forced sterilisation and experimental contraception compounding barriers faced by others in the community such as cost, access and stigma.

Thank you for the invitation to attend the hearing today. As I said before, I am here as a local GP and also an MS-2 Step, or early medical abortion prescriber, with Ms Tanya Robertson, who is a fellow local GP who works with vulnerable youth. We are both members of the Canberra Deep End GPs, who are an independent, collegiate, supportive group of GPs and other clinicians who specifically provide care to vulnerable people within our community. Today, and at Deep End GPs, we represent ourselves and try to give voice to the people in the community who are marginalised.

There are large numbers of people in the ACT who face barriers in accessing healthcare services and information. There are a multitude of facets to these barriers, including poverty. However, we have a duty to ensure that everyone has access to the

health care they need. Access to reproductive health care, including abortion, is a healthcare right. As the WHO *Abortion care guideline* states:

> Sexual and reproductive health and rights are grounded in a range of human rights recognized and guaranteed in national and international law, and are inextricably linked to the achievement of the public health policy goals … including the SDGs [sustainable development goals].

They recommend that abortion should be provided on demand.

The ACT was the first jurisdiction in Australia to enact a Human Rights Act, in 2004. The ACT Human Rights Commission website states:

> Human rights are universal, and enjoyed by everyone in the ACT regardless of gender, religious belief, nationality, race or any other point of difference.

However, I question this premise in relation to sexual and reproductive health rights.

Legislation and decriminalisation are not enough. We need better access to information about reproductive health care and services—information that is accessible in terms of language, cultural appropriateness and trauma informed, as well as in different formats, not just website pages. We need better and equal access to services and improved affordability of services. We need coordinated pathways for providing services to pregnant people at all gestations and for this to be led at an ACT level.

Hospitals need not only to have provision of abortion on their list of services but also to commit to ongoing training of skilled staff. Even healthcare providers can struggle to assist patients to access the reproductive health care they need, especially when we have gestational limits for available services and cost limitations for patients. For healthcare providers there is information available on HealthPathways, but not everyone uses or remembers to use this portal and there are no clear pathways to assist someone seeking termination beyond nine weeks who cannot access surgical termination at GCA or MSI due to cost, gestation or anaesthetic risk.

Other submissions have highlighted the great difficulties that pregnant people have even in knowing where to access timely information about options when they have been faced with an unplanned pregnancy. Being health literate does not help when search engines do not bring up local providers, and that is already a hurdle for anyone who cannot access the internet or does not have the required English literacy level.

For pregnant patients who do see a health professional, if the health professional is a conscientious objector they have a duty to inform the patient of this, but they do not have a duty in the ACT to provide them with information about where they can go for this healthcare need which is a human right. This is out of step with most of the rest of the country and is an additional barrier to access. This perceived judgement levelled at a vulnerable person may be enough for them to stop seeking the health care they want and need.

I have probably still only prescribed fewer than a hundred early medical abortions over the last three and a bit years of being a prescriber. Sometimes it could be two

times a week; other times it is once a month. Most patients find me through contacting SHFPACT. What I have found is that, while each story is individual, there are often similar threads: not being on contraception due to not being regularly sexually active or being told to stop it from a gynaecologist, or a contraceptive failure—for example, a condom falling off. They might already have significant caring responsibilities for children, often with high needs, or their family might be dependent on their income and their job is not flexible for pregnancy and subsequently being able to afford a further child. There are also pregnant people who do not want to be tethered to a partner by having a child with them.

What I do not know about are the pregnant people who do not make it through the door, the ones who do not have access to information or cannot make it to a doctor, and those who cannot safely make a phone call. We need an enabling environment, as per the WHO *Abortion care guideline*, to provide quality abortion, which includes services being effective, efficient, accessible, acceptable, including patient centred, equitable and safe, including trauma informed and culturally safe. Foundational to abortion care are the core values of dignity, autonomy, equality, confidentiality, communication, social support, supportive care and trust.

Before I finish my opening statement, I want to acknowledge that I recognise my privilege as a white, cisgendered heterosexual woman who is a wife and mother in my forties, highly educated, non-disabled, not culturally nor linguistically diverse, literate in English and health literate, financially secure, reasonably tech savvy and not living with violence, abuse or reproductive coercion. I know that I would not necessarily feel confident to navigate where to go for non-judgemental services if I were not working specifically alongside abortion care providers. I am happy to answer anything about contraceptive access as well.

THE CHAIR: Thank you, Dr Dorrington. Dr Robertson?

Dr Robertson: I do not have an opening statement. I am here to provide support, but I am very happy to take questions.

THE CHAIR: I appreciate that. Thank you so much. I will start with questions and then we will move along. Dr Dorrington, I am really interested in picking your brain a bit more about culturally safe and trauma-informed access to information. We have heard that a lot and I have read that a lot in the submissions, but I have struggled to help relay to laypeople what that looks like practically. In terms of the government providing culturally safe and trauma-informed information, particularly digitally, what does that practically look like?

Dr Dorrington: A lot of the time it is about not making assumptions and that when we make information available in that format it is actually inclusive for everyone. In making something culturally safe, for example, for Aboriginal and Torres Strait Islander people, in general that is going to be the best option for everyone. In general, I think that when we are inclusive actually that gives us the best coverage for everyone.

I think it is about understanding that people come from different places to where they are; they have faced different stigmas, barriers, traumas in their life. We can start off

just by being supportive and not trying to make assumptions, but also, when any information is provided, having it reviewed by appropriate consumer groups to make sure that we are not missing something because it is just not our life experience.

THE CHAIR: That makes sense.

Dr Robertson: I would just add that I think the information about availability should be at the level that is available universally for everybody and that nobody feels that it does not apply to them—that information that we are talking about. Then you get to a service provider and you get that very non-judgemental conversation and trauma-informed approach. I work with vulnerable youth, so most of them have come from complex trauma backgrounds. It is about recognising that it may take multiple attempts; it may take multiple phone calls. A lot of what happens in the health system is that if somebody does not take a phone call they just get their appointments cancelled. There are a whole lot of reasons behind why that happens and that is where we need to be a flexible system. Information is one thing, but accessibility and helping and supporting people through their different journeys may take multiple times, but we need to be there the whole way.

THE CHAIR: I want to pick up on that point, particularly when it comes to accessing reproductive health care. Are either of you aware of any situations like the one you have described where a culturally diverse person, someone who needs a trauma-informed healthcare experience, has missed that phone call and subsequently been unable to access care and treatment, particularly reproductive health care?

Dr Robertson: Yes.

THE CHAIR: How regularly would you say that happens?

Dr Robertson: That has happened very recently for me. The only reason that in fact we were able to access a termination was with me spending an hour and 20 minutes, with the person in the room with me, on the phone, contacting three different agencies because of timing issues around access in order for that to actually go ahead. I would argue that that was a near miss, but, yes, that is exactly what happened. People did not turn up to something and then that was it—all cancelled—and then they were overwhelmed and picked up by us at the last minute.

THE CHAIR: Safe to say, in that example: were it not for your support that individual would have almost certainly not accessed reproductive health care?

Dr Robertson: Completely. Completely.

THE CHAIR: And would have essentially been forced to make a choice they would otherwise not have made.

Dr Robertson: Correct; yes.

THE CHAIR: Was that person—cognisant of confidentiality—someone who would have been eligible to access free abortion under the government's recently announced funding model?

Dr Robertson: There is no free abortion.

Dr Dorrington: The one from July next year?

Dr Robertson: Yes, you mean in the future?

THE CHAIR: Right. Yes, of course.

Dr Robertson: As opposed to two weeks ago.

THE CHAIR: Yes, of course.

Dr Robertson: Yes, they would have been eligible.

Dr Dorrington: Depending on the gestation.

Dr Robertson: Yes. Just. That was our problem; we were running out of time.

THE CHAIR: I see.

Dr Dorrington: The announcement has only been for up to 16 weeks.

Dr Robertson: Yes.

THE CHAIR: Okay.

Dr Dorrington: There is nothing for if you find out you are pregnant later than that.

Dr Robertson: Yes. There continues to be a huge financial barrier. The service that I work with provided the deposit to allow that to be booked.

THE CHAIR: That obviously is not standard practice; that is just a flexibility you were able to provide, I imagine, because you knew the person—

Dr Robertson: Because of the service that I work in, yes.

THE CHAIR: Yes. Right. Okay.

Dr Robertson: Correct, yes.

THE CHAIR: Thank you.

DR PATERSON: My question is around people who may have experienced sexual assault or family violence and whether there are unique situations that may arise where people may need to access an abortion but they cannot, due to these circumstances or because the challenges are very great. Could you describe any particular circumstances that may occur where we could better support people going through those things in accessing reproductive health care?

Dr Dorrington: I think for people who report, the FAMSAC service, Forensic Adult Medical—I cannot ever remember what it actually stands for—provides holistic care in terms of emergency contraception and then follow-up if someone is pregnant. I do not know what happens at that end, but I think for someone who has reported, they have got that sorted. It would be people who have not reported who are then stuck in the same circumstance as everyone else. The Women's Health Service have a very small capacity, for people who are facing violence, to offer the service, but up to nine weeks. Beyond that, again, you are on your own because it is surgical and we do not have access to surgical.

DR PATERSON: Can you describe the gestational issue—so up to nine weeks is medicated and then post that is surgical.

Dr Dorrington: Surgical is an option the whole way.

Dr Robertson: All the way.

DR PATERSON: Yes. Okay.

Dr Dorrington: And then medical, currently, is approved until nine weeks. There is work done elsewhere around the world where they have extended that time frame, so it is possible that in the next few years we will be able to offer medical further. That is certainly well beyond anything the ACT government can do. But, yes, medical is only up to nine weeks, currently, 63 days specifically, and then surgical is up until whatever is appropriate within the private facilities.

Dr Robertson: Here in the ACT that is to 14 weeks and beyond 14 weeks it means going to Sydney and extraordinarily expensive.

Dr Dorrington: And also can be limited by things like the BMI or comorbidities of the pregnant person.

Dr Robertson: Yes. The other very significant thing is that, in order to be absolutely sure about that gestation, we need an ultrasound. Access to pregnancy ultrasounds for the whole Canberra community, no matter how wealthy or affluent you are, is difficult and hard to get in a very timely way. Particularly in the service where I work, people will present very late with an unplanned pregnancy, for a range of reasons, and so we have often not got weeks available for people to be able to make their choice of option, which is that they wish to terminate the pregnancy, following discussion and counselling et cetera. We then become limited because we just cannot even get the tests done that will determine whether we could go for a medical termination or whether we have to go for surgical or whether we are getting so close to that time frame that we are going to go to Sydney.

DR PATERSON: Do you have to have a scan for a medical abortion as well?

Dr Dorrington: Yes.

Dr Robertson: Yes, because you need to know that you are under the nine weeks and if you happen to be nine weeks and five days, under the current rules, that would not

be available.

DR PATERSON: And why do we not provide surgical terminations post 14 weeks in the ACT?

Dr Dorrington: It is the surgical services limit.

Dr Robertson: Only certain service providers are willing to do it.

Dr Dorrington: It is what their facilities are able to do.

Dr Robertson: Yes, here, that is right. For them it is about having the trained staff and the right facilities, and that can only happen in certain parts of the country.

Dr Dorrington: The other reason for ultrasound is to prove that it is an intrauterine pregnancy, rather than an ectopic pregnancy, because we do not want to mask a ruptured ectopic pregnancy when we provide a medical abortion.

THE CHAIR: You really do not know what you do not know. Dr Robertson, your example of needing an ultrasound and, in particular, with the clients that you work with, there being a very limited opportunity in some instances, are there—

Dr Robertson: It is actually all people. It is hard to get an ultrasound. It is not provided at all through the public system unless you present in an emergency situation or a critical situation. Sonographers are not easily available. It can take one to two weeks to get an appointment.

THE CHAIR: I think Dr Paterson just asked this question in not so many words, but just to be clear in my mind: everybody who wants an abortion needs an ultrasound and we do not have enough places and people do to that.

Dr Robertson: Correct.

Dr Dorrington: We can get them fitted in sometimes. Sometimes—

Dr Dorrington: We do, but, again, we spend ages on the phone explaining why and why it is so critical.

THE CHAIR: Yes. I can only assume that—particularly in the instances that you have described, Dr Robertson, where you have managed to stay on the phone and talk some nice receptionist or doctor into fitting somebody in because of a time frame—someone else is getting bumped.

Dr Robertson: Yes, or they are adding into their lists.

Dr Dorrington: Yes, they are coming in at the beginning of the day, early, to fit them in. But it also means that that person has to get to that location that will do it.

THE CHAIR: Would it be fair to say, then, based on what you have described to me, that there are people in this city who are not getting abortions that they would

otherwise get or access to broader reproductive choice because they cannot access an ultrasound?

Dr Robertson: Possibly, yes. Also, unfortunately, with that same kind of trauma background and people's difficult lives and all sorts of things that can happen unexpectedly, we can have bent over backwards and begged somebody to do a scan for us and they do not turn up and then we need to go back in and help and facilitate—and without any blame on that person, because something has happened—but then we have got to go again, so that can make things difficult.

Dr Dorrington: And it can lose our time and we are at the expensive end.

Dr Robertson: Then things were time critical when we had time, but now we have no time.

THE CHAIR: All right. These ultrasound providers, are they all private providers that you have fostered a good relationship with and they understand the people that you work with and therefore accommodate them when your name pops up on the phone?

Dr Robertson: Or they probably say, "Oh no! It's her again." Yes.

THE CHAIR: Right. So what is the solution there? Is it government providing ultrasound services for eligible patients, patients like the ones that you describe, people like the people that you work with? I am asking you: what is the solution there, do you think? Where is the government intervention necessary?

Dr Dorrington: I think that is probably multi-pronged. I think there would be opportunities for those of us who provide medical termination, and possibly beyond that, to use ultrasound machines and maybe have that subsidised by the government, just to have in-room ultrasound that we can do so that we can get the basic measurements and we can say, "Yes, it is intrauterine." That is actually all I need to know, because we have dates.

Dr Robertson: That is about training and skills.

Dr Dorrington: And equipment.

Dr Robertson: And equipment.

Dr Dorrington: Expensive equipment.

Dr Robertson: Expensive equipment, which then you have to—

Dr Dorrington: Expensive training.

Dr Robertson: Yes, yes.

Dr Dorrington: That is where those gaps are.

Dr Robertson: So I think this needs to be really carefully looked into, but definitely an access barrier is the requirement for that ultrasound as part of the whole process.

Dr Dorrington: Yes. But we are generally also often—well, reasonably often; always—having to ask the imaging provider to not charge a gap, because that is hundreds of dollars for an ultrasound.

DR PATERSON: So there are only 13 GPs that provide?

Dr Dorrington: It is possibly more. Even as a GP providing the service, it is hard to know how many other people are out there. I came across two more, so maybe it is slightly more, but it is a handful of providers and not everyone that is trained provides the service. Not everyone who provides the service does it for the community; some only do it for their own patients.

Dr Robertson: There will be a group of GPs who are very happy to provide that service within the practice, to patients within the practice or to their own patients, but who have no capacity to take on new patients. They also do not want to become known as the place to go, because that is only one small component of the broad care that they deliver.

DR PATERSON: Do you flag yourselves to other services? Could someone find you online and know that you offer that service? Is that how it works?

Dr Dorrington: Technically, when I looked, there were four practices, potentially, that I came across, after you dig through page after page. You can get there and find us. We have it written on our website, but it does not come up early as an option. Even just the other day, I went back to our practice manager and said, "I don't know; we've done it as termination of pregnancy. I think we need to put 'abortion' up there as well, because we are not coming up in a Google search." The others have "abortion" up there, and they are not particularly coming up high, so it is—

Dr Robertson: As GPs, it is hard for us to identify, too. Mel talked about HealthPathways, which is a go-to place for us, and there are some listed there, but there are also others that you know about that have said, "No, I don't want to be listed there," for those same reasons that we spoke about.

DR PATERSON: If it is a basic healthcare right, why isn't it just across the board, so that you can go to any GP and it is a total—

Dr Robertson: You have to have specific skills training and registration.

Dr Dorrington: It is not onerous; it is a four-hour online training program, which you redo every three years. When you redo it, it takes about half an hour. But there is not currently enough in our education. It is not in our medical school training. I asked not that long ago—I think this was across abortion providers—"What do you remember about medical school and what you get taught?" For me, all I remember is that it was the ethical question that we were discussing about abortion, rather than abortion care.

In general practice training, abortion care is not an element that we get taught. With

O&G, I believe they have just brought it in that they have to do it. That is the thing; if they are not being trained, and currently in the ACT they are really not, in general—they may be starting to—you do not have the workforce. No-one knows how to do it anymore.

MR MILLIGAN: A common theme in a lot of the submissions is lack of access to information. I noticed that you mentioned lack of information on surgical and medical; also potentially a lack of information on any other reproductive options—adoption, fostering and other supports available to those who might choose to go through the birth and raise the child, with what supports are available to them post birth. You also mentioned that the government should potentially develop a reproductive health strategy. I am keen to know a little bit more about that. Would that potentially cover the lack of information that is available in that health strategy?

Dr Dorrington: You would hope so, yes. The strategy should cover the whole gamut, from what we are actually doing in schools, in terms of education in schools, to what we have out there that is language accessible and disability accessible. Pretty much everyone, no matter their disability, has the ability to have sex, and they should be able to do that without worrying about pregnancy. How are they getting appropriate information? I believe SHFPACT does quite a bit of work in that area.

There needs to be a whole focus–and, I would say, not missing out abortion there, either. I went to a Christian school, and we did not get much in terms of contraception education. It is not just a matter of saying, "This is a condom," or "You can have a pill." That, to me, is not education. It is about what is actually going on when you fall pregnant. In terms of cycles, what happens when you fall pregnant, how do the different contraceptive options actually work, and what happens with abortion? I think that the majority of the community does not understand what happens with abortion.

A reproductive health strategy has to be about education, it has to be about information provision and it has to be about access, with KPIs attached.

MR MILLIGAN: More information is key; right?

Dr Dorrington: It is.

MR MILLIGAN: I could only imagine what an individual would be going through, particularly if it is the first time that they have fallen pregnant. They do not know what to expect. It is a very scary moment, and you do not want them to make an irrational decision without proper information being available.

Dr Robertson: Absolutely.

MR MILLIGAN: There should be information on adoption, fostering and abortion. There should also be information on what is available for them if they do choose to go through the birth.

Dr Robertson: Correct. We have a lot of young people who do choose to continue their pregnancies successfully; yes, absolutely. I agree; you do need to have all of that information available. One of the most go-to emotions that people have in that

situation, which is very human, and the first one, is denial. That is why it is often late: "I haven't actually missed my period" or "I'm probably just a bit late." So a whole other month goes by, and that is where we then get into difficulties around timing, too.

MR MILLIGAN: Do you know what supports are available for anyone who is considering abortion? Is there counselling or support available before they make a decision?

Dr Robertson: Absolutely.

MR MILLIGAN: In your opinion, is it adequate? Are there enough meetings on offer for the lady to make that decision? Also, as part of it, is the male involved as well or offered involvement in that decision-making, or involvement in that counselling and support—or is it typically only offered to the female?

Dr Dorrington: From my experience, from discussions with patients, and from my reading, the evidence base shows that the majority of people have made a decision. The people who need counselling support in making their decision are minimal. That is not to say it should not be available, even for people who have made the decision. For some people, there is no question. With the people that I am seeing, the majority of them are not interested in counselling afterwards. They are getting on with their lives. With other people, yes, they do. I would actually say that is minimal in terms of any significant undertaking.

There are quite a few GPs—and I am making an assumption that the other abortion providers are like me and have done training to do non-directive pregnancy counselling. There is specific training that we can do so that we can bill a specific item number. There is SHFPACT's counselling line as well. Having those options available is really important.

In terms of the male being involved, the evidence shows that a lot of the time they are not interested, will just support whatever the pregnant person wants, or you get into the reproductive coercive type partners who make the life of the pregnant person more difficult in accessing the care they need and cause delays in accessing care, which may mean that it is too late for them to access an abortion.

MR MILLIGAN: Is any form of counselling mandatory before going through the abortion process?

Dr Robertson: You cannot just walk in and say, "Here I am today and that's what I want." There are multi steps involved.

MR MILLIGAN: There are?

Dr Dorrington: Yes. But it is not mandated as such.

Dr Robertson: Not in the ACT, no.

Dr Dorrington: I do not think you would find a provider that would do it without talking through with the person, "What's your story? Tell me what's going on," and

finding out where they come from.

MR MILLIGAN: Do you think it should be mandated?

Dr Robertson: No.

MR MILLIGAN: Do you think support should be offered? Counselling—

Dr Robertson: Offering is one thing; mandating is a slippery slope.

Dr Dorrington: And it can become a barrier.

MR MILLIGAN: My concern is that there might be regret by the individual; how do you provide support for her?

Dr Dorrington: The evidence is that there is grief, yes, but people have made the decision for a specific set of circumstances that they are in at that point in time. Generally, they are confident, and they are not questioning that. If there is concern about regret, that is generally because there is other stuff going on.

You have to make sure that it is voluntary consent that the person is giving you. I have had one situation where I was concerned about that, where it was a young person. I said, "I'm concerned that this is really what you want." They said, "No, really." I said, "Maybe I need to get you back and talk to you again," and they said, "No, I really need to just get this over and done with now." There is this element of thinking, "I don't really want to do this, but I know this is what I have to do," because they were not in stable housing, they did not have family support, they did not have what you would need as a minimum to support a young person through a pregnancy and having a child.

Yes, fostering and adoption, technically, are options. That is where your regret comes in most, in terms of adoption—those that choose that path. That is where the evidence is. To go through a pregnancy and have everyone see that you are pregnant, and to then not have a child—there is a lot that goes with that, because it is very public. There are people who do it, and hats off to them. They would be very strong people. But most know that the system is overwhelmed, you do not know how that child that you brought into the world is being cared for, and most people will choose to look after the child themselves rather than adopt.

DR PATERSON: With the issue around young people, particularly, I am assuming, those under 18 that may need an abortion, do they need consent from their parents? No? Okay.

Dr Robertson: It is around Gillick principles of capability for consenting. There are strict considerations for that. No, they do not.

Dr Dorrington: It is similar to Medicare card access and information.

DR PATERSON: Do you find that young people do come to you later because they do not know what to do, so they are in more of a situation where they may need to

have a surgical abortion or they may need to leave the ACT for an abortion? How are those young people supported? In particular, how do they navigate telling their parents? What happens if they do need to go to Sydney? There is nothing?

Dr Dorrington: Pretty much nothing.

Dr Robertson: They come to our service, and we will try and help with all of those aspects, particularly around communicating with family members. Most of the people that come to our service, though, actually do not have much contact with their family of origin at all.

DR PATERSON: Some of the submissions recommended government subsidised or government provided accommodation and support for residents who do have to go to Sydney for an abortion. Is that something that you support?

Dr Dorrington: I would support the fact that they do not have to go to Sydney to access the care that they need.

Dr Robertson: Yes. The better option would be not having to go.

Dr Dorrington: We are the nation's capital. There is truly no reason why we cannot provide the care here. It is just that it has been chosen not to at this point in time.

Dr Robertson: Yes, and we would like our public hospitals to do a bit more in that space.

THE CHAIR: Dr Robertson and Dr Dorrington, thank you so much for joining us today, and thank you very much for your written submissions. When available, our committee secretary will forward you a copy of the proof transcript, to check for accuracy. Do let us know if there have been any omissions or mistakes. If you took any questions on notice—I do not believe you did—or if there is any further context or information, based on what you provided today, that you want to provide to the committee to help inform our work, please feel free to send that through at some point in the next week. Thank you again for appearing.

Hearing suspended from 11.04 to 11.17 am.

KILLEN, DR GEMMA, Acting Chief Executive Officer and Head of Policy, ACT Council of Social Service
DARUWALLA, MS AVAN, Policy Officer, ACT Council of Social Service

THE CHAIR: Welcome back to this hearing of the Standing Committee on Health and Community Wellbeing in its ongoing inquiry into abortion and reproductive choice here in the ACT.

On the first occasion that witnesses appear and present today, please state the capacity in which you appear, and acknowledge that you have read and understood the privilege statement, which sits on the table to your right.

We will now hear from our friends at ACTCOSS, the ACT Council of Social Service, Dr Gemma Killen and Ms Avan Daruwalla. Could you acknowledge that you have read the privilege statement?

Dr Killen: I am the Acting CEO of ACTCOSS, and I have read and acknowledge the privilege statement.

Ms Daruwalla: I am a policy support officer at ACTCOSS, and I have also read and understood the privilege statement.

THE CHAIR: Would you like to make an opening statement?

Dr Killen: I have not prepared an opening statement. I will just acknowledge that there is strong support in the community for this inquiry and for doing the best that we can to implement universal access to abortion care in the ACT. We are happy to take questions.

THE CHAIR: I will start. Your recommendation list is pretty comprehensive. One of the challenges for government is always to prioritise what comes first and in what importance. Can I take from your submission that your recommendations are written in order of importance or is there something in particular in your recommendations that you would insist on the committee focusing on and stressing to government, in the interests of providing better reproductive health choice?

Dr Killen: I do not think we wrote them in order of importance. Probably increasing access to abortion is the priority. That would be around cost and providers. I note that there are a small number of GPs in the ACT that can provide medical abortions, in particular. Increasing that would be great, and increasing the capacity of services like Marie Stopes.

Providing more services and at much lower or no cost would be the absolute priority, as well as making sure that those services are culturally appropriate and have appropriate cultural awareness and diversity training so that they can provide services to whoever happens to come to them.

THE CHAIR: The government announced earlier in the year that it would provide funding so that there would be free abortion access in the ACT. That comes in in the

middle of next year. We heard before the break from two local GPs who told the committee, at the risk of verballing them, that there are not enough GPs. What is ACTCOSS's view about providing the funding so that the cost barrier is removed but there is still actually a barrier to accessing providers? How do you think the ACT government can improve access to providers, in particular?

Dr Killen: The first issue is probably a commonwealth issue, which is around bulk-billing access in the ACT, which is very low. The ACT government probably cannot do that much, except talk to federal colleagues about how to improve bulk-billing access here in the ACT. We also understand that there is certain training that doctors have to do in order to provide, particularly, medical abortion. Do you want to add anything about access to that training?

Ms Daruwalla: It is part of our recommendations that the ACT government should be incentivising not only bulk-billing but also GPs to get the accreditation. Basically, from what we have read, a lot of GPs see cost and time as a barrier to getting that training. That is something that definitely deserves an intervention.

THE CHAIR: Just to be crystal clear, you would support the government subsidising the cost of general practitioners to access the training required to become abortion providers?

Ms Daruwalla: Yes.

THE CHAIR: Do you have any idea, based on conversations with your members, of how many potential, newly qualified general practitioners that would provide—a rough number for whom cost is the barrier?

Dr Killen: We have not surveyed GPs to find out specifically which ones think that cost is the barrier. How many of the GPs in Canberra—

Ms Daruwalla: There are 54 active prescribers—then, of the pharmacies, there are 157 active dispensers—which is only, I think, nine per cent of GPs in the ACT.

Dr Killen: If we did subsidise training, we would at least see some rise above nine per cent.

DR PATERSON: Learning about this today, it is quite shocking, really, that there are so few providers in our GP community. Also, hearing from the GPs in the previous session, there is the fact that it is add-on education. The fact that it is not taught as regular medical training is really concerning. I think it highlights the real cultural issue here, more than anything. I am interested in how deep we need to go in this issue. We can provide the access, but if there is not that training and there is that cultural issue in the background, it becomes very difficult. Do you have thoughts on that?

Dr Killen: I think that is absolutely right. It would be useful to investigate ways to make sure that it was not add-on training, for example, and that all doctors could be qualified, as they became doctors in the ACT, to provide that care. It is not clear why it is add-on training. Essentially, it is just administering medication, and doctors do not have to do extra training to provide other kinds of medication.

DR PATERSON: Maybe the ACT government could do some work with our local institutions to support medical practitioners being trained in this?

Dr Killen: I think that would be great, yes.

Ms Daruwalla: A big factor as well in the accessibility issue is that not only are there only 54 active prescribers but there is no list available. A lot of people experiencing pregnancy will have to work it out by trial and error, which means they could go through multiple GPs before they find one who could prescribe.

MR MILLIGAN: In your submission you mention that there is a need for more information to support people who would like to know what reproductive choices are available in the community. Do you think that there is enough information available to support those young people who may want to go through and give birth?

Dr Killen: We have heard from some of our community sector organisations that there is not necessarily enough, in particular, non-religious pregnancy counselling or reproductive counselling to make those decisions. One of our recommendations is to invest more in a broader church—for lack of a better word—of counselling options for people who might want to see a pregnancy through.

MR MILLIGAN: I also noted you mentioned those with a disability. What information needs to be provided to them and to other different community groups or community areas who need that information and support?

Dr Killen: I think AFI and Women With Disabilities ACT speak about that in their submission, and we would support their recommendations on this particular topic. They call for ensuring that decision-making is not coerced but supported. That means providing a lot of options and a lot of information; then supporting people through their decision-making process without coercing people into either abortion or retaining a pregnancy.

THE CHAIR: Do you believe there are many Canberrans who make the choice to take a pregnancy to term because they were not provided with the support or awareness of abortion services or the capacity to have an abortion? To take Mr Milligan's point, I believe that the reverse is true: without that counselling, people are seeing a pregnancy to term that otherwise would not.

Dr Killen: We have had some issues around that, especially in relation to victims of sexual assault or people in family violence situations. The more significant barrier that we hear about is cost and the time that it takes to access abortion here in the ACT. Those things are a more significant barrier than accessing counselling to making those decisions to abort.

THE CHAIR: Should the ACT government invest in more counselling services? We heard from doctors before who put it to us that the evidence suggests these services do not necessarily help women to make a decision one way or the other; rather, they support people through a decision that they have already made. What risks, if any, do you identify that those additional services, counselling supports, may be coercive by

nature? What should the ACT government be alive to and how can we mitigate that risk?

Dr Killen: That is a good question. Again, speaking to AFI and Women With Disabilities ACT's submission, there is some concern, particularly for women with disabilities, for example, that the decision-making process of carers or caregivers might be prioritised over that of the person with a disability who is pregnant. That might be an issue in counselling as well. Does that answer the question?

THE CHAIR: It does to a point. It is perhaps something that I will continue to bring up with other people today, because we have heard already today this recurring theme about providing support, advice and counselling services to the pregnant person to help inform their decision. Can you observe some risk in that—due to the nature of this topic, the person providing the support could be prejudicial or biased in the advice and support that they give? If government were to increase those services or fund those services that already exist, I imagine government has a responsibility to make sure they are not helping people with a biased view, and I am trying to make sure that we stop that, and minimise that risk.

Dr Killen: Yes. Something else that we talked about when we held our consultation was about culturally and linguistically diverse communities in Canberra. Often we are talking about a very small community. If they are seeing a counsellor from within their community, there might be a risk of stigma or the rest of the community becoming involved in the decision.

Those are the kinds of risks that we have to handle really carefully. We want to make sure that, if there is counselling, it is culturally appropriate and safe. Sometimes that means coming from within the community, but without adding stigma, bias or pressure from within the community.

Ms Daruwalla: It also speaks to the issue of communication around services that are culturally aligned with people and culturally safe and informed. The fact that people seek out people with some more experience for support means that those services in particular need to be funded, like Aboriginal-controlled community organisations.

THE CHAIR: I want to pick up on your recommendation about investing in infrastructure to support provision of abortions post 16-week gestation. I was surprised to learn from the GPs who joined us before the break that it is near impossible, if not impossible, to get an abortion post 16 weeks in the ACT, in spite of all that we say about being very progressive on this issue. How exactly would you recommend that the ACT government do that? Is it about funding providers who are experts? Is it about providing those post 16-week gestation abortions ourselves? Where is the ACT government intervention, would you suggest?

Dr Killen: There are a few options on the spectrum. I know that some submissions recommend that the ACT government provide travel funds, for example, as a starting point, if people need to leave the state to access those abortions. We could build up the infrastructure and the capacity of Marie Stopes, for example, to provide those terminations.

One of the tricky things about post 16 weeks is that often—not always but often—it is a termination for medical reasons. Those can happen through the Canberra Hospital. But it is not necessarily transparent or clear when it happens through the Canberra Hospital and whether there are associated waiting times and things like that.

If we had more providers than just the Canberra Hospital, that would be really good, because that would lower those waiting times. In the absence of providing that infrastructure, if we had funds and support for travelling outside the ACT, that would be really good. Often it is a lengthy process. With an abortion post 16 weeks, someone is giving birth, so that usually includes a lengthy hospital stay and recovery time from giving birth. Going interstate to do it becomes especially tricky because you are taking a lot of time off work. You might be separated from your support networks and things like that. That has to be considered really carefully, and it would be much better if we had the infrastructure here in the ACT.

DR PATERSON: Working with your members, are there any unique situations in respect of family violence circumstances and the care that a person who is requiring a termination may receive or need to protect them or support them that has come to light that you could inform the committee about?

Dr Killen: Yes. When we spoke particularly to DVCS, they highlighted cost and timeliness as two of the most important factors. The research tells us that you are most at risk in a family violence situation when you are pregnant, and most at risk particularly of escalating violence and death. Often decisions have to be made quickly, and sometimes secretly as well. That can be very difficult if we are talking about a large sum of money or a lengthy waiting period. There need to be ways to expedite the process wherever possible and to make sure that it is as close to free as possible.

DR PATERSON: I am interested in the exclusion zone. That is an interesting aspect of our legislation here not being consistent with that of the other states. Is it because of the location of the service that it only requires a 50-metre exclusion zone? Do you think it is actually necessary to change the legislation?

Dr Killen: It would be good if we could be in line with the rest of the country. Also, because it is in the middle of the city, with the current exclusion zone, there is potential for people to encounter protesters as they go to the clinic because the exclusion zone is not large enough.

Ms Daruwalla: Especially in light of the new funding, the likelihood of protest will probably increase in the near future. Every other jurisdiction has a 150-metre exclusion zone, so it does not make sense for the ACT to be different.

DR PATERSON: We can ask the service when they appear, but do you know how many protests they get? We have had an exclusion zone for a few years, but—

Dr Killen: I do not know. It did not come up in our consultation.

THE CHAIR: Ms Daruwalla and Dr Killen, thank you very much for presenting on behalf of ACTCOSS. On behalf of the committee, I thank you for appearing and for your written submission. A copy of the proof transcript will be provided to you in the

coming days, to check for accuracy. If there are any inaccuracies or any further context or information you would like to provide to the committee, please feel free to get that through to us within the next week. Thank you very much for your time.

CAINS, MS BEVERLY, President, ACT Right to Life Association Inc
RULE, MR CHRISTOPHER, Councillor, ACT Right to Life Association Inc

THE CHAIR: Welcome, everybody. We move now to our next witnesses appearing today. On behalf of the committee, thank you for appearing today and for your written submission to the inquiry. I remind you of the protections and obligations that are afforded to you by parliamentary privilege and draw your attention to the privilege statement. I ask you to acknowledge that you have read and understood the privilege statement. Ms Cains, if you would not mind, can you acknowledge that you have read and understood the privilege statement?

Ms Cains: Yes, thank you.

THE CHAIR: Thanks, Ms Cains; and Mr Rule?

Mr Rule: Yes, I have read the statement.

THE CHAIR: Thank you very much. I appreciate that. I am more than happy for you to kick-off with a brief opening statement, if you would like.

Ms Cains: Thank you for hearing us today. We think it is very important that statistics be kept. We say that in our opening statement, because I start to wonder how, as a government, you can virtually hand over $4.6 million to be spent of the health budget to allow women to have free abortions over the next four years, when you do not know how many abortions are happening in the ACT. It has been a practice not to keep statistics. We have campaigned for many years, so please take that as one of our very important recommendations.

I feel it has been a political statement more than an interest in women, because I read that the greater Newcastle area, with a population of over 660,000, which is a 100,000 plus on the ACT, now has no clinic operating offering surgical abortions, and they are only offering medical abortions, or tablets, and a 1800 number. My suspicion is that the Marie Stopes clinic in the ACT has been complaining about the low number, because what has happened since the year 2000 up to 2020 is the growth in the number of women having medical abortions—taking pills. This is not from a life institute; it is from the Guttmacher Institute, which is probably more supportive of your point of view. As well as that, the ACT abortion clinic stands as a kind of citadel, and I think there has been so much money given there: it is an insult to the ratepayers and the taxpayers of the ACT.

Where you have this, the drug mifepristone RU486 is being used for more than half of the abortions in the USA and in the UK, and it is probably happening here too. Those figures from 2020 would have probably grown more. In the United States, the FDA has linked the drug to at least 26 women's deaths and 4,000 serious complications. Those figures stopped in 2018 because President Obama stopped requiring that non-fatal complications from RU486 be reported.

Chemically ending the lives of 500,000 pre-born babies each year, with the abortion bill since 2000, is a staggering and sobering number. The pre-abortion regime is

approved through 70 days, but the industry is already committing abortions well past this time line. The testing, which is supported by the FDA, the federal drug administration, is searching to extend that out to 12 weeks of pregnancy.

With the medical abortion, very often women do not see a doctor. The important thing is for them to see a doctor, to have an ultrasound and then the doctor can advise them how far advanced they are and whether they need a surgical abortion, or whether they could partake of a medical abortion.

We have had the groups which support our point of view reporting that women are ringing up because they get a shock, the poor things, when they have to deliver the baby at home. They want to know what can be done with the remains of a baby, and it is not particularly a good thing that should go into our system.

However, there have been a few statistics available in Queensland, and I would like to point them out to you as a barbaric thing that happens. Two hundred and four babies were born alive as a result of abortions in the 10-year period. In Queensland, there are clinical guidelines which say that if, during abortion, live birth occurs, the baby must be left to die. Are we that barbaric? What led me to take this line is to wake you up: all the promotion material from MSI is very much that abortion is a safe procedure.

THE CHAIR: Thank you, Ms Cains. Thank you, Mr Rule. Having read your submission and heard your opening statements I do not have any questions.

MR MILLIGAN: The common theme is information availability to those people considering abortion and other reproductive choices. Do you think there is adequate information available to inform women on what is available—not just for abortion but for what supports are available to go through birth and post-birth, including adoption, fostering or even raising a child themselves? I notice that you mentioned Marymead, which provides some of those services, but what else could be done in that space?

Mr Rule: Put it this way: I think there are quite a few services available, but I do not think the information is made available to all women who are seeking abortions. I think if you go to places like MSI or ACT Health you are probably likely to get mainly one option, and that is abortion. I think something like the Osborne legislation would be a good thing: that people actually have to have a cooling-off period and they are given information so they can then make a reasonable choice, or a reasoned choice.

MR MILLIGAN: Can you talk a little bit about the Osborne legislation?

Mr Rule: That was in 1998, was it not?

Ms Cains: Yes. Previously, in the Assembly there was a three-day waiting period, where a woman seeking an abortion was given a pamphlet which discussed the other options more: adoption, having the baby yourself or continuing. At that stage, it was put forward by a member who was Paul Osborne. That all came about. We knew there were some figures we could collect in that short period, and the number of women who actually did change their mind was quite significant—167, I think it was, in a three-year period.

MR MILLIGAN: What are your thoughts in terms of counselling that is offered one on one? Do you think that that should be a mandatory process?

Ms Cains: If it is a bit better than what is given. It is given as safe. It is said it is safer than childbirth. Here is the statistic. I have these to hand to you to see.

A report was then shown.

It is quite a good report, which shows you the women who have not had a baby, the women who have had no pregnancy, the women who have had miscarriage and the women who have had an abortion.

The number of women who die in the first year after abortion, through some outside cause very often like distress or suicide, is just extraordinary. Some of these papers were too long, seeing as we only had a very limited time to speak to you, so we have compiled them and have them ready to give to you.

DR PATERSON: Do you think we should be investing heavily in contraception and providing contraception to—

Ms Cains: Contraception should be advised, yes—after all the other options, as were mentioned. Adoption has got a very poor—but it is increasingly better. There was a recent film made, which is in the public cinemas around the town, and it shows the possibilities for a woman. The person who was adopted was able to be in touch with his mother once he turned 18, et cetera. We know that everything is not a success, but we have got to ask that these women be given some form of choice, rather than be bowled into abortion. The fact that abortion clinics are closing the world over, and women are moving to these barbaric types of stay-at-home abortions is not good for women. We are concerned about the life of the woman, as well as the babes. Brutality is right there.

Mr Rule: Can I just say: I am not sure that contraception is necessarily the answer. I think, in fact, it leads to abortion, because if contraception fails, then people see abortion as the last resort. I am not saying there should not be family planning, but there are other alternatives to artificial contraception, which the British medical journal, the *Lancet*, said were equally as effective as contraception itself.

THE CHAIR: The time being 11.50 am, we will move on to our next participant. I would like to thank you Ms Cains and Mr Rule for appearing today before the committee and for your written submissions. In the coming days, a copy of the proof transcript will be sent to you to check for accuracy. Please provide any notes to the committee secretary if those *Hansard* recordings are not accurate, and we appreciate your time today. Thank you very much.

Mr Rule: Thank you for hearing us.

Ms Cains: Thank you. As we finish, I would like to make the point that being human confers rights, not being born: you are human once you are conceived.

THE CHAIR: Thank you, Ms Cains. I feel it is my responsibility as Chair to remind

those in the room and those witnessing the committee's hearings today online that the committee secretariat and the Assembly more broadly are readily available to connect anyone concerned with testimony heard as part of today's hearings to mental health supports, including: the Access Mental Health line on 1800 629 354, Lifeline on 13 11 14 and Beyond Blue at 1300 224 636.

Short suspension.

PROWSE, ARCHBISHOP CHRISTOPHER, Archbishop, Catholic Archdiocese of Canberra and Goulburn
McARDLE, DR PATRICK, Chancellor, Catholic Archdiocese of Canberra and Goulburn

THE CHAIR: We will move to our next witnesses appearing today, Archbishop Prowse and Dr Patrick McArdle, from the Catholic Archdiocese of Canberra and Goulburn. On behalf of the committee, thank you very much for appearing today and for your written submission to our inquiry. Can I remind you of the protections and obligations afforded by parliamentary privilege, and draw your attention to the privilege statement that sits to your right on the table? Gentlemen, could you confirm for the record the capacity in which you appear, and that you have read and understood the privilege statement?

Archbishop Prowse: I am the Catholic Archbishop of the Archdiocese of Canberra and Goulburn, and I have read the privilege statement.

Dr McArdle: I am the Chancellor of the Archdiocese of Canberra and Goulburn, and I have also read the privilege statement.

THE CHAIR: Would you like to present a brief opening statement to the committee?

Archbishop Prowse: Yes. Thank you so much for inviting us. The Catholic Church and its agencies are the largest non-government employer in the ACT. The 2021 census recorded that at least 20 per cent of territorians are Catholic. The Catholic Church upholds the dignity of the human person and strives always to promote the common good. Because of these positions, we hold that life from conception to natural birth is to be protected.

Since its foundation, the Catholic Church has always sought to play a role in civic society, both promoting human flourishing and advocating for the vulnerable. Our submission to this inquiry sought to highlight the challenges facing the vulnerable in the ACT: the country's lowest bulk-billing rates, dire shortages of social housing and increasing rates of homelessness, especially for women and young people, and lack of services for those who are vulnerable, pregnant and seeking to give birth. This gap is both during pregnancy and in the immediate post-birth years.

We have noted where the church directly, through its agencies and partners, have sought to address the needs that we now encounter together. Today we want to highlight two programs. The services operated by Marymead CatholicCare, my archdiocese's social welfare agency, seeks to serve those in need of support in terms of housing and social welfare. MacKillop House serves the needs of 26 women, including those with children. This service was enabled to commence through support from the ACT government to address homelessness during the COVID time, and we are very grateful for that support.

However, we know the needs are much greater. Over 1,600 people in the ACT are homeless at any given time. The fastest growing cohort of these are women and children. Certainly, more could be done if this partnership were to be expanded. In

terms of this inquiry, the support offered to such highly vulnerable women who may find themselves pregnant is too little to enable them to have genuine choice.

The second service is one that has recently been established, called First Steps Pregnancy Support, which will operate in Queanbeyan and the ACT region. This is an initiative of two doctors, a social worker and an educator, who have, from their different experiences, recognised a need which they are seeking to support. From their own resources of time, skills and expertise, they are offering services to women who are seeking to continue their pregnancies, but who, for a variety of reasons, are in especially vulnerable situations or have additional needs.

Based on their clinical practice and experiences, they estimate that there are at least 90 women each year in the Queanbeyan and ACT region who require their services, from bulk-billing to health care during pregnancy and the establishment of adequate social supports and seeking to meet housing needs. The needs are best expressed in their own team articulation, when they say:

> When a woman is faced with an unexpected pregnancy, there are several different choices available to her. Termination of pregnancy is locally available and increasingly subsidised by local and state governments. Referrals are not required to access these services, but for those who are facing difficult circumstances and choose to continue with their pregnancy, there are very few places in the ACT/Queanbeyan region that offer this type of support.
>
> It is these women that the First Steps Pregnancy Support Group seeks to be there for. The role of FSPS is to provide a woman with the community and care she needs so that continuing on to motherhood is a real valid option and choice for her, particularly if she is experiencing significant disadvantage or difficult circumstances. The First Steps Pregnancy Support will provide ongoing, comprehensive care for these women throughout their pregnancy, linking them in with local services and continuing to walk alongside them into the parenting journey.

This is a statement from Dr Sarah Jensen and Dr Ingrid Kensey, together with Ms Laura Lamerton, social worker, and Ms Stella Shelly, educator and educational leader.

It should be noted that a number of submissions that cite the work of Calvary Health Care are erroneous. Calvary does not receive funding for health services that it does not provide. For instance, it does not receive funding for most paediatric care, since almost all services are provided at Canberra Hospital. However, across its network it is a very significant provider of maternity services and palliative care services.

Around 50 per cent of the submissions to this inquiry either oppose increasing access to terminations or increasing public funding of such services. My archdiocese is of the view that the ACT is seeking to provide ready access to termination for those who seek to end a pregnancy, but it is offering very little support and few options for those who seek to continue a pregnancy.

Recognising that in a civil society such as the ACT and Australia the church is only one entity within a whole polity, we hold that termination for those who choose it should be safe, legal and rare. We also argue that governments have an obligation to

care for the most vulnerable members of our society. That is absolute. Currently, the state of health, welfare and community services available to those seeking to continue pregnancy in the ACT and region is deficient.

This inquiry should argue for much higher levels of support for those agencies seeking to empower women and to support them in their choice to have and support families. Thank you very much for giving me the opportunity to make this statement.

THE CHAIR: Thank you, Archbishop Prowse. I will kick off with the first question. Can I say from the outset that, while we are unlikely to agree on the question of abortion, I thank you for your submission addressing the terms of reference. I think there are an awful lot of areas here where we can share agreement. I refer in particular to point 8(c), where you speak about improved access to quality health care that is bulk-billed, improved social housing options and additional financial support in particular for those fleeing domestic violence. There is a lot of common ground there.

Do you have a view, with respect to those many varied but important priorities the government should fund, about which ones it should prioritise? Where are you seeing the most urgent and pressing need in particular for people who can get pregnant?

Dr McArdle: Obviously, the most pressing thing is in fact shelter. Housing is in dire shortage in the territory. Social housing, for those who are in vulnerable situations with limited financial resources, is dire. I am deliberately picking that over some of the others because some of the others are federal responsibilities—bulk-billing, for example. I was struck by one of the submissions that noted—I think it was from the Health Directorate—that there are 6,000 GPs in the territory, which seems a reasonable number, yet we have almost none who provide bulk-billing services. I acknowledge that there is little that the territory can do in that space.

On the other hand Marymead CatholicCare has sought to enter into further partnerships with the ACT government to provide additional social housing. To date that has not been accepted. I am sure there are a range of budget constraints, but our agencies, and those of other community groups, would be more than willing to make our own resources available if there was sufficient government support for that.

DR PATERSON: My question is in respect of conscientious objectors. There have been some recommendations through the submissions that the ACT should alter the Health Act to insert a requirement for conscientious objectors to provide a referral to an equivalent health service. I am interested in your views about that.

Dr McArdle: I fail to see how conscientious objection works if you are required to actually then refer somebody. With the classic conscientious objection, "I don't want to go to war," I have to identify my next-door neighbour as somebody who is willing to go to war, for that to have meaning. I am not sure that is valid. Often the conscientious objection is an institutional one. Calvary Health Care does not offer these services and would not choose to do so, yet that obligation would seem to fall on its employees to refer someone, and there is no guarantee that somebody working in emergency at Calvary would know—they may do, but they would not necessarily know that. I am not sure that it is fair to apply that caveat on the objection. Even if you did, how would it be enforceable, given that I could reasonably claim I do not

know?

DR PATERSON: As a human rights jurisdiction, you can conscientiously object, but, by not providing that information to patients, you might be making that objection for them.

Dr McArdle: I would want to see that reasoned out. In most human rights, I do need to defend the rights of another person. I do not know that I need to provide them with all of the information required for that. It would also be interesting to discuss, for example, whether we were going to check on those providing counselling in these circumstances, to ensure that they were offering referrals to people who would seek to sustain you in pregnancy—if it was going to be an equal thing enabling the choice of the person.

MR MILLIGAN: Thank you for your attendance today and for your submission to this important inquiry.

Archbishop Prowse: Thank you for inviting us.

MR MILLIGAN: You mentioned in the submission that you would like to see recommendations in terms of providing information for those people who would like to go through to birth. I would like you to talk more about that, as well as what supports and services are available post birth for the parents of that child, and whether the government should consider putting some funding towards that. Just as they are putting funding towards abortion, maybe they should do the same for those that are going through to birth.

Archbishop Prowse: Thank you for that. We often talk about "my choice", but in this particular issue it is also "our choice", because so many are in the webs of communication in society—family and friends are involved. It seems to us that there is an extraordinary paucity of the choice of care. What types of care could be provided? The abortion, the termination, one seems to be there in brilliant lights, flashing. A person in that situation needs some time out to reflect and to consider. Once that happens, all sorts of other options that are not terminal could be seen as a real option.

Dr McArdle: That is right. Enabling people to see that there is an available array of choice would be helpful in the pre-birth period. In the post-birth period, the ACT is one of those jurisdictions that has remarkably lower levels of community support for these kinds of things. As an older, well-educated, well-heeled parent, but one without family supports in Canberra, I found the experience of having kids challenging in those first couple of years. If I was on my own and in a vulnerable situation, I do not know how that would be done.

In the submission we pointed to the excellent program that Winnunga is running for Indigenous women, with tangible support for the first two years. I am certainly not seeking to replace that or not recognise the particular plight of Indigenous women in that situation. However, that program, extended by offer to every woman in the ACT, I suspect would have remarkable results, not only for those who seek to give birth in these circumstances, but in terms of maternal and child welfare outcomes across the

board. It could be viewed as an early intervention program and, as we know, the return on investment in those sorts of programs is enormous.

MR MILLIGAN: In terms of adoption and fostering, as I understand it, it can be quite a difficult, lengthy process to go through here in Australia, and in the ACT. Should reform there be looked at? Should the government be looking at how to make that process easier? Do you think that might help some decision-making, going forward, by potential mothers?

Archbishop Prowse: Clearly, we have diametrically opposite ethical standards in many respects. There is the grey area in between—and here is a good one—where we can work together. The hoops that people have to go through for adoption and other such options need to be somewhat untangled.

Dr McArdle: One of the really big challenges here is that there is actually an enormous stigma on women who choose to offer their child for adoption compared to termination. That has flipped enormously in the last 50 years. I do not pretend to understand how traumatic that decision would be and how every day it would be something you would question. However, one of the benefits of adoption is that your child is still alive.

I do not know that that remedies it for the woman who is making those decisions. That is why we are advocating for much greater support for those who choose to give birth, so that they are enabled not only to have a live child but to be able to support that child and live with that child in the best possible circumstances. However, we also need to recognise that there are many people who would choose adoption and foster care as an option if only that were feasibly available in the territory.

THE CHAIR: Archbishop Prowse and Dr McArdle, thank you very much, on behalf of the committee, for your time today and for your written submission. In the coming days, our committee secretary will provide you with a proof transcript of today's hearing, for you to check for accuracy. If there are any issues, omissions or errors, please let us know so that we can correct the record. We thank you again very much for your time today.

Archbishop Prowse: Thank you so much for inviting us.

THE CHAIR: The committee will reconvene at 1.10 pm.

Hearing suspended from 12.11 to 1.10 pm.

HAKIM, MR JAMAL, Managing Director, MSI Australia
RYAN, MS MELISSA, Nurse Unit Manager, MSI Canberra

THE CHAIR: Good afternoon, everybody. Welcome back to this public hearing of the Legislative Assembly Standing Committee on Health and Community Wellbeing's inquiry into abortion and reproductive choice in the ACT. On the first occasion that witnesses speak they will need to acknowledge that they have read and understood the privilege statement which sits on the pink laminated card to your right.

We are now going to hear from Mr Jamal Hakim and Ms Melissa Ryan from MSI Australia. Thank you both very much for being here and for your written submission. I will ask if, one at a time, you introduce yourselves and acknowledge that you have read and understood the privilege statement.

Mr Hakim: Thank you very much. I am the managing director of MSI Australia, formerly Marie Stopes Australia. I have read the statement.

Ms Ryan: Hello. I am here as the nurse unit manager representing the Canberra clinic of MSI. I have read the privilege statement.

THE CHAIR: Fantastic. Mr Hakim, Ms Ryan, thank you very much. Would you like to start with an opening statement?

Mr Hakim: Yes, please. Thank you. I might open this up and then I will ask Mel to also introduce herself and make a statement and I will finish off that opening statement. I first would like to acknowledge that we are meeting on land where sovereignty has not been ceded. I would like to pay our respects to the Ngunnawal people and extend that to Aboriginal and Torres Strait Islander people here. It is Aboriginal land. It will always be Aboriginal land. It is really critical for us to discuss and acknowledge that, because reproductive justice can only happen in consideration of the rights of Aboriginal and Torres Strait Islander peoples and what that means for culturally safe services.

I am going to hand over to Mel, who is going to do an introduction, and then I will do a quick introduction too. I am conscious that we want to use most of the time for questions.

Ms Ryan: Good afternoon again. I am the nurse unit manager for MSI Australia's Canberra clinic. I am a proud Canberran. I grew up here. I am raising my family here, so I am very excited to be involved in this process. My role is to oversee the day-to-day operations at the clinic. I manage a team of doctors and nurses, as well as admin staff. As well as the hands-on clinical role that I undertake, I also manage the staffing, financial planning and education and training for the unit.

Over my time leading this facility I have been exposed to the areas of reproductive health that are lacking in the ACT. Affordability remains a significant barrier to access for many clients, particularly those without Medicare. This is not just related to the in-clinic costs of the procedure. It is also related to parking, time off work, child care and, in some cases, accommodation and travel as well. Physical access is also a

challenge. Clients who may have a disability or a diverse body type cannot always be facilitated at our clinic, due to the infrastructure available. To us at MSI, greater accessibility means being able to provide care to all of the ACT's diverse population and promote bodily autonomy and reproductive choices for the community.

Mr Hakim: Thanks, Mel. I just want to acknowledge as well the ACT government's commitment to sexual and reproductive health care—the public funding that we have all been talking about and that commitment to infrastructure. I think that is really terrific.

I am a proud Canberran. I currently live in Melbourne but I grew up in Canberra, so I am really proud to be here today and to be part of what is going to be the best provision of services, in that the government is committed to supporting every single person, whether they be on temporary visas, refugees. Regardless of the status of the woman or pregnant person needing access, they are being included, and I want to salute that. It is something that I am really conscious of. I come from a single mother household. I was raised with my mum and my two brothers here in Canberra, so I know the difficulty of having no support as a family unit. Canberra does that really well in how we support each other as a community.

But intersectionalities are really critical, and I bring my entire intersectionality into what I do, as a queer migrant man. I also want to recognise that my position as head of this organisation is not as a woman or a person who can be pregnant. My role here is to facilitate support and ensure that those voices are heard. I want to recognise that as well, first and foremost.

I will speak to you on the feedback that I have received and the processes that are common, and Mel will be able to share with you some of those experiences in the clinic and what happens right here in Canberra. I want to briefly just touch on the fact that, as an organisation, MSI Australia is part of a global network and charity around the world that delivers sexual reproductive help and, most importantly, contraception in 37 countries, for the last 46 years, saving the lives of over 100 million woman around the world. We have operated in Australia for 21 years and in Canberra since 2014. We also own, through a subsidiary, MS Health Proprietary Limited, which is, I think, the only non-profit pharmaceutical distributor in the country that distributes the MS-2 Step drug for medical abortion.

We deliver care across the country. It is a speciality service. It is a very difficult landscape, but all your questions are really important. Ultimately, this is about embedding care in health systems. It is about ensuring that it is woman and pregnant person led and that it is treated as an extension of the health system. Thus, our three recommendations are around providing universal access to sexual reproductive health; strategising for sexual reproductive health and preventing reproductive violence; and, ultimately, ending the abortion postcode lottery and ensuring that there is quality, safe, free and unfettered access. We welcome your questions.

THE CHAIR: Thank you both very much. As Chair, I will start. One of the main recurring themes we have heard from people who have presented today has been a lack of information. In that spirit, for those here today and those watching at home, I am going to ask you to talk to me like I am five. Where are you? How many people

do you help? What does walking through the doors of MSI in the ACT look like for a healthcare consumer?

Ms Ryan: The process begins with booking. Now we can do online bookings for our clinic, as well as over the phone. That would be your first step: making an appointment. We are open Tuesday to Friday. We do not have full-time activity, but we are open four days a week. You will come to your appointment. We are in the community health building on Moore Street. It is a little bit of an adventure to get there. You find the building, find a car space and come up to the first floor. We are then through locked doors. You need to use an intercom to access our facility and then you will be seen by the team of nurses and doctors to either receive your tablets or have your surgical procedure. It is all done in the one location.

Mr Hakim: I can add to that what happens through the website. The first port of call will be the website, or another website where you get information. We are upgrading our website—a new website will be coming—because we recognise that over 80 per cent of people access information through their mobile phones. I think it is a really important piece of information. Mobile phone information is really critical. So is language. The website uses Google Translate. We brought in online booking as a way to really support people to get to their appointment as quickly as possible and also to get the price as easily and readily as possible.

A speaker said earlier today that out-of-pocket costs for non-Medicare card holders were not on the website. They are on the website now and you can go through a quote calculator. You can then have a choice, when you call or when you make a booking, before you come for an appointment, if you have not made a decision, to speak to a nurse or a doctor or a counsellor as part of your decision-making process. So before you have even made an appointment we facilitate a number of different services that are at no cost, at MSI.

Regarding post care, there is an after-care line as well, 24/7, where a nurse will pick up the phone to support somebody who is having any complications or pain or bleeding that seems unusual or just anxious about where they are in that post-care environment. That means they can get support to be able to, in an emergency, seek assistance in hospital, for example.

THE CHAIR: Are you able to meet the demand currently on your service?

Ms Ryan: No.

THE CHAIR: How many people in a 12-month period—I will not hold you to a number, but to give the committee a rough guide—would you say you either turn away or refer to other services?

Ms Ryan: I do not know that we have the data on that.

Mr Hakim: We do not turn away anybody who wants the service. That is probably the bottom line. There is a waiting period at the moment because it is very much led by the workforce and there is a shortage of workforce in Canberra especially, and in the whole country. We know that.

The way that we can deliver care is something that we are working on in the next six months—how we change that. Regulation is really critical in that. It is anywhere between a seven and a two-week waiting period. That is why we have introduced medical abortion via telehealth. Right now, you can get an appointment in the next 24 to 48 hours for the first consultation.

The ultrasound appointment is what can take a long time right here in Canberra. There is an issue with ultrasound and third-party providers, particularly with bulk-billing to get that. Then you can go on to the second appointment. We are looking at how you can do no ultrasound, with a telehealth appointment There is literature on that overseas. We have just won an award with RANZCOG on the research that we are doing in that space, so watch that space. We are making changes to the way that our service delivery is done so that we can fast-track access where there are issues with workforce or that lack of ultrasound, for example.

But we do not turn anyone away. We work find a solution for further access, whether that is trying to find a GP who might be able to provide it, if they are under nine weeks, or whether it is in surgical abortion. That means going to Sydney, for example, or to Melbourne. That is where the public provision in hospital, for example, is really critical to be able to support people who cannot otherwise get access to services.

THE CHAIR: What kind of relationship do you have with the ACT government in terms of having an open dialogue about some of these challenges? I ask that in the context that I received the news positively that the ACT government will put that $4.6 million aside to provide free abortions, but you and other providers are telling me that the challenge is actually about a workforce shortage. So I am foreshadowing—and I wonder if you share the concern—that this funding will come online to create some equitable access to health care, but when the phone rings and your service and other similar services do not have the trained medical professionals, what good is this money? Is that a concern that you foreshadow and is that a conversation that you have already had with government?

Mr Hakim: It is a multi-pronged approach. It certainly is a conversation we are having with government. We have that conversation all the time. We talk very closely with the ACT government but also the Department of Health around those concerns. Training is partly to do with government but it is also partly the relationship with RANZCOG and RACGP and their obligations around including training for abortion and conception care within their colleges. That is improving. RANZCOG is doing a lot of work in that space. RACGP need to do a little bit more work in that space, but they are aware of that. So that is continuing.

I think the issue of workforce is one that is more universal in health systems. This is where nurse-led care is really critical when we talk about medical abortion in particular. If we can release doctors to be able to do some of the more complex work, nurses are more than proficient to deliver some of the work, such as medical abortion under nine weeks. That will relieve some of that tension in the system. So that conversation is happening.

We are doing some work with the TGA, for example, in the next few months, on the

activation of a risk management plan that will allow that on the regulatory side. The next part will be around government changes in legislation that enable that. It is a live conversation. I know that the Minister for Health is very interested in that and very supportive of that. It is about talking to the various colleges to make sure that they also support that.

THE CHAIR: I will ask my last supplementary on the workforce shortage thing, because it is our role to make recommendations to government and we will obviously emphasise and prioritise. You said it is a multi-pronged approach, which I understand. If you were in the Minister for Health's shoes, if you were in government, where would you propose that the most immediate intervention could be made to combat some of those workforce challenges? What could we start to do, or do tomorrow, or put on top of the list?

Mr Hakim: The number one thing—and, Mel, jump in, particularly around nursing, and I know you have had complications getting doctors—is ensuring that that training in the courses is being done and supported, whether that means providing particular funding to make sure that that happens. I think that is really critical. It needs to go through the entire training system so that you have an acceptance and understanding of what happens. As we heard this morning from our fellow GPs who are delivering, training is really essential in prescribing MS-2 Step because there is no training initially. There is no training when you become a doctor. Nobody knows what to expect, what to do.

The conversation we have with GPs is that we actually appreciate the training as part of the prescribing program. We would be more hesitant if that was not there, because we do not otherwise get training. I think support that was introduced around providing some sort of funding for that would be terrific. The steps taken to make it free are really critical from an end user side, but it is also really critical to make sure that specialists like us are able to then offer continued workforce opportunities for doctors and nurses as well.

Ms Ryan: I think promoting and initiating nurse-led care models would definitely help in terms of workforce. At the moment, to run a medical termination list, we need one doctor and three nurses. If those three nurses could be utilised to facilitate more equipment then the demand would be lessened and we could take some of that pressure off the doctors to run those lists. So, yes, that is the way to go.

THE CHAIR: Thank you.

DR PATERSON: How many people do you think would be pushed up the ranks of intervention because they cannot get the care in time? When would be the average time that someone would come to you for a medical abortion in the gestational period—or is it just any time?

Ms Ryan: Any time within the range. You need to be within five and nine weeks to access a medical abortion. If you come any time in that range, that is okay. At the moment there is about a two-week wait at our clinic. So if you come to us and you are already eight weeks then you might be out of luck in accessing our clinic, but not necessarily in accessing the abortion. Sorry; I have lost my train of thought.

Mr Hakim: While you are just recollecting that, Mel, I can add that 85 per cent of abortions occur below 14 weeks. When we talk about nine weeks gestation for medical abortion, around 70 to 75 per cent of abortions occur in that gestational band. When most people realise they are pregnant and consider an abortion would be around the six to seven-week gestation period. So it gives them a very short window for medical abortion. We are now talking to the federal government and looking at extensions for those gestations. It is 9.6 in most OECD countries. That is on label. We know that there is off-label use up to 12 weeks.

When I talk about on label and off label, off label means it is being used without TGA-approved indication. It is safe. It requires an additional number of tablets for Misoprostol and for the support. There is an extra step that needs to be taken—three-step, if you like. But we are looking at that and the time lines to be able to get a product. It is a new product application, so that could take anywhere between 18 months and three years through the TGA process. We are talking about how we can fast-track that to support better access, particularly in more regional areas. We know that we have those capacity issues here in Canberra when it comes to the health system. In a regional area you have fewer people in the health workforce, and particularly in regional New South Wales, coming in to Canberra.

DR PATERSON: Your submission talks about surgical abortion care up to 14 or 16 weeks. What is the issue? Is it 14 or is it 16—or 14 to 16?

Ms Ryan: It depends on the practitioner.

DR PATERSON: Okay.

Ms Ryan: At our clinic, it is at the discretion of the doctor. The facility is licensed for up to 16 weeks, but it depends on which doctor is there.

DR PATERSON: Okay. And then people have to go to Sydney for their care; is that correct?

Ms Ryan: Yes.

DR PATERSON: To facilitate abortions post 16 weeks in the ACT, what do you see needs to happen? Would your service be able to do that?

Ms Ryan: We would, but probably not in the current clinic. We would need an improvement in infrastructure, a clinic more suited to that sort of procedure. At the moment it is set up as a day hospital, which is okay for some procedures, but for some that become more complex we would need more equipment, more staff and more access to tertiary hospitals if something were to become too complicated for the clinic.

Mr Hakim: Yes, and it really comes from a regulatory perspective too. As you can imagine, there has been a real change in regulation since 2014. The facility we are in is no longer adequate, so we are working with ACT Health on what does the next facility look like? But, certainly, for over 16 weeks it requires a different type of facility. It comes down to the pre and post care, because there is a lot more

involvement when we talk about, for example, situations above 16 weeks. Often it is a two-day process, because there is dilation work that needs to be done on day one, in the preparation of the cervix, and the actual abortion happens on day two.

DR PATERSON: Thank you.

MR MILLIGAN: In your submission you suggested that the ACT fully fund reproductive health care, develop a health strategy and also fund research into reproductive coercion. I was wondering if you could briefly speak to those three areas?

Mr Hakim: Thank you for that question, Mr Milligan. First of all, on the first one, around funding universal access to sexual and reproductive health care, we know that having fully funded services, removing that barrier of cost, means that people can truly consider their options; they can consider their choices. What is happening right now—and I will be really plain about this—is that MSI Australia has been subsidising care for a very, very long time in Australia. That is because we believe in affordable care. Despite that, it is quite expensive for a lot of people. But we subsidise surgical abortion to the tune of 40 per cent. It continues to be more expensive as medical abortion increases as well, because there are fewer people seeking surgical abortion. We do that because we know that if we increase the price to cover the true cost, that will not be possible.

In the hospital system, the cost of delivery of a service would be about three times what our cost is. We see that overseas. Removing that out-of-pocket cost means that everyone is able to access the service that they would like and they are able to make the decisions they like and that we would be able to work through that. That includes things like financial support for grief, and going through any sort of specific cultural rituals. Cultural safety is really important.

Looking at other health initiatives and sexual reproductive health around contraception, such as STI checks and vasectomy, we do not talk about vasectomy very often. I think we forget men's responsibility here. In Western Australia we have full funding in the north metro health region, and the take-up of vasectomy has increased substantially as a result of full funding. Again, that brings accountability in the family unit back to men and it takes off that burden from women and pregnant people. I think those conversations are really important, and fully funding that makes a big difference.

We have brought on board free contraception for every surgical abortion client—and, by the way, it is completely their choice. I is about saying, "If you would like contraception now, it is available for free; you just have to buy the device." That option is taken up by almost double the number of people, so it shows that when choice is available then the woman or pregnant person is able to consider all aspects of their life.

Secondly, a sexual reproductive health strategy is really critical because it is about linking to both the men's health strategy and the women's health strategy nationally. It is about ensuring that it is co-designed with consumers, with the industry, with doctors, to ensure that what you need to deliver from a priorities perspective, as you

have said before, is actually delivered and we have a road map, we are measuring it. You cannot deliver if you do not measure something. So we see that strategy as essential to delivering care into the future. It also means that it can be renewed with clinical guidelines. There is a continued change in clinical guidelines over time and a strategy would allow those to be included as well, and things like harmonisation of legislation, of course.

Finally, reproductive coercion and violence is a really important aspect. We deliver free counselling as part of our service. Everyone, in fact, is offered counselling. What we know from our counselling clients, those who do seek counselling, is that 15 per cent tell us about instances of reproductive coercion. That reproductive coercion could be either towards or away from—so either having an abortion or having a child. It is really critical to understand that and to be able to put in place support for the person but also for clinicians to be able to deliver care.

As a specialist, we have got our own guidelines. For example, our counsellors always ensure that there is a full suite of services or options available. They operate as a separate unit to our service delivery arm and they offer everything from "How do you get adoption?" to if they need access to prenatal care or other options that are available to them. But we do see that reproductive coercion as an aspect of it. In clinic—and Mel can probably talk a little bit more to that—the team is always ready to enact support around that. We have done in the past, including how you work with police services, how you work with homelessness shelters et cetera.

Ms Ryan: Yes. We provide lots of options at the clinic to make sure that the care received is discrete and as safe as possible, whether that is no post or no text messages to the person's direct phone or address. We have resources for domestic violence support in discrete locations, like in the women's bathrooms, and also how we conduct the consult in the clinic. The partners are not welcome in that discussion; it is just for the patient.

But there are other indirect forms of coercion that come into play as well. For example, a woman who we saw recently, for medical reasons, could not use contraception, particularly hormonal models, but her husband refused to get a vasectomy or use any of his own form of contraception, so she was at her fourth visit to us, with four children at home. Giving people the choice and the ability to influence their own health is really important, especially for people like her. If vasectomies maybe were more affordable or if there were more options for her then she might be in a slightly different situation—if there was more social support as well.

THE CHAIR: I am going to open a can of worms in the two minutes we have left.

Ms Ryan: Please.

THE CHAIR: Mr Hakim, you are the first person today to mention vasectomies and men's responsibility to avoid unwanted pregnancy. Can you talk more to me about how those are provided here in the ACT and what more you think the ACT government could do, particularly to encourage men to participate more in what they need to do?

Mr Hakim: Thank you. I will let Mel jump into that one, but we do provide vasectomy in our service. Do you want to talk a little bit more about vasectomy?

Ms Ryan: Yes. We run two vasectomy lists a month at our clinic. You can have it with sedation or without. It removes the discomfort from it if you want to have an IV sedation. It is quite affordable. Often it can be cheaper than an abortion. If you have private health cover and Medicare, it often ends up being much cheaper. And it is a one off—one and done. There is a three-month waiting period to follow that, to make sure that it has been successful. But if we had greater facilities and more doctors who would come and do it then we would absolutely be welcoming the boys to come in.

Mr Hakim: Vasectomy is not anything that is invasive. It is a painless technique that we use. It is very successful. It has a high success rate. It comes back to asking, "What is one of the options around bringing men's responsibility into this conversation?" One of the few things that men can do to shoulder that responsibility is a vasectomy. Most of the men who do come to see us say, "I have seen my wife or partner have side effects to the contraception that they are on. We have got enough children and it is time for me to take that burden. We do not want any more children and we are making that decision."

And it is a perfectly legitimate choice. Often we get men come in groups. They tell their friends, everyone reaches the same age and they do it. They will send the first one in: "You will be the guinea pig," and find that, actually, that did not hurt a lot. With our doctors it is actually quite fun, because with vasectomy everyone makes a joke—you know: "It slipped! No, it did not slip, so it is all good." It is a very simple technique.

There is one gentleman who has booked ten times with us and keeps not showing up. It is that fear of what a vasectomy is. I think on the other side we have got men who want to get a vasectomy but cannot afford it. What we see in WA is that when you fund vasectomy the take-up goes up around four times, because it means that there is a choice that is different, that is easy, that is permanent and it means that the men can shoulder that burden, going forward, and it really does provide relief for the family unit around things like unplanned pregnancy.

THE CHAIR: To put a bow on that, the ACT government is investing $4.6 million over four years to remove out-of-pocket costs for abortion. Would you encourage the ACT government to fund a not dissimilar program so that men can get vasectomies?

Mr Hakim: A hundred per cent.

Ms Ryan: Absolutely.

THE CHAIR: Great.

Mr Hakim: Absolutely.

DR PATERSON: I cannot wait for the recommendation.

THE CHAIR: I am writing that as we speak. Ms Ryan, Mr Hakim, thank you very

much for your time today and for your written submission. The secretariat will send you a copy of the proof transcript to check for omissions and errors. If there is any information you wish to provide the committee to assist in our deliberations, including maybe some illustrations on a vasectomy, Mr Milligan and I would be keen to take a look at those and we will take them on advisement. But thank you very much.

Ms Ryan: Thank you so much.

Mr Hakim: Thank you.

TOOHEY, MS KAREN, Discrimination, Health Services and Disability and Community Services Commissioner, ACT Human Rights Commission

THE CHAIR: Thank you so much, Ms Toohey, for joining us today. On behalf of the committee, I thank you for your written submission, as well as your time. Can you acknowledge that you have read the privilege statement?

Ms Toohey: I acknowledge the privilege statement.

THE CHAIR: Thank you, Ms Toohey. Would you like to start with an opening statement?

Ms Toohey: I had not actually prepared one, particularly because our submission is quite short. I am very conscious of the fact that what my colleagues from frontline service delivery will tell you is probably more of what you want to hear from people. I am very happy to answer any questions.

THE CHAIR: When I think of the Human Rights Commission as it relates to abortion and reproductive choice, I think of situations where women and people who can get pregnant have received, or potentially have received, less than ideal health care or less-than-ideal advice in a healthcare setting. To your knowledge, what is the prevalence of that in Canberra at the moment?

Ms Toohey: I have endeavoured, from my experience, particularly as the health services commissioner, to draw on some of the examples that we have seen over the last 12 months of areas where people have either struggled to get access to the services or particularly some of the areas that I have specifically referred to around referral practices from GPs who do not want to prescribe particular services or do not want to be involved in particular service provision.

I have also drawn on some examples of concerning circumstances that we have had of people presenting to particular services in the ACT with a partial termination or a partial miscarriage and having quite some difficulty accessing those services in a timely and effective manner.

You have already heard some evidence today of people's concerns about stigma. We have certainly had a number of matters brought to our attention where people presented, assuming that all of the health services—all of the EDs, for example, in the ACT—would provide the same type of service, and that has not been their experience.

Sometimes the reports that we receive relate to what is referred to as conservative management—presumptions about a process that someone might go through after they have had a partial termination or partial abortion—and that the information they are provided with is that they might want to go home and just see how it goes, whereas the individual has expressed to us, sometimes right in the middle of those processes, that what they are looking for is surgical intervention.

Again, from our experience, we are sometimes the organisation that people come to when they are experiencing those difficulties. As I have said in the submission,

certainly, clarity of information around what services are available would be of great assistance to people. I noted, for example, some evidence this morning where a person presenting to Calvary was concerned that they might not get a particular service. That was not their experience, but the concern, as we know, is often what contributes to a person's wellbeing, particularly in such a traumatic circumstance. Certainly, again, from a number of matters we have seen, even quite recently, there have been both delays in services—and I have referred to a couple of examples around access to D&Cs and that being delayed—and access to surgical intervention versus, as I have said, conservative management.

The other issue that comes through in the complaint work that we do is GP practices not being clear about what services they provide. That can cause confusion for people. When you have a very short time frame to access services, that can be quite difficult for people, if there is no clarity about that. The other aspect that has been brought to our attention is that, in other areas of tertiary health care, you would be required to refer people on if you could not provide a particular treatment or you wanted to transfer treatment. That does not occur in this space, so people are often, as you have already heard today, left hanging, without a clear direction. I have heard you refer a number of times today to the lack of clear information about who provides these services, how to access them and what the time frames are; that contributes to access issues that are then presented to us as complaints.

That comes from well-educated, literate, well-qualified pregnant people and women, as well as from cohorts in the community that clearly need some support in that space—women with disabilities, people from the Aboriginal community, and people from backgrounds that are less articulate and less health literate.

There is a range of issues that we have tried to traverse, while acknowledging that we see a very small number of the matters. It is the frontline health service providers, who are also appearing today, that have that very detailed experience that they can convey to you.

DR PATERSON: Some of the submissions talk about the conscientious objector issue. In the ACT we do not legislate that they have to refer someone on to someone else.

Ms Toohey: Yes.

DR PATERSON: I am interested, from a human rights perspective, in your view. Do you think that the legislation should be changed to ensure that people that may go to a GP that has an objection to termination are referred on to someone else?

Ms Toohey: I think it falls less within the human rights space, in that human rights provide that women should be provided with appropriate health services, but it certainly falls within our remit as the health services regulator in the ACT. Again, we would say that it compromises or has the potential to compromise patient safety if there are not clear pathways for people. We know there is information available, but I think there has been consistent evidence presented that the information is not necessarily as easily available, as accessible, as it could be.

With the conscientious objection, obviously, we would not object to that from a balancing of rights perspective, but we do note that, as I said, in other areas of health practice there is an obligation for a practitioner to refer on if they cannot provide the service, are unqualified to provide the service or, equally, for whatever reason, if the person needs to access a different type of service. There is actually a proactive obligation in the codes.

My experience with that issue is that we have had the odd call where people have called us, asking where to go. I am in the fortunate position of having good Google skills, but that is an inappropriate way for people to be accessing those services. I am sure you have heard the same story from other frontline service providers here today.

MR MILLIGAN: My question was addressed then, so I am happy to pass back to you, Chair.

THE CHAIR: Ms Toohey, I do not want to put you in a challenging space when I ask this, but you referenced the first submitter that we had today, who explained their experience or their fear about the kind of health care that might be provided at Calvary—not because it is not staffed by qualified professionals but because the organisation has a well-known, publicised, faith-based ethos. Given that that is a public hospital, paid for with ratepayers' money, how do you find that that intersects with the ACT being a human rights jurisdiction and therefore obligated to provide secular health care?

Ms Toohey: Yes, it is a challenging place to be. Thank you for that question. It is a conversation that we have with our colleagues at Calvary on a regular basis. We understand the contractual arrangements that they have entered into. They are, however, also a public authority for the purposes of the Human Rights Act in the ACT. I would say that, at a minimum, that obliges them—again, I have had this discussion with them—to ensure that people understand the scope of the services that they provide and, if there are limitations on those services, that that is in the public domain, so that people are clear about what their choices are.

Certainly, as the organisation that administers the Human Rights Act in the ACT, we understand the need for balancing of rights. I do not necessarily agree wholeheartedly with the argument about public funding, but I certainly agree with the argument that, as a public authority in the ACT, there are particular obligations that arise for faith-based organisations delivering services on behalf of the ACT government, and that includes things like access to information and privacy rights.

There is a real issue—again, some of the matters we have seen—of people assuming that the services being provided in both of our EDs or both of our public hospitals would be the same. It is not always the same experience. I am not saying that it is necessarily faith based, but it does appear to us, from the matters that we have seen, that even if there is not a policy in that space, there is a perception, perhaps, amongst staff that there are limitations on the services that Calvary provides. We have made some recommendations about consistency of information delivery on what services are provided where; equally, if there are limitations on that, that should be acknowledged so that people do not have to go ED shopping in order to find the service that they are looking for.

With my colleagues, when I have raised some of the examples I mentioned before—for example, the approach around conservative management—there might be an argument that that is an appropriate clinical approach to the situation. I completely agree that it is a clinical call. When the patient is asking for a particular service, surgical intervention, and that is not provided, that is why those matters end up with me, because that is a health service that someone is entitled to. If there is a particular reason why that service is being deferred or delayed then that should be made clear to people.

As I said, that is a discussion we have had with my colleagues at Calvary over a period of time, over a number of issues. It is a matter for the committee as to whether they make recommendations around whether the services should be equivalent, given it is public funding. Certainly, again, from a human rights perspective, we understand the need to balance rights, but we would also argue strongly and strenuously that there are public authority obligations that exist for Calvary in the ACT in the way they go about those services.

DR PATERSON: The exclusion zone issue: do we have 50 metres here?

Ms Toohey: Yes.

DR PATERSON: But it is 150 metres everywhere else.

Ms Toohey: Yes.

DR PATERSON: Do you think that should be changed? Is that important?

Ms Toohey: We have suggested that the equivalent should be considered by the committee. In my role as discrimination commissioner, I have had a number of complaints made to me from people of faith wanting to protest outside or be present outside some of these facilities, and objecting to when they are being moved on. So it is an active issue; it is not theoretical. We have certainly made the suggestion that the committee consider bringing the ACT into alignment with other jurisdictions on that matter.

DR PATERSON: Is 150 metres enough? Should it go further or are there other restrictions that should be implemented in respect of access?

Ms Toohey: I have had a number of debates with some of my colleagues internally about that, as you can imagine. 150 metres has been recognised in the courts as being appropriate. Canberra is quite small, so 150 metres is quite a long way. Certainly, as I said, in a couple of matters that I have dealt with, people have travelled from other parts of Canberra to have lunch on a seat outside a particular facility, whilst perhaps referencing their faith. I think we need to be conscious, as I said, that it is not a theoretical issue; it is a practical issue that people experience. As we know, it increases the level of anxiety and distress that people are already experiencing.

THE CHAIR: I do not have any further questions, having read your submission.

Ms Toohey: I am very happy to be brief, Mr Davis, as you know.

DR PATERSON: On accessibility to abortion post 16 weeks, I would be interested in whether you would voice your support for offering that service here in the ACT.

Ms Toohey: From a health services commissioner perspective and a disability commissioner perspective, I would support that. There are quite significant issues—again, as has already been alluded to—particularly around information access. Also, the fact is that we do not want people to have to go interstate to access services. We are very grateful for the government's announcement about the additional funding.

I am certainly aware of a number of matters that have come to our attention where the very tight time frames and the very short periods of access have caused significant issues for people. It is not, for everybody, a decision that can be made quickly or easily. For example, I have dealt with a matter to do with a young woman with a disability where we needed to get some assistance in terms of supported decision-making. That is not a quick process. As health services commissioner, I would certainly support the committee giving consideration to that.

DR PATERSON: On that issue of supported decision-making, as you said, it is probably a much lengthier process; what do we need to put in place in the ACT? Are there other things that we should have in place to be able to support people in that situation to make informed or consensual decisions?

Ms Toohey: You would be aware that there is a lot of work going on in the supported decision-making space. Again, as people have alluded to, it is a complex decision that often has to be made in a very constrained time frame, often in isolation. I do not know about you; I struggle to get in to see my GP. It is about acknowledging the various functional issues and functional barriers that occur for people in endeavouring to access what should be a universally accessible medical or health procedure.

While I fully endorse the great work that my colleagues around the room do, in the ACT there are limited services, and we know that. Some of the earlier comments—indeed we have referenced this in our submission—around nurse-led medical support in this space, clinical support, is a really important consideration. We would welcome the committee giving consideration to that. We have some excellent nurse practitioners and midwives in the ACT. They are already providing support to a lot of people on these issues, and it would be appropriate to think about expanding that as a very important resource. As we have said, that would increase not only accessibility but also the ways that people could access that information.

THE CHAIR: Thank you, Ms Toohey. On behalf of the committee, we appreciate your time today and your written submission. A copy of the proof transcript will be sent to you in the coming days, to check for accuracy and omissions. Let us know if we have missed anything or got anything wrong; otherwise we really appreciate your time.

Ms Toohey: Thank you very much.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health
TRAVERS, MS MARIA, Executive Branch Manager, Partnerships and Programs Division, ACT Health Directorate

THE CHAIR: Welcome back, everybody. On behalf of the committee, thank you for appearing today and for your written submission to this inquiry. I remind witnesses of the protections and obligations that are afforded by parliamentary privilege and draw to your attention the privilege statement to your right on the table. Before we begin, could I ask you to acknowledge you have read and understood the privilege statement.

Ms Stephen-Smith: I have read, understood and acknowledge the privilege statement.

Ms Travers: I have read and acknowledge the privilege statement. Thank you.

THE CHAIR: Thank you both very much. Do you have an opening statement for the committee, or would you like to go to questions?

Ms Stephen-Smith: I am happy to go straight to questions.

THE CHAIR: Wonderful. I am going to kick us off with a spicy one, Ms Stephen-Smith, because I have been inspired by a previous submitter today. The ACT government has made the announcement of $4.6 million to fund free abortions up to 16 weeks. How much money does the ACT government spend to help provide free vasectomies?

Ms Stephen-Smith: I suspect we will have to take that question on notice. It is not the same thing, obviously.

THE CHAIR: No.

Ms Stephen-Smith: An abortion and a vasectomy are very different types of healthcare—

THE CHAIR: Naturally.

Ms Stephen-Smith: one of which—I think I heard Ms Toohey talking about earlier—is something that needs to be decided in a short period of time, at a particular point in a woman or pregnant person's life; the other is a form of contraception, obviously. In terms of the announcement that we made in relation to the $4.6 million, that also includes long-acting reversible contraception at the time of abortion or shortly after.

It is certainly something we are very conscious of in terms of the broader conversation that is being had around sexual and reproductive health, and I acknowledge the calls from a number of submitters for a sexual and reproductive health strategy for the ACT. I am sure in that context, that topic may arise.

THE CHAIR: I have been very cheeky by starting with a very specific question, but I

would be interested, if you would not mind speaking more broadly, about what role the ACT government believes it has to provide an equity of access to these reproductive choice services that, by design, limit unwanted pregnancy. We have heard some compelling evidence today about the virtue of men's responsibility and men taking responsibility in this space, so where in the government's current policy framework do vasectomies and other men's responsibilities around reproductive healthcare sit? Where do we prioritise it? How do we facilitate access to those services?

Ms Stephen-Smith: Would you mind, Ms Travers?

Ms Travers: Certainly. Again, for the ACT government, we always look at the family as a whole unit, however that family is made up, so we are certainly very conscious of the rights and obligations of men within that framework. I think with all the policy that we develop, particularly around abortion and reproductive health, the role of men is very well intertwined. I do think that perhaps for some of the specifics, as you mentioned previously, around vasectomy, we will need to come back to you with some further information. Is there anything else further?

THE CHAIR: No, and to be entirely honest, it is just my propensity to be naturally curious and go on the last thing that I heard. So I thought I would give you a cheeky one!

Ms Stephen-Smith: The only other thing I would say in relation to that is, obviously, there are both commonwealth and state and territory responsibilities in relation to healthcare, and, by and large, vasectomy is something that would be done in the community and may attract some commonwealth funding in association with that, as does abortion. I recognise that there is a parallel there, in the sense that we are stepping in to pay and close the gap in those costs, and pay for out-of-pocket costs, but it is not simply an ACT government responsibility.

THE CHAIR: I appreciate that, thank you.

DR PATERSON: In many of the submissions there was the issue of pregnant people having to travel to Sydney for a termination post-16 weeks, or potentially post-14 weeks in the ACT. I am interested to know your views on that and why we do not offer those services here? Are we in a position to begin to think about providing those services here?

Ms Stephen-Smith: It clearly depends on the circumstances. Some people who require a termination post-16 weeks would be getting it in the ACT through Canberra Hospital if there is a medical need for that—if that is arising as a result of a specific, identified medical need in relation to the pregnancy. It is certainly something we are keen to explore with MSI in particular, as the provider of surgical abortions in the ACT. Their current facility would not enable that service to be provided, and we are in conversation with them about a new location for them that would be a more appropriate clinical space, both for the services they currently provide in terms of abortion and to expand that service.

DR PATERSON: Thank you.

MR MILLIGAN: Minister, are you able to indicate, provide or maybe even take on notice what funding is currently available, or the government gives, to such service providers like Marymead, who provide support and services for anyone who is pregnant, as well as for post pregnancy. What funding is available? Where does it go, and to what service providers?

Ms Stephen-Smith: I do not know if Ms Travers has some specific information on that. We would probably have to take the breadth of the question on notice. Is there something more specific in relation to Marymead? I am conscious that is it a Catholic organisation unlikely to be providing support and advice to people who are seeking a termination.

MR MILLIGAN: It was mentioned earlier by a witness. It is more or less to find out what the balance is. What funding and support does the government give to future parents who would like to go through to birth? What funding is provided to service providers to help them through that process, as well as post birth?

Ms Stephen-Smith: There is a range of funding: from mental health support to funding we provide to support Sexual Health and Family Planning ACT, for example, to provide non-directive counselling services for people who are experiencing an unplanned pregnancy. That is outlined in our submission, and they can also provide referrals to external counsellors as might be required.

The ACT government also funds the Junction Youth Health Service, and their integrated primary health services include family planning and sexual health services for people aged 12 to 25. Again, that might be a non-judgmental, non-directional support for someone who finds out they are pregnant and are just looking for a safe place.

Most people would access that early support from a GP, you would expect, or a nurse practitioner if that is their preferred form of primary care support. Again, related to the earlier conversation with Mr Davis, there are services funded by ACT government, there are services funded by the commonwealth and there is a combination of both.

In terms of the breadth of services, our submission at page 17 outlines a non-exhaustive list of organisations that provide information, including: Women's Health Matters; Sexual Health and Family Planning; MSI Australia; Pregnancy, Birth and Baby, operated by Healthdirect Australia; and Children by Choice. So, there are a range of a services available in the ACT that would provide various different forms of support. I am happy to take on notice your specific question and come back with more of a breadth of services and some specific information about ACT government funding for those.

MR MILLIGAN: Yes, it would be useful to find out what funding and supports are given to those service providers that are listed in your submission. That would be useful, thank you.

THE CHAIR: Minister, the submission from the government to this inquiry speaks a fair bit about Calvary Health Care and the Calvary network agreement. The

committee has also heard today, in evidence and in submissions, a range of different perspectives on how people in the community feel about accessing Calvary services in the first instance for reproductive healthcare and abortion, and then their experience in different parts of the hospitals, noting that it does have a faith-based ethos and does adhere to the Catholic Health Australia code of ethical standards, which you have stipulated in your submission.

I wonder how we reconcile, as a government, being a human rights jurisdiction that is willing to publicly fund free and safe abortions, that one of our only two public hospitals adheres to a code diametrically opposed to that view?

Ms Stephen-Smith: I think this is an ongoing conversation with Calvary around the way the support and advice is provided to people at Calvary hospital and the services that they provide, as you note. They are informed by the *Code of ethical standards for Catholic health and aged care services in Australia*. That has been recognised throughout the period of funding of Calvary, which pre-dates the existence of the ACT government. But I recognise that it is a point of concern, particularly, I think, given that Canberra Hospital also does not specifically provide abortion services and that there are non-government organisations and GPs, for medical abortion, that are funded to provide those services.

There is not such a disconnect there between Calvary and Canberra Hospital because neither of them specifically provide surgical abortions. But with things like direct advice on post-partum contraception and contraception for people who have experienced rape and sexual assault that then cannot access the morning after pill, for example, through Calvary Public Hospital, we do recognise that those are things that people raise on a regular basis.

In terms of your question about accessibility of services in a human rights jurisdiction, it is not that those services are not available in the ACT. There are other providers of all of those services and all of those services are readily accessible within the ACT. But I absolutely recognise that for someone who attends Calvary hospital, particularly after they have had a distressing experience or they have given birth at Calvary and they expect to have that holistic service, that can raise concerns for those individuals.

THE CHAIR: Can I take you up on one point? You did say that those other services are readily accessible. They may be, but if there is a common theme that our evidence has heard it is that there has been a lack of information about where to access those services. I suppose the first part of that question is: what role does the ACT government see that it has in promoting those services and access to those services? If we believe that the government has a strong role, what are we currently doing and where have we identified areas where we could do it better?

Ms Stephen-Smith: Part of the announcement of the budget funding was around a communication information element. Ms Travers might want to speak a little bit more about this, but we have certainly recognised that it is hard to find all that information in one place and that people are not necessarily aware. We have heard that from submitters, as well, to the inquiry.

Ms Travers: Thank you, Minister. At the moment we are working with Women's

Health Matters on this particular issue. At the present time we are going and consulting with stakeholders about the design of future abortion services and the communications that we need. So we are in that very first phase, but it is very much at the forefront of our minds that the communication about how to access services, and timely access, is really important.

THE CHAIR: When you say you are in the first phase, do you have an expectation of when you might complete that work? I am cognisant that the funding, the $4.6 million, starts to come online in July next year.

Ms Travers: That is right.

THE CHAIR: Do you imagine that this work will be completed at that point and that it will be complemented by an awareness and information-sharing campaign?

Ms Travers: Absolutely. We are hoping to conclude the foundation work by the end of this year. Then there will be a roundtable in 2023 with key stakeholders. Then we really do hope to commence the procurement process early on in 2023, with a view to having that funding available in the final quarter and services available and a comms strategy happening.

THE CHAIR: You were so prepared for that question you would have thought it was a dixer.

Ms Stephen-Smith: Just to clarify: you said July 2023? The aim is to certainly to have things in place before that, in the final quarter of this financial year.

THE CHAIR: Tremendous. Good to know.

DR PATERSON: One of the things that has come out of today that I think is quite concerning is the lack of certified prescribers, GPs, of the drug for termination. I think we heard that about nine per cent of GPs have done the training, which we have heard is a four-hour online training module. What could the government be doing to create an environment where GPs feel supported, encouraged, incentivised to do the training? What sorts of limitations do you see with that?

Ms Stephen-Smith: I think that is probably part of the work that the directorate will be doing. Women's Health Matters also is looking at how we broaden information for general practitioners to ensure that they are confident and comfortable. We are also going through the expression of interest process in relation to our own funding for GPs to participate in that. Ms Travers may want to talk a little bit more about that.

I also am aware that people have raised nurse prescribing as well. That is certainly something that, from our perspective, is a commonwealth question—whether nurse practitioners are able to prescribe. Certainly, something I have discussed with Minister Butler is expanding the practices of nurse practitioners and for them to get moving on some of the work that they have already done around both the MBS review and any prescribing that goes along with that.

THE CHAIR: Can I just clarify: did you just say that the government currently does,

to some degree, subsidise the cost for GPs to access that training? Is that what I heard? Did I mishear that?

Ms Stephen-Smith: No. What I was talking about was the expression of interest to participate in the free abortion initiative, which includes both medical and surgical abortions. We need to go through a process. We have obviously only got one provider of surgical abortions. That is a conversation directly with MSI. On the medical side, do you want to talk, Maria, about how that process is going to work?

Ms Travers: Certainly. With medical abortions the model can be a bit more complex because of those things that were raised. That is around that GP interface and it is also around the funding structure because of the commonwealth providing funding to GPs—and we have an ACT contribution as well. That is going to be complex in the way that it plays out. One thing with general practice, too, is that we always are quite aware that GPs are very hesitant to advertise that they provide abortion services, which is also a threshold issue to work on as we develop the model. As I said, the complexity around that model of surgical abortions is really going to have to tackle that issue.

DR PATERSON: If we have GPS who feel that the stigma is so great, professionals offering a healthcare service and they feel that they cannot advertise what they are doing, does that speak to a broader problem: that the stigma is so great and we actually do need to do a lot of work with the community around reducing the stigma associated with termination?

Ms Travers: Yes. I think you are right. We do. That has certainly been in the government's mind around the communication strategy and the funding to help provide these services. That is going to really help to remove the stigma.

THE CHAIR: At the risk of offending every doctor in the city, we heard from the general practitioners who came in before that only nine per cent of GPs in the ACT are currently appropriately qualified and registered to provide medical abortions. But a range of easily publicised polls would say that community sentiment on approval for terminations is much, much higher than that. Do we have a divide between community expectations, what Canberrans expect, and what the healthcare industry is willing to provide? If the government's view is that we do, in fact, have that, do we have strategies or ways to intervene, particularly with the medical profession, to try and bring that nine per cent number up closer to community expectation?

Ms Stephen-Smith: Certainly, from my perspective, I would find it hard to make a judgment call about what is driving that. I think it would be a useful thing to explore what is driving that low uptake from GPs. It may be more about the financial arrangements and the funding that they receive from the commonwealth. We already know that GPs are saying that their practices are not viable on the basis of the existing funding. If they are making a judgment call that this is not a viable service for them to provide, taking into account that they need to do four hours of training, that might not sound like a lot but that is an additional thing that they have to do.

As Ms Travers has indicated, if they feel like it is not something that they are necessarily going to want to advertise, that might be about the whole practice. I just

do not know what is driving that decision-making. I would be hesitant for me or for the committee to leap to conclusions that it is because GPs do not support people having access to abortion. There may be some practical barriers around that as well that just mean it is actually not a service that they feel confident and comfortable in providing or that they think is a viable thing for them to provide, particularly if they think that the numbers coming through are going to be quite low. You might do the training and then not having someone seeking a medical abortion for another six months. That means you are trying to dig back into your training. I think there are probably a whole range of things that feed into that decision-making.

THE CHAIR: We have had a bit of a conversation on this today already, with the general practitioners that we met earlier. The proposal was that perhaps the ACT government could intervene by subsidising the cost of participating in that training. Based on what you have just said, do we need to go back two steps before that and engage in a bit of a consultation with general practitioners in Canberra to identify what the barriers are to providing medical terminations? It would appear that, based on the funding announcement, the government clearly has the desire to make sure that this is accessible. So is that something that the ACT government has considered doing or would have the capacity to do?

Ms Travers: It is certainly something that we have considered doing as part of our consultations. I think this issue also goes to the complexity of the consultations that happen between the doctor and the patient. There is a time issue there. You are not going to have a patient turning to have a conversation about a medical abortion who is going to have your usual 15-minute consult. It is going to be a long consultation. I think that goes into the mix, as well as Canberra having one of the lowest rates of bulk-billing. There are all these things that absolutely need to be considered. My team has been having conversations particularly with the Academic Unit of General Practice, also based in the ACT Health Directorate, and that would absolutely feed into those views.

DR PATERSON: A further step back from that, we have heard evidence today that, even through medical training, when you do your basic medical degree, abortion is discussed as an ethical issue, as opposed to a medical one. I am wondering whether there is work that the ACT government could do in discussions with tertiary institutions here in the ACT around how they are training their students, who hopefully end up practising in the ACT.

Ms Stephen-Smith: I think that is also a question for the colleges, as well as the universities. The universities do medical school training but, following medical school, there is a whole lot more training that is managed by colleges. It probably is a good conversation to be having with all of our providers—both the university-based and postgraduate education, for want of a better term.

MR MILLIGAN: Minister, has the government considered or is the government considering developing a sexual and reproductive health strategy? If you are, what will you be covering in that and what consultation will you do?

Ms Stephen-Smith: Certainly, I have heard the calls for that. I think we will wait and see what the inquiry comes back with before we make any commitment in that regard.

We have got a lot of work on our plate at the moment. This team, who would be doing that work, has a lot of other streams of work that it is currently committed to. I would not be sitting here and making a commitment right now that we are going to do that.

MR MILLIGAN: You can make a policy announcement; that is fine.

Ms Stephen-Smith: I will be interested to see what the committee recommends in that regard. We are constantly expanding the scope of our strategic thinking around health services planning. In August we released the ACT Health Services Plan, which sets a range of priorities for ACT government investment in clinical services but also our strategic thinking. One of the early priorities out of that is the child and adolescent clinical services plan. We have recently released the maternity strategy. We are currently working on a disability health strategy, in the second phase of developing that work, and then there is a whole lot of north-side clinical services planning as well. A whole range of services planning is underway. We are out on consultation for the next drug strategy plan also. I think it is not a lack of desire to have a sexual and reproductive health strategy; it is more a question of how we fit that into the program of work over the next few years.

MR MILLIGAN: Thank you.

THE CHAIR: I will keep on my trend of asking spicy questions, Minister. Should the committee resolve to recommend that the government does conduct this strategy—of course taking on board that absolutely that there are workforce pressures in the health department to meet a pretty ambitious policy agenda—does that not speak to the fact that you might need a slightly bigger department?

Ms Stephen-Smith: I will be continuing to have that conversation with the Treasurer, through the budget process. At the moment, in the way that the whole budget is structured, we do have a health funding envelope and a growth envelope for health funding that needs to balance our investment in policy and ongoing work on the public preventative health side with our frontline staffing. That is a constant juggle, as it is for all health ministers.

THE CHAIR: The perfect way to end. Thank you very much. Minister Stephen-Smith and Ms Travers, thank you very much for appearing and for your written submission to the committee's inquiry.

Ms Stephen-Smith: Sorry; I have just been reminded that there is indeed a commitment in the Health Services Plan to develop a sexual health and sexually transmitted blood infections and blood-borne viruses services plan.

THE CHAIR: Tremendous. What a great way to end. Ms Travers, Minister Stephen-Smith, thank you very much for your time. A copy of the proof transcript will be forwarded to you in the coming days to check for omissions and accuracy. Please get in touch with the committee secretary if there is any record-correcting that needs to go on. Otherwise, we thank you so much for your time.

Ms Stephen-Smith: Thank you.

THE CHAIR: The committee will take a short break.

Hearing suspended from 2.30 to 2.47 pm.

BRIEFFIES, MS JAE, Student Researcher, ANU Law Reform and Social Justice Research Hub

THE CHAIR: Welcome back to the inquiry by the Legislative Assembly Standing Committee on Health and Community Wellbeing into abortion and reproductive choice here in the ACT. We now invite the ANU Law Reform and Social Justice Research Hub to join us at the table. Could you acknowledge that you have read and understood the privilege statement?

Ms Brieffies: I have read and accept the privilege statement.

THE CHAIR: Would you like to begin with an opening statement?

Ms Brieffies: That would be wonderful. Thank you for the opportunity to appear before the Standing Committee on Health and Community Wellbeing on behalf of the ANU LRSJ Research Hub. The research hub aims to engage students from the ANU College of Law within processes of law reform by supporting them to work in consultation with academics in making submissions to parliamentary inquiries concerning issues of justice and public interest.

Our submission was co-authored by a team of three student legal researchers. I wish to acknowledge my fellow co-authors, Harry Fell and Eugenie Maynard, who, unfortunately, were unable to appear today. The opinions that we express in our submission and that I will articulate today do not represent the views of the wider health research project, nor of the ANU, but are views arrived at through independent research, consultation and deliberation. I should also note as an employee of the Australian public service that I am appearing in my personal capacity today.

I welcome the opportunity to answer the committee's questions in relation to our submission and the law reform recommendations for the inquiry into abortion and reproductive choice in the ACT. These issues sit at sharp junctures between the word of the law and its application to the lives and the choices of pregnant people in the ACT. It is a privilege to appear before the committee as a young person keen to contribute to building stronger policy through law reform and as a young person who relies on reproductive health services in the ACT. I hope to bring these perspectives to the issues raised by the committee today and I look forward to answering your questions.

THE CHAIR: Thank you so much, Ms Brieffies. I will ask the first question. I would like to start with recommendation 5, as it touches on the main topic of conversation that we just had with Minister Stephen-Smith, in terms of Calvary hospital and their objection to abortion and reproductive choice access. You say in recommendation 5:

> … reconsider allowing Calvary Hospital to maintain its position as a public hospital exempt from providing these services in the ACT.

That may very well be a very controversial position. Could you elaborate on that recommendation?

Ms Brieffies: Yes, absolutely. I acknowledge that. I think the starting point for this recommendation is a distinction regarding individual conscientious objection, which is an important part of the rights-balancing process when it comes to complex issues like abortion, which may raise issues for people of religious persuasions and so forth. Individual conscientious objection is protected under the Health Act and there is institutional conscientious objection, on which the law is mostly silent, but it is assumed that service providers can provide or not provide the services that they wish to. I think that is a strong starting point, or a lens through which to view the issue of Calvary hospital's objection, noting also that it is obviously a public hospital that receives public funding.

Various organisations land on different sides of that debate. I note the AMA's position is that institutions can object to providing any sorts of services; on the contrary, the World Health Organisation recommends that institutional objection is not on the table as a matter of ensuring access to abortion. It is an issue that has been floated in various jurisdictions. From my research I could not find any relating specifically to the issue of abortion, but I note last year that, with regard to voluntary assisted dying, the Queensland parliament raised the issue of institutional objection and introduced provisions to the effect that institutions have to enable access to willing providers for people seeking information about voluntary assisted dying.

I do not think it would be the case that every single practitioner at Calvary hospital would hold a religious objection to providing abortion services and services that are incidental to abortion. I know there has been a lot of discussion of D&C, for instance. A good compromise—obviously, it is my personal opinion—at law is protecting the rights of individuals to conscientiously object to procedures or deliver any procedures that they might not be willing to, for any range of reasons, while acknowledging that publicly funded health institutions must and should enable people seeking treatment to have access to a person who can reasonably provide those treatments.

DR PATERSON: From a law reform perspective, would you view that as the pinnacle of law reform, if this committee were to make recommendations, or do you think there are other areas of law reform in the ACT?

Ms Brieffies: On a very similar note, I would consider the obligation to refer as part of conscientious objection to be probably a pivotal issue in terms of law reform in this area. I note that the ACT is somewhat out of step with many other jurisdictions in that sense. Obviously, we protect individuals' rights to conscientiously object, but we do not actually require them to refer patients to an equivalent service. That ties in to the Calvary issue. I would say that, on the scale of law reform issues, while they are both important, I would place the obligation to refer higher. The committee has received a lot of submissions, and heard from witnesses today, outlining essentially that there are issues with the chain of referral and issues with accessibility to information in relation to willing providers. I cannot remember the exact submission, but conscientious objection stops people getting abortions in the ACT, and it has stopped people getting abortions in the ACT. I would stay that strengthening referral pathways is probably, as a law reform priority, top, from my perspective.

MR MILLIGAN: In your submission, recommendation 2 refers to investigating options for lifting the gestation period for self-managed medical abortions. Can you

elaborate on and explain that a little bit for me, and the impact and result of that?

Ms Brieffies: Yes. Obviously, I am not a health professional, and you have heard from a wide range of very experienced and knowledgeable health professionals. The perspective that I brought in the submission was from the World Health Organisation's best practice guidelines in terms of the safety of gestational limits for self-managed medical and/or surgical abortions. I note that the gestational limits recommended by those best practice guidelines are higher than what they are in the ACT. You have also heard from various practitioners today, including MSI, that often there is a very small window in which people are able to access abortions. You might not know that you are pregnant for a period of four to six weeks, medical abortions are only available up to nine weeks and, for ultrasounds, booking times can be up to three weeks. Even to book into Marie Stopes can take two weeks.

There tends to be a very small window of opportunity for people seeking medical abortions. I know that this would probably be an area which would require consultation on and work with the federal government, other governments and the TGA. I think there is good cause to look at trying to implement that, in order to widen that window of opportunity in which people can safely access medical abortions. In many circumstances they are preferable, and less invasive than surgical.

THE CHAIR: I will touch on recommendation 1. You state:

> Invest in researching and finding alternatives to mandating unnecessary ultrasound and blood testing …

These are perhaps questions that I should have put to the doctors that we heard from earlier today. I do not recall hearing any evidence that these ultrasounds were unnecessary, just that there were a lot of them that needed to get done and a lot of them were not being done because of demand.

Ms Brieffies: Yes.

THE CHAIR: Explain to me how you have used that word and if, in fact, in many cases, with self-managed or community health professionally managed medical abortions, the ultrasound is unnecessary, and what impact that might have.

Ms Brieffies: Again, this is from my knowledge of the best practice guidelines. Having re-read the submission this morning, I thought that the use of the term "unnecessary" could have been done better on my part, so I do apologise. I am not suggesting that all blood tests and ultrasounds prior to a medical abortion are unnecessary, by any means, but the best practice guidelines definitely point in a direction of increasing self-managed care, including trends towards self-managing eligibility.

The key point here is that the more touchpoints that there are with the medical system and with services that are required for accessing an abortion, the more opportunities there are for barriers to access to arise. That could be conscientious objection by various providers—even pharmacists. Particularly for people who may be in circumstances of domestic violence or may have to travel in order to access such

resources, there is the burden of an increased number of touchpoints. The GPs who appeared before you earlier today did a wonderful job of summarising the sheer amount of touchpoints that there can be in order to access an abortion.

The key point is that increasing the number of times that an individual has to interact with a service provider before accessing an abortion may have a prohibitive effect in the long run. I say that, obviously, with a view to the submissions that were given to the committee and the best practice guidelines.

THE CHAIR: If it is your group's view, to summarise it, to limit the touchpoints so that a person that wants this care can access this care, how would you feel about the government investing or providing supports to providers to try and co-locate and even co-manage some of these services? I have been surprised to learn some things today. I naively thought that, when you go to get an abortion, you go to the place and you get an abortion, but it turns out that that is not the case; you go to a few different places. What would your group's view be about that co-locating in instances where things like ultrasounds and blood testing are necessary, to protect the person who can get pregnant?

Ms Brieffies: That would be a very helpful solution. Speaking on behalf of the group, we would welcome any opportunity to minimise those amounts of touchpoints, or the amount of touchpoints that individuals have to go through. Particularly with regard to the terms of reference and the groups that you have identified as requiring particular consideration with regard to abortion access in the ACT, and in particular the groups I noted before, that would be a very helpful scenario.

DR PATERSON: One of the themes we have heard about today is the issue of stigma. As a student on campus, do you think there is more that we could be doing to reduce stigma around abortion in the ACT?

Ms Brieffies: That is a great question. It would require me to do a whole lot more consultation with my peers, I believe. I am comfortable in saying that the attitude of many students towards abortion and reproductive health care is very progressive. Having read some of the submissions to the inquiry, it does not appear that that would be the same for the general population.

There are issues of accessibility for students, particularly international students, who face additional barriers in terms of insurance and language barriers. I note, particularly, in regard to the decentralising of care, and enabling community nurses and community health workers to manage that kind of care, from a student perspective, that would be very life changing. With the quality of on-campus health care, we have to wait for a long time to access on-campus health care; that is the short story.

Being able to navigate systems, particularly as a 17 or 18 year old who has moved to Canberra for the first time, as many students do, is incredibly daunting. Having decentralised structures for accessing reproductive health care, even on campus, would be excellent.

I realise that that does not quite answer your stigma question. I do welcome the ACT

government's approach. I think we are one of the most progressive jurisdictions, on the face of it, in which to access reproductive health care. Putting aside the issues that have been identified by various witnesses to the committee, it is a difficult question to answer. There is always more that can be done, but I welcome the efforts that are being made. The stigma also exists on a societal level, and that will only change over time. It is a difficult question; I am sorry for my convoluted answer.

THE CHAIR: Thank you so much for your time today, and for your written submission. Please thank the whole group for us, on behalf of the committee. We appreciate it. We will provide a copy of the proof transcript in a couple of days, which you can check for omissions and accuracy. Let us know if there is anything that we need to tidy up; otherwise thank you so much for appearing today.

Ms Brieffies: Thank you very much.

ANDREW, DR MERRI, Senior Health Promotion Officer, Women's Health Matters
LISTO, DR ROMY, Senior Health Promotion Officer, Women's Health Matters

THE CHAIR: Dr Listo and Dr Andrew, thank you for appearing today. Could you acknowledge that you have read and understood the privilege statement?

Dr Andrew: I have read and acknowledge the privilege statement.

Dr Listo: I have also read and acknowledge the privilege statement.

THE CHAIR: Would you like to start with a brief opening statement?

Dr Listo: Yes, thank you. I would like to start by acknowledging the Ngunnawal and Ngambri people as the traditional owners of the land, and pay my respects to elders past and present and to all Aboriginal people here today.

On behalf of Women's Health Matters, I thank the committee for the opportunity to appear today for this timely inquiry. Women's Health Matters aims to be the voice of women's health in the ACT, and we do this through research, health promotion and advocacy. Abortion is health care, and it is health care that is critical to the equal human rights of women and people with uteruses. It is much more than choice. It is fundamental to bodily autonomy and health, safety and economic security.

In the course of doing consultation for this submission, we undertook a survey with 102 people who had sought an abortion in the ACT, and held six key informant interviews. In this process we heard repeatedly that accessing abortion in the ACT is a difficult experience which has significant lived impacts. These are the words of one survey participant:

> My first time trying to access abortion, I was much younger and ended up with a child because I had been referred to an old, private-billed OB-GYN. I wish more GPs did referrals straight to places who don't push keeping a baby on you and that old men keep their opinions to themselves. My life is not what I had hoped it would be, because I didn't have access or knowledge of how to access cheap and safe abortion the first time. I won't let my child make that same mistake.

Women and people with uteruses are currently faced with a landscape with very little information about their options of either procedures or services and which they need significant health literacy to navigate. Barriers include the cost of services, concerns about privacy, the burden of coordinating multiple appointments, each with their own chance of encountering stigma and judgement, and for some the need to travel interstate for a late gestation abortion—although, as we have heard, there is no gestational limit in ACT legislation.

In particular, we have heard that young people, people experiencing domestic and family violence, and migrant and refugee people, particularly those on temporary visas, are particularly disadvantaged. There is a gap between the legislative framework that we have and the actual service provision available, which we believe needs to be addressed.

While some people who participated in our consultation had positive experiences or

reported positive experiences of accessing abortion, we heard overall that the quality of care was poorer than what would be reasonable to expect for other forms of health care.

This inquiry presents an opportunity to recommend a more coordinated approach. The budget commitment to providing free abortion will go some way to alleviating the current challenges, but it will not address all of the barriers, including stigma in the community and, amongst health practitioners, the lack of navigation for accessing abortion or the availability of services. It is more than an issue of funding, and that is why we are recommending the development of the sexual and reproductive health strategy which would, among other things, allow for a coordinated approach to the provision of abortion in the ACT that is consistent with the human rights commitments of our jurisdiction and is guided by principles of reproductive justice.

THE CHAIR: Thank you very much. I will start with questions. On the second page of your submission there is a line that might make some people say, "Please explain." It states:

> We note the limited scope of this inquiry and that reproductive choice requires reproductive justice, not only universal access to abortion services.

I have said it once today, and I will say it again: talk to me like I am five; what does reproductive justice look like?

Dr Listo: There are three parts that we would consider when talking about reproductive justice. There is the right not to have children, if a person does not want to have children, the right to be able to parent, if a person wants to parent, and to be able to parent free from violence and coercion. We would see reproductive justice as encompassing all of those things and we believe that all of those things are important to facilitate choice and bodily autonomy.

THE CHAIR: We have heard two main, key things today—and you touched on it in your opening presentation—about the medical profession. We have heard that we do not have enough doctors to provide all sorts of health care, including reproductive health care. But we have also heard this nine per cent figure of doctors that are qualified to provide abortions. If the government were to prioritise trying to get more doctors or trying to lift that nine per cent, where would you ask the government to concentrate its resources?

Dr Listo: That is a good question. Something that we feel is quite important, and because we think that the quality of care that women receive is important, is that the people who are providing abortion care need to be supportive of the choice of their patients. We would tend to move away from recommending, say, that we get rid of conscientious objection and that kind of thing. We would support whichever of those options would be more likely to facilitate more doctors who support the choice of their patients.

DR PATERSON: We heard from the archbishop for the ACT and New South Wales region this morning. He said that the population is about 20 per cent Catholic. We know that there are other religious beliefs and beliefs in the community, in addition to

Catholics, that may oppose abortion. We are also looking at this nine per cent figure of GPs that are trained in medical terminations.

I am concerned by the fact that religious beliefs are actually quite a small part of the community, yet, with the health care we are offering, to me, it seems that there is widespread stigma around this issue but not a clear reason for it. I am interested, as both of you have health promotion backgrounds; to me there is huge scope for health promotion work in the community. What would you suggest are first steps in addressing the stigma issue? Is it education? What do we need to do?

Dr Listo: One of the other things that we have heard today, and which we have definitely talked about in our submission, is that generally there is a lack of information available about the kind of services that are available to people in the community. There is no public list of GPs and it is very difficult to navigate.

The first thing to do in terms of addressing that stigma is to talk about abortion more and to make it very clear where these services are available. We know that, overwhelmingly, people do support choice, but at the moment it seems to be something that is very taboo. That, I think, relates to the fact that there is not a lot of information, clear information and consistent information, out there about where people can actually go.

I think that is one thing—to talk about it more, to support our health practitioners who might be interested in being prescribers more, so that they feel that they are not part of a small minority of people who are prescribing, but that they are supported to be able to do that through networks or whatever else might be useful there.

There is much more targeted health promotion that we can do with communities as well. We do not have to reinvent the wheel there; a lot of other jurisdictions have been doing work like this. For example, Children by Choice in Queensland has developed some great resources recently, working with their migrant and refugee communities. We can look to other jurisdictions for where to start with that. It probably needs a multipronged approach to be able to address some of that stigma issue.

DR PATERSON: I would put to you that the decision of choice also has a basis of education and understanding reproduction and reproductive health are. We heard from a woman this morning who gave quite an interesting statement. She was highly educated and she was saying that, in terms of her friendship group, she was the one that knew all of these things about contraception, sexual health and that type of thing. I would suggest that she is unique in that knowledge.

It is about the provision of the service and making sure people understand and have the information, but do you think there is a step back from there, in terms of our community education around sexual health and reproductive health, that we need to be focusing on, so that people can make informed choices?

Dr Andrew: Generally, people get a lot of health information from their peers, families and networks. This is another situation like that.

DR PATERSON: Broader community education and discussion?

Dr Listo: Absolutely. We have seen enormous progress in comfort in the community with talking about sexual health and reproductive health over maybe the last decade, but there is still an enormous way to go. Many people might not have grown up in the ACT; they might have grown up in places where they did not have access to information about sexual and reproductive health. There is a role to play for community education in building people's capacity to understand what kind of options are available.

MR MILLIGAN: In your submission you have quite a few tables, figures and stats. Could you give us a brief rundown of some of those, and some of the most alarming or concerning figures that you might have there? Are there any trends or predictions on where you think things are heading?

Dr Andrew: I am not sure about trends or predictions, but I can certainly give you a bit of a rundown. As Dr Listo mentioned, we did a survey that got responses from 102 people in the community, 90 of whom had been able to access an abortion and 12 of whom had tried but been unable to. We found that, among those who had not been able to, the key reason was medical professionals not providing the service and, after that, affordability.

For people who were able to access an abortion, they still experienced a lot of challenges. Key among those was affordability. That speaks to the importance of the recently announced scheme. That was by no means the only barrier or challenge. Even among those who were able to access an abortion, a great many had experienced judgement or stigma from healthcare providers. In some cases they found that healthcare providers were unable or chose not to provide the service. While affordability and having free access are clearly supported by the findings of our survey, it is by no means the end of the issue.

Another finding—and I know this was touched on by other people before the committee—was that the gestation of a pregnancy does limit the options available to people. This was reported as one of the main reasons for being unable to access an abortion in the ACT after having tried to do so. A third of people who were unable to access, despite trying to, listed the gestation of their pregnancy as one of the reasons. For those people, as for the people that Romy quoted before, it is concerning that in many cases that would have led to an outcome that was not what they wanted.

THE CHAIR: Your submission is comprehensive. There are 18 recommendations to government. One of the challenges, though, that we heard from the minister is that the government has quite an ambitious policy agenda and so few people to do it. While I do not want to sound defeatist—it is hard to find a recommendation here that is not one that is exciting—where would you ask us to prioritise? If this committee were to take a blowtorch to government and say, in bold print and underlined, "This has to happen yesterday," where would you direct us to, in your submission?

Dr Listo: The really important place to start would be in developing a sexual and reproductive health strategy. We need to bring what we are doing in terms of abortion service provision into a coordinated approach with our wider approach to sexual health and relationships and sexuality education in schools, so that we can work out

where we are, where we are going and what needs to be done to be able to get there.

DR PATERSON: We have not discussed as much as I would have liked today reproductive coercion. We are more and more looking at coercive control in terms of family violence. There are a lot of issues that come up with reproductive coercion. Do you want to speak to your proposal that there should be some research on this in the ACT and why that is needed?

Dr Listo: We are in a place at the moment where we need to know more about what is happening in terms of reproductive coercion in the ACT. Generally, there is not a lot of data collection around reproductive coercion nationally, either. In terms of being able to address the problem, that is always an important place to start—knowing more about it.

THE CHAIR: Thank you very much, Dr Andrew and Dr Listo, from Women's Health Matters. Thank you very much for your time and for your written submission. The committee secretary will provide you with a copy of the proof transcript in the coming days, to check for omissions and accuracy. If there is anything that is wrong, please let us know; otherwise thank you so much, and have a good afternoon.

BAVINTON, MR TIMOTHY, Executive Director, Sexual Health and Family Planning ACT Inc

THE CHAIR: I will now invite Mr Bavinton from Sexual Health and Family Planning ACT to join us. Thank you, Mr Bavinton, on behalf of the committee, for appearing today and for your written submission to this inquiry. I remind you of the protections and obligations that are afforded to you by parliamentary privilege and draw your attention to the privilege statement which sits to your right. Before we begin, could you note that you have seen and understand the privilege statement?

Mr Bavinton: Thank you, Chair. I acknowledge that I have read and understand the privilege statement.

THE CHAIR: Tremendous. Would you like to begin with an opening statement?

Mr Bavinton: I will keep it very brief to give time for conversation and questions. Thank you for the opportunity to present both a submission in writing and to give evidence today to the committee. I would like to add my acknowledgement of country. I acknowledge the Ngunnawal and Ngambri people on whose land we meet and have been talking today.

We welcome the opportunity to contribute to this conversation and this discussion. We have a longstanding commitment, as an organisation, to advocacy and service around sexual and reproductive health and rights here in our ACT community and supporting access to all reproductive choices for pregnant people. We are very proud to have collaborated and cooperated over many years with key community organisation partners, including health service providers, therapists, general practitioners, specialists in the women's sexual and reproductive health sphere and a wide range of other civil society actors and organisations across the education, health and community services industries.

While this inquiry and the majority of the submissions it has received are significantly focused on the issue of abortion and abortion access, SHFPACT works in an integrated way across the range of drivers for good reproductive and sexual health outcomes in our community, which includes access to appropriate, timely, relevant, accurate health education and information that builds the health literacy of individuals, couples and families, and communities in our society.

We want to build a skilled, confident and responsive workforce across the education, health and community services industries that enables that. We believe strongly in the provision of high quality, safe clinical care and counselling support across the continuum of reproductive and sexual health needs and options and we need a skilled, supported workforce to provide these in reliable way for everyone in our community.

We need a responsive service system to the range of varied needs in our diverse community. I will point you to the accessibility criteria we talked about in our submission as well: that interaction with the healthcare system should promote equality, equity and dignity, not diminish these in our community, and that we mean physical and geographic accessibility, economic and financial accessibility and

affordability and information accessibility when we talk about that concept.

We will lend our voice strongly to the call for a reproductive and sexual health policy and strategy for the ACT and for investment in reproductive and sexual health that reflects the diversity, complexity and integrated way that people actually live their reproductive and sexual lives, not necessarily the silos by which we structure services. Thank you.

THE CHAIR: Thank you so much, Mr Bavinton. As Chair, I will start the questions. The most eye-watering sentence in your submission, if I can take you to point 7, says:

> Continuing access to reproductive health services is significantly affected by an available, trained, and supported workforce.

You go on to say:

> Future workforce capacity and capability may be the greatest single risk to abortion access in the Australian healthcare system.

How do we fix that, Mr Bavinton?

Mr Bavinton: You are not going to hear from me today binary, simple "it is either this or that" answers. These are complex pieces of a puzzle that come together to solve complex needs. I do not believe these are un-understandable, but we need to have patience and we need to have sustained attention to make sense of that complexity. We need to start looking at the way that we do undergraduate professional qualifying programs for healthcare providers in our country, most of which is outside the scope and influence of the ACT government directly, but the ACT government can certainly be lending its voice and pulling levers or creating pressures where that is relevant.

At the moment, abortion access and abortion care is not something that most healthcare professionals have encountered in their qualifying degree. They will usually only encounter it in their postgraduate training if they have an interest in reproductive and sexual health care and access. So we do need to normalise it. You have heard from several other people today who have provided evidence that the colleges, RANZCOG and RACGP being the two primary ones here—ACRRM, as well; we should remember them; the College of Rural and Remote Medicine—need to play a role in how they include abortion care as part of the continuum of reproductive health care that all people should be expected to understand and contribute to appropriately from their professional training.

We need to think about how we skill others who work in referral and information roles across health education and community services to understand what abortion access entails and how they can play their role in both providing information and referring people appropriately for the care that they need. That is where we start.

THE CHAIR: That is a great answer. Thank you very much. On the workforce planning, though, I think it is an interesting conversation, particularly as this committee currently has another inquiry open for comment on the nursing and

midwifery workforce and some of the pressures on that sector. We heard from submitters earlier today about expanding the nursing scope of practice. We heard that from the minister and we have also heard that from GPs. What would you contribute to that discussion? Do you think that would be valuable? And what are some of the opportunities, but also some of the risks, in expanding that nursing scope of practice?

Mr Bavinton: I think reproductive and sexual health care is often a bellwether for how well our system works generally. We do not utilise nurses as effectively in the Australian healthcare system as we could. Other countries do tend to find a better way to support a safe and appropriate clinical scope of practice for nurses. In this area of abortion access specifically, and more broadly around reproductive and sexual health care generally, yes, we can see a better role for nurses, but we do not finance it well. It is not cost effective in primary care to deploy nurses in the way that it is doctors.

We all see across Australia at the moment, in these years after COVID, that we do have a workforce shortage. So even if we could stand up more positions, we cannot necessarily fill them with trained and qualified people immediately. So we need, again, to think about how we are bringing nurses through their qualifying programs to expect some engagement with reproductive and sexual health care, including abortion, as part of their training. We also need to think about how we can actually reflect that and pay nurses to do safe, appropriate clinical practice within their scope.

THE CHAIR: Great. Thank you so much.

DR PATERSON: Since being elected I have done a lot of work around sexual consent, and probably one of the most alarming things that has arisen in my conversations in the community about that has been some of the stuff that goes on in relationships. I am interested in the idea of reproductive coercion and the extent that it is abuse, but also how this presents in the service that you run. Is it common and what can we be doing in the ACT to address this or start to expose this as an issue?

Mr Bavinton: I think you heard just now from my colleagues at Women's Health Matters, who have correctly identified that we do not collect good data systemically in Australia around this experience. I think conceptually we understand that reproductive coercion forms part of the continuum of violence that people can experience in their relationships and in their families. It has provided a very useful way for us to think about the experience that we sometimes see at the pointy end, in the clinic room or in the referral process, in terms of access to other healthcare services that we do not directly provide ourselves, where we can see pressure at play but where perhaps more traditional models that focus on physical violence do not explain what is going on.

Obviously, when it comes to human reproduction, relationships and sexuality, we start to touch on things that people hold strong and deeply held views on from a personal, moral, religious or cultural perspective. When those ideas about what should be happening and what is happening conflict, humans also sometimes resolve them in unhelpful ways through violence, pressure or coercion.

I think it is completely appropriate to expect that reproductive coercion is a significant factor in many people's experience of pressure from partners, maybe from other family members and possibly even from peers in the choices that they get to make or

not make around abortion specifically or reproductive choices more generally. I do not know that we have yet good solid evidence on exactly what those patterns look like or how many people it might affect at any given point in time, so I would always point to more research, more sociological work like that which Women's Health Matters does to help fill out and understand what we are talking about as a dynamic, conceptually first, then in practice, and then services can respond in how we should screen for that, how we should support people.

You have heard from some providers today how they try to manage that concern. That might be about excluding partners from certain parts of the episode of care so that they can try to judge as best they can whether this is a decision that someone is making independently, for themselves and by themselves, or whether this is something that has actually got other pressures at play.

DR PATERSON: Thank you.

MR MILLIGAN: Given that you have a lot of expertise and professionalism in community education, health promotion, health education, information services and the like, what advice or direction should the government be taking, do you think, in providing this information to the community? What mechanism should it be using and what should the messages be?

Mr Bavinton: Are you asking, Mr Milligan, about abortion access information specifically or something more generally?

MR MILLIGAN: Yes, abortion specifically, but also other support that is available to an individual, all the way through to giving birth, potentially.

Mr Bavinton: Regarding services that work in this area, I will point both to our own website and to the Having a Baby in Canberra material that is produced by Women's Health Matters and draws on the input of lots of other service providers. It is available. It is out there. What we tend to do with health information in our community is silo it. We do not necessarily duplicate it across the various forums where we know people might initially seek it. Then we have a conversation like this and we say there is not enough information out there, so the very next thing we do is create a new information silo that then has to be updated, kept current and connected to the places and the ways that people will seek information.

Obviously, an online platform these days is essential—not just significant but essential—because that is how most people will first seek to answer their own question. They will do a quick Google search of: "What can I find out about it" or "Where can I get a service?" So we want online platforms. We then need to think about that digital divide in our community around who does not have access to the tools that they need to access online information; and how do we make information available for them in language, in easy English formats, in visual formats that are not necessarily reading text, and put them in the places where they will go and seek information.

I think we need to ask a lot more about where people naturally seek information first and then put those sources of information there. But my big concern is that we do not

answer these questions by creating a new silo that then sits, gets out of date quickly, that no-one knows about because we do not promote it out into the community, and then we come back in five years and we still have gaps.

MR MILLIGAN: Yes. Obviously, doing a Google search, there is a lot of information out there; right? It is hard for a lot of people to decipher what is useful and what is not and what to ignore and what to actually look for. Have you or your organisation thought about who you can partner up with in the medical profession? Do you provide information through medical practices? Do you provide information through our hospital networks and other service providers? How else can you reach out to people directly? Have you got partnerships?

Mr Bavinton: In terms of how do we do that at the moment?

MR MILLIGAN: Yes. And have you got partnerships with medical professionals, medical practices and the like?

Mr Bavinton: Yes. We work with a whole range of players in the healthcare system. It depends on what we are promoting. If we are promoting information about our services, there are a set of channels that do that. If we are promoting access to the training and workforce development activities we have, obviously that is different from talking to the broader community. We communicate out through our pathology and pharmaceutical partners in terms of their reach into primary healthcare systems for those kinds of activities. You may be looking for a specific answer that I am not touching on, but everybody, I think, has to use multiple communication channels, mindful of who we think we are trying to talk to and how they interact and seek information themselves first.

There is a place and a role for schools in health education, of course, that needs to touch on all of these issues, but I would caution that we often see schools as a location of convenience. Just because we have lots of young people in these institutions regularly does not mean that all of them at particular points are developmentally primed to learn about or learn certain things. We need to think in a more sophisticated and complex way around how we do health education that is not just about classroom teaching at key points like year 6 or year 9 in a one-off way, but how we build across the experience of engagement with education and duplicate and replicate that for people who are less connected or disconnected from education systems.

MR MILLIGAN: Okay. Thanks.

DR PATERSON: On the issue of education, as you said, schools are great, but you are relying on a whole heap of structures and a whole level of different individuals delivering education in different ways, and different schools—Catholic, Christian, government et cetera. Do you think there is scope for more broad community education and health promotion that the government could be doing to try to reduce the stigma and create awareness and normalisation of sexual and reproductive healthcare services and educate generally?

Mr Bavinton: I do, Dr Paterson. I think that we sometimes reduce health promotion to information campaigns. While that is an important component of a health

promotion framework, it is obviously not everything that is going on. I think general community awareness is one way to address the information silos or gaps that have been raised in this inquiry. It is also a way to potentially address the issue of stigma around abortion and reproductive choice. But just talking about something does not necessarily reduce stigma about it. One of the ways we can reduce stigma is to normalise abortion as part of reproductive health care in our system, with the kinds of announcements we have had to fund access, to look at the way the public system has to play its part, alongside NGOs and private providers of health care.

I think there is a role for raising awareness of where we would go to find accurate, current information around abortion access, and reproductive health information more broadly. That would help us to reduce that siloing effect, if we could get the right resources in one place and then promote that broadly. We have to sustain that; it is not one campaign that goes for two weeks and then we stop. We have to go back and update that information constantly to keep it current and we also have to keep pointing people back to it as an information source over a long period of time so that people come to trust it, know about it and then share that information with others in their own networks.

DR PATERSON: You have worked in this space for a long time. Do you feel that attitudes have changed and stigma has reduced around abortion in the ACT or do you feel that it is not so different to how it was perhaps 10 years ago?

Mr Bavinton: I am not sure that 10 years is the right time frame. I think we might think about it more generationally. Over two or three decades I think we can certainly see shifts in how healthcare systems are providing services. We can point to the evidence, again, that my colleagues from Women's Health Matters did, that, generally, choice enjoys strong support in the Australian community and that genuinely means choice. Those of us who work in health services in a pro-choice kind of perspective want to support the outcome that the patient or the client or the consumer themselves identifies as important and appropriate to them. It is actually not about a pro-abortion kind of stance; it is absolutely about making sure that we work with the person in front of us, understand what their needs are, support them with the information and the decision-making that they are going through and then back them on the decision that they make.

I have gone off on a slight tangent there from your question; I am sorry. I think there is an important role to play around actually reducing stigma by just normalising the place that all options have in reproductive health care. That is not really anyone else's business other than the person and their healthcare practitioner that they seek some support from to make those decisions on their behalf. That typically enjoys strong support in the Australian community, regardless of where people know individually they will position themselves if they face an unplanned pregnancy. Some will absolutely know they are going to carry to term and make a decision to parent. Others will be very clear, quite up-front, that they do not wish to continue that pregnancy but they understand that that decision is best made by the person themselves.

DR PATERSON: We have been reiterating the point about the nine per cent of GPs who offer medical terminations. You could argue that health consumers or patients in the ACT are not getting that equal access to choice if only that proportion of GPs are

able to offer that service or willing to offer that service. So maybe we do have a cultural problem in the medical profession or in the services or education that they are receiving.

Mr Bavinton: I do not think it is that simple. We have pointed, in our own submission, to some issues around stigma within the health workforce an why people may not want to publicly advertise that medical termination of pregnancy is a service that they provide. I would not read that in a reductionist way—that just because nine per cent of GPs in the ACT have done that training and registered means that only nine per cent are open or would provide a non-directive, all-options referring interaction with their patients.

That means nine per cent have certainly identified that it is a service that they are interested in providing that may be relevant to their patients as they currently understand it, but they may not feel confident to inquire who else might need that. I would not treat that as a direct: "Seventy-five per cent of the community supports; only nine per cent of doctors do." That would be to read that data in the most superficial way and the least meaningful way.

We should definitely promote that training. I checked with my colleagues earlier, in the break. Having done the training means you can actually do better abortion referral and contraceptive counselling for your patients, even if you actually never do the prescribing yourself as a GP. So there is good reason to promote that kind of online professional training that is accessible. It does not cost a fee to participate in. It is a cost of time, but that could definitely promote better abortion referral and a better patient counselling process in primary care that can then refer into the service where that is appropriate.

THE CHAIR: Mr Bavinton, reproductive choice is often a spectrum where, at one end, there is access to an abortion. I wonder, with your expertise, particularly with SHFPACT, what more the ACT government can do to make sure access to contraception is accessible and equitable? To not put too fine a point on it, what more can government do to assist people who have no intention of getting pregnant to be able to affirm that choice?

Mr Bavinton: I think we have seen a really great start by acknowledging that supporting access to abortion can come with supporting access to long-acting, reversible contraception methods. I think that is a great component of that initiative. We can write a reproductive and sexual health strategy that actually talks about the integrated nature and the range of options that are required.

The limitation we have in public policy in the ACT at the moment is that we really only have public policy on STI and BBV priorities. We are not talking about the eight other domains of reproductive and sexual health that need consideration, and contraception sits at the heart of them. In fact, as we have noted in our submission, some of the health services planning and commissioning that we are going through at the moment is potentially narrowing scope away from currently resourced reproductive and sexual health options like contraception to a focus exclusively on STI and BBV priorities.

We need the strategy. We need resources that back that. In that equality, equity and dignity sense we want to resource access, for people where affordability is going to be an issue, to the preferred and most appropriate contraceptive method for them. That means funding for some and it means improving contraceptive information and "where I can access the best health support on contraception for me" for others.

It does mean broadening our thinking and our planning around how the health system works together, because it is complicated. We are working with both commonwealth and state and territory levels of responsibility for resourcing inputs. When they cross and cut over each other we create perverse outcomes sometimes. We are not using nurses as effectively as we could in the system. It is not easy but it is not un-understandable and there are certainly some things that advocates in the reproductive and sexual health and rights space know work, from global experience. Again, as my colleagues from Women's Health Matters noted, we can look to other states that are doing some of this work a little bit better than we are perhaps.

THE CHAIR: That was so comprehensive. We have heard a lot today about vasectomies, which surprised me, but now I am shocked that it surprised me, on reflection. I ask this to you not only as someone who knows what they are talking about but as a man. In this conversation around reproductive choice and abortion, how much more effort needs to be put in socially but then also led by government, I suspect, to acknowledge men's responsibilities in this conversation and advocate for and resource things like vasectomies that help men to take responsibility in this space too.

Mr Bavinton: I was talking earlier today with some of my colleagues about it. I think we still carry some ideas that men are not interested in contraceptive responsibility. I think some men are not interested in that, but that is a complex phenomenon in its own right. A lot of men are and, as Mr Hakim from MSI reported, when you fund and make access easier for certain kinds of healthcare options some people will take them.

To see a quadrupling of access for vasectomy in WA because it was funded I think is a stark reminder that there are multiple factors going in. Not all men are going to want a vasectomy. Not all couples will decide that vasectomy is the right way for them to manage their contraception. I think we can go a little bit more upstream and talk about shared responsibility and men's responsibility in the reproductive health field, from a primary prevention point of view, through sexuality and relationships education, much more effectively.

We want, across a range of things from sexual violence to contraceptive responsibility in relationships through to STI and BBV issues, to build an idea that everybody in the relationship is responsible for their part. I think there is a lot of room. Again, a broader policy and strategic view would give us room to unpack and talk about these things. I would not want to see us get narrowed down to the only thing we have got to do here around getting men to be more responsible is just provide a few free vasectomies and we kind of tick the box. I think that would be an unhelpful conclusion to draw from the conversation.

THE CHAIR: Not to put too fine a point on that. Thank you so much.

DR PATERSON: On the concept of dignity, your submissions says that healthcare system design should strive for quality, equity and dignity. I am interested to know: with regard to abortion and sexual reproductive health care in the ACT, are there particular things in respect to dignity that we could address?

Mr Bavinton: Service sought and denied diminishes dignity. When people fear stigma, as we heard from some witnesses this morning, and when people experience stigma or less than optimal or poorer treatment on the basis of their presenting health need we have reduced dignity in engagement with the health system. So, yes, I think, unfortunately, we have got a range of examples of where dignity is diminished rather than enhanced in this area of abortion access specifically. It is an area where people have strong opinions around reproductive health care generally. We heard Ms Toohey from the Human Rights Commission point to the kinds of cases that she reviews, hears, sees in that organisation, where dignity is diminished by engagement or by the absence of a place to engage effectively. Those are the kinds of things we mean in this space.

DR PATERSON: Thank you.

THE CHAIR: On behalf of the committee, thank you so much, Mr Bavinton, and Sexual Health and Family Planning more broadly, for appearing today and preparing your written submission. The committee secretary will provide you with a copy of the proof transcript in the coming days, to check for omissions and accuracy. Let us know if we have stuffed it up and we will fix that up for you. Otherwise, thank you so much for appearing today.

Mr Bavinton: Thank you. Thank you all.

VILLIERS, MR NICHOLAS, Co-Chair, ACT Youth Advisory Council
HARRISON, MS LILY, Co-Chair, ACT Youth Advisory Council

THE CHAIR: We move to our last witnesses appearing today, from the Youth Advisory Council. On behalf of the committee, thank you so much for your time this afternoon and for your written submission. I remind you that appearing today affords you protections and obligations under parliamentary privilege. I draw to your attention the privilege statement. It sits on the piece of paper to your right. I suspect that you have had a chance to have a read of it before. Would you acknowledge that you have read and understood that privilege statement.

Mr Villiers: I have read and acknowledge the privilege statement.

Ms Harrison: I have also read and acknowledge the privilege statement.

THE CHAIR: Wonderful. Thank you both very much. Do you have an opening statement you would like to provide?

Ms Harrison: We do. Thank you.

THE CHAIR: Please do. Go right ahead.

Ms Harrison: We would like to start by thanking you for the opportunity to appear before the Standing Committee on Health and Community Wellbeing today and to provide a submission to the inquiry into abortion and reproduction in the ACT.

Members would know that the ACT Youth Advisory Council provides young people aged 12 to 25 years with an opportunity to take a leading role in participation and consultation activities on issues that affect their lives. The council provides advice on youth issues to the Minister for Education and Youth Affairs, giving young people a voice in the ACT government.

Council has a membership of up to 15 young people and is reflective of a diversity of young people residing in the ACT, including different genders; representation from young people who identify as an Aboriginal young person; Torres Strait Islander young people; a young person from a culturally, linguistically and diverse background; a young person with disability; and a young person who identifies as a member of the LGBTIQA+ community.

We are proud to be a conduit between young Canberrans and the ACT government, facilitating young people's needs, ideas and aspirations, as well as their concerns, and ensuring that their voices are heard through participation, in consultation, surveys, community forums, open meetings and written submissions. We welcome the opportunity to provide this submission and to speak here today, and to provide a youth perspective to the conversation about the accessibility, affordability and legal protections for abortion and reproductive choice in the ACT and our community.

Council commend the new funding for free abortion services, as we believe every young woman and person who can get pregnant should have the right to make

decisions about their body. Young Canberrans do not feel equipped to make informed decisions about abortion and reproduction health choices. Our submission noted that accessibility and affordability of abortion and reproductive choice disproportionately affects young women and those who do not have the financial means and financial support to access services.

Our submission highlights several barriers for young people when accessing abortion services, such as the location and accessibility of service, as young public transport users; lack of culturally safe care; lack of accurate information; and the shame and stigma that may impact access to support and can increase or exacerbate poor mental health. Our submission also highlights that young people feel the method of contraception available to them is often limited to what the health professional is comfortable to prescribe, removing the right to choose what is right for them. Young people often get information about other options from their peers and/or social media, and this is not necessarily credible information.

Council would just remind the committee to never lose sight of the fact that the needs of ACT women, including young women, are different. The barriers they face can be similar. They can also be different. When developing solutions, young women need to be included in the conversation. As co-chair, I would like to reaffirm council's view that every woman and person who can become pregnant has the right to make independent and informed choices about their reproductive lives. Council believes all Canberrans should have credible and unbiased information that enables them to be well-informed citizens, support persons, partners and individuals. Thank you.

THE CHAIR: Thank you. I will start with questions. Many of the submissions the committee has received have asked for the same thing—a reproductive choice and sexual health strategy. I wonder if that is a call that the council would support. If so, what sorts of things do you think need to inform that strategy, particularly for young people?

Mr Villiers: We have not actually considered that, but, as Lily has correctly pointed out, that should involve consultation with young people to make sure their needs are met.

THE CHAIR: If the government did decide to develop such a strategy and bring some of these things together, what would be some of the best ways that, on this particular subject, the government could consult with young people—in addition to the wonderful council, of course?

Mr Villiers: Yes. You might want to start with the Youth Advisory Council, of course. We find that, normally, when you want to work out what works for young people you need to meet them where they are, doing what they are doing. Do not expect young people to come to you. You have to go to all the different pockets and make sure you get a diversified view. Really try to involve every perspective and every young person.

Ms Harrison: And through a diversity of mediums. That means allowing them to provide written submissions and anonymous feedback through surveys but also to speak with people one on one and have the opportunity to have a conversation.

DR PATERSON: In your opening remarks you were talking about young people not being informed about different forms of contraception. It is one of your recommendations. How widespread do you feel that issue is—that if a young person goes to a health professional they are not given all the information or broad information to make an informed choice?

Ms Harrison: In the council's view it was a unanimous piece of feedback that we received that particularly things like the pill and condoms are pushed as the only contraceptive options for them that doctors will be comfortable to prescribe. If it is something like the IUD, there is often a financial barrier to that, which means that they can't necessarily take up that option.

MR MILLIGAN: In your submission you suggest that there be a list of GPs made available who provide this type of service. How would that be made available to the community, do you think, to help young people to decide where to go? What information should be available?

Ms Harrison: Council have not discussed how that information should be made available, but having a list of GPs and healthcare providers who will provide abortion services, and having that freely available through something like an online platform, is very important to young people as a means of being able to do some research and know exactly where to go without needing to come into contact with lots of different

MR MILLIGAN: What type of information would you expect to be publicly available for people?

Ms Harrison: Just whether a GP or healthcare provider will or will not provide abortion services.

Mr Villiers: We also talked, in our submission, about the cost and the location of different services. I think having where they are, if it costs to access that service, and any sorts of issues that might help a young person decide whether that is accessible for them would also be useful.

Ms Harrison: I would say what services they provide as well—whether it is the abortion pill or whether it is referrals to have a surgical abortion and things like that.

MR MILLIGAN: Would the counselling and other service providers they partner with be useful, do you think?

Ms Harrison: Yes, I think that would definitely be useful.

THE CHAIR: One of the things this committee and other committees have discussed a lot in the short time I have been here is that when you want to talk to young people you just send it to school. You add it to the long list of things that teachers have to do and that you have to fit into your six-hour day. I am not that old, so I can recall these conversations being had in the classroom. They turn into a bit of a circus because everyone makes a bit of a joke around these themes—sex and sexuality and reproductive choice and stuff. Would you have any advice for the committee about

how these subjects could be better spoken about in schools in a way that is efficient and useful to you?

Ms Harrison: In addition to some of the barriers you listed there at the start of your question, I would add that not all young people go to school—whether they are home-schooled or not able to access schooling—so definitely these conversations need to be had outside of schools as well. The council has not discussed how teaching should happen, so I cannot answer that part of the question for you. If you could re-ask the second part for me that would be very useful.

THE CHAIR: More broadly, it is about how these subjects can be dealt with in the school environment in a way that is not just another tick and flick or another thing that has to be put at the bottom of a teacher's already pretty impressive list on a work day. What are the things you would want to hear in school—maybe that is a better way of asking this question—around this subject, around reproductive choice and abortion and access to these services?

Mr Villers: One of the issues we have talked about is the fact that different people, no matter who you talk to, will have a set of options that they know about or they are aware of or they prefer. They will communicate those to you and usually none of the other ones. So probably a comprehensive set of options that are available to young people that actually meet their needs would be helpful.

I do not know how you would run this, but in this situation you could talk about "these are the sorts of things you can access without prescribing something". Leave the choice open for the young person's decision-making. Let them have autonomy over the decision process, but have a comprehensive set of things they can access to meet their needs and their situation.

Ms Harrison: I think, across the board, what young people are asking for is clear, concise and frank information that does not talk down to them but lets them know what their options are and provides that in a really legible and accessible way.

THE CHAIR: Thank you.

DR PATERSON: Some of the submissions that we have received in this inquiry have exposed some generational differences and views on this subject. I am very interested in the stigma and shame associated with abortion or reproductive health care. I am interested in, from your perspective, as youth representatives, not what parents or older people may think but what your peers think. Do you see stigma as a big issue amongst your peers or do you think this is an issue that people are quite empowered or informed to talk about?

Ms Harrison: What we heard from young people and what I think was highlighted in the submission is that young people feel there is a very strong need-to-know basis around things like reproductive options and abortion and that they do not feel information is freely available or that they are empowered to access that. That is especially so when they add things like family who are not supportive of some of those decisions or different cultural values. Young people are feeling that this is not a space where they can have free conversations with different stakeholders.

Mr Villiers: We also know that a lot of young people will only get access to information when it is currently needed, when they need to access the service or if the need is urgent. It is probably best that young people know that beforehand so that there is not that pressure and that time constraint or resource constraint imposed upon the young person and they feel that they can make the right decision at the right time and have time to actually think through the decisions they make.

DR PATERSON: How important is that, given some of the issues that you have talked about like not accessing school, perhaps couch surfing or not being engaged in the family home and having that support and financial support? How important is it that young people do have broad and general access to this information so that in times of great challenge or need they are not having to search to try to find these things out themselves?

Ms Harrison: I would say it is very important. Some of our recommendations are about having that list of service providers and having mandatory referrals from service providers if they are not willing to streamline that process for young people, and making sure that that information is there. I guess the community as a whole supporting them to get the service and the support that they need is very important.

THE CHAIR: Thank you both very much, Nicholas and Lily, for appearing today, on behalf of the Youth Advisory Council. Our committee secretary will send you a copy of the proof transcript of today's hearing, so if we have gotten anything wrong you have the opportunity to let us know. Between your written submission and your physical appearance today, thank you very much for your time.

Ms Harrison: Thank you.

Mr Villiers: Thank you very much.

THE CHAIR: That brings our hearing to a close. I would like to thank everybody who appeared today. It has been a long list of very impressive, very capable people who have given the committee an awful lot to consider. I also thank all of those who provided written submissions, who, based on time, were unable to appear today. If any member of the Assembly wishes to lodge a question on notice, they can provide them to our committee secretary, Dr Chenoweth, within five working days of this hearing. The hearing is now adjourned. Have a good afternoon and a good weekend.

The committee adjourned at 4.05 pm.