

**Situational Report:
Sexual and Reproductive Health Rights in Australia**

A request for collaboration and action to maintain contraception and abortion care throughout the SARS-COV-2 / COVID-19 pandemic

Updated 16 August 2021

Acknowledgement

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

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Marie Stopes Australia is a national, accredited not-for-profit sexual and reproductive health organisation. The aim of this document is to update key stakeholders about the current issues we are witnessing in contraception and abortion access in Australia.

Given the constantly evolving public health context, this content is most relevant at the date of publication. Throughout the pandemic, the most recent version will be online at this same link: <https://resources.mariestopes.org.au/SRHRinAustralia.pdf>.

Contents

Executive Summary	4
The Situation.....	5
Abortion is time-critical and essential.....	5
Regional surgical abortion clinics are closing.....	5
Decreased access to sexual and reproductive health products	6
Despite decriminalisation, national abortion access issues remain.....	6
National telehealth is in high demand but lacks clarity	8
South Australia needs to act on abortion law reform commitments	8
The rates of delayed presentation and complex cases increased.....	8
Sexual and reproductive coercion is occurring.....	9
People are making different choices about pregnancy and care giving	10
People experiencing financial hardship cannot afford abortion care	10
People who can't access abortion need support and protection	11
There has been enhanced healthcare inequity and discrimination	11
Discrimination in the health sector impacts staff wellbeing	12
Co-design in virtual healthcare is future proofing	12
Access to PPE is critical.....	13
International aid and development is valued.....	13
Recommendations	14
Embed sexual and reproductive health in pandemic management planning	14
Public health and hospital services should enable reproductive autonomy	15
Invest in Pharmaceutical and Medicare Benefits Schemes.....	16
Evolve models of care.....	16
Consider that mental health is sexual and reproductive health	17
Collaborate for equity, access and agency	18
Legislation and policy should enable healthcare.....	20
Action	22
References	23

Executive Summary

Access to contraception and abortion now will mitigate broader public health risks for years to come.¹ Since March 2020 Marie Stopes Australia has had to make a number of changes to remain sustainable and continue to deliver critical services.

Marie Stopes Australia has had to:

- Close regional clinics and shift to a centralised model of service provision
- Evolve models of care in an effort to maintain access to care amidst continually changing localised movement restrictions and physical distancing requirements
- Respond to medication shortages alongside increased demand
- Respond to situations of delayed presentation and associated complexities
- Reduce in-clinic list capacity and cancel surgical abortion care lists
- Reduce financial support for people experiencing financial hardship
- Reduce our national gestational limit for surgical abortion to 22 weeks
- Navigate reduced availability and fluctuating costs of PPE
- Respond to patients experiencing sexual and reproductive coercion

Key recommendations at this point in the pandemic include:

- Ensure all governments and health and hospital services continue to maintain abortion as an essential service with Category 1 classification
- Provide financial support for women and pregnant people who want contraception or abortion but cannot afford the cost of healthcare
- Implement the *South Australian Termination of Pregnancy Act 2021*², or use the *Emergency Response Act COVID 19 (SA) 2020* to suspend the clauses that create barriers to abortion care
- Increase medical abortion provision to 70 days/10 weeks' gestation, supported by the Pharmaceutical Benefits Scheme (PBS)
- Increase Medicare Benefits Scheme (MBS) support for multidisciplinary providers of medical abortion, contraception, sexually transmitted infections (STI) and blood borne viruses (BBV) telehealth and virtual care consultations
- Embed sexual and reproductive coercion prevention and response mechanisms across sectors
- Undertake collaborative research to monitor and evaluate evolving models of care

This document provides further detail on these points and a longer list of recommendations that Australia will need to consider in order to maintain sexual and reproductive health rights.

The Situation

Abortion is time-critical and essential

Abortion is a procedure that has strict time constraints with increased complexity and risk with gestation. Both the World Health Organisation (WHO) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) urge that reproductive healthcare, including abortion, be considered an essential service.³ In Australia, abortion can be classified as an elective, semi-elective or essential procedure. Classification varies by state/territory government, health and hospital system, and at the individual clinic level.

While international and national health associations have spoken up and advocated and confirmed that abortion should be considered essential during the pandemic, those organisations do not have the power to determine how this is applied in a clinical setting. In practice both contraceptive and abortion care provision is largely up to the individual health or hospital service, and the treating doctor to determine one of three outcomes healthcare is provided, the patient is referred elsewhere, or the patient is turned away without a referral.

Regional surgical abortion clinics are closing

Surgical abortion is largely inaccessible in many regional, rural and remote areas of Australia.⁴ Surgical abortion access will be further affected by the upcoming closure of regional surgical abortion clinics.

Four surgical abortion clinics operated by Marie Stopes Australia will be closing in August. These are the Newcastle clinic in New South Wales, and the Southport, Rockhampton and Townsville clinics in Queensland. All four clinics are day procedure services; meaning they provide both medical and surgical abortion care alongside contraceptive care. Tenure was maintained as long as possible, some had even been staffed by charter flights. Without adequate funding streams these clinics are not financially viable.

Marie Stopes Australia will continue to work with health and hospital services to transition care options and patient pathways in these regions. This includes providing non-judgmental pregnancy options counselling, engaging patient travel schemes and working with women's health services that support regional, rural and remote health equity. Forty-nine people are currently working in roles that will be either be repurposed or made redundant. While some will move into other roles at Marie Stopes Australia, others will be supported to move onto alternative roles in the health sector.

It is the end of an era during which countless people have worked hard to maintain specialist surgical abortion clinics in regional areas; in coming months both Queensland and New South Wales will further centralise abortion care. Marie Stopes Australia will continue to deliver safety and quality in clinical care in now centralised Brisbane, Canberra, Melbourne, Perth, Sydney and Teleabortion clinics.

Decreased access to sexual and reproductive health products

Menstrual products have been less accessible. A study of adults in Australia and reproductive health during the March-May 2020 movement restrictions demonstrates that access to menstrual health products both decreased and changed.⁵ Almost one in three (32.7%) of participants had trouble accessing their usual menstrual health products, of whom nearly half (48.5%, 65/134) said that they changed their use of products as a consequence.⁶

Contraceptive and STI prevention products have been less accessible.⁷ There have been shortages of contraception and emergency contraception,⁸ condoms,⁹ gloves and dental dams.¹⁰ The same reproductive health survey found that 9.2% of participants had difficulty accessing contraception.¹¹ Women aged 18-24 years old were more likely to experience barriers to accessing contraception than women in older age cohorts.¹²

Medical abortion was in short supply. In late January 2021 not-for-profit pharmaceutical distributor of abortion medication in Australia MS Health announced a medication shortage.¹³ The shortage was due to pandemic related workforce restrictions in Spain followed by a severe weather event which created a significant airfreight backlog. The health sector collaborated to ensure there were no interruptions to accessibility at clinic level. Since then new stock has been re-distributed throughout Australia.¹⁴

Despite decriminalisation, national abortion access issues remain

Abortion care, including access to medical abortion via telehealth is now legal nationally, following South Australian abortion decriminalisation in March 2021. The next steps of national reform require state and territory health departments to invest in medical abortion access and equity. A key part of that is increasing the number of medical abortion prescribers and dispensers.

In July MS Health published medical abortion prescriber and dispenser data. At the end of June 2021 there were 3,018 active prescribers of medical abortion and 5,556 active dispensers of medical abortion in Australia.

Active prescribers and dispensers of medical abortion by State/Territory									
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	National
Active Dispensers	141	1,518	128	1,196	240	262	1,620	451	5,556
Active Prescribers	53	841	106	595	158	102	916	247	3,018

Table 1: MS Health data on the number of prescribers and dispensers at 30 June 2021.¹⁵

MS Health mapped the number of prescribers and dispensers by region, and the estimated number of women of childbearing age within those regions. The data highlights particular access gaps in regional and remote areas, which must be interpreted contextually within specific state or territory geography.

Estimated number of women of childbearing age per prescriber by region								
	NT	NSW	ACT	VIC	QLD	SA	WA	TAS
Metro	-	2,788	2,301	2,291	2,852	2,840	3,633	-
Regional	557	2,088	0	1,306	2,267	4,472	2,184	1,269
Remote	822	8,474	-	0	607	3,369	984	2,106

Table 2: MS Health data on the number of 'women of childbearing age per prescriber by region' at 30 June 2021.^{16a}

Estimated number of women of childbearing age per dispenser by region								
	NT	NSW	ACT	VIC	QLD	SA	WA	TAS
Metro	-	1625	826	1,171	1,242	1,736	1,687	-
Regional	448	923	185	760	995	1,040	1,170	485
Remote	462	1,211	-	0	371	1,685	416	0

Table 3: MS Health data on the number of 'women of childbearing age per dispenser by region' at 30 June 2021.^{17a}

Until these gaps are filled, women and pregnant people across Australia will continue to experience barriers to medical abortion. Incentives will be required for potential prescribers and dispensers to consider certification.

^a A zero value indicates there are locations in that state or territory with that classification but no prescribers or dispensers are registered. A dash signifies there are no locations in that state or territory that fall under that classification. Classifications align with definitions provided by the Australian Bureau of Statistics (ABS).

National telehealth is in high demand but lacks clarity

A range of sexual and reproductive health services can be delivered via telehealth, an important service being teleabortion. Delivery of medical abortion via telehealth is a safe, acceptable and effective method of abortion access in Australia.¹⁸ Nurses and doctors provide clinical care, medication is delivered via courier, and patients have 24/7 access to after care. In terms of patient privacy, telehealth can provide similar or superior levels of discretion in healthcare provision.¹⁹ Medicare Benefits Schedule (MBS) item numbers for telehealth provide subsidies and reduce cost to consumers.

From April to September 2020, national uptake for medical abortion via telehealth at Marie Stopes Australia increased in all states and territories compared to the same time in 2019, with the exception of Tasmania where rates remained unchanged. Nationally, medical abortion by telehealth uptake increased by 69%. In Victoria, the jurisdiction with the longest temporary movement restrictions, medical abortion via telehealth uptake increased by 126%. This increase did not necessarily demonstrate an increase in the number of abortions; rather it indicated a change in how and where people are choosing to access abortion care.

Throughout the pandemic, sexual and reproductive health access has been intermittently supported by short term telehealth reforms. These reforms provided temporary MBS item numbers, enabling patients with Medicare Cards to access bulk-billed doctor consultations via telehealth. These reforms had enabled timely and more affordable sexual and reproductive health services, including medical abortion. These MBS item numbers have now been made permanent; however, access has been restricted and intermittent.

South Australia needs to act on abortion law reform commitments

Progress on the *South Australian Termination of Pregnancy Act 2021*²⁰ is unclear. It has now been almost six months since the Bill was passed by the South Australian Parliament. As the new law is not yet operational, people still cannot access medical abortion via telehealth anywhere in the state.

Marie Stopes Australia's telehealth clinic is ready to deliver medical abortion care in South Australia, however these legislative and regulatory barriers continue to prevent service provision. At the very least, South Australia should use the *Emergency Response Act COVID 19 (SA) 2020* to suspend the clauses of S82A of the *Criminal Law Consolidation Act SA 1935* (Medical Termination of Pregnancy) to enable medical abortion via telehealth in the interim.

The rates of delayed presentation and complex cases increased

Patients seeking abortion have been presenting with complex cases and potential trauma linked to the pregnancy.²¹ Delayed presentation of medical concerns occurs

due to a lack of agency and is more prevalent in situations of reduced health literacy, systemic discrimination, trauma and financial distress. The pandemic context has exacerbated these enablers. Usually, delayed presentation creates a waitlist bottleneck, but when medical concerns such as abortion access are time-bound, it means that some people cannot access their desired medical procedure at all.

Sexual and reproductive health concerns can have chronic and intergenerational physical, mental and social health impacts.²² The risks of these impacts increase with delayed presentation. For example, delayed presentation of people seeking treatment for STIs can lead to future infertility and congenital conditions. Delayed presentation of unintended pregnancy can lead to unsafe abortion and unwanted births. Delayed presentation of reproductive coercion can lead to anxiety, depression, heart disease, stroke, physical violence and homicide.²³ Due to increased complexity and risk, delayed presentation can incur higher financial costs, adding to financial stress.

Sexual and reproductive coercion is occurring

Woman and pregnant people are presenting at Marie Stopes Australia clinics with experiences of sexual and reproductive coercion linked to poverty and financial hardship, which is linked to unemployment and economic insecurity primarily due to the pandemic.

In the lead up to and during the pandemic, 2.2% of women experienced sexual violence, and 5.8% of women experienced coercive control.²⁴ Emotionally abusive, harassing and controlling behaviours were experienced by 11.6% of women, with 2.8% experiencing these behaviours for the first time.²⁵ People who already have restricted bodily autonomy are facing uniquely coercive contexts, for example people living with a disability, people on temporary visas, people who are incarcerated and people in state care. People accessing abortion care are more likely to be at higher risk of intimate partner violence than the general population.²⁶

The House Standing Committee on Social Policy and Legal Affairs adopted an inquiry into family, domestic and sexual violence in June 2020 and the Committee published their report in April 2021. The report recommended that reproductive coercion be considered within broader definitions of violence, and listed relationships and sexuality education as a violence prevention mechanism.²⁷ It is critical that this report is read alongside a wide body of existing evidence to strategise for a *National Plan to Reduce Violence Against Women and Their Children* beyond 2022 to enable long term prevention, support and recovery within and beyond healthcare settings.

People are making different choices about pregnancy and care giving

The pandemic context is affecting when people choose to access healthcare. Some people have been fast to identify unplanned pregnancy and access early abortion care, whilst others have delayed or deferred care. Reasons for escalating or delaying care include pressure from existing caregiving roles, financial hardship or general financial insecurity, fear of virus exposure or distress linked to uncertainty.

The pandemic context has affected people's current caregiving roles and their pregnancy outcome choices.²⁸ Family planning needs and desires are changing. For example, some people with planned pregnancies have decided to access abortion due to unforeseen financial insecurity and other emerging stressors. Some people want to change to more efficient methods of contraception, knowing that abortion access could be intermittent with movement restrictions. Some people with fetal anomalies who could not access their first choice of abortion have instead chosen to access care or kinship care. We are becoming increasingly aware of complex situations related to interpersonal and structural reproductive coercion where some people are more likely to continue with an unplanned pregnancy.

People experiencing financial hardship cannot afford abortion care

Non-profit women's health centres, community centres and domestic and family violence support agencies fill the funding gap in abortion care. When a woman or pregnant person wants to access abortion and cannot afford out of pocket costs, communities step in with crowdfund fundraising measures and by dipping into organisational reserves. These non-profit services cannot afford to continue subsidising healthcare access, particularly during a pandemic.

As a non-profit healthcare provider, Marie Stopes Australia uses income from full fee-paying patients and philanthropic donations to provide bursaries to patients experiencing financial hardship. These measures support those patients to access the essential healthcare and services they want but could not otherwise afford. In the past two years the Choice Fund has provided in excess of \$850,000 worth of contraception and abortion services for women and pregnant people experiencing financial hardship. During the pandemic, the number of regular Choice Fund donors, philanthropists, and the size of their donations has dramatically reduced.

This level of hardship support is not financially sustainable. For the first time in many years, Marie Stopes Australia has had to turn away women and pregnant people experiencing financial hardship who cannot afford to access their choice of healthcare. Many patients experiencing financial hardship also rely on financial support from women's health centres and sexual, family and domestic violence services. These services fundraise to cover part or all of their patients' clinical care and/or travel costs.

People who can't access abortion need support and protection

During the pandemic Marie Stopes Australia has had to reschedule and cancel later gestation surgical lists due to movement restrictions, travel limitations and reduced availability of clinicians. Patients without access to abortion care have had to continue with their pregnancies, forced towards one of the remaining options of adoption, care, kinship care or parenting. Some were experiencing fetal anomalies, and all were experiencing varying degrees of hardship.

Women and pregnant people have been empowered to take control over their own healthcare, which has the potential for a combination of positive and negative impacts.²⁹ During the pandemic people faced with an unplanned pregnancy had felt forced to take matters into their own hands, and some attempted unsafe abortion.³⁰ Marie Stopes Australia had contact with women and pregnant people who could not access abortion experiencing suicidal ideation and considering unsafe abortion methods. Unsafe abortion risks increase rates of maternal mortality and can lead to chronic health issues.³¹

Women and pregnant people who have attempted unsafe abortion are at risk of social stigma, healthcare discrimination and criminalisation. Whether their attempt at unsafe abortion was successful or not, these women and pregnant people may require ongoing healthcare. In order to access healthcare, they should be able to disclose their experiences to a health professional without fear of judgement, discrimination or prosecution.

Other pregnancy options have not been necessarily any easier to access. For example, adoption requires consent from all parents on the birth certificate. In an abusive relationship, this can result in child safety involvement or a custody dispute. Care in the context of a pandemic may involve extended periods of out-of-home care. Kinship care has complexities in contexts of movement restrictions and distancing. In contexts of adoption, care and kinship care, additional legal support may be required.

There has been enhanced healthcare inequity and discrimination

There has been patient confusion around shifting movement restrictions, fear of over-policing and border checks, fear of police discrimination due to movement to access abortion care, and fear of barriers to returning home after abortion care. For clinics this means that patients are more likely to cancel last minute, not show up to their appointment or struggle to find a support person. This places additional strain on both communities and Australian health systems.

Inequity during the pandemic has been greater for people who already experience barriers to healthcare, including Aboriginal and Torres Strait Islander communities; migrant and refugee communities including those on temporary visas; people with

disability; sex workers; LGBTIQ+ populations; young people; people who are incarcerated and people living in regional, rural and remote areas.

These patients are less likely to have access to ethical decision-making frameworks in clinical care and are at greatest risk of healthcare discrimination.³² Community controlled health providers and specialist services have experienced additional pressure to respond to the impacts of violence, reproductive coercion and/or unplanned pregnancies.³³

Discrimination in the health sector impacts staff wellbeing

Racist behaviour within communities has reduced our ability to maintain safe workplace environments at a time when wellbeing is critical.³⁴ Australia's health workforce is highly skilled, experienced, intersectional and diverse. Discrimination against health workers during the pandemic has increased workplace stress and reduced healthcare capacity.

Relationships in institutional settings can replicate toxic behaviours from local communities. Racism that evolved during the pandemic, including myths that a virus can be racialised, has been witnessed within clinical settings. Health workers have experienced a combination of covert and overt discrimination from both patients and their support people. Some patients refused to be treated by health workers of colour, withdrawing some or all consent for treatment and demanding another practitioner.

Experiences of discrimination in workplaces during the pandemic are an extension of discrimination that existed prior to the pandemic. Australia needs increasingly intersectional and community controlled health leadership structures that co-design systemic health reforms in partnership with health consumers.

Co-design in virtual healthcare is future proofing

Australia's health system is at a turning point of infrastructure planning and clinical design.³⁵ Multi-disciplinary teams are essential to design for infection control and systemic wellbeing. Health consumer advisors have provided important perspectives that have informed crisis responses. Co-design of telephone, online and face to face clinical care models have been critical throughout the pandemic. Integrating virtual care will be essential for health systems evolution.³⁶

All communication mechanisms have their limitations, and virtual health will never entirely replace in-person health communication. Any clinical interaction that requires an examination doesn't translate easily to virtual health. In the context of sexual and reproductive health, these include vulval and pelvic examinations. The Australian healthcare system requires innovative solutions, including advances in health

systems literacy and revisiting expectations of all stakeholders involved in providing and receiving clinical care.

Longer term investment in virtual care will enable us to better bridge gaps between in person care and telehealth.³⁷ There is much to learn from telehealth histories in remote healthcare, and we can build on the strengths of telehealth systems reform that occurred during the pandemic.³⁸

Access to PPE is critical

Availability of Personal Protective Equipment (PPE) has been intermittent. Since March 2020 Marie Stopes Australia has faced fluctuating costs of PPE and varied quality of PPE, adding to existing procurement challenges. In various regions Primary Health Networks have assisted abortion providers with PPE access. As community needs for PPE change, Therapeutic Goods Administration (TGA) approved PPE needs to remain available to all health services.

It is as important as ever to consider mental health PPE.³⁹ While parts of Australia reflect pre-pandemic routine, the global pandemic continues, as does the strain on mental health for health professionals and their families. There is a continued risk to health professional mental health including compassion fatigue, vicarious trauma, trauma and burnout.⁴⁰ Given that some health professionals work in multiple clinical settings, collaboration within the health sector is required to protect sector health and wellbeing.

International aid and development is valued

The threat and disruption caused by this global public health crisis will not truly end for anyone, until it ends for everyone. Outside of Australia the pandemic is having devastating impacts on sexual and reproductive healthcare for our global friends, families and communities.⁴¹ A coalition of more than 150 Australian organisations have joined the #EndCovidForAll campaign.⁴²

In Australia, 72% of the public support ‘the provision of expertise and increased financial support to the poorest nations to help tackle the pandemic’.⁴³ Current Australian aid policy includes mention of maintaining sexual and reproductive healthcare as an essential service.⁴⁴ The policy focuses on health security, stability, and economic recovery with a geographic focus on Indonesia, the South Pacific and Timor-Leste.

If the virus is left unchecked, it will return to Australia from other countries once our borders are reopened, decimate our trading partners and therefore affect our economy by extension, and make our world more volatile overall. It is important that international aid and development funding is protected or increased to support countries to manage sexual and reproductive healthcare now and into the future.⁴⁵

Recommendations

In order to enable and ensure sexual and reproductive health rights in Australia, federal, state and territory governments need to make contraceptive and abortion care a priority.

Embed sexual and reproductive health in pandemic management planning

1. Sexual and reproductive health rights must be adequately covered within State and Territories pandemic plans, to ensure continued and safe access to services and make certain that we do not compound future public health issues.
2. Further support and assistance by government funded mechanisms set up to deal with international supply chain disruptions due to COVID-19 is required, to ensure medicines that are critically important to the health and wellbeing of people in Australia, such as medical abortion, are considered for the national priority list.
3. Ensure long term access to PPE:
 - a. All accredited sexual and reproductive healthcare providers, including private and community health providers, need access to the National Medical Stockpile for relevant PPE and medications.
 - b. Mental health PPE is essential. Supporting the health and wellbeing of all of our frontline sexual and reproductive healthcare workers including mechanisms for physical rest and some form of emotional recovery between shifts.
 - c. Private PPE providers should not discriminate against accredited abortion care providers. As an essential service, abortion care requires access to TGA approved PPE.
4. Sexual and reproductive health components of pandemic management plans should be designed and implemented with consumer input and community leadership.
5. Where needed, doctors and patients should be able to travel interstate and intrastate to deliver and access surgical abortion care. Doctors should be exempt from mandatory isolation providing they do not have a diagnosis or symptoms of the COVID-19 virus, or a history of high-risk exposure.
6. When reasons for patient or health professional movement require processing, relevant agencies need to maintain confidentiality at all times related to reasons for travel, for patients, their support people and the health professionals who provide abortion care.

7. Implement funding models that support people experiencing financial hardship to reduce out of pocket healthcare costs, including contraception and abortion care.
8. Support foster care, kinship care and care agencies given the escalated risk of unplanned pregnancy and decrease in abortion care access.
9. Increase public health messaging to prevent discrimination in clinical settings. Ensure our messaging can be responsive to various intersections of discrimination that emerge during the pandemic.
10. Overseas-trained doctors should have temporary exemptions to Section 19AB of the Australian Government Health Insurance Act 1973, in order to increase clinical capacity for the provision of sexual and reproductive healthcare.
11. Emergency contraception pill prescription and dispensation limitations should be lifted to ensure that pharmacists can prescribe to consumers of any age and that more than one pill can be accessed at a time and can be collected on behalf of another person, and that they can be stored at home in case of future need to access this option. Barriers to access vary by state and territory.
12. Make pregnancy tests, condoms, dental dams and menstrual health products freely available, while enabling privacy in collection/delivery and disposal.

Public health and hospital services should enable reproductive autonomy

13. Abortion care is an essential service. All governments, health and hospital services should maintain Category 1 classification for abortion care.⁴⁶
14. Public health and hospital services should not delay or refuse provision of abortion care. At a minimum, they need to provide high obstetric risk abortions.
15. Governments should fully fund all patients who choose contraception and/or abortion, particularly those with Health Care Cards and those with or without Medicare access who are experiencing financial hardship.
16. If a doctor or clinic objects to providing abortion care they should support the woman or pregnant person to access an alternative service that is willing to provide care as a duty of care.
17. All emergency departments should be able to provide emergency contraceptive options, including emergency contraceptive pills and the copper intrauterine device (IUD).
18. All stakeholders need to work together to ensure access to surgical abortion, particularly second trimester abortion. This includes working together to provide gestational scanning and sharing clinicians where required.

19. Contraceptive options should be provided at time of abortion and live birth.⁴⁷

Invest in Pharmaceutical and Medicare Benefits Schemes

20. Pharmaceutical Benefits Scheme (PBS) review to support:

- a. Medical abortion access up to 70 days/10 weeks gestation. In Australia, medical abortion is only available up to 63 days/9 weeks gestation and is covered by the PBS. The US Food and Drug Administration has licensed Mifepristone up to 70 days/10 weeks gestation.⁴⁸

21. Medicare Benefit Scheme (MBS) review to support:

- a. Additional item numbers for specialist sexual and reproductive care via telehealth, including Pre-Exposure Prophylaxis (PrEP), pregnancy options counselling and medical abortion access.⁴⁹
- b. Extended scope of health professionals including telehealth consults with Registered Nurses and Midwife Practitioners.
- c. Extended scope of consults including telehealth consults for STI prevention and screening within contraceptive consultations.
- d. Ultrasound provision by Registered Nurses with relevant training.
- e. Contraceptive implant care led by Registered Nurses and Midwife Practitioners.
- f. Additional item numbers for patients experiencing reproductive coercion to access sexual and reproductive telehealth at no cost, including medical abortion and contraception.
- g. Pregnancy options care for complex medical cases and delayed presentations.
- h. Consider which areas of sexual and reproductive healthcare cannot be addressed via telehealth and ensure that face to face services can be enhanced and maintained throughout potential future lockdowns.

Evolve models of care

22. Nurse-led care can increase healthcare access:⁵⁰

- a. Abortion providers should consider evolving nurse-led approaches to abortion care, including nurse-led manual vacuum aspiration (MVA).
- b. Nurse-led ultrasound is required in order to maintain capacity to deliver medical and surgical abortion care.⁵¹

23. In preventing unplanned pregnancy, consider the off-label/extended use of contraceptive devices including the contraceptive implant and intrauterine devices.⁵²
24. If it is known that a patient is at risk of unplanned pregnancy, the patient should be advised about their emergency contraceptive options, including a copper IUD. If emergency contraceptives are not accessible to them, health professionals should consider whether safety planning is required.
25. Where relevant and possible, health services should either screen or implement sensitive enquiry mechanisms to prevent and respond to sexual and reproductive coercion.
26. Invest in clinical education for health professionals to increase capacity for sexual and reproductive healthcare during the pandemic, particularly contraceptive care, medical abortion care, and STI and reproductive coercion prevention in general practice settings. Consider how virtual care can be integrated into communications components of clinical education.

Consider that mental health is sexual and reproductive health

27. Ensure that all people in Australia have access to non-judgemental and all-options pregnancy choices counselling, including options for abortion, adoption, care, kinship care and parenting. Any additional government funding for pregnancy counselling during the pandemic should prioritise all options, non-judgemental counselling and providers that employ qualified counsellors.
28. People need access to non-judgemental counselling when their first preference for health treatment cannot be honoured by the health system. Women and pregnant people who want an abortion but cannot access abortion should have optional access to non-judgemental telehealth counselling specific to the second pregnancy option of their choice; adoption, care, kinship care or parenting.
29. Pregnancy choices counselling providers should be required to openly disclose to clients if they do not support all pregnancy options, and if they are not a member of a relevant professional regulatory body. This should be communicated clearly on their website, disclosure statements and via any client referral mechanisms. Providers who choose not to provide all options pregnancy counselling services should be subject to the same duty of care as medical practitioners and be required to ensure that clients are given sufficient information to access the care that clients request.

30. Women and pregnant people who cannot access abortion and those who attempt unsafe abortion should be supported to access health and social services without judgement.

Collaborate for equity, access and agency

31. Provide incentives for prescribers and dispensers of medical abortion in order to increase telehealth access throughout rural, regional and remote areas of Australia. This is particularly relevant for South Australia during the post-abortion decriminalisation reform process.
32. Embed health consumer perspectives through evolving models of care to ensure their perspectives inform design, quality improvement and evaluation processes.
33. Consider how evolved models of sexual and reproductive healthcare that have developed during the pandemic can be evaluated, with efficiencies integrated into longer-term models of care.⁵³
34. Where scope of clinical practice has been extended during the pandemic, support practitioners to gain greater sexual and reproductive health experience. This could support Australia to increase sexual and reproductive healthcare capacity longer term.
35. Continue to integrate and support community-led initiatives and services that:
 - a. Co-design innovation in sexual and reproductive healthcare
 - b. Co-design inclusive sexual and reproductive health information communication
 - c. Provide mental health support
 - d. Engage trauma informed approaches to prevention and care
 - e. Prevent and respond to sexual, family and domestic violence
 - f. Consider primary, secondary and tertiary violence prevention mechanisms
 - g. Prevent and respond to reproductive coercion
 - h. Consider the intersectional and gendered impacts of disease.

In particular, collaborate with organisations led by and for Aboriginal and Torres Strait Islander communities, people with disability, LGBTIQ+ populations, migrant and refugee communities and sex workers.

36. Invest in community-led academic research that increases our understanding of:
- How to rapidly respond to chronic illness caused by lack of access to sexual and reproductive healthcare
 - How to increase capacity for trauma informed care in sexual and reproductive health systems during a pandemic
 - The impact and efficacy of evolving models of care emerging during the pandemic context
 - The intersections of isolation, violence and the escalation of reproductive coercion in the lead up to, during and post lockdowns
 - Enabling factors and benefits of sexual and reproductive health consumer leadership in co-design during a pandemic
 - Where and how virtual care can increase sexual and reproductive access and equity.
37. Develop a national list of ultrasound providers. Regional, rural and remote access to ultrasound will require collaboration among community, private and public health providers.
38. Due to lack of abortion access during the pandemic, there will need to be increased investment in organisations that provide support to:
- Children with a disability and their parents/kinship carers
 - Children with and without disability who are in out of home care
 - People seeking adoption, foster care and kinship care services
 - Families following a stillbirth.
- These individuals and their families should live freely without discrimination or judgement, particularly by social or child safety services.
39. Increase public health education messaging about consent (online and offline), safe sex, emergency contraception, STI prevention, broader contraceptive choices and pregnancy choices.
40. As movement restrictions shift, consider how those key messages are communicated to ensure that health consumers can access accurate movement information and can access clinics without fear of discrimination or persecution.
41. Any enforcement of pandemic related legislation should prevent over policing, support movement for essential services including healthcare.

42. In order to prevent violence and support access to telehealth, provide equitable and safe access to personal mobile devices, alongside increasing tech safety and tech confidence for people of all ages.

Legislation and policy should enable healthcare

43. Australia needs a Sexual and Reproductive Health Strategy.

44. South Australia needs to progress Termination of Pregnancy Act 2021 in order to enable provision of medical abortion via telehealth. If this is delayed, South Australia should use the *Emergency Response Act COVID 19 (SA) 2020* to suspend the clauses of S82A of the *Criminal Law Consolidation Act SA 1935* (Medical Termination of Pregnancy) that prohibit medical abortion via telehealth provision.

45. Resource, implement and evaluate provision of Federal strategies related to sexual and reproductive health, including the:

- a. Women's Health Strategy 2020-2030
- b. Men's Health Strategy 2020-2030
- c. National Aboriginal and Torres Strait Islander BBV and STI Strategy 2018-2022
- d. National Digital Health Strategy (2018)
- e. National Disability Strategy 2010-2020
- f. National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (2016)
- g. National Framework for Universal Child and Family Health Services (2011)
- h. National Hepatitis B Strategy 2018-2022
- i. National Hepatitis C Strategy 2018-2022
- j. National HIV Strategy 2018-2022
- k. National Plan to Reduce Violence Against Women and their Children 2010-2022 (next version in-press)
- l. National Preventative Health Strategy (2021-2030)
- m. National Sexually Transmissible Infections Strategy 2018-2022
- n. National Strategic Framework for Rural and Remote Health (2011)
- o. National Preventative Health Strategy (in-press)

46. Legislative, policy and licencing barriers to nurse-led abortion care should be reviewed and reconsidered to enable nurse-led healthcare. Barriers to nurse-led care vary by state and territory.⁵⁴
47. Australia's obligations for international aid and development remain. The federal government should continue to support countries in Australia's development program to manage ongoing and increased access to sexual and reproductive healthcare.
48. International aid and development funding must be protected and increased to support countries to achieve self-determination in sexual and reproductive healthcare now and into the future.⁵⁵
49. Avoid any new legislation, healthcare or otherwise, that could further limit sexual and reproductive health rights in Australia.

Action

Marie Stopes Australia is determined to maintain access to contraceptive and abortion care. Collaboration is welcome with federal, state and territory governments, professional associations, other non-profit organisations, other private clinical providers and key community stakeholders.

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Staying connected

Sign up for the Marie Stopes Australia healthcare professional [mailing list](#) to receive the regular updates on resources, events and training. Further information for healthcare professionals on COVID-19 and sexual and reproductive health access is available on the Marie Stopes Australia [website](#). Follow Marie Stopes Australia on [Twitter](#), [Linked In](#) or [Facebook](#).

Please share your feedback by completing our [anonymous online survey](#).

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