AUSTRALIAN LAWYERS FOR HUMAN RIGHTS™

Submission to inquiry into Universal Access to Reproductive Healthcare

Senate Standing Committees on Community Affairs
PO Box 6100 Parliament House Canberra ACT 2600

DECEMBER 2022

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Acknowledgements

Australian Lawyers for Human Rights (**ALHR**) acknowledges the traditional owners and custodians of the lands on which we work across Australia as the first people of this country. We recognise that the land belonging to these peoples was never ceded, given up, bought, or sold. We pay our deep respect to Elders past, present and emerging and express our strong support for the Uluru Statement from the Heart.

About Australian Lawyers for Human Rights

ALHR was established in 1993 and is a national association of Australian solicitors, barristers, academics, judicial officers and law students who practise and promote international human rights law in Australia. ALHR has active and engaged National, State and Territory committees and specialist thematic committees.

ALHR seeks to utilise its extensive experience and expertise in the principles and practice of international law and human rights law in Australia to:

- Promote Federal and State laws across Australia that comply with the principles of international human rights law;
- Engage with the United Nations in relation to Australian human rights violations;
- Promote and support lawyers' practice of human rights law in Australia;
- Engage internationally to promote human rights and the rule of law.

Through advocacy, media engagement, education, networking, research and training, ALHR promotes, practices and protects universally accepted standards of human rights throughout Australia and overseas.

Executive Summary

ALHR is grateful for the opportunity to provide this submission to the Senate Standing Committee's (**the Committee**) Inquiry into Universal Access to Reproductive Healthcare (**the Inquiry**) and welcomes the Government's commitment to dismantling barriers to universal access to reproductive healthcare.

The principles, priorities and objectives set out in the National Women's Health Strategy 2020-2030 (NWHS) are consistent with Australia's obligations under international human rights law.[1] After outlining the human rights framework in which the NWHS is situated, our submission will address parts (a), (b), (f) and (i) of the terms of reference.

[1] See for example Tania Penovic and Ronli Sifris, 'Expanding the Feminisation Dimension of International Law: targeted anti-abortion protest as violence against women' (2018) *Cambridge International Law Journal,* Vol. 7 No. 2, 241–267; Johanna B Fine, Katherine Mayall and Lilian Sepulveda, 'The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally' (2017) 19(1) *Health and Human Rights Journal* 69.

The International Human Rights Law Framework

Advancing access to sexual and reproductive health information, treatment and services accords with Australia's obligations to respect, protect and fulfil the human rights of women and pregnancy-capable people.[2] United Nations (**UN**) human rights bodies have recognised that sexual and reproductive health rights are an integral part of the right to health[3] and fall within a number of human rights standards, including the right to privacy and autonomy,[4] the right to security of person,[5] the right to equality and non-discrimination,[6] women's equal right to decide freely and responsibly on the number and spacing of their children,[7] the right to protection from cruel, inhuman or degrading treatment[8] and equality of access to health care services, including those related to family planning.[9]

The Vienna Declaration and Program of Action emanating from the World Conference on Human Rights held in Vienna in 1993 affirmed '*a woman's right to accessible and adequate health care and the widest range of family planning services' and education on the basis of equality with men*.[10] This position was expanded upon at the International Conference on Population and Development held in Cairo in 1994, where reproductive rights were seen to '*embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents*' and be underpinned by recognition of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to access the information and means to do so, and '*make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents*'.[11]

This consensus was expanded upon at the Fourth World Conference on Women held in Beijing in 1995, and reflected in the ensuing Beijing Declaration and Platform for Action, which affirmed that '*the human rights of women include their right to have control over an decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence*' and recognised that

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[2] ALHR uses the term women, noting that the submission is concerned with the National Women's Health Strategy, while acknowledging that sexual and reproductive healthcare may be accessed by a diverse range of people, including those who do not identify as women.

[3] See for example the work of the UN Special Rapporteur on the Right to Health at https://www.ohchr.org/en/special-procedures/sr-health/sexual-and-reproductive-health-rights

[4] Article 17 of the International Covenant on Civil and Political Rights.

[5] Article 9(1) of the International Covenant on Civil and Political Rights.

[6] See for example article 3 of the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights, article 1 of the Convention on the Elimination of All Forms of Discrimination against Women.

[7] Article 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination against Women.

[8] Article 7 ICCPR and article 16 of the Convention on the Elimination of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

[9] Art 12(1) of the Convention on the Elimination of All Forms of Discrimination against Women.

[10] Office of the High Commissioner on Human Rights, *Vienna Declaration and Programme of Action*, adopted by the World Conference on Human Rights (25 June 1993) [41].

[11] International Conference on Population and Development, *Programme of Action* (Cairo, September 1994) [7.3].

women are '*subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction'*.[12]

UN treaty bodies charged with monitoring the implementation of core human rights treaties ratified by Australia have called on state parties to respect, protect and fulfil sexual and reproductive rights. The UN Committee on Economic, Social and Cultural Rights (**CESCR**) has recognised that the right to sexual and reproductive health is an integral part of the right to health and includes a set of rights and entitlements, including the right to make autonomous decisions concerning one's body and entitlement to unhindered access to health facilities, goods, services and information.[13]

The CESCR has established that the right to sexual and reproductive healthcare requires health facilities, goods, information and services related to the underlying determinants of sexual and reproductive health, including safe abortion and post-abortion services, which are available, accessible, affordable, acceptable and of good quality.[14] The CESCR has furthermore recognised the right to sexual and reproductive health as being indivisible from and interdependent with other human rights[15] and that the realisation of gender equality requires the removal of barriers to accessing sexual and reproductive health, services, goods and information, including the adoption of legal and policy measures to guarantee 'access to affordable, safe and effective contraceptives and comprehensive sexuality education including for adolescents; to liberalise restrictive abortion laws; to guarantee women and girls' access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.'[16]

This position has been echoed by the UN Committee on the Elimination of Discrimination Against Women (**CEDAW Committee**) which has found that laws, policies and practices which serve to bar access to reproductive healthcare services are discriminatory and may cause or constitute gender-based violence[17] and in some circumstances amount to cruel, inhuman and degrading treatment or torture:[18]

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[12] Fourth World Conference on Women, *Beijing Declaration and Platform for Action*, UN Doc A/CONF.177/20 and A/CONF.177/20/Add.1 (1995), [96]-[97].
[13] Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the Right to Sexual and Reproductive Health* (*Article 12 of the International Covenant on Economic, Social and Cultural Rights*), UN Doc E/C.12/22 (2 May 2016) [1], [5].
[14] Ibid [11]-[21].
[15] Ibid [10]
[16] Ibid [28].
[17] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, A/54/38/Rev 1 (1999) [11]; Summary of the Inquiry into the Philippines under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, CEDAW/C/OP.8/PHL/1, 2015, [77], *L.C.v Peru*, Communication No. 22/2009, C/50/D/22/2009, 2011[8.15]-[8.19].
[18] CEDAW Committee, *General Recommendation 35 on Gender-Based Violence against Women, Updating General Recommendation No 19* (14 July 2017) [18].

> "*Violations of women's sexual and reproductive health and rights, such as criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, and forced continuation of pregnancy, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.*"[19]

The UN Working Group on discrimination against women has emphasised that the:

> "*..right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights."*[20]

In its Concluding Observations on Australia's implementation of the Convention on the Elimination of All Forms of Discrimination against Women (**CEDAW**), the CEDAW Committee called on Australia to review state and territory laws, policies and practices:

> '*to guarantee access to legal and prescribed abortion services and to raise awareness of sexual and reproductive health rights among women and girls, parents, teachers, medical professionals and the general public and create safe zones around abortion clinics*.'[21]

This was one of the four recommendations with respect to which the Committee requested written follow-up regarding the steps taken by Australia to implement the recommendations within two years.[22]

Like the CEDAW Committee, the UN Human Rights Committee (**UNHRC**) which monitors the implementation of the International Covenant on Civil and Political Rights (**ICCPR**) has found the denial of access to safe and lawful abortion to violate the right to non-discrimination and freedom from cruel, inhuman and degrading treatment as well as the right to privacy and the right of minors to measures of protection.[23]

Access to reproductive healthcare has been undermined by '*ideologically based policies or practices, such as the refusal to provide services based on conscience,* [which] *must not be*

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[19] Committee on the Elimination of Discrimination against Women, General Recommendation 35 (2017) on gender-based violence against women, updating general recommendation 19, para. 18.
[20] Working Group on the issue of discrimination against women in law and in practice, A/HRC/38/46 (2018), para. 35.
[21] Committee on the Elimination of Discrimination against Women, *Concluding observations on the eighth periodic report of Australia,* CEDAW/C/AUS/CO/8 (25 July 2018) [50(a)].
[22] Ibid [62].
[23] See eg *Llantoy Huamán v Peru*, HRC, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005); *LMR v Argentina,* HRC, Communication No 1608/2007, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011); *Mellet v Ireland,* HRC, Communication No 2324/2013, UN Doc CCPR/C/116/D/2324/2013 (9 June 2016); *Whelan v Ireland,* HRC, Communication No 2425/2014, UN Doc CCPR/C/119/D/2425/2014 (11 July 2017).

a barrier to accessing services.'[24] The UN Committee against Torture and UN Special Rapporteur on Torture have recognised women's vulnerability to ill-treatment or torture on the basis of '*actual or perceived non-conformity with socially determined gender roles*',[25] in the context of access to sexual and reproductive healthcare, particularly for women seeking abortions.[26] The Special Rapporteur on Torture has recognised the intersectional effect of this vulnerability to ill-treatment, which has a disproportionate impact on marginalised and disadvantaged women, and concluded that denying safe abortions and '*subjecting women and girls to humiliating and judgmental attitudes in such contexts of extreme vulnerability and where timely health care is essential amounts to torture or ill-treatment*'.[27]

UN Human Rights bodies have also highlighted the disproportionate impact on particular groups where access to reproductive health services is limited. The CEDAW Committee has expressed particular concern about the fact that rural women are more likely to resort to unsafe abortion than women living in urban areas, putting their lives and health at risk.[28]

The Committee on the Rights of the Child (**UNCRC**) has urged States "*to decriminalise abortion to ensure that girls have access to safe abortion and postabortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions*."[29] The UNCRC has emphasised the right of children, in accordance with evolving capacities, to confidential counseling and to access to information without parental or guardian consent. It has also recommended that "*States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion*."[30]
Article 25 of the UN Convention on the Rights of Persons with Disabilities (**UNCRPD**) explicitly requires state parties to "*provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health*," to ensure such services are provided "*as close as possible to people's own communities, including in rural areas*."

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[24] Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the Right to Sexual and Reproductive Health* (*Article 12 of the International Covenant on Economic, Social and Cultural Rights*), UN Doc E/C.12/22 (2 May 2016) [14].
[25] Special Rapporteur on Torture, Report of the SR-Torture, (A/HRC/31/57, 5 January 2016) para 42; see also *Committee against Torture, 'General Comment 2: Implementation of Article 2 by States Parties', (UN Doc CAT/C/GC/2, 24 January 2008)* [22].
[26] Special Rapporteur on Torture*, Report of the Special Rapporteur on Torture*, (A/HRC/31/57, 5 January 2016) para 42; *Committee against Torture, 'General Comment 2: Implementation of Article 2 by States Parties', (UN Doc CAT/C/GC/2, 24 January 2008)* [22].
[27] Ibid [42], [44].
[28] United Nations Committee on the Elimination of Discrimination against Women, General Recommendation 34 (2016) on the rights of rural women, para. 38.
[29] UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016, CRC/C/GC/20, para. 60
[30] Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15, para 31.

and to "*require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent*."[31]

The Committee on the Rights of Persons with Disabilities (**CRPD Committee**) has provided clear guidance to States that certain sexual and reproductive rights violations may be considered torture, cruel, inhuman, degrading treatment or punishment, including forced, coerced and otherwise involuntary sterilisation or pregnancy; as well as any other medical procedures or interventions performed without free and informed consent, such as contraception and abortion; invasive and irreversible surgical practices including, female genital mutilation or surgery or treatment performed on intersex children without their informed consent; the administration of chemical restraints (through practices such as menstrual suppression).[32]

UN Human Rights bodies have called on states to remove barriers to access to timely sexual and reproductive healthcare services such as mandatory waiting periods, the requirement to travel long distances, an absence of respectful care, court orders, and third party authorisation and notification provisions.[33]

UN Human rights bodies have also emphasised that noone should be deprived of any sexual and reproductive health information or service due to a refusal of care or conscientious objection by health service providers.[34] Australia's obligations to respect, protect and fulfil sexual and reproductive rights are, therefore, not limited to the conduct of state actors. They extend to the conduct of private actors, including individuals who deny and obstruct access to reproductive healthcare. Such actors include medical practitioners who conscientiously object to providing sexual and reproductive healthcare and fail to comply with statutory obligations to refer patients to a practitioner who holds no such objection. Australia has an obligation of due diligence to prevent, investigate and prosecute conduct by non-state actors which denies and obstructs access to reproductive healthcare in order to facilitate the realisation of sexual and reproductive rights.[35] Arguments by private actors that Victoria's

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[31] UN General Assembly, Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106 Article 25

[32] General Comment No 1 (2014) - Equal recognition before the law, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) and see Women With Disabilities Australia WWDA4 POSITION STATEMENT SEXUAL AND REPRODUCTIVE RIGHTS available here: https://disability.royalcommission.gov.au/system/files/2021-10/DRC.9999.0080.0001.pdf

[33]Committee on the Elimination of Discrimination against Women, General Recommendation 34, paras. 38-39; Committee on the Rights of Persons with Disabilities, General Comment 3 (2016), on women and girls with disabilities, para. 44; Working Group on Discrimination against Women, A/HRC/32/44 (2016), para. 107; Special Rapporteur on extrajudicial, summary or arbitrary executions, A/73/314 (2018), para. 53; Committee on the Elimination of Discrimination against Women, Concluding Observations on Iceland, CEDAW/C/ISL/CO/7-8 (2016). paras. 35-36; Concluding Observations on Rwanda, CEDAW/C/RWA/CO/7-9 (2017), paras. 38-39; Human Rights Committee, CCPR/C/BGD/CO/1, paras. 15-16.

[34] Committee on Economic, Social and Cultural Rights, General Comment 22, para. 43; Committee on the Elimination of Discrimination against Women, General Recommendation 24, para. 11; Committee on the Rights of the Child, General Comment 15, para. 69; Human Rights Committee, General Comment 36, para. 8. 40 Human Rights Committee, General Comment 36, para. 8; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/

[35] See for example Special Rapporteur on Violence against Women, its Causes and Consequences, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women: The Due Diligence Standard as a Tool for the Elimination of Violence against Women*' (Commission on Human Rights, 20 January

laws prohibiting any person from obstructing access to a reproductive healthcare facility represent a breach, by Victoria, of the implied right to freedom of political communication under the Australian Constitution, have been unsuccessful. In Clubb v Edwards, Preston v Avery (2019) 267 CLR 171, the High Court considered that the burden imposed by the communication prohibition was justified by reference to its legitimate purposes, including the protection of the safety, wellbeing, privacy and dignity of persons accessing lawful medical services.

A. Cost and Accessibility of Contraceptives

Research has uncovered a high unmet need for effective contraception in Australia.[36] Barriers to access to effective contraception include cost, the lack of available and accurate information about contraception and barriers associated with the training, expertise, attitudes and availability of health professionals. These barriers have an intersectional effect and a disproportionate impact on women and girls who experience various forms of disadvantage and marginalisation, including refugee and migrant women, culturally and linguistically diverse women, women with a disability, women experiencing family violence, women living in rural and regional Australia and Aboriginal and Torres Strait Islander women.

Barriers to contraceptive access have been amplified by the COVID-19 pandemic, which has seen increased levels of financial hardship and distress, limited face-to-face appointments and an increased need for telehealth services. A study of the impact of COVID-19 on reproductive health found that difficulties in accessing suitable contraception were experienced disproportionately by young women and those experiencing financial hardship.[37] The International Planned Parenthood Federation has observed that COVID-19 exacerbated existing inequalities and heightened discrimination against already marginalised groups, including refugees, people with disabilities and those in extreme poverty.[38]

The cost of contraceptive products and services, some of which require repeat prescriptions and/or medical appointments and out-of-pocket fees, is prohibitive for many women and girls. In addition to financial barriers to access, there is a lack of sexual and reproductive health literacy, particularly among young women which is associated with reliance on less effective forms of contraception.[39] The use of long-acting reversible contraceptives, which

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2006), [29]; Special Rapporteur on Violence against Women, its Causes and Consequences, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women,* E/CN.4/1999/68/Add.4, 21 January 1999, [46]-[47]; CEDAW Committee, *General Recommendation 35 on Gender-Based Violence against Women, Updating General Recommendation No 19* (14 July 2017) [24]-[26].

[36] Taft AJ, Shankar M, Black KI, Mazza D, Hussainy S, Lucke JC. Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes, (2018) 209(9) *Medical Journal of Australia* 407; SPHERE, Sexual and Reproductive Health Coalition, Increasing access to effective contraception in Australia, 20 July 2022 https://www.spherecre.org/coalition-outputs

[37] Jacqueline Coombe et al, 'The impact of COVID-19 on the reproductive health of people living in Australia: findings from an online survey', MedRxiv preprint doi: https://doi.org/10.1101/2020.08.10.20172163

[38] International Planned Parenthood Federation, *IMAP Statement on COVID-19 and Sexual and Reproductive Health and Rights*, (April 2020). See also Barbara Baird and Erica Millar, 'Abortion at the edges: Politics, practices, performances' 80 (2020) *Women's Studies International Forum*.

[39] See for example D Mazza, D Bateson, M Frearson, P Goldstone, G Kovacs and R Baber, 'Current Barriers and Potential Strategies to increase the use of long acting reversible contraception to reduce the rate of

are extremely effective in reducing unintended pregnancy, remains low in Australia compared to other parts of the world.[40] There is a clear need for the cost of contraceptive products and services to be subsidised and for greater information and education around effective contraception.

Practitioner training, attitudes and availability

Further barriers to access to contraception emanate from the knowledge, training, attitudes and beliefs of health professionals. Research has found a lack of knowledge and training regarding long-acting reversible contraceptives among health practitioners, especially outside metropolitan areas, leading to a lack of service availability.[41]

The attitudes of health practitioners towards contraception also serves as a barrier to access. While conscientious objection arises more often in the context of abortion, as discussed below, it also plays a significant role in undermining access to contraception in Australia, both at the institutional and individual level.

At an institutional level, Catholic hospitals ascribe to Catholic Health Australia's code of ethical standards, which addresses contraception in the following terms:

> *"The use of procedures or drugs deliberately to deprive the marital act of its procreative potential, whether temporarily or permanently, is not permissible. Also unacceptable are birth control methods that involve a significant risk of preventing an embryo from implanting or induce the shedding of the lining of the womb together with any already implanted embryos: such procedures are in fact abortifacient not contraceptive.'*[42]

This code has supported institutional conscientious objection, barring access to contraception, compromising care, undermining medical judgment, denying patients essential medical treatment, and generating inaccuracies in medical records and data collection.[43]

For many women, the public hospital in their local catchment area is a Catholic hospital. Healthcare workers who have worked in Catholic hospitals have described their frustration in the face of being unable to accede to requests for tubal ligation from patients, including

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unintended pregnancies in Australia: An expert roundtable discussion' 15 (2017) *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 206-212.

[40] Ibid; Sarah Larkin and Priscilla Page, 'Access to Contraception for Remote Aboriginal and Torres Strait Islander Women: Necessary but not sufficient' (2016) 205 (1) *Medical Journal of Australia* 18-19.

[41] D Mazza, D Bateson, M Frearson, P Goldstone, G Kovacs and R Baber, 'Current Barriers and Potential Strategies to increase the use of long-acting reversible contraception to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion', 15 (2017) *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 206-212.

[42] Catholic Health Australia, *Code of Ethical Standards for Health and Aged Care in Australia*, June 2001, https://www.cha.org.au/wp-content/uploads/2021/06/Code-of-ethicsfullcopy.pdf [2.5]

[43] See for example Annika Blau, 'In Good Faith', *ABC RN* Background Briefing (3 December 2022) https://www.abc.net.au/news/2022-12-03/catholic-hospitals-denying-womens-healthcare-australia-hospitals/101712558

women who have had multiple caesarean deliveries. In an investigation into access to reproductive healthcare in Australia for ABC Radio National's Background Briefing, Annika Blau reported as follows:

> '*One current Catholic hospital worker said in a previous role in a disadvantaged area, she's seen women 'come in for their eighth baby and maybe fourth caesarean, which is potentially very dangerous. There'd be lots of frowning at them, as another caesarean puts their life at risk, but if they requested a tubal ligation, we'd say "No, you have to wait until you've healed and then go on the waitlist for another hospital". Pretty often they'd come back with another pregnancy in the meantime. These were refugee or migrant women with very limited social and financial support, often parenting completely on their own. I felt very ashamed of having to do that.'* [44]

In regional areas, the problem of institutional and individual conscientious objection is particularly acute. Catholic hospitals service large geographic catchments, supervising the training of junior doctors. Women who attend these hospitals may be unaware that their code of ethics serves as a barrier to the full range of contraceptive care. Furthermore, Catholic hospitals play an influential role within their local catchment which may have the effect of deterring health practitioners from providing reproductive healthcare, including contraception and abortion.

In nationwide research into barriers to reproductive healthcare in Australia conducted by Tania Penovic and Ronli Sifris, the religious beliefs of health professionals emerged as a significant barrier to access, particularly in rural and regional Australia. One health practitioner described the influence of the large private Catholic hospital in the following terms: 'We live in a very Catholic town. It's a very, very conservative Catholic town. Basically, people have previously told if they helped provide this service, they wouldn't be able to practice at the only private hospital in town, because it's Catholic.'[45] A retired gynaecologist and obstetrician observed that 'in every country town it's a major problem because some have one or two doctors who could be deeply religious and won't provide contraception.'[46] A general practitioner working in regional Queensland described the situation in the following terms:

> "*You know, very paternalistic attitudes that obviously aren't as widespread in medicine as they used to be but are still there. You know, some communities where we know that the GPs don't provide contraception or any kind of termination counselling. So, Toowoomba for example, there have been improvements, but certainly up till about five years ago, there were whole pockets of GPs where there were no contraceptive services provided...There are definitely GPs out there who don't provide contraception…*"[47]

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[44] Ibid.
[45] Interview with a staff specialist working in reproductive health in regional Victoria (Tania Penovic/Ronli Sifris, 1 May 2017)
[46] Interview with a retired obstetrician and gynaecologist in regional New South Wales and Victoria (Tania Penovic/Ronli Sifris, 15 October 2018).
[47] Interview with a general practitioner working in regional Queensland (Tania Penovic/Ronli Sifris, 9 July 2019)

Aboriginal and Torres Strait Islander women and girls

For Aboriginal and Torres Strait Islander women, access to sexual and reproductive health services cannot be considered in isolation from their lived experience of systemic discrimination and mistreatment, forced child removal, involuntary sterilisation and eugenically informed birth control.[48] Suspicions held by Aboriginal women around measures of reproductive control coalesce powerfully with other barriers to access; including limited access to health services[49] and an adequately trained and resourced workforce to implement culturally appropriate sexual health education programs and access to contraceptive products.[50]

Cultural barriers can also impact access to adequate sexual and reproductive health education.[51] The Australian Human Rights Commission's *Wiyi Yani U Thangani* (Women's Voices) report, reveals that many Aboriginal and Torres Strait Islander women who contributed to the report 'emphasised the importance of connecting to traditional processes' to ensure that girls and young women are supported in decision-making around sexual health and reproduction and observed 'the need for passing on women's business by supporting the involvement of elder women and providing culturally safe spaces within health services.'[52]

Recommendations:

To facilitate access to contraception, ALHR recommends that:

- The cost of contraception be subsidised to ensure that cost is not a barrier to access.
- Public hospitals under their funding arrangements should be required to provide contraception services.
- Training of health professionals should be directed to increasing knowledge of contraception, including long-acting reversible contraception
- Community education should be directed to increasing understanding within the community about methods of contraception, including long-acting reversible contraception.

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[48] Aileen Moreton-Robinson, *Talkin' up to the White Women: Indigenous Women and Feminism* (University of Queensland Press, St Lucia, 2000) 171; Larissa Behrendt, 'Aboriginal Women and the White Lies of the Feminist Movement: Implications for Aboriginal Women in Rights Discourse' (1993) 1 *Australian Feminist Law Journal*. 27, 29-30; Emily Maguire, *This is What a Feminist Looks Like: the Rise and Rise of Australian Feminism* (National Library of Australia, Canberra 2019) 149-150.

[49]Sarah Larkin and Priscilla Page, 'Access to contraception for remote Aboriginal and Torres Strait Islander women: necessary but not sufficient' (2016) 205(1) *Medical Journal of Australia* 18, 18-19.

[50] Natalie A Strobel and James Ward, 'Education programs for Indigenous Australians about sexually transmitted infections and bloodborne viruses', *Australian Government* (Report, May 2012) <https://www.aihw.gov.au/getmedia/00250e14-7b83-4da8-994e-723a25d96ab7/ctgc-rs14.pdf.aspx?inline=true>; Sarah Larkins et al, 'Attitudes and behaviours of young Indigenous people in Townsville concerning relationships, sex and contraception: the "U Mob Yarn Up" project' (2007) 186(1) *Medical Journal of Australia* 513, 513.

[51] Australasian Society for HIV Medicine, 'Djiyadi - Can we talk?' (Report, 2011) 8,11, 29 <https://www.ashm.org.au/products/product/1976963384>.

[52] *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future* Report p 405.

- Support and training should be provided for Aboriginal and Torres Strait Islander doctors, nurses, midwives and health workers to facilitate culturally safe healthcare and address staff shortages.

B. Cost and Accessibility of Abortion

Laws criminalising abortion in each state and territory, built on the template of the United Kingdom's *Offences Against the Person Act 1861,* have operated as a significant legal barrier to abortion access, creating uncertainty around the parameters of lawful abortion, stigmatising abortion, undermining medical education and training and the willingness of health professionals to provide medical services. In the past two decades, the states and territories have charted a trajectory of decriminalisation, in line with legislative reforms in other liberal democracies and the recognition that access to safe and lawful abortion is supported by norms of international human rights.

Legislative reforms in each state and territory have dealt with the activities of individuals engaged in clinic picketing.[53] The presence of clinic picketers interfered with the privacy of women seeking reproductive health care and undermined safety, well-being and access to healthcare. Safe access zone legislation in every state and territory has stopped the targeted harassment of patients, staff and others outside clinics and reduced the stigmatisation of abortion by enabling abortion to be treated in the same manner as other medical procedures.[54]

While legislative reforms have dismantled some legal barriers to abortion access, decriminalisation alone does not facilitate access to healthcare[55] and significant access barriers persist. Barriers emanating from the legal framework include the following:

- The lack of harmonisation of state and territory laws, leading to confusion and uncertainty around their parameters for those who seek and provide abortion services. For example, state and territory laws impose different requirements with respect to disclosure of conscientious objection and referral to another practitioner, generating confusion with respect to the nature of health practitioners' duties and preventing the timely referral of patients to health practitioners who can provide appropriate care.
- The imposition of gestational limits for abortion on request, after which the approval of medical practitioners is required.

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[53] Ronli Sifris, Tania Penovic and Caroline Henckels, 'Advancing Reproductive Rights through Legal Reform: The Example of Abortion Clinic Safe Access Zones' (2020) 43(3) *University of New South Wales Law Journal,* 1078.

[54] See for example Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317; Ronli Sifris, Tania Penovic and Caroline Henckels, 'Advancing Reproductive Rights through Legal Reform: The Example of Abortion Clinic Safe Access Zones' (2020) 43(3) *University of New South Wales Law Journal,* 1078.

[55] Barbara Baird, 'Decriminalization and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197; Louise Keogh et al., 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18, 20.

- The significant disparity between jurisdictions, with gestational limits for abortion on request ranging from 16 weeks to 24 weeks, with the consequence that some women have been denied healthcare or required to travel to another jurisdiction in order to obtain access with concomitant expense and delay in accessing time-critical healthcare.
- Western Australian law continues to impose onerous requirements for abortion access after twenty weeks' gestation.
- Legal restrictions as to who is permitted to perform abortions create workforce shortages, barring the delivery of services by health practitioners such as nurse practitioners and midwives who are well positioned to provide safe and accessible medical abortion and alleviate staff shortages.

In addition to these barriers, abortion access in Australia is undermined by a range of barriers which do not emanate from the current legislative framework, some of which are attributable to the legacy of criminalisation and the failure of the healthcare system to adapt to legislative reforms. These barriers overlap with the barriers to access to contraception, discussed above and include financial barriers, lack of information, language barriers, 'pregnancy advisory services' operated by groups opposed to abortion, reproductive coercion, geographic barriers and barriers associated with the training, attitudes and availability of health professionals.[56]

Cost of abortion services [57]

There is a lack of access to affordable abortion care in Australia. Inadequate public funding of abortion services has led to a lack of abortion services in public hospitals and a preponderance of abortions being performed in the private health system. With abortion services located primarily in metropolitan areas, some women must travel long distances to obtain healthcare, compounding the costs of abortion, generating delays in accessing time-critical medical care and making abortion inaccessible for some women.[58] The costs of abortion services are compounded for many women by the cost of travel, accommodation and childcare and women who are ineligible for government support, such as those on temporary visas, must fund the costs of abortion services in full.

While low-cost surgical abortions are available in some clinics, there are significant cost disparities between, and within Australia's states and territories. The cost of surgical abortion in the private health system rises as pregnancy progresses and the cost of late gestation abortions can amount to thousands of dollars. In a study of women seeking abortion at 18 to 24 weeks' gestation (which comprise 2 per cent of abortions in Australia), Hayes, Keane and Hurley observed that the women they worked with in their role as counsellors 'have often faced a myriad of gendered, racial, geographic and economic inequalities and barriers in

[56] See generally Ronli Sifris and Tania Penovic, 'Barriers to abortion faced by Australian women before and during the COVID-19 Pandemic' Vol 86 (2021) *Women's Studies International Forum,* Article 102470.
[57] This section is drawn in part from Ronli Sifris and Tania Penovic, 'Barriers to abortion faced by Australian women before and during the COVID-19 Pandemic' Vol 86 (2021) *Women's Studies International Forum,*102470.
[58] See for example MSI Australia, Australian Abortion Access Scorecard, updated 15 July 2022 at https://www.msiaustralia.org.au/abortion-access-scorecard//

their lives, such as gendered violence, poverty, homelessness, poor mental health and lack of access to regional or culturally appropriate healthcare.'[59] The cost of abortion presents a formidable barrier for these women to obtain the healthcare and support they require.

Barriers to access to medical abortion

Some barriers to access to medial abortion have emanated from federal government policy. The World Health Organization recognised mifepristone as an essential medicine in 2005[60] and, in combination with misoprostol, the drug has provided a safe alternative to surgical abortion for women in many countries for more than two decades. Yet in Australia, a ministerial veto over its importation and registration which was introduced in 1996 remained in place until 2006. A further six years elapsed before an application was made to include mifepristone on the Register of Therapeutic Goods and another year elapsed before it was included on the Pharmaceutical Benefits Scheme.

Mifepristone and misoprostol are now registered for early medical abortion up to 63 days' gestation under the name MS-2 Step. But access to medical abortion is encumbered by over-regulation. The Pharmaceutical Benefits Scheme confines prescriptions to medical practitioners. Therapeutic Good Administration guidelines require providers to complete an online training program and register to prescribe MS-2 Step and to re-register every three years. Pharmacists must also obtain certification to dispense MS-2 Step.

Research undertaken by Subasinghe et al has found that medical abortion is not yet integrated into primary healthcare in Australia[61] and less than 10 per cent of general practitioners are registered to provide medical abortion.[62] The figure is much lower in rural and regional Australia. 30% of women in Australia (including 50% of women in remote parts of Australia) live in areas in which MS-2 Step was not prescribed by a general practitioner or dispensed by a community pharmacy during 2019.[63] Mazza et al have observed that doctors have been deterred from registration due to concerns about the legality of provision, fear of stigmatisation, the erroneous assumption that they need to be on call 24 hours a day, the perception that medical abortion is beyond their scope of practice and a sense of isolation and lack of peer support.[64]

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[59] Trish Hayes, Chanel Keane and Suzanne Hurley, 'Counselling "late women" - The experience of women seeking abortion in the eighteen to twenty-four-week gestational period: Critical reflections from three abortion counsellors', 78 (2020) *Women's Studies International Forum* 102327, 6.
[60] See World Health Organization, 'Essential Medicines List Application Mifepristone–Misoprostol for Medical Abortion' (Application, 2018) 1 https://www.who.int/selection_medicines/committees/expert/22/applications/s22.1_mifepristonemisoprostol.pdf?ua=1
[61] Asvini K Subasinghe, Kevin McGeechan, Jessica E Moutlon, Luke E Grzeskowiak and Danielle Mazza, Early Medical Abortion services provide in Australian primary care,' (2021) 215(8) *Medical Journal of Australia* 366.
[62] MS Health, July 2022-Update, Medical abortion prescriber and dispenser update, July 2022 https://www.mshealth.com.au/wp-content/uploads/06072022-MS-Health-July-2022-Update-1.pdf
[63] Asvini K Subasinghe, Kevin McGeechan, Jessica E Moutlon, Luke E Grzeskowiak and Danielle Mazza, Early Medical Abortion services provide in Australian primary care,' (2021) 215(8) *Medical Journal of Australia* 366.
[64] Danielle Mazza, Gwendoline Burton, Simon Wilson, Emma Boulton, Janet Fairweather and Kirsten Black, 'Medical Abortion' (2020) 49(6) *Australian Journal of General Practice*, 324.

The current regulatory framework applies unnecessarily onerous conditions on the prescribing and dispensing of medications used for medical abortion, exacerbating the significant unmet need for medical abortion services in primary care. Access could be increased by revising the regulatory framework for prescribing and dispensing MS-2 Step. Research supports the safety and efficacy of mifepristone and misoprostol for early medical abortion up to 77 days' gestation[65] and countries including the United Kingdom allow the use of mifepristone and misoprostol for up to 70 days. Access to medical abortion could furthermore be increased, particularly in rural and regional areas, by expanding the range of prescribers to include nurse practitioners and midwives.

Another barrier to medical abortions is the control of Google in relation to how abortion services can be advertised. A recent example is Google's ban of abortion clinic MSI Australia's advertisements on the search engine. MSI claims the ban in December 2022 as a misinterpretation of Australian laws, restricting access to abortions and information about abortions in Australia.[66]

Training, attitudes and beliefs of health professionals

Like contraception, abortion access has been undermined by healthcare staff shortages, gaps in the education and training of health professionals and the attitudes and beliefs of health professionals. Abortion has not been adequately addressed in doctor training and medical curricula, attributable in part to the criminalisation of abortion and the failure of medical education to adapt to decriminalisation.

Abortion care remains highly susceptible to the moral and religious beliefs of health professionals. Conscientious objection at the institutional and individual level presents a significant barrier to abortion access, as it does with contraception. For many women, the public hospital in their local catchment area is a Catholic hospital and large Catholic-run tertiary hospitals cover expansive parts of rural and regional Australia.

Catholic Health Australia's Code of Ethics proscribes abortion care and provides that-

> *[u]nless there is a serious risk to the mother's life, she should be encouraged to carry her child until approximately full term. However, when the continuation of pregnancy poses a serious threat to the mother or child, therapeutic interventions (e.g. induction of labour) are permitted provided they do not involve a direct assault on the unborn child, not involve an unwarranted risk to the child's life or health, given the medical resources available and the child's prognosis if the intervention is delayed.*[67]

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[65] See for example The Royal College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) infection and abortion care, Information for healthcare professionals, UK: Royal College of Obstetricians and Gynaecologists; 2020 1 April 2020.

[66] See https://www.theguardian.com/technology/2022/dec/15/australian-abortion-and-contraceptive-providers-ads-banned-by-google

[67] See for example Annika Blau, 'In Good Faith,' *ABC RN* Background Briefing (3 December 2022), [2.30] https://www.abc.net.au/news/2022-12-03/catholic-hospitals-denying-womens-healthcare-australia-hospitals/101712558

Beyond barring access to abortion, institutional conscientious objection has operated to prevent some maternity hospitals from providing comprehensive healthcare in their area of operation, undermining access to timely and essential reproductive healthcare. Catholic Health Australia's proscription of termination of pregnancy is reported to be associated with delay and denial of medical care for women carrying a foetus with no chance of survival and women experiencing miscarriage. A clinician is reported to have told the ABC of a woman who attended a Catholic public hospital after her waters broke at around 17 or 18 weeks. The clinician reported '[i]n any other hospital, I would say '*You've broken your waters, there's a very small chance the baby will live, but the bigger risk is an infection that's life threatening to you, so the best option is to terminate this pregnancy*.' But in a Catholic hospital, I couldn't have that discussion…' When the patient began developing an infection, the clinician advised her to drive to a secular public hospital and present to the emergency department to obtain the termination she required, an action which the clinician believed saved the woman's life.[68]

Catholic-run hospitals include large tertiary hospitals in which reproductive healthcare involving contraception or abortion is not taught or practiced. Trainee doctors are accordingly unable to receive comprehensive training in reproductive healthcare. In regional areas, the problem of institutional and individual conscientious objection is particularly acute. As discussed above with respect to contraception, research undertaken by Penovic and Sifris has found that doctors have been deterred from providing abortion care for fear of being blacklisted and unable to work in local Catholic hospitals. A retired obstetrician and gynaecologist described the problem of conscientious objection in regional Australia as 'critical', with abortion-providing doctors subjected to threats and ostracism, observing 'you're putting yourself out there if you support terminations.'[69]

Penovic and Sifris were told of abortion providing doctors having their homes targeted, receiving death threats and being shamed and stigmatised in their local community.[70] They were told about rural and regional general practitioners and surgeons '*who started to provide terminations at country public hospitals* [and] *then ceased because of direct threats and abuse to them and their families in the regional towns. So they stopped. They stopped providing the service*.'[71] They were furthermore told of conscientiously objecting doctors who failed to comply with their statutory obligation to refer, and of health professionals who shamed and humiliated women seeking abortions and generated deliberate delays to obstruct healthcare access. A doctor providing abortion services in a number of states described delays in abortion care in the following terms:

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[68] See for example Annika Blau, 'In Good Faith', *ABC RN* Background Briefing (3 December 2022) https://www.abc.net.au/news/2022-12-03/catholic-hospitals-denying-womens-healthcare-australia-hospitals/101712558

[69] Interview with a retired obstetrician and gynaecologist (Tania Penovic/Ronli Sifris, 15 October 2018).

[70] Interview with a nurse practitioner and midwife (Tania Penovic/Ronli Sifris, 27 March 2017); Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (Tania Penovic/Ronli Sifris, 22 March 2017); Interview with clinic staff, anonymous (Tania Penovic/Ronli Sifris, 12 April 2017); Interview with the medical director of a community health centre (Tania Penovic/Ronli Sifris, 15 May 2017).

[71] Interview with a social worker, Melbourne (Tania Penovic/Ronli Sifris, 20 March 2017).

> '*Tassie used to be the classic. Somebody would go see their GP and their GP would go, "Well, you need some counselling". Send them off to a counsellor. "You need an ultrasound". Send them off, do an ultrasound. Delay and delay and delay until they would be too far to present for a termination; that was the classic, or frankly say, "No, I'm sorry, I'm not referring you. I don't do that" and not give them any alternative*.[72]

Reproductive coercion

A further barrier to abortion access is reproductive coercion, a form of gender-based violence described by Miller et al as 'any attempt to dictate a woman's reproductive choices or interfere with her reproductive autonomy.'[73] Reproductive coercion may involve coercing a women to have an abortion or continue a pregnancy against her will, or sabotage of contraception. Research has shown an increase in reproductive coercion during the COVID-19 pandemic[74] and lockdown measures and movement restrictions introduced in response have decreased access to healthcare for some women. Health professionals require training to enable the identification of reproductive coercion and to ensure that women are provided with counselling, information and access to contraception and healthcare.

Recommendations

To remove barriers to abortion access, ALHR recommends that

- Public hospitals under their funding arrangements be required to provide abortion services and not engage in conduct that discourages abortions
- The Therapeutic Goods Administration and Pharmaceutical Benefits Advisory Committee approvals should be amended to address the overregulation of medical abortion, including
    - the 63 day gestational limit,
    - simplifying registration requirements for doctors and pharmacists, and
    - expanding the range of providers of MS-2 Step to nurse practitioners and midwives.
- Increase training of health professionals in abortion care, both medical and surgical, to build expertise, address abortion stigma and increase services.
- Increasing public awareness of medical abortion and referral obligations of health professionals with a conscientious objection.
- Increase the training of health professionals with respect to the obligation to refer and investigate and sanction non-compliance.
- Increase the training of health professionals with respect to identifying reproductive coercion and supporting women in securing reproductive autonomy and access to healthcare.
- Provide support and training for Aboriginal and Torres Strait Islander doctors, nurses, midwives and health workers to facilitate culturally safe healthcare.

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[72] Interview with a medical practitioner providing abortion services in Victoria, Tasmania and New South Wales (Tania Penovic/Ronli Sifris, 19 November 2019).
[73] Elizabeth Miller et al, 'Pregnancy coercion, intimate partner violence and unintended pregnancy' (2010) 18(4) *Contraception* 316.
[74] Monash Gender and Family Violence Prevention Centre, *Responding to the Shadow Pandemic* (June 2020).

F. Experience of Women and Girls with Disability

Women and girls with a disability experience heightened levels of violence and discrimination in Australia. The Australian Law Reform Commission has found that 90% of women with an intellectual disability have experienced sexual abuse and 68% have experienced such abuse before the age of 18.[75] 20% of women with a disability have reported a history of unwanted sex, compared with 8.2% of women without a disability.[76] The real figures are likely to be higher, given the underreporting of violence and sexual abuse. Violence against women and girls with disability has been observed by Frohmander et al to have fallen 'through legislative, policy and service response 'gaps' as a result of the failure to understand the intersectional nature of the violence that they experience, and the multiple and intersecting forms of discrimination which make them more likely to experience, and be at risk of, violence.'[77]

Concern about violations of sexual and reproductive rights of women and girls with a disability have been expressed by UN human rights mechanisms and treaty bodies, including the CEDAW Committee, the Committee on the Rights of Persons with Disabilities, the Committee on the Rights of the Child, the Committee against Torture and the Committee on Economic, Social and Cultural Rights.[78] In addition to the human rights standards considered above, the Convention on the Rights of Persons with Disabilities recognises the right of persons with disabilities to enjoy legal capacity on an equal basis with others,[79] to be free from exploitation, violence and abuse,[80] the right to found a family, to decide freely and responsibly on the number and spacing of their children and to retain their fertility on an equal basis with others.[81] State parties to the Convention undertake to combat stereotypes,

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[75] Australian Law Reform Commission (ALRC) (2010) Family Violence — A National Legal Response. ALRC Final Report 114 http://www.alrc.gov.au/ publications/family-violence-national-legal-response-alrcreport-114

[76] Dowse, L., Soldatic, K., Didi, A., Frohmader, C. and van Toorn, G. (2013) *Stop the Violence: Addressing Violence Against Women and Girls with Disabilities in Australia*, Background Paper, Women with Disabilities Australia cited in Frohmader, C., Dowse, L., and Didi, A. (2015) 'Preventing Violence against Women and Girls with Disabilities: Integrating A Human Rights Perspective'. Women With Disabilities Australia (WWDA), Hobart, Tasmania. ISBN: 978-0-9585268-4-5, 14.

[77] Frohmader, C., Dowse, L., and Didi, A. (2015) 'Preventing Violence against Women and Girls with Disabilities: Integrating A Human Rights Perspective', Women With Disabilities Australia, Hobart, Tasmania. ISBN: 978-0-9585268-4-5, 17.

[78] Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Australia*, UN Doc CEDAW/C/AUS/CO/7 (30 July 2010) [42]. See also Committee on the Rights of the Chid, *Concluding Observations: Australia*, 60th sess, UN Doc CRC/C/AUS/CO/4 (28 August 2012) [25], [57]; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Combined Second and Third Periodic Reports of Australia,* 22nd sess, UN Doc CRPD/C/AUS/CO/2-3 (15 October 2019) [33], [34]); Committee on the Rights of the Chid, *Concluding Observations: Australia*, 60th sess, UN Doc CRC/C/AUS/CO/4 (28 August 2012) [57]; Committee Against Torture, *Concluding Observations on the Combined Fourth and Fifth Periodic Reports of Australia*, 53rd sess, UN Doc CAT/C/AUS/CO/4-5 (23 December 2014) [20]; Committee on Economic, Social and Cultural Rights, General Comment No. 5: Persons with disabilities Eleventh session (1994) [31]. See also Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/22/53, 1 February 2013, 5-8; Report of the Special Rapporteur on violence against women, its causes and consequences. United Nations General Assembly, UN Doc No. A/67/227 (2012).

[79] Article 12, Convention on the Rights of Persons with Disabilities.

[80] Article 16, Convention on the Rights of Persons with Disabilities.

[81] Article 23(1), Convention on the Rights of Persons with Disabilities.

prejudices and harmful practices relating to persons with disabilities and to promote awareness of the capabilities of persons with disabilities.[82] Yet in Australia women and girls with a disability have been subjected to the non-consensual administration of contraceptives, and the performance of abortion and sterilisation without consent.

These practices have been based on a range of harmful stereotypes and prejudices, including the assumption that they lack autonomy and capacity to care for children,[83] lack capacity to control their sexuality and fertility and are incapable of managing menstruation. Involuntary sterilisation has been rationalised in some cases by the erroneous assumption that it will reduce the risk of sexual abuse despite the reality that it may increase the risk of abuse which may otherwise be exposed by pregnancy.[84] The practices of sterilisation, abortion and administration of contraception without consent are built on misconceptions and stereotypes which have robbed women and girls with disability of autonomy and violated their human rights.

UN treaty bodies have repeatedly called on Australia to introduce national uniform legislation to ensure that the use of sterilisation, abortion and the administration of contraception can only be carried out with prior, free and fully informed consent.[85] Recommendations have also called on Australia to take immediate steps to replace substitute decision-making with supported decision-making and repeal all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities concerned. ALHR stresses that these recommendations should be adopted as a matter of urgency.

[82] Article 8(1), Convention on the Rights of Persons with Disabilities.
[83] See for example John Tobin and Elliot Luke, 'The Involuntary, Non-Therapeutic Sterilisation of Women and Girls with an Intellectual Disability – Can it Ever be Justified?' (2013) 3 *Victoria University Law and Justice Journal* 27, 29.
[84] See for example Willene Holness, 'Informed Consent for Sterilisation of Women and Girls with Disabilities in the Light of the Convention on the Rights of Persons with Disabilities' (2013) 27(4) *Agenda* 35, 38.
[85] Committee on the Elimination of Discrimination Against Women, *Concluding Observations: Australia*, UN Doc CEDAW/C/AUS/CO/7 (30 July 2010) [42]. See also Committee on the Rights of the Chid, *Concluding Observations: Australia*, 60th sess, UN Doc CRC/C/AUS/CO/4 (28 August 2012) [57]; Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia*, 10th sess, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [39], [40].

I. Other Related Matters

The ALHR welcomes the NWHS, the clear commitment to securing its implementation and the federal government's commitment to the promotion of sexual and reproductive rights in domestic and foreign policy.

The vulnerability of sexual and reproductive rights has been laid bare in recent months by developments in the United States (US). The overturning of *Roe v Wade*[86] by the US Supreme Court and the subsequent criminalisation of abortion in numerous US states has stripped women and pregnancy-capable people of fundamental human rights in a nation which already had the highest maternal death rate among high income countries.[87] The decision and the subsequent legislative restrictions which it facilitated are the product of more than four decades of politicisation, in which the anti-abortion movement became increasingly enmeshed within the Republican Party.[88]

Australia would appear to be far removed from the febrile legislative setting of the United States. Abortion remains a conscience vote issue and Prime Minister Anthony Albanese has observed that '*[i]t is a good thing that in Australia, this is not a matter for political debate*.'[89] But efforts to politicise sexual and reproductive healthcare have intensified in Australia, particularly with respect to abortion,[90] alongside the highly damaging politicisation of healthcare for - and social inclusion of - transgender and non-binary people.[91] In order to advance human rights and achieve the priorities of the NWHS, efforts to politicise healthcare access must be identified and repudiated.

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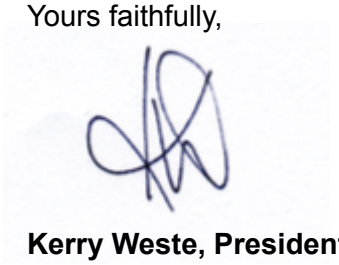
[86] *Roe v Wade* 410 US 113 (1973), see *Dobbs v Jackson Women's Health Organization* 597 US (2022)
[87] Munira Z, Gunja, Shanoor Seervai, Laurie Zephyrin and Reginald D Williams II, 'Health and Health Care for Women of Reproductive Age: How the United States Compares with Other High-Income Countries, *The Commonwealth Fund* (1 April 2022) https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age
[88] See Tania Penovic, 'The Fall of *Roe v Wade*, the US anti-abortion movement and its influence in Australia' (2022) 47(4) *Alternative Law Journal* 253-260, https://doi.org/10.1177/1037969X221132565
[89] Daniel Hurst, '"Devastating": Australian politicians respond to US supreme court's decision on abortion rights', *Guardian Australia* (27 June 2022) https://www.theguardian.com/australia-news/2022/jun/27/devastating-australian-politicians-respond-to-us-supreme-courts-decision-on-abortion-rights.
[90] See Tania Penovic, 'The Fall of *Roe v Wade*, the US anti-abortion movement and its influence in Australia' (2022) 47(4) *Alternative Law Journal* 253-260, https://doi.org/10.1177/1037969X221132565
[91] See for example Billie Elder, ''My anxiety is at an all-time high': How the election affected transgender families', *Sydney Morning Herald* (21 May 2022) https://www.smh.com.au/politics/nsw/my-anxiety-is-at-an-all-time-high-how-the-election-affected-transgender-families-20220513-p5al61.html, Mama Alto, '"Words can do untold damage." I'm trans. This is how it feels to be this election's political football', *Mamamia.Com* (23 April 2022) https://www.mamamia.com.au/transgender-politics-election/; Michael Koziol, 'Liberal candidate Deves invoked stolen generations in deleted trans tweets' *Sydney Morning Herald* (18 April 2022) https://www.smh.com.au/politics/federal/liberal-candidate-deves-invoked-stolen-generations-in-deleted-trans-tweets-20220418-p5ae3q.html

If you would like to discuss this submission, please contact president@alhr.org.a ALHR would be happy to provide any further information or to appear before the Committee to give oral evidence.

Yours faithfully,



Kerry Weste, President

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