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Barriers to abortion access in Australia before and during the COVID-19 pandemic

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\section*{ABSTRACT}

Access to abortion in Australian has been the subject of significant legal reforms to the point that in some jurisdictions, most legal barriers to access have been dismantled. Nevertheless, research reveals that many Australian women will not be in a position to fully realise their reproductive rights until the non-legal barriers to access are adequately addressed. Between March 2017 and November 2020, the authors conducted qualitative research into the barriers faced by Australian women when accessing, or attempting to access, abortion services. Three of the primary non-legal barriers to access raised repeatedly in our research are financial barriers to access, geographic barriers to access; and deficiencies in practitioner attitudes, education and training. Part I of this article focuses on these barriers to abortion access while Part II considers the significant new challenges created by the COVID-19 pandemic for women’s access to reproductive health services. The paper concludes that the pandemic and the measures introduced in response have amplified pre-existing barriers and generated a disproportionate and intersectional impact on the most marginalised and disempowered women in society.

\section*{1. Introduction}

Across Australia, significant legal reforms have expanded the legal availability of abortion to the point that in some jurisdictions, the preponderance of pre-existing legal barriers to access have been dismantled.\textsuperscript{1} For example, in the State of Victoria abortion has been decriminalised, and is available ‘on request’ up to 24 weeks’ gestation and after that if two medical practitioners believe that ‘abortion is appropriate in all of the circumstances’.\textsuperscript{2} While conscientious objection is permitted, a doctor with such an objection to abortion is nevertheless subject to what has become known as an ‘obligation to refer’ in order to ensure a woman’s continuity of health care.\textsuperscript{3} Yet even within a permissive and progressive legal framework, research has revealed that problems of access persist; while decriminalisation is often perceived as presenting the solution to problems of access, this perception is inaccurate and may serve to mask a full examination of persistent non-legal barriers to abortion access.\textsuperscript{4} These barriers are in part attributable to the legacy of criminalisation and the failure of the public and private healthcare system to adapt to the new legislative landscape. For example, a study of access to abortion in

\textdagger We are grateful to Zoe Tripovich and Anna Wotherspoon for their excellent research assistance.
\textsuperscript{1} Before 2002, abortion was a crime in every Australian jurisdiction. In 2002, the Australian Capital Territory decriminalised abortion. Since then, all remaining jurisdictions except Western Australia have decriminalised abortion in the following years: Victoria 2008; Tasmania 2013; Northern Territory 2017; Queensland 2018; NSW 2019; South Australia 2021. In Western Australia, abortion is unlawful unless the woman has provided informed consent; the effect of this is that, up to 20 weeks gestation, while abortion is technically a crime, it is legally permissible as long as the requirements for informed consent are met.
\textsuperscript{2} Abortion Law Reform Act 2008 (Vic) ss 4, 5.
\textsuperscript{3} Abortion Law Reform Act 2008 (Vic) s 8. It should be noted that the authors use the term ‘women’ in this article as the preponderance of persons seeking abortions are women while acknowledging that people who do not identify as women may also require abortions.
\textsuperscript{4} Barbara Baird, ‘Decriminalization and Women’s Access to Abortion in Australia’ (2017) 19(1) Health and Human Rights Journal 197.

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Victoria concludes that “abortion law reform, while a positive development, had changed little about the practical provision of abortion, and much ‘unfinished business’ remained.” Thus despite the legal progress, many women will remain unable to fully realise their reproductive rights until non-legal barriers to access are adequately addressed.

Between March 2017 and November 2020, the authors conducted qualitative research into the barriers faced by Australian women when accessing, or attempting to access, abortion services. Data was collected through semi-structured, in-depth interviews with 41 professionals engaged in health policy, and staff working in clinics providing abortion services in every state and territory (n = 14 in Victoria; n = 7 in Tasmania; n = 3 in Northern Territory; n = 7 in Queensland; n = 3 in Western Australia; n = 3 New South Wales; n = 1 in Australian Capital Territory; n = 3 in South Australia). Participants were asked specifically about the conduct of anti-abortionists and more generally about the barriers to abortion access in Australia. Four interviews were conducted during the COVID-19 pandemic and focused on its impact on abortion access. All interviews were recorded digitally and transcribed verbatim and the data was analysed thematically through a process of data familiarisation, coding and identification of themes.

Our research seeks to interrogate the gendered context of healthcare access, examining the entrenched inequality that underpins barriers in access to health services. These barriers have an intersectional impact on the most marginalised and disempowered women in society, including women with disability, refugee women and Aboriginal and Torres Strait Islander women. This impact extends beyond abortion access to other restrictions on reproductive freedom such as involuntary sterilisation procedures. For Indigenous women, access to abortion cannot be considered in isolation from their lived experience of systemic discrimination and mistreatment, including eugenically informed birth control, forced child removal and exclusion from feminist discourses. Suspicions held by Indigenous women around measures of reproductive control coalesce powerfully with other barriers to access; requiring an approach to health care that responds to women’s needs, ‘strengthens culture and takes in the whole of life— starting with women, their partners and extended family and communities.’

Three of the primary non-legal barriers to access that have been reiterated throughout our research are financial barriers, geographic barriers; and barriers flowing from deficiencies in practitioner attitudes, education and training. Part I of this article focuses on these barriers as a means of illustrating the point that in order to fully realise the reproductive rights of Australian women the enactment of formal legal rights is not enough. Government, and we as a society, must act to facilitate the practical realisation of those rights. In 2020, a significant new challenge to women’s ability to access the full range of reproductive health care has emerged in the form of the COVID-19 pandemic. While in Australia abortions have continued to be performed even when other forms of medical treatment were suspended, measures imposed to slow the spread of the virus have had an indirect negative impact on access to abortion care for many Australian women. The impact of COVID-19 on abortion access is examined in Part II.

2. Part I: barriers to abortion access

Non-legal barriers to abortion access are multifarious. They include, for example, lack of information; anti-abortion counselling, also sometimes referred to as ‘pregnancy advisory services’; and language barriers. In recent years, there has been increased recognition of the role that reproductive coercion and abuse plays in impeding women’s access to abortion. Reproductive coercion is a form of gender-based violence characterised by Miller et al. as ‘any attempt to dictate a

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5 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. See also Barbara Baird, ‘Decriminalization and Women’s Access to Abortion in Australia’ (2017) 19(1) Health and Human Rights Journal 197.

6 Interviews in all jurisdictions except New South Wales took place after the decriminalisation of abortion. The New South Wales interviews pre-date decriminalisation in that state.

7 Virginia Braun, Victoria Clarke, Nikki Hayfield, and Gareth Terry, ‘Theoretical Analysis’ in Franee Lianmputtong (Ed), Handbook of Research Methods in Health Social Sciences (Springer, Singapore 2019) 843–860. The research into barriers and received prior approval by the Human Research Ethics Committee at Monash University (Project No. 10588) in November 2016 and in September 2020 with respect to the impact of COVID-19 on the basis that it meets the requirements of Australia’s National Statement on Ethical Conduct in Human Research. Most interviews were conducted face-to-face with the remainder conducted via telephone or online technology, the latter of which became the only means of conducting interviews during the pandemic. While some participants chose to maintain confidentiality in the dissemination of the research data, some opted for identification of their name, position and workplace and some agreed to having their position and workplace identified but not their name. It should be noted that the NSW interviews pre-date decriminalisation in that state.

8 See generally Maureen C. McHugh and Lisa Cosgrove (2002). ‘Gendered subjects in psychology: Dialectic and satirical positions’ in Lynn H. Collins, Michelle R. Dunlap, and Joan C. Chisler (Eds.), Charting a New Course for Feminist Psychology (Praeger, Westport, 2002) 3–19.

9 Kimberle Crenshaw, ‘Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color’ (1991) 43(6) Stanford Law Review 1241–1299; Bonnie Thornton Dill & Marla H. Kohlman, ‘Intersectionality: A Transformative Paradigm in Feminist Theory and Social Justice’ in Sharlene Nagy Hesse-Biber (ed.), Handbook of Feminist Research: Theory and Praxis (SAGE Publications, Thousand Oaks, 2020); Deborah Bateson, Kirsten Black and Shailandra Sawleshwarar, ‘The Guttmacher-Lancet Commission on sexual and reproductive health and rights: how does Australia measure up?’ (2019) 210 (6) Medical Journal of Australia 250-252e1 2019.

10 Ronli Sifris, ‘The involuntary sterilisation of marginalised women: power, discrimination, and intersectionality’ (2016) 25(1) Griffith Law Review 45.
woman’s reproductive choices or interfere with her reproductive autonomy. Sometimes described as ‘reproductive coercion and abuse’ in order to encapsulate the physical or sexual tactics used in addition to coercion and the context of fear and control, this conduct may include coercing a woman to become or remain pregnant against her will. This issue was not extensively discussed in our interviews but has been the focus of significant research in recent years and recognised as a problem exacerbated by the COVID-19 pandemic. The Australian Institute of Family Services has observed a strong correlation in the research between unintended pregnancy and domestic and family violence and referenced research where ‘women described various ways in which abusive partners had controlled their reproductive and sexual choices including sabotaging their contraception; refusing to use contraception; rape; and attempting to influence the outcome of pregnancies’. Imposing restrictions on reproductive autonomy may therefore be seen as ‘an extra mechanism through which violent partners control and abuse women.’ The three primary non-legal barriers raised by our interviewees were financial barriers, geographic barriers; and deficiencies in practitioner attitudes, education and training. These are considered below.

2.1. Financial barriers to abortion access

In Australia, States are responsible for the provision of abortion services in public hospitals while federal funding is available to subsidise the cost of abortions performed in the private sector for those entitled to access Medicare. Deficiencies in both the public provision of abortion services and the subsidisation of abortions performed in the private realm has created significant financial barriers to access in most Australian jurisdictions. Even in South Australia, where abortions are provided primarily through the public health system, publicly funded facilities tend to be concentrated in and around the capital of Adelaide, meaning that women living some distance from Adelaide may still face financial obstacles to access. Abortion services across Australia are mostly delivered by private providers, generating enormous cost discrepancies between - and within - jurisdictions. For example, a medical (as opposed to surgical) abortion in Victoria may cost as little as $6.10 (for a disadvantaged woman connected with a sympathetic doctor who coordinates with the ultrasound providers to provide an accessible service) to a sum in excess of $440 at other private clinics. A medical abortion at one private Perth clinic costs $650 and at one clinic in regional Queensland costs $770. This is despite the fact that the drugs required for a medical abortion are included on the Pharmaceutical Benefits Scheme such that the cost per patient could be limited to approximately $40. Thus a General Practitioner in Victoria observed that: ‘We are just a little six-doctor GP practice with one prescriber of medical abortion and we are the single biggest provider of medical abortion in Victoria, outside of the Royal Women’s [Hospital]. Why is that? I can’t explain it, except that we bulk bill everybody, so the cost is very low. I think cost is a huge factor. I don’t know how the clinics that charge people four, five, six hundred dollars for a medical termination, I don’t know how they justify it, to be frank.’

This is not an isolated Victorian issue. For example, an obstetrician and gynaecologist from Tasmania noted that: ‘cost is, I think as always, the biggest thing. There’s no public clinic which is probably what would make the biggest difference. The fees that people charge are ridiculously high. I rang up [a specific clinic] and I was just chatting and I asked how much is it. It was $650. And I said “that’s just stupid!” and they said “but it costs a lot to do” I said

Elizabeth Miller et al., ‘Pregnancy coercion, intimate partner violence and unintended pregnancy’ (2010) 18(4) Contraception 316.
3. See Laura Tarzia et al., ‘Reproductive Coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia’ (2021) Culture, Health and Sexuality 1; Heather Douglas and Katherine Kerr, ‘Domestic and Family Violence, Reproductive Coercion and the Role for Law’ (2018) 26 Journal of Law and Medicine 341.
26. See for example Laura Tarzia et al., ‘Reproductive Coercion and abuse against women from minority ethnic backgrounds: views of service providers in Australia’ (2021) Culture, Health and Sexuality 1–2.
27. See discussion in Part II below.
28. Monica Campo, ‘Domestic and family violence in pregnancy and early parenthood,’ Australian Government, Australian Institute of Family Studies (Web Page, December 2015) https://aifs.gov.au/cfca/publications/domestic-an-d-family-violence-pregnancy-and-early-parenthood#:~:text=0%20of%20those%20women%2C%2022%25%20experienced%20violence%20first%20occurred%20during%20pregnancy.,. Citations omitted.
29. Monica Campo, ‘Domestic and family violence in pregnancy and early parenthood,’ Australian Government, Australian Institute of Family Studies (Web Page, December 2015) https://aifs.gov.au/cfca/publications/domestic-an-d-family-violence-pregnancy-and-early-parenthood#:~:text=0%20of%20those%20women%2C%2022%25%20experienced%20violence%20first%20occurred%20during%20pregnancy.,. The research referenced was Moore, A. M., Frowirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. Social Science & Medicine, 70 (11), 1737–1744.
30. Monica Campo, ‘Domestic and family violence in pregnancy and early parenthood,’ Australian Government, Australian Institute of Family Studies (Web Page, December 2015) https://aifs.gov.au/cfca/publications/domestic-an-d-family-violence-pregnancy-and-early-parenthood#:~:text=0%20of%20those%20women%2C%2022%25%20experienced%20violence%20first%20occurred%20during%20pregnancy.,. For an in-depth discussion of reproduction coercion see: Heather Douglas and Katherine Kerr, ‘Domestic and Family Violence, Reproductive Coercion and the Role for Law’ (2018) 26 Journal of Law and Medicine 341; Marie Stopes Australia, ‘Hidden Forces: Shining a Light on Reproductive Coercion: White Paper’ (Web Page, 2018) <https://www.mariestopes.org.au/wp-content/uploads/Hidden-Forces-MSA-RC-White-Paper_FINAL_WEB.pdf>.
31. The Medicare Benefits Scheme, often simply referred to as ‘Medicare’, is the scheme by which the federal government subsidises the costs of medical treatment in Australia and the Pharmaceutical Benefits Scheme (PBS) is the scheme by which the federal government subsidises the costs of certain pharmaceuticals.
32. Barbara Baird, ‘Decriminalisation and Women’s Access to Abortion in Australia’ (2017) 19(1) Health and Human Rights Journal 197, 198.
33. Interview with Tracey Greaves, Senior Social Worker, Pregnancy Advisory Centre, Adelaide, (Ronli Sifris/Tania Penovic, 18 April 2019). See generally Amelia Paxman, ‘Legalisation is just one hurdle – access and cost is the real barrier for women seeking abortion’ The Sydney Morning Herald (13 May 2017).
34. Barbara Baird, ‘Decriminalisation and Women’s Access to Abortion in Australia’ (2017) 19(1) Health and Human Rights Journal 197, 198; Caroline de Moel-Mandel and Julia M Shelley, ‘The legal and non-legal barriers to abortion access in Australia: a review of the evidence’ (2017) 22(2) The European Journal of Contraception & Reproductive Health Care 114.
35. Interview with General Practitioner working in sexual and reproductive health in regional Victoria, Melbourne, (Ronli Sifris/Tania Penovic, 2 May 2017).
36. Interview with Medical Director of Gateway Health Wodonga, (Ronli Sifris/Tania Penovic, 15 May 2017); Interview with General Practitioner working in sexual health in regional Victoria, (Ronli Sifris/Tania Penovic, 2 May 2017).
37. Amelia Paxman, ‘Legalisation is just one hurdle – access and cost is the real barrier for women seeking abortion’ The Sydney Morning Herald (13 May 2017).
38. See http://www.pbs.gov.au/medicine/item/102111K. It should be acknowledged that there are other costs involved besides the medication alone, such as ultrasound costs.
39. Interview with General Practitioner working in sexual and reproductive health in regional Victoria, (Ronli Sifris/Tania Penovic, 15 May 2017).
“you do realise that I actually run this practice all by myself completely unsubsidised, it doesn’t cost that at all”.34

There is only one private clinic in Australia that performs abortions post 20 weeks gestation, and these are mainly for reasons other than foetal abnormality as abortions for foetal abnormality are usually performed within the public system.35 Later abortions in Victoria may cost thousands of dollars when performed outside of the public sector, with the cost increasing as the pregnancy progresses, as described by Tracy Little, Centre Manager at Dr. Marie Maroondah:

Well, the cost goes up in increments every week, which is part of our structure and the way that the payments are. But it goes up to, like, with Medicare Card, up to seven and a half thousand dollars at 24 weeks, which is a huge amount of money.36

While it must be acknowledged that the challenges inherent in performing an abortion increase with the stage of gestation, it is also an unfortunate reality that those requiring an abortion at a later gestational stage are often in the most desperate and vulnerable circumstances.

In summary, the lack of public funding for abortion has led to a situation where most abortions across Australia are provided in the private system. This has led to significant cost discrepancies between providers and rendered abortion services unaffordable for many women, demonstrating the gendered face of healthcare inequality in a nation which prides itself on providing universal publicly funded access to healthcare.

2.2. Geographic barriers to abortion access

Abortion access differs between Australia’s six States and two territories. This has led to a certain amount of “reproductive tourism”, such that ‘there is evidence that women in Australia will travel interstate to more liberalised jurisdictions, due to the existence of restrictive political abortion climates or other related state-wide access difficulties.’37 For example, one of our interviewees from Western Australia commented that ‘we also get patients coming down from Darwin who are above their gestational limits’ in that jurisdiction.38 Further, Australia is geographically expansive, with vast distances between urban centres; thus for women living in rural and remote areas, geography may pose a significant barrier to access. For example, in Tasmania, there is a lack of publicly funded abortion services and, following the closure of clinics in both Launceston and Hobart, there is now only one known private provider of surgical abortion services in that State, located in Hobart.39

Therefore, women residing outside of Hobart must either travel to Hobart or interstate by air or sea to access a surgical abortion.

Geographic constraints are apparent nationwide.40 Brown has noted that ‘(a)ccess is a geographical and space-dependant issue. Access without availability is not access.’41 This is illuminated by Australia’s urban/rural divide. For instance, we were told by one health professional that ‘it is much easier to access reproductive health rights in the city. There’s absolutely no doubt about that’42 and another that ‘there are geographical barriers throughout Australia, because Australia is so large and many people live in rural and remote areas.’43 With respect to medical abortion in South Australia, an interviewee observed that ‘at present, regional women, most of them are coming here.’44 The need to travel to access abortion services is exacerbated in the context of later abortions. For example, Hayes, Keane and Hurley note that they know of women who have been forced to continue with pregnancies when services are inaccessible. The fact that women [outside of Victoria] must often travel interstate to access abortion (a necessity common for women needing second-trimester abortions for reasons other than foetal abnormality) suggests that the incessant focus on second-trimester abortions in current debates over law reform is reflected in stigmatising healthcare.45

There is also a link between financial and geographic barriers to access. For example, women living in rural or remote areas, or those who live in legally restrictive jurisdictions and need to travel to access abortion services will often face additional costs, such as transportation and accommodation costs, which add to the existing burden of overcoming barriers of distance.46 Further, financial and geographic disadvantage often compound other forms of disadvantage, leading to presentations at a clinic at a later stage of gestation and to the additional costs and potential complications that are a corollary of abortion at a later stage of gestation.47

The advent of telehealth has provided a vehicle for offering a medical abortion by which geographic limitations may be ameliorated. Paul Hyland, founder of the Tabbot Foundation (the first provider of medical

34 Interview with Obstetrician and Gynaecologist in Hobart, Tasmania, (Ronli Sifrìs/Tania Penovic, 2 November 2017).
35 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.
36 Interview with Tracy Little, Centre Manager, Dr. Marie Maroondah, (Ronli Sifrìs/Tania Penovic, 26 October 2017).
37 Caroline de Moel-Mandel and Julia M Shelley, ‘The Legal and Non-Legal Barriers to Abortion Access in Australia: A Review of the Evidence’ (2017) 22 The European Journal of Contraception & Reproductive Health Care 114, 119.
38 Interview with Leigh Keane, Nurse Unit Manager, Murray Stopes Clinic Midland, (Ronli Sifrìs/Tania Penovic, 26 September 2018). It should be noted that the distance between Darwin and Perth, the capital of Western Australia, is 4147 km (or 2577 miles).
39 Gina Rushton, ‘Tasmania’s main surgical abortion provider has shut up shop’ BuzzFeed (12 January 2018). According to this article, ‘[t]here is a single remaining provider in the state, private gynaecologist Dr. Brett Daniels, who only performs a handful of the state’s terminations per year.’
40 It should be noted that this is not just an Australian problem. In Canada, for example, there is virtually no access to abortion in rural and remote areas: Barbara Baird and Erica Millar, ‘Abortion at the edges: Politics, practices, performances’ 80 (2020) Women’s Studies International Forum.
41 Lori Brown, Contested spaces: abortion clinics, women’s shelters and hospitals: politicizing the female body ( Routledge, London and New York, 2013)
42 Interview with General Practitioner working in sexual and reproductive health in regional Victoria, (Ronli Sifrìs/Tania Penovic, 2 May 2017).
43 Interview with Caroline de Costa, Professor of Obstetrics and Gynaecology at James Cook University, College of Medicine in Cairns, (Ronli Sifrìs/Tania Penovic, 27 August 2019).
44 Interview with Tracey Greaves, Senior Social Worker, Pregnancy Advisory Centre, Adelaide, (Ronli Sifrìs/Tania Penovic, 18 April 2019).
45 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.
46 Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, Inquiry in laws governing termination of pregnancy in Queensland (August 2016) 73; Frances Doran and Julie Hornibrook, ‘Barsriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia’ (2016) 16 Rural and Remote Health (online).
47 See for example Midiula Shankar et al., ‘Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-Sectional Study’ (2017) 41(3) Australian and New Zealand Journal Public Health 309. It should be noted that later abortions comprise a relatively small proportion of abortions in Australia; it is estimated that approximately 1–3% of abortions in Australia occur after 20 weeks gestation. See: Erica Millar, ‘Here’s why there should be no gestational limits for abortion’ The Conversation (12 August 2019).
abortion using telehealth in Australia) commented that ‘we’ve shown that this is providing a service in regions where it was not provided before. And that’s why most of our patients come from regional or remote areas, because in major cities we’re, of course, competing with established surgical providers.’ Tabbot Foundation data shows that between June 2015 and December 2016, 1010 women received medications, of whom 56% lived outside of major cities. Evidently, these services have been particularly beneficial for women living outside major cities in areas that are underserved by abortion clinics. By having medications sent directly to them, women can avoid the requirement of using a local pharmacy as intermediary and the concomitant risks associated with lack of stock and staff attitudes toward abortion.

However, telehealth is not a complete solution to the problem of geography. De Costa et al. have observed that telehealth abortion services are ‘not available to all women, especially in rural and remote areas, and in particular to Indigenous women, who often present later and have to travel further to access abortion care.’ In addition, telehealth is only useful in the context of a medical abortion (up to nine weeks’ gestation); some women have a clear personal preference for surgical abortion, and telehealth cannot be used in cases where a medical abortion is unsuitable. Furthermore, women are still required to access ultrasound and pathology facilities and The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommends that ‘[m]edical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care’ should this prove necessary. Thus even with the advances associated with the availability of medical abortion, women who live in remote areas may still face significant access challenges.

2.3. Practitioner attitudes, education and training

The barriers posed by geography intersect with those associated with the education, training and attitudes held by medical practitioners. Regarding this intersection, retired Obstetrician and Gynaecologist Pieter Mourik commented 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. They definitely won’t refer for a termination. So the country situation is very critical... There is a real problem in the country with women accessing proper women’s health reproductive advice. The doctors put off training in this area because of the personal attacks that happen, the attacks to your family. You’re putting yourself out there if you support terminations.

The paternalistic healthcare paradigm, whereby the patient’s agency is minimised or erased altogether, is one in which ‘women have historically fared the worst’ and has to some extent persisted in the context of reproductive healthcare. Abortion access necessarily requires the involvement of medical practitioners yet has occupied a grey and stigmatised area of practice, outside the purview of mainstream medicine. Further, as Hayes, Keane and Hurley note, ‘[n]ot all abortion is equal’ and abortions performed after 18 weeks gestation are further stigmatised. Opposition to abortion by doctors has presented a significant barrier to access. In a recent survey of the Fellows and specialist trainees of RANZCOG a significant minority (13.7%) of respondents reported total opposition to abortion on religious or conscientious grounds. Some jurisdictions have endeavoured to address this barrier by imposing a legal ‘obligation to refer.’ We have nevertheless been informed by a number of health practitioners about doctors who have failed to comply with this obligation, the policing of which is frustrated by the reality that women seeking abortions may not be aware of it and are in any event unlikely to complain. As one interviewee told us, ‘if you’re a woman from the country who’s in a small town, are you really going to dob your doctor ... and you wouldn’t probably ever know it was bad professional advice a lot of the time.’

Our research accords with a recent study of conscientious objection in Victoria which estimated that around 15% of Australian health care professionals are conscientious objectors; the study found that some doctors were directly contravening the law by not providing referrals while some were deliberately delaying women’s access or attempting to make women feel guilty for seeking an abortion. As Hayes, Keane and Hurley have observed, ‘we’ often hear women say that their doctors

50 It should be noted that the Tabbot Foundation permanently closed down in early 2019. See Gina Rushton, ‘A Postal Abortion Service That Sent RU486 To Thousands Of Women Is Shutting Down’ BuzzFeed (21 March 2019).

51 Interview with Dr. Paul Hyland, Tabbot Foundation, (Ronli Sifris/Tania Penovic, 31 October 2017).

52 Paul Hyland et al., ‘A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 Months’ (2018) Australian and New Zealand Journal of Obstetrics and Gynaecology, 1.

53 Paul Hyland et al., ‘A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 Months’ (2018) Australian and New Zealand Journal of Obstetrics and Gynaecology, 5.

54 Paul Hyland et al., ‘A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 Months’ (2018) Australian and New Zealand Journal of Obstetrics and Gynaecology, 5. For a discussion and critique of abortion stigma see: Erica Millar, (2020) 78 Women’s Studies International Forum.

55 Caroline M Costa, Kirsten I Black, Darren B Russell, ‘Medical abortion: it is time to lift restrictions’, (2019) Medical Journal of Australia, https://doi.org/10.5694/mja2.50362, 248-249.e1

56 See for example the following study where a number of interviewees expressed a preference for surgical abortions: Frances Doran and Julie Hornibrook, ‘Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia’ (2016) 16 Rural and Remote Health (online).

57 For a discussion of conditions which render medical abortion unsuitable, see: https://www.mariestopes.org.au/your-choices/surgical-abortion-vs-medical-abortion/. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, The Use of Misoprostol for Medical Termination of Pregnancy (2016).

58 Claudia Gillberg and Geoffrey Jones, ‘Feminism and Healthcare: Toward a Feminist Pragmatist Model of Healthcare Provision’ in P. Liamputtong (ed.), Handbook of Research Methods in Health Social Sciences, (Springer Nature, Singapore, 2019) 205–222, 208.

59 Caroline de Costa, ‘Who are the abortion providers and what does the future hold?’ in Louise Swim (Ed), Choice Words: A Collection of Writing about Abortion (Allen and Unwin, Sydney, 2019) 47.

60 Irish 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.

61 Hon Chuen Cheng et al., ‘Views and practices of induced abortion among Australian fellows and trainees of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists: A second study’ (2020) Australian and New Zealand Journal of Obstetrics and Gynaecology 290.

62 Ronli Sifris, ‘Tasmania’s Reproductive Health (Access to Terminations) Act 2013: An Analysis of Conscientious Objection to Abortion and the ‘Obligation to Refer’’ (2015) 22(4) Journal of Law and Medicine 900. See: Reproductive Health (Access to Terminations) Act 2013 (Tas) s. 7; Abortion Law Reform Act 2008 (Vic), s. 8; Termination of Pregnancy Law Reform Act 2017 (NT), s 12(2); Termination of Pregnancy Act 2018 (Qld); Abortion Law Reform Act 2019 (NSW) s 9(5); Termination of Pregnancy Act (SA) s 11(3).

63 Interview with Dr. Lesley French, former senior advisor to Minister for Health, Tasmania, (Ronli Sifris/Tania Penovic, 2 November 2017).

64 Louise Anne Keogh et al., ‘Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers’, BMC Medical Ethics 20, Article number: 11 (2019).
kept sending them for ultrasounds until they were 12 weeks pregnant and then told them it was too late for an abortion.65 Women’s access to abortion thus remains susceptible to the moral and religious beliefs of doctors, even where the legal framework seeks to ensure that such beliefs do not operate as a barrier to access.

Some doctors who are not conscientious objectors have been reluctant to become involved in the provision of abortion services themselves due to stigma and the risk of personal attacks. A social worker described the reality that the decriminalisation of abortion and the introduction of safe access zones in Victoria have not removed the shaming and threats that remain a concomitant of abortion practice, particularly in some rural and regional areas:

I am aware of country, rural and regional ... GPs [and] surgeons who started to provide surgical 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. I am aware of GPs who are now doing the medication abortion but who chose not to talk about that broadly. That could still happen. The access zone doesn’t necessarily change those things but that is an example of people who may choose not to do the work or who chose to stop the work because of anti-choice actions against them.66

The ability to provide abortion services is also affected by doctors’ knowledge or training about abortion as a component of women’s reproductive health services. Abortion has been largely absent from medical curricula and doctor training. This omission is to some degree attributable to the laws which operated for decades to criminalise abortion in Australia’s states and territories. A recent survey of fellows and specialist trainees of RANZCOG found that there was strong support for the inclusion of abortion in the Fellowship training program67 yet doctor education and training has not readily adapted to the liberalisation of abortion law. Health professionals described to us a link between access to appropriate medical care and the education and training provided to medical graduates and doctors around abortion.68 One interviewee observed that the lack of training in medical schools led to ‘ignorant doctors who don’t know the system’.69 After decades of exclusion from university curricula, abortion is now included in the curriculum of only half of Australia’s medical schools, where it is often non-compulsory and limited in duration, often comprising a single hour-long lecture.70 RANZCOG has recently introduced mandatory online education about abortion for trainee doctors but there continue to be no mandatory requirements with respect to clinical experience.71 In the context of abortions after 18 weeks’ gestation, the inadequacy of practitioner training and expertise compounds the stigmatisation of abortion and has resulted in a significant nationwide shortage of surgeons who are willing and able to provide the service.72

In order to secure access to abortion, the removal of legal barriers must be accompanied by other measures, including the provision of training and education which is premised on the reality that abortion is an essential component of women’s reproductive health care. Safe access to abortion is essential to the realisation of reproductive rights. Until abortion is fully included and normalised within university curricula and doctor training, it will remain outside the purview of mainstream medical practice, undermining access to services and appropriate medical care.

Accordingly, our empirical research demonstrates that in the struggle to secure women’s reproductive rights, the dismantlement of legal barriers is no rationale for complacency.73 Significant non-legal barriers which must be addressed include financial barriers, geographic barriers, negative practitioner attitudes and deficiencies in practitioner training. These barriers intersect with women’s lived experience and pose a heightened challenge for those who are disempowered for reasons such as race, disability and socioeconomic status. The spread of COVID-19 into Australia and the measures introduced in response have served to exacerbate existing barriers and generate further barriers to access. These are the subject of Part II below.

3. Part II: the impact of COVID-19 on abortion access

Australia has not experienced the same level of exponential growth in COVID-19 numbers seen elsewhere, with less than 30,000 confirmed cases as at 16 February 2021.74 Nevertheless, the pandemic and the measures introduced in response have undermined access to the full range of reproductive health care. Federal, State and Territory governments have adopted a variety of measures in their efforts to contain the pandemic, including: movement restrictions, isolation measures for suspected cases and a freezing of non-essential medical treatment.75 RANZCOG correctly categorised abortion as urgent medical treatment; therefore the March/April freeze on elective medical treatment which applied in Australia did not apply to abortion.76 Nevertheless, restrictions on movement, including isolation measures, have had unintended consequences for abortion access. Similarly, the indirect barriers

65 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.
66 Interview with a social worker, Melbourne, (Ronli Sifris/Tania Penovic, 20 March 2017).
67 Hon Chueng Cheng et al., ‘Views and practices of induced abortion among Australian fellows and trainees of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists: A second study’ (2020) Australian and New Zealand Journal of Obstetrics and Gynaecology 290.
68 Interview with Professor Caroline de Costa, Professor of Obstetrics and Gynaecology at James Cook University, (Ronli Sifris/Tania Penovic, 27 August 2019); Interview with Emma Perkins, Associate Nurse Unit Manager at Marie Stopes, Rockhampton, (Ronli Sifris/Tania Penovic, 22 August 2019); Interview with Obstetrician and Gynaecologist, Melbourne, (Ronli Sifris/Tania Penovic, 6 August 2018).
69 Interview with Leigh Keane, Nurse Unit Manager, Murray Stopes Clinic Midland, (Ronli Sifris/Tania Penovic, 26 September 2018).
70 Caroline de Costa, ‘Who are the abortion providers and what does the future hold?’ in Louise Swinn (Ed), Choice Words: A Collection of Writing about Abortion (Allen and Unwin, Sydney, 2019) 44.
71 Caroline de Costa, ’Who are the abortion providers and what does the future hold?’ in Louise Swinn (Ed), Choice Words: A Collection of Writing about Abortion (Allen and Unwin, Sydney, 2019) 45.
72 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.
73 See, eg, 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.
74 John Hopkins University, Coronavirus Resource Center, https://coronavirus.jhu.edu/map.html (16 February 2021).
75 For details of the federal government’s response see: https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/government-response-to-the-covid-19-outbreak. As an example of a State’s response, see https://www.dhhs.vic.gov.au/coronavirus.
76 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, COVID-19: Category 1 (Australia) and Urgent (New Zealand) Gynaecological Conditions and Surgical Risks (25 March 2020; updated 4 April 2020) https://ranzcoh.edu.au/news/category-1-gynaecological-conditions. This is to be contrasted with the United States where several States used the pandemic to classify abortion as ‘nonessential’ healthcare and to block access: Barbara Baird and Erica Millar, ‘Abortion at the edges: Politics, practices, performances’ 80 (2020) Women’s Studies International Forum.


3.1. Restrictions on movement

Responding to the declaration of COVID-19 as an international public health emergency, Australia’s federal government imposed restrictions on international travel and a number of Australian States and Territories closed their borders, restricting inter-state travel.77 These restrictions on movement have compounded and served to amplify pre-existing barriers by preventing patients from traveling to access abortion services and doctors traveling to provide such services. While increased access to tele-health has helped many women to overcome the barriers posed by travel restrictions, abortions via tele-health are unsuitable for some women and unavailable to others.78

In the discussion above regarding practitioner attitudes and training, it is observed that stigma combined with a lack of training have led to a shortage of doctors prepared to provide abortion services. This shortage requires some patients to travel interstate to receive - and some doctors to travel interstate to provide - abortion services. Such travel has been halted by the physical barriers of mandatory isolation measures, or by State border closures. Travel restrictions disproportionately affect women in regional, rural and remote areas of Australia where abortion services are not locally accessible, further amplifying the geographic barriers to abortion access discussed above.77 They also have a significant impact on the small proportion of women needing to access abortions at a later gestational stage. For these women, legal impediments may inhibit access within their home jurisdiction. Alternatively, even where the law does not present a barrier to access, there may be no available doctors who are willing and able to perform the procedure. Thus abortion may only be available in a different jurisdiction or provided by doctors who routinely travel from interstate. Movement restrictions and border closures have led to a decline of Australia’s domestic flight industry, thereby exacerbating the challenges for women seeking abortions where there is no provider close to home. Abortion providers have taken such measures as chartering private planes to offer services in remote or isolated areas,80 but these expensive and time-consuming options are not viable long-term solutions for abortion access.

As a result of travel restrictions, medical abortions by telehealth, also known as ‘tele-abortions’, have emerged as the only option for some women to access abortion services. Indeed it has been observed that the pandemic illuminated the importance of providing this option. For example, Dr. Catriona Melville, Deputy Medical Director of Marie Stopes Australia, detailed the importance of tele-abortion in an interview with the authors:

> Because we had this really well-established telehealth service. So … it just reinforced … how critical this service was when the pandemic hit… because even just things like accessing later abortions in some areas became harder because clients or patients and clinicians were unable to travel across borders, or even within States. So, therefore it became in a way even more critical that people could access really timely care. And so, to be able to pick up the phone and access the [tele-abortion] service at quite an early gestation, that could make the difference between waiting for a couple of weeks, and then being too late to access medical abortion.81

As noted above, tele-abortions are available up to nine weeks’ gestation and administered through phone consultations and countered medication,82 though women still need to access ultrasound and pathology services. A number of countries have expanded access to tele-abortions due to the pandemic, including the United Kingdom and the Republic of Ireland (which only recently legalised abortion).83 This expansion of access accords with the advice of the International Campaign for Women’s Right to Safe Abortion that ‘[e]very country could and should move most abortions out of hospitals and clinics by ensuring women can obtain abortion pills and self-manage their abortions up to 10–12 weeks at home, with a number to call for advice and back-up care if needed’.84

Due to the barriers to healthcare access created by the pandemic and the dangers of community transmission arising from face-to-face healthcare, Australia’s federal government made some welcome adjustments to its Medicare Benefits Scheme. Temporary telehealth item numbers85 have been applied since 13 March 2020 to a range of sexual and reproductive health services, including testing for sexually transmitted infections and medical abortion via telehealth and enabled timely and more affordable access to medical abortion.86 Marie Stopes Australia documented a significant increase in uptake of 163% when comparing the rates of medical abortion via telehealth carried out from January to June 2019 with the same period in 2020.87 However, changes which commenced on 20 July 2020 restrict this federal rebate to services provided via a general practitioner,88 and require patients to have consulted the practitioner at least once in the previous year,89 thereby amplifying the concerns discussed above with respect to geographic barriers and practitioner attitudes, education and training.

Furthermore, the funding for telehealth services is temporary. Removal of such federal funding has the potential to create a ‘public sexual and reproductive health crisis’ as it would make reproductive health services harder to access via telehealth at a time when ‘[t]elehealth is the only option for many’ Australian women.89

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81 Interview with Dr. Catriona Melville, Deputy Medical Director of Marie Stopes Australia (Ronli Sifris/Tania Penovic, 16 November 2020).
82 Emilie Gramenz, ‘Abortion Providers Take Private Flights to Regional Queensland as Coronavirus Triggers Industry Collapse,’ ABC News (Web Page, 2 May 2020) <https://www.abc.net.au/news/2020-05-02-abortion-providers-take-private-flights-during-coronavirus/12181846>.
83 Barbara Baird and Erica Millar, ‘Abortion at the edges: Politics, practices, performances’ 80 (2020) Women’s Studies International Forum.
84 International Campaign for Women’s Right to Safe Abortion, An International Call to Action (27 March 2020).
85 See MBS Online, Medicare Benefits Schedule (22 June 2020) <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-Telehealth>.
86 Marie Stopes Australia, Situational Report: Sexual and Reproductive Health Rights in Australia (Situational Report, 24 July 2020) 5: https://resources.mariestopes.org.au/SRHRinAustralia.pdf
87 Marie Stopes Australia, COVID-19 has increased the take up of medical abortion via telehealth (28 September 2020) at https://www.mariestopes.org.au/your-choices/covid-increased-teleabortion/.
88 Marie Stopes Australia, Situational Report: Sexual and Reproductive Health Rights in Australia (Situational Report, 24 July 2020) 5: https://resources.mariestopes.org.au/SRHRinAustralia.pdf
89 The Hon Greg Hunt MP, ‘Continuous care with telehealth stage seven’ (Media Release, 10 July 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/continuous-care-with-telehealth-stage-seven>.
90 ASHM and Marie Stopes Australia, Exemption to Medicare changes will avert sexual and reproductive health crisis, Media Statement (17 July 2020).
3.2. Family violence and reproductive coercion

Women experiencing reproductive coercion and other forms of family violence may face additional obstacles to accessing abortion services – whether in person or via telehealth. Financial stress has been linked with increases in domestic abuse and the significant economic impact of the pandemic has been associated with heightened household stress. While it is difficult to obtain reliable statistics on the rates of family violence during the pandemic, evidence suggests an increase. For example, at the global level the World Health Organization has observed that “physical distancing and ‘stay at home’ measures have dramatically increased exposure to partner violence.” At the local level, research conducted by the Monash Gender and Family Violence Prevention Centre has found that the pandemic has led to an increase in both the frequency and severity of violence against women, including an increase in first time family violence reporting and new forms of intimate partner violence. Similarly, research conducted by the Australian Institute of Criminology has revealed that “the COVID-19 pandemic appears to have coincided with the onset of physical or sexual violence or coercive control for many women. For other women, it coincided with an increase in the frequency or severity of ongoing violence or abuse.”

As Gausman explains:

[s]pikes in domestic violence during times of crisis are another area of grave concern for women’s health, and as governments continue to put into place more extreme measures to enforce social distancing, for some women, more time at home may mean more time spent with an abusive partner. Fewer social interactions may also mean less accountability for perpetrators and few opportunities for others to intervene.

It seems that a corollary of the pandemic has been an increase in reproductive coercion as a specific form of family violence. For example, Carolyn Mogharbel, team leader of Victoria’s 1800 My Options helpline, has noted an increase in women reporting reproductive coercion. Further, Marie Stopes Australia has noted that structural reproductive coercion has increased through decreased access to appropriate healthcare ‘due to movement restrictions and the healthcare system prioritisation of the pandemic response’. While tele-abortion may provide an additional option for women seeking to terminate a pregnancy, women experiencing family violence may still struggle to effectively access this service. For example, regardless of the legality of tele-abortion, women experiencing reproductive coercion or other forms of family violence may not have the privacy needed in their homes to safely converse with doctors over the phone and to receive and administer abortion medication. This lack of privacy may be exacerbated by factors such as poverty, disability and multi-generational living arrangements more common in culturally and linguistically diverse communities. The ramifications of ‘stay at home’ measures are reflected in the reality that family violence complaints have risen in Australia during the pandemic while reports made by phone have fallen, with many victims unable to make calls for fear of being overheard by abusive partners in isolated home environments. One medical practitioner has described telephone consultations during which ‘there’s someone in the background…potentially lurking that you definitely can’t police.’ As reproductive coercion can involve partners forcing women to continue a pregnancy against their will, forced compliance with ‘stay-at-home’ measures in environments of family violence may render tele-abortions unattainable for many women.

3.3. Amplifying intersectional disadvantage

Beyond its heightened impact on abortion access for rural and regional women and those experiencing domestic and family violence, Australia’s pandemic response has furthermore had a disproportionate impact on women experiencing various forms of marginalisation and disadvantage. The ability to access abortion is conditioned by intersectional vectors of identity and lived experience. These include geographic location and experiences of gender-based violence (as outlined above) and encompass further factors such as race, migration status, disability, sexual orientation, age, housing arrangements, health and socio-economic status. As the International Planned Parenthood Federation has observed, ‘Covid-19 is escalating existing inequalities for women and girls and discrimination of already marginalised groups, including refugees, people with disabilities and those in extreme poverty.’ Marie Stopes Australia has also identified the healthcare inequity extant for women seeking abortions:

97 Christopher D. Maxwell, Rebecca J. G. Stone, The Nexus between Economics and Family Violence: The Expected Impact of Recent Economic Declines on the Rates and Patterns of Intimate, Child and Elder Abuse, (2010) National Institute of Justice <https://nij.ojp.gov/library/publications/nexus-between-economics-and-family-violence-expected-impact-recent-economic>
98 Catriona Melville, Jacquie O’Brien and Bonny Corbin, ‘Sexual and reproductive health, violence and coercion during COVID-19’ Medium (Webpage, 11 June 2020) <https://medium.com/@mariestopesau/sexual-and-reproductive-health-violence-and-coercion-during-covid-19-e483bedc0b01>
99 World Health Organisation, COVID-19 and Violence Against Women: What the Health Sector/System Can Do (Report, 7 April 2020).
100 Monash Gender and Family Violence Prevention Centre, Responding to the ‘Shadow Pandemic’ (8 June 2020).
101 Australian Institute of Criminology, The prevalence of domestic violence among women during the COVID-19 pandemic, Statistical Bulletin 28 (July 2020).
102 Jewel Gausman, ‘Sex and Gender Disparities in the COVID-19 Pandemic (2020) 29(4) Journal of Women’s Health 465. See also Kun Tang et al., ‘Sexual and reproductive health (SRH): a key issue in the emergency response to the coronavirus disease (COVID-19) outbreak’ (2020) 17(59) Reproductive Health; International Planned Parenthood Federation, IMAP Statement on COVID-19 and Sexual and Reproductive Health Rights, (April 2020).
103 Megan Clement, ‘There are Fears Coronavirus is Stopping Australia’s Migrant Women from Accessing Abortions’, SBS News (Web Page, 26 April 2020) <https://www.sbs.com.au/news/there-are-fears-coronavirus-is-stopping-australia-s-migrant-women-from-accessing-abortions>.
104 Kimberle Crenshaw, ‘Mapping the Margins: Margins: Intersectionality, Identity Politics, and Violence Against Women of Color’ (1991) 43(6) Stanford Law Review 1241–1299.
105 International Planned Parenthood Federation, IMAP Statement on COVID-19 and Sexual and Reproductive Health Rights, (April 2020). See also Barbara Baird and Erica Millar, ‘Abortion at the edges: Politics, practices, performances’ 80 (2020) Women’s Studies International Forum.
People seeking abortions will carry trauma linked with the pregnancy. These impacts are greater for people who already experience barriers to healthcare, including Aboriginal and Torres Strait Islander communities, migrant and refugee communities and those on temporary visas, people with disabilities, LGBTIQ+ populations, young people and people living in regional, rural and remote areas.\textsuperscript{105}

Similarly, Todd-Gher and Shah have observed that ‘[f]ailing to ensure abortion access… has a disparate impact on those with low or no incomes and/or who lack housing, migrants, refugees, people with disabilities and adolescents, and compelling pregnancy worsens health outcomes, particularly in the context of COVID-19.’\textsuperscript{106}

Prior to the pandemic, barriers to abortion access which pose challenges for the general population were heightened for women who experience systemic inequality and disadvantage. These challenges extend beyond abortion access to other restrictions on women’s reproductive freedom.\textsuperscript{107} The pandemic has served to exacerbate those barriers. For example, as noted above, a lack of adequate public funding for abortion has created significant financial barriers to access which have been exacerbated by the pandemic. The worst affected groups include migrant women holding temporary visas (including international students) who are ineligible for government financial support.\textsuperscript{108} In addition, some women face a heightened risk of family violence, including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, and people living in regional, rural and remote communities.\textsuperscript{109} An additional example of the amplification of the pandemic of intersectional disadvantage is found in the reality that language barriers pose challenges to the conduct of tele-abortions (and the communication of relevant information more broadly) which is problematic given the increased importance of tele-health during the pandemic.\textsuperscript{110} It is therefore evident that COVID-19 has generated a significant burden that ‘interacts with pre-existing vulnerabilities to create yet another dimension of disempowerment.’\textsuperscript{111}

4. Conclusion

Australian women face a number of barriers when accessing abortion services.\textsuperscript{112} Part I of this article examined the primary non-legical barriers that have been reiterated in our research as a means of illustrating the point that in order to fully realise the reproductive rights of Australian women, the enactment of formal legal rights is not enough; government, and we as a society, must act to facilitate the practical realisation of those rights. Such action should include adequate public funding and provision of abortion services throughout Australia (in both rural and urban areas) as well as appropriate practitioner training and measures which enhance both the willingness and ability of medical practitioners to provide the service.

The COVID-19 pandemic, examined in Part II, has generated additional obstacles for Australian women and may serve as a lens through which systemic barriers to access may be illuminated. Though Australia has not directly prohibited access to abortion during COVID-19, federal and State government responses to curbing the spread of the virus have had an indirect and disproportionate impact on women in the context of abortion access. Vectors of lived experience and identity have intersected with systemic barriers to access which have been amplified by the pandemic response. Women who have experienced compounded and intersectional barriers to access include those experiencing family violence (with its concomitant link to problem pregnancies), women living in rural and regional areas, migrant women on temporary visas and Aboriginal and Torres Strait Islander women. Ongoing scrutiny of Australia’s rapidly changing social and legal landscape is required to ensure that women are able to timely exercise the reproductive rights.

Declaration of competing interest

None.

\textsuperscript{105} Marie Stopes Australia, \emph{Situational Report: Sexual and Reproductive Health Rights in Australia} (Situational Report, 24 July 2020) 11: https://resources.mariestopes.org.au/SRHRinAustralia.pdf

\textsuperscript{106} Jaime Todd-Gher & Payal K Shah, ‘Abortion in the context of COVID-19: a human rights imperative’ (2020) 28(1) \emph{Sexual and Reproductive Health Matters} 1, 2.

\textsuperscript{107} See for example Ronli Sifris, ‘Involuntary Sterilization of HIV-Positive Women: An Example of Intersectional Discrimination’ (2015) 37 \emph{Human Rights Quarterly} 464.

\textsuperscript{108} Megan Clement, ‘There are Fears Coronavirus is Stopping Australia’s Migrant Women from Accessing Abortions’, \emph{SBS News} (Web Page, 26 April 2020) <https://www.sbs.com.au/news/there-are-fears-coronavirus-is-stopping-australia-s-migrant-women-from-accessing-abortions>.

\textsuperscript{109} ‘Vulnerable Groups,’ \emph{National Domestic and Family Violence Bench Book} (Web Page, July 2019) <https://dfvbenchbook.aija.org.au/dynamics-of-domestic-and-family-violence/vulnerable-groups>.

\textsuperscript{110} Interview with Dr. Catriona Melville, Deputy Medical Director of Marie Stopes Australia (Ronli Sifris/Tania Penovic, 16 November 2020).

\textsuperscript{111} Kimberle Crenshaw, ‘Mapping the Margins: Margins: Intersectionality, Identity Politics, and Violence Against Women of Color’ (1991) 43(6) Stanford Law Review 1241–1299, 1249.

\textsuperscript{112} Megan Clement, ‘There are Fears Coronavirus is Stopping Australia’s Migrant Women from Accessing Abortions’, \emph{SBS News} (Web Page, 26 April 2020) <https://www.sbs.com.au/news/there-are-fears-coronavirus-is-stopping-australia-s-migrant-women-from-accessing-abortions>.

\textsuperscript{113} For a similar observation in the Canadian context see Erin Nelson, ‘Autonomy, Equality, and Access to Sexual and Reproductive Health Care’ (2017) 54(3) \emph{Albera Law Review} 707.