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

15 December 2022

Dear Officer,

RE: Universal Access to Reproductive Healthcare

The Australian National University Law Reform and Social Justice Research Hub ('ANU LRSJ Research Hub') welcomes the opportunity to provide this submission to the Senate Standing Committee on Community Affairs, responding to the terms of reference of the inquiry.

The ANU LRSJ Research Hub falls within the ANU College of Law's Law Reform and Social Justice program, which supports the integration of law reform and principles of social justice into teaching, research and study across the College. Members of the group are students of the ANU College of Law, who are engaged with a range of projects with the aim of exploring the law's complex role in society, and the part that lawyers play in using and improving law to promote both social justice and social stability.

Summary of Recommendations:

1. Coordinate national data collection standards on abortion rates, in order to ensure an accurate national dataset;
2. Support MS Health-sponsored amendments to the TGA Risk Management Plan for MS-2 Step to improve accessibility of abortion and reproductive justice in Australia;
3. Allocate greater federal attention to rural and regional healthcare and investigate gaps in the provision of health services in such areas. Where possible, restore telehealth systems, improve access to training for nurses and doctors, and increase targeted funding for regional and rural areas;
4. Consider sponsoring TGA approval of MS-2 Step at higher gestational limits to reflect international best practice in the field of medical abortion;
5. Coordinate a law harmonisation scheme to unify abortion law in a number of key areas including decriminalisation, conscientious objection, and safe access zones;
6. Investigate the efficacy of the Health and Community Services Union for Reproductive Health and Wellbeing Leave. Develop guidelines and model legislation for a reproductive/sexual health leave policy scheme; and
7. Investigate the implementation of the national curriculum regarding sexual and reproductive health education across jurisdictions and in non-government schools. Investigate the degree to which ACARA is incorporating marginalised sexual identities in

its national curriculum 9.0. Produce guidelines for state authorities to create accessible information, training, and community led groups for parents, teachers, and students.

On behalf of the ANU LRSJ Research Hub,

Introduction

This submission addresses the Senate Community Affairs References Committee on its inquiry into universal access to reproductive healthcare. This submission consists of five sections, each encompassed in the terms of reference released by the committee. Sections 1 and 2 are particularly relevant for terms of reference (a) and (b) as they argue for increasing the accessibility of medical abortion and reproductive healthcare. Section 1 also outlines how inaccessibility is more pronounced in rural and regional settings. Section 3 provides a harmonisation framework to respond to the disparity of abortion legislation across Australian jurisdictions. This analysis focalises decriminalisation, conscientious objection, and safe access zones as harmonisation imperatives. Section 4 addresses reproductive healthcare leave and provides a brief overview of the arguments for it. Section 5 analyses sexual and reproductive health literacy in Australia and gives recommendations for its improvement.

Large parts of our submission has emphasised abortion legislation and access. This is not to discredit the importance of other areas of reproductive and sexual healthcare, such as contraceptives, In Vitro Fertilisation, or Sexually Transmitted Illnesses. Equally, our submission's focus on regional and rural access is not reflective of a preference over other stakeholders. In both cases, access to research and former areas of research have largely determined choice of topic.

1. Proposed amendments to TGA approval of prescriptions for medical abortion

Medical abortions are a less invasive procedure than surgical abortions, which involve the ingestion of prescription medications which induce termination. One such medication is the combination of mifepristone and misoprostol.

Notably, data collection on instances of abortion in Australia is poor. States do not routinely report abortion data, and the national dataset has been incomplete in the past.[1] The data set from which the following statistic was extracted from both the reporting of surgeries in the National Hospital Morbidity Database ('NHMD'), and the number of prescriptions of medications for medical abortion recorded in the Pharmaceutical Benefits Scheme ('PBS') database.[2] Good policy making and law reform requires good data, highlighting the need for a coordinated national data collection regime, applying to all jurisdictions in Australia.

[1] Narelle Grayson, Jenny Hargreaves and Elizabeth Sullivan, *Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia* (2005) (Australian Institute of Health and Wellbeing Report No 30, Perinatal Statistics Series No 17, 2005).
[2] Louise Keogh, Lyle Gurrin and Patricia Moore, 'Estimating the Abortion Rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme Data' (2021) 215(8) *Medical Journal of Australia* 375.

Recommendation 1: Coordinate national data collection standards on abortion rates, in order to ensure an accurate national dataset.

The number of prescriptions for the medical abortifacient combination mifepristone/misoprostol ('MS-2 Step') increased from 3220 in 2014–15 to 20 741 in 2017–18.[3] This represents in excess of a six-fold increase. The registration of MS-2 Step through the Therapeutic Goods Administration ('TGA'), sponsored by MS Health, took place in 2012 after thorough assessment of the drug's safety.[4] After a decade, the drug has been used by thousands of pregnant people seeking terminations, and its safety and efficacy is well settled. The growth of medical termination options has been central to accessibility of reproductive healthcare across Australia, but particularly for vulnerable target communities, including people in regional, rural, and remote areas, and victims of domestic violence, coercive control and reproductive coercion.[5]

The Research Hub understands that MS Health has sponsored a review of a number of components of the Risk Management Plan for MS-2 Step.[6] Notably, the proposed reforms include enabling medical and other healthcare professionals to become prescribers of MS-2 Step.[7] This will remove the TGA restrictions on who can become a prescriber of the medication, leaving it to states and territories to determine who may prescribe. Authorised prescribers may be nurses, midwives, pharmacists and pharmacy workers, or Aboriginal and Torres Strait Islander health workers.[8] Further amendments would remove the requirement for individual dispensing pharmacists of MS-2 Step to be registered. This requirement has proven to be a barrier to access to the medications in a timely and efficient manner - as dispensing pharmacists often move or are casual or part-time workers, and efforts to maintain a unitary database of dispensers have proven unsatisfactory.[9] The sponsored amendments would remove the registration requirement, enabling pharmacists to simply place an order for MS-2 Step as would be done with any other medication, removing confusion around authority to dispense and availability of the medication in contexts where access may already be difficult and rare.[10] The proposed amendments to the Risk Management Plan would thus forge a path for greater decentralisation of medical abortion care.

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[3] Ibid.
[4] Therapeutic Goods Administration, *Australian Public Assessment Report for Misoprostol* (Risk Assessment, October 2012) ('*Risk Assessment Report*').
[5] Dr Philip Goldstone, 'The Road to Abortion Equity: How the Senate Inquiry Shapes Universal Access' (Speech, MSI Australia, 9 November 2022).
[6] Ibid.
[7] Ibid.
[8] Guidelines Review Committee, Sexual and Reproductive Health and Research, World Health Organisation, *Abortion Care Guideline* (Guideline, 8 March 2022) 69 ('*Abortion Care Guideline*').
[9] Goldstone (n 5).
[10] Ibid.

Decentralising service provision is a key strategy in increasing the accessibility of abortion and other reproductive services. The World Health Organisation's *Abortion Care Guideline* ('the Guideline') recommends enabling a wide range of community and public health workers to administer part or all of medical abortion procedures.[11] Those potential providers include community health workers, pharmacists and pharmacy workers, traditional and complementary medicine professionals, nurses, auxiliary nurses, midwives, generalist and specialist medical practitioners.[12] Evidence provided to the expert panel behind the recommendations affirmed that 'the potential to increase equitable access to quality abortion care… is high', where service provision can be decentralised and a diverse range of health workers are empowered to provide the service.[13]

Increasing options for management of medical abortion services by community and other health professionals are an important step in increasing accessibility of abortions for pregnant people who otherwise face barriers to accessing these services. Particularly, those people who often lack facilities to safely and discreetly access abortion services are able to benefit from accessing the procedure through a community health professional. This includes:

- rural and regional people;
- people from culturally and linguistically diverse backgrounds;
- non-permanent residents and non-citizens;
- people experiencing domestic and family violence, including coercive control;
- young people and students;
- people with disabilities; and
- LGBTQIA+ people, particularly transgender and intersex people.[14]

Understanding the transformative effects which decentralised service provision would have on the accessibility of abortion care in Australia, the Research Hub strongly supports MS Health-sponsored amendments to the TGA Risk Management Plan for MS-2 Step, which will improve reproductive health equity across Australia. We commend the Committee, acting in its capacity, to likewise support these amendments.

Recommendation 2: Support MS Health-sponsored amendments to the TGA Risk Management Plan for MS-2 Step to improve accessibility of abortion and reproductive justice in Australia.

1.1 Rural and regional people

[11] *Abortion Care Guideline* (n 8)
[12] Ibid.
[13] Ibid.
[14] Women With Disabilities Australia, *WWDA Position Statement 4: Sexual and Reproductive Rights* (Position Statement, September 2016).

Access to reproductive healthcare in rural and regional areas is significantly lower than that in urban areas. This inaccessibility poses an economic, health, and social cost on members of the regional population that could be remedied by effective policy changes.

First, due to the geographical isolation of rural/regional populations, it is inherently difficult to provide services that would match the supply in urban areas. Women have been found to require travel up to 9 hours to reach sufficient professional clinical care for their reproductive healthcare in some cases.[15] This is financially untenable for many families, as it often limits the working capacity of at least one of the members of the family. This cost is compounded by the multi-stage nature of much reproductive healthcare. Often, diagnosis and treatment of STIs, cervical diseases, pregnancy, and termination procedures will require a number of successive appointments, meaning that accessible reproductive healthcare needs to be sufficiently proximate to allow for work and family at the same time.

Secondly, the inaccessibility of reproductive healthcare in regional areas imposes significant health problems in these communities. Inhibitive travel costs for treatment, lacking education, and absence of services in rural areas may lead to the ignorance of symptoms. The consequences of this ignorance can be very significant. STI rates in regional communities are higher than in urban areas, while there is significantly less testing. This asymmetry is mirrored across cervical cancer, endometriosis, and many other sexual and reproductive healthcare dimensions.

Third, professional reproductive healthcare services provide important safe places for women in regional communities. Their absence can enable social ills to proliferate unnoticed. As Family Planning NSW submitted to a NSW inquiry into the accessibility of reproductive healthcare, sexual healthcare providers, alongside their physical healthcare services, also provide contact to women suffering domestic violence and reproductive coercion.[16] Given that many regional communities suffer higher rates of these phenomena (for educational, economic, demographic, and other reasons), it is vital that these services are present in these communities.[17] Furthermore, as healthcare providers serve an important educational function for regional communities, their effect on sexual behaviours can improve regional social outcomes. Indeed, reduced knowledge of and access to contraception alongside lacking (medical and surgical) termination services may lead to higher rates of unintended pregnancy, issues that are resolvable with greater access to healthcare knowledge. Reducing unintended pregnancy, domestic violence, and reproductive coercion are all key to lifting women out from danger and poverty in regional communities. Greater community knowledge also gives a more accurate depiction of the scale of demand in regional communities as more people uptake services.

[15] Frances M Doran and Julie Hornibrook, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia', (2016) (1) 3538 *Rural and Remote Health* 6, 9.
[16] Family Planning NSW, Submission No 107 to NSW Portfolio Committee No. 2 - Health, *Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales,* (15 January 2021) 5.
[17] Monica Campo and Sarah Tayton, 'Domestic and Family Violence in Regional, Rural and Remote Communities: An Overview of Key Issues' (Policy and Practice Paper, Australian Institute of Family Studies, December 2015) 1-7.

These social benefits ought to be considered when assessing the role of sexual and reproductive healthcare providers in regional communities.

Given these three aspects to reproductive and sexual healthcare in regional and rural areas, it is vital to improve accessibility. Alongside the empowerment of nurses and limiting conscientious objections (as outlined in the submission at pages 4-5 and 13-15), there are three innovations which warrant the committee's investigation to improve access to healthcare for regional and rural people.

1.1.1. Accessible training

In some communities, despite the potential for sexual and reproductive healthcare to be safely provided, there is a lack of General Practitioners with the sufficient training to perform procedures. Providing more accessible programmes to GPs and nurses would engender greater uptake in training, increasing the supply of providers. Online or mobile training programmes, alongside greater funding for providers, could be effective means of implementing these systems.

1.1.2. Increasing online consultations

To reduce the travel costs imposed by repeat face-to-face consultations, where possible, online telehealth appointments should be a focus to increase accessible healthcare. From 1 January 2022, a number of the phone-based telehealth services were discontinued.[18] Systems that emerged throughout the COVID-19 pandemic may be important innovations moving forward to provide support to geographically isolated regions. As access to strong wifi connection may limit video telehealth consultations, restoring the phone-based system may be an effective means of improving access to healthcare. Changing circumstances do not necessitate the abandonment of such innovations. Indeed, this system may not only address former deficits in healthcare provision, but also expand it from its pre-existing point. Where many patients would not continue with postoperative consultations when they involved expensive travel costs, the potential for online consultations may provide an easier means of expanding the provision of such meetings.

1.1.3. Funding

Greater funding of regional providers would have several consequences for access to services. Better incomes may attract greater supply of doctors and nurses to regional areas. It would also enable healthcare centres and practitioners to invest in equipment which may be lacking, which could allow for the provision or more efficient provision of healthcare. Finally, it may facilitate public awareness of the services, which could increase their demand. This would both have improved health and social outcomes and give a better sense of the scale of demand in regional and rural areas.

[18] 'Changes to MBS Specialist Telehealth from 1 January 2022' (Fact Sheet, Department of Health and Aged Care, 16 December 2021) 2-6.

Recommendation 3: Allocate greater federal attention to rural and regional healthcare and investigate gaps in the provision of health services in such areas. Where possible, restore telehealth systems, improve access to training for nurses and doctors, and increase targeted funding for regional and rural areas.

2. Gestational limitations on medical abortion and TGA regulation of MS-2 Step

Prescriptions of MS-2 Step for medical abortion are approved by the TGA for administration up to 9 weeks' gestation, or 63 days.[19]

This gestational limit is a relatively conservative one compared to best practice standards. The FDA in the United States of America has, in the past few years, approved the prescription of Mifeprex for administration up to 70 days, or 10 weeks.[20] In other nations, widespread use of the medications occurs safely off-label up to 84 days, or 12 weeks.[21] Further, the *WHO Best Practice Guideline* recommends that medical abortion services administered by non-physicians should be available up to 10 weeks' gestation, and for services administered by physicians, up to 12 weeks' gestation, pending assessment of the procedure's safety for the pregnant person.[22]

Raising the gestational limit on medical abortion is an issue of accessibility. People seeking medical abortions face systemic and administrative barriers which inhibit timely, safe, and easy access to medical abortions. Ultrasounds and blood tests may be required before prescription of MS-2 Step, and waiting times for these services in strained health systems may be in excess of 3 weeks.[23] Pregnant people may only become aware of a pregnancy following a missed menstrual period - often up to 4 weeks after the person has become pregnant. Access to pre-requisite services for prescription of medical abortifacients may be exacerbated for people in contexts where access to health services is limited - for instance, people experiencing coercive control or domestic violence, and people in rural and remote areas who must make accommodations to travel for access to services. The result is a very narrow window of opportunity in which medical abortion, as a less-invasive, self-managed, more accessible option for termination, is available to a pregnant person. Administration of medical abortifacients at higher gestations has proven safe and reliable, and lifting the approved gestation period for prescription abortifacients is thus a question of accessibility and health equity.

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[19] *Risk Assessment Report* (n 4)
[20] Goldstone (n 5).
[21] Ibid.
[22] Ibid.
[23] Dr Melanie Dorrington, Submission No 43 to Standing Committee on Health and Community Wellbeing, ACT Legislative Assembly, *Inquiry into Abortion and Reproductive Choice in the ACT* (6 September 2022), 16.

There is currently no sponsorship for TGA approval of MS-2 Step at higher gestational limits. Sponsorship of this amendment is not currently a financially viable option for MS Health, a not-for-profit organisation engaged in a range of reproductive justice activities.[24]

With this in mind, the Research Hub commends the committee to investigate options for sponsoring TGA approval of a raised gestational limit on prescription of MS-2 Step, in order to increase accessibility of self-managed medical abortions for all Australians.

Recommendation 4: Consider sponsoring TGA approval of MS-2 Step at higher gestational limits to reflect international best practice in the field of medical abortion.

3. Law harmonisation

The states and territories are responsible for the vast majority of legislation on abortion and reproductive justice. This has resulted in inconsistencies arising between states and territories in particular areas of regulation. It is in the interests of the Australian people to have a coordinated and consistent national system of healthcare. Access should not be determined by one's location or vicinity to services - and those who cannot afford to travel to cross borders should not be entitled to a lower standard of care than those who can.

The Research Hub urges the committee to recommend a program of legislation harmonisation across Australian jurisdictions with regard to a number of core areas of regulation in the realm of abortion and reproductive healthcare. Harmonisation is in the interests of accessibility, equity, and health justice. People living in Australia should have access to a consistent system of healthcare no matter their location, and securing this would require harmonisation of a number of regulatory areas.

3.1 Total decriminalisation of abortion

The Australian Capital Territory is the only jurisdiction to have completely decriminalised abortion on demand at all gestations.[25] All other states and territories have decriminalised abortion up to gestations ranging between 16 weeks (Tasmania) and 24 weeks (Victoria and the Northern Territory), with additional requirements such as the grounds-based approval of two doctors in order for an abortion to be legal past these gestations.[26]

[24] Goldstone (n 5).
[25] *Health Act 1993* (ACT).
[26] *Termination of Pregnancy Bill 2018* (Qld); *Abortion Law Reform Act 2019* (NSW); *Abortion Law Reform Act 2008* (Vic); *South Australia Termination of Pregnancy Act 2021* (SA); *Reproductive Health (Access to Terminations) Bill 2013* (Tas); *Health (Miscellaneous Provisions) Act 1911* (WA); *Crime: Criminal Code Act*

The Research Hub acknowledges that the larger objective outlined in the *WHO Best Practice Guideline* is a shift away from grounds-based service provision towards medical abortion on request of the pregnant person.[27] This means abortion on request at all gestations. Criminalisation of abortion on demand past certain gestations creates additional administrative barriers to access for pregnant people who are already facing a difficult and traumatising decision, and the process of approval exposes pregnant people to additional stigma, judgement, and potential traumatisation.

Acting in a manner consistent with international best practice and principles of reproductive justice means that no person should be criminalised for seeking access to reproductive healthcare, including abortion, at all stages of pregnancy, and regardless of the grounds. This approach recognises the individual as the most well-equipped healthcare decision-maker, respects the dignity and autonomy of pregnant people over their bodies, and empowers people to make decisions about reproductive health in a regulatory environment that is intolerant of stigma, judgement, and reproductive paternalism.[28]

The Research Hub urges the committee to recommend the harmonisation of abortion legislation across the country, in following the approach of the ACT, to decriminalise abortion on demand at all gestations, for all reasons.

3.2 Safe access zones

Safe access zones provide protective bubbles around clinics and institutions in which abortions are provided, which prohibit protest activities from interfering with the access or treatment of people seeking abortions and other reproductive healthcare services.[29] Safe access zones are an essential step in protecting both patients and staff engaged in reproductive health services, and have been held to be consistent with the freedom of political communication by the High Court in *Clubb v Edwards; Preston v Avery*, in which both Victorian and Tasmanian legislation on safe access zones were unsuccessfully challenged.[30]

Marie Stopes Australia published a paper in collaboration with the University of Queensland which outlined the experiences of staff and patients at their Midland clinic in Western Australia, then the only state to not have instituted safe access zones.[31] The following quotes were provided to clinic staff and reflect the experiences of persons seeking services or employed by the clinic:[32]

Compilation Act (WA); *Termination of Pregnancy Law Reform Legislation Amendment Act 2021* (NT) ('Respective state and territory legislation').
[27] *Abortion Care Guideline* (n 8).
[28] Ibid.
[29] Marie Stopes Australia, *Safe Access Zones in Australia* (Report, 2020).
[30] *Clubb v Edwards; Preston v Avery* [2019] HCA 11.
[31] Marie Stopes Australia (n 27).
[32] Ibid.

- 'Made the mistake of walking into carpark past them.'
- 'Using very emotive language. You're killing babies, Jesus hates sinners.'
- 'Rude and harassing protesters approached us….'
- 'Absolutely unacceptable and inappropriate.'
- 'Feel threatened.'
- 'Disgusting the way they speak to people. As a patient was confronting and unnecessary. Should not be able to make females feel like that in a hard time.'
- 'Felt very judged.'
- 'Very emotional - confronting posters of babies.'
- 'Approached by protesters who were pushing views and ancient opinions….'
- 'Both myself and my partner were affected by this totally unacceptable.'
- '…quite intimidating especially in the way they approached me. I am here as a support person for my sister I'm glad I was approached and not her.'
- 'Protestor put hand inside car and dropped a bag, I threw it back.'
- 'Protester paced onto the driveway, I had to brake and she waived her brochures at me while trying to tap on my window.'

All states and territories have now instituted some form of safe access zones around abortion clinics and other facilities (such as pharmacies dispensing medical abortion medications in Tasmania).[33] Legislative approaches to safe access zones vary across a number of factors, including the following:

3.2.1 Distance around clinics in which behaviours are prohibited

Prohibited behaviours are not permitted within 150 metres of an abortion providor in all states and territories except for the ACT, where the distance is 50 metres.[34] Some jurisdictions provide that the relevant Minister may declare that the prescribed distance of 150 metres is inconsistent in the context of particular service providers, and provide that the distance be extended (eg. Queensland). This approach - that the prescribed distance may be by Ministerial declaration and no less than a standard distance of 150 metres - is the preferred approach to ensure provisions can be made to protect the safety, privacy, and dignity of abortion seekers and clinic staff.[35]

3.2.2 The type of behaviour prohibited

[33] *Termination of Pregnancy Act 2018* (Qld) Part 4, *Public Health Act 2010* (NSW) Part 6A, *Health Act 1993* (ACT) Part 6 Div 6.2 ss 85-87, *Public Health and Wellbeing Act 2008* (Vic) Part 9A ss 185A-185H, *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9, *Termination of Pregnancy Law Reform Act 2017* (NT) Part 3 ss 14-16, *Public Health Amendment (Safe Access Zones) Act 2021* (WA), *Health Care (Health Access Zones) Amendment Bill 2019* (SA).
[34] Marie Stopes Australia (n 29).
[35] Ibid.

The types of behaviour prohibited include, with variation across jurisdictions:[36]

- Any conduct relating to termination which could be visible or audible to a person seeking reproductive health services - the High Court of Australia has determined in *Clubb v Edwards; Preston v Avery* that it is immaterial what the content of the communication is and whether it is positive or disparaging communications;
- Taking audio or visual recordings of a person seeking reproductive health services in a manner which identifies them, or distributing such content;
- Obstructing physical access to a facility;
- Intimidating, besetting, threatening, hindering, obstructing or impeding; and
- Behaviour that is likely to cause actual anxiety or distress.

Clearly, jurisdictions vary in their approach to the type of behaviour prohibited in safe access zones. Marie Stopes recommends a uniform approach be adopted which reflects the definition of prohibited conduct provided in Victorian legislation:[37]

> *Public Health and Wellbeing Act 2008* (Vic) Part 9A s185B(1):
>
> ***prohibited behaviour means –***
>
> (a) in relation to a person accessing, attempting to access, or leaving premises at which abortions are provided, besetting, harassing, intimidating, interfering with, threatening, hindering, obstructing or impeding that person by any means; or
>
> (b) subject to subsection (2), communicating by any means in relation to abortions in a manner that is able to be seen or heard by a person accessing, attempting to access, or leaving premises at which abortions are provided and is reasonably likely to cause distress or anxiety; or
>
> (c) interfering with or impeding a footpath road or vehicle, without reasonable excuse, in relation to premises at which abortions are provided; or
>
> (d) intentionally recording by any means, without reasonable excuse, another person accessing, attempting to access, or leaving premises at which abortions are provided, without that other person's consent; or
>
> (e) any other prescribed behaviour;

3.2.3 The type of premises protected

Many abortions are obtained at public hospitals. It is therefore essential that public hospitals are subject to the protection of safe access zones, as well as specialist reproductive health clinics

[36] Ibid.
[37] Ibid.

and other facilities.[38] The Research Hub's preferred definition for a premesis protected by a safe access zone is any place where an abortion is provided. Tasmanian legislation provides that this includes pharmacies where medical abortion medications may be dispensed, but other states have explicitly excluded pharmacies from the protection of safe access zones on account of the potential extensive restriction resulting from the protection of a large number of pharmacies in urban spaces, which may unduly infringe on freedom of political communication.[39]

3.2.4 The penalty for infringement

The Research Hub recommends a uniform penalty for prohibited behaviour in safe access zones across all jurisdictions, at maximum 12 months' custodial sentence or an appropriate equivalent fine.[40]

3.2.5 The manner in which a safe access zone is established

Safe access zones exist automatically around designated premises in all jurisdictions except for the ACT, where facilities are protected within safe access zones by Ministerial approval.[41] The Research Hub's recommended approach is automatic activation of safe access zones around designated premises.

3.3 Conscientious objection

Conscientious objection allows health professionals with moral or religious objections to abortion to decline to provide the service. The right to conscientious objection exists both for individual practitioners across all Australian jurisdictions. The right of institutional objection also exists in all states and territories.[42]

The *WHO Best Practice Guideline* outlines the following in relation to conscientious objection:

> In spite of the human rights obligation to ensure conscientious objection does not hinder access to quality abortion care, and previous WHO recommendations aimed at ensuring conscientious objection does not undermine or hinder access to abortion care, conscientious objection continues to operate as a barrier to access to quality abortion care. It is critical that States ensure compliance with regulations and design/ organize health systems to ensure access to and continuity of quality abortion care. If it proves impossible to regulate conscientious objection in a way that respects, protects and fulfils abortion seekers' rights, conscientious objection in abortion provision may become indefensible… international human rights law provides some guidance as to how States can ensure that human rights of abortion seekers are respected, protected and fulfilled. These include:

[38] Marie Stopes Australia (n 29).
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Respective state and territory legislation (n 26).

- …prohibiting institutional claims of conscience;
- requiring objectors to provide prompt referral to accessible, non-objecting providers…. [43]

Conscientious objection by health practitioners and providers of abortion services threatens the accessibility of those services. Existing stigma, judgement, and structural and systemic barriers to accessing the procedure, particularly for more vulnerable or disadvantaged groups, may be compounded by the conscientious objection of a service provider.[44] Resulting outcomes may prevent the individual from seeking out or being able to access an abortion through another provider.

As outlined in the *Guideline*, where it is impossible to regulate conscientious objection in a manner that is consistent with people's rights to access a safe, easy, discreet abortion, conscientious objection may become indefensible.[45] Where conscientious objectors are not required to assist the patient by providing a referral to an equivalent service, the rights of the patient to access a service may be undermined.

Currently, the ACT is the only Australian jurisdiction to not implement an obligation for a conscientious objector to refer a patient to another doctor or to provide information on where the patient may access an alternative equivalent service.[46] Where abortion providors are few and far between, it is of utmost importance that legislation provides a safety net for pregnant people who come up against conscientious objection. A failure to provide a referral requirement otherwise threatens to undermine access to abortion, particularly for vulnerable communities who are particularly prone to facing additional barriers to accessing a willing providor.

A further barrier can arise in institutional objection by public health institutions. Over 20 publicly-funded hospitals and health facilities around Australia are operated under religious codes of ethics which prohibit or strongly advise against the provision of many reproductive health services, including abortion and procedures auxiliary to abortion such as dilation and cutterage ('D&C'), as well as contraceptive services including provision of the emergency contraceptive pill.[47] People seeking these services at these publicly-funded, religious institutions, may be turned away on the basis of institutional objection. Such an objection proves to be a major barrier to access. This is particularly true where there are few proximate health service providers. Uniform national legislative activity needs to be coordinated in order to regulate objection by public institutions to the provision of reproductive health services. The *WHO Best Practice Guideline* strongly recommends prohibiting institutional objection, while

[43] *Abortion Care Guideline* (n 8).
[44] Louise Keogh et al, 'Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers' (2019) 20(11) *BMC Medical Ethics* 1.
[45] *Abortion Care Guideline* (n 8).
[46] *Health Act 1993* (ACT).
[47] Annika Blau, 'How a Catholic Code of Ethics is Influencing Women's Healthcare at Australian Public Hospitals', *ABC News* (online, 3 December 2022) <https://www.abc.net.au/news/2022-12-03/catholic-hospitals-denying-womens-healthcare-australia-hospitals/101712558>.

maintaining the right of individual practitioners within those institutions to conscientiously object to providing reproductive health services.[48] Extinguishing institutional conscientious objection will relieve load on public hospitals by more equitably distributing the execution of reproductive health services, reduce wait times, and increase accessibility of these services for pregnant people seeking reproductive healthcare.

We recommend the Committee pushes for legislation harmonisation in the area of conscientious objection, both individual and institutional, to strengthen and unify the rights of pregnant people to receive willing, empowering, and supportive reproductive healthcare in all states and territories. Particularly, we urge the Committee to draw attention to the need to harmonise the obligation to refer by conscientiously objecting practitioners, and reforms required to regulate institutional objection by public religious health facilities to providing reproductive health services.

3.4 Legislation harmonisation

The Research Hub urges the Committee to recommend a programme of legislation harmonisation to bring together regulation of abortion across all states and territories. Harmonisation creates consistency, clarity, and improves outcomes for pregnant people. It represents an important step in increasing health literacy and the capacity of pregnant people to confidently navigate reproductive health services in a manner that is just and empowering. It represents an important step in improving access for vulnerable groups, including low income people, people in rural, regional and remote areas, Aboriginal and Torres Strait Islander people, and people experiencing domestic violence or coercive control. Legislation harmonisation leads the way for progressive reform of abortion law that secures reproductive justice for all pregnant people.

There are a number of mechanisms available to the Commonwealth to undertake legislation harmonisation efforts, but particularly, the Research Hub recommends the creation of a National Taskforce on abortion access and reproductive justice, coordinating the creation of model legislation and cooperative legislation reform across jurisdictions.[49]

Recommendation 5: Coordinate a law harmonisation scheme to unify abortion law in a number of key areas including decriminalisation, conscientious objection, and safe access zones.

[48] *Abortion Care Guideline* (n 8).
[49] House of Representatives Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *Harmonisation of legal systems within Australia and between Australia and New Zealand* (Report, November 2006) 5-31.

Table 1: comparison of Australian jurisdictions in their legislative approaches to key areas of abortion regulation.

State	*Criminalisation*	*Safe access zones*	*Conscientious objection*
NSW	Decriminalised, but limited after 22 weeks.	Instituted, 150m, automatic application to all clinics.	If a doctor is approached by a patient about abortion and has a conscientious objection to carrying out an abortion, they must advise the patient of this and refer them to a doctor who does not have a conscientious objection to abortion and who can provide them with advice about and access to abortion.
ACT	Completely decriminalised.	Instituted, 50m, by Ministerial declaration.	S84A Health Act. Individual, institutional also. No referral requirement.
Vic	Lawful up to 24 weeks, requires doctors' approval after 24 weeks.	Instituted, 150m, automatic application to all clinics.	A medical practitioner with a conscientious objection is legally required to inform the person requesting an abortion and provide contact information for local abortion providers or refer them onto an abortion care provider. Registered health practitioners must inform and refer to another health practitioner without a conscientious objection, unless in an emergency where the abortion is necessary to preserve the life of the pregnant woman.
QLD	Lawful up to 22 weeks, requires 2 doctors' approval after 22 weeks.	Instituted, 150m, automatic application to all clinics.	Health practitioners with a conscientious objection are legally required to inform the person requesting an abortion and must direct them to a service or someone who does not hold a conscientious objection.
SA	Lawful up to 22 weeks and 6 days, requires 2 doctors' approval after 22 weeks.	Instituted, 150m, automatic application to all clinics.	Health practitioners with a conscientious objection are legally required to inform the person requesting an abortion and provide information on how to locate or contact a medical practitioner who does not have a conscientious objection. Health practitioners can also transfer the person's care to another health service provider at which the requested service can be provided by another registered health practitioner who does not have a

			conscientious objection to the performance of the termination.
NT	Lawful up to 24 weeks, requires 2 doctors' approval after 22 weeks.	Instituted, 150m, automatic application to all clinics.	Medical practitioners with a conscientious objection to abortion care are legally required to inform the person requesting an abortion and provide information on how to contact or refer them onto an abortion care provider, unless in an emergency. The medical practitioner must 'refer the woman, within a clinically reasonable time' to another medical practitioner that doesn't have a conscientious objection. Health practitioners who assist in providing abortions that have an objection must identify a replacement health practitioner to assist.
WA	Lawful on request up to 20 weeks. Very limited after 20 weeks, only if: Two medical practitioners who are members of a panel appointed by the minister have agreed that the mother, or the unborn child, have a severe medical condition that justifies the procedure; and The abortion is performed in an approved facility.	Instituted, 150m, automatic application to all clinics.	The law states that 'no person, hospital, health institution, other institution or service is under a duty' to perform an abortion.
Tas	Lawful up to 16 weeks, requires 2 doctors' approval after 16 weeks.	Instituted, 150m, automatic application to all clinics, including pharmacies.	A doctor with a conscientious objection is legally required to inform the person requesting an abortion and provide information on how to contact or refer them onto prescribed provider.

4. Reproductive Health Leave

Reproductive leave policies are motivated towards balancing workers' paid work obligations with their sexual, reproductive, and general well-being. They are particularly necessary for members of the workforce attempting to start families, undergoing reproductive/sexual illnesses or body transformation.[50] Given that such healthcare is necessary all across the gender spectrum, leave is suited to all people and workplaces.

Currently, there is no reproductive or sexual healthcare leave available in any jurisdiction across Australia. This is not a unique national situation; few countries around the world have legally binding labour provisions for specifically reproductive and sexual healthcare related leave.[51] None offer them for all labourers regardless of gender. However, private corporations have begun to implement such policies sporadically for their employees, including superannuation company FutureSuper, period underwear brand Modibodi, and music streaming platform Spotify.[52] Despite the small uptake of such leave policies, to the extent that reproductive and sexual healthcare leave may offer significant medical and social benefits, the Research Hub urges this committee to investigate its implementation.

The Health and Community Services Union includes Reproductive Health and Wellbeing Leave as a key claim in their collective bargaining agreement.[53] The proposed clause may serve as a useful model for future investigation:

Definition

For the purpose of this clause, reproductive health is defined as any condition relating to menstruation, perimenopause, menopause, poly-cystic ovarian syndrome and endometriosis, In Vitro Fertilisation (IVF) and other forms of assisted reproductive health services, vasectomy, hysterectomy and Terminations.

[50] Marian Baird, Elizabeth Hill and Sydney Colussi, 'Balancing Work and Fertility isn't Easy - but Reproductive Leave Can Help' *The Conversation* (Opinion article, 25 November 2021) <https://theconversation.com/balancing-work-and-fertility-isnt-easy-but-reproductive-leave-can-help-171497> ('Balancing Work and Fertility').

[51] Though Taiwan, Indonesia, Japan, South Korea and Zambia have menstrual leave, this does not extend to more general sexual and reproductive healthcare.

[52] Sydney Colussi, Elizabeth Hill and Marian Baird, 'Paid Leave for Periods and Menopause will Improve Gender Equality', *The Sydney Morning Herald* (Opinion article, 2 June 2021) <https://www.smh.com.au/national/paid-leave-for-periods-and-menopause-will-improve-gender-equality-20210527-p57vsf.html>; Housnia Shams, 'Menstrual Leave Adopted by More Australian Businesses as Debate Grows Around Policy' *ABC News* (News article, 24 June 2021) <https://www.abc.net.au/news/2021-06-24/menstrual-leave-australia-womens-health-employment-workplace/100235920>.

[53] Health and Community Services Union, 'Proposed Clause' *What is Reproductive Health and Wellbeing Leave?* (Web page, September 2020) <https://www.reproductivehealthleave.com.au/what-is-reproductive-health-and-wel#:~:text=An%20Employee%2C%20including%20a%20casual,addition%20to%20any%20personal%20leave.>.

An Employee, including a casual Employee, experiencing reproductive health issues is entitled to up to 5 days per year of paid reproductive health leave for the purpose of treatment and management of ill health/symptoms, in addition to any personal leave.

Notice and Evidentiary Requirements

The Employee shall give his or her employer notice as soon as reasonably practicable of their request to take leave under this clause.

If required by the Employer, the Employee must provide evidence that would satisfy a reasonable person that the leave is for the purpose as set out in clause X.1. Such evidence may include a document issued by a doctor or other treating health professional (including a medical certificate) or a statutory declaration.

Flexible Working Arrangements

This clause supplements the entitlement to request flexible work arrangements pursuant to clause X of this Agreement.

In order to provide support to an Employee to manage and/or alleviate symptoms relating to reproductive health and to provide a safe work environment, the Employer will approve any reasonable request from an Employee experiencing reproductive health issues, including but not limited to:

1. The right to work from home
2. flexible working hours
3. Reasonable changes to work environment to provide comfortable working environment to alleviate symptoms or facilitate treatment
4. the right to access reasonable unpaid leave

NB: This is a draft clause only. The final clause may be quite different.

While it might be expected that medical leave might be negotiated on an ad-hoc basis between certain employers and their employees, this inconsistent approach has several flaws. Firstly, employers have an incentive to ignore the leave requests of their employees for productivity and efficiency costs. While this ignores the productivity costs of suffering through untreated ill health,[54] it psychologically justifies employers' refusal of leave on a wide scale. Secondly, in

[54] 'Women's Health: Endometriosis' WorkSafe Tasmanian Government (Information page, 9 August 2022) <https://worksafe.tas.gov.au/topics/Health-and-Safety/health-and-wellbeing/wellbeing-a-z/womens-health>.

many circumstances, employees may not even come forth with their medical problems, either suffering in silence, or using other forms of leave to hide their ill-health. In a recent English public health review, it was found that even when women identify symptoms of reproductive ill-health, less than half sought help for them.[55] The severity of symptoms was a lesser barrier than embarrassment, judgement, and stigma, all of which are perpetuated by workplace dynamics. Similar results have been produced in the United States of America.[56] Given the similarities between the gender and labour conditions of the three countries, it is likely that a similar phenomenon occurs in Australia. By creating an inclusive and binding policy, stigma around menstruation, reproductive healthcare, and sexual health could be broken down and the health of individuals improved.

Furthermore, providing either paid or unpaid leave gives individuals the opportunity to prioritise and plan for their future families without the fear of punishment or judgement. By freeing up time for couples to attend consultations, reproductive leave would facilitate a more pro-family work environment and hopefully improve Australian fertility. This is particularly important as fertility rates are predicted to drop to a record low of ~1.6 babies per woman in Australia in the next generation.[57] Trends in the Australian economy will require a young population to go into healthcare and aged-care sectors in the future, making this figure, which is below 'replacement level', a worrying sign of future workforce strain. As work imposes not only a time burden but also a significant social and mental burden for couples, affording time to individuals to look into their reproductive health would serve as a welcome relief for many. Some changes in this direct fertility related area are already being made. The NSW Government recently expanded the leave offered to its employees undergoing fertility treatment.[58] It now offers five days paid special fertility treatment leave per calendar year. This development is a promising endorsement of the fertility benefits of reproductive healthcare leave.

Leave policies make the workplace more equal as they remove the burden from employers to voluntarily incurring the costs of leave. This would mean that women could more comfortably remain in jobs without the fear of punishment when taking health-related leave, as their choices would be legally legitimised. It would also reduce the use of other forms of leave for women when attempting to hide their healthcare related choices. Both of these mechanisms reduce the stigma surrounding pregnancy and reproductive healthcare in the workplace. Furthermore, as the leave would ideally be offered to all members of the workforce, the numbers of men opting for sexual health check-ups, vasectomies, and other sexual and reproductive healthcare related issues would hopefully see an increase. Given the rising trend of male testicular cancer since the 1990s, the Research Hub hopes that reproductive leave would contribute to gender equality

[55] Sue Mann et al, 'What do Women Say? Reproductive Health is a Public Health Issue' (2018) *Public Health England* 5.
[56] Sheryl A. Kingsberg et al 'Female Sexual Health: Barriers to Optimal Outcomes and a Roadmap for Improved Patient-Clinician Communications', (2019) 28(4) *Journal of Women's Health* 432, 433-435.
[57] Baird, Hill and Colussi, 'Balancing Work and Fertility' (n 50).
[58] 'Paid Leave in the Event of a Miscarriage, Pre-Term Birth or When Undergoing Fertility Treatment' (Premier's Memorandum, NSW Premier and Cabinet, 4 October 2022).

in the workplace.[59] Finally, individuals undergoing gender affirming treatment could gain the benefit of such a policy to great effect. It would free up both the time and the psychological burden involved in difficult, stressful periods for such workers, increasing productivity and equality in the workplace.

Some have argued that menstrual-related policies and reproductive leave may contribute to a stigma against women and a disincentive for female employment.[60] This argument ought not to be given undue weight. Companies that actively hire against gender equality are often 'named-and-shamed' to their own detriment. Furthermore, it would often be economically untenable to have such policies to the exclusion of such a large portion of the labour market. This said, the design of any reproductive or sexual healthcare leave policy ought to consider the implications it may have on the employment of women, particularly regarding the effect of the policy on the age of employment for women. As reproductive and sexual healthcare leave policies increase the gender equality and health of the labour force, the Research Hub recommends consideration of a reproductive healthcare leave policy in the committee's investigation.

Recommendation 6: Investigate the efficacy of the Health and Community Services Union for Reproductive Health and Wellbeing Leave. Develop guidelines and model legislation for a reproductive/sexual health leave policy scheme.

5. Sexual and Reproductive Health Literacy

Sexual health literacy refers to the ability of individuals to make safe choices about their sexual and reproductive healthcare.[61] These include making safe decisions upon participating in sexual behaviour, knowing when and being equipped to consult medical or advisory assistance, understanding the signs of pregnancy and symptoms of sexual illnesses, and recognising unsafe circumstances like peer pressure or intoxicating substances. By enhancing sexual and reproductive health literacy, the physical and mental harms of sexual ill health and danger can be avoided, the social difficulties of unintended pregnancies and diseases mitigated, and the taboos around sexual health and participation deconstructed.

Sexual health literacy in Australia is decentralised to a large extent. The most salient period of sexual health education occurs at the primary and secondary schooling period. While the Australian Curriculum and Reporting Agency (ACARA) curriculum is accepted by all jurisdictions, each state and territory retains significant authority over that which is taught to students in their jurisdiction. Furthermore, there are a range of provisions per state/territory

[59] 'Testicular Cancer' *Cancer Council Australia* (Fact sheet, 2022) <https://www.cancer.org.au/cancer-information/types-of-cancer/testicular-cancer>.
[60] Baird, Hill and Colussi, 'Balancing Work and Fertility' (n 50).
[61] World Health Organization: Regional Office for Europe, 'Sexual and Reproductive Health: Fact sheet on Sustainable Development Goals' (2017) <https://apps.who.int/iris/handle/10665/340880>.

allowing private and/or religious schools to offer different information to students on sexual and reproductive health.

The *WHO Best Practice Guideline* advises that international human rights law informs the obligation to provide abortion information relating to sexual and reproductive health of a general nature to the public. This information must be 'comprehensive, non-discriminatory, scientifically accurate and age-appropriate… on sexuality and reproduction, including information on abortion, both in and out of schools'.[62] Alongside the, these principles are useful guidance for the production of materials for the sexual and reproductive literacy of youth and for the assessment of the efficacy of their provision.

Despite the emphasis on sex education in each state and territory, there remain worrying signs regarding the knowledge and understanding of Australian students. In qualitative reviews, many students have recounted the lacking relevance of the information they were taught at school, a sentiment particularly shared by members of the LGBTIQ+ community.[63] Furthermore, quantitative data demonstrates a moderate to low level of knowledge of Sexually Transmitted Illnesses (STIs) and of the risks of unprotected sex.[64] Finally, the inconsistent application of sex education across private and/or religious schools poses a problem for general sexual literacy. Each of these dimensions demonstrates and has contributed to a reduction in general sexual and reproductive health literacy.

5.1 Improving communication of sexual and reproductive information

As many teachers report difficulty in communicating sexual education to their students, it is necessary to implement innovative strategies when approaching sexual education.[65] This is particularly necessary as despite the ubiquity of sexual education, there remain gaps in the knowledge of secondary students on the subject. While more rigorous teacher training on the subjects to be addressed is one means of addressing these difficulties, another approach may be the utilisation of community groups to discuss sexual education can be an effective means of

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[62] *Abortion Care Guideline* (n 8) 12.
[63] Sophie Meixner, 'Does Australia's Sex Education Curriculum Need to Include More on Sex Positivity, LGBTQI+ Relations and Intimacy?' *ABC News,* (Opinion piece, 27 January 2021) <https://www.abc.net.au/news/2021-01-27/sex-education-lgbt-sexuality-young-high-school-pleasure-respect/12960062>.
[64] James May, 'Sexuality Education in Australian Secondary Schools: Averting a Sexual Health Crisis Among Young People' (2013) 11(1) *HIV Australia,* <https://www.afao.org.au/article/sexuality-education-australian-secondary-schools-averting-sexual-health-crisis-among-young-people/#:~:text=Australian%20secondary%20students%20see%20school,and%20young%20women%20(48.8%25)>; Christopher Fisher et al, 'Study Protocol: 6th National Survey of Australian Secondary Students and Adolescent Sexual Health, 2018' (2019) 7(217) *Front Public Health* 1; Paulina Ezer et al 'School-Based Relationship and Sexuality Education: What has Changed since the Release of the Australian Curriculum' (2020) 20(6) *Sexuality, Society and Learning* 642, 645-655.
[65] Ruth Walker et al, 'Teachers' Perspectives of Sexual and Reproductive Health Education in Primary and Secondary Schools: A Systematic Review of Qualitative Studies' (2021) 2(:6) *Sex Education* 627, 634-639 <https://doi.org/10.1080/14681811.2020.1843013>; Doortje Braken and Ilka Rondinelli, 'Sexual and Reproductive Health Needs of Young People: Matching Needs with Systems' (2012) 119(1) *International Journal of Gynecology & Obstetrics* 60 <https://doi.org/10.1016/j.ijgo.2012.03.019>.

resolving awkwardness and disengagement. By bringing youth-friendly services into the classroom, students may feel more comfortable and willing to participate.

5.2 Revision, scrutiny, and implementation of the syllabus

The Research Hub acknowledges and welcomes the recent updates to the ACARA curriculum in version 9.0, particularly with regard to its emphasis on consent in healthy relationships. Despite this, investigation and improvements ought to be made regarding the applicability of the syllabus to marginalised sexual groups and identities. Given the pre-existing social marginalisation of the LGBTIQ+ community, it is vital that taboos are deconstructed from as young an age as possible. This will erode taboos and social divisions, and will also provide needed guidance for individuals struggling with their sexual orientations.

5.3 Resources for parents

Schools are not the only setting for sexual and reproductive health literacy. The research hub acknowledges the fundamental role that parents and healthcare providers, namely General Practitioners ('GPs'), offer when educating young people on their health.[66] It is important that parents are informed in culturally sensitive and accessible ways of the syllabus their children are engaging with, and that they themselves are well-informed when their children call on them for information and support. By encouraging schools to engage with parents, distributing sexual education information at a state-level, and informing parents of the possibility of speaking to GPs with their children, parents will be more comfortable and better equipped to teach sexual and reproductive health information. These initiatives should be provided in every language for which there is demand, and in culturally sensitive ways. All of these initiatives occur largely at the state jurisdiction, but could be encouraged through research and investigation by this committee.

5.4 Addressing uptake of the national curriculum

While the ACARA national curriculum is not designed to be universally implemented without adjustment, it is important to note that disparities in the uptake of the national curriculum will produce differing levels and dimensions of knowledge across the country. An uneven degree of knowledge and understanding will perpetuate differing and potentially conflictual social attitudes at tertiary education and the workplace. Furthermore, pursuant to the *WHO Best Practice Guideline,* comprehensive sexuality education ought to be available to all persons, including without the consent of their parents or guardians.[67] As such, where there are legislative allowances for private and/or religious schools to reject sex education, or increased rates of parental withdrawal of their students from such education, scrutiny must take place to ensure that students are receiving a baseline knowledge of the important tenets of sexual and reproductive healthcare.

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[66] Fisher (n 63) 5.
[67] *Abortion Care Guideline* (n 8) 12.

Recommendation 7: Investigate the implementation of the national curriculum regarding sexual and reproductive health education across jurisdictions and in non-government schools. Investigate the degree to which ACARA is incorporating marginalised sexual identities in its national curriculum 9.0. Produce guidelines for state authorities to create accessible information, training, and community led groups for parents, teachers, and students.

3. Conclusion

The Research Hub hopes that the analyses and recommendations within this submission are of use to the inquiry in its process. We would welcome the opportunity for future engagement with the Committee regarding this submission should it be necessary or useful. The Research Hub acknowledges the powers and limitations of the Inquiry and has sought to provide both realistic and idealistic recommendations throughout its submission. While complexity inheres to the provision of universal reproductive healthcare, the Research Hub maintains that the importance of such healthcare demands aspiration and progress. Reproductive healthcare ought to be accessible, equitable, and effective, and the Research Hub is excited for the outcomes of this inquiry.