MONASH University

CASTAN CENTRE FOR HUMAN RIGHTS LAW

Castan Centre for Human Rights Law

Follow-Up Report:

Australia's Compliance with the Convention on the Elimination of all Forms of Discrimination against Women

May 2021

Introduction

The Castan Centre for Human Rights Law (Castan Centre) is an academic research centre within the Faculty of Law at Monash University in Melbourne, Australia. We undertake research, policy work, student programs and public engagement on human rights and have sought to inform government policy and legislation to ensure that human rights are respected and protected. This report is written by the Castan Centre's research group leader in gender and sexuality, Dr Tania Penovic and its Deputy Director, Dr Ronli Sifris.

We are grateful for the opportunity to provide a shadow follow-up report to the Committee on the Elimination of Discrimination against Women. Our submission seeks to address the recommendations in paragraphs 12(b), 50(a) and 54(b) of the Committee's concluding observations on Australia's eighth periodic report. The component of our report which addresses paragraph 50(a) draws on our nationwide empirical research into access to reproductive health services and is the most detailed part of our report.[1]

Committee Recommendation 12(b):

Australia's Constitution has not been amended to recognise First Nations peoples. While all State constitutions now contain statements of recognition of Indigenous people (albeit largely symbolic), the Commonwealth Constitution remains notable in its absence of recognition. The recommendations of an appointed committee, the Prime Minister's Expert Panel in 2012, followed by the enactment of the *Aboriginal and Torres Strait Islander Peoples Recognition Act 2013* (Cth) indicated a renewed political energy for constitutional reform. However, there seems to be consensus that until there is widespread political and public support for constitutional recognition, no referendum should be presented to the general public as the consequences of a failed referendum are too damaging to contemplate.[2]

In 2017 a series of Indigenous Conventions were held around Australia, to discuss what Indigenous peoples wanted in terms of constitutional reform, recognition or representation. In May 2017 the final First Nations Constitutional Convention, held at Uluru, in the Northern

[1] This component draws on the following: Ronli Sifris and Tania Penovic, 'Barriers to abortion faced by Australian women before and during the COVID-19 Pandemic' Vol 86, May-June 2021 *Women's Studies International Forum,* Article 102470 at https://doi.org/10.1016/j.wsif.2021.102470

[2] Lisa Burton Crawford et al, *Public Law and Statutory Interpretation* (Federation Press, 2021) section 3.5.

Territory, issued a statement, known as the Uluru Statement from the Heart.[3] This statement calls for two substantive reforms, the first being a Voice to Parliament and the second being a Makarrata Commission with responsibilities for developing a treaty. These recommendations for reform are encapsulated by the phrase *Voice Treaty Truth.* It is not yet known when, or if, these calls for substantive reform will be put to the people in a referendum.[4]

Having so far rejected the Indigenous Voice to Parliament proposed in the 2017 Uluru Statement from the Heart on contentious and contested grounds, the Australian Government has proceeded with a co-design process which has progressed slowly and failed to meet expected timeframes. The Uluru Statement represents the consensus of Indigenous delegates from around Australia on Constitutional recognition. Polling has found that a majority of Australians support its proposal to 'change the constitution to set up a representative Indigenous body to advise the parliament on laws and policies affecting Indigenous people.' The Australian Government's failure to embrace the statement represents a lost opportunity to support Indigenous self-determination and participation rights set out in the UN Declaration on the Rights of Indigenous Peoples. The importance of self-determination to the realisation of fundamental rights featured prominently in the Australian Human Rights Commission's *Wiyi Yani U Thangani (Women's Voices)* consultations. Further, as Megan Davis has eloquently expressed, '[t]he overwhelming support of the Australian people for a referendum is clear … If it was to be ignored by the Co-Design group and the politicians, in plain view, it would only entrench further the voicelessness and powerlessness that drives the disadvantage in our communities.'[5] We call on the Australian Government to revisit the Uluru Statement and consider the voices of Indigenous women which have for too long remained unheard in shaping law and policy[6] and achieving Constitutional recognition of Aboriginal and Torres Strait Islander Australians.

---

[3] Ibid.
[4] Ibid.
[5] Megan Davis, 'Listen to the people as they call for constitutional action', *Weekend Australian*, 1 May 2021.
[6] Megan Davis, 'Deploying and Disputing Aboriginal Feminism in Australia', in Joyce Green (ed), *Making Space for Indigenous Feminism* (2nd ed, Fernwood Publishing, Halifax and Winnipeg, 2017); Larissa Behrendt, 'Aboriginal Women and the White Lies of the Feminist Movement: Implications for Aboriginal Women in Rights Discourse' (1993) 1 *Australian Feminist Law Journal* 27; Tania Penovic, 'Illuminating the invisible: women's human rights in Australian law and policy' in Melissa Castan and Paula Gerber (Eds), *Critical Perspectives on Human Rights Law in Australia: Volume 1* (Thomson Reuters, 2021), 215-250.

Committee Recommendation 50(a):

While significant progress has been made since the release of the Committee's concluding observations in July 2018, the implementation of recommendation 50(a) remains a work in progress.

Legal reform

Abortion laws have been liberalised in a number of jurisdictions. In New South Wales (NSW), legislation establishing safe access zones of 150 metres around reproductive health clinics was passed in June 2018.[7] In October 2019, abortion was effectively decriminalised in NSW and health practitioners with a conscientious objection to providing abortion services are now required to disclose their objection to persons seeking abortion and refer them to a practitioner who does not have a conscientious objection.[8] Significant legislative reforms have also been enacted in Queensland, decriminalising abortion and establishing 150 metre safe access zones around clinics. The most recent state to remove abortion from its criminal code is South Australia which passed legislation in March 2021 to decriminalise abortion and create safe access zones around clinics. Western Australia, where abortion after 20 weeks' gestation is unlawful unless strict criteria around informed consent are met, remains the only state in Australia yet to pass safe access zone legislation.[9]

While decriminalisation is often perceived as the solution to abortion access, some legal barriers to access have persisted. These include the following:

- a lack of clarity around abortion laws and concomitant lack of public awareness;
- a lack of uniformity between jurisdictions, contributing further to uncertainty and a lack of public awareness. For example, some jurisdictions but not others require medical practitioners with a conscientious objection to providing abortion services to disclose their objection and refer persons seeking abortion to a practitioner who does not have a conscientious objection;
- legal restrictions as to who is permitted to perform abortions; in all jurisdictions except South Australia and the Northern Territory, abortions can only be performed by medical doctors;

[7] *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018*.
[8] *Abortion Law Reform Act 2019.*
[9] The *Public Health Amendment (Safe Access Zones) Bill 2020* passed the Legislative Assembly and awaits debate in the Legislative Council.

- the imposition of gestational limits for abortion on request (which range from 16 weeks in Tasmania to 24 weeks in Victoria)[10] after which doctors become the gatekeepers for access to abortion and patients are denuded of agency;
- gestational limits have required some women to travel interstate to access abortion services, often at great financial cost, and doctors to routinely travel to provide these services.

Non-legal barriers

In addition to persisting barriers under the law, a number of non-legal barriers remain. These are in part attributable to the legacy of criminalisation and the failure of the healthcare system to adapt to legislative reform. Between March 2017 and November 2020, we conducted nationwide qualitative research into the barriers faced by Australian women when accessing, or attempting to access, abortion services.[11] 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. We have found that significant inconsistencies in access persist across Australia's six states and two territories. Key barriers which arose in our research were financial barriers, geographic barriers; and barriers generated by the attitudes, education and training of health professionals.

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.[12] A lack of public funding for abortion has resulted in a preponderance of abortions being provided in the private health system, where significant cost discrepancies between providers have rendered abortion services unaffordable for many women. For example, medical (non-surgical, medication based) abortion is available in Australia up to nine weeks' gestation. Although the medications required for medical abortion are included on the Pharmaceutical Benefits Scheme and the cost of medication per patient

[10] The Northern Territory requires approval by one medical practitioner for abortions performed up to 14 weeks' gestation, and two medical practitioners between 14 and 23 weeks' gestation: *Termination of Pregnancy Reform Act 2017*.

[11] See Ronli Sifris, Tania Penovic and Caroline Henckels, 'Advancing Reproductive Rights through Legal Reform: The Example of Abortion Clinic Safe Access Zones' (2020) 43(3) *University of New South Wales Law; Journal,* 1078; Tania Penovic and Ronli Sifris, 'Expanding the Feminisation Dimension of International Law: targeted anti-abortion protest as violence against women' (2018) 7(2) *Cambridge International Law Journal,* 241; Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe-Access Zones: An Analysis' (2018) 44 *Monash University Law Review.*

[12] The Medicare Benefits Scheme (known as 'Medicare') is the scheme by which the federal government subsidises the costs of medical treatment.

could be limited to approximately $40, medical abortions in some parts of Australia cost as much as $770.[13] The cost of surgical abortions in the private health system rises as pregnancy progresses and later abortions may cost thousands of dollars. While later-gestation abortions comprise a small proportion of abortions performed in Australia; women requiring these procedures are often in the most desperate and vulnerable circumstances.[14]

Cost disparities have 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 health care. This inequality is further entrenched by geographic barriers. Abortion services are located predominantly in metropolitan areas, requiring women living in rural or remote areas to travel long distances to access healthcare. Some must travel interstate due to restrictions on access in their home state. For example, a lack of publicly funded abortion facilities in the state of Tasmania has required many women to travel to Victoria to access abortion.[15] Additional costs, such as transportation and accommodation costs, compound the existing burden of overcoming barriers of distance.[16] Further, financial and geographic disadvantage may create delays in accessing time-critical medical care, generating additional costs and potential complications that are a corollary of abortion at a later gestational stage.[17]

Medical practitioners are necessarily involved in the provision of abortion services, yet abortion remains a stigmatised area of medical practice. Abortion access remains susceptible to the moral and religious beliefs of doctors and those with a conscientious objection to abortion continue to delay and obstruct abortion access, even in jurisdictions which have imposed an

[13] 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).
[14] Erica Millar, 'Here's why there should be no gestational limits for abortion' *The Conversation* (12 August 2019); 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.*
[15] 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; Gina Rushton, 'Tasmania's main surgical abortion provider has shut up shop' *BuzzFeed* (12 January 2018).
[16] 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, 'Barriers Around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16 *Rural and Remote Health.*
[17] Mridula 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.

'obligation to refer'.[18] The policing of this obligation is frustrated by the reality that women seeking abortions may not be informed about the obligation and are in any event unlikely to complain. Threats and ostracization remain a corollary of abortion practice, particularly in some rural and regional areas, as described to us by a retired medical practitioner:

> 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.[19]

Doctor training and expertise have been compromised by the legacy of criminalisation and stigmatisation of abortion. Abortion is largely absent from medical curricula and training, compounding stigma and resulting in a shortage of health practitioners willing and able to provide the service.[20]

Intersectional Impact

The barriers outlined above have had a disproportionate impact on those who experience intersectional forms of disadvantage, including women with disability, Aboriginal and Torres Strait Islander women, refugees and migrant women on temporary visas, women living in rural and regional areas and those experiencing family violence. For Indigenous women, access to abortion and other reproductive health services cannot be considered in isolation from their lived experience of systemic discrimination and mistreatment, including eugenically informed birth control,[21] forced child removal and exclusion from feminist discourses.[22] While the practice is not well-documented, Indigenous women have been sterilised without consent[23] and

---

[18] Se for example 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.

[19] Interview with PM, Retired Obstetrician and Gynaecologist, (Ronli Sifris/Tania Penovic, 15 October 2018).

[20] Hayes et al, note 14.

[21] Aileen Moreton-Robinson, *Talkin' up to the White Women: Indigenous Women and Feminism* (University of Queensland Press, St Lucia, 2000) 171; Larissa Behrendt, note 6, 29-30; Emily Maguire, *This is What a Feminist Looks Like: the Rise and Rise of Australian Feminism* (National Library of Australia, Canberra 2019) 149-150.

[22] See for example Jackie Huggins, 'Black women and women's liberation', (1987) 13(1) *Hecate* 77; Moreton-Robinson, Ibid, 171.

[23] Behrendt, note 6, 29-30.

coerced into taking contraceptives not approved for use in Australia.[24] In light of the removal of children and sterilisation of women, Behrendt has observed that 'Aboriginal women were losing their right to be mothers; the right to be a mother was not an issue for white women who at this time were concerned with right to choose whether or not to be a mother at all by agitating for access to safe contraception and securing safe abortions.'[25] 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.'[26]

Telehealth

Telehealth services have taken on particular importance during the COVID-19 pandemic due to stay-at-home measures, movement restrictions and the dangers of community transmission via face-to-face healthcare. Adjustments to the Commonwealth government's Medicare Benefits Scheme through the creation of temporary telehealth item numbers have increased access to government funded, time-sensitive services such as medical abortion, emergency contraception and post-exposure prophylaxis, long-acting reversible contraceptives and complex contraceptive issues, services related to endometriosis and other causes of heavy menstrual bleeding, fertility and infertility issues, sexual health advice and cervical cancer screening.[27] Clinical care is provided by nurses and doctors via telephone and medication is delivered by courier, with access to aftercare by telephone.[28] While telehealth item numbers are now permanent, access is restricted to general practitioners who have consulted face-to-face with a patient in the previous twelve months, limiting access to sexual and reproductive healthcare.[29]

---

[24] Moreton-Robinson, note 21, 171.
[25] Behrendt, note 6, 30.
[26] Kerry Arabena, 'Addressing structural challenges for the sexual health and well-being of Indigenous women in Australia' *Sexually Transmitted Infections 2016 Mar; 92(2): 88–89 doi: 10.1136/sextrans-2015-052412*
[27] Ruby Prosser Scully, 'Telehealth restrictions 'jeopardise sexual and reproductive health', *Medical Republic*, (Web Page, 16 July 2020) <http://medicalrepublic.com.au/telehealth-restrictions-jeopardise-sexual-and-reproductive-health/31649>
[28] l. Fix et al, 'At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations' (2020) *BMJ Sex Reproductive Health*1–6 <doi:10.1136/bmjsrh-2020-200612>.
[29] Only 10 per cent of general practitioners are authorised to prescribe medical abortion: MS Health (2021). Impact Report 2020, Melbourne, Australia: MSI Reproductive Choices viewed 20 April 2021 at https://www.mshealth.com.au/

While facilitating access to telehealth is critical, Dr Caroline de Costa and others 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.'[30] Further, teleabortion is not available after nine weeks' gestation and is not suitable or acceptable for all women. Access to ultrasound and pathology facilities is required and it is recommended that '[m]edical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care.'[31] Some women in remote areas still face significant access challenges in accessing medical abortion via telehealth.

Conclusion

Action must be taken to facilitate the practical realisation of abortion law reform. Such action includes adequate public funding and provision of abortion services throughout Australia (in both rural and urban areas), appropriate practitioner training (including university curricula and doctor training) and measures which recognise abortion as an essential component of women's reproductive health care.

Committee Recommendation 54(b):

According to evidence provided before Senate Estimates on 2 March 2021, there are currently 211 asylum seekers remaining in Nauru, 228 in Papua New Guinea and 1,220 individuals from the offshore cohort currently in Australia.[32] Of the 439 asylum seekers remaining offshore, there are no children and one women in Nauru, with eight women having been granted a transfer to Australia for medical purposes in late February.[33] A family of four has been held at Christmas Island for three years, after residing in Queensland for four years and as at 28 February 2021, there were 1,527 people held in closed immigration detention in mainland Australia.

In mainland immigration detention, concerns about the unnecessary and disproportionate use of force have been raised by the Commonwealth Ombudsman, who observed 'an increasing tendency across the immigration detention network for force to be used to resolve conflict or

[30] Caroline de Costa et al, 'Medical abortion: it is time to lift restrictions', (2019) *Medical Journal of Australia*, 10.5694/mja2.50362, 248-249.e1
[31] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *The Use of Mifepristone for Medical Termination of Pregnancy* (2016).
[32] Official Committee Hansard, Senate, Legal and Constitutional Affairs Legislation Committee, *Estimates*, 2 March 2020, 182
[33] Ibid 182, 195

non-compliant behaviour as the first rather than the last choice.'[34] Serious neglect and acts of verbal, physical and sexual abuse have been reported in Nauru[35] and Papua New Guinea, where asylum seekers have remained for more than seven years. The determination of their status has been marked by long delays, a lack of timelines and transparency and no clear information about processing and resettlement.

While the number of individuals remaining in Nauru and Papua New Guinea has fallen, the Australian government has not implemented Recommendation 54(b). Regional processing and immigration detention remain core features of Australia's asylum seeker policy which seeks to bar irregular maritime arrivals from entering Australia and engaging its international obligations.

Australia's asylum seeker policy has failed to comply with international standards.[36] This Committee and other treaty bodies and human rights mechanisms have called repeatedly on Australia to abandon its harsh and exclusionary policy which was the subject of numerous expressions of concern and recommendations in the second cycle of Australia's Universal Periodic Review and remained so in the interactive dialogue of its third cycle in January 2021. It is time for Australia to take steps towards meeting these calls and cease its longstanding practice of defining asylum seekers not by their protection needs but instead by the arbitrary and irrelevant consideration of the means by which they have travelled.

[34] Commonwealth Ombudsman, Monitoring Immigration Detention, *Review of the Ombudsman's Activities in Overseeing Immigration Detention*, June-December 2019, [6.35].
[35] Australian Senate, Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru, *Final Report* (March 2015), 36-42.
[36] See generally Tania Penovic, 'Boat People and the Entrenchment of Exclusion' in Melissa Castan and Paula Gerber (Eds), *Critical Perspectives on Human Rights Law in Australia-Volume 1* (Thomson Reuters, 2021), 373-408.