



When More is Less: Emergency Powers, COVID-19 and Abortion in South Australia, 2020

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Abstract

In March 2020, when emergency powers legislation was invoked in South Australia to manage COVID-19, the South Australian Abortion Action Coalition (*saaac*) had been campaigning to decriminalise abortion since 2015. The group quickly realised that COVID-19 restrictions would amplify pre-existing difficulties for abortion providers and their patients and focused its efforts on persuading members of the government and the Chief Public Health Officer to use emergency powers to suspend aspects of abortion law to enable better and safer access to abortion services, specifically medical abortion via telehealth. This article offers an account of *saaac*'s 2020 campaign and asks why the needs of abortion patients and their healthcare providers were sidelined at the height of the COVID-19 lockdown in SA in early 2020.

Keywords: Abortion; COVID-19 pandemic; criminal law; emergency powers; medical abortion.

Introduction

Emergency powers are special powers given to the executive arm of government during periods defined as comprising dire threats to a society or nation, usually associated with war, terrorism, natural disaster or another large-scale emergency. The need for nationally coordinated responses to a crisis like the COVID-19 pandemic is widely accepted, but specific deployments of emergency powers are often contested (Chua and Lee 2020; Moulds 2020).

This article examines an instance where a community group—the South Australian Abortion Action Coalition (*saaac*)—campaigns for the use of emergency powers to expand access to abortion in South Australia (SA). From March to May 2020, *saaac* unsuccessfully argued for emergency powers to be used to relax SA's criminal law requirements restricting abortion. This article considers the campaigns for and against the use of emergency powers to improve the safe provision of abortion care and questions why the attempt to shape the exercise of emergency powers was rebuffed. It argues that the answer lies in representations of social and healthcare needs intersecting with conventional exceptionalising discourses about abortion plus resistance from decision-makers to the perceived politicisation of the emergency pandemic response.

Various commentators have criticised emergency power provisions and highlighted their undemocratic nature, extensive punitive and constraining impacts, and continuance beyond the emergency. Since the 11 September 2001 attacks on the World Trade Centre in New York City and the ensuing 'war on terror', scholarly interest in emergency powers has intensified (Agamben 2005; Scheuerman 2006; Head 2017). The emerging critical literature on the use of emergency powers during the



COVID-19 pandemic underscores governmental control strategies and reliance on police enforcement and criminal penalties and assesses the capacity of legal and parliamentary structures to scrutinise such powers (Evans and Petrie 2020; Young 2021).

This case study contributes to debates on emergency powers raising questions that emanate from a progressive community-based call for their use that went against the grain of their usual purpose, proposing less surveillance, more individual autonomy and the dismantling of patriarchal features of the criminal law. By addressing the legal barriers to abortion in SA made more acute by pandemic conditions, it contributes to the emerging international literature about adjustments to abortion provisions in the context of COVID-19 (Bojovic et al. 2021). While Australian health authorities deemed abortion essential healthcare, in line with international trends, the particularities of SA criminal law meant that barriers to access could only be addressed via emergency powers.

Research Question and Methodology

After establishing how emergency powers were invoked in SA in 2020, this article explains the regulation of abortion under the *Criminal Law Consolidation Act 1935* (SA). It highlights the ways in which the law created significant obstacles to abortion access that were amplified in pandemic conditions while exposing abortion patients and healthcare workers to unnecessary COVID-19 risk. The article asks why emergency powers were not used in SA to enable safer and more accessible delivery of abortion care in the context of COVID-19.

To answer this question, the research team created a document archive containing media coverage, legislation, campaign and policy documents, anti-abortion social media and blog posts, and correspondence between *saaac* and government officials. From 2020 to 2021, we undertook 10 in-depth interviews to obtain information from several vantage points regarding the experience of providing abortion care, the challenges that the legal status of abortion presented and the nature of public health and political responses to this situation.¹

Interviewees were recruited through researchers' existing networks based on their professional or scholarly expertise or their role in *saaac*'s campaign. They were a co-convenor of *saaac*, one politician and one legal academic, one sexual and reproductive health advocate, four abortion providers and two workers from women's safety services. Each interview took an average of one hour and sought information on interviewees' professional and personal experiences of the legal status of abortion provision in SA, their insights regarding the unchanged nature of the law and their perceptions of key players, events and arguments. The semi-structured interviews enabled interviewees to describe events and their recollections in their own words (Babbie 2021). Each interview was transcribed, and interviewees were provided with their transcription for approval or amendment. Close reading of the transcripts identified emerging themes giving insight to the law in action, while the documents provided information on the socio-legal context of the pandemic.

Emergency Powers and COVID-19 in SA

In Australia, federal-, state- and territory-based legislation provide special powers that can be invoked in times of disaster or emergency. The SA *Emergency Management Act 2004* (hereafter the *Emergency Act*) establishes 'strategies and systems for the management of emergencies'. A stated purpose is 'to promote community resilience and reduce community vulnerability in the event of an emergency' (section 2 (1)(b)). It defines an emergency as 'an event that causes, or threatens to cause' death or injury, destruction or damage, disruption to essential services or harm to the environment (section 3). The *Emergency Act* identifies specific roles, including the Chief Public Health Officer (CPHO) (section 25(3)) and the Commissioner of Police, who becomes State Coordinator (sections 14, 15 and 25). The *South Australian Public Health Act 2011* (SA) also vests power in these two roles.

On 22 March 2020, four days after the World Health Organization (WHO) declared COVID-19 a global pandemic, the State Coordinator announced a public health emergency under the *Emergency Act*. At that time, there were 20 cases of COVID-19 in SA, all people who had travelled overseas or their close contacts (Keane 2020). The State Coordinator declared a major emergency on 22 March and on 8 April the State Parliament passed the *COVID-19 Emergency Response Act 2020*. The Act passed both houses of parliament unopposed and with little debate (SA House of Assembly 2020; SA Legislative Council 2020). The Legislative Council COVID-19 Response Committee was appointed on 8 April 'to monitor and scrutinise all matters related to the management of the COVID-19 response and any related policy matter and any other related matter' (SA Parliament 2020). The public emergency was extended 28 times, most recently on 13 November 2021, and ceased in May 2022 (Chapman and Kelsall 2022).

Submissions from professional and community groups to SA's COVID-19 Response Committee express concern about the *Emergency Act*. The Law Society of SA assessed the powers as 'incredibly broad and coercive', unprecedented in Australian history, and the power given to police 'truly extraordinary' (2020: 1). In June 2020, when the COVID-19 risk was low in SA, legal academics questioned 'the extent to which all of these measures remain necessary and proportionate to the threat posed by the pandemic in light of their impact on other competing public interests and on individual rights' (University of SA—Justice and Society Unit 2020: 1–2). Submissions revealed unease about the impact of movement restrictions on vulnerable people experiencing poverty, precarious housing or domestic violence (Law Society of South Australia 2020; Morley et al. 2021). During the interviews, Tammy, a politician, and Sarah, a legal academic, questioned the capacity of the committee to meaningfully protect human rights. Sarah viewed it as poorly resourced, given little political authority, hampered by low-level interest and limited public legal, political and general literacy relating to emergency powers. The *Emergency Act* was not imagined in relation to continuing emergencies. Sarah and Tammy noted that the length of the pandemic highlighted problems with the 'quite extraordinary powers' of the State Coordinator. In contrast to these critiques, we explore arguments about emergency powers as a potential tool for extending and improving access to abortion.

Abortion Provision in SA

In Australia, healthcare is regulated primarily by state and territory law, while federal laws deal with health regulation and prescription medication. Abortion has long been exceptionalised by its regulation in criminal law, but successful campaigns to decriminalise abortion have occurred in every Australian state and territory beginning in 2002. Although SA was the first state to liberalise abortion law in 1969, with reforms explicitly mirroring the UK's *Abortion Act 1967*, it did not remove abortion from the criminal law until 2 March 2021, after six other jurisdictions already having done so in the first two decades of the twenty-first century (Baird and Millar 2021). At the beginning of the COVID-19 pandemic, the *Criminal Law Consolidation Act 1935* (as amended 1969) established the conditions under which abortion could be lawfully provided in SA: only within a 'prescribed hospital' and if two medical practitioners examined the patient and agreed the abortion was medically necessary (s 82A; Heath and Mulligan 2016).

In Australia, medical abortion has been increasingly easily available since 2013, currently for people pregnant up to 63 days (Baird 2015). This safe and simple method comprises pharmaceutical drugs mifepristone combined with misoprostol, ideally taken 24–48 hours apart. In all parts of Australia except SA, medical abortion can be provided via telehealth in a home setting. An initial telephone or video consultation with a doctor, usually after the provision of an ultrasound, is followed by mail or courier dispatch of medication. Post-abortion advice and care can be provided by telephone or video. Some complications must be dealt with locally (Hyland, Raymond and Chong 2018). Australian research reports high levels of safety and patient satisfaction (Mulligan and Messenger 2011; Goldstone, Walker and Hawtin 2017). Noting its safety and potential to increase access where abortion is unavailable or unlawful, feminist and pro-choice advocates endorse medical abortion for its capacity to deliver patient control, autonomy and privacy (Berer and Hoggart 2018; Erdman, Jelinska and Yanow 2018).

While medical abortion was available in SA, abortion law significantly impacted the accessibility of these drugs, particularly for rural and remote patients. In rural areas, general practitioners (GPs) had to physically attend hospital premises to oversee the provision of the drugs (Mulligan and Messenger 2011). The compulsory examination by two medical practitioners further inhibited the provision of medical abortion in regional areas where willing doctors were scarce, even when the hospital requirement was met. In 2020, SA residents were the only in Australia unable to access medical abortion from their local GP clinic or by telehealth. In 2018, the most recent year for which statistics are available, 83% of people resident in non-metropolitan areas who had an abortion travelled to Adelaide, the capital city, to access the service (SA Abortion Reporting Committee 2020: 6), potentially involving round trips of hundreds of kilometres.

The difficulties in accessing abortion services experienced by people living in rural and remote areas were a significant motivating factor in the formation of *saaac* in late 2015. *saaac*'s goal is to improve abortion access and initially it focused principally on decriminalisation. In this endeavour, *saaac* was supported by over 40 state and national professional and community-based organisations representing legal, medical and feminist perspectives. In early 2019, the (then) Attorney-General Vickie Chapman referred the matter of abortion law reform to the SA Law Reform Institute. Its report recommended several measures that would mostly remove abortion from the criminal law and regulate it as healthcare (Williams et al. 2019). High levels of pro-choice sentiment existed in SA, with a mid-2019 survey showing that 79.4% of respondents supported decriminalisation (Cations, Ripper and Dwyer 2020). At the end of 2019, the Attorney-General announced that she would introduce a bill to decriminalise abortion in the new year.

When emergency measures were imposed in SA, the drafting of a Termination of Pregnancy Bill had begun. *saaac* had spent several years working to increase awareness among politicians and the community about the obstacles to abortion in SA and

the importance of legislative change. However, the overwhelming effects of the pandemic on the government paused parliamentary progress towards decriminalisation. *saaac* turned its attention to the effects of the pandemic on sexual and reproductive health care. It argued there was an urgent need to re-think abortion provision considering access to care and infection risk in hospitals to patients and healthcare workers. Specifically, *saaac* called for the use of emergency powers to enable medical abortion via telehealth.

After more than a month of concerted activism and considering the declining numbers of COVID-19 cases in SA, *saaac* accepted that emergency powers would not be used for this purpose. Given the very wide powers of the State Coordinator and the enthusiasm of state and federal governments for telehealth, it is striking that emergency powers were not implemented to temporarily expand abortion access.

COVID-19 and Abortion Care

At the outset of the pandemic, international and national sexual and reproductive health experts quickly identified two key conditions as necessary to maximise access to safe abortion. The first was the need for governments and health authorities to recognise that abortion care was essential medicine (UN Population Fund 2020; International Campaign for Women's Right to Safe Abortion 2020; Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2020). The second was the availability of medical abortion by telehealth, which would reduce unnecessary patient exposure to COVID-19. On 27 March, the International Campaign for Women's Right to Safe Abortion (2020) requested the WHO to encourage all national ministers of health to set aside legal barriers to self-managed abortion 'thus allowing many women to remain at home'. In early June, the WHO (2020) updated its guidelines on the pandemic and recommended that 'individuals in the first trimester (up to 12 weeks pregnant) can self-administer mifepristone and misoprostol medication without direct supervision of a healthcare provider' (p. 3).

During COVID-19, national responses to abortion differed. In the United States, eight conservative states attempted to restrict abortion provision by designating abortion as 'non-essential' medical care (Donley, Chen and Borrero 2020). The pandemic also prompted innovations in the delivery of sexual and reproductive health including, where appropriate, the shift to telehealth delivery (Bateson et al. 2020). The UK and Irish governments acted in late March and early April 2020, respectively, adjusting regulations to temporarily allow patients to access medical abortion at home (Margolis 2020; Holland 2020). This was of particular significance for SA, as its law was nearly identical to the UK's *Abortion Act 1967*, including the prescribed hospital and two medical practitioner requirements.

In Australia, abortion was designated as essential healthcare, and we are not aware of any government, health department or public hospital categorising abortion as an elective procedure. Nonetheless, the pandemic posed challenges. In Australia, NGO Marie Stopes Australia (MSA) (renamed MSI Australia in 2022) is the leading private provider of abortion care and operates in all states except SA, where nearly all abortion care is provided through the public health system.² In response to COVID-19, MSA had to adjust services by 'evolv[ing] models of care' to manage significant workforce challenges (MSA 2021: 4). This led to the cancellation of surgical abortion lists, a reduction of the gestational upper limit at one Victorian clinic and the chartering of private planes to fly doctors to rural clinics (Davey 2020; Gramenz 2020). Carla, a sexual and reproductive health advocate, discussed the difficulties MSA initially faced accessing Personal Protective Equipment. As a private clinic, they were not eligible to access the National Medical Stockpile. One major provider of surgical face masks refused to supply to MSA because they were reserving their stocks for health professionals (Rushton 2020). Smaller private providers experienced similar challenges.

In early March 2020, the federal government introduced a new item covering telehealth consultations to the Medicare schedule of medical procedures for which a rebate can be claimed (Medicare is the federal universal healthcare insurance scheme). The federal Minister for Health stated:

Whole of population telehealth will allow people to access essential health services in their home and will support self-isolation and quarantine policies to reduce risk of exposure and spread of COVID-19. It will also help vulnerable doctors to continue to deliver services to their patients. (Hunt and Kidd 2020)

This was not an abortion-specific measure but enabled affordable GP prescription of medical abortion by telehealth. As the major provider of telehealth abortion in Australia, MSA reported significant increases in medical abortion by telehealth in the first six months of 2020, up 163% in metropolitan areas and 189% in remote areas, compared to the same period in 2019 (MSA 2021: 5). Carla understood that early in the pandemic, SA residents also made requests to access MSA telehealth services, which surprised staff in MSA's support centres. These requests could not be met due to the requirements of SA law.

COVID-19, Emergency Powers and Abortion in SA

During COVID-19, when all other GP services in SA were transferred from in-person to telehealth, patients receiving abortion care were still required to attend a prescribed hospital, including when seeking a medical abortion. COVID-19 led to the amplification of the effects of barriers to abortion access, in conjunction with the new risk of infection. *saaac* called on the state government to use its emergency powers to override the SA criminal law and enable telehealth delivery of medical abortion. Over six weeks of lobbying, *saaac*'s argument shifted from pandemic-driven problems of increased demand and compromised access to emphasising the unnecessary risk of exposure to COVID-19 infection experienced by abortion patients and healthcare providers.

saaac corresponded with the Attorney-General, the Minister for Health and the CPHO, and urged SA Health to prepare for the anticipated move to telehealth provision of medical abortion. Ten partner organisations from the legal, medical and women's health sectors called for the use of emergency powers to improve abortion access. *saaac* initially claimed that COVID-19 would likely increase demand for abortion care while compromising access (*saaac* 2020a). They drew from scholarship on the gendered consequences of emergencies and the increased vulnerability of women and girls to violence and coercion while stressing the pre-existing challenge in SA of limited access to abortion services for those in rural and remote areas (Davies et al. 2020; RANZCOG 2020; UN Development Programme 2010). In late March, *saaac* updated government ministers about the UK and Irish governments' changes to allow medical abortion via telehealth and New Zealand's decriminalisation of abortion (*saaac* 2020b, 2020c).

As parliament prepared to debate COVID-19-specific emergency powers in early April, Brigid recalled that *saaac* was pleased with what seemed like a straightforward remedy to the problem of the *Criminal Law Consolidation Act 1935* (SA) because authorities would 'have the power to just set aside certain ... pieces of law'. Brigid contacted the CPHO's office immediately prior to the passage of the *COVID-19 Emergency Response Act 2020* (SA) on 8 April. Her impression was that as soon as the legislation was passed, requirements around abortion provision would be modified. At this point, when it seemed that the criminal law was no longer of central importance, *saaac*'s lobbying focused almost exclusively on the Department of Health and the CPHO, and their correspondence addressed health rather than legal or governance claims. Two media services covered the call for the use of emergency powers (MacLennan 2020; Skujins 2020), the latter stating on 17 April that access to medical abortion via telehealth in SA was imminent. *saaac* was optimistic, having learned through 'informal networks' that SA Health was preparing to offer a medical abortion telehealth service (*saaac* 2020d).

By the end of April, there had been no adjustment in the regulations surrounding abortion care. In a letter to the Minister for Health (22 April), *saaac* pointedly noted that it had been 'waiting since [passage of the emergency powers legislation] for an announcement that these would be used to enable change in the ways that abortion can be provided, to meet the needs of women during the time of pandemic and social isolation' (*saaac* 2020d). The same day, *saaac* wrote to the CPHO, observing that delayed telehealth abortion meant patients and providers were prevented 'from being able to comply as best as possible with the guidance and expectation of your office and the government' (*saaac* 2020e). On 6 May 2020, *saaac* sent the CPHO and all parliamentarians a letter and briefing note on 'avoidable exposure to COVID-19 risk resulting from current SA abortion law', offering the conservative calculation that every week, the two doctor and prescribed hospital requirements led to over 200 avoidable exposures to COVID-19 risk. In their letter to the CPHO, they again urged her 'to provide formal advice on the substantive need for this action in advance of future outbreaks of infection, as a matter of public health priority in accordance with the *Emergency Management Act*' (*saaac* 2020f).

In late May, *saaac* received two letters that signalled the failure of their campaign. The CPHO wrote to *saaac* on 20 May, stating that 'the decision not to change the current legislation on abortion was influenced by the fact that there was no evidence that this core health service had been impacted by the COVID-19 pandemic'. The final sentence stated that alteration to the abortion law 'will be carefully considered and only be implemented outside the normal legislative process if there is a significant public health imperative' (Spurrier 2020). The notion of a 'decision' that had been 'influenced' and the use of future tense pointing to the possibility of change suggests a process of consideration that might be re-visited, but the reference to 'normal legislative process' implicitly echoed arguments, discussed below, made by groups that opposed the emergency powers campaign. The reference to the lack of impact on abortion (presumably access to services) and the absence of acknowledgement of the issue of exposure to the virus for patients and providers indicated that the anticipated increased need for abortion and the unnecessary risk of infection had not been considered, or perhaps were not given adequate weight to inform decision-making.

On 25 May, the Minister for Health wrote to *saaac* and gave more detail about the CPHO's process, noting the CPHO had 'reviewed month by month comparisons of terminations completed in SA, and has identified that there has been no change'

(Wade 2020). Unlike the CPHO's letter, the Minister spelled out the chain of decision-making, writing that the CPHO 'has not felt the need to make a recommendation to the State Coordinator' to change abortion provision and continued:

I understand that the State Coordinator has referred to the Chief Public Health Officer's advice in his letter to stakeholders on 7 May 2020, explaining that he has not formed an opinion that it is necessary to make a direction, under the major emergency declaration, that would vary the provision of health services relative to termination of pregnancy services in South Australia. (Wade 2020)

The reference to a 'letter to stakeholders' puzzled *saaac*. It had not received a letter from the State Coordinator, and the identity of these stakeholders was unclear.

Unbeknownst to *saaac*, other groups were closely following the potential use of emergency powers to modify abortion provision in SA and a handful of state, interstate and national anti-choice groups engaged in lobbying, albeit directed at a different target. From 25 March, the Australian Christian Lobby (ACL), a national conservative entity with state branches, repeatedly warned its followers and anti-choice groups nationwide about the alleged dangers of telehealth abortion (which it dubbed 'DIY abortion'). This was even though such care was legal and available in all other Australian jurisdictions. ACL relied heavily on the rhetoric of public health and risk, (falsely) claiming that the dangers of telehealth abortion would lead to 'more hospital admissions' at the moment when the pandemic made hospital emergency beds 'precious' (Francis 2020).

From early April, ACL focused closely on the possibility that emergency powers might be used in SA to facilitate access to telehealth abortion (Brohier 2020a). The day before the *COVID-19 Emergency Response Act 2020 (SA)* passed in the Legislative Council, ACL linked the bill to telehealth abortion, warning that 'the package of measures rushing through State Parliament this afternoon potentially enable the Chief Public Health Officer to use unprecedented new powers to allow this dangerous practice' (Brohier 2020b). Two days later, ACL's exhortations were taken up by Love Adelaide, a group formed in late 2019 to oppose the reform of SA's abortion law, asking followers to 'Keep women safe from high risk telehealth abortions'. The petition outlined an array of claims contrary to published scientific evidence about the safety of medical abortion while reiterating ACL's argument about the potential use of emergency powers, describing them as a 'blatant attempt to bypass our parliamentary system'. The petition called for 'all abortion laws [to be] treated as a conscience issue by both major parties' insisting 'no changes to abortion laws should be made unless all of the relevant medical information, research statistics and implications to women's health can be investigated, discussed and decided upon by our elected parliamentarians' (Love Adelaide 2020a).

Anti-choice groups directed followers to contact state politicians, the CPHO and the State Coordinator. After an article published in *InDaily* incorrectly stated 'the emergency laws would now allow medical abortions via telehealth' (Skujins 2020), Love Adelaide, joined by ACL and interstate groups such as Cherish Life (Queensland) and LifeChoice Australia (New South Wales), intensified lobbying but narrowed their focus, presenting the situation in SA as a matter of extreme urgency and encouraging opponents of abortion to directly contact the State Coordinator (Johnson 2020; Rodrigues 2020). The national *Catholic Weekly* claimed that the SA State Coordinator was 'under pressure to use his new powers' and repeated ACL's claim that SA's pandemic response 'was being hijacked ... using the COVID-19 emergency as a pretext' (Rodrigues 2020).

Despite *saaac*'s continuing campaign into May, there is evidence that the decision not to enable telehealth abortion had been made already. Two brief videos, uploaded by Love Adelaide on 26 April and ACL on 27 April, thanked supporters for 'putting the brakes on' the use of emergency powers for telehealth abortion. In the Love Adelaide video, Jodie Pickard sat in her well-appointed living room and thanked members and other 'pro-life groups' for the 'approximately 500 letters' which, together with the Change.org petition signed by 'nearly 2000', were 'hand delivered' to the State Coordinator. She thanked '100s more of you who emailed directly into SAPOL [South Australia Police]' (Brohier 2020c; Love Adelaide 2020b). It had not occurred to *saaac* to urge pro-choice supporters to write to the State Coordinator, the CPHO or elected officials, nor had *saaac* considered lobbying the State Coordinator. We suggest that this was likely because *saaac* viewed the campaign to use emergency powers as a response to a specific public health emergency rather than a matter of politics. *saaac*'s strategy thus relied on health arguments and medical evidence shared with those responsible for SA's public health response to COVID-19.

It seems evident that the CPHO and the State Coordinator were both engaged in decision-making about the provision of abortion services in response to *saaac*'s request to enable medical abortion via telehealth. As Sarah noted, the conventions of administrative law mean the CPHO enjoys the delegation of responsibilities on matters of healthcare provision, and usually, this would oblige the State Coordinator to act on the CPHO's advice. Under emergency powers, this convention may not be observed and there is the additional 'complication that that State Coordinator is in the meantime ... making a lot of laws themselves'. We can only speculate on the exact process of the decision-making—whether, as the CPHO writes, the decision

was hers or, as the Minister for Health and Wellbeing writes, and as anti-choice groups believed, the State Coordinator played a role.

The reason the CPHO gave for the decision, repeated by the Minister, did not respond to *saaac*'s argument that pregnant people accessing abortion were being required to risk exposure to COVID-19 for themselves and healthcare workers, a risk being avoided in every other possible circumstance. Further, the reason given was founded on unstated assumptions that the demand for abortion services in the early months of 2020 would be the same as the demand in previous, non-pandemic years. Showing that the number of abortions performed to date in 2020, month by month, matched those at the same time in previous years did not consider that demand may have risen but not been met in the early months of the pandemic.

Certainly, abortion-care providers interviewed for this research commented that their facilities were noticeably busier in the March and April period. Metropolitan GP Rosie, who referred patients to abortion services and who had close knowledge of the major metropolitan abortion services, remembered April 2020 as the clinic's 'busiest month in the last five years', while rural GP Maria concluded 'our numbers increased quite dramatically ... we went from seeing one a week to three a week for a couple of months'. Increased demand for abortion was predicted by several sources in the first half of 2020 (Bateson et al. 2020; International Campaign for Women's Right to Safe Abortion 2020). MSA reported increased demand for later gestation abortions during COVID-19, implying delayed decision-making and/or difficulty in accessing services (Marie Stopes Australia 2021: 4).

Discussion

The campaign offers an interesting case study of the possibility that emergency powers could be used to make sexual and reproductive healthcare less restricted, safer and more accessible. Ironically, contrary to the critical caution around the use of emergency powers, while the campaign sought the relaxation of criminal law restriction, this was to enable social isolation that is elsewhere cast as a suspiciously anti-democratic practice (Kotsko 2022). However, the social isolation enabled by telehealth abortion advances physical safety in relation to exposure to the virus and ameliorates the social and economic costs for those who otherwise must travel long distances to access abortion care.

The campaign was led by *saaac*, an experienced, well-connected and well-respected group, which brought the weight of more than four years of activism and decades of abortion research and abortion-care provision. *saaac* acted quickly, calling for measures that were backed up with medical and public health evidence and arguments based on the experience of abortion-care provision and the emerging global literature on abortion during the COVID-19 pandemic. Significant national and state-based community and professional bodies actively supported the campaign that followed requests by international bodies and the actions by governments with comparable legal frameworks, notably the UK. The campaign sought only to make available in SA what was available in every other Australian jurisdiction and to implement measures used in many other areas of healthcare to minimise exposure to COVID-19. It exerted democratic pressure on the deployment of emergency powers, and while this demand for action ultimately went unheeded, it showed that emergency powers could potentially be used in response to a community definition of need. Less apparent in the mainstream public sphere was the campaign in opposition to *saaac*'s call for the use of emergency powers. If the decision not to use emergency powers to make abortion safer and more accessible was an effect of democratic adjudication of competing interests, this was never clearly acknowledged nor made public.

The decision *not* to use emergency powers in relation to abortion provision may render it a case study of a close hold on the exercise of emergency powers by a structure headed by the State Coordinator. The legal and legislative parameters of the SA response to an emergency may assist in an explanation. Sarah identified the absence of any legislated human rights framework in SA translating into no statutory imperative through which authority to change the law regarding the provision of abortion services could be summoned. Across many jurisdictions, rights to reproductive autonomy, including the right to access safe abortion care, have been expressed as human rights. This was not an option in SA, which in 2020 remained one of only two Australian jurisdictions in the shadow of abortion's regulation by criminal law. As well as the absence of legislated human rights, the emergency powers framework gives no legal authority to respond to requests from the community, which arguably carry little political authority. While the *Emergency Act* refers to high-minded goals of building 'community resilience' and reducing 'community vulnerability', it contains no reference to public consultation or working with the community. These goals will presumably be achieved via top-down planning and management, implemented by those who are delegated authorities according to the *Emergency Act*, under the leadership of the State Coordinator.

Another explanation for the refusal to use emergency powers to enable medical abortion via telehealth in SA rests on legal-cultural reticence to change criminal law in the context of an emergency. Sarah described the fear among lawyers that emergency powers would be used to override criminal law. The context for this concern may be as much about the risk of

dismantling the rights that the criminal law confers on citizens as about the sacrosanct nature of criminal law. In fact, SA's criminal law was changed in response to the pandemic when, on 24 July, after the failure of *saaac*'s emergency powers campaign, the *COVID-19 Emergency Response (Further Measures) (No 2) Amendment Act 2020* (SA) came into effect and temporarily modified the *Criminal Law Consolidation Act 1935* (SA) to enable the lawful provision of pharmacy services by 'internet or other electronic communication'.

Emergency powers tend to enable surveillance and constraint of personal and social behaviour. They do not generally seek to relax existing legal restrictions. There are exceptions to this rule, including the legislation relating to pharmacists. Possibly, *saaac*'s call to suspend criminal law regarding abortion was unintelligible or incoherent to key decision-makers in terms of the discourse of emergency response.

The discursive framing of abortion as exceptional in relation to healthcare, as moral transgression and as outside dominant gender norms, cannot be avoided in the assessment of the failure of *saaac*'s campaign (Millar 2017). This discursive work has material and subjective effects on those seeking abortion and those who make decisions about abortion provision. Given the enabling of telehealth abortion in the UK by the Conservative Party-led government, where the campaign to decriminalise abortion was less advanced than it was in SA in 2020, we suggest there can be no universalising application of a theory of 'abortion stigma' to explain the decision not to use emergency powers to enable telehealth abortion (Millar 2020; Weatherby 2019). This directs attention back to the local.

In contrast to state and territory counterparts around Australia, the (then) SA Premier Steven Marshall's pandemic leadership rhetoric was distinct for the degree of emphasis placed on the crucial role of the State Coordinator and the CPHO. His 'low-key style' saw him explicitly defer to 'the experts' and implement their recommendations (Parkin 2020). While the Victorian, Queensland and West Australian premiers were the principal public faces of pandemic governance in those states, Marshall distanced himself from the detail of pandemic management. When the CPHO and State Coordinator were not addressing the public directly in their daily briefings, the Premier was reinforcing their directions. Compounding this distance from pandemic decision-making, Marshall's actions were, overall, supported by the Opposition leader Peter Malinauskas, who became Premier in 2022 (Parkin 2020). With parliamentary sitting times reduced and the media focused on managing a crisis, politicians' pre-pandemic appetite for discussing abortion almost vanished. The most visible public figures during the pandemic—the CPHO and the State Coordinator—showed little interest in publicly entering a debate about abortion which was in a phase of increased, if suspended, politicisation.

Perhaps the response to *saaac*'s campaign can be explained by the delegation of state power to unelected officials converging with the exceptionalised status of abortion. Emergency powers were delegated to unelected leaders whose primary responsibility was the protection of the community in crisis. Their non-party political status suggests the bipartisan, apolitical or impartial nature of those roles. The CPHO and State Coordinator may have resisted exercising their powers to effect changes that were the subject of debates in the parliament on the eve of the pandemic, perceiving them as primarily political, not healthcare, matters.

In contrast, Brigid recalled that as the *saaac* campaign stalled, a parliamentary staffer was blunt about the 'problem' they faced, emphasising to her that 'the Public Health Officer makes the recommendation, but the Police Commissioner makes the declaration'. As the final arbiter in this case, perhaps the political history of the State Coordinator, Police Commissioner Grant Stevens, is relevant in explaining the failure of *saaac*'s campaign. In August 2019, when the SA parliament was debating the decriminalisation of sex work, Stevens intervened in public debate and stated that SAPOL would not support decriminalisation unless police were given 'wider powers'. That is, in a debate like abortion, since both relate to the regulation of gender and sexual norms in criminal law, he had previously opposed relaxing law (Langenberg 2019).

We cannot establish whether the anti-abortion movement's petitioning of the State Coordinator was a successful measure because of the State Coordinator's (and the CPHO's) personal positions on the legal status of abortion. We have, however, demonstrated that the weight of international research and national opinion was behind the position tendered by *saaac* on behalf of abortion patients and abortion-care providers. We suggest that the State Coordinator and CPHO perceived a decision to suspend aspects of legal restriction to abortion access to be a political step too far. Seeking to keep the community onside while they imposed difficult pandemic conditions, the leaders of the emergency response refused to publicly engage with issues that might not be generally understood as central to pandemic management. Cast by the Marshall Government in the two principal pandemic roles, they maintained the existing obstacles to abortion access, despite the heightened risks they posed during the COVID-19 pandemic and a well-supported campaign for change. The opportunity to use emergency powers to advance democratic community-led decision-making was unfortunately missed.

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² In all other states except Victoria and the Australian Capital Territory, public health provision is not more than 10% of all abortions in the state, thus most people must fund their abortions. In Victoria it is not more than 20%.

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Interviews Conducted By the Authors and in Their Possession (*indicates pseudonym)

Brigid, SA, 2020

Carla*, Victoria, 2020

Maria*, SA, 2020

Rosie*, SA 2020

Sarah, SA, 2020

Tammy, SA, 2020