



**Review of termination of pregnancy
laws**

Consultation Paper

Queensland
Law Reform Commission

**Review of termination of pregnancy
laws**

Consultation Paper

WP No 76
December 2017

Postal address: PO Box 13312, George Street Post Shop, Qld 4003
Telephone: (07) 3247 4544
Facsimile: (07) 3247 9045
Email: lawreform.commission@justice.qld.gov.au
Website: [www.qlrc.qld.gov.au](http://www qlrc.qld.gov.au)

© State of Queensland (Queensland Law Reform Commission) 2017.

ISBN: 978-0-6481164-0-0

SUBMISSIONS

You are invited to make a written submission on the issues raised in this Consultation Paper. Submissions should be sent to:

The Secretary

Queensland Law Reform Commission

PO Box 13312

George Street Post Shop QLD 4003

Email: lawreform.commission@justice.qld.gov.au

Facsimile: (07) 3247 9045

Closing date: 13 February 2018

PRIVACY AND CONFIDENTIALITY

Any personal information you provide in a submission will be collected by the Queensland Law Reform Commission for the purposes of its review of Queensland's laws relating to the termination of pregnancy.

Unless you clearly indicate otherwise, the Commission may refer to or quote from your submission and refer to your name in future publications for this review. Further, future publications for this review will be published on the Commission's website.

Please indicate clearly if you do not want your submission, or any part of it, or your name to be referred to in a future publication for the review. Please note however that all submissions may be subject to disclosure under the *Right to Information Act 2009* (Qld), and access applications for submissions, including those for which confidentiality has been requested, will be determined in accordance with that Act.

COMMISSION MEMBERS

Chairperson: **The Hon Justice David Jackson**

Part-time members: **Ms Ruth O’Gorman
Dr Nigel Stobbs
Ms Penny White
The Hon Margaret Wilson QC**

SECRETARIAT

Director: **Mr David Groth**

Assistant Director: **Mrs Cathy Green**

Secretary: **Mrs Jenny Manthey**

Senior Legal Officers: **Ms Anita Galeazzi
Mrs Elise Ho
Ms Paula Rogers**

Administrative Officer: **Ms Kahren Giles**

Glossary

AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
conscientious objection	A refusal by a medical or other health practitioner to provide, or participate in, a lawful treatment or procedure because it conflicts with that practitioner's personal beliefs, values or moral concerns.
gestation	This refers to the number of weeks progress during the pregnancy and the 'age' of the fetus. It is usually calculated from the first day of the woman's last menstrual period so that the average pregnancy reaches full term at 40 weeks. (In biological terms, it may be counted from the time of fertilisation, to give a full term gestation of 38 weeks, but this time is usually not known with certainty.)
gestational limit	In many jurisdictions, legislation restricts terminations of pregnancy after a certain number of weeks gestation. Gestational limits on the performance of terminations of pregnancy also sometimes operate as a matter of clinical practice.
health practitioner	Person registered under the <i>Health Practitioner Regulation National Law (Queensland)</i> to practise in a health profession in Queensland, including medical practitioners, nurses, midwives, pharmacists and psychologists.
MBA	Medical Board of Australia
medical practitioner	Person registered under the <i>Health Practitioner Regulation National Law (Queensland)</i> to practise in the medical profession. A medical practitioner is a type of 'health practitioner'.
medical termination	The use of pharmaceutical drugs to induce a termination of pregnancy, commonly by the combined use of the drugs mifepristone and misoprostol (which are available together as 'MS-2 Step').
the Parliamentary Committee	<p>Except where otherwise specified, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, which considered the:</p> <ul style="list-style-type: none"> • Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and aspects of the laws governing termination of pregnancy in Queensland (the 'first Bill' and 'Inquiry'); and • Health (Abortion Law Reform) Amendment Bill 2016 (the 'second Bill').

Parliamentary Committee Report No 24 (2016)	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland (2016)</i>
Parliamentary Committee Report No 33a (2017)	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, <i>Health (Abortion Law Reform) Amendment Bill 2016 (2017)</i>
perform a termination of pregnancy	Unless the context requires otherwise, 'perform a termination of pregnancy' means perform a surgical termination or provide a medical termination.
Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014)	Queensland Government, <i>Maternity and Neonatal Clinical Guideline: Perinatal Care at the Threshold of Viability (2014)</i> < https://www.health.qld.gov.au/qcg/publications#neonatal >
Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013)	Queensland Government, <i>Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy (2013)</i> < https://www.health.qld.gov.au/qcg/publications#maternity >
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
safe access zone	A defined area around premises where termination of pregnancy services are provided, in which certain behaviour is prohibited.
surgical termination	Procedure by which the contents of a woman's uterus are surgically removed to terminate a pregnancy, commonly by means of dilation and curettage.
termination of pregnancy (or termination)	Deliberately induced miscarriage (in contrast with a spontaneous miscarriage) by medical or surgical means. Termination is also commonly referred to as 'abortion', including in the context of international human rights.
viability	The time at which a fetus, if born prematurely, is said to be capable of existing independently.
VLRC Report (2008)	Victorian Law Reform Commission, <i>Law of Abortion</i> , Report No 15 (2008)
WHO	World Health Organization

* Except where otherwise indicated, references to legislation in this Paper are references to Queensland legislation.

Table of Contents

GLOSSARY	i
CONSULTATION QUESTIONS	v
INTRODUCTION	1
Background to the review.....	1
Terms of reference.....	2
Structure of this paper.....	3
Making a submission.....	3
PART A: BACKGROUND	5
THE LEGAL FRAMEWORK.....	5
Queensland.....	5
Other jurisdictions	10
THE CLINICAL FRAMEWORK IN QUEENSLAND.....	12
Methods for terminating a pregnancy	15
THE INCIDENCE OF TERMINATIONS	18
Queensland.....	19
ACCESSIBILITY AND AVAILABILITY	23
Surgical terminations.....	23
Medical terminations	24
COMMUNITY ATTITUDES	27
PART B: ISSUES	29
INTRODUCTION	29
WHO SHOULD BE PERMITTED TO PERFORM OR ASSIST IN PERFORMING TERMINATIONS?	31
Medical practitioners	32
Other health practitioners.....	33
A woman causing her own termination	34
Consultation questions.....	35
GESTATIONAL LIMITS AND GROUNDS	36
Should the legislation impose gestational limits or grounds?	36
Gestational limits.....	40
Grounds.....	43
Consultation questions.....	48
CONSULTATION BY THE MEDICAL PRACTITIONER	50
Queensland.....	50
Should the legislation require consultation with other practitioners or referral to a committee?.....	52
Consultation questions.....	56
CONSCIENTIOUS OBJECTION.....	57
Guidelines about conscientious objection.....	58
Legislating for conscientious objection to termination of pregnancy.....	58
Consultation questions.....	64
COUNSELLING.....	65
Consultation question.....	67

PROTECTION OF WOMEN AND SERVICE PROVIDERS AND SAFE ACCESS ZONES	68
Defining the area of a safe access zone	72
Prohibited behaviour	73
Constitutional considerations	76
Consultation questions	77
COLLECTION OF DATA ABOUT TERMINATIONS OF PREGNANCY	79
Consultation question	80
APPENDIX A.....	81
TERMS OF REFERENCE	81
APPENDIX B.....	85
COMPARATIVE TABLE OF TERMINATION OF PREGNANCY LAWS IN OTHER JURISDICTIONS	85
APPENDIX C.....	89
DEVELOPMENT AND MORAL STATUS OF THE FETUS	89
Stages of fetal development.....	89
Views about the moral status of the fetus	91
APPENDIX D.....	95
INTERNATIONAL HUMAN RIGHTS AND ABORTION	95
Introduction.....	95
Rights of women	96
Recognition of the fetus	110
Freedoms of conscience and expression	120
Overview tables.....	126

Consultation questions

The Commission seeks your views on the questions below about the proposed new legislation on the termination of pregnancy and related issues:

Who should be permitted to perform or assist in performing terminations*

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

Gestational limits and grounds

Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?

Q-4 If yes to Q-3, what should the gestational limit or limits be? For example:

- (a) an early gestational limit, related to the first trimester of pregnancy;
- (b) a later gestational limit, related to viability;
- (c) another gestational limit or limits?

Q-5 Should there be a specific ground or grounds for a lawful termination of pregnancy?

Q-6 If yes to Q-5, what should the specific ground or grounds be? For example:

- (a) a single ground to the effect that termination is appropriate in all the circumstances, having regard to:
 - (i) all relevant medical circumstances;
 - (ii) the woman's current and future physical, psychological and social circumstances; and
 - (iii) professional standards and guidelines;
- (b) one or more of the following grounds:
 - (i) that it is necessary to preserve the life or the physical or mental health of the woman;
 - (ii) that it is necessary or appropriate having regard to the woman's social or economic circumstances;
 - (iii) that the pregnancy is the result of rape or another coerced or unlawful act;

(iv) that there is a risk of serious or fatal fetal abnormality?

Q-7 If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

Consultation by the medical practitioner

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

If yes to Q-8:

Q-9 What should the requirement be? For example:

- (a) consultation by the medical practitioner who is to perform the termination with:
 - (i) another medical practitioner; or
 - (ii) a specialist obstetrician or gynaecologist; or
 - (iii) a health practitioner whose specialty is relevant to the circumstances of the case; or
- (b) referral to a multi-disciplinary committee?

Q-10 When should the requirement apply? For example:

- (a) for all terminations, except in an emergency;
- (b) for terminations to be performed after a relevant gestational limit or on specific grounds?

Conscientious objection*

Q-11 Should there be provision for conscientious objection?

Q-12 If yes to Q-11:

- (a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?
- (b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?

Counselling

Q-13 Should there be any requirements in relation to offering counselling for the woman?

Protection of women and service providers and safe access zones*

Q-14 Should it be unlawful to harass, intimidate or obstruct:

- (a) a woman who is considering, or who has undergone, a termination of pregnancy; or**
- (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?**

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

If yes to Q-15:

Q-16 Should the provision:

- (a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or**
- (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?**

Q-17 What behaviours should be prohibited in a safe access zone?

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Collection of data about terminations of pregnancy

Q-20 Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

* See 'conscientious objection', 'perform a termination of pregnancy' and 'safe access zone' in the Glossary to this Paper

Introduction

Background to the review

[1] In Queensland, the Criminal Code prohibits unlawfully attempting to procure an abortion (a ‘termination of pregnancy’).¹ The relevant offences are found in sections 224, 225 and 226.

[2] On 10 May 2016, Mr Robert Pyne MP, the then Member for Cairns, introduced a Private Member’s Bill — the Abortion Law Reform (Woman’s Right to Choose) Amendment Bill 2016 (the ‘first Bill’) — into Parliament. The first Bill proposed to remove the crime of abortion from Queensland law by repealing sections 224, 225 and 226 of the Criminal Code.

[3] The first Bill was referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the ‘Parliamentary Committee’) for detailed consideration.² Concurrent with its consideration of the Bill, the Parliamentary Committee was also asked to conduct a broader inquiry into options for the reform of Queensland’s termination of pregnancy laws (the ‘Inquiry’).³ The Parliamentary Committee’s report on the first Bill and Inquiry was tabled on 26 August 2016.⁴

[4] On 17 August 2016, Mr Pyne MP, introduced a second Private Member’s Bill — the Health (Abortion Law Reform) Amendment Bill 2016 (the ‘second Bill’) — into Parliament. The Bill, which sought to amend the *Health Act 1937* to ‘improve clarity for health professionals and patients in the area of medical termination of pregnancy’,⁵ was referred to the Parliamentary Committee for examination.⁶ The Committee’s report on the second Bill was tabled on 17 February 2017.⁷

1 See n 11 below as to ‘procure’.

2 Queensland, *Parliamentary Debates*, Legislative Assembly, 10 May 2016, 1526–8 (R Pyne).

3 Parliamentary Committee Report No 24 (2016) [1.2].

4 Parliamentary Committee Report No 24 (2016). The Report and other information relating to the Committee’s consideration of the first Bill and Inquiry (including transcripts of evidence and submissions) are available at <<http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/AbortionLR-WRC-AB2016>>.

5 Queensland, *Parliamentary Debates*, Legislative Assembly, 17 August 2016, 2892 (R Pyne). The second Bill proposed amendments to the *Health Act 1937* (Qld) in relation to matters such as who may perform a termination of pregnancy, the requirements for terminations after 24 weeks gestation, the circumstances in which a person may refuse to perform a termination, and protections for patients attending facilities at which terminations are performed.

6 Queensland, *Parliamentary Debates*, Legislative Assembly, 17 August 2016, 2892–3 (R Pyne).

7 Parliamentary Committee Report No 33a (2107). The Report and other information relating to the Committee’s consideration of the second Bill (including transcripts of evidence and submissions) are available at <<http://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/18-HealthAbortion>>.

[5] As part of its consultation process for the first and second Bills and Inquiry, the Parliamentary Committee held numerous public hearings and received more than 2600 submissions.⁸

[6] On 28 February 2017, both Bills were withdrawn from Parliament on the motion of Mr Pyne MP.⁹ On the same day, the Government announced that it would refer the current laws in relation to the termination of pregnancy to the Queensland Law Reform Commission.¹⁰

Terms of reference

[7] On 19 June 2017, the Commission received terms of reference from the then Attorney-General and Minister for Justice and Minister for Training and Skills to conduct a review and investigation into modernising Queensland's laws relating to the termination of pregnancy.

[8] Specifically, the terms of reference ask the Commission to recommend how Queensland should amend its laws relating to the termination of pregnancy to:

1. Remove terminations of pregnancy that are performed by a duly registered medical practitioner(s) from the Criminal Code sections 224 (Attempts to procure abortion), 225 (The like by women with child), and 226 (Supplying drugs or instruments to procure abortion).
2. Provide clarity in the law in relation to terminations of pregnancy in Queensland.

[9] The Commission is required to provide its final report by 30 June 2018.

[10] The terms of reference ask the Commission to prepare draft legislation based on its recommendations.

[11] Among other things, the Commission is to have regard to the stakeholder consultation that occurred during the Parliamentary Committee's consideration of the first and second Bills, and consult with any group or individual to the extent it considers necessary.

⁸ Parliamentary Committee Report No 24 (2016) [1.3]; Parliamentary Committee Report No 33a (2017) [1.2]. In its report on the first Bill and Inquiry, the Committee noted that many submitters 'addressed only whether or not they supported the [Bill], rather than the broader terms of reference': Parliamentary Committee Report No 24 (2016) [1.3.1].

⁹ Queensland, *Parliamentary Debates*, Legislative Assembly, 28 February 2017, 282 (R Pyne).

¹⁰ Premier and Minister for the Arts, the Hon Anastacia Palaszcuk MP, Deputy Premier, Minister for Transport and Minister for Infrastructure and Planning, the Hon Jackie Trad MP, and Attorney-General and Minister for Justice and Minister for Training and Skills, the Hon Yvette D'Ath MP, 'Queensland Law Reform Commission to examine termination of pregnancy laws' (Ministerial Media Statement, 28 February 2017) <<http://statements.qld.gov.au/Statement/2017/2/28/queensland-law-reform-commission-to-examine-termination-of-pregnancy-laws>>.

The media statement announced that the Government had been advised that the first and second Bills would be withdrawn, and that the Commission's recommendations would be 'the basis for legislation the Government will introduce to Parliament ... [i]n the next term of Government'.

Structure of this paper

[12] Part A of this paper contains explanatory material. Part B discusses the key issues raised by the terms of reference.

[13] The questions posed in the paper are set out in full on pages v–vii above. You are encouraged to read the relevant sections of the paper which provide a background to the issues that the questions address. Responses to the questions will inform the development of the Commission’s recommendations for proposed new legislation in relation to the termination of pregnancy.

Making a submission

[14] The Commission invites written submissions in response to the questions in this paper by **13 February 2018**. Information about how to make a submission is set out at the beginning of the paper.

Part A: Background

The legal framework

Queensland

Abortion

[15] Presently, the Criminal Code contains three offences relevant to the termination of pregnancy — sections 224, 225 and 226:¹¹

224 Attempts to procure abortion

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.

225 The like by women with child

Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.

226 Supplying drugs or instruments to procure abortion

Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment for 3 years.

[16] The Criminal Code does not define 'unlawful' for the purpose of these provisions. However, it contains a limited defence for surgical operations and medical treatment in section 282. The scope of what is 'unlawful' under sections 224 to 226, and the application of the defence in section 282, have also been the subject of judicial interpretation.

11

These provisions are based on an English statute, *Offences Against the Person Act 1861*, 24 & 25 Vict, c 100, ss 58, 59. They have not been amended since their enactment in Queensland in 1899, except to remove the words 'with hard labour': *Corrective Services (Consequential Amendments) Act 1988* (Qld) s 5, sch 2.

The term 'procure' is not defined in the Criminal Code (Qld). In *R v F; Ex parte Attorney-General* [2004] 1 Qd R 162, [3], [28], [42], the Queensland Court of Appeal observed that 'procure' is a plain English word and not a term of art; its meaning may change depending on the context in which it is used. In that case, Williams JA, at [34], also referred to *Attorney-General's Reference (No 1 of 1975)* [1975] 2 All ER 648, in which Lord Widgery CJ (Bristow and May JJ agreeing) stated that '[t]o procure means to procure by endeavour. You procure a thing by setting out to see that it happens and taking the appropriate steps to produce that happening'. See also *R v Hawke* [2016] QCA 144, [58]. See further *R v Mills* [1963] 1 All ER 202 as to the meaning of the term 'procure', in the context of the phrase 'unlawfully supply or procure', in English legislation equivalent to s 226 of the Criminal Code (Qld).

[17] Unlike many other jurisdictions, the current grounds on which a termination of pregnancy may lawfully be carried out in Queensland do not include any gestational limit (although such limits may operate as a matter of clinical practice).¹²

Defence for surgical operations and medical treatment

[18] Section 282 provides a defence for surgical operations and medical treatment.¹³ It applies to medical practitioners (but not, for example, to a woman seeking a termination of pregnancy).

[19] Section 282 provides:

282 Surgical operations and medical treatment

- (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—
- (a) a person or an unborn child for the patient's benefit; or
 - (b) a person or an unborn child to preserve the mother's life;
- if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.
- (2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.
- (3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.
- (4) In this section—

health professional see the *Hospital and Health Boards Act 2011*, schedule 2.

medical treatment, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

patient means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

¹² See 'gestational limit' in the Glossary and the discussions at [56]–[57], [61] and [120] ff below.

¹³ Section 282 was amended in 2009 to apply to 'medical treatment' as well as to 'surgical operations': *Criminal Code (Medical Treatment) Act 2009* (Qld) s 3. Prior to that amendment, the section applied to a surgical operation performed upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life; 'patient' was not defined: see *Criminal Code* (Qld) s 282 (as at 4 September 2009). Following the 2009 amendment, the section was amended to change the definition of 'health professional': *Health and Hospitals Network Act 2011* (Qld) s 332, sch 1; *Health and Hospitals Network and Other Legislation Amendment Act 2012* (Qld) s 54, sch.

surgical operation, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child.

Judicial interpretation

[20] In considering the scope and operation of laws akin to sections 224 and 282 of the Criminal Code, Australian courts have developed a doctrine, based on necessity and proportionality, under which termination of pregnancy by a medical practitioner, with the consent of the woman, is 'lawful'.

[21] In the leading case of *R v Davidson*¹⁴ (also known as the 'Menhennitt ruling'), the Supreme Court of Victoria held that, for the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done was:¹⁵

- necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and
- in the circumstances not out of proportion to the danger to be averted.

[22] The Menhennitt ruling was followed in New South Wales, in *R v Wald*.¹⁶ In that case, the District Court of New South Wales held that, when assessing the risk to the woman's health, consideration could be given to the woman's 'economic, social or medical' circumstances.¹⁷

[23] The Menhennitt ruling was also considered in Queensland in *R v Bayliss and Cullen*.¹⁸ In that case, the District Court of Queensland held that the same principles applied in Queensland.¹⁹ However, the Court did not go so far as *R v Wald* to refer to the economic or social circumstances of the woman. Judge McGuire emphasised that the doctrine applies 'in exceptional cases' and does not justify 'abortion on demand'.²⁰

[24] *R v Bayliss and Cullen* was followed by the Supreme Court of Queensland in *Veivers v Connolly*.²¹ Justice de Jersey found that the defence in section 282 allows a termination of pregnancy that is 'necessary to preserve the woman from a serious danger to her mental health which would otherwise be involved should the pregnancy continue'. Further, he held that a 'serious danger' to mental health could

¹⁴ [1969] VR 667 (Menhennitt J). That case concerned the application of former s 65 of the *Crimes Act 1958* (Vic) in substantially similar terms to s 224 of the Criminal Code (Qld).

¹⁵ *Ibid* 672.

¹⁶ (1971) 3 DCR (NSW) 25 (Levine DCJ). The test in *R v Davidson* and *R v Wald* was applied by the New South Wales Court of Appeal in *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

¹⁷ *R v Wald* (1971) 3 DCR (NSW) 25, 29.

¹⁸ (1986) 9 Qld Lawyer Reps 8, 45 (McGuire DCJ). In that case, the two accused were both doctors charged under s 224 of the Criminal Code (Qld). The accused relied on s 282 as a defence.

¹⁹ *Ibid*.

²⁰ *Ibid*.

²¹ [1995] 2 Qd R 326, 329 (de Jersey J).

include 'a danger which would not fully afflict [the woman] in a practical sense until after the birth'.²²

Killing an unborn child or a child

[25] Section 313 of the Criminal Code creates two offences.

[26] Section 313(1) provides:²³

313 Killing unborn child

- (1) Any person who, when a female is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, the person would be deemed to have unlawfully killed the child, is guilty of a crime, and is liable to imprisonment for life.

[27] Section 313(2) was inserted into the Criminal Code in 1997.²⁴ It provides:

- (2) Any person who unlawfully assaults a female pregnant with a child and destroys the life of, or does grievous bodily harm to, or transmits a serious disease to, the child before its birth, commits a crime.

[28] The maximum penalty for both offences is life imprisonment.

[29] Section 292 deals with when a child becomes 'a person capable of being killed' for the purposes of the Criminal Code.²⁵ It provides:

292 When a child becomes a human being

A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel-string is severed or not.

Consent to medical treatment

[30] At common law, medical treatment (such as a termination of pregnancy) ordinarily requires the patient's consent.²⁶ The provision of treatment in the absence of valid consent may give rise to liability in tort or criminal proceedings.

²² Ibid. This point was approved in *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47, 60 (Kirby ACJ).

²³ Section 313(1) has not been substantially amended since its enactment in 1899, except to remove the words 'with hard labour' and to change the word 'woman' to 'female': *Corrective Services (Consequential Amendments) Act 1988* (Qld) s 5, sch 2; *Criminal Law Amendment Act 1997* (Qld) s 47(1).

²⁴ The *Criminal Law Amendment Act 1997* (Qld) s 47(2) enacted s 313(2) of the Criminal Code (Qld) as a 'response to a recent case in which a young pregnant women was kicked in the abdomen': Queensland, *Parliamentary Debates*, Legislative Assembly, 4 December 1996, 4872 (DE Beanland, Attorney-General and Minister for Justice). See also Report of the Criminal Code Advisory Working Group to the Attorney-General (July 1996) 47–52.

²⁵ Section 294 of the Criminal Code (Qld) also provides that a person is deemed to have killed a child if the child dies as a consequence of an act done or omitted to be done by the person before or during its birth.

²⁶ Prior to the performance of a medical procedure, a health practitioner must obtain a patient's consent to undergo the proposed treatment. Generally, consent can be implied, oral or in writing: *Rogers v Whitaker* (1992) 175 CLR 479, 489; *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102–103; LexisNexis, *Halsbury's Laws of Australia* (at 10 February 2016) 280 Medicine, 'Consent' [280–3000].

[31] For an adult's consent to be valid, the adult must be competent to give the consent (that is, have the capacity to understand in broad terms the nature of the procedure to be performed)²⁷ and the consent must be voluntary²⁸ and specific to the proposed treatment. A health practitioner must provide a patient with sufficient information to enable the patient to make an 'informed decision' about whether to give consent for the treatment.²⁹

[32] In Queensland, there is a statutory framework for the appointment of a substitute decision-maker for an adult who does not have the capacity to make their own decisions (including giving consent to medical treatment).³⁰ If a woman does not have the capacity to consent to a termination, the Queensland Civil and Administrative Tribunal may give valid consent for the termination.³¹ The Supreme Court of Queensland, exercising its *parens patriae* jurisdiction, may also authorise a termination of pregnancy for a woman who does not have the capacity to give consent.³²

[33] In some circumstances, a child or young person under 18 years can give consent to medical treatment if they have the capacity to do so. Specifically, a child is 'capable of giving informed consent when [the child] "achieves a sufficient understanding and intelligence to enable [the child] to understand fully what is proposed"'.³³ This is also described as having 'sufficient intelligence and maturity to understand the nature and consequences' of the proposed medical treatment.³⁴

[34] A child who does not have the capacity to consent is unable to validly consent to medical treatment.³⁵ In some circumstances, the parent of a child who does not have the capacity to consent may give consent to medical treatment on that child's behalf. However, consent to some types of medical treatment, including the

²⁷ *Chatterton v Gerson* [1981] QB 432, 443; *Rogers v Whitaker* (1992) 175 CLR 479, 489.

²⁸ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113–14 (Lord Donaldson MR).

²⁹ *Rogers v Whitaker* (1992) 175 CLR 479, 489; LexisNexis, *Halsbury's Laws of Australia* (at 10 February 2016) 280 Medicine, 'Consent' [280–3000], [208–3005]. This information may include the material risks and possible complications associated with the treatment, the likelihood of a risk or complication eventuating and alternative options for treatment: *Rogers v Whitaker* (1992) 175 CLR 479, 489, citing *F v R* (1983) 33 SASR 189, 192–3.

³⁰ See generally *Guardianship and Administration Act 2000* (Qld) ch 5; *Powers of Attorney Act 1998* (Qld) ch 3-4. An adult is presumed to have the capacity to consent to their own medical treatment (unless and until that presumption is rebutted): *Guardianship and Administration Act 2000* (Qld) sch 1, pt 1, s 1; *Powers of Attorney Act 1998* (Qld) sch 1, pt 1, s 1.

³¹ *Guardianship and Administration Act 2000* (Qld) s 68. Termination of pregnancy is defined as 'special health care' under that Act, and is not a matter for which a substitute decision-maker for the woman can give consent: s 65, sch 2, s 7(c). The Tribunal may give its consent for a termination of pregnancy for an adult woman 'only if the Tribunal is satisfied the termination is necessary to preserve the adult from serious danger to her life or physical or mental health': s 71.

³² *Guardianship and Administration Act 2000* (Qld) s 240. The *parens patriae* jurisdiction is based on the need to protect those who lack the capacity to protect themselves.

³³ *Secretary, Department of Health and Community Services v JWB and SMB ('Marion's Case')* (1992) 175 CLR 218, 237, citing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 189. See also LexisNexis, *Halsbury's Laws of Australia* (at 22 June 2015) 205 Family Law, 'Medical Treatment of Children' [205–2130].

³⁴ Parliamentary Committee Report No 24 (2016) [2.6.1.2], [11.1]; LexisNexis, *Halsbury's Laws of Australia* (at 22 June 2015) 205 Family Law, 'Medical Treatment of Children' [205–2130]. A child who reaches this standard is commonly referred to as 'Gillick-competent'.

³⁵ *Marion's Case* (1992) 175 CLR 218, 249–59.

termination of a child's pregnancy, is outside the scope of parental decision-making authority. In those circumstances, the Supreme Court, by an order made in its *parens patriae* jurisdiction, may authorise the termination.³⁶ In making such an order, it must act in the best interests of the pregnant child.³⁷

Other jurisdictions

[35] Historically, the criminal laws in each of the Australian States and Territories treated the unlawful termination of pregnancy as a crime punishable by imprisonment. This reflected the position in England under the *Offences Against the Person Act 1861*.³⁸

[36] Beginning in the 1950s, there has been an overall trend, especially in industrialised countries, toward the liberalisation of such laws and the recognition of termination as a health matter.³⁹

[37] There remain some jurisdictions in which termination of pregnancy is either prohibited entirely or permitted only to save the woman's life.⁴⁰ However, many jurisdictions provide that termination is lawful in a wider range of circumstances.⁴¹ In the least restrictive jurisdictions, termination of pregnancy is no longer the subject of specific criminal laws and is instead regulated as a health matter.⁴²

[38] In Australia, most jurisdictions have amended their laws to decriminalise termination of pregnancy in particular circumstances. The least restrictive approach is taken in the Australian Capital Territory, which provides that termination is lawful if carried out by a medical practitioner in an approved medical facility.⁴³ Victoria has adopted a similar approach, but imposes additional requirements for termination of a pregnancy of more than 24 weeks gestation.⁴⁴ Tasmania, the Northern Territory and Western Australia have adopted various combinations of legal grounds,

³⁶ *State of Queensland v B* [2008] QCS 231, [17], [23]; *Central Queensland Hospital and Health Service v Q* [2016] QSC 89, [20], [30]–[33].

³⁷ *Marion's Case* (1992) 175 CLR 218, 270, 280; *State of Queensland v B* [2008] QCS 231, [3], [17]; *Central Queensland Hospital and Health Service v Q* [2016] QSC 89, [18]; LexisNexis, *Halsbury's Laws of Australia* (at 22 June 2015) 205 Family Law, 'Medical Treatment of Children' [205–2140]. The Supreme Court's *parens patriae* jurisdiction does not extend to the unborn child: *K v T* [1983] 1 Qd R 396, 400–401; *State of Queensland v B* [2008] QCS 231, [4].

³⁸ *Offences Against the Person Act 1861*, 24 & 25 Vict, c 100, ss 58, 59.

³⁹ See, eg, L. Finer and J. B. Fine, 'Abortion Law Around the World: Progress and Pushback' (2013) 103(4) *American Journal of Public Health* 585.

⁴⁰ See, eg, Ireland, where termination is permitted only if there is a risk to the woman's life: *Protection of Life During Pregnancy Act 2013* (Irl) ss 7–9. According to some research, as at 2011, 'roughly 39% of the world's population lives in countries with highly restrictive laws governing abortion': Finer and Fine, above n 39, 585.

⁴¹ See generally WHO, *Global Abortion Policies Database* (2017) <<http://srhr.org/abortion-policies/>>.

⁴² See, eg, Canada, where the criminal law was overturned (but where there remain practical barriers to access): see n 129 and [127] below.

⁴³ *Health Act 1993* (ACT) pt 6 div 6.1.

⁴⁴ *Crimes Act 1958* (Vic) s 65 and *Abortion Law Reform Act 2008* (Vic) ss 4–7, introduced following a review by the Victorian Law Reform Commission: see, in particular, proposed 'Model B' in VLRC Report (2008) ch 6.

gestational limits and procedural requirements to define the circumstances in which termination performed by a qualified person is lawful.⁴⁵

[39] In contrast, New South Wales, like Queensland, continues to treat termination of pregnancy as a criminal offence with limited exceptions.⁴⁶

[40] A comparative table of other jurisdictions is provided in Appendix B, and reference to other jurisdictions is made where relevant in Part B of this paper.

⁴⁵ Criminal Code (Tas) ss 178D, 178E, *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; Criminal Code (NT) s 208A, *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7–10; Criminal Code (WA) s 199, *Health (Miscellaneous Provisions) Act 1911* (WA) s 334.

⁴⁶ *Crimes Act 1900* (NSW) pt 3 div 12. Cf *Criminal Law Consolidation Act 1935* (SA) pt 3 div 17, which retains criminal offences with legislative exceptions where termination is performed on particular grounds and where particular procedural requirements are met.

The clinical framework in Queensland

[41] The provision of lawful termination of pregnancy services in Queensland is governed by a comprehensive legal and regulatory framework, the key features of which are discussed below.

[42] Under the *Health Practitioner Regulation National Law (Queensland)* a person practising in a health profession must be a 'registered health practitioner'.⁴⁷ Relevantly for the provision of termination of pregnancy services, registered health practitioners include medical practitioners, nurses and nurse practitioners, midwives, pharmacists and Aboriginal and Torres Strait Islander health practitioners.⁴⁸ There are different types of registration to reflect different levels of training and expertise and to recognise specialists.⁴⁹

[43] Registered health practitioners must comply with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards), policies and guidelines.⁵⁰ Non-compliance may result in disciplinary action, for example the suspension of, or imposition of conditions on, a practitioner's registration.⁵¹

⁴⁷ *Health Practitioner Regulation National Law (Queensland)* pt 7. A person must register with the National Board relevant to their profession. For example, medical practitioners must be registered with the Medical Board of Australia, nurses and midwives with the Nursing and Midwifery Board of Australia, and pharmacists with the Pharmacy Board of Australia: pt 5. The *Health Practitioner Regulation National Law (Queensland)* applies by virtue of the *Health Practitioner Regulation National Law Act 2009* (Qld) s 4.

⁴⁸ *Health Practitioner Regulation National Law (Queensland)* ss 5 (definitions of 'health practitioner', 'health profession', 'registered health practitioner', 'health services' and 'health service provider'), 95.

⁴⁹ For example, a medical practitioner may be registered as a specialist in obstetrics and gynaecology: *Health Practitioner Regulation National Law (Queensland)* pt 7 div 2; Medical Board of Australia, *List of specialties, fields of specialty practice and related specialist titles* (25 July 2013). Specialist registration is available to medical practitioners who have been assessed, by an Australian Medical Council accredited specialist college, as being eligible for fellowship: see Medical Board of Australia, *Specialist Registration* (24 August 2015) <www.medicalboard.gov.au/Registration/Types/Specialist-Registration.aspx>. RANZCOG trains and accredits medical practitioners in the specialties of obstetrics and gynaecology, and Fellowship of the College ('FRANZCOG') is the qualification awarded to a medical practitioner who has completed the FRANZCOG training program to become a specialist obstetrician/gynaecologist: see RANZCOG, *Specialist Training* (2017) <www.ranzcog.edu.au/Training/Specialist-Training>.

⁵⁰ See *Health Practitioner Regulation National Law (Queensland)* pt 5 div 3, pt 6; and, eg, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014); Nursing and Midwifery Board of Australia, *Code of Professional Conduct for Nurses in Australia* (2006); Pharmacy Board of Australia, *Code of Conduct* (March 2014).

⁵¹ *Health Practitioner Regulation National Law (Queensland)* pt 8. See, eg, *Medical Board of Queensland v Freeman* [2010] QCA 93.

[44] Health practitioners are also required to undergo a process of 'credentialing'⁵² and the definition of their scope of clinical practice⁵³ as part of a wider organisational quality and risk management system.⁵⁴

[45] The *Health (Drugs and Poisons) Regulation 1996* regulates which health practitioners can dispense, prescribe, supply and administer medications used for the termination of pregnancy.⁵⁵ All prescription medicines must be included on the Australian Register of Therapeutic Goods and are subject to a classification system that controls their supply, among other things.⁵⁶

[46] Depending on the circumstances, termination of pregnancy services may be provided in public or licensed private health facilities,⁵⁷ on an inpatient or an outpatient basis. In some instances, termination of pregnancy services may also be provided through a general practitioner or a telehealth service.⁵⁸

52 'Credentialing' means 'the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments': Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 70 (definition of 'credentialing'). See also Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 51 (definition of 'credentialing').

53 'Scope of clinical practice' means 'the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation': Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 75 (definition of 'scope of clinical practice'). See also Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 55 (definition of 'scope of clinical practice').

54 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2nd ed, November 2017) 10, Actions 1.23 and 1.24. Queensland Health has also developed a series of documents regarding the credentialing and defining of the scope of clinical practice of health professionals in hospitals and health services: see, eg, Queensland Health, Department of Health Guideline QH-GDL-390-1-1:2017, *Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists: A Best Practice Guideline* (23 October 2017) 58. See also *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1; Chief Health Officer, *Credentials and Clinical Privileges Standard (Version 4)* (1 September 2016) <<https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards>>, in relation to licensed private health facilities.

55 See [55]–[56] below in relation to medications commonly used for terminations of pregnancy. See also [88] and [112] below in relation to which health practitioners can dispense, prescribe, administer or supply medications used for medical terminations of pregnancy.

56 See generally Therapeutic Goods Administration, *Medicines and TGA Classifications* <www.tga.gov.au/medicines-and-tga-classifications>; and see *Therapeutic Goods Act 1989* (Cth) s 52D; *Poisons Standard October 2017* (Cth) (The Standard for the Uniform Scheduling of Medicines and Poisons). The *Poisons Standard* is given effect in Queensland by the *Health (Drugs and Poisons) Regulation 1996* (Qld).

57 As to licensed private health facilities, see generally the *Private Health Facilities Act 1999* (Qld). A 'private health facility' is defined as a private hospital or a day hospital: s 8; see also ss 7, 9–10 as to the meaning of the terms 'health service', 'private hospital' and 'day hospital'.

58 Access to termination of pregnancy through a general practitioner or a telehealth service generally relates to a medical termination of pregnancy. As to telehealth services see, for example, the Tabbot Foundation, which is a privately operated service that offers women seeking a termination of pregnancy a telephone consultation with a medical practitioner and (if applicable) a clinical psychologist. Where a termination of pregnancy is approved, the service will provide the medications for a medical termination of pregnancy by mail, and provide support by a registered nurse and an on-call doctor: <<https://www.tabbot.com.au/>>.

[47] Private health facilities are required to be licensed under the *Private Health Facilities Act 1999*.⁵⁹ That Act also empowers the Chief Health Officer to make standards ‘for the protection of the health and wellbeing of patients receiving health services at [licensed] private health facilities’.⁶⁰ Relevantly, the Speciality Health Services Standard requires that the provision of ‘speciality health services’, which includes termination of pregnancy services, be in accordance with the Clinical Services Capability Framework for Public and Licensed Private Health Facilities (the ‘CSCF’) and the CSCF Companion Manual,⁶¹ and ‘appropriate college / professional body guidelines’.⁶²

[48] The CSCF ‘is applicable to both public [hospitals] and licensed private health facilities’.⁶³ It sets out ‘the minimum support services, staffing, safety standards and other requirements’ that apply to those facilities in Queensland,⁶⁴ including for the delivery of termination of pregnancy services. It categorises clinical services into six service levels, which reflect increasing levels of patient complexity.⁶⁵

[49] Generally, termination of pregnancy services are to be provided at the lowest service level that can safely facilitate the care.⁶⁶ A licensed private health facility that provides termination of pregnancy services must be classified as at least a level three service and satisfy specific requirements relating to the assessment of patients, the provision of care and performance of procedures by appropriate staff, and access to pre-termination and post-termination counselling.⁶⁷

⁵⁹ *Private Health Facilities Act 1999* (Qld) pt 6.

⁶⁰ *Private Health Facilities Act 1999* (Qld) s 12; *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1.

⁶¹ *Private Health Facilities (Standards) Notice 2016* (Qld) s 3 sch 1; Chief Health Officer, *Specialty Health Services Standard (Version 5)* (1 September 2016) <<https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards>>. In relation to the CSCF and CSCF Companion Manual, see generally Queensland Health, *Clinical services capability framework* (22 May 2017) <<https://www.health.qld.gov.au/system-governance/licences/private-health/cscf>>. The CSCF Companion Manual is also referred to as the ‘Private Health Facilities’ Companion Document’.

⁶² Namely, Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013); Queensland Health, Clinical Excellence Division, ‘Guide to Informed Decision-making in Health Care’ (2nd ed, 2017); Australian Day Surgery Nurses Association, ‘Best Practice Guidelines for Ambulatory Surgery and Procedures’ (2013); Australian and New Zealand College of Anaesthetists, ‘Recommendations for the Post-Anaesthesia Recovery Room’ (PS04, 2006); Australian and New Zealand College of Anaesthetists, ‘Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures’ (PS09, 2014); Australian and New Zealand College of Anaesthetists, ‘Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations’ (PS55, 2012); RANZCOG, ‘Termination of Pregnancy’ (C-Gyn 17, July 2016); RANZCOG, ‘Late Termination of Pregnancy’ (C-Gyn 17A, May 2016); and RANZCOG, ‘The use of Mifepristone for Medical Termination of Pregnancy’ (C-Gyn 21, February 2016): Information provided by Queensland Health, 13 December 2017.

⁶³ Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [1], [6.1]; see also [47] above.

⁶⁴ Queensland Health, *Clinical services capability framework* (22 May 2017) <<https://www.health.qld.gov.au/system-governance/licences/private-health/cscf>>; see also Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) 3.

⁶⁵ Department of Health, *Clinical services capability framework: Fundamentals of the framework* (Version 3.2, 2015) [7].

⁶⁶ Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015) 2.

⁶⁷ Department of Health, *Clinical services capability framework companion manual: Termination of pregnancy services* (Version 4.3).

[50] Since 2014, the CSCF has included a requirement that '[w]here termination of a live fetus from 22 weeks gestation or more is clinically indicated, the woman is to be referred to a Level six service with ability to provide this service'.⁶⁸ Currently, terminations of pregnancy at 22 weeks gestation or more are permitted to be performed at one major hospital in northern Queensland and three major hospitals in south-east Queensland.⁶⁹

[51] Queensland Health has published a clinical guideline for health practitioners about therapeutic termination of pregnancy.⁷⁰ Among other things, the guideline sets out a suggested procedure for health practitioners to undertake a clinical assessment of a woman requesting a termination of pregnancy. The suggested procedure involves either two medical specialists or, in complex cases, a case review with at least one other relevant health professional.⁷¹

[52] Where approval is granted, a medical or surgical termination of pregnancy may be performed.⁷² The clinical guideline also recommends the provision of post-termination care, which may include further clinical testing, referrals for counselling and contraceptive advice.⁷³

[53] There are also other clinical guidelines in Queensland that address perinatal care for births at low gestational ages.⁷⁴

Methods for terminating a pregnancy

[54] A termination of pregnancy may be performed as a medical termination or a surgical termination. The choice of procedure depends on the gestation of the

68 Information provided by Queensland Health, 15 December 2017; Department of Health, *Clinical services capability framework: Maternity services* (Version 3.2, 2015) 2. The CSCF also states that '[c]onsultation with a maternal fetal medicine unit should occur for women where fetal anomaly has been identified'. See also Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [6.1].

69 Information provided by Queensland Health, 15 December 2017.

70 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013); see also [47] above. The term 'therapeutic termination of pregnancy', as used in the clinical guideline, 'refers to the deliberate ending of a pregnancy where necessary to preserve the woman from a serious danger to her life or physical or mental health' (notes omitted): *ibid* [1], citing *R v Davidson* [1969] VR 667.

The clinical guideline includes a number of general statements regarding clinical practice and care. Among other things, it states that clinical material offered in the guideline 'does not replace or remove clinical judgment or the professional care and duty necessary for each specific patient case', and that clinical care delivered in accordance with the guideline 'should be provided within the context of locally available resources and expertise'. Further, the clinical guideline 'assumes that individual clinicians are responsible to ... provide care within scope of practice, meet all legislative requirements and maintain standards of professional conduct': *ibid* 2.

71 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3.2]; see also [187] below. The guideline states that the purpose of a process for determining approval 'is to establish and document a considered process for the woman and to provide reassurance and support to the health practitioner'. The processes outlined by the guideline are described as 'suggested approval mechanisms'. The guideline suggests that a facility should determine its own appropriate approval structure and that, although it is not a legal requirement, it is 'strongly recommended' that a treating obstetrician should comply with that approval structure.

72 See [55]–[58] and [59]–[61] below.

73 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) 13–14, [9].

74 See [143] below.

pregnancy, the risk of complications and other relevant circumstances. It may also be influenced by the availability of a procedure in a particular location.⁷⁵

Medical termination

[55] A ‘medical termination’ refers to the use of pharmaceutical drugs to induce a termination of pregnancy.⁷⁶ Currently, mifepristone and misoprostol used in combination is the preferred drug regime; however misoprostol alone is also common and, in some circumstances, other drugs may be used.⁷⁷

[56] In Australia, mifepristone and misoprostol are available together as ‘MS-2 Step’, which is ‘indicated ... for the medical termination of a developing intrauterine pregnancy, up to 63 days [nine weeks] of gestation’.⁷⁸ Mifepristone is taken first, followed between 24 and 48 hours later by misoprostol. Together, these medications have the effect of causing expulsion of the products of conception.⁷⁹

[57] In Queensland, the clinical guideline states that determination of the most appropriate setting for a medical termination of pregnancy depends upon local service capabilities and the woman’s circumstances, including her proximity to emergency care. The clinical guideline also states that, generally, a woman may be cared for on an outpatient basis where her pregnancy is less than nine weeks gestation, and she has appropriate support and access to medical care.⁸⁰

⁷⁵ Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) 3, [6], [6.1].

⁷⁶ Ibid [7]. See also RANZCOG, ‘The use of Mifepristone for Medical Termination of Pregnancy’ (C-Gyn 21, February 2016) Rec 1, [2]; M Permezel, S Walker and K Kyprianou, *Beischer & McKay’s Obstetrics, Gynaecology and the Newborn* (Elsevier Australia, 4th ed, 2015) 463–4.

⁷⁷ Ibid; WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) 42. For example, gemeprost may be used for a termination in the second trimester of pregnancy: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [7].

⁷⁸ Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Public Summary* (20 October 2016); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product Information* (28 March 2017) 7. It is recommended that the duration of the pregnancy be confirmed by ultrasound (which may also be used to exclude ectopic pregnancy).

MS-2 Step is also included in the Pharmaceutical Benefits Scheme: Australian Government, Department of Health, *The Pharmaceutical Benefits Scheme: Mifepristone & Misoprostol* <<http://www.pbs.gov.au/medicine/item/10211K>>.

Mifepristone is separately registered and indicated for use in the termination of pregnancy beyond the first trimester: Australian Register of Therapeutic Goods, ARTG ID 175671, *Mifepristone—Public Summary* (9 June 2015); Australian Register of Therapeutic Goods, ARTG ID 175671, *Mifepristone—Product Information* (28 March 2017) 4.

⁷⁹ Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product Information* (28 March 2017) 3–4; Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Consumer Medicine Information* (28 March 2017) 2; Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) App B; RANZCOG, ‘The use of Mifepristone for Medical Termination of Pregnancy’ (C-Gyn 21, February 2016) [2], [3.1]; WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) 43; Permezel, Walker and Kyprianou, above n 76, 464. It is generally recommended that the misoprostol is taken 24 to 48 hours after the mifepristone for pregnancies less than nine weeks gestation, and 36 to 48 hours after for pregnancies of nine to 12 weeks gestation.

⁸⁰ Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [7.2]. RANZCOG is also supportive of outpatient care for a pregnancy of less than nine weeks gestation provided there is access to suitable emergency care: RANZCOG, ‘The use of Mifepristone for Medical Termination of Pregnancy’ (C-Gyn 21, February 2016) Rec 3, [3.3].

[58] In some circumstances, a pregnancy may be terminated by inducing labour, using medication.⁸¹ This process may involve the administration of mifepristone and misoprostol.⁸²

Surgical termination

[59] A 'surgical termination' refers to a procedure during which the contents of a woman's uterus are surgically removed to terminate a pregnancy.⁸³

[60] Usually, this involves dilation of the woman's cervix. Procedures used to surgically remove the contents of the woman's uterus include vacuum aspiration and curettage.⁸⁴

[61] In Queensland, the clinical guideline states that surgical curettage is generally suitable for termination of pregnancy up to 14 weeks gestation. In pregnancies of between 14 and 16 weeks gestation, the clinical guideline recommends the procedure be performed only by an experienced medical practitioner.⁸⁵

Appendix B of the clinical guideline includes some suggested protocols for the use of mifepristone and misoprostol at a gestation of greater than nine weeks and into the second trimester of pregnancy. See also WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 43–5. RANZCOG states that where the gestation exceeds nine weeks, the administration of medication and passing of the products of conception should occur in an appropriate facility: RANZCOG, 'The use of Mifepristone for Medical Termination of Pregnancy' (C-Gyn 21, February 2016) (February 2016) Rec 4, [3.4].

81 In some instances, the induction of labour may be preceded by administration of a chemical to stop the fetus' heart: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [6.1]; Permezel, Walker and Kyrianiou, above n 76, 82.

82 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) App B; Permezel, Walker and Kyrianiou, above n 76, 82. See generally Parliamentary Committee Report No 24 (2016) [7.2.3].

83 See generally Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [8]; WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 40–42; Permezel, Walker and Kyrianiou, above n 76, 464.

84 Ibid.

85 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [8].

The incidence of terminations

[62] There is no formal national monitoring of the number of terminations of pregnancy in Australia, and incomplete data for Queensland.⁸⁶

[63] It is estimated that half of all pregnancies in Australia are unplanned, and that half of those are terminated. It is also estimated that between one quarter and one third of Australian women will experience a termination of pregnancy.⁸⁷

[64] Estimated national figures show that the number of terminations in Australia in 2003 was about 84 000, with the highest number among women aged between 20 and 24 years, and the lowest among girls aged younger than 15 years.⁸⁸

[65] According to the United Nations Department of Economic and Social Affairs, the rate of terminations in Australia in 2010 was 14.2 per 1000 women aged 15 to 44 years. An indicative comparison with the rates in other countries is provided below.⁸⁹

⁸⁶ Parliamentary Committee Report No 24 (2016) [7.4.1.1]. South Australia, Western Australia and the Northern Territory are the only Australian jurisdictions in which data collection is required: see [274]–[277] below. Available data show that the rate of terminations per 1000 women aged 15 to 44 years increased in South Australia in the 1970s and 1990s to reach a peak of 17.9 in 1999, but has since steadily declined to 13.8 in 2014; and has declined in Western Australia from 19.7 in 1999 to 16.4 in 2012: see respectively Pregnancy Outcome (Statistics) Unit, SA Health, *Pregnancy Outcome in South Australia 2014* (2016) 51 and Department of Health (WA), 'Induced Abortions in Western Australia 2010–2012' (Statistical Series No 96, July 2013) 8. The initial increase in South Australia is attributed 'mainly to the shift from the clandestine sector and to better reporting' of terminations: F Yusuf and S Siedlecky, 'Legal abortion in South Australia: a review of the first 30 years' (2002) 42(1) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 15, 16.

⁸⁷ Children By Choice, *Australian Abortion Statistics* (19 September 2017) <<https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>>.

⁸⁸ See N Grayson, J Hargreaves and EA Sullivan, 'Use of routinely collected national data sets for reporting on induced abortion in Australia' (Perinatal Statistical Series No 17, Australian Institute of Health and Welfare, December 2005) 34.

⁸⁹ United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (2013) <<https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml>>. The scope and availability of official statistics vary between countries, making comparisons difficult. It has been observed, however, that there is a general trend among industrialised countries of declining rates of termination: see, eg, G Sedgh et al, 'Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends' (2016) 388 *The Lancet* 258. Available data in Canada, for example, show that, whilst there was an initial increase in the rate of terminations following decriminalisation in 1988 (for example, from 11.6 in 1988 to 14.7 in 1991 per 1000 women aged 15 to 44 years), the number of terminations has remained fairly steady and has been decreasing (for example, from 108 844 in 2011 to 100 104 in 2015): see Statistics Canada, *Selected Therapeutic Abortions Statistics, 1970–1991*, Cat No 82-550 (1994) 13; Statistics Canada, *Induced Abortion Statistics 2005*, Cat No 82-223-X (2008) 7, 11; Canadian Institute for Health Information, *Induced Abortions Reported in Canada in 2015* (2017) 5. See also, eg, TC Jatlaoui et al, *Abortion Surveillance—United States, 2014*, Centers for Disease Control and Prevention (24 November 2017) <https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm?s_cid=ss6624a1_w>.

Australia	New Zealand	England Scotland Wales	Ireland	Denmark	Norway	Sweden	Iceland	France	Germany	Canada
14.2	18.2	14.2	4.5	15.2	16.2	20.8	14.5	17.4	6.1	13.7

Table 1: Termination rates, selected countries⁹⁰

Queensland

[66] It has been estimated that between 10 000 and 14 000 terminations are performed each year in Queensland, with most performed in the first trimester of pregnancy.⁹¹

[67] Data from the Queensland Hospital Admitted Patient Data Collection indicates that a total of 10 421 terminations of pregnancy were performed in Queensland public hospitals and licensed private health facilities in 2016, with the highest number among women aged 20 to 29 years and the lowest among those aged 40 years or older and 19 years or younger. However, this excludes terminations performed in an outpatient setting, including medical terminations carried out by general practitioners.⁹²

[68] The total number of terminations identified from the Queensland Hospital Admitted Patient Data Collection has declined overall since 2011:⁹³

2011	2012	2013	2014	2015	2016
11 694	11 906	12 020	11 285	10 814	10 421

Table 2: Total admitted patient episodes for termination of pregnancy services in public hospitals and licensed private health facilities

⁹⁰ United Nations Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013* (2013) <<https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.shtml>>. Rates are per 1000 women aged 15 to 44 years. The rates given are for 2010, with the exception of France and Canada, which are given for 2009. The highest known rate was in the Russian Federation (37.4) and the lowest in Mexico (<0.05).

⁹¹ Parliamentary Committee Report No 24 (2016) [7.4.1.2]; Children By Choice, *Australian Abortion Statistics* (19 September 2017) <<https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics>>.

In 2003, an estimated 14 000 Queensland woman underwent a termination of pregnancy: Grayson, Hargreaves and Sullivan, above n 88, 33. It was estimated that 11.5% of those women had the procedure outside their state of residence.

⁹² Information provided by Queensland Health, 13 December 2017. This relates to data for admitted patient episodes, in both public hospitals and licensed private health facilities in Queensland, that are coded at the time of the patient's 'separation' as involving termination of pregnancy. All public hospitals and licensed private health facilities are required to submit data to the Department of Health about patients 'separated' (meaning discharged, died, transferred or statistically separated) from those hospitals. The data is collated and maintained by the Department of Health as the Queensland Hospital Admitted Patient Data Collection. The figures for 2016 are preliminary and subject to change.

⁹³ Ibid.

[69] Based on Medicare data, it appears that the number of surgical procedures that include terminations of pregnancy has decreased in Queensland, consistently with the trend in other Australian jurisdictions.⁹⁴ On the other hand, it has been suggested that the number of medical terminations has likely increased following the inclusion of the drugs mifepristone and misoprostol on the Australian Register of Therapeutic Goods in 2012.⁹⁵

Licensed private health facilities

[70] Most termination of pregnancy services in Queensland are provided in the private sector. An average of 11 002 admitted patient episodes for care for termination services occur each year in licensed private health facilities, with 9 929 such episodes in 2016.⁹⁶ This excludes public hospital procedures and terminations performed in an outpatient setting including medical terminations carried out by general practitioners.

2011	2012	2013	2014	2015	2016
11 410	11 599	11 723	10 967	10 387	9 929

Table 3: Admitted patient episodes for termination of pregnancy services in licensed private health facilities⁹⁷

[71] Most of the 9 929 terminations performed in 2016 in licensed private health facilities were among women aged 20–29 years, with the fewest among those aged 40 years or older and 19 years or younger.⁹⁸

⁹⁴ For example, the total number of services recorded in Queensland for Medicare items 35639 and 35640 (uterus, curettage of), 35643 (evacuation of the contents of the gravid uterus by curettage or suction curettage) and 16525 (management of second trimester labour) was 17 508 in 2002–03 and 12 552 in 2016–17: see Department of Human Services, *Medicare Item Reports*, Medicare Australia Statistics (24 November 2017) <http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp>. Difficulties have been identified in using Medicare data to estimate the incidence of terminations in Queensland, including that the items are not specific to termination of pregnancy and may cover other procedures: see Grayson, Hargreaves and Sullivan, above n 88, 20–22, 27. See also Parliamentary Committee Report No 24 (2016) [7.5.1].

⁹⁵ See Parliamentary Committee Report No 24 (2016) [7.4.1.2]. Mifepristone was available in Australia since 2006 through the Therapeutic Goods Administration Authorised Prescriber Scheme, and was added to the Australian Register of Therapeutic Goods in 2012: see Department of Health, Therapeutic Goods Administration, *Registration of medicines for the medical termination of early pregnancy* (30 August 2012) <<https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>>. See further [45], [56] nn 78 and 79 above.

⁹⁶ Information provided by Queensland Health, 13 December 2017, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland perinatal data collection, for admitted patient episodes in licensed private health facilities between 2011 and 2016. See further n 92 above. See also Parliamentary Committee Report No 24 (2016) [7.4.2] relating to data between 2005 and 2011.

⁹⁷ Information provided by Queensland Health, 13 December 2017.

⁹⁸ *Ibid.* This is consistent with previous years. The 2016 figures are preliminary and subject to change:

≤19	20–24	25–29	30–34	35–39	≥40	Total
952	2569	2580	1930	1303	595	9 929

Public hospitals

[72] Queensland public hospitals provide limited termination services. Most terminations performed in public hospitals are carried out on the basis of fetal abnormality or maternal illness or complications.⁹⁹

[73] In 2016, there were 492 terminations performed in the public hospital system,¹⁰⁰ a significantly lower number than were performed in licensed private health facilities.

2011	2012	2013	2014	2015	2016
284	307	297	318	427	492

Table 4: Admitted patient episodes for termination of pregnancy services in public hospitals¹⁰¹

[74] Most of the 492 terminations performed in 2016 in public hospitals were among women aged 25–34 years, with the fewest among women aged 19 years or younger.¹⁰²

Later gestation terminations

[75] Late terminations of pregnancy are comparatively rare.

[76] Most terminations of pregnancy performed in public hospitals and licensed private health facilities occur before 20 weeks gestation. Of the 10 421 terminations performed in 2016 in Queensland public hospitals and licensed private health facilities, only 140 occurred at 20 weeks gestation or more.¹⁰³

⁹⁹ Parliamentary Committee Report No 24 (2016) [7.4.1.3], [7.4.2], [7.5].

¹⁰⁰ Information provided by Queensland Health, 13 December 2017, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland perinatal data collection, for admitted patient episodes in public hospitals between 2011 and 2016. See further n 92 above. See also Evidence to the Parliamentary Committee, 12 July 2016, 10 (Dr J Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health) in relation to 2015 data.

¹⁰¹ Information provided by Queensland Health, 13 December 2017.

¹⁰² Ibid. This is consistent with previous years. The 2016 figures are preliminary and subject to change:

≤19	20–24	25–29	30–34	35–39	≥40	Total
19	89	113	137	93	41	492

¹⁰³ Information provided by Queensland Health, 13 December 2017, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland perinatal data collection: see further n 92 above. Of the 140 terminations performed at 20 weeks gestation or more in 2016, 76 occurred at 22 weeks gestation or more: Information provided by Queensland Health, 21 December 2017.

	2011	2012	2013	2014	2015	2016
≤ 19 weeks	11 580	11 786	11 890	11 144	10 682	10 281
≥ 20 weeks	114	120	130	141	132	140
Total	11 694	11 906	12 020	11 285	10 814	10 421

Table 5: Admitted patient episodes for termination of pregnancy services in public hospitals and licensed private health facilities, by gestation¹⁰⁴

[77] The Queensland perinatal data collection records perinatal deaths of at least 20 weeks gestation or 400 grams in weight. The most recent data show that, in 2015, there were 136 such deaths identified as a termination of pregnancy.¹⁰⁵ Although the reported number of such terminations has increased, it continues to account for only about 1.26% of all terminations performed in Queensland.¹⁰⁶

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
3	21	66	81	86	91	99	104	115	136	136

Table 6: Perinatal deaths identified as terminations of pregnancy (at least 20 weeks or 400 g)¹⁰⁷

[78] As explained above, in Queensland, terminations at 22 weeks gestation or more are currently permitted to be performed only at particular hospitals.¹⁰⁸ There are fewer terminations at more than 20 weeks gestation performed in licensed private health facilities than in the public sector.¹⁰⁹

¹⁰⁴ Ibid.

¹⁰⁵ The Queensland perinatal data collection is derived from information collected from public hospitals, private hospitals and homebirth practitioners. A 'perinatal death' is a stillbirth (of at least 20 weeks gestation or 400 g birth weight) or a neonatal death (of a live born infant within the first 28 days of life). See Queensland Department of Health, *Perinatal Statistics: Queensland 2015* (December 2016) 9, 12–14, Table 10.13; *Public Health Act 2005* (Qld) ch 6 pt 1.

¹⁰⁶ Based on figures of 10 387 terminations performed in licensed private health facilities and 427 performed in public hospitals for 2015: see tables 3 and 4 at [70] and [73] above.

¹⁰⁷ See Parliamentary Committee Report No 24 (2016) [7.5.2]; Table 10.13 in the Queensland Health Perinatal Statistics Annual Reports for 2009–2015 at Queensland Health, *Perinatal reports and information* <<https://www.health.qld.gov.au/hsu/perinatal>>.

¹⁰⁸ See [50] above.

¹⁰⁹ In 2016, of the 140 terminations performed at 20 weeks gestation or more, 31 were performed in licensed private health facilities and 109 were performed in public hospitals: Information provided by Queensland Health, 21 December 2017, relating to data from the Queensland Hospital Admitted Patient Data Collection, and linked with the Queensland perinatal data collection: see further n 92 above. See also [85] below.

Accessibility and availability

[79] The accessibility and availability of termination of pregnancy services vary depending on where a woman is located, her financial resources and the gestation of her pregnancy.

[80] One recent study observed that ‘women who are socially, geographically and economically disadvantaged, have limited choice and access to abortion’.¹¹⁰

[81] Women in rural, regional and remote areas may have to travel long distances to access termination services and face additional financial costs (for example, the cost of travel and accommodation).¹¹¹

Surgical terminations

[82] As mentioned above, most terminations in Queensland are performed in licensed private health facilities.¹¹²

[83] There are currently nine private clinics that perform surgical terminations. The majority are located in the south-east corner (Brisbane, the Gold Coast and Sunshine Coast). There is a clinic in Rockhampton and another in Townsville.¹¹³ Women must pay for these services upfront.

[84] Children by Choice reported that, for Medicare card holders, the cost of a surgical termination up to 11–12 weeks gestation could range from approximately \$350 to \$580 in Brisbane, Gold Coast and Sunshine Coast clinics, and approximately \$715 to \$755 in Rockhampton and Townsville.¹¹⁴ The cost for a termination increases after 11–12 weeks gestation of pregnancy. It can be as much as \$650 to \$1410 at 14–15 weeks gestation and \$1500 to \$3065 at 16–19 weeks gestation.¹¹⁵

[85] Most private clinics perform surgical terminations to 14 or 15 weeks gestation. Only a few clinics, all of which are located in the south-east corner, offer

110 M 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 of Public Health* 309, 313.

111 See, eg, C Nickson, A Smith and J Shelley, ‘Travel undertaken by women accessing private Victorian pregnancy termination services’ (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329; F Doran and J Hornibrook, ‘Barriers around access to abortion experienced by women in New South Wales, Australia’ (2016) *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* (online).

112 See [70] above.

113 This information has been compiled from Children by Choice, *Queensland abortion providers* (6 December 2017) <<https://www.childrenbychoice.org.au/25-for-women/abortion/23-clinics-qld>>. In its submission to the Parliamentary Committee, Children by Choice stated that this includes all private clinics, but only some general practitioners: Submission 794 to the Parliamentary Committee on the first Bill and Inquiry. These clinics also provide medical terminations, discussed at [86] ff below.

114 Children by Choice, *How much will an abortion cost?* (27 April 2017) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>. The cost is higher for non-Medicare card holders. The cost is higher in Rockhampton and Townsville due to a shortage of locally based, qualified providers, with doctors required to be flown in from Brisbane or interstate: Parliamentary Committee Report No 24 (2016) [12.3].

115 Parliamentary Committee Report 24 (2016) [12.6.4].

termination of pregnancy services after this time.¹¹⁶ As noted above, terminations at 22 or more weeks gestation are currently permitted to be performed only at particular hospitals.¹¹⁷

Medical terminations

[86] There are a number of clinics offering medical terminations to nine weeks gestation of pregnancy in various locations, including Brisbane, the Gold Coast and Tweed Heads, the Sunshine Coast, Rockhampton, Townsville, Cairns and Cooktown.¹¹⁸ Some providers also offer telehealth services.¹¹⁹

[87] The cost for medical termination of pregnancy services varies. It is approximately \$400 to \$600 upfront for Medicare card holders in Brisbane, Gold Coast and Sunshine Coast clinics and approximately \$790 upfront for clinics in Rockhampton and Townsville.¹²⁰

[88] The medication that is commonly used, MS-2 Step,¹²¹ can be prescribed only by medical practitioners who are registered as certified prescribers with MS Health Pty Ltd (a not-for-profit pharmaceutical company).¹²² To become a certified prescriber, a general practitioner must complete an online training module. An obstetrician or gynaecologist may register to become a certified prescriber by

116 Parliamentary Committee Report 24 (2016) [12.6.4]. Women seeking to terminate a pregnancy in a private clinic after this time may travel to Victoria, where clinics are able to provide terminations up to 24 weeks. See, eg, Evidence to the Parliamentary Committee, 2 August 2016, 15 (Mr A Apostolellis, Chief Executive Officer, Marie Stopes International); Nickson, Smith and Shelley, above n 111, 329.

117 See [50] above. See also [187]–[190] and n 249 below in relation to requirements for medical practitioners to consult other practitioners or refer to a committee.

118 See Children by Choice, *Queensland abortion providers* (6 December 2017) <<https://www.childrenbychoice.org.au/25-for-women/abortion/23-clinics-qld>>.

119 Whilst the medications for termination of pregnancy may be provided by mail following a phone consultation, a woman is still required to have an ultrasound and any other necessary tests (such as a blood test). A woman must be within one hour of a hospital when they take the medication, in case she needs emergency care. See further n 58 above; Marie Stopes Australia, *Medical abortion over the phone (tele-abortion)* <<https://www.mariestopes.org.au/abortion/tele-abortion/>>.

120 There may be a \$60–\$90 rebate to claim through Medicare depending on the clinic. See Children by Choice, 'How much will an abortion cost?' (27 April 2017) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>; Parliamentary Committee Report No 24 (2016) [12.6.4].

121 See [56] above.

122 MS Health Pty Ltd is the sponsor of the MS-2 Step composite pack: *Therapeutic Goods Act 1989* (Cth) s 3 (definition of 'sponsor'); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Public summary* (20 October 2016); Australian Register of Therapeutic Goods, ARTG ID 210574, *MS-2 Step composite pack—Product information* (28 March 2017) 7.

MS-2 Step is classified as a 'restricted drug': *Health (Drugs and Poisons) Regulation 1996* (Qld) s 5(2), app 9 (definition of 'restricted drug'); *Poisons Standard October 2017* (Cth) sch 4 entries for 'mifepristone' and 'misoprostol'. See also Queensland Health, *List of Approved Medicines* (1 December 2017), "Mifepristone and Misoprostol "MS-2 Step"; Australian Government, *The Pharmaceutical Benefits Scheme: Mifepristone and Misoprostol* <<http://www.pbs.gov.au/medicine/item/10211K#>>.

providing evidence of their specialist qualification.¹²³ A pharmacist must register with MS Health Pty Ltd to become a certified dispenser.¹²⁴

[89] The cost for a medical termination through a general practitioner is approximately \$350 to \$580 upfront, plus the cost of the medication (between \$12 and \$50, depending on whether the person has a Health Care Card).¹²⁵

[90] In Queensland, there are currently 212 certified prescribers of MS-2 Step, of whom 118 are general practitioners.¹²⁶ There are 647 certified dispensers. In 2016, medication used for medical terminations (such as MS-2 Step and the mifepristone single pack) was dispensed over 3600 times.¹²⁷

[91] Whilst the provision of medical termination services by general practitioners has the potential to improve access to terminations, it appears this potential is not yet fully realised for a number of practical reasons.¹²⁸

[92] A recent study assessing the impact of the 2008 law reform in Victoria concluded that, whilst it had increased clarity and safety for doctors who perform terminations, significant practical barriers remained in relation to the accessibility and availability of termination of pregnancy services.¹²⁹ In particular, it noted the lack of

123 As they are specialists in this area, obstetricians and gynaecologists are not required to complete the online training, although they may opt to do so: Information provided by Marie Stopes International and MS Health Pty Ltd, 22 November 2017.

124 Ibid.

125 Children by Choice, 'How much will an abortion cost?' (27 April 2017) <<https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>>. Medicare card holders may be eligible for a partial rebate.

126 In addition, 80 are obstetricians and gynaecologists, four are sexual health physicians and 11 are other specialists: Information provided by Marie Stopes International and MS Health Pty Ltd, 22 November 2017.

127 Ibid. Data is not collected in relation to the number of women who access a medical termination of pregnancy in an outpatient setting. Whilst data on the number of times that certain medications are dispensed gives some indication of the incidence of medical terminations, it does not provide an accurate number (for example, because one pharmacy group in Queensland supplies mifepristone and misoprostol to health professionals in other States): Parliamentary Committee Report No 24 (2016) [7.5.3]. See also [55] above.

128 One study identified a number of practical reasons for the low rate of certification by general practitioners, including inadequate referral pathways in case of complications and lack of support. It was also noted that, particularly in rural areas, there are practical difficulties such as organising ultrasounds in a timely manner and finding pharmacists who are certified dispensers and have the medication in stock: A Dawson et al, 'Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study' (2017) 14(39) *Reproductive Health* (online).

129 L Keogh et al, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18. See also B Baird, 'Decriminalisation and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197, 198, commenting on the effect of decriminalisation in the Australian Capital Territory, Victoria and Tasmania. Similar concerns have been identified in Canada: see, eg, AM Foster et al, "'If I ever did have a daughter, I wouldn't raise her in New Brunswick": exploring women's experiences obtaining abortion care before and after policy reform' (2017) 95 *Contraception* 477; J Sabourin and M Burnett, 'A Review of Therapeutic Abortions and Related Areas of Concern in Canada' (2012) 34(6) *Journal of Obstetrics and Gynaecology Canada* 532, 539–40 and the sources cited there.

a State-wide strategy for equitable service provision and an unsustainable workforce.¹³⁰

[93] United Nations treaty bodies have recognised that full enjoyment of the right to health, including sexual and reproductive health, requires access to the full range of health services without discrimination, including availability, physical and geographical accessibility, and affordability, particularly for women in rural areas.¹³¹

¹³⁰ Keogh et al, above n 129, 22–3. In 2017, the Victorian Government released a women's sexual and reproductive health strategy. Among other things, the strategy sets out three key actions in the area of reproductive health. They are to: increase women's and primary health professionals' awareness about medical termination; increase women's access to medical termination in primary care; and improve access to surgical termination, especially for women in rural and regional Victoria: State of Victoria, Department of Health and Human Services, *Women's Sexual and Reproductive Health: Key priorities 2017–2020* (March 2017) 12, 15.

¹³¹ See [23]–[25] and [29]–[30] in Appendix D.

Community attitudes

[94] Several public opinion surveys have been conducted in Australia over the last decade which attempt to gauge community attitudes toward termination of pregnancy, including the Australian Survey of Social Attitudes,¹³² the Australian Election Study¹³³ and various surveys commissioned by particular groups at different times.¹³⁴

[95] Each survey has its own strengths and limitations.¹³⁵ Taking this into account, the Victorian Law Reform Commission reported in its review of termination of pregnancy laws that the available evidence provides general support for the following conclusions:¹³⁶

- A majority of Australians support a woman's right to choose whether to have an abortion.
- A subset of those supporters regard the right as capable of limitation, with restriction of choice based on factors such as gestational age and women's reasons for seeking the abortion. However, there is insufficient evidence to estimate the size of that subset.
- Several socio-demographic characteristics are associated with positive (and negative) views of abortion. For example, there is less support for abortion among persons with religious beliefs than among persons without religious beliefs; nonetheless, even among persons with religious beliefs, supporters remain in the majority.

[96] In Queensland, the Parliamentary Committee reported that:¹³⁷

Recent surveys of attitudes towards abortion in Australia suggest that approximately 60% of the Australian population supports women being able to obtain an abortion readily, a substantial sized minority (between one quarter and one third) support abortion only in special circumstances and a smaller group (somewhere between 5 and 20%) believe abortion is never acceptable.

¹³² See Australian National University, *The Australian Survey of Social Attitudes* <<http://aussa.anu.edu.au/index.php>>; and Australian Consortium for Social & Political Research Inc, *The Australian Survey of Social Attitudes* <<http://acspr.org.au/aussa>> which is described as the main source of national data for the study of 'social attitudes, beliefs and opinions'.

¹³³ See *The Australian Election Study* <<http://australianelectionstudy.org/index.html>> which aims to provide a 'long-term perspective on stability and change in the political attitudes and behaviour of the Australian electorate'.

¹³⁴ See T Gotis and L Ismay, 'Abortion law: a national perspective' (Briefing Paper No 2/2017, NSW Parliamentary Research Service, Parliament of New South Wales, 2017) [1.2]; VLRC Report (2008) [4.7]–[4.59]; Parliamentary Committee Report No 24 (2016) [8.1].

¹³⁵ See VLRC Report (2008) [4.7]–[4.59]; Parliamentary Committee Report No 24 (2016) [8.2].

¹³⁶ VLRC Report (2008) [4.82], based on conclusions drawn by Professor Studdert, Federation Fellow at the University of Melbourne commissioned by the Victorian Law Reform Commission to analyse the Australian Survey of Social Attitudes, the Australian Election Study and surveys commissioned, respectively, by the Southern Cross Bioethics Institute, the Australian Federation of Right to Life Associations and Marie Stopes International.

¹³⁷ Parliamentary Committee Report No 24 (2016) [8.3.1], drawing on the results of an analysis by Professor Matthew Gray and colleagues from the Australian National University commissioned by the Parliamentary Committee to assess the reliability of seven different community attitude surveys, including the Australian Survey of Social Attitudes and the Australian Election Study.

[97] It has been observed that community support for termination of pregnancy has generally increased over the years.¹³⁸ Results from the Australian Election Study in the period from 1979 to 2013 show that, whilst the percentage of Australians who believe that termination should be ‘banned’ has remained stable at approximately 5%, the proportion who believe that ‘women should be able to obtain an abortion readily when they want one’ has increased from 48.5% to 65.7%; and the percentage who believe that ‘abortion should be allowed only in special circumstances’ has decreased from 46.2% to 30%.¹³⁹

[98] Similar trends are observed for results from that study from Queensland residents:¹⁴⁰

Between 1996 and 2013, the percentage of Queenslanders believing women should be able to readily obtain an abortion has increased by ten percentage points, from 54.4% to 64%. Similarly, the percentage believing abortion should only be allowed in special circumstances has fallen from 41.9% to 32.5% over the 17-year period. The percentage of Queenslanders who believe abortion should be banned has remained stable between 2.6% (in 2001) and 4.4% (in 2010).

[99] However, it is also observed that support for a woman’s ability to obtain a termination of pregnancy can depend on the circumstances in which termination is sought.¹⁴¹ For example, responses to the 2009 Australian Survey of Social Attitudes showed that 23% of Australians believe termination is ‘always wrong’ where it is sought because ‘the family has a very low income and cannot afford any more children’ (compared to 45% who believe it is not wrong); and 8% believe termination is ‘always wrong’ where it is sought because ‘there is a strong chance of serious defect in the baby’ (compared to 67% who believe it is not wrong).¹⁴²

138 Ibid [8.4]; Gotis and Ismay, above n 134, 4–5.

139 Parliamentary Committee Report No 24 (2016) [8.4], referring to data from the Australian Election Study, which began in 1987, and the earlier Australian National Political Attitudes Surveys, which were conducted in 1967, 1969 and 1979. As to the latter, see Australian Election Study, *About the Australian National Political Attitudes Surveys (ANPAS)* <<http://australianelectionstudy.org/anpas.html>>.

140 Parliamentary Committee Report No 24 (2016) [8.4], referring to Australian Election Study data.

141 Ibid [8.4.1]; Gotis and Ismay, above n 134, 4–5.

142 Parliamentary Committee Report No 24 (2016) [8.4.1], App D [6], referring to the Australian Survey of Social Attitudes, 2009.

Part B: Issues

Introduction

[100] It has been observed that the current law in Queensland ‘has created uncertainty among doctors about how the law works in practice’ and that the possibility of prosecution ‘acts as a deterrent to doctors, impeding the provision of a full range of safe, accessible and timely reproductive services for women’.¹⁴³ This may disproportionately impact on women who are already disadvantaged, including women in low socio-economic groups, women in rural, regional and remote areas and Aboriginal and Torres Strait Islander women.¹⁴⁴

[101] At present, a medical practitioner must rely on section 282 of the Criminal Code to obtain protection from criminal responsibility for surgical operations and medical treatment.¹⁴⁵

[102] Removing terminations of pregnancy that are performed by a medical practitioner from the existing offences in the Criminal Code¹⁴⁶ raises the issue of how to define the circumstances in which such terminations will be considered lawful; as well as the extent to which the law should clarify the criminal responsibility of other health practitioners who might assist in performing a termination and of the woman concerned.¹⁴⁷

[103] The reform of termination of pregnancy laws also raises other relevant issues for consideration, including conscientious objection, counselling, safe access zones and data collection.¹⁴⁸

[104] Relevantly, United Nations treaty bodies have urged that laws criminalising termination of pregnancy should be removed, especially where they impose punitive consequences on women who undergo terminations, and that barriers to access to safe termination should be minimised. Treaty bodies have identified that denying access to termination can constitute discrimination and a violation of women’s rights, including the right to health.¹⁴⁹

143 Parliamentary Committee Report No 24 (2016) [12.1.1].

144 Ibid [12.6.3]–[12.6.5] and, eg, Evidence to the Parliamentary Committee, 12 July 2016, 2–3 (Dr W Burton, Royal Australian College of General Practitioners); 28 (Ms J Whybrow, Australian Association of Social Workers, Queensland Branch).

145 This provision is set out in full at [19] above.

146 See terms of reference, para 1.

147 See terms of reference, para 2.

148 See Parliamentary Committee Report No 24 (2016) [6.8.2.1], [13]. The termination of pregnancy legislation in several jurisdictions deals with many of these issues: see, eg, *Termination of Pregnancy Law Reform Act* (NT); *Health (Miscellaneous Provisions) Act 1911* (WA) ss 334–336.

149 See generally Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (2015) <<http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>>. See also WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012). Several international human rights instruments to which Australia is a party are relevant in this context, including the *International Convention on the Elimination of all forms of Discrimination Against Women*. See further Appendix D below.

[105] In the context of modernising the current law,¹⁵⁰ guiding principles include the promotion of autonomy and health (including access to safe medical procedures), clarity and certainty, consistency with modern clinical practice, national harmonisation and community expectations.

¹⁵⁰ See terms of reference, para C.

Who should be permitted to perform or assist in performing terminations?

[106] The terms of reference ask the Commission to draft legislation to remove terminations of pregnancy performed by duly registered medical practitioners from sections 224, 225 and 226 of the Criminal Code,¹⁵¹ and to provide clarity in the law in relation to terminations of pregnancy. In doing so, the Commission is to have regard, among other things, to existing clinical practices and services.

[107] Whether a practitioner is qualified to perform, or assist in the performance of, a termination of pregnancy is determined by a range of matters, including the health practitioner's registration, credentialing and the definition of the practitioner's scope of clinical practice. In relation to who can dispense, prescribe, supply and administer drugs used for a termination of pregnancy, relevant classification and approval requirements and drugs and poisons regulations apply.¹⁵²

[108] As shown in the following table, most Australian jurisdictions provide that a termination of pregnancy is unlawful unless performed by a medical practitioner.¹⁵³ In some jurisdictions, the legislation also expressly provides that it is lawful for other health practitioners, such as nurses and pharmacists, to assist in the performance of a termination, and that a woman is not criminally responsible for the termination of her own pregnancy.

151 These provisions are set out in full at [15] above.

152 See [41]–[45] above.

153 *Health Act 1993* (ACT) s 81; *Criminal Code* (NT) s 208A and *Termination of Pregnancy Law Reform Act 2017* (NT) ss 4–10; *Criminal Law Consolidation Act 1995* (SA) s 82A; *Criminal Code* (Tas) ss 51(1A), 178D and *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–5; *Crimes Act 1958* (Vic) ss 65–66 and *Abortion Law Reform Act 2008* (Vic) ss 4–5; *Criminal Code* (WA) s 199.

	Criminal offences			Who can perform or assist in performing terminations	
	<i>Offence to perform termination</i>	<i>Woman criminally responsible for own termination</i>	<i>Offence to procure drug, instrument or thing</i>	<i>Medical Practitioners</i>	<i>Other health practitioners</i>
ACT	✓ (by person who is not a doctor)			✓	
NSW	✓ (any person)	✓	✓ (any person)		
NT	✓ (by unqualified person)	No (offence does not apply to the woman)	✓ (by unqualified person)	✓ (if suitably qualified)	✓ (authorised ATSI health practitioner, midwife, nurse, pharmacist (at not more than 14 weeks, under direction of medical practitioner))
QLD	✓ (any person)	✓	✓ (any person)		
SA	✓ (any person except legally qualified medical practitioner)	✓	✓	✓	
TAS	✓ (unless performed by medical practitioner)	No (offence does not apply to the woman)	(not an offence to procure or supply any thing for purpose of discontinuing pregnancy)	✓	(not an offence for nurse or midwife to administer drug under direction of medical practitioner)
VIC	✓ (by unqualified person)	No (offence does not apply to the woman)		✓	✓ (nurse, pharmacist (at not more than 24 weeks if authorised, or after 24 weeks if employed or engaged by a hospital and under the written direction of medical practitioner))
WA	✓ (unless performed by medical practitioner)	✓ (unless performed by medical practitioner)		✓	

Table 7: Persons permitted to perform or assist in performing terminations of pregnancy in Australian legislation

Medical practitioners

[109] At present in Queensland, ‘any person’ who unlawfully does an act with intent to procure a woman’s miscarriage commits a criminal offence.¹⁵⁴ However, as explained above, a termination of pregnancy may be lawfully performed by a medical practitioner in appropriate circumstances.¹⁵⁵

¹⁵⁴ Criminal Code (Qld) s 224.

¹⁵⁵ See Criminal Code (Qld) s 282 and [18]–[24] above.

[110] The legislation in all other Australian jurisdictions, except New South Wales, expressly provides that termination of pregnancy is unlawful unless performed by a medical practitioner.¹⁵⁶

Other health practitioners

[111] As a matter of clinical practice, other health practitioners, such as nurses and midwives, Aboriginal and Torres Strait Islander health practitioners and pharmacists may also assist in performing terminations of pregnancy. As noted above, health practitioners are subject to a complex legal and regulatory framework at both national and State level.¹⁵⁷ Any legislative provision governing who is permitted to lawfully perform terminations of pregnancy would need to accord with this framework and be flexible enough to adapt to future changes.

[112] Section 282(2)–(3) of the Criminal Code enables substances to be administered to, or procured or supplied for, a patient under the lawful direction or advice of a health professional.¹⁵⁸ This is of particular relevance in relation to medical terminations. As noted above, only a medical practitioner who is registered as a certified prescriber can prescribe MS-2 Step and a pharmacist must be registered as a certified dispenser.¹⁵⁹ A medical practitioner, nurse practitioner, midwife or a registered or enrolled nurse may supply¹⁶⁰ or administer¹⁶¹ MS-2 Step pursuant to, and subject to any restrictions in, the *Health (Drugs and Poisons) Regulation 1996*.¹⁶²

¹⁵⁶ *Health Act 1993* (ACT) s 81; Criminal Code (NT) s 208A(1)(c), (5)(a); *Criminal Law Consolidation Act 1995* (SA) s 82A(1); Criminal Code (Tas) s 178D(1)(a); *Crimes Act 1958* (Vic) s 65; Criminal Code (WA) s 199(1). The legislation also generally provides that termination is lawful only if performed on certain grounds or in accordance with other requirements: see [123] and [185] below.

¹⁵⁷ See [41] ff above.

¹⁵⁸ This provision is set out in full at [19] above. Similar provision in relation to medical and surgical operations is made in the Criminal Code (Tas) s 51 and the Criminal Code (WA) s 259.

¹⁵⁹ See [88] above.

¹⁶⁰ 'Supply' means 'give, or offer to give, a person one or more treatment doses of the drug or poison, to be taken by the person during a certain period': *Health (Drugs and Poisons) Regulation 1996* (Qld) s 3 app 9 (definition of 'supply').

¹⁶¹ 'Administer' means 'give a person a single treatment dose of the drug or poison, to be taken by the person immediately': *Health (Drugs and Poisons) Regulation 1996* (Qld) s 3 app 9 (definition of 'administer').

¹⁶² For example, nurse practitioners may administer or supply MS-2 Step in accordance with the drug therapy protocol for nurse practitioners. Registered nurses and midwives may administer (and midwives may also supply) MS-2 Step on the oral or written direction of a doctor, nurse practitioner or physician's assistant. Registered nurses and midwives may also administer MS-2 Step to the person for whom it was dispensed under the instructions stated by the dispenser. An enrolled nurse may administer a restricted drug to the person for whom it was dispensed under the supervision of a doctor, midwife or registered nurse. Pharmacists practising pharmacy at a public sector hospital may supply a restricted drug on the oral or written instruction of a doctor, nurse practitioner or physician's assistant, to a person being discharged from the hospital or an outpatient of the hospital. (A similar provision is made for registered nurses practising at a hospital in an isolated practice area). See *Health (Drugs and Poisons) Regulation 1996* (Qld) ss 161(1)(c)–(d), 162(1)(b)–(c), 4(b)–(c), 167(1)(c)–(d), 171(1)(e), 175(1)(b), (2)(b)–(c), (3), (8)(b), app 9 (definition of 'midwife', 'nurse', 'nurse practitioner', 'physician's assistant' and 'restricted drug').

[113] The Parliamentary Committee reported that most submitters and witnesses considered that only a qualified, experienced and competent health practitioner should perform a termination of pregnancy.¹⁶³

[114] In the Northern Territory and Victoria, the legislation expressly removes other health practitioners from criminal responsibility for assisting in the performance of a termination, as follows:

- In the Northern Territory, an ATSI health practitioner, midwife or nurse authorised under the *Medicines, Poisons and Therapeutic Goods Act* (NT) may supply or administer a termination drug, and an authorised pharmacist may supply a termination drug, if directed to do so by a suitably qualified medical practitioner to assist in the performance of a termination on a woman who is not more than 14 weeks pregnant.¹⁶⁴
- In Victoria, a registered pharmacist or registered nurse authorised under the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) may administer or supply a drug or drugs to cause a termination of pregnancy in a woman who is not more than 24 weeks pregnant.¹⁶⁵

[115] In Tasmania, the offence does not apply to the administration of a drug for the purpose of discontinuing a pregnancy by a nurse or midwife acting under the direction of a medical practitioner, or to the supply or procurement of any thing for the purpose of discontinuing a pregnancy.¹⁶⁶

[116] Such an approach might be considered appropriate to provide certainty for health practitioners who assist in performing a termination of pregnancy.

A woman causing her own termination

[117] Under the current law in Queensland, a woman is criminally responsible for procuring her own miscarriage.¹⁶⁷ The legislation in the Northern Territory, Tasmania and Victoria expressly removes criminal responsibility from a woman who consents to or assists in the termination of her own pregnancy.¹⁶⁸ This approach might be considered appropriate for consistency with the removal of criminal responsibility for medical practitioners.

¹⁶³ Parliamentary Committee Report 33a [4.4.1]. See also, eg, Submissions 702, 871, 904, 1024, 1209 and 1267 to the Parliamentary Committee on the second Bill.

¹⁶⁴ *Termination of Pregnancy Law Reform Act 2017* (NT) s 8. 'Termination drug' is defined to mean 'a substance or combination of substances, to which the current Poisons Standard applies under the *Therapeutic Goods Act 1989* (Cth), used for terminations': s 4.

¹⁶⁵ At more than 24 weeks, a registered pharmacist or registered nurse may administer or supply a drug or drugs to cause a termination only if they are employed or engaged by a hospital and only at the written direction of a registered medical practitioner: *Abortion Law Reform Act 2008* (Vic) ss 6–7.

¹⁶⁶ Criminal Code (Tas) ss 1 (definition of 'terminate'), 178D.

¹⁶⁷ Criminal Code (Qld) s 225, set out in full at [15] above.

¹⁶⁸ Criminal Code (NT) s 208A(4); Criminal Code (Tas) s 178D(1)(b) and *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 8; *Crimes Act 1958* (Vic) s 65(2). The provision in Tasmania extends to the woman performing her own termination.

[118] The Parliamentary Committee reported that views diverged on whether a woman should be criminally responsible for the termination of her own pregnancy.¹⁶⁹ Some submitters suggested that there should be an express provision that the woman is not criminally responsible for the termination of her own pregnancy, to clarify the law and provide certainty, particularly in relation to medical termination.¹⁷⁰ Others considered that the offence should remain as a deterrent to ‘backyard’ terminations, or to women ‘self-administering’ terminations without medical supervision.¹⁷¹

[119] United Nations treaty bodies have recommended the removal of laws that criminalise and impose punitive measures on women who undergo terminations of pregnancy, observing that such laws undermine women’s rights to equality and non-discrimination in sexual and reproductive health.¹⁷²

Consultation questions

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

¹⁶⁹ Parliamentary Committee Report 33a [4.4.2].

¹⁷⁰ Ibid. See also, eg, Submissions 565, 908, 1012, 1014, 1021, 1042 and 1267 to the Parliamentary Committee on the second Bill. One submitter stated that the inclusion of an express provision ‘would support the dignity and privacy of the woman’: Submission 904 to the Parliamentary Committee on the second Bill.

¹⁷¹ Ibid. See also, eg, Submissions 811, 1033 and 1083 to the Parliamentary Committee on the second Bill.

¹⁷² See [6]–[7], [13]–[15] and [108] in Appendix D.

Gestational limits and grounds

[120] Historically, whilst the criminal law prohibited unlawful termination of pregnancy, it recognised a general exception to preserve the woman's life. This included the woman's physical and mental health and, in some places, was extended to include consideration of the woman's social or economic circumstances.

[121] During the mid to late 20th century, further liberalisation of criminal termination of pregnancy laws occurred in many parts of the world to recognise a wider range of circumstances in which termination would be lawful. This coincided with an increased emphasis on patient autonomy and the recognition of reproductive rights.

[122] There is an emerging trend toward treating termination as a health matter, rather than a criminal matter. This has been coupled with a continued international focus on access to safe termination.

Should the legislation impose gestational limits or grounds?

[123] In most Australian jurisdictions, termination of pregnancy is lawful only within certain gestational limits and on particular grounds. As shown in the following table, the limits and grounds vary.

	'Decriminalised'					'Criminalised'			
	<i>Health legislation</i>	<i>Mainly health legislation but with some offences in the criminal law</i>					<i>Defined by statute</i>	<i>'Lawful' defined mainly by common law</i>	
	ACT	NT	TAS	VIC	WA	SA	NSW	QLD	
On request	✓		✓ (up to 16 weeks)	✓ (up to 24 weeks)					
Risk to woman's life		✓ (in an emergency)				✓ (taking into account actual or reasonably foreseeable environment)	✓ (taking into account economic, social and medical reasons)	✓	
Risk to woman's health (physical or mental)			✓ (after 16 weeks, if two medical practitioners concur; taking into account economic, social and other circumstances)		✓ (up to 20 weeks; or after 20 weeks if two medical practitioners of the relevant panel concur)	✓ (if two medical practitioners concur; taking into account actual or reasonably foreseeable environment)	✓ (taking into account economic, social and medical reasons)	✓	
Economic or social circumstances					✓ (serious personal, family or social consequences)				
Fetal abnormality					✓ (after 20 weeks if two medical practitioners of the relevant panel concur)	✓ (if two medical practitioners concur)			
'Appropriate' in all the circumstances		✓ (up to 14 weeks; from 14 weeks to 23 weeks if at least one other medical practitioner concurs— if appropriate in all the circumstances having regard to: all relevant medical circumstances; the woman's current and future physical, psychological and social circumstances; and professional standards and guidelines)		✓ (after 24 weeks if at least one other medical practitioner concurs— if appropriate in all the circumstances having regard to: all relevant medical circumstances; and the woman's current and future physical, psychological and social circumstances)					

Table 8: Gestational limits and grounds in Australian legislation¹⁷³

173

As to gestational limits and grounds in overseas jurisdictions, see Appendix B.

‘On request’ approach

[124] One approach is for the law to treat termination of pregnancy as a health matter, rather than a criminal matter, and to have no legally imposed gestational limits or grounds. Under this approach, the lawfulness of termination would be determined by the same principles as apply to any other health matter; if termination was medically indicated and there was informed consent, termination would be lawful.

[125] This is the approach in the Australian Capital Territory (and in Canada). Because those jurisdictions do not impose additional legal requirements, termination of pregnancy is described as being lawfully permitted ‘on request’.¹⁷⁴

[126] In the Australian Capital Territory, the former offences in the *Crimes Act 1900* (ACT) relating to procurement of a miscarriage were repealed.¹⁷⁵ Termination of pregnancy is dealt with under the *Health Act 1993* (ACT) which provides, in effect, that a medical practitioner may ‘carry out an abortion’ in an approved medical facility. It does not otherwise impose any additional requirements that must be satisfied for a termination to be lawful.¹⁷⁶

[127] In Canada, the Supreme Court found that the Criminal Code provision dealing with procurement of a miscarriage was invalid because it conflicted with the ‘right to life, liberty and security of the person’ in the *Canadian Charter of Rights and Freedoms*.¹⁷⁷ Separate legislation dealing with the lawfulness of termination of pregnancy has not subsequently been enacted, and it is treated as a health service.¹⁷⁸

[128] In Queensland, many submitters to the Parliamentary Committee considered termination of pregnancy to be a health decision made between a woman and her doctor which should be governed by the same legal principles that apply to other health care. Submitters also argued that the reasons women may have for seeking a termination are varied and personal and should not be subject to public scrutiny. On the other hand, submitters who opposed the decriminalisation of termination considered that the criminal law should continue to protect unborn life.¹⁷⁹

[129] The ‘on request’ approach might be considered appropriate for a number of reasons:

- It removes legal barriers to access.

¹⁷⁴ Whether termination of pregnancy is available in practice will depend on various matters related to clinical practice and access: see [41] ff, [79] ff above.

¹⁷⁵ *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT), repealing *Crimes Act 1900* (ACT) ss 44–46.

¹⁷⁶ *Health Act 1993* (ACT) ss 81–82.

¹⁷⁷ *R v Morgentaler* [1988] 1 SCR 30; *Canadian Charter of Rights and Freedoms*, s 7; Criminal Code RSC 1985 c C-46, s 287. A bill was introduced into the Canadian Parliament on 8 March 2017 to repeal s 287.

¹⁷⁸ In some provinces, including New Brunswick and Newfoundland and Labrador, access to publicly-funded termination services (under their equivalent to Medicare) is restricted by legislation.

¹⁷⁹ Parliamentary Committee Report No 24 (2016) [6.5.1.2], [6.5.1.4], [6.5.2.1]. See, eg, Submissions 537, 770, 835, 837, 839, 845, 541 and 551 to the Parliamentary Committee on the first Bill and Inquiry.

- It accords maximum respect for women’s autonomy.
- It might provide greater clarity for health practitioners because they are not required to interpret and apply additional legal tests and can focus on their primary role of determining their patient’s clinical interests.

[130] There are, however, arguments against an ‘on request’ approach. In particular:

- There is some community concern that an ‘on request’ approach would not regulate, and could therefore allow, termination of late term pregnancies up to birth, giving inadequate recognition to the interests of the fetus.¹⁸⁰ It has long been recognised that, as the fetus develops, its interests are entitled to greater recognition and protection.¹⁸¹
- There might also be some community concern about laws that could allow ‘abortion on demand’ where it is considered that there is an inadequate justification or reason for termination (for example, termination used for sex selection, as a primary form of contraception or for convenience).¹⁸²

A ‘combined’ approach

[131] As noted above, although most Australians in community attitude surveys support a woman’s right to choose, not all consider that this right should be absolute.¹⁸³

[132] Accordingly, some legal limits might be thought warranted. This would represent a ‘combined’ approach of neither total prohibition, nor absolute autonomy and women’s choice. Such an approach is taken, for example, in Victoria (and to varying extents in a number of other jurisdictions).

180 See, eg, Parliamentary Committee Report No 24 (2016) [6.5.2.3] and Submissions 541, 551, 597, 623, 680, 1113, 1117 and 1216 to the Parliamentary Committee on the first Bill and Inquiry.

181 See, eg, *R v Woolnough* [1977] 2 NZLR 508, 516–17 (Richmond P), quoted in *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 39:

it would, I think, be in accordance with the thinking of a great majority of people that the further a pregnancy progresses, the more stringent should be the requirements which will justify its termination.

See also, eg, H Farmer, ‘An analysis of New Zealand’s abortion law system and a guide to reform’ (2013) 1 *Public Interest Law Journal of New Zealand* 147; Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper No 58 (1989) 13; and G Williams, *The Sanctity of Life and the Criminal Law* (1957) 230:

The humane, ethical, and parental feeling of the plain man leads him to wish to extend the protection of the criminal law not only to the newly born child but to the viable child before birth.

See [18] in Appendix C.

182 See, eg, Submissions 548, 592, 704, 742, 1066, 1106, 1184, 1190, 1222, 1248 and 1286 to the Parliamentary Committee on the first Bill and Inquiry. See also, eg, G Gillett and R Wong, ‘Think of the children: Sex selection and child welfare’ (2015) 22 *Journal of Law and Medicine* 751.

183 See [95] and [99] above.

[133] Generally, this has tended to be done by a combination of gestational limits and grounds.¹⁸⁴ The challenge is in identifying what gestational limit(s) and which ground(s) the law should impose. These are considered in turn, but are related issues.

Gestational limits

[134] A gestational limit restricts the circumstances in which termination is lawful.¹⁸⁵ Once the gestational limit is reached, termination may still be lawful if specific grounds are met and any required procedures are followed.¹⁸⁶

[135] The Parliamentary Committee reported concern from some submitters about the imposition of legislative gestational limits, arguing that such limits are arbitrary or are better left to clinical practice.¹⁸⁷

[136] The RANZCOG statement on Queensland's termination of pregnancy laws prefers no specific gestational limits:¹⁸⁸

- Gestational limits discriminate against the most vulnerable of women and women in the most difficult of clinical circumstances. Often disadvantaged women may not access diagnosis of lethal or serious anomalies until later gestations.
- Gestational limits discriminate against women who may have severe congenital infections such as cytomegalovirus which may not be apparent until later gestations or may only be diagnosed beyond 20 weeks.

[137] Some jurisdictions impose early gestational limits; others impose later gestational limits.

Early gestational limits

[138] The legislation in Tasmania imposes a gestational limit of 16 weeks. It provides, in effect, that termination is lawful:¹⁸⁹

¹⁸⁴ And in some cases, with additional decision-making procedural requirements: see [183] ff below as to a requirement for the medical practitioner to consult with other practitioners or refer to a committee.

¹⁸⁵ In some overseas jurisdictions, gestational limits are imposed as an upper limit beyond which terminations are generally prohibited. For example, in Germany, the Criminal Code imposes a limit of 22 weeks, beyond which termination is an offence (except if it is medically necessary to avert a danger to the life, or danger of grave injury to the health, of the woman).

¹⁸⁶ See [155]–[182] below as to grounds and [183] ff below as to decision-making procedures (namely, a requirement for the medical practitioner to consult with other practitioners or refer to a committee).

¹⁸⁷ Parliamentary Committee Report No 33a (2017) [5.4.1]. See, eg, Submissions 701, 864, 1014 and 1209 to the Parliamentary Committee on the second Bill.

¹⁸⁸ RANZCOG, 'Queensland abortion law reform' (Media Statement, 15 February 2017). RANZCOG 'supports a multidisciplinary approach in assisting women in such circumstances and the availability of late termination of pregnancy for the rare situations where both managing clinicians and patient believe it to be the most suitable option in the circumstances': RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.4]; See also RANZCOG, 'Late Termination of Pregnancy' (C-Gyn 17A, May 2016).

¹⁸⁹ *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4, 5(1). The Criminal Code (Tas) s 178D makes it an offence for a person who is not a medical practitioner, or the pregnant woman, to perform a termination.

- up to 16 weeks on request; and
- after 16 weeks if two medical practitioners concur that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.

[139] A gestational limit is also imposed, for example, of 16 weeks in Iceland and of 12 weeks in Denmark, Norway and France.

[140] An early gestational limit might be considered appropriate for a number of reasons:

- It recognises that women's autonomy and choice have greatest weight, as against the interest of the embryo or fetus, at the earliest stages of pregnancy.
- It recognises that termination of early term pregnancy generally involves lower risk and is safer for the woman.
- It recognises that at least some time is required for the woman's pregnancy to be confirmed and to consider whether to seek a termination.

[141] The clinical guideline on therapeutic termination of pregnancy in Queensland states that, as a matter of clinical practice, a woman undergoing a medical termination may be cared for on an outpatient basis where her pregnancy is less than nine weeks gestation and she has appropriate support and access to medical care. It also states that surgical curettage is generally suitable for terminations up to 14 weeks.¹⁹⁰ Most terminations are performed in the first trimester (12 weeks).¹⁹¹

[142] The Parliamentary Committee heard from some witnesses who suggested that 12 weeks might represent best practice on an examination of the legislation in other countries.¹⁹²

Later (viability) gestational limits

[143] Under current clinical practice in Queensland, the threshold of viability for pre-term birth is between 23 weeks zero days and 25 weeks six days gestation. Viability is primarily determined by age but may be influenced by other factors such as weight or fetal abnormality. Life sustaining interventions are not generally recommended for an infant born at less than 24 weeks.¹⁹³

¹⁹⁰ See [57] and [61] above.

¹⁹¹ See [66] above.

¹⁹² See, eg, Evidence to the Parliamentary Committee, 27 October 2016, 35–6 (Ms W Francis, State Director, Australian Christian Lobby).

¹⁹³ Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability (2014) [5.7]. At less than 23 weeks, palliative care is recommended; at 23 weeks, life sustaining interventions are not usually recommended but might be provided if, after appropriate counselling, the parents make an informed decision or if parental wishes are unknown; at 24 weeks, life sustaining interventions are usually recommended, but palliative care might be provided if, after appropriate counselling, the parents make an informed decision; and at 25 weeks, life sustaining interventions are recommended and would be provided except in unusual circumstances. This is generally consistent with international approaches: see n 8 in Appendix C.

[144] In Victoria, the termination of pregnancy legislation adopts a gestational limit of 24 weeks. It effectively provides that termination is lawful:¹⁹⁴

- up to 24 weeks on request; and
- after 24 weeks if two medical practitioners concur that it is appropriate in all the circumstances having regard to specified matters.

[145] This reflects a ‘viability’ approach to lawful termination so that, once the fetus has reached the age at which it is considered capable of existing independently if born, the law imposes additional limits on when termination can be performed.

[146] A later gestational limit might be considered appropriate for various reasons:

- It gives greater autonomy and choice to the woman before the gestational limit is reached and so moves the law closer to the ‘on request’ approach.
- A limit informed by the concept of ‘viability’ recognises concerns about late term ‘abortion on demand’.¹⁹⁵
- It recognises that late term terminations are higher risk and may involve greater complications.
- It recognises that the interests of the fetus have increasing weight at the later stages of pregnancy.

[147] A viability approach, like that adopted in Victoria, recognises that it is at this stage that the fetus, if born, would be a child capable of being killed.¹⁹⁶

[148] Most terminations in Queensland are performed in licensed private health facilities, and occur in the first trimester.¹⁹⁷ Terminations at 22 weeks gestation or more are currently permitted to be performed only in particular hospitals, and most often occur where there is a severe or fatal fetal abnormality.¹⁹⁸ Severe or fatal fetal abnormalities are often not confirmed until later in the pregnancy.¹⁹⁹

[149] Late terminations of pregnancy are comparatively rare. The number of terminations after 20 weeks performed in Queensland public hospitals and licensed private health facilities has increased but continues to account for a very small percentage of all terminations in Queensland.²⁰⁰

¹⁹⁴ *Abortion Law Reform Act 2008* (Vic) ss 4, 5. Similar gestational limits are adopted in some overseas jurisdictions, including England, Scotland and Wales: see Appendix B.

¹⁹⁵ See, eg, [130], nn 181, 182 above and n 204 below.

¹⁹⁶ See Criminal Code (Qld) ss 292 and 313(1) at [25]–[29] above.

¹⁹⁷ See [66] and [70] above.

¹⁹⁸ See [50] and [72] above; Parliamentary Committee Report No 24 (2016) [7.2.3].

¹⁹⁹ See [178] below.

²⁰⁰ See [75]–[77] above.

[150] The Parliamentary Committee reported mixed views in its consultation about imposing a 24 week gestational limit. Some submitters favoured no gestational limit. For example, an obstetrician and gynaecologist expressed support for the RANZCOG position, arguing that:²⁰¹

the very uncommon later term abortions involve peculiar and rare circumstances that legislation could only complicate and make more traumatic for the families involved in making terribly difficult decisions about these pregnancies.

[151] Some submitters argued for a limit of 24 weeks on the basis of the potential viability of the fetus²⁰² and some, who preferred that there should be no gestational limit, nevertheless supported such an approach in the interest of addressing community concern.²⁰³ In contrast, others argued that ‘there should be an absolute ban on all late-term abortions’.²⁰⁴

Combination of different gestational limits

[152] In the Northern Territory, the legislation imposes two gestational limits of 14 weeks and 23 weeks. It provides, in effect, that termination is lawful:²⁰⁵

- up to 14 weeks if the medical practitioner considers it appropriate in all the circumstances having regard to specified matters;
- after 14 weeks and up to 23 weeks if two medical practitioners concur that it is appropriate in all the circumstances having regard to specified matters; and
- (at any stage) in an emergency if it is necessary to preserve the woman’s life.

[153] Combined gestational limits are imposed, for example, in Sweden (18 and 22 weeks) and Germany (12 and 22 weeks).

[154] The combination of earlier and later gestational limits has the effect of progressively narrowing the circumstances in which termination is lawful as the development of the fetus progresses.

Grounds

[155] As shown in the table at [123] above, the legislation in different Australian jurisdictions specifies various grounds on which termination of pregnancy is lawful.

[156] An ‘on request’ approach, like that in the Australian Capital Territory, does not require that any ground be satisfied before a termination may be lawfully performed.

²⁰¹ Submission 809 to the Parliamentary Committee on the second Bill. See [136] above as to RANZCOG’s general position on legislative gestational limits.

²⁰² See, eg, Submission 1267 to the Parliamentary Committee on the second Bill.

²⁰³ See, eg, Submission 1012 to the Parliamentary Committee on the second Bill. See also, eg, Evidence to the Parliamentary Committee, 15 July 2016, 14–15 (Prof C de Costa).

²⁰⁴ Parliamentary Committee Report No 33a (2017) [5.4.1]. See, for example, Submissions 859, 869, 889, 1002 and 1030 to the Parliamentary Committee on the second Bill.

²⁰⁵ *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 9, 10.

[157] A ‘combined’ approach, like that in Victoria, combines an ‘on request’ gestational limit with specific grounds so that, after the gestational limit is reached, a termination may be lawfully performed only in specific circumstances, that is, on the grounds.

[158] A ‘grounds only’ approach, like that in South Australia, requires that a specific ground or grounds be satisfied before any termination may be lawfully performed.

[159] Generally, the grounds imposed by legislation in other jurisdictions are framed in terms of matters of which the medical practitioner must be satisfied.

Life and health of the woman

[160] A common and longstanding ground on which termination of pregnancy is lawful is where the medical practitioner believes it is necessary to preserve the woman from a serious danger to her life or health. This covers both the woman’s physical and mental health (the ‘health ground’).

[161] United Nations treaty bodies have urged that termination of pregnancy should be lawful in these circumstances, consistently with respect for the woman’s rights to life and health. The WHO has referred in this context to its broad definition of ‘health’ as a state of ‘complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’.²⁰⁶

[162] There may be some uncertainty about how much the health ground covers and what matters might be relevant to a consideration of this ground, especially in relation to the woman’s mental health.²⁰⁷

Economic or social circumstances

[163] In some jurisdictions, the woman’s economic and social circumstances may be taken into account in determining whether the health ground is met. This is the case under the common law in New South Wales and in the legislation in Tasmania and South Australia, but not in Queensland.

[164] In some other jurisdictions, the woman’s social (and other) circumstances are expressly recognised in the legislation as, or as part of, a separate ground. The legislation in Western Australia permits termination where ‘the woman concerned will suffer serious personal, family or social consequences’ if the termination is not performed.²⁰⁸ In the Northern Territory and Victoria, the legislation provides that the woman’s current and future ‘social circumstances’ are to be taken into account in determining whether a termination of pregnancy is ‘appropriate in the all the circumstances’.²⁰⁹

²⁰⁶ See [17], [33], [39]–[40] and [109] in Appendix D.

²⁰⁷ See, eg, G Williams, ‘The Fetus and the “Right to Life”’ (1994) 53(1) *Cambridge Law Journal* 71.

²⁰⁸ *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(3)(b). Termination is unlawful under the Criminal Code (WA) s 199(1) unless it is performed in the circumstances provided in that section.

²⁰⁹ The ‘appropriate in all the circumstances’ test is the sole ground imposed by the legislation in those jurisdictions for lawful terminations and is outlined at [181] below.

[165] In Norway, for example, the legislation provides that termination is lawful after 12 weeks if 'the pregnancy, childbirth, or care of the child may place the woman in a difficult life situation', having regard to the woman's overall situation.²¹⁰ Similar considerations about the 'burden' to the woman, differently worded and varying in scope, also apply under the legislation in other Scandinavian countries.²¹¹

[166] The WHO has stated that such grounds involve consideration of both the actual and foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health.²¹²

Rape and other coerced or unlawful acts

[167] A possible ground for lawful termination is where it is contended that the pregnancy is the result of rape or other coerced or unlawful acts.

[168] None of the Australian jurisdictions expressly recognises this as a ground for lawful termination.

[169] The WHO recognises that mental health under the health ground for lawful termination is wide enough to encompass psychological distress or mental suffering caused by coerced sexual acts.²¹³

[170] In some overseas jurisdictions, including Germany and several Scandinavian countries, these circumstances are expressly recognised as a separate ground for lawful termination. For example, in Iceland, termination of pregnancy is lawful (up to 16 weeks) 'when the woman has been raped, or has become pregnant as a result of some other criminal act'.²¹⁴

[171] United Nations treaty bodies have stated that termination should be lawful where the pregnancy is the result of rape and that denying access to termination in such cases may amount to cruel, inhuman or degrading treatment.²¹⁵

[172] In Queensland, the Parliamentary Committee reported that, whilst some submitters considered that sexual assault does not justify termination of pregnancy,

210 *The Act Concerning Termination of Pregnancy* 1975 No 50 (Norway) s 2(b).

211 For example, in Denmark (where pregnancy, childbirth or care of a child would constitute a 'serious burden to the woman, which cannot otherwise be averted', taking into account the woman's interests and personal circumstances and the circumstances of her family); and in Iceland (where the woman and her closest family may be 'deemed unable to cope' with the pregnancy and birth of a child due to 'social circumstances beyond their control', taking into account a range of factors). See also Appendix B.

212 See [109] in Appendix D.

213 See [17] and [109] in Appendix D.

214 After 16 weeks, termination is lawful in Iceland only if there are indisputable medical reasons and the woman's life and health are placed at greater risk by continued pregnancy or birth, or if there is a great likelihood of fetal abnormality (and with the approval of a committee). In Germany, termination is lawful under the Criminal Code if, according to medical opinion, an unlawful act (such as rape or sexual assault) has been committed against the pregnant woman and there is strong reason to support the assumption that the pregnancy was caused by the act. See also Appendix B.

215 See [33], [36], [40] and [109] in Appendix D. Unintended pregnancy as the result of intimate partner rape (and abuse during pregnancy) has been associated with negative health outcomes, including higher rates of post-traumatic stress, substance use and threatened or attempted suicide: see, eg, J McFarlane, 'Pregnancy Following Partner Rape: What We Know and What We Need to Know' (2007) 8(2) *Trauma, Violence, & Abuse* 127.

others considered that termination should be available in such cases.²¹⁶ The Brisbane Rape and Incest Support Centre commented that restricted access to termination can compound existing trauma:²¹⁷

Sexual violence, incest and rape are violations of a person's bodily integrity, leading many survivors to feel out of control and powerless. One of the most significant steps towards healing from sexual violence is regaining agency and control, particularly over one's body. Thus, no or limited access to pregnancy termination compounds the trauma and powerlessness survivors are already experiencing.

[173] Some submitters, including the Women's Legal Service Queensland, also observed the link between domestic and family violence and unplanned pregnancy, and highlighted that violent relationships can involve various forms of reproductive coercion and other forms of control.²¹⁸

Fetal abnormality

[174] Termination where the pregnancy involves a diagnosis of fetal abnormality is a contentious issue.²¹⁹

[175] South Australia and Western Australia are the only Australian jurisdictions to expressly include fetal abnormality as a ground for lawful termination of pregnancy.²²⁰ The legislation in Western Australia provides, for example, that, after 20 weeks, a termination is justified if two medical practitioners have agreed that 'the unborn child has a severe medical condition that, in the clinical judgment of those two medical practitioners, justifies the procedure'.²²¹

[176] The WHO recognises that mental health under the health ground for lawful termination includes psychological distress or mental suffering caused to the woman by a diagnosis of fetal abnormality.²²²

[177] Fetal abnormality forms a separate ground in some overseas jurisdictions, including Denmark, Norway and Iceland. For example, in Norway, the legislation

²¹⁶ Parliamentary Committee Report No 24 (2016) [12.4].

²¹⁷ Submission 839 to the Parliamentary Committee on the first Bill and Inquiry.

²¹⁸ Parliamentary Committee Report No 24 (2016) [12.5]. See, for example, Submissions 759, 838 and 1178 to the Parliamentary Committee on the first Bill and Inquiry. See also, for example, CC Pallitto et al, 'Intimate partner violence, abortion, and unintended pregnancy: Results from WHO multi-country Study on Women's Health and Domestic Violence' (2013) 120 *Journal of Gynecology and Obstetrics* 3, which found a strong association between intimate partner violence and unintended pregnancy and termination.

²¹⁹ See, eg, J Herring, *Medical Law and Ethics* (Oxford University Press, 6th ed, 2016) 354–6; H Pringle, 'Abortion and Disability: Reforming the law in South Australia' (2006) 29(2) *UNSW Law Journal* 207. See also [92] in Appendix D.

²²⁰ *Criminal Law Consolidation Act Amendment Act 1969* (SA) s 82A(1)(a)(ii); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a).

²²¹ *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a). The medical practitioners must be members of a panel of at least six practitioners appointed by the Minister for the purpose of the section. The termination must also be performed at an approved facility: s 334(7)(b).

²²² See [17] and [109] in Appendix D.

provides that termination is lawful after 12 weeks if there is a ‘major risk’ that the child may suffer from a ‘serious’ genetic or other disease.²²³

[178] The seriousness of some fetal abnormalities may not be apparent until later than 24 weeks gestation.²²⁴

[179] The Parliamentary Committee reported concerns among some submitters and witnesses about the inadequacy of the current law in dealing with severe fetal abnormality. In particular, it was noted that women have to ‘hide behind the facts’ to obtain a termination under the health ground. Some considered that the law should clarify that fetal abnormality is covered. Others, including a representative of RANZCOG, expressed the view that, unless it gives rise to a negative impact on the woman’s health, it should not justify termination on its own.²²⁵

I think it is offensive to those children and their parents if the abnormality itself becomes grounds for termination. It is much preferred if it is the impact of that abnormality on the woman and her family that is the grounds, not actually the abnormality itself.

[180] United Nations treaty bodies have urged that lawful access to termination should be available in cases of severe fetal abnormality. The United Nations Committee on the Rights of Persons with Disabilities has, however, cautioned that termination of pregnancy laws should not involve distinctions based solely on disability.²²⁶

‘Appropriate’ in all the circumstances

[181] In contrast to other jurisdictions, the legislation in the Northern Territory and Victoria includes a single ground that takes into account a broad range of circumstances. It provides that termination is lawful if the medical practitioner(s) considers it is ‘appropriate in all the circumstances’, having regard to:²²⁷

- all relevant medical circumstances;
- the woman’s current and future physical, psychological and social circumstances; and
- (in the Northern Territory) professional standards and guidelines.

²²³ *The Act Concerning Termination of Pregnancy* 1975 No 50 (Norway) s 2(c). See also Appendix B.

²²⁴ Parliamentary Committee Report No 33a (2017) [5.4.1], referring to Evidence to the Parliamentary Committee, 28 October 2016, 27 (Prof M Permezel, President, RANZCOG). Screening and diagnostic testing for fetal anomalies may be carried out at various stages of pregnancy, including ultrasound and blood test screening at 11–13 weeks, sampling and testing of the amniotic fluid at 15 weeks and ultrasound screening for structural anomalies at 18–22 weeks. Results of some tests may take approximately one week to be returned. Where a major structural anomaly is detected, additional testing and counselling may be required before diagnosis and advice about prognosis can be given; each case must be considered individually with the help of a multi-disciplinary team, including maternal fetal medicine specialists, before the parents can reach an informed decision about how to proceed: Information provided by RANZCOG Queensland, 30 November 2017.

²²⁵ Parliamentary Committee Report No 33a (2017) [5.4.3], quoting Evidence to the Parliamentary Committee, 28 October 2016, 28 (Prof M Permezel, President, RANZCOG).

²²⁶ See [33], [36], [41]–[42], [84]–[88] and [109] in Appendix D.

²²⁷ *Termination of Pregnancy Law Reform Act 2017* (NT) s 7; *Abortion Law Reform Act 2008* (Vic) ss 5(2).

[182] RANZCOG has suggested that '[n]o specific clinical circumstance should qualify or not qualify a woman for termination' as the 'impact of any particular condition is highly individual and often complex'.²²⁸ In general terms, it has stated that a woman's 'physical, social, emotional and psychological needs should be taken into account'.²²⁹

Consultation questions

- Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?**
- Q-4 If yes to Q-3, what should the gestational limit or limits be? For example:**
- (a) an early gestational limit, related to the first trimester of pregnancy;**
 - (b) a later gestational limit, related to viability;**
 - (c) another gestational limit or limits?**
- Q-5 Should there be a specific ground or grounds for a lawful termination of pregnancy?**
- Q-6 If yes to Q-5, what should the specific ground or grounds be? For example:**
- (a) a single ground to the effect that termination is appropriate in all the circumstances, having regard to:**
 - (i) all relevant medical circumstances;**
 - (ii) the woman's current and future physical, psychological and social circumstances; and**
 - (iii) professional standards and guidelines;**
 - (b) one or more of the following grounds:**
 - (i) that it is necessary to preserve the life or the physical or mental health of the woman;**
 - (ii) that it is necessary or appropriate having regard to the woman's social or economic circumstances;**
 - (iii) that the pregnancy is the result of rape or another coerced or unlawful act;**
 - (iv) that there is a risk of serious or fatal fetal abnormality?**

²²⁸ Submission 845 to the Parliamentary Committee on the first Bill and Inquiry.

²²⁹ RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.3].

Q-7 If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

Consultation by the medical practitioner

[183] In jurisdictions with an ‘on request’ approach, such as the Australian Capital Territory, there is no legislative requirement for one (or more) medical practitioners to be satisfied that particular legal grounds for termination are met. This is said to position the woman as the final decision-maker, in consultation with her doctor; if termination is medically indicated and there is informed consent, termination is lawful.

[184] However, many jurisdictions, including those that have taken a ‘combined’ approach, commonly impose an additional requirement for consultation with a second medical practitioner or, in some cases, referral to a committee. This has been described as making the medical practitioners the final decision-makers or ‘gate-keepers’.²³⁰

[185] As shown in the table below, the legislation in most Australian jurisdictions requires at least two medical practitioners to concur in being satisfied of the necessary grounds for termination. With the exception of South Australia, the requirement is triggered by the gestational limit and accordingly applies only to a termination performed outside that limit.

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
When	X	X	For terminations after 14 weeks and up to 23 weeks, except in an emergency	X	For all terminations, except in an emergency	For terminations after 16 weeks	For terminations after 24 weeks	For terminations after 20 weeks
Who	X	X	At least two ‘suitably qualified medical practitioners’: including the practitioner who performs the procedure	X	Two ‘legally qualified medical practitioners’: including the practitioner who performs the procedure	Two ‘medical practitioners’: including the practitioner who performs the procedure one must be a specialist in obstetrics or gynaecology	At least two ‘registered medical practitioners’: including the practitioner who performs or directs the procedure	At least two ‘medical practitioners’ who are members of a panel of at least six medical practitioners appointed by the Minister

Table 9: Additional consultation requirements in Australian jurisdictions²³¹

Queensland

[186] The legislation in Queensland does not impose a requirement for consultation with other practitioners or referral to a committee.²³²

²³⁰ See, eg, K Petersen, ‘Abortion: Medicalisation and Legal Gatekeeping’ (2000) 7 *Journal of Law and Medicine* 267.

²³¹ As to additional consultation requirements in overseas jurisdictions, see Appendix B.

²³² The position is similar in New South Wales.

[187] However, ‘facility level approval’ is strongly recommended in the clinical guideline. As shown in the following table, the suggested procedures involve either two medical specialists or, in complex cases, a case review with at least one other relevant health professional.²³³

Queensland Clinical Guideline		
When	For all terminations	For ‘complex cases’ (where, in the treating doctor’s judgment, there are circumstances that complicate the decision-making process or the woman’s care and management) ²³⁴
Who	<p>Two medical specialists, one of whom must be a specialist obstetrician:</p> <ul style="list-style-type: none"> • ideally, including the practitioner performing or overseeing the procedure • the specialty of the second practitioner should be relevant to the circumstances of the individual case 	<p>The treating obstetrician and at least one other health professional as appropriate for the individual case, eg:</p> <ul style="list-style-type: none"> • social worker, psychiatrist, obstetrician, general practitioner, maternal fetal medicine specialist, paediatrician <p>Case review may also include, eg:</p> <ul style="list-style-type: none"> • lawyer, ethicist, religious officer, sexual assault worker
Procedure	<p>The circumstances of the individual case are considered by both doctors. Consideration is also given to local facility approval requirements, such as notification to or approval from the Executive Director of Medical Services or equivalent.</p> <p>The decision is made in partnership with the woman and her doctor.</p> <p>Where both doctors reasonably believe the termination meets the legal test, the decision should be documented. Local facility level approvals should also be documented.</p>	<p>A case review is conducted to consider the complexities specific to the individual case.</p> <p>The case review members consider all the circumstances and provide an opinion to the treating obstetrician and the Executive Director of Medical Services or equivalent on whether the legal test is met.</p> <p>The decision is made in partnership with the woman and her doctor.</p> <p>The decision of both doctors, and any local facility level approvals, should be documented.</p>

Table 10: Suggested facility level approval under the Queensland clinical guideline

[188] The purpose of the facility level approval is to ‘establish and document a considered process for the woman and to provide reassurance and support to the health practitioner’.²³⁵ Each facility determines its own ‘local approval structure and mechanisms appropriate to its service’.²³⁶

[189] For terminations of later term pregnancies (usually involving fetal abnormality), Queensland public hospitals refer the request to a hospital committee.

²³³ Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3.2], and see [4], [4.3]. The guideline applies to Queensland public hospitals and licensed private health facilities: see [48] above.

²³⁴ For example, the gestation of the pregnancy or the woman’s medical, social or economic circumstances, capacity to consent, mental health or age: *ibid* 4.

²³⁵ *Ibid* [3.2].

²³⁶ *Ibid*. See also n 71 above.

For example, terminations after 22 weeks at the Royal Brisbane and Women's Hospital require:²³⁷

- assessment by two specialist practitioners, including the treating practitioner and another obstetrician or maternal fetal medicine specialist;
- a psychiatric consultation with the patient; and
- consideration, and final decision, by a hospital ethics committee comprising representatives from the disciplines of obstetrics, psychiatry, law, ethics, nursing and midwifery.

[190] It has been observed that the ethics committee process takes between five and ten days.²³⁸

[191] Referral of later term terminations to hospital committees or multi-disciplinary teams also occurs in practice in many other Australian jurisdictions.²³⁹

Should the legislation require consultation with other practitioners or referral to a committee?

'On request' approach

[192] There is no requirement for consultation with a second medical practitioner or referral to a committee under the termination of pregnancy laws in the Australian Capital Territory. This is consistent with the 'on request' approach under which there is no requirement to satisfy specified grounds.²⁴⁰

[193] This approach might be considered appropriate on the basis that:

- It accords greater respect for the autonomy and privacy of the woman, and avoids the perceived need and difficulty for the woman to 'persuade' others of her need for termination;
- It seeks to regulate termination in the same way as any other medical procedure, leaving consultation and referral in appropriate cases to clinical practice;

²³⁷ Submission 112 to the Parliamentary Committee on the second Bill.

²³⁸ Ibid.

²³⁹ Evidence to the Parliamentary Committee, 4 August 2016, 14, 15 (Prof D Ellwood), referring to the Australian Capital Territory, New South Wales, Victoria and Western Australia. See also, eg, KL Black, H Douglas and C de Costa, 'Women's access to abortion after 20 weeks gestation for fetal chromosomal abnormalities: views and experiences of doctors in New South Wales and Queensland' (2015) 55 *Australian and New Zealand Journal of Obstetrics and Gynecology* 144; VLRC Report (2008) [3.37]–[3.41].

²⁴⁰ Canada is also generally described as having an 'on request' approach. Former s 287 of the Criminal Code RSC 1985 c C-46 had provided that termination was lawful if it was carried out in an accredited or approved hospital and was approved by the hospital's 'therapeutic abortion committee'. That provision was held invalid by the Supreme Court in *R v Morgentaler* [1988] 1 SCR 30, which found that the regime it established created delays and unequal access. Although there are no consultation or referral requirements under federal legislation, some provinces attempted to restrict access to publicly funded terminations through similar requirements: see, eg, R Johnstone and E Macfarlane, 'Public Policy, Rights, and Abortion Access in Canada' (2015) 51 *International Journal of Canadian Studies* 97.

- It avoids the delay, uncertainty and associated burden on the woman that might be involved in consulting with a second practitioner or referring to a committee in every case.

[194] However, there are also arguments in favour of a consultation requirement.²⁴¹

'Combined' approach, with or without a consultation requirement

[195] Jurisdictions that have adopted a 'combined' approach, with a combination of grounds and gestational limits, typically impose an additional requirement for consultation with other practitioners (or, in some overseas jurisdictions, referral to a committee).

[196] This approach, where a gestational limit triggers narrower grounds and the involvement of other medical practitioners, is consistent with the idea that the further a pregnancy develops, the more stringent the requirements for lawful termination should be.

[197] For example, in Victoria, termination up to 24 weeks is lawful 'on request', where it is essentially a matter for determination by the woman in consultation with her doctor. After 24 weeks, however, the decision-making requirements change: termination is lawful if the registered medical practitioner performing the termination reasonably believes it is appropriate in all the circumstances and 'has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances'.²⁴²

[198] Consultation with a second medical practitioner is also required by the legislation in the Northern Territory, Tasmania and Western Australia (only for a termination after the relevant gestational limit) and in South Australia, as well as in several overseas jurisdictions.²⁴³ In Tasmania, one of the practitioners must be a specialist in obstetrics or gynaecology; and in the Northern Territory, both practitioners must be 'suitably qualified'.²⁴⁴

[199] In contrast, in some overseas jurisdictions, such as Denmark and Sweden, requests for termination after the relevant gestational limit must be referred to a committee.

[200] A requirement to consult with other medical practitioners is also a feature of the legislation in some of the more restrictive countries. In Ireland, for example, the legislation provides that termination is lawful only to save the woman's life.

²⁴¹ See [202] below.

²⁴² *Abortion Law Reform Act 2008* (Vic) s 5(1). See also s 7(1).

²⁴³ *Termination of Pregnancy Law Reform Act 2017* (NT) s 9; *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(1)(b); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a). See also, eg, *Contraception, Sterilisation and Abortion Act 1977* (NZ) s 29; *Abortion Act 1967* (UK) s 1. See further Appendix B (eg, Iceland, Norway, Germany and France).

²⁴⁴ A 'suitably qualified medical practitioner' is defined to mean an obstetrician or gynaecologist or a practitioner who is credentialed in the provision of advice, performance of procedures and giving treatment in the area of fertility control: *Termination of Pregnancy Law Reform Act 2017* (NT) s 4. In South Australia, both practitioners must be 'legally qualified', although this is not defined.

Depending on the particular grounds (an emergency, physical illness, or potential suicide), the legislation requires one, two or three medical practitioners to concur that the termination is justified.²⁴⁵

[201] In some jurisdictions, such as the Northern Territory and South Australia, the additional requirement to consult with other medical practitioners does not apply in emergencies.²⁴⁶

[202] A legislative requirement for consultation with other medical practitioners or referral to a committee, especially if linked to a later gestational limit, might be considered appropriate for various reasons:

- It could ensure a multi-disciplinary approach is taken to decisions;
- It might be considered the best means of deciding whether termination is necessary on medical grounds;
- It would be consistent with current practice, particularly for complex cases;
- It might relieve pressure on individual medical practitioners, especially for complex or potentially controversial cases;
- It might encourage greater consistency of decision-making, through discussion and consensus;²⁴⁷
- It might promote community confidence by providing an additional level of oversight, especially for termination of later term pregnancies.

[203] On the other hand, an express requirement for consultation or referral might be considered inappropriate or unnecessary:

- It might undermine the woman's autonomy and respect for her decision-making ability in consultation with her doctor;²⁴⁸
- It might increase delay, uncertainty and expense;²⁴⁹

²⁴⁵ *Protection of Life During Pregnancy Act 2013* (Ire) ss 7 (physical illness, requiring an obstetrician and another medical practitioner of a relevant specialty), 8 (physical illness in an emergency, requiring a single medical practitioner), 9 (suicide, requiring an obstetrician and two psychiatrists). Other than in an emergency, one of the medical practitioners is also to consult, if practicable, with the woman's general practitioner: ss 7(3), 9(4).

²⁴⁶ *Termination of Pregnancy Law Reform Act 2017* (NT) s 10; *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(b).

²⁴⁷ See, eg, JE Dickinson, 'Late pregnancy termination within a legislated medical environment' (2004) 44 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 337, 340 in which it is observed that a 'stable' panel of practitioners could 'facilitate uniformity of the decision-making process, although not eliminate controversy about particular cases'.

²⁴⁸ See, eg, C Forster and V Jivan, 'Abortion Law in New South Wales: Shifting from Criminalisation to the Recognition of the Reproductive Rights of Women and Girls' (2017) 24 *Journal of Law and Medicine* 850, 856; NL Woodrow, 'Termination review committees: are they necessary?' (2003) 179 *Medical Journal of Australia* 92.

²⁴⁹ See, eg, Black, Douglas and de Costa, above n 239, in which it was reported that '[21] of the 22 practitioners or their colleagues [in that study] had to refer women interstate to have an abortion because the ethics committee would take too long to convene'.

- It could impact adversely on vulnerable women, including those in rural, regional and remote locations, if a second practitioner or a committee is not available or if access to such a process is delayed;
- If it involved a committee, it might be perceived as unfair, especially if the woman is not given an opportunity to appear before the committee;
- It might be perceived as unnecessarily intrusive or burdensome.

[204] Some submitters to the Parliamentary Committee considered that legislation is unnecessary given the clinical guideline and practice.²⁵⁰ For example, the Australian Clinical Psychology Association observed that ‘doctors already are required to ... seek appropriate support from colleagues’, and argued that a legislative requirement:²⁵¹

may undermine the woman as decision-maker, compromise the woman’s right to confidentiality, undermine the doctor-patient relationship, and be offensive to the strict and high standards of professional care Australian doctors must abide by [under] regulations and professional standards.

[205] Other submitters supported a requirement for consultation with another medical practitioner, consistently with the position in Victoria, to address community concerns about termination of later term pregnancies.²⁵² Many submitters considered, however, that this would provide little protection without additional safeguards to ensure the independence of the second medical practitioner.²⁵³

[206] There was little support for a requirement for referral to a committee.²⁵⁴ A maternal fetal medicine specialist commented, for example, that, whilst such processes can ensure collaborative decision-making and ‘collective ownership’ of decisions, they can be ‘burdensome for women in a very difficult and vulnerable situation’.²⁵⁵

²⁵⁰ Parliamentary Committee Report No 33a (2017) [5.4.2]. See, eg, Submissions 52, 1014 and 1039 to the Parliamentary Committee on the second Bill; Evidence to the Parliamentary Committee, 4 August 2016, 15 (Prof D Ellwood).

²⁵¹ Submission 52 to the Parliamentary Committee on the second Bill. A representative of RANZCOG also considered that consultation with, and examination by, another medical practitioner should be discretionary, but noted that the community may feel ‘more comfortable’ with a legislative requirement: Evidence to the Parliamentary Committee, 28 October 2016, 30–31 (Prof M Permezel, President, RANZCOG).

²⁵² See, eg, Submissions 565, 810, 861, 874, 877, 1004 and 1223 to the Parliamentary Committee on the second Bill.

²⁵³ Parliamentary Committee Report No 33a (2017) [5.4.2]. See, eg, Submissions 8, 20, 122, 811, 870, 889, 890, 1030, 1038 to the Parliamentary Committee on the second Bill; Evidence to the Parliamentary Committee, 27 October 2016, 18, 21 (Dr R Campbell, Director, Queensland Bioethics Centre).

²⁵⁴ See, eg, Evidence to the Parliamentary Committee, 15 July 2016, 15 (Prof C de Costa); 2 August 2016, 2 (Prof M Permezel, President, RANZCOG); 2 August 2016, 18 (Mr A Apostolellis, Chief Executive Officer, Marie Stopes International Australia); 4 August 2016, 14 (Prof D Ellwood); Submissions 97, 879, cf 713 to the Parliamentary Committee on the second Bill.

²⁵⁵ Evidence to the Parliamentary Committee, 4 August 2016, 14 (Prof D Ellwood).

[207] The RANZCOG statement on Queensland's termination of pregnancy laws states that it:²⁵⁶

supports agreement by two medical practitioners where the woman is more than 24 weeks pregnant and strongly recommends that a 'panel' not be introduced as obligatory as this has been shown to lead to delays and result in later termination of pregnancy.

[208] The WHO has recommended that authorisation from hospital authorities should not be required for access to terminations, noting that it may violate women's rights to privacy and non-discrimination in access to health care.²⁵⁷

Consultation questions

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

If yes to Q-8:

Q-9 What should the requirement be? For example:

(a) consultation by the medical practitioner who is to perform the termination with:

(i) another medical practitioner; or

(ii) a specialist obstetrician or gynaecologist; or

(iii) a health practitioner whose specialty is relevant to the circumstances of the case; or

(b) referral to a multi-disciplinary committee?

Q-10 When should the requirement apply? For example:

(a) for all terminations, except in an emergency;

(b) for terminations to be performed after a relevant gestational limit or on specific grounds?

²⁵⁶ RANZCOG, 'Queensland abortion law reform' (Media Statement, 15 February 2017). RANZCOG 'supports a multidisciplinary approach in assisting women' in the rare circumstances in which the managing clinicians and the patient consider termination to be the most suitable option: RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.4]; RANZCOG, 'Late Termination of Pregnancy' (C-Gyn 17A, May 2016).

²⁵⁷ See [110], and [27] in relation to the comments of the ESCR Committee, in Appendix D.

Conscientious objection

[209] Where there is a doctor-patient relationship, the medical practitioner owes a general duty of care to the patient which requires the practitioner to exercise 'reasonable care and skill' in the provision of professional advice and treatment.²⁵⁸

[210] Ethically, a medical practitioner may decline to enter into, or continue, a therapeutic relationship if an alternative health care provider is available and the situation is not an emergency.²⁵⁹ In exceptional circumstances, a medical practitioner may also exercise a conscientious objection to particular treatment.²⁶⁰

[211] In this context, 'conscientious objection' is a medical practitioner's refusal to provide, or participate in, a lawful treatment or procedure because it conflicts with the practitioner's 'personal beliefs and values' or 'sincerely held beliefs and moral concerns'.²⁶¹

[212] Concern has been raised that a medical practitioner's conscientious objection to termination of pregnancy may impede a woman's access to timely termination services,²⁶² especially if the objecting practitioner does not, or is not required to, refer the woman to another service or provider; or where alternative practitioners or facilities are not available, such as in rural, regional or remote areas.²⁶³

[213] International human rights law recognises the 'right to freedom of thought, conscience and religion'.²⁶⁴

²⁵⁸ Similarly, a hospital emergency department has a general duty to take reasonable care in dealing with persons who present for treatment. See generally L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) [2.46]–[2.48], [2.86]–[2.88], [7.12]; J McIlwraith and B Madden, *Health Care and the Law* (Thomson Reuters, 6th ed, 2014) [10.55], [10.170]; C Stewart, I Kerridge and M Parker, *The Australian Medico-Legal Handbook* (Elsevier, 2008) [4.2]; LexisNexis, *Halsbury's Laws of Australia* (at 26 August 2016) 280 Medicine, 'Professional Negligence' [280-2000], [280-2025].

²⁵⁹ AMA, *Code of Ethics* (2016) [2.1.11]–[2.1.12]; MBA, *Good Medical Practice: A Code of Conduct for Doctor's in Australia* (March 2014) [3.13]. Where a therapeutic relationship is discontinued, the practitioner must inform the patient and assist in facilitating arrangements for their ongoing care.

²⁶⁰ AMA, *Position Statement: Conscientious Objection* (2013) [1].

²⁶¹ Ibid [1]–[3]. The AMA states that a conscientious objection is not based on self-interest or discrimination, and that a refusal may occur 'in exceptional circumstances, and as a last resort'. In this context, the term 'participation' includes indirect actions such as referring a patient to another practitioner who is willing to provide the service. See, in contrast, international judicial consideration of the term 'participate' at n 283 below.

The term 'conscientious objection' is not defined by termination of pregnancy legislation in any Australian jurisdiction.

²⁶² Parliamentary Committee Report No 24 (2016) [16.5]. See also VLRC Report (2008) [8.27]–[8.28], [8.31].

See also Keogh et al, above n 129, 22, in which it is observed that some participants in a study of the Victorian legislation were of the view that the legislative provision for conscientious objection 'had increased the legitimacy of "opting out" of abortion provision, and that as a consequence of this clause, whole institutions could justify not providing abortion services'.

²⁶³ Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [16.4.4]; VLRC Report (2008) [3.102], [8.28], [8.31]. See also R Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An analysis of the conscientious objection to abortion and the "obligation to refer"' (2015) 22 *Journal of Law and Medicine* 900, 907, 910.

²⁶⁴ See [93] in Appendix D.

Guidelines about conscientious objection

[214] Conscientious objection to certain medical treatments is included in Australian codes of conduct and ethical standards for medical practitioners and other health practitioners (including nurses, midwives and pharmacists).²⁶⁵ Generally, they recognise that a health practitioner may decline to provide or participate in a treatment to which the practitioner conscientiously objects, and require an objecting practitioner to:

- inform their employer and patients of their objection;
- take action to ensure that a patient's access to care is not impeded, including by providing information to enable a patient to obtain services elsewhere; and
- provide medically appropriate treatment in an emergency despite their objection.

[215] RANZCOG acknowledges the right of practitioners to hold a conscientious objection to termination of pregnancy, but requires that patients seeking that service be referred elsewhere or informed where and how the service can be obtained.²⁶⁶

[216] Non-compliance with codes of conduct or ethical standards may be the subject of professional disciplinary action.²⁶⁷

[217] In Queensland, conscientious objection to termination of pregnancy is addressed in the clinical guideline on therapeutic termination of pregnancy, which provides that 'health care professionals may decline to provide termination of pregnancy care on the basis of conscientious objection'. When this occurs, the objecting health care professional has 'a professional responsibility to ensure [that an] appropriate transfer of care occurs within a reasonable time frame for the circumstances'.²⁶⁸

Legislating for conscientious objection to termination of pregnancy

[218] In the Australian Capital Territory, the Northern Territory, South Australia, Tasmania, Victoria and Western Australia, conscientious objection to termination of pregnancy is the subject of specific legislative provision.²⁶⁹

²⁶⁵ MBA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (March 2014), [2.4.6]–[2.4.7]; AMA, *Code of Ethics* (2016), [2.1.11]–[2.1.13], [4.2.3]; AMA, *Position Statement: Conscientious Objection* (2013) 1; Nursing and Midwifery Board of Australia, *Code of Ethics for Nurses in Australia* (February 2005) 2, 4; Nursing and Midwifery Board of Australia, *Code of Ethics for Midwives in Australia* (August 2008) 3, 5, 6; Australian Nursing and Midwifery Federation, *Policy: Conscientious Objection* (February 2015); Pharmacy Board of Australia, *Code of Conduct* (March 2014) 9; Pharmaceutical Society of Australia, *Code of Ethics for Pharmacists* (January 2017) 12, 18.

²⁶⁶ RANZCOG Obstetrics and Gynaecology Bioethics Working Group, *The RANZCOG Code of Ethical Practice* (May 2006) 3, 6; RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.6].

²⁶⁷ See [43] above.

²⁶⁸ Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3]. This guideline does not define the terms 'health care professional' or 'termination of pregnancy care'.

²⁶⁹ *Health Act 1993* (ACT) s 84; *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11–13; *Criminal Law Consolidation Act 1935* (SA) s 82A(5)–(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6; *Abortion Law Reform Act 2008* (Vic) s 8; *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

[219] These legislative provisions vary, as shown in the table below. However, their general effect is to provide that a person who holds a conscientious objection is not required (or is not under a duty) to perform or participate in a termination of pregnancy.²⁷⁰

[220] The legislative provisions are similar to the conscientious objection provisions in codes of conduct and ethical standards of professional bodies, including the AMA, also shown in the table below.²⁷¹

²⁷⁰ In the Australian Capital Territory and Western Australia, the legislation does not specifically require that a person declining to participate in termination of pregnancy hold a conscientious objection: *Health Act 1993* (ACT) s 84; *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

²⁷¹ In Queensland and New South Wales, conscientious objection to termination of pregnancy is dealt with only in guidelines: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3]; NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) [4.2].

		Legislation					Guidelines			
		ACT	NT	TAS	VIC	WA	SA	NSW	QLD	AMA
Performance or participation is not required		✓	✓	✓	✓	✓	✓	✓	✓	✓
Who may object	Any person	✓		✓		✓	✓			
	Health practitioner		✓ (medical practitioner, ATSI health practitioner, nurse, midwife, pharmacist)		✓ (registered health practitioner)			✓ (medical practitioner)	✓ (health care professional)	✓ (medical practitioner)
	Hospital, institution or service					✓				
What actions	Performance or participation	✓	✓	✓	✓	✓	✓		✓ (provision of termination of pregnancy care)	✓ (provide or participate in a treatment or procedure) ²⁷²
	Advice		✓		✓			✓		
	Direction, authorisation or supervision				✓			✓		
Exceptions for emergencies	Preserve life of pregnant woman		✓	✓	✓		✓			✓ (an 'emergency situation')
	Prevent serious injury			✓ (physical injury)			✓ (physical or mental injury)			
Requirement to refer	To another health service			✓					✓ ²⁷³	✓ ²⁷⁴
	To a practitioner without an objection	✓ ²⁷⁵	✓		✓	✓ ²⁷⁶		✓ (direction only)		

Table 11: Conscientious objection to termination of pregnancy in Australian jurisdictions

²⁷² See n 261, above, as to the meaning of the term 'participate' in this context.

²⁷³ The guideline refers to an 'appropriate transfer of care', without specifying whether this is to a service or a practitioner: Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) 8.

²⁷⁴ Specifically, the AMA states that a medical practitioner should not use his or her conscientious objection to 'impede access to treatments that are legal'. Medical practitioners are directed to inform a patient of their objection and of that patient's right to see another doctor. The practitioner must be 'satisfied [that] the patient has sufficient information to enable them to exercise that right', and 'take whatever steps are necessary to ensure [that the] patient's access to care is not impeded': AMA, *Position Statement: Conscientious Objection* (2013) [5]–[6]; see also MBA, *Good Medical Practice: A Code of Conduct for Doctor's in Australia* (March 2014), [2.4.6]–[2.4.7].

²⁷⁵ This requirement is included only in guidelines: Parliamentary Committee Report No 33a (2017) [6.3.1], citing ACT Government Health, *Canberra Hospital and Health Services Clinical Guideline—Management of Termination of Pregnancy, Miscarriage or Fetal Death* (4 August 2016) 4.

²⁷⁶ This requirement is included only in guidelines: Department of Health (WA), *Termination of pregnancy: Information and legal obligations for medical practitioners* (December 2007) 10.

[221] In relation to its consultation, the Parliamentary Committee reported an apparent ‘general consensus that health practitioners should have a right to conscientious objection allowing them to decline to perform, or participate in the performance of’ a termination of pregnancy.²⁷⁷

[222] However, there was mixed opinion about whether conscientious objection should be the subject of legislation. There was support for legislative provision on the basis that it would recognise the right of health practitioners to freedom of religion, thought and conscience and to conscientious objection.²⁷⁸ However, it was also suggested that legislation is unnecessary because the matter is adequately addressed by codes of conduct and ethical standards.²⁷⁹

Who may conscientiously object?

[223] In some jurisdictions, legislative conscientious objection provisions apply to persons who are health practitioners, for example medical practitioners, nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander health practitioners.²⁸⁰ In Western Australia, the provision also applies to a ‘hospital, health institution, other institution or service’.²⁸¹

[224] In its consideration of this issue, the Victorian Law Reform Commission noted that ‘freedom of conscience is generally understood to be held by individuals’, and that it may be inappropriate to extend this to corporate entities.²⁸²

What actions does conscientious objection apply to?

[225] In each of the jurisdictions that make legislative provision for conscientious objection, an objection may be made in relation to participating in or performing (or assisting in the performance of) a termination of pregnancy.²⁸³ In some jurisdictions,

²⁷⁷ Parliamentary Committee Report No 24 (2016) [16.5]. See also Parliamentary Committee Report No 33a (2017) [6.4.2].

²⁷⁸ Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.2]. See also, eg, Submissions 863, 894 and 1040 to the Parliamentary Committee on the second Bill.

²⁷⁹ Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.2]. See also, eg, Evidence to the Parliamentary Committee, 15 July 2016, 16, 24 (Dr H McNamee); 27 October 2016, 18 (Dr R Campbell, Director, Queensland Bioethics Centre); Submission 789 to the Parliamentary Committee on the first Bill and Inquiry; and Submissions 565, 871, 874 and 905 to the Parliamentary Committee on the second Bill.

²⁸⁰ *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11–13; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(3), (4); *Abortion Law Reform Act 2008* (Vic) s 8.

²⁸¹ *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

²⁸² VLRC Report (2008) [8.32]–[8.33].

²⁸³ *Health Act 1993* (ACT) s 84; *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(1); *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11(1), 12(1); *Abortion Law Reform Act 2008* (Vic) s 8(1); *Health (Miscellaneous Provisions) Act 2011* (WA) s 334(2).

The term ‘participate’ has been construed as referring to ‘actually taking part in treatment ... for the purpose of terminating a pregnancy’, and as not including ancillary, administrative, managerial or supervisory tasks that might be associated with the treatment: *Janaway v Salford Health Authority* [1988] 3 All ER 1079, 1082; *Greater Glasgow Health Board v Doogan* [2015] 2 All ER 1, [37]–[38]. These cases consider the *Abortion Act 1967* (UK) s 4, which provides generally that a person is not under any duty to participate in a termination of pregnancy if they hold a conscientious objection, except in emergency circumstances.

an objection may also be held in relation to advising a woman about a proposed termination of pregnancy (or directing, authorising or supervising a termination).²⁸⁴

Exceptions for emergencies

[226] The legislation in most jurisdictions provides that, despite any conscientious objection, a person is required to perform or participate in a termination of pregnancy in emergency circumstances.²⁸⁵ These circumstances include where the termination is necessary to save the life of a pregnant woman and, in some jurisdictions, to prevent serious injury to a woman's physical health.²⁸⁶

[227] The Parliamentary Committee reported mixed views in its consultation on the inclusion of an exception for emergencies. There was some opposition to this exception on the basis that 'the right to conscientious objection should be absolute' and that such an exception would force practitioners to act in opposition to their convictions.²⁸⁷ Practical concern was also noted about the potential 'ambiguity' of what circumstances would constitute an emergency.²⁸⁸

[228] Others supported an exception for emergencies, observing that it may achieve a reasonable balance between freedom of conscience and protection of women's health and rights.²⁸⁹

[229] The right to freedom of thought, conscience and religion may be limited by legislation to protect others' fundamental rights and freedoms. United Nations treaty bodies have stated that conscientious objection to termination of pregnancy by health practitioners should be regulated to ensure that it does not impede access to termination services, including by requiring an exception for emergencies.²⁹⁰

284 *Termination of Pregnancy Law Reform Act 2017* (NT) s 11(1); *Abortion Law Reform Act 2008* (Vic) s 8(1). See also NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) [4.2].

285 *Criminal Law Consolidation Act 1935* (SA) s 82A(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(2)–(4); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13; *Abortion Law Reform Act 2008* (Vic) s 8(2)–(4). Similar provision is made in New South Wales guidelines: NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) [4.2].

286 *Criminal Law Consolidation Act 1935* (SA) s 82A(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6(2)–(4). In South Australia, the provision applies to the prevention of grave injury to physical or mental health.

287 Parliamentary Committee Report No 33a (2017) [6.4.3]. See also, eg, Submissions 863, 870, 872, 898 and 1007 to the second Bill.

288 *Ibid.* See also, eg, Submissions 863 and 872 to the second Bill; and A O'Rourke, L de Crespigny and A Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87, 98–9.

289 *Ibid.* See also, eg, Parliamentary Committee Report No 24 (2016) [16.5]; Submissions 1221 and 1222 to the Parliamentary Committee on the first Bill and Inquiry; and Submissions 565, 908 and 1042 to the Parliamentary Committee on the second Bill.

290 See [94]–[95], [97]–[98] and [110] in Appendix D.

Requirement to refer

[230] In Tasmania, the Northern Territory and Victoria, the legislation includes a requirement to refer.²⁹¹ In Tasmania, an objecting practitioner is required to give a woman a list of prescribed services that can provide advice, information or counselling on the full range of pregnancy options.²⁹²

[231] In the Northern Territory and Victoria, a practitioner must refer a woman to another practitioner, in the same profession, who the practitioner knows does not have a conscientious objection.²⁹³ It has been suggested that this requirement may be satisfied by directing a woman to a public hospital or family planning service that can provide her with ‘advice and assistance’.²⁹⁴

[232] There is no legislative penalty for non-compliance with a requirement to refer; however, for health practitioners, non-compliance could result in professional sanctions.²⁹⁵

[233] The Parliamentary Committee reported opposition to the inclusion of a requirement to refer, because it was seen as requiring objecting practitioners to act in a way that is contrary to their beliefs and making them ‘complicit’ in any resulting termination. However, it was also suggested that the intent of a referral is to enable

291 This is consistent with the various guidelines that apply in most jurisdictions: see, eg, Parliamentary Committee Report No 33a (2017) [6.3.1], citing ACT Government Health, *Canberra Hospital and Health Services Clinical Guideline—Management of Termination of Pregnancy, Miscarriage or Fetal Death* (4 August 2016) 4; Department of Health (WA), *Termination of pregnancy: Information and legal obligations for medical practitioners* (December 2007) 10; NSW Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (2 July 2014) [4.2]; Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3].

292 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2). See *Reproductive Health (Access to Terminations) Regulations 2013* (Tas) r 4(1) for a list of prescribed health services. The medical practitioner must also include contact details for each service in the list: r 4(2).

293 *Termination of Pregnancy Law Reform Act 2017* (NT) s 11(2)(b); *Abortion Law Reform Act 2008* (Vic) s 8(1)(b). In the Northern Territory, a referral must occur within two working days: Northern Territory Government, Department of Health, *Clinical Guidelines for Termination of Pregnancy* (July 2017) 22.

The Northern Territory also requires that, when another practitioner who is directed to assist in a termination holds a conscientious objection, the medical practitioner who gave the direction must instead direct another person who does not hold a conscientious objection to provide that assistance: *Termination of Pregnancy Law Reform Act 2017* (NT) s 12.

294 See Victoria, *Parliamentary Debates*, Legislative Assembly, 11 September 2008, 3613 (Maxine Morand, Minister for Women’s Affairs); O’Rourke, de Crespigny and Pyman, above n 288, 107–8; Sifris, above n 263, 905–6.

295 See [43] above. In New South Wales, the Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 proposed to insert into *Health Practitioner Regulation National Law* (NSW) that, where a patient seeks a termination, or advice about a termination or about the full range of options regarding pregnancy, it is unsatisfactory professional conduct for a health practitioner who has a conscientious objection to fail to inform a patient of their objection; or to fail to refer that patient (in a timely manner) to either another health practitioner in the same profession whom the practitioner knows or reasonably believes does not hold a conscientious objection or a local Women’s Health NSW Centre, to enable the patient to obtain full information about their options in relation to a pregnancy: sch 1, cl 1.3. This Bill was not passed.

In Victoria, explanatory materials observed that a health practitioner who did not comply with the law regarding termination of pregnancy or with other relevant law (for example, relating to the supply or administration of drugs) could be found to have engaged in professional misconduct: Explanatory Memorandum, Abortion Law Reform Bill 2008 (Vic) cls 5, 6.

a woman to access a greater range of options, including termination, not specifically for a termination to occur.²⁹⁶

[234] Others supported the inclusion of a legislative requirement to refer, observing that it may appropriately balance the freedom of health practitioners to operate according to their own beliefs and values against the relevant rights of women, including rights to health and autonomy, and against the need to avoid those beliefs and values creating a barrier to timely access to termination services (particularly in rural, regional and remote areas). Additionally, it was suggested that, because medical practitioners are ‘in a position of power and authority’, a requirement to refer would ensure that women can receive advice and access treatment, and thereby have their rights realised in practice.²⁹⁷

[235] United Nations treaty bodies also support a requirement to refer, to assist in ensuring that access to termination services is not impeded.²⁹⁸

Consultation questions

Q-11 Should there be provision for conscientious objection?

Q-12 If yes to Q-11:

- (a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?**
- (b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?**

²⁹⁶ Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.4]. See also, eg, Evidence to the Parliamentary Committee, 1 August 2016, 49 (Dr A Klose, Queensland Baptists); Submissions 762, 773, 800 and 1216 to the Parliamentary Committee on the first Bill and Inquiry; Submissions 811, 1030 and 1040 to the Parliamentary Committee on the second Bill; O'Rourke, de Crespigny and Pyman, above n 288, 107–8; and Sifris, above n 263, 908–9. As to the intent of a referral see, eg, Evidence to the Parliamentary Committee, 4 August 2016, 17 (Dr G Gardner); 28 October 2016, 29 (Prof M Permezel, President, RANZCOG).

²⁹⁷ Parliamentary Committee Report No 24 (2016) [16.5]; Parliamentary Committee Report No 33a (2017) [6.4.4]. See also, eg, Evidence to the Parliamentary Committee, 13 July 2016, 10 (Prof L Willmott, School of Law, Queensland University of Technology); 14 July 2016, 23 (S Utting, Women's Health Centre); 2 August 2016, 2, 8 (Prof M Permezel, President, RANZCOG); 4 August 2016, 7, 10 (Dr C Portmann, Obstetrician, Gynaecologist, Maternal Fetal Medicine Specialist); 28 October 2016, 2 (E Price, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors); Submissions 738, 757, 763, 825, 834, 837, 839, 1221 and 1272 to the Parliamentary Committee on the first Bill and Inquiry; Submissions 52, 565, 701, 876, 877, 904, 908, 1008, 1014 and 1042 to the Parliamentary Committee on the second Bill; O'Rourke, de Crespigny and Pyman, above n 288, 97–8, 115; and Sifris, above n 263, 909–13.

²⁹⁸ See [97]–[98] and [110] in Appendix D.

Counselling

[236] There is no provision in the termination of pregnancy legislation in any of the Australian jurisdictions that requires a woman to attend counselling before or after a termination of pregnancy. In Western Australia, a medical practitioner is required to offer a woman a referral to counselling about matters related to terminating or completing a pregnancy, and inform her that counselling will be available if desired upon termination or after carrying the pregnancy to term.²⁹⁹

[237] In Queensland, the clinical guideline on therapeutic termination of pregnancy sets clinical standards for information and counselling in relation to termination of pregnancy. This includes offering counselling to a woman before and after any termination of pregnancy, and where a woman considers but does not proceed with a termination.³⁰⁰

[238] In this context, good medical practice includes providing 'accurate, impartial and easy to understand information' about options for continuing the pregnancy and parenting the child or placing the child for adoption, methods of termination of pregnancy and post-termination considerations such as contraception and counselling. It also includes offering confidential and non-judgmental support and counselling.³⁰¹

[239] Clinical guidelines in South Australia, the Northern Territory and New South Wales similarly recommend that counselling should be offered before and after any termination.³⁰²

[240] The RANZCOG statement on termination of pregnancy also states that counselling should be 'routinely available' before and after any termination.³⁰³

[241] The Parliamentary Committee reported that submitters and witnesses generally acknowledged the 'importance of having access to comprehensive information and counselling to support a woman in making decisions about her

299 *Health (Miscellaneous Provisions) Act 1911 (WA)* s 334(5)(b), (c). The counselling must be 'appropriate and adequate'. The Western Australian legislation also requires that a medical practitioner provide a woman with counselling about the medical risk of terminating or completing a pregnancy: s 334(5)(a).

300 Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [3], [5], [6], [9]. The clinical guideline states generally that referral to other services is especially relevant where risk factors are present, including youth, sexual assault, domestic violence and particular cultural beliefs or values: [6]. A referral for post-termination counselling is suggested where there are 'risk factors for long-term post-termination distress', such as ambivalence prior to termination, lack of a supportive partner, a history of psychiatric illness or membership of a religion or culture that is opposed to termination of pregnancy: [9].

301 *Ibid* [5]. Practitioners should also consider any requirement for a 'formal mental health referral', particularly if a woman has a history of mental illness. See also Parliamentary Committee Report No 24 (2016) [15.4.3].

302 See, eg, Government of South Australia, Department for Health and Aging, *Standards for the management of termination of pregnancy in South Australia* (March 2014) 7; Northern Territory Department of Health, *Clinical Guidelines for Termination of Pregnancy* (June 2017) 21, 24, 42–3; NSW Government, Ministry of Health, *Pregnancy—Framework for Terminations in New South Wales Public Health Organisations* (July 2014) 3, 7.

303 RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.3].

pregnancy'.³⁰⁴ Some supported a legislative requirement for counselling before a termination, to ensure that the woman is given information and support.³⁰⁵ Others opposed this on the basis that it might impact on a woman's decision-making autonomy. It was observed that many women reach a decision themselves, and that counselling may be unhelpful if the woman's attendance is forced.³⁰⁶ It was also observed that a requirement to attend counselling may be a barrier to accessing termination services.³⁰⁷

[242] Some witnesses supported a legislative requirement that counselling be offered.³⁰⁸ However, it was also observed that it is already available and offered in practice.³⁰⁹

[243] In Queensland, the clinical guideline also states that counselling should be provided by a person — such as a social worker, counsellor or psychologist — who is 'appropriately qualified and/or trained', familiar with issues relevant to termination of pregnancy and has no vested interest in the outcome of the woman's pregnancy.³¹⁰ Similarly, the RANZCOG statement on termination of pregnancy states that counselling should be provided by 'appropriately qualified personnel'.³¹¹

³⁰⁴ Parliamentary Committee Report No 24 (2016) [15.2]. See also, eg, Evidence to the Parliamentary Committee, 12 July 2016, 31–2 (Dr F Hardy and J Whybrow, Australian Association of Social Workers, Queensland Branch), 38 (H Gridley, Australian Psychological Society); 1 August 2016, 35 (C Toomey, and L Miranda, Priceless Life); and Submissions 896, 1010, 1033, 1040 and 1212 to the Parliamentary Committee on the second Bill.

³⁰⁵ See, eg, Evidence to the Parliamentary Committee, 14 July 2016, 2 (W Stott), 9 (O Kirk); 1 August 2016, 5 (J Borger, President, Cherish Life Queensland), 11 (W Francis, Queensland Director, Australian Christian Lobby), 40–41 (K Dooley, Managing Director, Women's Forum Australia); Submission 1393 to the Parliamentary Committee on the first Bill and Inquiry; and Submissions 858, 859, 860, 869, 1002 and 1030 to the Parliamentary Committee on the second Bill.

³⁰⁶ See, eg, Evidence to the Parliamentary Committee, 12 July 2016, 31–2 (Dr F Hardy and J Whybrow, Australian Association of Social Workers, Queensland Branch), 38 (H Gridley, Australian Psychological Society); 15 July 2016, 26 (L Shumack); 1 August 2016, 35 (C Toomey and L Miranda, Priceless Life), 47 (Dr N Smith, Social Justice Committee, St Vincent de Paul Society), 62 (Dr R Campbell, Director, Queensland Bioethics Centre); Submission 778 to the Parliamentary Committee on the first Bill and Inquiry; and Submission 701 to the Parliamentary Committee on the second Bill.

³⁰⁷ See, eg, Evidence to the Parliamentary Committee, 2 August 2016, 22 (B Calo, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors); 65 (L Hardiman, Maternity Choices Australia); 28 October 2016, 5, 7 (E Price, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors); 19 (K Kerr, Social Worker, Women's Legal Service); 7 November 2016, 26 (Dr D Bateson, Family Planning Alliance Australia); and Submissions 753, 758, 759, 778 and 1188 to the Parliamentary Committee on the first Bill and Inquiry.

³⁰⁸ See, eg, Evidence to the Parliamentary Committee, 12 July 2016, 45 (H Gridley, Australian Psychological Society); 1 August 2016, 56 (M Averill, Nexus Church), 62 (Dr R Campbell, Director, Queensland Bioethics Centre); 2 August 2016, 66 (L Hardiman, Maternity Choices Australia); and Submission 905 to the Parliamentary Committee on the second Bill.

³⁰⁹ See, eg, Evidence to the Parliamentary Committee, 15 July 2016, 9 (Dr H McNamee); 28 October 2016, 53 (Dr R Sekar, Consultant, Maternal-Fetal Medicine). In its consideration of this issue, the Victorian Law Reform Commission expressed difficulty in determining the 'practical value' of a legislative requirement to refer to counselling because 'referrals can already be made and such a provision could not compel women to undertake counselling', and stated that a requirement to refer may impact upon clinical judgement and patient autonomy: VLRC Report (2008) [8.137]-[8.139].

³¹⁰ Queensland Clinical Guideline: Therapeutic Termination of Pregnancy (2013) [5].

³¹¹ RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.3].

[244] The Parliamentary Committee noted that:³¹²

the provision of pregnancy counselling services is not regulated and providers are not bound to comply with any professional standards, guidelines, or codes of ethics unless they choose to become a member of a professional organisation or association (such as the Psychotherapy and Counselling Federation of Australia, or the Australian Association of Social Workers).

[245] Some submitters to the Parliamentary Committee considered that counselling about termination of pregnancy should be unbiased and non-directive, meaning that a counsellor does not impose views upon a woman but assists her in exploring options and reaching a decision.³¹³ The need to ensure that counselling is provided by a person with appropriate qualifications or training was also highlighted.³¹⁴

[246] The WHO recognises that women should have access to counselling before and after a termination of pregnancy, but that it should be voluntary, confidential, unbiased (or 'non-directive') and provided by a trained person.³¹⁵

Consultation question

Q-13 Should there be any requirements in relation to offering counselling for the woman?

³¹² Parliamentary Committee Report No 24 (2016) [15.2.1]. See, in relation to psychologists, Australian Psychological Society, *Code of Ethics* (2016). See also, in relation to social workers and counsellors, Australian Counselling Association, *Code of Ethics and Practice* (August 2015); Psychotherapy and Counselling Federation of Australia, *Interim Code of Ethics* (2015); Australian Association of Social Workers, *Code of Ethics* (2010). See also Council of Australian Governments Health Council, *National Code of Conduct for Health Care Workers (Queensland)* (October 2015).

³¹³ See, eg, Evidence to the Parliamentary Committee, 15 July 2016, 13 (Dr M Carette); 1 August 2016, 60 (Dr R Campbell, Director, Queensland Bioethics Centre); 2 August 2016, 23 (B Calo, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors), 29 (S Tooker, Counsellor, Children by Choice); 27 October 2016, 5 (D Purcell, Vice-President, Cherish Life Queensland); 31 (Dr K Haller, Senior Executive Officer, Right to Life Australia); Submissions 794 and 1393 to the Parliamentary Committee on the first Bill and Inquiry; and Submissions 701 and 896 to the Parliamentary Committee on the second Bill.

³¹⁴ See, eg, Submissions 537, 744, 778 and 794 to the Parliamentary Committee on the first Bill and Inquiry. See also VLRC Report (2008) [8.140], in which the Victorian Law Reform Commission 'encourage[d] the Minister for Health to initiate the development of uniform standards of practice to inform pregnancy and abortion counselling services, and to encourage accountability and quality'.

³¹⁵ See [110] including the comments of the CEDAW Committee about counselling and waiting periods, and also [27] and [31] in Appendix D.

Protection of women and service providers and safe access zones

[247] There is evidence in some jurisdictions that people who oppose termination of pregnancy sometimes engage in behaviour, such as demonstrating or providing ‘footpath counselling’,³¹⁶ at or around premises that provide termination of pregnancy services. Such behaviour may impact on the safety, privacy and wellbeing of women who are accessing those premises and of service providers.³¹⁷

[248] In Queensland, laws of general application may address some of these behaviours. For example, offensive, threatening or intimidating behaviour that interferes with public access to a health facility may constitute a public nuisance offence.³¹⁸ Unlawfully entering or remaining in a licensed private health facility may constitute trespass.³¹⁹ These laws are, however, generally limited in scope and their applicability is dependent on the precise circumstances of each case.

[249] Specific legislation to address behaviour outside premises that provide termination of pregnancy services, generally referred to as ‘safe access zone’ legislation, has been introduced in the Australian Capital Territory, Northern Territory,

³¹⁶ ‘Footpath counselling’ may include conduct such as handing out information, asking women entering the clinic if they ‘are sure they want to do this’, or praying. Footpath counsellors view themselves as providing assistance or an alternative to women: see, eg, Evidence to the Parliamentary Committee, 27 October 2016, 24, 28 (A Duff, State Vice-President, Australian Family Association); 7 November 2016, 26 (Mr SE Cramp MP).

³¹⁷ See, eg, the submissions received by the Scrutiny of Acts and Regulations Committee (Parliament of Victoria) in relation to the Public Health and Wellbeing Amendment (Safe Access Zones) Bill 2015 (Vic), published in App 5 of Alert Digest No 15 of 2015. See also A Humphries, *Stigma, Secrecy and Anxiety in Women Attending for an Early Abortion* (The University of Melbourne, Masters Thesis, 2011). In Queensland, see Parliamentary Committee Report No 33a (2017) 39–40, referring to Submissions 112, 702, 812, 1014, 1032 and 1267 to the Parliamentary Committee on the second Bill.

³¹⁸ See *Summary Offences Act 2005* (Qld) s 6, which provides that it is an offence if a person behaves in a disorderly, offensive, threatening or violent way, and the person’s behavior interferes, or is likely to interfere, with another person’s peaceful passage through, or enjoyment of, a public place. Local laws may also apply. For example, the Rockhampton Regional Council prohibits the following activities, among others, in all areas controlled by the local government: (a) taking part in a protest or other riotous, disorderly, indecent, offensive, threatening or insulting behaviour; (b) carrying or displaying a placard or other sign bearing an offensive or threatening message or image. It also prohibits creating a nuisance on a road within the local government area: *Local Law No 4 (Local Government Controlled Areas, Facilities and Roads) 2011* s 5(1); *Subordinate Local Law No 4 (Local Government Controlled Areas, Facilities and Roads) 2011* s 5(1), sch 1 column 2.

³¹⁹ See, eg, *Preston v Parker* [2010] QDC 264, in which a person who opposed termination of pregnancy was convicted of trespass under s 11(2) of the *Summary Offences Act 2005* (Qld) for unlawfully remaining in a place used for a business purpose. In this case, the person sat on the front steps of a premises at which termination services were provided to deter or prevent people from accessing a termination, and refused to move following a request by police.

Tasmania and Victoria, and proposed in New South Wales.³²⁰ This follows similar legislation enacted in parts of Canada.³²¹

[250] The purpose of safe access zone legislation is to protect the safety and wellbeing, and respect the privacy and dignity, of people accessing premises at which termination services are provided, as well as employees and others who need to access those premises in the course of their duties and responsibilities.³²²

[251] Although the provisions vary between jurisdictions, the legislation commonly prohibits a range of behaviours such as harassing, intimidating or obstructing a person from obtaining or performing a termination of pregnancy in a safe access zone, as shown in the following table.

³²⁰ See *Health Act 1993* (ACT) pt 6, div 6.2 (ss 85–87), as inserted by the *Health (Patient Privacy) Amendment Act 2015* (ACT) (commenced on 22 March 2016); *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3 (ss 14–16) (commenced on 1 July 2017); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9 (commenced on 12 February 2014); *Public Health and Wellbeing Act 2008* (Vic) pt 9A (ss 185A–185H), as inserted by the *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) (commenced on 2 May 2016). A private member's bill is currently before the Parliament of New South Wales: Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW), proposing the insertion of new pt 2, div 2C (ss 11I–11P) in the *Summary Offences Act 1988* (NSW).

³²¹ Safe access zone legislation was first enacted in British Columbia in 1996 and has since been enacted in Newfoundland and Labrador, Quebec and, most recently, Ontario: *Access to Abortion Services Act*, RSBC 1996, c 1; *Access to Abortion Services Act*, SNL 2016, c A–1.02; *An Act Respecting Health Services and Social Services*, CQLR c S–4.2, ss 9.2, 16.1 and 531.0.1; *Safe Access to Abortion Services Act*, SO 2017, c 19.

Legislation to address this situation has also been enacted in the United States of America. At the federal level, see the *Freedom of Access to Clinic Entrances (FACE) Act of 1994*, 18 USCA §248. A number of States have also enacted various laws to protect access to termination of pregnancy services: see Guttmacher Institute, *Protecting Access to Clinics* (1 December 2017) <<https://www.guttmacher.org/state-policy/explore/protecting-access-clinics>>.

³²² See, eg, *Public Health and Wellbeing Act 2008* (Vic) ss 185A and 185C.

	ACT	NT	TAS	VIC	NSW BILL
Safe access zone areas	As declared by Minister (but must be a minimum of 50 metres from premises where terminations provided)	150 metres around premises where terminations provided	150 metres around premises where terminations provided	150 metres around premises where terminations provided	150 metres around premises where terminations provided or a pedestrian access point to the premises
Offence to engage in prohibited behaviour in safe access zone	✓ (25 penalty units)	✓ (100 penalty units or 12 months imprisonment. Person must intentionally engage in behaviour and be reckless in relation to behaviour occurring in safe access zone)	✓ (75 penalty units and/or 12 months imprisonment)	✓ (120 penalty units or 12 months imprisonment)	N/A Separate offences re activities in safe access zone (150 penalty units or 12 months imprisonment)
Prohibited behaviour in safe access zones	Harassing, hindering, intimidating, interfering with, threatening or obstructing a person, including by intentionally recording or capturing visual data of a person without their consent.	✓ (if behaviour may result in deterring a person from entering or leaving the premises, or from performing or receiving a termination at the premises)	✓ (also includes besetting)	✓ (also includes besetting)	Offence of interfering with access of persons to premises where terminations are provided (includes harassing, intimidating, interfering with, threatening, hindering, obstructing or impeding, by any means)
	Footpath Interference		✓	✓ (also includes impeding or interfering with a road or vehicle without reasonable excuse)	Offence of obstructing, blocking or impeding footpaths or roads providing access to termination of pregnancy clinics
	An act or communication that can be seen or heard by person accessing or leaving clinic	✓ (during the 'protected period', if act is intended to stop a person from entering the approved medical facility or from having or providing a termination)	✓ (an act that may result in deterring a person from entering or leaving the premises, or from performing or receiving a termination at the premises)		✓ (a communication that relates to terminations and is reasonably likely to cause distress or anxiety)

323

'Protected period' means the period between 7 am and 6 pm on each day the facility is open, or any other period declared by the Minister.

	ACT	NT	TAS	VIC	NSW BILL
Prohibited behaviour cont.	✓(by any means)		✓(if is able to be seen or heard by a person accessing, or attempting to access, premises at which terminations are provided)		
Offence to publish of a recording	✓ (50 penalty units and/or 6 months imprisonment) (if the recording is made with the intention of stopping a person from having or providing a termination)	✓ (100 penalty units or 12 months imprisonment) (if the recording is published intentionally and made recklessly)	✓ (75 penalty units and/or 12 months imprisonment)	✓ (120 penalty units or 12 months imprisonment) (if the recording 'contains particulars likely to lead to the identification of that other person')	150 penalty units or 6 months imprisonment. Also includes offence of intentionally recording another person in a safe access zone without their consent.

Table 12: Legislative provisions or proposals for safe access zones in Australian legislation

[252] The Parliamentary Committee reported mixed views in its consultation about whether Queensland should introduce safe access zone legislation. Some submitters considered that demonstrations and ‘footpath counselling’ provide support and assistance to women, while others considered that safe access zones were necessary to support or protect women and service providers.³²⁴

[253] In introducing safe access zone legislation, the Victorian Government considered that existing laws were inadequate and a more comprehensive approach was needed ‘in order to prevent the harm and not just to respond to inappropriate conduct when it occurs’.³²⁵

[254] United Nations treaty bodies have observed that measures should be taken to prevent violence, harassment and obstruction of women seeking access to termination of pregnancy services and facilities.³²⁶ The United Nations Special Rapporteur on the right to health has also observed that measures should be taken to protect termination service providers from harassment and violence.³²⁷

³²⁴ Parliamentary Committee Report No 33a (2017) [7.4.2]. In its report on the first Bill (that had proposed termination of pregnancy law reform, but did not include specific provisions regulating safe access zones), the Parliamentary Committee noted that the majority of submitters who made representations about safe access zones supported their introduction to protect patients and employees of health facilities from ‘offensive and obstructive’ behaviour. It also noted that a number of submitters considered safe access zones in other Australian jurisdictions to be successful: Parliamentary Committee Report No 24 (2016) [17.3].

³²⁵ Victoria, Legislation Assembly, *Parliamentary Debates*, 22 October 2015, 3973 (J Hennessy, Minister for Health).

³²⁶ See [27] n 42 and [110] in Appendix D.

³²⁷ See [31] and n 48 in Appendix D.

Defining the area of a safe access zone

[255] In effect, the legislation in the Northern Territory, Tasmania and Victoria, and the New South Wales Bill, automatically establishes that a safe access zone is the area within a radius of 150 metres from premises at which termination of pregnancy services are provided.³²⁸

[256] In contrast, the legislation in the Australian Capital Territory provides that the responsible Minister must declare that an area around a medical facility approved by the Minister to perform terminations (an ‘approved medical facility’) is a ‘protected area’.³²⁹ In making the declaration, the Minister must be satisfied that the area declared is:³³⁰

- not less than 50 metres at any point from the approved medical facility; and
- sufficient to ensure privacy and unimpeded access for anyone entering, trying to enter or leaving an approved medical facility; but
- no bigger than necessary to ensure that outcome.

[257] Automatically establishing a fixed boundary around premises has the advantage of providing certainty. On the other hand, enabling the responsible Minister to make a declaration in relation to the area provides flexibility and enables the area to be appropriately tailored to the premises.

[258] The Parliamentary Committee reported that some submitters expressed a preference for safe access zones to be automatically established with a radius of 150 metres around relevant premises.³³¹

³²⁸ *Termination of Pregnancy Law Reform Act 2017* (NT) s 4 (definition of ‘safe access zone’); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of ‘access zone’); *Public Health and Wellbeing Act 2008* (Vic) s 185B(1) (definition of ‘safe access zone’); Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) sch 1, proposed s 111 (definition of ‘safe access zone’). The precise wording of these provisions varies. The NSW Bill also proposes that a safe access zone means the area within a radius of 150 metres of a pedestrian access point to a building that houses a reproductive health clinic at which terminations are provided.

³²⁹ *Health Act 1993* (ACT) ss 85(1) (definition of ‘approved medical facility’ and ‘protected area’), 86(1). An ‘approved medical facility’ is a medical facility (or part of a medical facility) approved by the Minister under s 83 as suitable on medical grounds for carrying out terminations.

³³⁰ *Health Act 1993* (ACT) s 86(2). See, eg, *Health (Protected Area) Declaration 2016 (No 2)* (ACT) (Disallowable instrument DI2016–58).

³³¹ Parliamentary Committee Report No 33a (2017) [7.4.2], referring to Submissions 45, 52, 565, 687, 701, 874, 894, 904, 1005, 1029, 1039 and 1209 to the Parliamentary Committee on the second Bill.

Prohibited behaviour

[259] The legislation in each jurisdiction makes it an offence to engage in prohibited conduct (Northern Territory) or behaviour (Australian Capital Territory, Tasmania and Victoria) in a safe access zone.³³²

[260] Prohibited behaviour includes:³³³

- besetting (Tasmania, Victoria),³³⁴ harassing, hindering, intimidating, interfering with, threatening or obstructing a person (Tasmania) by any means (Victoria, New South Wales Bill), that is intended to stop the person (Australian Capital Territory) or that may result in deterring the person (Northern Territory) from entering or leaving premises where terminations are performed, or from having or providing a termination at the premises;
- interfering with or impeding a footpath, road or vehicle, without reasonable excuse, in relation to premises at which termination services are provided (Victoria, New South Wales Bill), or footpath interference in relation to terminations (Tasmania);
- acts that can be seen or heard by a person in the premises and that are intended to stop a person (Australian Capital Territory), or that may result in deterring a person (Northern Territory) from entering or leaving the premises, or from having or performing a termination at the premises;
- communicating by any means in relation to terminations in a manner that is able to be seen or heard by a person accessing, attempting to access, or leaving a premises at which termination services are provided and is reasonably likely to cause distress or anxiety (Victoria, New South Wales Bill);³³⁵
- a protest in relation to terminations (Australian Capital Territory, Tasmania) by any means (Australian Capital Territory), or that is able to be seen or heard

³³² *Health Act 1993* (ACT) s 87(1); *Termination of Pregnancy Law Reform Act 2017* (NT) s 14; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(2); *Public Health and Wellbeing Act 2008* (Vic) s 185D. In the Northern Territory, a person commits the offence if the person intentionally engages in prohibited conduct, the prohibited conduct occurs in a safe access zone and the person is reckless in relation to that circumstance: *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(1). The Act expressly states that it is not an offence if the person engaging in prohibited conduct is a police officer acting in the duties of law enforcement, or a person employed at premises for performing terminations, and the conduct is reasonable in the circumstances: s 14(2). The New South Wales Bill proposes the introduction of four separate offences in relation to certain behaviour: Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) sch 1, proposed ss 11K, 11L, 11M and 11N(1).

³³³ *Health Act 1993* (ACT) s 85(1) (definition of 'prohibited behaviour'); *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(4) (definition of 'prohibited conduct'); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(1) (definition of 'prohibited behaviour'); *Public Health and Wellbeing Act 2008* (Vic) s 185B(1) (definition of 'prohibited behaviour'); Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) sch 1, proposed ss 11K–11N.

³³⁴ 'Watching and besetting' means to attend or be near any place in numbers or in a manner calculated to intimidate a person in that place; or to obstruct the entrance or exit; or to lead to a breach of the peace. The watching must be such as would amount to a nuisance at common law: LexisNexis, *Encyclopaedic Australian Legal Dictionary* (at 6 December 2017), referring to *Re Van der Lubbe* (1949) 49 SR (NSW) 309.

³³⁵ However, this does not apply to an employee or other person who provides services at premises at which termination services are provided: *Public Health and Wellbeing Act 2008* (Vic) s 185B(2).

by a person accessing, or attempting to access, premises at which termination services are provided (Tasmania);

- intentionally capturing visual data (Australian Capital Territory, New South Wales Bill)³³⁶ or recording by any means (Northern Territory, Tasmania, Victoria) a person accessing or attempting to access premises at which termination services are provided without that person's consent;³³⁷ or
- any other prescribed behaviour (Tasmania).

[261] In contrast with other jurisdictions, the offence in the Australian Capital Territory is limited to prohibited behaviour that occurs during the 'protected period' (between 7 am and 6 pm on each day the facility is open).³³⁸

[262] The following penalties are prescribed:³³⁹

- a maximum fine of \$3750 (25 penalty units) (Australian Capital Territory);
- a maximum fine of \$11 925 (75 penalty units) or imprisonment for a term not exceeding 12 months (Tasmania);
- a maximum fine of \$13 000 (100 penalty units) or 12 months imprisonment (Northern Territory);
- a maximum fine of \$19 028 (120 penalty units) or imprisonment for a term not exceeding 12 months (Victoria);
- a maximum fine of \$16 500 (150 penalty units) or imprisonment for 12 months (New South Wales Bill).

[263] In each jurisdiction, it is also an offence to publish or distribute a recording of another person entering or leaving, or trying to enter or leave, premises where terminations are performed, unless the recorded person has given their consent (Australian Capital Territory, Northern Territory, Tasmania, Victoria and New South

³³⁶ A person 'captures visual data' of another person if the person captures moving or still images of the other person by a camera or any other means in such a way that a recording is made of the images, or the images are capable of being transmitted in real time with or without retention or storage in a physical or electronic form, or the images are otherwise capable of being distributed: *Health Act 1993* (ACT) s 85(1) (definition of 'capture visual data'); Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) sch 1, proposed s 11N(3) (definition of 'capture visual data').

³³⁷ In Victoria, this is not an offence unless also done 'without reasonable excuse'. The Tasmanian legislation states that a law enforcement officer is not guilty of engaging in prohibited behaviour within an access zone by intentionally recording, by any means, a person accessing or attempting to access premises at which termination services are provided without that person's consent if, at the time of making the recording, the officer was acting in the course of his or her duties and their conduct was reasonable for the performance of those duties: *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(3).

³³⁸ Or any other period declared by the Minister: *Health Act 1993* (ACT) s 85(2) (definition of 'protected period').

³³⁹ *Health Act 1993* (ACT) s 87(1) and *Legislation Act 2001* (ACT) s 133; *Termination of Pregnancy Law Reform Act 2017* (NT) s 14(1) and *Penalty Units Act* (NT) ss 4, 5; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(2) and *Penalty Units and Other Penalties Act 1987* (Tas) ss 4, 4A; *Public Health and Wellbeing Act 2008* (Vic) s 185D and *Monetary Units Act 2004* (Vic) s 5.

See also Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) sch 1, proposed ss 11K–11N; and *Crimes (Sentencing Procedure) Act 1999* (NSW) s 17.

Wales Bill),³⁴⁰ or the person publishing the recording has a reasonable excuse (Northern Territory and Victoria).³⁴¹

[264] A person commits this offence only if:

- the recording is made with the intention of stopping a person from having or performing a termination (Australian Capital Territory);³⁴²
- the recording is published intentionally and made recklessly (Northern Territory);³⁴³ or
- the recording contains particulars likely to lead to the identification of that other person (Victoria, New South Wales Bill).³⁴⁴

[265] The prescribed penalty for this offence is the same as for engaging in prohibited behaviour,³⁴⁵ except in the Australian Capital Territory where a person is liable to a maximum fine of \$7500 (50 penalty units), imprisonment for six months, or both.³⁴⁶

[266] The Parliamentary Committee reported that some submitters expressed concern about potential ambiguity in what would constitute prohibited behaviour.³⁴⁷ One submitter considered that the list of prohibited behaviour would need to be broad enough to allow some actions which, 'while not providing a direct impediment to staff and patients seeking to access a service, may still be emotionally distressing'.³⁴⁸ Another submitter considered that the inclusion of any intention requirement 'creates an unnecessary extra element of the offence and a barrier to enforcement'.³⁴⁹

340 *Health Act 1993* (ACT) s 87(2), (3); *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(1); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 9(4); *Public Health and Wellbeing Act 2008* (Vic) s 185E; Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) s 11N(2)(a).

341 *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(3); *Public Health and Wellbeing Act 2008* (Vic) s 185E. In the Northern Territory, it is not an offence if the recording is published to a person who is authorised under a law in force in the Territory to receive the information in the recording; *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(2).

342 *Health Act 1993* (ACT) s 87(2)(b).

343 *Termination of Pregnancy Law Reform Act 2017* (NT) s 15(1).

344 *Public Health and Wellbeing Act 2008* (Vic) s 185E; Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW) s 11N(2)(b).

345 See [262] above.

346 *Health Act 1993* (ACT) s 87(2).

347 Parliamentary Committee Report No 33a (2017) [7.4.2].

348 *Ibid*, referring to Submission 565 to the Parliamentary Committee on the second Bill. See also, eg, Evidence to the Parliamentary Committee, 28 October 2016, 3, 6 (E Price, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors); 10 (S Tooker, Counsellor, Children by Choice); 7 November 2016, 26 (Dr D Bateson, Family Planning Alliance Australia).

349 *Ibid*, referring to Submission 894 to the Parliamentary Committee on the second Bill.

Constitutional considerations

[267] Freedom of expression is protected under international human rights law, but it can legitimately be limited by legislation that is necessary and proportionate to protect others' fundamental rights, including rights to privacy and health.³⁵⁰

[268] The Australian Constitution does not expressly protect a right to 'freedom of speech'.³⁵¹ However, the High Court has recognised an implied freedom of political communication as a necessary part of the system of representative and responsible government established by the Constitution. This is not a personal right, but a right to freedom from government restraint on political communication. Legislation may place some restrictions on the freedom, provided they are reasonably appropriate and adapted to serve a legitimate purpose in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government.³⁵²

[269] The constitutional validity of safe access zone legislation in Australia has not been considered by the High Court.³⁵³

[270] The Parliamentary Committee reported that a number of submitters expressed concern about the possible impact of safe access zone legislation on 'freedom of speech'.³⁵⁴ Conversely, it also reported that a number of submitters suggested that safe access zones appropriately balanced this freedom with the rights of women and service providers to privacy, safety and self-determination.³⁵⁵

[271] During the Parliamentary Committee's consultation, a constitutional law expert submitted that arguably, legislation prohibiting harassing, intimidating, threatening or obstructing behaviour would be constitutionally valid, but legislation prohibiting protests would not:³⁵⁶

While it is strongly arguable that [both provisions] place burdens on the freedom, it is also arguable that they pursue objectives that are compatible with the

³⁵⁰ See [99]–[107] in Appendix D.

³⁵¹ Some States have introduced rights legislation protecting, among other things, the freedom of expression: see *Human Rights Act 2004* (ACT) s 16; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 15. No such legislation has been introduced in Queensland.

³⁵² *McCloy v New South Wales* (2015) 257 CLR 178, referring to *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520 and *Coleman v Power* (2004) 220 CLR 1. See also *Brown v Tasmania* [2017] HCA 43.

³⁵³ A number of prosecutions for offences under safe access zone provisions have been reported: see, eg, R Sifris and T Penovic, 'Court convicts woman for anti-abortion protesting' on Monash University, *Castan Centre for Human Rights Law: The Official Blog* (16 October 2017) <<https://castancentre.com/2017/10/16/anti-abortion-protesters-have-acted-with-impunity-for-decades-that-ends-now/>>; T Mills, 'Pro-lifers draw inspiration from Bob Brown in defence of abortion clinic charges', *The Age* (29 October 2017); P Billings, 'Pro-life protester John Graham Preston in court challenge', *The Mercury* (16 October 2016); G Taylor, "'Right to life' campaigners deny prayers outside abortion clinic were in protest, court hears', *ABC News*, Online (8 November 2017).

³⁵⁴ Parliamentary Committee Report No 33a (2017) [7.4.3], referring to Submissions 19, 23, 51, 539, 705, 836, 883, 901, 1003, 1020, 1031 and 1040 to the Parliamentary Committee on the second Bill.

³⁵⁵ *Ibid*, referring to Submission 112 to the Parliamentary Committee on the second Bill and Evidence to the Parliamentary Committee, 28 October 2016, 24 (Dr C de Costa).

³⁵⁶ Submission 1020 to the Parliamentary Committee on the second Bill; Evidence to Parliamentary Committee, 27 October 2016, 51 (Prof N Aroney, TC Beirne School of Law, University of Queensland), referred to in Parliamentary Committee Report No 33a (2017) [7.4.4].

constitutionally prescribed system of representative government, namely to enable persons to have access to abortion facilities and protect their privacy ...

In terms of compatibility, in my opinion, paragraph (c) [prohibiting protests] is not compatible with the Constitution. This is because ... it is directed at protests per se whether or not such protests are intended to stop a person from entering an abortion facility or from having an abortion. The prohibition on protesting per se is not a purpose which is compatible with the Constitution.

[272] A legal academic also gave evidence that:³⁵⁷

What ... the parliament and the drafters would have to grapple with is balancing the genuine constitutional right to protest and to make their political views known with the right of a woman to be able to obtain health care in circumstances where she is not harassed or intimidated. It is a balancing of that right. There might be constitutional issues to make sure that balance is correct, but there are legislative models.

Consultation questions

Q-14 Should it be unlawful to harass, intimidate or obstruct:

- (a) a woman who is considering, or who has undergone, a termination of pregnancy; or
- (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

If yes to Q-15:

Q-16 Should the provision:

- (a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or
- (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?

Q-17 What behaviours should be prohibited in a safe access zone?

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

³⁵⁷

Evidence to Parliamentary Committee, 28 October 2016, 72 (Prof L Willmott, School of Law, Queensland University of Technology).

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

Collection of data about terminations of pregnancy

[273] As mentioned above,³⁵⁸ there is no standardised national data collection or publication in relation to termination of pregnancy and Queensland data is incomplete. Some limited data is collected in relation to patients admitted to public hospitals and licensed private health facilities, but no data is collected on the number of medical terminations of pregnancy that occur in an outpatient setting.³⁵⁹

[274] The legislation in South Australia, Western Australia and the Northern Territory requires the notification of detailed information in relation to terminations of pregnancy. The information that must be disclosed varies in each jurisdiction, but generally includes information about where and when the termination occurred, the reason for termination, the gestation of the pregnancy and the method of termination, as well as anonymised details about the patient (such as the patient's age and place of residence).³⁶⁰

[275] In South Australia, the medical practitioner who performed the termination must complete a certificate and notice in the prescribed forms and deliver or post them to the Chief Executive³⁶¹ within 28 days of the termination. In addition, the chief executive officer of a hospital at which a pregnancy has been terminated during any calendar month must, within 20 days of the end of that month, provide the Chief Executive with notice of the number of pregnancies terminated during the month.³⁶² Failure to comply with these notification requirements is an offence.³⁶³ The collected data is published online.³⁶⁴

[276] In Western Australia, a medical practitioner who performs a termination of pregnancy must notify the Chief Health Officer in the prescribed form within 14 days.³⁶⁵

³⁵⁸ See [62] above. See also Parliamentary Committee Report No 24 (2016) [7.4.1.1].

³⁵⁹ See [67] above. See also Parliamentary Committee Report No 24 (2016) [7.4]–[7.5]; Evidence to the Parliamentary Committee, 12 July 2016, 10–11, 15 (Dr J Wakefield, Deputy Director-General, Clinical Excellence Division, Queensland Health).

³⁶⁰ *Criminal Law Consolidation Act 1935* (SA) s 82A(4)(b); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) s 4, sch 1; *Health (Miscellaneous Provisions) Act 1911* (WA) s 335(5); *Health (Section 335 (5)(d) Abortion Notice) Regulations 1998* (WA) s 2, sch 1; *Termination of Pregnancy Law Reform Act 2017* (NT) s 17; *Termination of Pregnancy Law Reform Regulations* (NT) ss 8, 9.

³⁶¹ The Chief Executive means the chief executive of the administrative unit of the Public Service that is, under the relevant Minister, responsible for the administration of the *Health Care Act 2008* (SA): *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) s 3 (definition of 'chief executive').

³⁶² *Criminal Law Consolidation Act 1935* (SA) s 82A(4)(b); *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) ss 4, 5, sch 1 and 2.

³⁶³ *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011* (SA) s 8. It is also an offence to knowingly provide information that is false or misleading. The maximum penalty for both offences is a fine of \$200.

³⁶⁴ Pregnancy Outcome (Statistics) Unit, SA Health, *Pregnancy outcome statistics* (30 November 2017) <<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics>>.

³⁶⁵ *Health Act 1911* (WA) s 335(5)(a)(d). The notification must not contain any particulars that may identify the patient: s 335(5)(e).

[277] In the Northern Territory, the legislation requires a medical practitioner who performs or directs the performance of a termination to report prescribed information to the Chief Health Officer within 28 days after the performance of a surgical termination or, for a medical termination, within 28 days of the medical practitioner's last consultation with the woman in relation to the termination.³⁶⁶ Failure to report is an offence.³⁶⁷

[278] In its 2008 report, the Victorian Law Reform Commission considered the inclusion of similar legislative notification requirements. However, it found that this was not necessary in Victoria because private providers are required to give detailed statistics as part of their registration requirements,³⁶⁸ and public providers must report similar statistical information as part of their funding agreements.³⁶⁹

[279] The Parliamentary Committee reported that a number of submitters and witnesses considered that the criminal offences for termination of pregnancy 'contribute to limits on data collection and transparency'.³⁷⁰ Some observed that the lack of accurate information in relation to terminations of pregnancy makes it difficult to plan for service delivery, monitor trends, evaluate the effectiveness of public health interventions and develop practice improvements.³⁷¹ To address this, some submitters and witnesses considered that legislation should provide for the mandatory reporting of anonymised data about terminations of pregnancy.³⁷²

Consultation question

Q-20 Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

³⁶⁶ *Termination of Pregnancy Law Reform Act 2017* (NT) s 17; *Termination of Pregnancy Law Reform Regulations* (NT) ss 8, 9.

³⁶⁷ *Termination of Pregnancy Law Reform Regulations* (NT) s 10. The maximum penalty is a fine of 20 penalty units (\$3080). It is a defence if the medical practitioner has a reasonable excuse.

³⁶⁸ See *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002* (Vic).

³⁶⁹ VLRC Report (2008) [8.191]–[8.202], [8.196]–[8.198], Rec 12.

³⁷⁰ Parliamentary Committee Report No 24 (2016) [7.4.1.1].

³⁷¹ See, eg, Evidence to the Parliamentary Committee, 15 July 2016, 19 (Prof C de Costa); and Submissions 794, 857 and 1213 to the Parliamentary Committee on the first Bill and Inquiry.

³⁷² See, eg, Evidence to the Parliamentary Committee, 2 August 2016, 6–7 (Prof M Permezel, President, RANZCOG); 20 (Mr Apostolellis, Chief Executive Officer, Marie Stopes International Australia); and Submission 777 to the Parliamentary Committee on the first Bill and Inquiry.

Appendix A

Terms of reference

Queensland's laws relating to the termination of pregnancy

Background

In Queensland, an unlawful abortion is a crime. The relevant sections are found in Queensland's Criminal Code and are as follows:

Section 224 (Attempts to procure abortion)

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.

Section 225 (The like by women with child)

Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.

Section 226 (Supplying drugs or instruments to procure abortion)

Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment for 3 years.

Section 282 (Surgical operations and medical treatment)

- (1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—
 - (a) a person or an unborn child for the patient's benefit; or
 - (b) a person or an unborn child to preserve the mother's life;if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.
- (2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.
- (3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.
- (4) In this section—

health professional see the *Hospital and Health Boards Act 2011*, schedule 2.

medical treatment, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

patient means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

surgical operation, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child.

In 2016, two Bills that sought to reform the law relating to termination of pregnancy were introduced into the Queensland Legislative Assembly by the Member for Cairns, Mr Robert Pyne MP, namely:

- the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 (the first Bill); and
- the Health (Abortion Law Reform) Amendment Bill 2016 (the second Bill).

The first Bill was introduced on 10 May 2016 and referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Parliamentary Committee (the Parliamentary Committee) for detailed consideration.

On 26 May 2016, the Legislative Assembly expanded the Parliamentary Committee's referral to require it to also conduct a wide-ranging enquiry into the law and clinical practice of terminations in Queensland (the general enquiry).

The Parliamentary Committee held public hearings and received over 1,400 submissions in relation to the first Bill.

On 26 August 2016, the Parliamentary Committee tabled its report on the first Bill and its general enquiry (Report on the first Bill). The Parliamentary Committee was of the view that the first Bill failed to address a number of important policy issues and to achieve a number of its own stated objectives. It did not recommend that the Bill be passed.

On 17 August 2016, the second Bill was introduced to the Queensland Legislative Assembly and was also referred to the Parliamentary Committee for detailed consideration. Over 1,200 submissions were received on the second Bill.

On 17 February 2017, the Parliamentary Committee tabled its report on the second Bill (the Report on the second Bill). The Committee was unable to reach agreement on whether or not the second Bill should be passed.

On 28 February 2017:

- both Bills were withdrawn from the Legislative Assembly by the Member for Cairns; and
- the Queensland Government announced that Queensland's laws in relation to the termination of pregnancy would be referred to the Queensland Law Reform Commission for its advice, with a view to a Bill being introduced in the next term of Government so as to modernise Queensland's laws relating to the termination of pregnancy.

Terms of Reference

I, YVETTE MAREE D'ATH, Attorney-General and Minister for Justice and Minister for Training and Skills, refer to the Queensland Law Reform Commission, for review and investigation, the issue of modernising Queensland's laws relating to the termination of pregnancy pursuant to section 10 of the *Law Reform Commission Act 1968*.

Scope

The Queensland Law Reform Commission is asked to recommend how Queensland should amend its laws relating to the termination of pregnancy to:

1. Remove terminations of pregnancy that are performed by a duly registered medical practitioner(s) from the Criminal Code sections 224 (Attempts to procure abortion), 225 (The like by women with child), and 226 (Supplying drugs or instruments to procure abortion).
2. Provide clarity in the law in relation to terminations of pregnancy in Queensland.

The Queensland Law Reform Commission is asked to prepare draft legislation based on its recommendations.

In providing advice and preparing draft legislation, the Queensland Law Reform Commission should have regard to the following:

- A. Existing practices and services in Queensland concerning termination of pregnancy including those provided by medical practitioners, counsellors and support services.
- B. Existing legal principles relating to termination practices in Queensland.
- C. The Queensland Government's commitment to modernise and clarify the law in relation to terminations of pregnancy.
- D. The consultation with stakeholders that occurred during the Parliamentary Committee's consideration of the first and second Bills.
- E. The views of experienced clinical practitioners.
- F. The views of the Queensland community.
- G. Legislative and regulatory arrangements in other Australian and international jurisdictions.

Consultation

The Queensland Law Reform Commission shall consult with any group or individual, in or outside of Queensland, to the extent that it considers necessary.

Timeframe

The Queensland Law Reform Commission is to provide a report on the outcomes of the review to the Attorney-General and Minister for Justice and Minister for Training and Skills by **30 June 2018**.

Dated the 13th day of June 2017

YVETTE D'ATH MP

Attorney-General and Minister for Justice
Minister for Training and Skills

Appendix B

Comparative table of termination of pregnancy laws in other jurisdictions

The table on the following pages provides an overview of termination of pregnancy laws in Australia¹ and across a range of international jurisdictions.²

¹ See *Health Act 1993* (ACT) pt 6 divs 6.1–6.2 (ss 80–87); *Crimes Act 1900* (NSW) ss 82–84; Criminal Code (NT) s 208A; *Termination of Pregnancy Law Reform Act 2017* (NT) pts 2 and 3 (ss 4–16); Criminal Code (Qld) ss 224–226; *Criminal Law Consolidation Act 1935* (SA) ss 82–82A; Criminal Code (Tas) ss 178D, 178E; *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 4–9; *Crimes Act 1958* (Vic) s 65; *Abortion Law Reform Act 2008* (Vic) pt 2 (ss 4–8); *Public Health and Wellbeing Act 2008* (Vic) pt 9A; Criminal Code (WA) s 199; *Health (Miscellaneous Provisions) Act 1911* (WA) s 334.

² See generally WHO, *Global Abortion Policies Database* (2017) <<http://srhr.org/abortion-policies/>>; Centre for Reproductive Rights, *The World's Abortion Laws 2017* (2017) <<http://worldabortionlaws.com/map/>>; Law Library of Congress, *Abortion Legislation in Europe* (15 Sept 2016) <<https://www.loc.gov/law/help/abortion-legislation/europe.php>>; and International Planned Parenthood Federation European Network, *Abortion legislation in Europe* (September 2012) <<http://ippfen.org/resource/abortion-legislation-europe>>.

	Australia								Ireland	Northern Ireland
	ACT	VIC	TAS	NT	WA	SA	NSW	QLD		
Termination lawful on request	✓	✓ (up to 24 weeks)	✓ (up to 16 weeks)	X	X	X	X	X	X	X
Termination lawful if doctor(s) satisfied of certain matters		✓ (after 24 weeks, if appropriate in all the circumstances)	✓ (after 16 weeks, if risk to physical or mental health)	✓ (up to 23 weeks, if appropriate in all the circumstances, or if emergency)	✓ (up to 20 weeks for most grounds; after 20 weeks, if woman or fetus has severe medical condition)	✓ (risk to life or health, fetal abnormality, or emergency)	✓ (risk to life or health: common law)	✓ (risk to life or health: common law)	✓ (risk of loss of life from physical illness, potential suicide, or emergency)	✓ (risk to life or health: common law)
More than one doctor, or a committee, must be satisfied	X	✓ (after 24 weeks, at least 2 doctors)	✓ (after 16 weeks, 2 doctors, including a specialist)	✓ (after 14 weeks and up to 23 weeks, at least 2 suitably qualified doctors; except in emergency)	✓ (after 20 weeks, at least 2 doctors from a panel)	✓ (2 doctors, except in emergency)	X	X	✓ (depending on the grounds, 1, 2 or 3 doctors)	X
Offences for unlawful termination	✓ (but not for a doctor)	✓ (but not for a doctor or other qualified person, or the woman)	✓ (but not for a doctor or the woman)	✓ (but not for a doctor or other qualified person, or the woman)	✓ (but not for a doctor)	✓	✓	✓	✓	✓
Conscientious objection by doctors recognised	✓	✓ (except in emergency)	✓ (except in emergency)	✓ (except in emergency)	✓	✓ (except in emergency)	X	X	✓	X
Doctors who object to refer woman to other provider	X	✓	✓	✓	X	X	X	X	✓	X
Counselling					(referral to counselling to be offered)					
Safe access zones established	✓	✓	✓	✓	X	X	X	X	X	X

International									
New Zealand	England, Scotland and Wales	Iceland	Norway	Germany	France	Denmark	Sweden	Canada	
X	X	X	✓ (up to 12 weeks)	✓ (up to 12 weeks)	✓ (up to 12 weeks)	✓ (up to 12 weeks)	✓ (up to 18 weeks)	✓	Termination lawful on request
✓ (up to 20 weeks for most grounds; after 20 weeks to save life or prevent serious permanent injury)	✓ (risk to life, grave permanent injury, fetal abnormality; up to 24 weeks if risk to health)	✓ (preferably before 12 weeks but up to 16 weeks for most grounds; after 16 weeks if risk to life or health or fetal abnormality)	✓ (risk to life or health; up to 18 weeks on specific grounds; after 18 weeks if special grounds and fetus is not viable)	✓ (danger to life or grave injury to health; up to 12 weeks if rape, up to 22 weeks in exceptional cases)	✓ (serious danger to health or fetal abnormality)	✓ (threat to life or health; after 12 weeks on specific grounds eg. rape, fetal abnormality)	✓ (serious threat to life or health; up to 22 weeks for special reasons)	Not in statute (<i>former criminal law held invalid</i>)	Termination lawful if doctor(s) satisfied of certain matters
✓ (2 doctors, except in emergency)	✓ (2 doctors, except in emergency)	✓ (2 doctors or a doctor and a social worker; after 16 weeks, a committee)	✓ (after 12 weeks, a board of 2 doctors)	✓ (2 doctors)	✓ (after 12 weeks, 2 doctors from team)	✓ (after 12 weeks, a committee)	✓ (after 18 weeks, national board)		More than one doctor, or a committee, must be satisfied
✓	✓	✓	✓ (but not for the woman)	✓	✓	✓ (but not for the woman)	✓ (but not for a doctor or the woman)	X (<i>former criminal law held invalid</i>)	Offences for unlawful termination
✓	✓ (except in emergency)		✓	✓ (except in emergency)	✓	✓			Conscientious objection by doctors recognised
X	X				✓	✓			Doctors who object to refer woman to other provider
(to be advised of right to seek counselling)		(information about available social support to be given)	(information about available social support to be given)	(pre-termination counselling required)	(counselling to be offered; pre-termination counselling required for minors)	(to be advised of right to information about available social support)	(emotional support to be offered)		Counselling
X	X							✓ some provinces	Safe access zones established

Appendix C

Development and moral status of the fetus

STAGES OF FETAL DEVELOPMENT	89
VIEWS ABOUT THE MORAL STATUS OF THE FETUS	91
From conception	92
The potentiality view	93
From birth	93
At viability	93
Developmental or gradualist view	94
Other views	94

Stages of fetal development

[1] A number of stages in the progression of a woman's pregnancy and fetal development can be identified:¹

- fertilisation and formation of the zygote;
- formation of the blastocyst;
- implantation;
- embryo; and
- fetus.

¹ See, eg, J Oats and S Abraham (eds), *Llewellyn-Jones Fundamentals of Obstetrics and Gynaecology* (Mosby Elsevier, 9th ed, 2010) ch 3–4; M Permezel, S Walker and K Kyprianou (eds), *Beischer & MacKay's Obstetrics, Gynaecology and the Newborn* (Elsevier Australia, 4th ed, 2015) ch 2; M Hill, *Embryology* (2017) <https://embryology.med.unsw.edu.au/embryology/index.php/Main_Page>; H Marcovitch, *Black's Medical Dictionary* (A&C Black, 42nd ed, 2009); E Martin, *Concise Medical Dictionary* (Oxford University Press, 9th ed, 2016).

		Weeks after fertilisation	Gestational weeks²	
Fertilisation and formation of the zygote	The sperm fuses with the egg (or ovum) to form the first diploid cell, called the zygote. ³	Day zero	Week 2	1st trimester (gestational weeks 1–12)
Formation of the blastocyst	The zygote is propelled along the woman's fallopian tube and cell division begins leading to the formation of a mass of cells, with a fluid-filled cavity, called the blastocyst.	Week 1	Week 3	
Implantation	The blastocyst undergoes a process of attaching to the uterine lining, and begins differentiating into different cell structures which will develop into the embryo and the placenta.	Week 2 ⁴	Week 4	
Embryo	The stage of development from implantation until the seventh or eighth week after fertilisation when the main organs have formed.	Week 3–8	Week 5–10	
	<ul style="list-style-type: none"> • 4–5 mm, about 1.3 g • 10–12 mm. The connection between the fetal and placental circulation has been established. • 20–25 mm. The embryo begins to show a distinctly human form. 	Week 4 Week 5 Week 6	Week 8 Week 7 Week 8	
Fetus	The stage of development from the eighth to tenth week after fertilisation to birth. During this period, placental development is completed and the fetus undergoes extensive growth and ongoing differentiation and growth of organ systems.	Week 8–38	Week 10–40	2nd and 3rd trimesters (gestational weeks 13–27 and 28–40)
	<ul style="list-style-type: none"> • 8–9 cm, 30–60 g • The woman may sense the movements of the fetus from about this time • 15–25 cm, 170–340 g • 32–35 cm, 1360–1820 g • 45–60 cm, >3200 g⁵ 	Week 12 Week 18 Week 20 Week 28 Week 38	Week 14 Week 20 Week 22 Week 30 Week 40	

Table 1: Fetal development⁶

² See 'gestation' in the Glossary to this Paper.

³ 'Diploid' meaning having two sets of chromosomes, in contrast to 'haploid' cells that contain only a single set of chromosomes.

⁴ Beginning at six to eight days after fertilisation and usually completed by about the ninth or tenth day after fertilisation.

⁵ Weight at 40 weeks is likely to depend on the level of obesity in the particular population, and will generally be greater, on average, than 3200 g. In 2015, the average live birth weight of Australian infants was 3342 g: Australian Institute of Health and Welfare, *Australia's mothers and babies, 2015—in brief* (2017) 22.

⁶ With particular reference to Hill, above n 1; read together with Oats and Abraham, above n 1, ch 3–4; Permezel, Walker and Kyprianou, above n 1, ch 2; and Marcovitch, above n 1, definition of 'fetus'.

[2] At 23 to 25 weeks gestation,⁷ the sustainability of the life of the fetus, if born pre-term, is uncertain. In Queensland, life sustaining interventions are not generally recommended for an infant born at less than 24 weeks.⁸

[3] The term ‘conception’ is not precise. It is commonly used to refer to the onset of pregnancy, either at fertilisation or implantation or both.⁹ It ‘signifies the complex set of changes which occur in the ovum and in the body of the mother at the beginning of pregnancy’.¹⁰

Views about the moral status of the fetus

[4] Determining the moral status of the fetus or unborn child is contentious. It cannot be resolved by medical facts:¹¹

The answer to that question—which deals with the moral status of the fetus—is arrived at by a process that entwines medical facts with experiences, values, religious and philosophical beliefs and attitudes, perceptions of meaning, and moral argument. Such a process extends beyond the special competency of medicine.

⁷ Between 23 weeks zero days and 25 weeks six days gestation: the ‘threshold of viability’ in Queensland: see [143] above.

⁸ See [143] above. There is general international consensus about the concept of different ‘zones’ in determining the threshold of viability for the care of extremely preterm infants. See, eg, A Janvier and JD Lantos, ‘Variations of practice in the care of extremely preterm infants’ in DS Diekema, MR Mercurio and MB Adam (eds), *Clinical Ethics in Pediatrics: A Case-Based Textbook* (Cambridge University Press, 2011) 95:

The first zone is that in which good outcomes are likely and thus, the initiation of intensive care is generally considered morally obligatory. A second zone is often called ‘the grey zone’. In the grey zone, outcomes are considered sufficiently ambiguous or uncertain that both intensive care and comfort care are considered two ethically defensible options. Finally, there is a third zone in which newborns are not considered viable and in which intervention is considered ‘non-beneficial’.

Those authors observe (at 94–5) that, in most industrialised countries, ‘the “physiological” lower limit of viability’ is generally 22 weeks, but that there is ‘tremendous variation’ in survival rates between countries at 22 to 25 weeks and between the ‘borders of the grey zone’:

Unlike the physiological limit of viability, which is the same around the globe, the borders between these three zones are fuzzy, elastic, and subjective. The policies of most industrialised countries vary considerably, with the borders of the grey zone ranging somewhere between 21 and 26 weeks, depending on where the baby is born.

A comparison of international guidelines, published in 2008, found that intensive care is generally considered justifiable from 25 weeks, compassionate (or palliative) care at 22 weeks or less, and an individual approach at 23 to 24 weeks consistent with the parents’ wishes and the infant’s clinical conditions: MS Pignotti and G Donzelli, ‘Perinatal Care at the Threshold of Viability: An International Comparison of Practical Guidelines for the Treatment of Extremely Preterm Births’ (2008) 121(1) *Pediatrics* e193. In 2005, a multi-disciplinary forum in the Australian Capital Territory and New South Wales adopted a consensus statement that the ‘grey zone’ is between 23 weeks and 25 weeks 6 days: K Lui et al, ‘Perinatal care at the borderlines of viability: a consensus statement based on a NSW and ACT consensus workshop’ (2006) 185(9) *Medical Journal of Australia* 495.

⁹ See, eg, the definitions of ‘conception’ given in *Medical Dictionary* (2017) <<http://medical-dictionary.com/results.php>>; *MedlinePlus, Medical Dictionary* (Merriam-Webster, 2017) <<http://c.merriam-webster.com/medlineplus/conception>>.

¹⁰ Marcovitch, above n 1, definition of ‘conception’.

¹¹ A Rosenfeild and S Iden, ‘Abortion: I Medical Perspectives’ in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 1.

[5] There is a diversity of views about the moral status, or personhood, of the fetus. The Law Reform Commission of Canada, in its working paper on crimes against the fetus, helpfully summarised the range of views in this way:¹²

Some see the fetus as a miniature person alike in all respects but ease of visibility to a newborn baby and want the law to put it on the same footing as the latter without distinguishing between born and unborn children. Others regard it as a non-person and want the law to reflect what they perceive as overwhelming differences between those merely undergoing biological development in the womb and those participating in social relations outside it, especially in cases of conflict between fetal and other human interests. Yet others take a halfway position and look upon fetuses as potential persons, in some respects like, but in others unlike, persons, ie, special cases which are more than just collections of human cells but for most of the time less than what ordinarily count as persons. (notes omitted)

[6] Within this broad spectrum, a number of positions can be identified, outlined below.¹³

[7] In part, the diversity of views arises because ‘the fetus is significantly unlike other entities of moral concern’ and its relationship with the pregnant woman is in many ways unique.¹⁴ Some commentators have suggested that, although a consensus is lacking, it can be agreed that the fetus is a living human entity and that decisions about it must be taken responsibly.¹⁵

From conception

[8] At one end of the spectrum is the view that the fetus is a person deserving full protection from the moment of conception or fertilisation. Some of the arguments in support of this view are that the genetic makeup of the physical organism is complete by conception, the human fetus is a whole organism rather than a collection of cells, and conception is the clearest point in fetal development to indicate the beginning of life.

[9] On the other hand, it is argued that personhood is created by psychological wholeness and experiential capacity rather than genetic identity, the fetus is not necessarily a complete organism at conception given the proportion of early development devoted to creation of the placenta and amniotic sac, and conception is a process that occurs over time and so does not provide a clear line.

¹² Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper No 58 (1989) 9.

¹³ The outline at [8]–[20] below is informed, in particular, by the summaries in J Herring, *Medical Law and Ethics* (Oxford University Press, 6th ed, 2016) 329–42; and E Wicks, *Human Rights and Healthcare* (Hart Publishing, 2007) 184–7. See also, eg, A Marzilli, *Fetal Rights: Point/Counterpoint* (Chelsea House Publishers, 2006); and LSM Johnson, ‘Abortion: II Contemporary Ethical and Legal Aspects: A. Ethical Perspectives’ in SG Post (ed), *Encyclopedia of Bioethics* (Thomson Gale, 3rd ed, 2004) vol 1, 8–17.

¹⁴ Johnson, above n 13, 8. See also, eg, C Mackinnon, ‘Reflections on Sex Equality Under Law’ (1991) 100(5) *Yale Law Journal* 1281, 1316.

¹⁵ See, eg, Wicks, above n 13, 186–7.

The potentiality view

[10] A related argument in favour of treating the fetus as a person from the moment of conception is that, even if the fetus is not a person at conception, it has the potential to become a person and should therefore be treated as if it were a person.

[11] On the other hand, it is argued that we do not usually treat someone who has the potential to be something as if they have already achieved that status. The 'potentiality' problem has been described in this way:¹⁶

It might appear that one could in such circumstances appeal to a notion of potentiality in order to argue that since fetuses ... are potential persons, they must *eo ipso* be accorded the rights and standing of persons. ...

[However], [i]f X is a potential Y, it follows that X is not a Y. If fetuses are potential persons, it follows clearly that fetuses are not persons. As a consequence, X does not have the actual rights of Y, but only potentially has the rights of Y. ...

Undoubtedly, the language of potentiality is itself misleading, for it is often taken to suggest that an X that is a potential Y in some mysterious fashion already possesses the being and significance of Y. It is therefore perhaps better to speak not of X's being a potential Y but rather of its having a certain probability of developing into Y.

From birth

[12] At the other end of the spectrum is the view that personhood does not begin until (or even after) birth. In support of this view it is said that this is the point at which the fetus becomes a child with a separate existence from its mother and is able to engage with the world, and provides a clear and unambiguous boundary. It also fundamentally changes the relationship between the woman and the child.

[13] On the other hand, it is argued that birth is simply an arbitrary event and there may be no real distinction between a late term or fully developed fetus that is yet to be born and one that is born, even if kept alive in an incubator.

At viability

[14] In between these two extremes of 'from conception' and 'from birth', there are numerous other views.

[15] One such view, historically, was that the fetus attains personhood upon 'quickening'. This referred to the time at which the pregnant woman could first feel the movements of the fetus.

[16] A commonly held view today is that the fetus should obtain protection upon viability. Viability is the time at which the fetus, if born prematurely, is capable of existing independently. Proponents of this view see viability as marking a transition

¹⁶ HT Engelhardt, *The Foundations of Bioethics* (Oxford University Press, 1986) 110–11.

from being an entity dependent for its survival on the woman to one that is capable of independent life.¹⁷

Once a fetus is capable of being born alive and has the potential to survive independently of its mother's body, there is a strong argument that the issue is no longer one internal to the mother but rather one which the state and its laws should regulate. If the fetus has a good chance of a life outside the mother's womb it should not at that stage be destroyed within the mother, especially if there is no good reason to do so.

[17] However, it has been observed that viability lacks certainty; 'it is a shifting boundary dependent upon the state of modern technology and its availability to a particular fetus'.¹⁸

Developmental or gradualist view

[18] An alternative view is the recognition that the status of the fetus changes during pregnancy such that the older and more developed the fetus becomes, the greater respect and protection it should obtain. This view:¹⁹

denies that a bright line can be drawn at any particular point in natural development when the fetus acquires moral standing. The developmental view hinges on the continuity of fetal development, and the difficulty of non-arbitrarily picking out properties that qualify some fetuses, but not others, as persons. Since infants are generally regarded as persons with a right to life, and the difference between a late term fetus and a neonate—particularly in the case of viable premature infants—is merely a matter of location, it appears that in the continuous process of embryonic and fetal development, there is no non-arbitrary place to draw a line where personhood begins. This view is in line with the intuition, shared by many on both sides of the abortion conflict, that fetal life becomes increasingly important as gestation continues, but that it is impossible to say with certainty when, exactly, a fetus becomes a person. The inherent vagueness of [this view] is an obstacle to translating it into practical ... public policies, however.

Other views

[19] There are other views. One approach is to shift the focus of discussion away from the status of the fetus in isolation to the relationship between the fetus and the woman. This emphasises the interdependence of and connection between the fetus and the woman, who 'are both two and one'.²⁰

[20] Another approach is to consider the fetus the 'property' of the pregnant woman who should therefore be protected against third parties but not against the actions of the woman herself.

17 Wicks, above n 13, 185.

18 Ibid. See also n 8 above.

19 Johnson, above n 13, 8.

20 Herring, above n 13, 340.

Appendix D

International human rights and abortion

INTRODUCTION	95
RIGHTS OF WOMEN.....	96
Right to non-discrimination and equality, including in family relations and health care.....	96
Right to health, including sexual and reproductive health and autonomy	98
Access to health services, including abortion services	102
Related rights, including the right to privacy and family and the right to life	106
Right to health of girls and adolescent females	108
RECOGNITION OF THE FETUS	110
Right to life and the fetus or unborn child	110
Non-discrimination on the basis of disability	117
FREEDOMS OF CONSCIENCE AND EXPRESSION.....	120
Freedom of thought, conscience and religion	120
Freedom of opinion and expression.....	122
OVERVIEW TABLES	126
Decriminalisation of abortion.....	126
Legal grounds for abortion	126
Other requirements or restrictions.....	128
Accessibility	130

Introduction

[1] Several international instruments are relevant to reform of termination of pregnancy laws, including:

- the *Universal Declaration of Human Rights* ('UDHR');
- the *International Convention on the Elimination of all forms of Discrimination Against Women* ('CEDAW');
- the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR');
- the *International Covenant on Civil and Political Rights* ('ICCPR'); and
- the *Convention on the Rights of the Child* ('CRC').

[2] Each of those instruments has been ratified by the Commonwealth Government. Such instruments have no direct legal effect on domestic law¹ until given effect in legislation.² Recourse might also be had to relevant international law in the interpretation of ambiguous or uncertain legislation, or in the development of the common law.³

Rights of women

Right to non-discrimination and equality, including in family relations and health care

[3] The CEDAW imposes an obligation on state parties, including Australia, to take all appropriate measures, including legislation, to eliminate discrimination against women⁴ and to ensure the full development and advancement of women for the purpose of their enjoyment of human rights and fundamental freedoms on an equal basis with men.⁵

[4] Relevantly, the CEDAW requires a state party to take all appropriate measures to eliminate discrimination against women in the field of health care⁶ (article 12(1)) and in all matters relating to family relations (article 16(1)). In particular, article 16(1)(e) stipulates that a state party is to 'ensure, on a basis of equality of men and women':⁷

The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

¹ See, eg, *Bradley v Commonwealth* (1973) 128 CLR 557, 582 (Barwick CJ and Gibbs J); *Simsek v MacPhee* (1982) 148 CLR 636, 641–42 (Stephen J); *Koowarta v Bjelke-Petersen* (1982) 153 CLR 168, 211–12 (Stephen J); *Kioa v West* (1985) 159 CLR 550, 570–71 (Gibbs CJ); *Dietrich v The Queen* (1992) 177 CLR 292, 305 (Mason CJ and McHugh J); *Attorney-General (Can) v Attorney-General (Ont)* [1937] 1 DLR 673, 678–9 (Lord Atkin).

² The Commonwealth Parliament has power to enact legislation to implement for Australian law the terms of international agreements to which Australia is a party under the external affairs powers in s 51(xxix) of the *Constitution: Commonwealth v Tasmania* (1983) 158 CLR 1; and *Richardson v Forestry Commission (Tas)* (1988) 164 CLR 261.

³ See, eg, *Garland v British Rail Engineering Ltd* [1983] 2 AC 751, 771 (Lord Diplock); *Jago v District Court (NSW)* (1988) 12 NSWLR 558 (CA), 569 (Kirby P), 581–82 (Samuels JA); *Dietrich v The Queen* (1992) 177 CLR 292, 306 (Mason CJ and McHugh J), 321 (Brennan J), 337 (Deane J), 360 (Toohey J), 373 (Gaudron J); *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287–8 (Mason CJ and Deane J); *Mabo v Queensland [No 2]* (1992) 175 CLR 1, 41–2 (Brennan J).

⁴ *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 2(f), (g), including by modifying or abolishing existing laws that discriminate against women and removing national penal provisions which constitute discrimination against women.

⁵ *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 3.

⁶ Including in relation to 'family planning'. See also art 12(2) which provides for 'appropriate services in connection with pregnancy, confinement and the post-natal period'; art 10(h) which requires state parties to ensure, on a basis of equality of men and women, 'access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning'; and art 14(2)(b) which requires state parties to ensure to women in rural areas, on a basis of equality of men and women, 'access to adequate health care facilities, including information, counselling and services in family planning'.

⁷ Similar provision is included in the *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 23(1)(b).

[5] The United Nations Committee on the Elimination of Discrimination against Women (the 'CEDAW Committee') has explained, in relation to article 16(1), that:⁸

The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women's lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.

... Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government.

[6] The CEDAW Committee has also explained, in relation to article 12(1), that:⁹

It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women ... [and that] barriers to women's access to appropriate health care include laws that criminalise medical procedures only needed by women [and that] punish women who undergo those procedures.

[7] In this context, the CEDAW Committee has recommended that:¹⁰

When possible, legislation criminalising abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.

[8] In its consideration of Australia's most recent state party report, the CEDAW Committee expressed concern that the 'sexual and reproductive health needs of

⁸ Committee on the Elimination of Discrimination against Women, *General recommendation No 21: Equality in marriage and family relations*, 13th sess (1994) [21]–[22].

⁹ Committee on the Elimination of Discrimination against Women, *General recommendation No 24: Article 12 of the Convention (women and health)*, 20th sess (1999) [11]–[14]. See also *Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review*, 57th sess (10–28 February 2014) 1–2.

¹⁰ CEDAW Committee General Recommendation No 24, above n 9, [31](c). See also Statement of the CEDAW Committee, above n 9, 2; and Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined seventh and eighth periodic reports of Peru*, 58th sess, UN Doc CEDAW/C/PER/CO/7-8 (24 July 2014) in which the Committee recommended, among other things, that 'punitive measures for women who undergo abortion' be removed: [36](c).

women are not equally met within all the States and Territories' of Australia.¹¹ In its concluding observations, the Committee stated that:¹²

[It] remains concerned about the lack of harmonisation or consistency in the way that the Convention is incorporated and implemented across the country, particularly when the primary competence to address a particular issue lies with the individual States and Territories. It notes, for example, that inconsistent approaches have arisen with regard to the imposition of criminal sanctions, for example with regard to abortion.

Right to health, including sexual and reproductive health and autonomy

[9] In addition to article 12(1) of the CEDAW, the ICESCR recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.¹³

[10] This is understood to include the right to sexual and reproductive health and associated freedoms.¹⁴ In particular, reproductive health is said to concern 'the capability to reproduce and the freedom to make informed, free and responsible decisions'.¹⁵

¹¹ Committee on the Elimination of Discrimination against Women, *List of issues and questions with regard to the consideration of periodic reports: Australia*, 46th sess, UN Doc CEDAW/C/AUL/Q/7 (14 September 2009) [30]. See Australia's response in Committee on the Elimination of Discrimination against Women, *Responses to the list of issues and questions with regard to the consideration of the combined sixth and seventh periodic reports: Australia*, 46th sess, UN Doc CEDAW/C/AUL/Q/7/Add.1 (29 January 2010) [191]:

State and territory governments are responsible for legislation relating to the performance of abortions. The Australian Government respects the rights of state and territory governments to manage legislation relevant to their jurisdictions and has not announced any plans to intervene in abortion legislation.

¹² Committee on the Elimination of Discrimination against Women, *Concluding observations of the Committee on the Elimination of Discrimination against Women: Australia*, 46th sess, UN Doc CEDAW/C/AUL/CO/7 (30 July 2010) [16]. The CEDAW Committee went on to state (at [17]) that:

The Committee acknowledges the important role played by the Standing Committee of Attorneys-General in harmonising anti-discrimination strategies, but reiterates its previous recommendation that the State party promote and guarantee the implementation of the Convention throughout the country, including through its power to legislate for the implementation of treaty obligations in all states and territories.

¹³ *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966, art 12(1). Similar provision is made in the *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 25.

¹⁴ See generally Committee on Economic, Social and Cultural Rights, *General Comment No 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/GC/22 (2 May 2016) [1]; and Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000)—The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc E/C.12/2000/4 (11 August 2000) [8], [11], [14], [21]. See also, eg, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011) 2, [6]–[10]; and Statement of the CEDAW Committee, above n 9, 1.

¹⁵ ESCR Committee General Comment No 22, above n 14, [6]. See also United Nations Population Fund, *Programme of Action of the International Conference on Population and Development 1994* (20th Anniversary ed, 2014) [7.2].

[11] The United Nations Committee on Economic, Social and Cultural Rights (the 'ESCR Committee') has explained that:¹⁶

The right to sexual and reproductive health entails a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the [ICESCR].

[12] The ESCR Committee has further observed that:¹⁷

Due to women's reproductive capacities, the realisation of the right of women to sexual and reproductive health is essential to the realisation of the full range of their human rights. The right of women to sexual and reproductive health is indispensable to their autonomy and their right to make meaningful decisions about their lives and health. Gender equality requires that the health needs of women, different from those of men, be taken into account and appropriate services provided for women in accordance with their life cycles.

[13] The ESCR Committee has recognised that restrictive abortion laws undermine autonomy and the right to equality and non-discrimination, and that state parties should repeal or reform such laws.¹⁸ It has explained that such laws — particularly those that criminalise women undergoing abortions — interfere 'with an individual's freedom to control his or her own body and ability to make free, informed and responsible decisions in this regard'.¹⁹

[14] Similarly, in relation to article 12 of the CEDAW, the CEDAW Committee has recognised that health services should 'be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice'.²⁰ It has expressed concern about, and called for measures to prevent, coercion in sexual and reproductive health (including the removal of laws that criminalise abortion).²¹

¹⁶ ESCR Committee General Comment No 22, above n 14, [5].

¹⁷ Ibid [25].

¹⁸ Ibid [34], and see [40]–[41]. One of the core obligations of state parties under the ICESCR is to repeal laws and policies that criminalise or undermine access to sexual and reproductive health services: [49](a).

¹⁹ Ibid [56]–[57].

²⁰ CEDAW Committee General recommendation No 24, above n 9, [31](e).

²¹ See Committee on the Elimination of Discrimination against Women, *General recommendation No 19: Violence against women*, UN Doc A/47/38 (1993) [24](m); Committee on the Elimination of Discrimination against Women, *General recommendation No 35 on gender-based violence against women, updating general recommendation No 19*, UN Doc CEDAW/C/GC/35 (14 July 2017) [31](a); CEDAW Committee General Recommendation No 21, above n 8, [22].

[15] Taking account of the relevant international instruments, the United Nations Special Rapporteur on the right to health has observed that:²²

Criminal laws penalising and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realisation of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes ... Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.

[16] The ESCR Committee has explained that, in fulfilling their core obligations to ensure the right to sexual and reproductive health under the ICESCR, state parties should be guided by the guidelines of United Nations agencies such as the World Health Organization ('WHO') and the United Nations Population Fund ('UNFPA').²³

[17] The WHO adopts a broad understanding of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.²⁴ This is also applied in the context of sexual and reproductive health.²⁵

[18] The WHO has released a number of guidelines on reproductive health issues, including safe abortion.²⁶ The Safe Abortion Guidance is intended to provide evidence-based best practices for policy-makers, programme managers and service providers. It aims to improve women's health outcomes, recognising that maternal

²² *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011) [21]. See also *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 71st sess, Agenda Item 69(b), UN Doc A/71/304 (5 August 2016) [46]. Special Rapporteurs are independent experts appointed by the United Nations Human Rights Council to examine and report on specific issues: see United Nations Human Rights Office of the High Commissioner, *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2017) <<http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx>>.

²³ ESCR Committee General Comment No 22, above n 14, [49]. See also, eg, *Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014—Report of the Secretary-General*, UN Doc A/69/62 (12 February 2014) [504](c) which urges countries to take the actions indicated by the WHO to remove legal barriers to abortion services.

²⁴ *Constitution of the World Health Organization*, preamble. The objective of the WHO is the attainment by all people of the highest possible level of health. Australia is a signatory to the Constitution: art 1. In addition, it has been observed that the right to health in art 12 of the ICESCR 'embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health': ESCR Committee General Comment No 14, above n 14, [4].

²⁵ See UNFPA Programme of Action, above n 15, [7.2]:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

See also, eg, WHO, *Sexual and reproductive health: Defining sexual health* (2017) <http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/>; WHO, *Reproductive health* (2017) <http://www.who.int/topics/reproductive_health/en/>.

²⁶ WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) (the 'Safe Abortion Guidance'). See also WHO, 'Health worker roles in providing safe abortion care and post-abortion contraception' (Guideline, 2015); and WHO, 'Preventing gender-biased sex selection' (Interagency Statement, 2011).

deaths due to unsafe abortions are largely preventable.²⁷ As well as addressing clinical care and health system issues, it contains recommendations about legal and regulatory matters, including the grounds on which abortion should be lawful.²⁸ The tables beginning at [108] below summarise these recommendations.

[19] The Office of the United Nations High Commissioner for Human Rights ('OHCHR') has also released an information series on sexual and reproductive health and rights, including on abortion. It provides guidance on key issues, including the decriminalisation of abortion.²⁹ This is also reflected in the tables beginning at [108] below.

[20] Reproductive health also forms a key component of the Programme of Action of the International Conference on Population and Development ('ICPD') and its subsequent activities³⁰ and the work of the UNFPA.³¹ The Programme of Action emphasises the holistic nature of reproductive health, the importance of informed choice and the need to prevent unwanted pregnancies. It states that abortion should not be promoted as a method of family planning, but that, where abortion is legal, it should be safe and women should have access to post-abortion care, counselling and family planning support.³²

[21] In its statement as part of the 2014 follow-up to the Programme of Action, the CEDAW Committee explained that:³³

State parties have obligations to enable women to prevent unwanted pregnancies, including through family planning and education on sexual and reproductive health. The Committee has also called upon State parties to address the power imbalances between men and women, which often impede

²⁷ WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 1:

[globally,] an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional five million women. Almost every one of these deaths and disabilities could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion. (note omitted)

²⁸ WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) ch 4.

²⁹ Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (2015) <<http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>>.

³⁰ The ICPD was convened in 1994 under the auspices of the United Nations. More than 175 governments (as well as several inter-governmental and non-governmental organisations) attended the ICPD, which adopted the UNFPA Programme of Action, above n 15. See generally United Nations Population Fund, *International Conference on Population and Development (ICPD)* <<http://www.unfpa.org/events/international-conference-population-and-development-icpd>>.

Implementation of the Programme of Action was reviewed, resulting in a further Framework of Actions in the Beyond 2014 Report, above n 23. As part of the review, an expert meeting on women's health was convened in Mexico City in 2013: see *ICPD Beyond 2014 Expert Group Meeting on Women's Health: Rights, Empowerment and Social Determinants—Meeting Report*, UN Doc UNFPA/WP.GTM.2 (9 December 2013).

³¹ See generally United Nations Population Fund, *Sexual & reproductive health* (16 November 2016) <<http://www.unfpa.org/sexual-reproductive-health>>. The UNFPA is the lead agency for the Programme of Action.

³² United Nations Population Fund, *Programme of Action of the International Conference on Population and Development 1994* (20th Anniversary ed, 2014) [8.25].

³³ Statement of the CEDAW Committee, above n 9, 2.

women's autonomy, particularly in the exercise of choices on safe and responsible sex practices.

Unsafe abortion is a leading cause of maternal mortality [death] and morbidity [injury]. As such, State parties should legalise abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe fetal impairment, as well as provide women with access to quality post-abortion care, especially in cases of complications resulting from unsafe abortions. State parties should also remove punitive measures for women who undergo abortion.

[22] Health, including universal access to sexual and reproductive health care services and the prevention of maternal and newborn mortality, is also one of seventeen Sustainable Development Goals adopted by the United Nations General Assembly in 2015.³⁴ Australia is due to review its implementation of those Goals in 2018.³⁵

Access to health services, including abortion services

[23] Full enjoyment of the right to sexual and reproductive health requires 'access to a whole range of health facilities, goods, services and information', without discrimination,³⁶ including education and information, family planning and contraception, and safe abortion.³⁷

[24] The ESCR Committee has explained that there are four inter-related and essential elements of comprehensive sexual and reproductive health care:³⁸

- Availability — This encompasses the availability of health facilities, goods and services, the availability of trained and skilled personnel and providers, and the availability of essential medicines. Relevantly, this requires that medicines for abortion and post-abortion care be available and that refusal to provide services based on conscience 'must not be a barrier to accessing services'.

³⁴ *Transforming our world: the 2030 Agenda for Sustainable Development*, GA Res 70/1, UN GAOR, 70th sess, Agenda Items 15 and 116, UN Doc A/RES/70/1 (21 October 2015). Sustainable Development Goal 3 is to '[e]nsure healthy lives and promote well-being for all at all ages' and encompasses nine targets including for reducing maternal and neonatal mortality and ensuring access to sexual and reproductive health services.

³⁵ See generally United Nations Department of Economic and Social Affairs, *High-Level Political Forum on Sustainable Development: Voluntary National Reviews* <<https://sustainabledevelopment.un.org/vnrs/>>. Member states are encouraged to conduct regular and inclusive reviews of progress; reviews are voluntary: The 2030 Agenda for Sustainable Development, above n 34, [72]–[74], [79].

³⁶ ESCR Committee General Comment No 22, above n 14, [5], [34], and see [45] in which it is explained that, in meeting their obligation to fulfil the right of everyone to sexual and reproductive health, state parties should:
aim to ensure universal access without discrimination for all individuals, including those from disadvantaged and marginalised groups, to a full range of quality sexual and reproductive health care, including ... safe abortion care ...

³⁷ See generally *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Interim Report of the Special Rapporteur of the Human Rights Council*, 66th sess, Agenda Item 69(b), UN Doc A/66/254 (3 August 2011).

³⁸ ESCR Committee General Comment No 22, above n 14, [11]–[21], and see [49](c) and [62]. See generally *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, above n 22, [79] as to the core requirements of availability, accessibility, acceptability and quality for the right to health.

- Accessibility — This encompasses physical and geographical accessibility of health facilities, goods and services (including to persons living in rural and remote areas), affordability of services and accessibility of information.
- Acceptability — That is, health facilities, goods, services and information must be respectful of diverse cultures and needs.
- Quality — That is, facilities, goods, services and information should be ‘evidence-based and scientifically and medically appropriate and up-to-date’. Relevantly, the quality of care is impaired by the failure to incorporate technological advances and innovations, such as medication for abortion.

[25] This involves the removal of both legal and practical barriers to access.

[26] Core obligations under the ICESCR include the obligations to remove laws and policies that criminalise or undermine access to sexual and reproductive health services, to guarantee universal and equitable access to such services and to take measures to prevent unsafe abortions and provide post-abortion care and counselling.³⁹ The ESCR Committee has explained, for example, that:⁴⁰

Preventing unintended pregnancies and unsafe abortions requires States to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalise restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.

[27] More specifically, the ESCR Committee has identified that state parties should:⁴¹

- remove third party authorisation requirements, ‘such as parental, spousal and judicial authorisation requirements’, for access to abortion services and information;
- remove biased counselling and mandatory waiting periods for access to abortion services;
- prohibit and prevent third parties from imposing practical or procedural barriers to services, such as physical obstruction of facilities and dissemination of misinformation;⁴² and

³⁹ ESCR Committee General Comment No 22, above n 14, [49](a), (c), (e).

⁴⁰ Ibid [28]. See also, eg, CEDAW Committee General Recommendation No 19, above n 21, [24](m) in which state parties are urged to take measures to ‘ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control’.

⁴¹ ESCR Committee General Comment No 22, above n 14, [41]–[43].

⁴² The ESCR Committee has further observed (at *ibid* [59]) that:

- regulate the practice of conscientious objection so that it does not inhibit access⁴³ or the performance of services in urgent or emergency situations.

[28] The CEDAW Committee has expressed similar concerns. For example:⁴⁴

The obligation to respect rights requires State parties to refrain from obstructing action taken by women in pursuit of their health goals. ... For example, State parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorisation of husbands, partners, parents or health authorities, because they are unmarried or because they are women. (note omitted)

[29] The CEDAW Committee has also referred to the particular obstacles faced by rural women in accessing sexual and reproductive health care, including safe abortion:⁴⁵

Globally, the presence of skilled birth attendants and medical personnel is lower in rural than urban areas and leads to poor prenatal, perinatal and postnatal care. There is a greater unmet need for family planning services and contraception owing to poverty, the lack of information and the limited availability and accessibility of services. Rural women are more likely to resort to unsafe abortion than their urban counterparts, a situation that puts their lives at risk and compromises their health. Even in countries in which abortion is legal, restrictive conditions, including unreasonable waiting periods, often impede access for rural women. When abortion is illegal, the health impact is even greater.

[30] The CEDAW Committee has recommended that state parties should ensure that high quality health care services are physically accessible to and affordable for rural women (including access to safe abortion and post-abortion care) and that laws that criminalise or require waiting periods or third party authorisation for abortion should be repealed.⁴⁶

Violations of the obligation to protect occur when a State fails to take effective steps to prevent third parties from undermining the enjoyment of the right to sexual and reproductive health. This includes the failure to prohibit and take measures to prevent all forms of violence and coercion committed by private individuals and entities, including ... abuse and harassment ...; violence targeting ... women seeking abortion or post-abortion care ...

43 '[I]ncluding by requiring referrals to an accessible provider capable of and willing to provide the services being sought': *ibid* [43]. See also Committee on Economic, Social and Cultural Rights, *Concluding observations on Poland*, UN Doc E/C.12/POL/CO/6 (26 October 2016) [46]–[47]; Committee on the Elimination of Discrimination against Women, *Concluding observations on Poland*, UN Doc CEDAW/C/POL/CO/7-8 (14 November 2014) [36]–[37](a)–(b); and CEDAW Committee General Recommendation No 24, above n 9, [11] in which it is stated that, if services are refused on the basis of conscientious objection 'measures should be introduced to ensure that women are referred to alternative health providers'.

44 CEDAW Committee General Recommendation No 24, above n 9, [14]. See also [11] in relation to conscientious objection:

It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

45 Committee on the Elimination of Discrimination against Women, *General recommendation No 34 (2016) on the rights of rural women*, UN Doc CEDAW/C/GC/34 (7 March 2016) [38], and see [37]. See also *Convention on the Elimination of All Forms of Discrimination against Women*, GA Res 34/180, 18 December 1979, art 14(2)(b) described at n 6 above.

46 CEDAW Committee General Recommendation No 34, above n 45, [39](a), (c).

[31] The United Nations Special Rapporteur on the right to health has similarly raised concerns about laws that restrict access to safe abortion, including restrictive grounds on which abortion is lawful, conscientious objection laws, mandatory waiting periods and counselling requirements, and requirements for third party authorisation.⁴⁷ He has also observed that measures should be taken to protect abortion service providers from harassment and violence.⁴⁸

[32] The Special Rapporteur has highlighted a number of concerns about the consequences of restrictive abortion laws, including the ‘chilling effect’ on information and data collection, ‘stigmatisation’ of those who use or provide abortion services, the greater likelihood of unsafe abortions and associated health risks, and negative impacts on mental health.⁴⁹ He has expressed the view that legal restrictions on abortion should be evidence-based on the grounds of public health and proportionate to ensure respect for human rights:⁵⁰

When criminal laws and legal restrictions used to regulate public health are neither evidence-based nor proportionate, States should refrain from using them to regulate sexual and reproductive health, as they not only violate the right to health of affected individuals, but also contradict their own public health justification.

[33] In addition to general recommendations for laws criminalising abortion to be removed, the ESCR and CEDAW Committees have each called on individual state parties to review their legislation and decriminalise abortion where the pregnancy endangers the life or health of the woman,⁵¹ results from rape or incest⁵² or involves serious fetal impairment.⁵³ (In the case of fetal impairment, the United Nations Committee on the Rights of Persons with Disabilities has cautioned, however, against distinctions based solely on disability.⁵⁴)

47 *Interim Report of the Special Rapporteur of the Human Rights Council*, above n 37, [23]–[24].

48 *Ibid* [28].

49 See *ibid* [24]–[28], [31]–[36].

50 *Ibid* [18].

51 See Committee on Economic, Social and Cultural Rights, *Concluding observations on Costa Rica*, UN Doc E/C.12/CRI/CO/4 (4 January 2008) [46]; Committee on Economic, Social and Cultural Rights, *Concluding observations on Nepal*, UN Doc E/C.12/1/Add.66 (24 September 2001) [55]; Committee on the Elimination of Discrimination against Women, *Concluding observations on Angola*, UN Doc CEDAW/C/AGO/CO/6 (27 March 2013) [32](g). See also Committee on the Elimination of Discrimination against Women, *Views: Communication No 22/2009*, 50th sess, UN Doc CEDAW/C/50/D/22/2009 (25 November 2011) (*TPF v Peru*) [9.2](a).

52 See Committee on Economic, Social and Cultural Rights, *Concluding observations on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories*, UN Doc E/C.12/GBR/CO/5 (12 June 2009) [25]; Committee on Economic, Social and Cultural Rights, *Concluding observations on Chile*, UN Doc E/C.12/1/Add.105 (1 December 2004) [53]; ESCR Committee Concluding Observations on Costa Rica, above n 51, [46]; ESCR Committee Concluding Observations on Nepal, above n 51, [55]; Committee on the Elimination of Discrimination against Women, *Concluding observations on the Dominican Republic*, UN Doc CEDAW/C/DOM/CO/6-7 (30 July 2013) [37](c); CEDAW Committee Concluding Observations on Angola, above n 51, [32](g). See also *TPF v Peru*, UN Doc CEDAW/C/50/D/22/2009, [9.2](c).

53 See ESCR Committee Concluding Observations on the United Kingdom, above n 52, [25]; CEDAW Committee Concluding Observations on the Dominican Republic, above n 52, [37](c).

54 See [85]–[87] below.

Related rights, including the right to privacy and family and the right to life

[34] The reproductive health rights of women also intersect with rights in other international instruments, in particular, the ICCPR.

[35] The CEDAW Committee has identified, for example, that violations of women's reproductive rights may amount to torture or cruel, inhuman or degrading treatment:⁵⁵

Violations of women's sexual and reproductive health and rights, such as forced sterilisations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.

[36] This is confirmed in the jurisprudence of the United Nations Human Rights Committee ('HRC'), which has found that denying access to abortion in circumstances where the pregnancy involves a fatal fetal impairment⁵⁶ or is the result of rape⁵⁷ is a violation of the prohibition against cruel, inhuman or degrading treatment.

[37] It has also been recognised that the right to private and family life under article 17 of the ICCPR encompasses women's reproductive decisions.⁵⁸ The HRC has explained in its General Comment that:⁵⁹

[An] area where States may fail to respect women's privacy [under article 17] relates to their reproductive functions, for example, where there is a requirement for the husband's authorisation to make a decision in regard to sterilisation; ... or where States impose a legal duty upon doctors and other health personnel to report cases of women who have undergone abortion.

⁵⁵ CEDAW Committee General Recommendation No 35, above n 21, [18].

See also Committee Against Torture, *General Comment No 2: Implementation of article 2 by State parties*, UN Doc CAT/C/GC/2 (24 January 2008) [22], in relation to the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, GA Res 39/46, 10 December 1984. Freedom from torture and cruel, inhuman or degrading treatment is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 5; *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 7; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 37(a); and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 15.

⁵⁶ See Human Rights Committee, *Views: Communication No 2425/2014*, 119th sess, UN Doc CCPR/C/119/D/2425/2014 (12 June 2017) ('*Whelan v Ireland*') [7.7], [8]; Human Rights Committee, *Views: Communication No 2324/2013*, 116th sess, UN Doc CCPR/C/116/D/2324/2013 (17 November 2016) ('*Mellet v Ireland*') [7.6], [8]; and Human Rights Committee, *Views: Communication No 1153/2003*, 85th sess, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005) ('*Huamán v Perú*') [6.3].

⁵⁷ See Human Rights Committee, *Views: Communication No 1608/2007*, 101st sess, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011) ('*VDA v Argentina*') [9.2], [10]. See also Human Rights Committee, *General Comment No 28: Article 3 (The equality of rights between men and women)*, UN Doc CCPR/C/21/Rev.1/Add.10 (29 March 2000) [11].

⁵⁸ The right to private and family life is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 12; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 16; and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 22.

⁵⁹ HRC General Comment No 28, above n 57, [20].

[38] In its jurisprudence, the HRC has found that denying access to abortion in certain circumstances, by unreasonably interfering in the woman's decision, constitutes a violation of article 17.⁶⁰

[39] In addition, it has been recognised that the right to life in article 6 of the ICCPR is relevant in this context.⁶¹ In particular, the HRC has identified that the right to life requires consideration of measures 'to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions'.⁶²

[40] The HRC has called on individual state parties to review their legislation to provide exceptions to their prohibitions against abortion, particularly to protect the life or health of the woman and in cases of rape or incest.⁶³

[41] Most recently, it has called on Ireland to amend its restrictive laws to ensure compliance with the ICCPR:⁶⁴

the State party should amend its law on voluntary termination of pregnancy, including if necessary its Constitution, to ensure compliance with the Covenant, including ensuring effective, timely and accessible procedures for pregnancy termination in Ireland, and take measures to ensure that health-care providers are in a position to supply full information on safe abortion services without fearing being subjected to criminal sanctions ... (note omitted)

[42] That direction was made in the context of a case involving a fatal fetal impairment. The HRC explained:⁶⁵

The Committee considers it well-established that the author was in a highly vulnerable position after learning that her much-wanted pregnancy was not viable. As documented in the psychological reports submitted to the Committee, her physical and mental situation was exacerbated by the following circumstances arising from the prevailing legislative framework in Ireland and by the author's treatment by some of her health care providers in Ireland: being unable to continue receiving medical care and health insurance coverage for her treatment from the Irish health care system; feeling abandoned by the Irish health care system and having to gather information on her medical options alone; being

⁶⁰ See *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [7.9], [8]; *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [7.8], [8]; *Huamán v Peru*, UN Doc CCPR/C/85/D/1153/2003, [6.4]; and *VDA v Argentina*, UN Doc CCPR/C/101/D/1608/2007, [9.3], [10].

⁶¹ *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 6(1). The right to life is also recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 3; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 6(1); and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 10. See [53]–[57] below.

⁶² HRC General Comment No 28, above n 57, [10].

⁶³ See Human Rights Committee, *Concluding observations on the Philippines*, UN Doc CCPR/C/PHL/CO/4 (13 November 2012) [13]; Human Rights Committee, *Concluding observations on the Dominican Republic*, UN Doc CCPR/C/DOM/CO/5 (19 April 2012) [15]; Human Rights Committee, *Concluding observations on Guatemala*, UN Doc CCPR/C/GTM/CO/3 (19 April 2012) [20]. See also Human Rights Committee, *Concluding observations on Panama*, UN Doc CCPR/C/PAN/CO/3 (17 April 2008) [9].

⁶⁴ *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [9]. See also *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [9]. As to the *Constitution of Ireland*, see [75] below.

⁶⁵ *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014, [7.5]. See also *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, [7.4], which involved similar facts.

forced to choose between continuing her non-viable pregnancy or traveling to another country while carrying a dying fetus, at personal expense and separated from the support of her family; suffering the shame and stigma associated with the criminalisation of abortion of a fatally-ill fetus; having to leave the baby's remains in a foreign country; and failing to receive necessary and appropriate bereavement counselling in Ireland. Much of the suffering the author endured could have been mitigated if she had been allowed to terminate her pregnancy in the familiar environment of her own country and under the care of health professionals whom she knew and trusted; and if she had received necessary health benefits that were available in Ireland, which she would have enjoyed had she continued her non-viable pregnancy to deliver a stillborn child in Ireland.

Right to health of girls and adolescent females

[43] The CEDAW and ESCR Committees recognise that the right to sexual and reproductive health and autonomy extends to children and adolescents, in accordance with their evolving capacities.⁶⁶

[44] Moreover, the right to 'the enjoyment of the highest attainable standard of health' is expressly recognised for children in article 24(1) of the CRC.⁶⁷ This has been interpreted to include the right to sexual and reproductive health.

[45] The United Nations Committee on the Rights of the Child (the 'CRC Committee') has explained that:⁶⁸

Children's right to health contains a set of freedoms and entitlements. The freedoms, which are of increasing importance in accordance with growing capacity and maturity, include the right to control one's health and body, including sexual and reproductive freedom to make responsible choices. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.

[46] The CRC Committee has observed the importance of recognising the life course and evolving capacities of the child:⁶⁹

Childhood is a period of continuous growth from birth to infancy, through the preschool age to adolescence. Each phase is significant as important developmental changes occur in terms of physical, psychological, emotional and social development, expectations and norms. The stages of the child's development are cumulative and each stage has an impact on subsequent phases, influencing the children's health, potential, risks and opportunities.

⁶⁶ See, eg, CEDAW Committee General Recommendation No 24, above n 9, [8]; ESCR Committee General Comment No 22, above n 14, [49](f); and Statement of the CEDAW Committee, above n 9, 1. The CEDAW Committee has noted that 'girl children and adolescent girls are often vulnerable to sexual abuse by older men and family members, placing them at risk of physical and psychological harm and unwanted and early pregnancy': CEDAW Committee General Recommendation No 24, above n 9, [12](b).

⁶⁷ *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 24(1). 'Child' is defined to mean 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier': art 1. See also art 24(2)(f) which provides for 'preventive health care ... and family planning education and services'.

⁶⁸ Committee on the Rights of the Child, *General Comment No 15: on the right of the child to the enjoyment of the highest attainable standard of health (art 24)*, UN Doc CRC/C/GC/15 (17 April 2013) III [A].

⁶⁹ *Ibid* II [F].

Understanding the life course is essential in order to appreciate how health problems in childhood affect public health in general [and] ... children's evolving capacities have a bearing on their independent decision-making on their health issues.

[47] The CRC Committee has highlighted the importance of ensuring access by adolescents to comprehensive sexual and reproductive health services, including sexuality education, family planning and safe abortion.⁷⁰ It has observed that state parties should 'work to ensure that girls can make autonomous and informed decisions on their reproductive health' and that:⁷¹

[sexual and reproductive health services] should be designed to enable all couples and individuals to make sexual and reproductive decisions freely and responsibly, including the number, spacing and timing of their children, and to give them the information and means to do so.

[48] In this context, the CRC Committee has observed, for example, that adolescents should not be 'deprived of any sexual and reproductive health information or services due to providers' conscientious objections'.⁷²

[49] The Programme of Action of the ICPD also specifically highlighted the need to address 'adolescent sexual and reproductive health issues, including unwanted pregnancy [and] unsafe abortion':⁷³

Recognising the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need ... In doing so ... these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.

[50] This was reiterated in the 2014 follow-up to the Programme of Action, which also emphasised the importance of preventing unsafe abortion among young women. In particular, it provides that:⁷⁴

⁷⁰ The Special Rapporteur on the right to health has also observed that '[d]uring adolescence, the right to be heard and to be taken seriously transitions into the right to make autonomous decisions about one's health care and treatment': *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 32nd sess, Agenda Item 3, UN Doc A/HRC/32/32 (4 April 2016) [57].

⁷¹ CRC Committee General Comment No 15, above n 68, III [B].

⁷² *Ibid.*

⁷³ UNFPA Programme of Action, above n 15, [7.44], [7.45] (note omitted).

⁷⁴ Beyond 2014 Report, above n 23, [371] and see [320]–[325], [361]–[376]. It is explained (at [375]) that:
Young adolescents face a higher risk of complications from unsafe abortions, and women under the age of 25 account for almost half of all abortion deaths. Evidence points to the fact that adolescents are more likely to delay seeking an abortion and, even in countries where abortion may be legal, they resort to unsafe abortion providers owing to fear, lack of knowledge and limited financial resources. (notes omitted)

States should remove legal barriers preventing women and girls from access to safe abortion, including revising restrictions within existing abortion laws, in order to safeguard the lives of women and girls and, where abortion is legal, ensure that all women have ready access to safe, good-quality abortion services.

[51] The CRC Committee has also called on individual state parties to decriminalise abortion in particular circumstances, including where the pregnancy endangers the life or health of the girl⁷⁵ or results from rape or incest.⁷⁶

[52] In his report on the right to health of adolescents, the Special Rapporteur on the right to health has similarly observed the importance of such measures:⁷⁷

States are strongly encouraged to decriminalise abortion, in accordance with international human rights norms, and adopt measures to ensure access to legal and safe abortion services. Criminal laws with respect to abortion result in a high number of deaths, poor mental and physical health outcomes, infringement of dignity and amount to violations of the obligations of States to guarantee the right to health of adolescent girls. Furthermore, information about and access to abortion services must be available, accessible and of good quality, without discrimination, at a minimum in the following circumstances: when the life or health of the mother is at risk, when the mother is the victim of rape or incest and if there is severe and fatal fetal impairment. Post-abortion care must be available and accessible to all adolescent girls irrespective of the legal status of abortion. (note omitted)

Recognition of the fetus

Right to life and the fetus or unborn child

[53] The UDHR declares that ‘all human beings are born free and equal in dignity and rights’ (article 1) and that ‘[e]veryone has the right to life, liberty and security of person’ (article 3).

[54] The right to life of every human being is also recognised in the ICCPR (article 6). Specifically, article 6(1) of the ICCPR provides that:

Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

[55] The HRC has described this as the ‘supreme right’, basic to all human rights, ‘from which no derogation is permitted’ and which should not be narrowly

See also ICPD Beyond 2014 Expert Group Meeting, above n 30, Rec 1(c). It is observed in that report that the ‘majority of those who die or are injured’ from unsafe abortions ‘are low-income women and adolescent girls who have neither money nor the knowledge needed to find a safe provider’: 25.

⁷⁵ Committee on the Rights of the Child, *Concluding observations on Chile*, UN Doc CRC/C/CHL/CO/3 (23 April 2007) [56]; Committee on the Rights of the Child, *Concluding observations on Chad*, UN Doc CRC/C/15/Add.107 (24 August 1999) [30].

⁷⁶ CRC Committee Concluding observations on Chile, above n 75, [56].

⁷⁷ *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, above n 70, [92].

interpreted.⁷⁸ It is not, however, absolute; it prohibits the ‘arbitrary deprivation’ of life.⁷⁹

[56] The right to life in article 6 of the ICCPR is reaffirmed in article 10 of the *Convention on the Rights of Persons with Disabilities* (the ‘CRPD’).⁸⁰

[57] In addition, the right to life of children is specifically recognised in article 6 of the CRC, which provides that:

1. State Parties recognise that every child has the inherent right to life.
2. State Parties shall ensure to the maximum extent possible the survival and development of the child.⁸¹ (note added)

[58] Under article 1 of the CRC, ‘child’ is defined to mean ‘every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier’.

[59] It has been argued that the right to life under those instruments is capable of applying to the fetus or unborn child.⁸² For example, it has been suggested that the natural and ordinary meaning of provisions such as articles 1 and 6 of the CRC includes the ‘unborn child’:⁸³

78 Human Rights Committee, *General Comment No 6: Article 6 (Right to life)*, 16th sess (27 July 1982) [1]; Human Rights Committee, *General Comment No 14: Article 6 (Right to life)*, 23rd sess (1984) [1]. See also Human Rights Committee, *General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life—Revised draft prepared by the Rapporteur*, 120th sess (July 2017) [2]–[3].

79 See, eg, HRC General Comment No 36, above n 78, [16].

80 See [82] below.

81 ‘Survival and development’ rights under art 6(2) of the CRC ‘include rights to adequate food, shelter, clean water, formal education, primary health care, leisure and recreation, cultural activities and information about [the child’s] rights’: Unicef, *Rights under the Convention on the Rights of the Child* (7 August 2014) <https://www.unicef.org/crc/index_30177.html>. ‘Development’ is to be interpreted ‘as a holistic concept, embracing the child’s physical, mental, spiritual, moral, psychological and social development’: Committee on the Rights of the Child, *General Comment No 5 (2003): General measures of implementation of the Convention on the Rights of the Child*, 34th sess, UN Doc CRC/GC/2003/5 (27 November 2003) 4.

82 See, eg, PA Tozzi, ‘International Law and the Right to Abortion’ (International Organizations Law Group Legal Studies Series No 1, Catholic Family and Human Rights Institute, 2010) 6, 7; PJ Flood, ‘Does International Law Protect the Unborn Child?’ in JW Koterski (ed), *Life and Learning XVI: Proceedings of the Sixteenth University Faculty of Life Conference at Villanova University 2006* (2007) 3, 7–8, 9; T Finegan, ‘International Human Rights Law and the “Unborn”: Texts and Travaux Préparatoires’ (2016) 25 *Tulane Journal of International & Comparative Law* 89, 116, 120–21; R Joseph, *Human rights and the unborn child* (Martinus Nijhoff, 2009).

In support of this view, reference has been made to various provisions including: *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 6(5), which provides that ‘[s]entence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women’; *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 24(2)(d), which requires, among other things, measures to ‘ensure appropriate pre-natal and post-natal health care for mothers’; and *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, preamble para [9], which refers to ‘safeguards and care ... before as well as after birth’ (see [62]–[65] below).

83 Finegan, above n 82, 116–17. See also Flood, above n 82, 6, 7, 10; and Tozzi, above n 82, 7:

A plain reading of the language in the CRC also favors protection of unborn life. CRC article 1 defines a child as ‘every human being below the age of eighteen years.’ It thus defines a ceiling, but not a floor, as to who is a child—in other words, it pointedly does *not* say that the status of the ‘child’ attaches at the time of birth. (emphasis in original)

a strong case can be made that the ‘natural and ordinary meaning’ of both Articles 1 and 6 [of the CRC] includes the unborn human being. Article 1 refers to ‘every human being below the age of eighteen years’—the unborn child satisfies both these criteria. Article 6 refers to ‘every child’ having ‘the inherent right to life’. ‘Inherent’, as a natural law term, means existing in something on the basis of that thing’s essential nature, which in this context can only mean the child’s human nature.

[60] However, none of those instruments explicitly extends the right to life to the fetus or unborn child. It is generally regarded that the right to life under those instruments applies from birth; whilst the fetus or unborn child may be entitled to some protections, it is left to individual countries to provide for any such protections in their domestic laws, provided they are not inconsistent with their other human rights obligations.⁸⁴ This is consistent with the position adopted under regional human rights treaties, including the *European Convention on Human Rights*.⁸⁵

[61] In support of this view, reference has been made to the history of the drafting and negotiation of the instruments, which shows ‘a consistent pattern of avoiding any explicit recognition’ of rights before birth.⁸⁶ During the drafting of the UDHR, the ICCPR and the CRC, various proposals to extend the relevant articles to

⁸⁴ See, eg, RJ Cook and BM Dickens, ‘Human Rights Dynamics of Abortion Law Reform’ (2003) 25(1) *Human Rights Quarterly* 1, 24; P Alston, ‘The Unborn Child and Abortion Under the Draft Convention on the Rights of the Child’ (1990) 12 *Human Rights Quarterly* 156, 161, 177–8. See further [66] and [71] below.

⁸⁵ The *Convention for the Protection of Human Rights and Fundamental Freedoms*, 213 UNTS 221 / ETS No 5, as amended by Protocols No 11 and 14 (the ‘*European Convention on Human Rights*’), art 2(1) provides:

Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

Relevantly, the interpretation of art 2(1) is summarised in the following oft-quoted passage of the judgment of the European Court of Human Rights in *Vo v France* (2004) 8 Eur Court HR 67, 106–7 [80]:

in the circumstances examined to date by the Convention institutions—that is, in the various laws on abortion—the unborn child is not regarded as a ‘person’ directly protected by Article 2 of the Convention and ... if the unborn do have a ‘right’ to ‘life’, it is implicitly limited by the mother’s rights and interests. The Convention institutions have not, however, ruled out the possibility that in certain circumstances safeguards may be extended to the unborn child.

Cf the *American Convention on Human Rights*, OAS Treaty Series No 36 (1960), art 4(1), which provides:

Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.

It has been noted that the *American Convention on Human Rights* (also known as the ‘Pact of San José’) is the only human rights treaty to have a provision that protects life before birth: see, eg, Amnesty International, ‘The UN Human Rights Committee’s Proposed General Comment on the Right to Life: Amnesty International’s Preliminary Observations’, Submission to the Human Rights Committee (2015) 20. Article 4(1), by including the words ‘in general’ and ‘arbitrarily’, has been interpreted by the Inter-American Commission on Human Rights as not conferring an absolute right to life on the fetus or unborn child such as would prevent terminations of pregnancy in appropriate cases, for example, to save the life of the mother: Inter-American Commission on Human Rights, *Baby Boy* (case 2141), Resolution 23/81, 6 March 1981, [19](h), [25], [30].

⁸⁶ Alston, above n 84, 161. See also, eg, MK Eriksson, ‘The Legal Position of the Unborn Child in International Law’ (1993) 36 *German Yearbook of International Law* 86, 104.

recognise a right to life ‘from the moment of conception’ were made, but did not succeed.⁸⁷

[62] There was also debate about incorporating in the CRC the reference to ‘safeguards and care ... before as well as after birth’ that appears in the preamble to the Declaration of the Rights of the Child.⁸⁸ The final outcome was for the preamble to the CRC to quote directly from the Declaration. Accordingly, the ninth paragraph of the preamble to the CRC states that:

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth’ ...

[63] However, a statement was included in the preparatory materials on behalf of the working group that, ‘in adopting this paragraph’, it is ‘not intend[ed] to prejudice the interpretation of article 1 or any other provision of the Convention by State Parties’.⁸⁹

[64] The CRC does not itself provide guidance about the precise scope of the ninth paragraph of the preamble. It has been suggested that the protection to which it refers might include provision of maternal health care to promote a child’s capacity to survive and thrive after birth.⁹⁰

[65] It has been said that the preambular paragraph is not itself enforceable and does not extend the meaning of articles 1 or 6 of the CRC:⁹¹

it would be inconsistent with general principles of treaty interpretation to suggest that a provision in the preamble which is not reflected in the operative part of the text, can be relied upon, on its own, to extend very considerably the natural and ordinary meaning of the actual terms used in Articles 1 and 6 [of the CRC]. While the preambular paragraph can be considered to form one part of the basis for interpretation of the treaty, there is no obvious reason why the preamble would be resorted to in order to interpret what would otherwise appear to be a natural

⁸⁷ See, eg, Commission on Human Rights, *Report of the Working Group on a draft convention on the rights of the child*, 45th sess, UN Doc E/CN.4/1989/48 (2 March 1989) [76]–[77]; LA Rehof, ‘Article 3’ in A Eide et al (eds), *The Universal Declaration of Human Rights: A Commentary* (Scandinavian University Press, 1992) 73, 75–6; R Copelon et al, ‘Human Rights Begin at Birth: International Law and the Claim of Fetal Rights’ (2005) 13(26) *Reproductive Health Matters* 120, 122; Alston, above n 84, 159, 162–63; and Eriksson, above n 86, 104 in relation to art 3 of the UDHR, art 6 of the ICCPR and art 1 of the CRC.

⁸⁸ See *Declaration on the Rights of the Child*, GA Res 1386 (XIV), 20 November 1959, preamble para [3].

⁸⁹ Commission on Human Rights, *Report of the Working Group on a draft convention on the rights of the child*, 45th sess, UN Doc E/CN.4/1989/48 (2 March 1989) [43]–[44]. It is noted that the paragraph is, therefore, of ‘limited purpose’: Copelon et al, above n 87, 122.

⁹⁰ Cook and Dickens, above n 84, 24; Copelon et al, above n 87, 122. Cf Joseph, above n 82, 121–3 which criticises this interpretation for failing to accord adequate recognition to protection of the child before birth.

⁹¹ Alston, above n 84, 169–70. Cf Finegan, above n 82, 117 in which it is argued that:

The preamble to a treaty ... enunciates the broad general principles relevant to the treaty. The ninth preambular paragraph thus enunciates the principle that what proceeds it concerns all children, born and unborn. No article of the [CRC] comes close to contradicting this principle.

As to the interpretation of treaties, see the *Vienna Convention on the Law of Treaties*, 115 UNTS 331, arts 31, 32.

and ordinary meaning of the term 'child'. In international law, at least, there is no precedent for interpreting either that term, or others such as 'human being' or 'human person' as including a fetus. Where the intention has been to extend the reach in that way, the practice has been to specify that fact⁹²—an approach which was rejected in the drafting of the [CRC]. (notes omitted; note added)

[66] The approach taken to the CRC was to leave the question of rights before birth unaddressed, giving individual countries the flexibility to adopt their own position.⁹³ It has been explained that:⁹⁴

The text of the [CRC], as currently drafted, clearly leaves open the possibility for individual ratifying states to adopt 'appropriate' legal and other measures to protect the unborn child. ... Equally, however, it is clear that neither the text of the Convention itself, nor any of the relevant circumstances surrounding its adoption, lend support, either of a legal or other nature, to the suggestion that the Convention requires legislation to recognise and protect the right to life of the fetus.

[67] The CRC Committee has not released a General Comment on article 6 of the CRC. However, in its General Comment on the right to health of children, it has highlighted the importance of maternal health to the health of newborn infants:⁹⁵

Among the key determinants of children's health, nutrition and development are the realisation of the mother's right to health and the role of parents and other caregivers. A significant number of infant deaths occur during the neonatal period, related to the poor health of the mother prior to, and during, the pregnancy and the immediate post-partum period, and to suboptimal breastfeeding practices. The health and health-related behaviours of parents and other significant adults have a major impact on children's health.

⁹² See *American Convention on Human Rights*, OAS Treaty Series No 36 (1960), art 4(1), discussed at n 85 above.

⁹³ Alston, above n 84. See also, eg, Eriksson, above n 86, 105: 'there was consensus that the matter be left unaddressed'; AF Janoff, 'Rights of the Pregnant Child vs. Rights of the Unborn Under the Convention on the Rights of the Child' (2004) 22 *Boston University International Law Journal* 163, 167: '[t]he plain meaning of the [CRC's] terms does not clarify whether the Convention provisions apply to a "child" before birth'. See also Australia, *Parliamentary Debates*, Senate, 26 October 1989, 2313 (G Evans, Foreign Minister):

Although a reference to the rights of the child 'before as well as after birth', taken from the 1959 United Nations Declaration on the Rights of the Child does appear in the preamble of the draft convention, at the same time a statement in the *travaux préparatoires*—the preparatory materials—makes it clear that the contentious issue of the child's rights before birth is a question to be determined by individual state parties.

Some countries entered declarations, when ratifying the CRC, of their views on this question. Declarations were entered by: the United Kingdom, to the effect that it considers the CRC to be applicable 'only following a live birth'; China, France and Tunisia, to the effect that the CRC should be not be interpreted to present an obstacle to their national laws on termination of pregnancy; and Argentina, Guatemala and the Holy See, to the effect that in their view the right to life applies before birth. See United Nations Treaty Collection, Status of Treaties, ch IV, [11] Convention on the Rights of the Child.

⁹⁴ Alston, above n 84, 177–78. Cf Finegan, above n 82, 120–21, in which it is acknowledged that Alston's article remains the most influential on the topic, but is suggested that 'sensitivities over domestic abortion laws were the reason' for omitting an explicit recognition of the right to life before birth and that the CRC, which was not 'an entirely neutral compromise', leaves room for the recognition of such rights outside the context of abortion.

⁹⁵ CRC Committee General Comment No 15, above n 68, II [D]. See also *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), 16 December 1966, art 12(2)(a) which identifies 'the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child' as an aspect of the right to health.

[68] The CRC Committee has also released a General Comment on the implementation of the convention rights in early childhood. It notes that early childhood includes ‘all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school’.⁹⁶ With respect to the rights to life, survival and development in article 6 of the CRC, it observes that:⁹⁷

State parties are urged to take all possible measures to improve perinatal care for mothers and babies, reduce infant and child mortality, and create conditions that promote the well-being of all young children during this critical phase of their lives.

[69] In its General Comment on article 6 of the ICCPR, the HRC has similarly identified the reduction of infant mortality as an aspect of the fulfilment of the right to life, particularly through the elimination of ‘malnutrition and epidemics’.⁹⁸

[70] Accordingly, protections are indirectly provided to the child before birth through the promotion of maternal health care.

[71] The HRC is presently drafting a new General Comment on article 6 of the ICCPR.⁹⁹ In the first reading draft released in 2015, the question of the right to life before birth was addressed in the following terms, clarifying that it cannot be assumed that article 6 imposes an obligation to recognise the right to life of unborn children:¹⁰⁰

the Covenant does not explicitly refer to the rights of unborn children, including to their right to life. In the absence of subsequent agreements regarding the inclusion of the rights of the unborn within article 6 and in the absence of uniform State practice which establishes such subsequent agreements, the Committee cannot assume that article 6 imposes on State parties an obligation to recognise the right to life of unborn children. Still, State parties may choose to adopt measures designed to protect the life, potential for human life or dignity of unborn children, including through recognition of their capacity to exercise the right to life, provided that such recognition does not result in violation of other rights under the Covenant, including the right to life of pregnant mothers and the

⁹⁶ Committee on the Rights of the Child, *General Comment No 7 (2005): Implementing child rights in early childhood*, 40th sess, UN Doc CRC/C/GC/7/Rev.1 (20 September 2006) [1], [4].

⁹⁷ *Ibid* [10]. The CRC Committee refers, in particular, to addressing ‘malnutrition and preventable diseases, ... adverse living conditions, [and] neglect, insensitive or abusive treatment’. It also observes that the right to survival and development must be implemented in a ‘holistic manner’, including through the enforcement of other convention rights such as the ‘rights to health, adequate nutrition, social security, an adequate standard of living, a healthy and safe environment, education and play’.

⁹⁸ HRC General Comment No 6, above n 78, [5].

⁹⁹ See Office of the United Nations High Commissioner for Human Rights, *Draft General Comment on Article 6 of the International Covenant on Civil and Political Rights—Right to life* (2017) <<http://www.ohchr.org/EN/HRBodies/CCPR/Pages/GC36-Article6Righttolife.aspx>>.

¹⁰⁰ Human Rights Committee, *Draft general comment No 36: Article 6 Right to life*, 115th sess, UN Doc CCPR/C/GC/R.36/Rev.2 (2 September 2015) [7]. The HRC commenced its first reading of the draft during its 115th session, following a half day of general discussion focusing on the views of national human rights institutions, non-government organisations, academics and submissions from other interested parties. The HRC completed its first reading at its 120th session, and invited further submissions on a revised draft. The excerpt quoted at [71] above does not appear in the revised draft.

prohibition against exposing them to cruel, inhuman and degrading treatment or punishment. (notes omitted)

[72] The draft General Comment also recognises that the right to life of a pregnant woman requires access to safe, lawful abortions:¹⁰¹

Although State parties may adopt measures designed to regulate terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or her other rights under the Covenant, including the prohibition against cruel, inhuman and degrading treatment or punishment. Thus, any legal restrictions on the ability of women to seek abortion must not, inter alia, jeopardise their lives or subject them to physical or mental pain or suffering which violates article 7. State parties must provide safe access to abortion to protect the life and health of pregnant women, and in situations in which carrying a pregnancy to term would cause the woman substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or when the fetus suffers from fatal impairment. State parties may not regulate pregnancy or abortion in a manner that runs contrary to their duty to ensure that women do not have to undertake unsafe abortions. [For example, they should not take measures such as criminalising pregnancies by unmarried women or applying criminal sanctions against women undergoing abortion or against physicians assisting them in doing so, when taking such measures is expected to significantly increase resort to unsafe abortions]. Nor should State parties introduce humiliating or unreasonably burdensome requirements on women seeking to undergo abortion. The duty to protect the lives of women against the health risks associated with unsafe abortions requires State parties to ensure access for women and men, and, in particular, adolescents, to information and education about reproductive options, and to a wide range of contraceptive methods. State parties must also ensure the availability of adequate prenatal and post-abortion health care for pregnant women. (notes omitted)

[73] This is consistent with the jurisprudence and comments made by the HRC and other treaty bodies concerning the reproductive health rights of women and girls.

[74] It is recognised that, whilst protections may be accorded to the fetus or unborn child, an absolute right to life before birth would conflict with the rights of pregnant women and girls.¹⁰² In the balance between such rights, the general trend has been for ‘the rights of the mother [to] supersede the right to life of an unborn child’.¹⁰³

[75] Some countries have specifically recognised the right to life of the fetus in domestic law. For example, the Irish Constitution provides that:¹⁰⁴

¹⁰¹ Human Rights Committee, *General Comment No 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life—Revised draft prepared by the Rapporteur*, 120th sess (July 2017) [9]. See also the comments to the same effect in the earlier draft: Human Rights Committee, *Draft general comment No 36: Article 6 Right to life*, 115th sess (2 September 2015) UN Doc CCPR/C/GC/R.36/Rev.2, [7].

¹⁰² See, eg, Copelon et al, above n 87, 125–6; Alston, above n 84, 174, 178; and Amnesty International, above n 85, 21.

¹⁰³ Janoff, above n 93, 188. See also the statement in *Vo v France* (2004) 8 Eur Court HR 67, [80], quoted at n 85 above, that ‘if the unborn do have a “right” to “life”, it is implicitly limited by the mother’s rights and interests’.

¹⁰⁴ *Constitution of Ireland* s 40(3)(3).

The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

[76] As discussed at [41]–[42] above, Ireland has been called upon by the HRC to amend its laws, including its Constitution if necessary, to ensure compliance with the ICCPR regarding women’s access to safe terminations of pregnancy.

[77] The Australian Government has taken the view that the right to life under the ICCPR ‘was not intended to protect life from the point of conception but only from the point of birth’.¹⁰⁵

Non-discrimination on the basis of disability

[78] The CRPD is intended to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’.¹⁰⁶

[79] Article 4(1) of the CRPD requires state parties to ‘undertake to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability’, including by the adoption of appropriate legislative measures and the modification or abolition of existing laws that constitute discrimination.

[80] Further, article 5(2) prohibits ‘all discrimination on the basis of disability’.

[81] The CRPD reaffirms several fundamental rights, including the rights to family (article 23)¹⁰⁷ and health, including sexual and reproductive health

¹⁰⁵ Joint Standing Committee on Treaties, Parliament of Australia, *Report No 95: Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008* (2008) 17, quoting Evidence to Joint Standing Committee on Treaties, Parliament of Australia, Canberra, 16 June 2008, 6 (Peter Arnaudo, Attorney-General’s Department). See also National Interest Analysis [2008] ATNIA 18, attachment on consultation [16].

¹⁰⁶ *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 1. Art 1 further provides that:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

¹⁰⁷ *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 23(1)(b) requires state parties to ‘take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships’, including to ensure:

The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided.

Article 23(1)(c) also requires measures to ensure that ‘[p]ersons with disabilities, including children, retain their fertility on an equal basis with others’.

(article 25).¹⁰⁸ It also recognises the right of children with disabilities to the full enjoyment of rights and freedoms on an equal basis with other children (article 7).¹⁰⁹

[82] As noted above, article 10 of the CRPD also reaffirms, for persons with disabilities, the right to life:

State Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

[83] Consistently with other treaties, article 10 is silent on the question of the right to life before birth, 'leaving each state to determine when life begins according to its own ... legal principles'.¹¹⁰

[84] Although the CRPD does not expressly recognise rights before birth, the United Nations Committee on the Rights of Persons with Disabilities (the 'CRPD Committee') has raised concerns about abortion laws in some countries that permit termination of pregnancy on the basis of fetal impairment.

[85] The CRPD Committee has not released a General Comment canvassing this issue, but has called on some countries to amend their laws to abolish distinctions based solely on disability.

[86] For example, in its concluding observations on Spain, the CRPD Committee made the following comment and recommendation:¹¹¹

¹⁰⁸ *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 25(a) recognises that persons with disabilities have 'the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability' and requires, among other things, provision to persons with disabilities of:

the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.

¹⁰⁹ See also *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, preamble para (r).

¹¹⁰ CJ Petersen, 'Reproductive Justice, Public Policy, and Abortion on the Basis of Fetal Impairment: Lessons from International Human Rights Law and the Potential Impact of the Convention on the Rights of Persons with Disabilities' (2015) 28(1) *Journal of Law and Health* 121, 158. See also 153:

the drafters of the CRPD agreed to describe the 'right to life' in very simple terms. The provision on the 'right to life' ... does not refer to 'the unborn' and it does not state that life begins at conception. ... the drafters decided against including any express reference to abortion within the treaty. (notes omitted)

See also Joint Standing Committee on Treaties, Parliament of Australia, *Report No 95: Treaties tabled on 4 June, 17 June, 25 June and 26 August 2008* (2008) 17; and National Interest Analysis [2008] ATNIA 18, attachment on consultation [16]:

A number of submissions suggested that Article 10—the right to life—obliges State Parties to prohibit abortion; particularly abortion on the basis of disability confirmed through in utero testing. Life from the point of conception was not intended to be protected by the right to life, as enunciated in Article 6 of the [ICCPR]. Given that the [CRPD] does not create any new rights, the Australian Government considers that Article 10 of the Convention carries this meaning also.

¹¹¹ Committee on the Rights of Persons with Disabilities, *Concluding observations on Spain*, UN Doc CRPD/C/ESP/CO/1 (19 October 2011) [17]–[18].

The Committee takes note of Act 2/2010 of 3 March 2010 on sexual and reproductive health, which decriminalises voluntary termination of pregnancy, allows pregnancy to be terminated up to 14 weeks and includes two specific cases in which the time limits for abortion are extended if the fetus has a disability: until 22 weeks of gestation, provided there is 'a risk of serious anomalies in the fetus', and beyond week 22 when, *inter alia*, 'an extremely serious and incurable illness is detected in the fetus'. ...

The Committee recommends that the State party abolish the distinction made in Act 2/2010 in the period allowed under law within which a pregnancy can be terminated based solely on disability.

[87] The CRPD Committee made similar comments and recommendations in its concluding observations on Hungary and Austria.¹¹²

[88] Those comments and recommendations were made in the context of the general provisions about non-discrimination under articles 4 and 5 of the CRPD, and not with reference to the right to life in article 10.

[89] The effect of the Committee's comments has been questioned. One academic commentator has observed, for example, that:¹¹³

It appears that the Committee is implicitly taking the position that a fetus enjoys rights under the CRPD, despite the lack of any explicit statement to this effect in the treaty. If this is the case, the Committee's approach marks a departure from the predominant approach in international law, which has traditionally not provided for fetal rights in human rights treaties but rather allowed each individual state to determine whether a fetus enjoys legal rights within that state's domestic legal system. ... In this author's view, the only other possible interpretation of the Committee's recommendation [to] abolish all distinctions based upon disability in [the] abortion law[s] is that the Committee may believe that permitting abortion on the ground of fetal impairment devalues, and therefore discriminates against, people who are already living with disabilities. (notes omitted)

[90] That author has argued that the CRPD Committee's comments, by focusing on the removal of formal discrimination in the legislative framework, are 'too simplistic and do not adequately acknowledge the tensions between reproductive freedom and the rights of persons with disabilities':¹¹⁴

Ironically, Spain and Hungary could both comply with the Committee's comments by amending their laws to provide all women with unfettered access to abortion. Such amendments would address what the Committee views as the formal discrimination in the legislative framework, but would do nothing to reduce the incidence of disability-selective abortions. On the other hand, if a country moves in the opposite direction, and reduces access to abortion, it could have the effect of violating numerous human rights treaties, including the CRPD, which give persons with disabilities the right to determine the number and spacing of their

¹¹² Committee on the Rights of Persons with Disabilities, *Concluding observations on Hungary*, UN Doc CRPD/C/HUN/CO/1 (22 October 2012) [17]–[18]; Committee on the Rights of Persons with Disabilities, *Concluding observations on Austria*, UN Doc CRPD/C/AUT/CO/1 (30 September 2013) [14]–[15].

¹¹³ Petersen, above n 110, 159, commenting in particular on the CRPD Committee's concluding observations on Hungary.

¹¹⁴ *Ibid* 161–2.

children and the right to reproductive health services. Such legislation could also motivate more women to seek illegal and unsafe abortions ... (note omitted)

[91] In that author's view, 'more systemic ways of encouraging prospective parents to voluntarily continue a pregnancy that may lead to the birth of a child with disability' should be considered.¹¹⁵

[92] This also raises more complex questions about 'disability-selective' abortion:¹¹⁶

the decision to abort [following a diagnosis of fetal impairment] does not necessarily reflect a societal policy of trying to prevent the birth of persons with disabilities. Rather, it might reflect compassion for the pregnant woman, respect for her right to physical autonomy, or recognition that she is in the best position to determine whether she should continue the pregnancy.

However, many disability rights scholars and activists would argue that society does not simply allow pregnant women to make their own decisions. Instead, the medical profession and other powerful institutions actively encourage disability-selective abortion by recommending genetic screening and prenatal testing and then counselling prospective parents in a manner that discourages them from continuing a pregnancy if the tests reveal fetal impairment. (note omitted)

Freedom of conscience and expression

Freedom of thought, conscience and religion

[93] Both the UDHR (article 18) and the ICCPR (article 18) recognise the right to 'freedom of thought, conscience and religion', including the freedom to manifest a religion or belief either individually 'or in community with others and in public or private'.¹¹⁷

[94] Article 18(3) of the ICCPR provides that the freedom to manifest one's religion or beliefs may be restricted, but only by limitations prescribed by law and that are 'necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others'.¹¹⁸

115 Ibid.

116 Ibid 137.

117 See Human Rights Committee, *General Comment No 22: Article 18*, 48th sess, UN Doc CCPR/C/21/Rev.1/Add.4 (27 September 1993) [1]:

The right to freedom of thought, conscience and religion (which includes the freedom to hold beliefs) in article 18(1) is far-reaching and profound; it encompasses freedom of thoughts on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others.

The freedom of thought, conscience and religion is also recognised in the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 14(1).

118 See also, in the same terms, the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 14(3).

[95] The HRC has explained that:¹¹⁹

paragraph 3 of article 18 is to be strictly interpreted: restrictions are not allowed on grounds not specified there, even if they would be allowed as restrictions to other rights protected in the Covenant, such as national security. Limitations may be applied only for those purposes for which they were prescribed and must be directly related and proportionate to the specific need on which they are predicated. Restrictions may not be imposed for discriminatory purposes or applied in a discriminatory manner.

[96] The ICCPR does not expressly refer to a right of conscientious objection. However, the HRC has observed that such a right (in the context of military service) can be derived from article 18.¹²⁰

[97] In the context of the sexual and reproductive health rights of women and girls (and in relation to abortion specifically), treaty bodies have identified that the practice of conscientious objection by health professionals should be regulated to ensure that it does not inhibit access to services, including in emergencies and by referral to alternative health providers.¹²¹ The HRC has also observed that article 18 of the ICCPR ‘may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion’.¹²²

[98] The WHO Safe Abortion Guidance recommends that health professionals who claim conscientious objection should be required to refer the person to another provider so that access to lawful abortion services is not impeded.¹²³

Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure, while not referring the woman to an abortion provider. In the absence of a readily available abortion-care provider, this practice can delay care for women in need of safe abortion, which increases risks to their health and life. While the right to freedom of thought, conscience, and religion is protected by international human rights law, international human rights law also stipulates that freedom to manifest one’s religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others. Therefore laws and regulations should not entitle providers and institutions to impede women’s access to lawful health services.

119 HRC General Comment No 22, above n 117, [8].

120 Ibid [11].

121 See the comments and observations of the ESCR Committee referred to at [24], [27] and n 43 above, the comments of the CEDAW Committee referred to at nn 43 and 44 above and the comments of the CRC Committee referred to at [48] above. See also, eg, Statement of the CEDAW Committee, above n 9, 2; Committee on the Elimination of Discrimination against Women, *Concluding observations on Italy*, UN Doc CEDAW/C/ITA/CO/7 (24 July 2017) [41](d), [42](d); Committee on the Elimination of Discrimination against Women, *Concluding observations on Croatia*, UN Doc CEDAW/C/HRV/CO/4-5 (28 July 2015) [30](a), [31](a); *Report of the Office of the United Nations High Commissioner for Human Rights: Practices in adopting a human rights-based approach to eliminate preventable maternal mortality and human rights*, UN Doc A/HRC/18/27 (8 July 2011) [30]. The Special Rapporteur on the right to health has also raised concerns about conscientious objection: see [31] above.

122 HRC General Comment No 28, above n 57, [21].

123 WHO, ‘Safe abortion: technical and policy guidance for health systems’ (Guidelines, 2nd ed, 2012) [4.2.2.5], and see [3.3.6]. See also the table at [110] below.

Health-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health. Health services should be organised in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation. (notes omitted)

Freedom of opinion and expression

[99] Both the UDHR (article 19) and the ICCPR (article 19) recognise the right to freedom of opinion and expression.¹²⁴ This includes the freedom to hold opinions without interference¹²⁵ and the freedom to seek, receive and impart information and ideas regardless of frontiers and through any media.¹²⁶

[100] The HRC has described these freedoms as constituting 'the foundation stone for every free and democratic society' and as forming 'a basis for the full enjoyment of a wide range of other human rights'.¹²⁷ They are closely linked with the rights to freedom of association and assembly and freedom of thought, conscience and religion,¹²⁸ and are enjoyed individually and collectively.¹²⁹

124 See also the *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 13; and *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 24 January 2007, art 21.

125 See, in particular, *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 19(1) which provides that '[e]veryone shall have the right to hold opinions without interference'. Freedom of opinion is said to be largely a private matter, in contrast with the freedom of expression in art 19(2) which is said to be largely a public matter: *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression*, 51st sess, Agenda Item 10, UN Doc E/CN.4/1995/32 (14 December 1994) [24], [26].

126 See, in particular, *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, art 19(2) which provides:

Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

Article 19(2) includes, for example, political discourse, commentary on one's own and on public affairs, discussion of human rights and religious discourse. It also encompasses the right of access to public information: Human Rights Committee, *General Comment No 34: Article 19 (Freedoms of opinion and expression)*, 102nd sess, UN Doc CCPR/C/GC/34 (12 September 2011), [11], [18].

127 HRC General Comment No 34, above n 126, [2], [4].

128 Ibid [4]; *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression*, 14th sess, Agenda Item 3, UN Doc A/HRC/14/23 (20 April 2010) [27].

The freedoms of association and peaceful assembly are recognised in the *Universal Declaration of Human Rights*, GA Res 217A (III), 10 December 1948, art 20; *International Covenant on Civil and Political Rights*, GA Res 2200A (XXI), 16 December 1966, arts 21, 22; and *Convention on the Rights of the Child*, GA Res 44/25, 20 November 1989, art 15.

129 *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 128, [29]:

[Freedom of opinion and expression] endows social groups with the ability to seek and receive different types of information from a variety of sources and to voice their collective views. This freedom extends to mass demonstrations of various kinds, including the public expression of spiritual or religious beliefs or of cultural values.

[101] Freedom of opinion is not subject to restriction.¹³⁰ However, article 19(3) of the ICCPR recognises that freedom of expression ‘carries with it special duties and responsibilities’ and may be restricted in certain circumstances:¹³¹

The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:

- (a) For respect of the rights or reputations of others;
- (b) For the protection of national security or of public order (*ordre public*), or of public health or morals.

[102] It has been observed that the reference in article 19(3) to ‘special duties and responsibilities’ recognises that ‘the exercise of freedom of expression might entail a violation of the rights of others’ so that there is a responsibility ‘not to abuse’ the freedom.¹³²

[103] In addition, article 5 of the ICCPR provides that:

Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognised herein or at their limitation to a greater extent than is provided for in the present Covenant.

[104] The HRC has explained that restrictions on the freedom of expression may be imposed only in accordance with article 19(3) and in conformity with ‘the strict tests of necessity and proportionality’.¹³³ In addition, restrictions must not jeopardise the right of freedom of expression itself, or other rights and principles under the ICCPR.¹³⁴

[105] The United Nations Special Rapporteur on the right to freedom of opinion and expression has identified the following principles on restrictions of the freedom of expression:¹³⁵

¹³⁰ See HRC General Comment No 34, above n 126, [9]. See also *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (1994), above n 125, [24].

¹³¹ See also art 20 of the ICCPR which prohibits propaganda for war and requires that advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence shall be prohibited by law.

¹³² *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (1994), above n 125, [36].

¹³³ HRC General Comment No 34, above n 126, [22].

¹³⁴ *Ibid* [21], [26].

¹³⁵ *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 128, [77], [79](a)–(g), (i), (k)–(l). See also the additional principles at [79](h) and (j) in relation, for example, to propaganda for war, child pornography, racial hatred, genocide and declared states of emergency.

- As a general principle, permissible restrictions must constitute an exception and be kept to the minimum necessary to pursue the legitimate aim of safeguarding other human rights.¹³⁶
- In particular—
 - Restrictions must not undermine the essence of the freedom;
 - The relationship between the freedom and the restriction (or the rule and the exception) must not be reversed;
 - Restrictions must be provided for in laws;¹³⁷
 - Laws imposing restrictions must be accessible and unambiguous so that they can be understood by and applied to everyone;
 - Laws imposing restrictions must provide remedies for, or mechanisms for challenging, unlawful or abusive applications of the restriction (including judicial review);
 - Laws imposing restrictions must not be arbitrary or unreasonable;
 - Restrictions must be necessary;¹³⁸
 - The continued relevance of restrictions should periodically be examined;
 - Restrictions must be consistent with other recognised human rights, and with fundamental principles of universality, interdependence, equality and non-discrimination; and
 - Where there is doubt about the scope or interpretation of a law imposing a restriction, the prevailing consideration must be the protection of fundamental human rights.

[106] The Special Rapporteur has identified that the requirement of ‘necessity’ means that restrictions must:¹³⁹

- (i) Be based on one of the grounds for limitations recognised by the Covenant;
- (ii) Address a pressing public or social need which must be met in order to prevent the violation of a legal right that is protected to an even greater extent;

¹³⁶ See further [107] below.

¹³⁷ See further HRC General Comment No 34, above n 126, [24]–[25].

¹³⁸ See further [106] below.

¹³⁹ *Report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression* (2010), above n 128, [79](g).

- (iii) Pursue a legitimate aim;
- (iv) Be proportionate to that aim and be no more restrictive than is required for the achievement of the desired purpose. The burden of demonstrating the legitimacy and the necessity of the limitation or restriction shall lie with the State.

[107] As to proportionality, the HRC has explained that ‘restrictions must not be overbroad’:¹⁴⁰

‘restrictive measures must conform to the principle of proportionality; they must be appropriate to achieve their protective function; they must be the least intrusive instrument amongst those which might achieve their protective function; they must be proportionate to the interest to be protected ... The principle of proportionality has to be respected not only in the law that frames the restrictions but also by the administrative and judicial authorities in applying the law’. The principle of proportionality must also take account of the form of expression at issue as well as the means of its dissemination (note omitted).

¹⁴⁰ HRC General Comment No 34, above n 126, [34], quoting from Human Rights Committee, *General Comment No 27: Freedom of movement (article 12)*, 173rd sess, UN Doc CCPR/C/21/Rev.1/Add.9 (1 November 1999) [14] and citing Human Rights Committee, *Views: Communication No 1157/2003*, 87th sess, UN Doc CCPR/C/87/D/1157/2003 (10 August 2005) (*Coleman v Australia*).

Overview tables

[108] The following tables briefly summarise key aspects of the WHO Safe Abortion Guidance, the United Nations OHCHR information series on abortion and United Nations treaty body jurisprudence and guidance.¹⁴¹

Decriminalisation of abortion

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Criminal offences for the woman	[4.1]–[4.2]: International and regional human rights bodies increasingly recommend that States reform laws that criminalise medical procedures only needed by women and that punish women who undergo those procedures, including abortion. Restricting legal access to abortion does not decrease the need for abortion but is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality. Given the clear link between access to safe abortion and women's health, it is recommended that laws and policies should protect women's health and their human rights.	Criminalisation of health services that only women require, including abortion, is a form of discrimination against women. Treaty bodies have requested States to decriminalise abortion and remove punitive measures for women who undergo abortion.	Criminalisation of abortion may amount to cruel or inhuman treatment. (1) Punitive measures imposed on women who undergo abortion should be removed. (2, 4, 9)
Criminal offences for the provider		Criminalisation of doctors who provide abortion services violates women's rights. Treaty bodies have expressed concern about the criminalisation of health care providers who offer abortion services. Imposing a legal duty on doctors to report cases of women who have undergone abortion may violate women's right to privacy.	Imposing a legal duty on health providers to report cases of women who have undergone abortion may violate women's right to privacy. (5)

Legal grounds for abortion

[109] The WHO has explained that '[e]vidence increasingly shows that, where abortion is legal on broad socioeconomic grounds and on a woman's request, and where safe services are accessible, both unsafe abortion and abortion-related mortality [death] and morbidity [injury] are reduced'.¹⁴²

¹⁴¹ See WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012); and Office of the United Nations High Commissioner for Human Rights, *Information Series on Sexual and Reproductive Health and Rights: Abortion* (2015) <<http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>>.

¹⁴² WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 90.

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Threat to life	[4.2.1.1]: This is consistent with the human right to life, which requires protection by law, including when pregnancy is life-threatening or a pregnant woman's life is otherwise endangered. Both medical and social conditions can constitute life-threatening conditions.	Ensuring women's rights requires access to abortion where there is a threat to the woman's life. Treaty bodies have requested States to legalise abortion in cases where the pregnancy endangers the life of the woman.	Abortion should be decriminalised to allow access to abortion where the pregnancy endangers the woman's life. (7, 11, 12, 16, 17, 19, 20, 21, 23)
Threat to health (physical or mental)	[4.2.1.2]: This fulfils women's human rights. Physical health includes conditions that aggravate pregnancy and those aggravated by pregnancy. Mental health includes psychological distress or mental suffering caused by, eg, coerced sexual acts and diagnosis of fetal impairment. Social circumstances are also taken into account. The WHO defines 'health' as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'; this is to be implied in the interpretation of laws that allow abortion on this ground.	Ensuring women's rights requires access to abortion where there is a threat to the woman's health. Treaty bodies have requested States to legalise abortion in cases where the pregnancy endangers the health of the woman. Health has been understood broadly to include mental health.	Abortion should be decriminalised to allow access to abortion where the pregnancy endangers the woman's health. (7, 11, 12, 16, 17, 23)
Where pregnancy results from rape or incest	[4.2.1.3]: Protection of women from cruel, inhuman and degrading treatment requires access to safe abortion services on this basis. Some countries require evidence of the criminal act, which can delay and restrict access. Administrative requirements should be minimised and clear protocols established to facilitate prompt referral and access.	Ensuring women's rights requires access to abortion where the pregnancy is the result of rape or incest. Treaty bodies have requested States to decriminalise abortion when the pregnancy results from rape or sexual abuse.	Denying access to abortion where the pregnancy is the result of rape is cruel, inhuman or degrading treatment, and a violation of the right to privacy. (25) Abortion should be decriminalised to allow access to abortion in such cases. (5, 7, 8, 9, 11, 12, 13, 14, 16, 17, 18, 20, 23)
Where there is fetal impairment	[4.2.1.4]: Some countries specify the kinds of impairment, and others specify lists of impairments. Lists tend to be restrictive and a barrier to access. In some countries, the law does not refer directly to fetal impairment but health protection or social reasons are interpreted to include distress caused by the diagnosis of fetal impairment. A woman is entitled to know the status of her pregnancy and to act on this information.	Treaty bodies have recommended ensuring access to abortion services in cases of fetal impairment, while also putting in place measures to ensure the elimination of discrimination against persons with disabilities.	Denying access to abortion in cases of fatal fetal impairment is cruel, inhuman or degrading treatment, and a violation of the right to privacy. (24, 26, 27) Abortion should be decriminalised to allow access to abortion in cases of severe fetal impairment. (8, 9, 14) However, distinctions based solely on disability should be removed. (22)

For economic or social reasons	[4.2.1.5]: This is interpreted by reference to whether continued pregnancy would affect the actual or foreseeable circumstances of the woman, including her achievement of the highest attainable standard of health.		
On request	[4.2.1.6]: This recognises the woman's free choice. Most countries that allow abortion on this ground also set gestational limits.		
Gestational limits	[4.2.1.7]: Gestational limits can have negative consequences for women who have exceeded the time limit. They can force women to seek services from unsafe providers or providers in other countries (or to resort to unsafe self-induced methods). As well as legal gestational limits, some services can restrict access with limits that are not evidence-based, eg, offering outpatient services only up to 8 weeks when they could safely be provided up to 12–14 weeks.		

Other requirements or restrictions

[110] The WHO has explained that there are a range of 'laws, policies and practices that restrict access to abortion information and services', including prohibiting access to information, requiring third party authorisation, restricting available methods of abortion, restricting the range of providers and facilities, misrepresenting health information, excluding coverage under health insurance, failing to guarantee confidentiality and privacy, and restrictive interpretation of legal grounds:¹⁴³

These barriers contribute to unsafe abortion because they:

- deter women from seeking care and providers from delivering services within the formal health system;
- cause delay in access to services, which may result in denial of services due to gestational limits on the legal grounds;
- create complex and burdensome administrative procedures;
- increase the costs of accessing abortion services; [and]
- limit the availability of services and their equitable geographic distribution.

¹⁴³

WHO, 'Safe abortion: technical and policy guidance for health systems' (Guidelines, 2nd ed, 2012) 94.

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Access to information	<p>[4.2.2.1]: Information about safe, legal abortion is crucial to protect women's health and human rights. Many women and health-care providers do not know what the law allows. Fear of violating the law has a chilling effect. States should provide clear guidance on how legal grounds for abortion are to be interpreted and applied, as well as information on how and where to access lawful services.</p> <p>[4.2.2.7]: Women have a right to be fully informed of their health care options. Information must be complete, accurate and easy to understand, and be given in a way that facilitates free and fully informed consent and respects the woman's dignity and privacy. See also [2.1.8.2].</p>		
Third party authorisation	<p>[4.2.2.2]: Third party authorisation should not be required for women to obtain abortion services. The requirement for authorisation by a spouse or hospital authorities may deter or delay access and violate the right to privacy and access to health care on the basis of equality of men and women.</p>	<p>Steps should be taken to remove barriers to the provision of abortion services, including third party authorisation provisions.</p>	<p>Third party authorisation requirements for access to abortion services should be removed. (2, 4)</p>
Consent for minors	<p>[4.2.2.2]: Parental authorisation, often based on an arbitrary age limit, denies the recognition of evolving capacities of young women. To protect the best interests and welfare of minors, and taking into consideration their evolving capacities, policies and practices should encourage, but not require, parents' engagement through support, information and education.</p>	<p>The CRC Committee has especially emphasised the right of the child, in accordance with evolving capacities, to confidential counselling and access to information, and has recommended that States consider allowing young people, in accordance with their evolving capacities, to consent to reproductive health services.</p>	<p>Third party authorisation requirements for access to abortion services, such as parental consent for young people capable of consenting in accordance with their evolving capacities, should be removed. (2, 4, 6)</p>
Special personnel and facilities	<p>[4.2.2.4]: Restrictions on the range of providers or facilities that are legally authorised to provide abortion reduce the availability of services and their equitable geographic distribution, causing women to travel greater distances and incur greater costs and delays. The regulation of facilities and providers should be evidence-based to protect against over-medicalised, arbitrary or otherwise unreasonable requirements.</p>		

Conscientious objection	[4.2.2.5]: Freedom of thought, conscience and religion is protected, but can be limited where necessary to protect the fundamental human rights of others. Laws and regulations should not entitle providers and institutions to impede women's access to lawful health services. Health care providers who claim conscientious objection must refer the woman to another provider or, if that is not possible, provide abortion to save the woman's life or prevent damage to her health.	Conscientious objection cannot be allowed to prevent women or adolescent girls from accessing health services. The CEDAW Committee has stated that, if health providers refuse to perform services based on conscientious objection, measures should be taken to ensure that women are referred to alternative health providers.	Conscientious objection must be regulated so that it does not inhibit access to abortion services (including by requiring referrals to other providers) or to emergency services. (2, 4, 9, 10, 15) Adolescent girls should not be deprived of information or services due to providers' conscientious objections. (6)
Counselling and waiting periods	[2.1.8.1]: Counselling should be offered, but many women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counselling. Provision of counselling to women who desire it should be voluntary, confidential, non-directive and by a trained person. [4.2.2.6]: Waiting periods should not jeopardise women's access to safe, legal abortion services. States should consider eliminating waiting periods that are not medically required. [2.3]: Women should also receive appropriate post-abortion care, including being offered contraceptive counselling.	The CEDAW Committee has explained that the legal framework for access to abortion must include a mechanism for rapid decision-making, with a view to limiting risks to the woman's health.	Biased counselling and mandatory waiting periods for abortion should be removed. (4) Health care providers should be in a position to supply full information on safe abortion services without fear of criminal sanction. (27)

Accessibility

	WHO Safe Abortion Guidance	UN OHCHR Information Series	UN Treaty body comments
Accessibility and availability	[4.2.2.9]: The respect, protection and fulfilment of human rights require that governments ensure that lawful abortion services are accessible in practice. [4.3]: An enabling environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. [3.3.1] and [3.6.2]: Access should not be denied or delayed because of a woman's inability to pay; and health facilities should have appropriate referral mechanisms.	Where abortion is lawful, procedures must be put in place for making abortion services safe and accessible to all women without discrimination. Legal reform alone is not enough to fulfil human rights obligations.	A core obligation under the ICESCR is to guarantee universal and equitable access to sexual and reproductive health services, and to take measures to prevent unsafe abortions. (4) Services must be accessible and affordable for rural women. (3) The right to life requires measures to prevent life-threatening clandestine abortions. (5)

Safe access zones			Third parties should be prohibited and prevented from imposing practical barriers to services, such as physical obstruction of facilities, dissemination of misinformation and harassment or violence targeting women seeking abortion services. (4)
-------------------	--	--	--

Table notes—

1. CEDAW Committee General Recommendation No 35, above n 21
2. CEDAW Committee General Recommendation No 24, above n 9
3. CEDAW Committee General Recommendation No 34, above n 45
4. ESCR Committee General Comment No 22, above n 14
5. HRC General Comment No 28, above n 57
6. CRC Committee General Comment No 15, above n 68
7. CEDAW Committee Concluding Observations on Angola, above n 51
8. CEDAW Committee Concluding Observations on the Dominican Republic, above n 52
9. CEDAW Committee Concluding Observations on Peru, above n 10
10. CEDAW Committee Concluding Observations on Poland, above n 43
11. ESCR Committee Concluding Observations on Costa Rica, above n 51
12. ESCR Committee Concluding Observations on Nepal, above n 51
13. ESCR Committee Concluding Observations on Chile, above n 52
14. ESCR Committee Concluding Observations on the United Kingdom, above n 52
15. ESCR Committee Concluding Observations on Poland, above n 43
16. HRC Concluding Observations on the Philippines, above n 63
17. HRC Concluding Observations on the Dominican Republic, above n 63
18. HRC Concluding Observations on Guatemala, above n 63
19. HRC Concluding Observations on Panama, above n 63
20. CRC Committee Concluding Observations on Chile, above n 75
21. CRC Committee Concluding Observations on Chad, above n 75
22. CRPD Committee Concluding Observations on Spain, above n 111; CRPD Committee Concluding Observations on Hungary, above n 112; CRPD Committee Concluding Observations on Austria, above n 112
23. *TPF v Peru*, UN Doc CEDAW/C/50/D/22/2009
24. *Huamán v Peru*, UN Doc CCPR/C/85/D/1153/2003
25. *VDA v Argentina*, UN Doc CCPR/C/101/D/1608/2007
26. *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013
27. *Whelan v Ireland*, UN Doc CCPR/C/119/D/2425/2014