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Dear Minister

Submission on termination of pregnancy law reform

Australian Lawyers for Human Rights ("**ALHR**") thanks you for your invitation to comment on the proposed changes to legislation governing termination of pregnancy in the Northern Territory.

ALHR was established in 1993 and is a national organisation of Australian solicitors, barristers, academics, judicial officers and law students who practise and promote international human rights law in Australia. ALHR has active and engaged National, State and Territory committees and a secretariat at La Trobe University Law School in Melbourne. Through advocacy, media engagement, education, networking, research and training, ALHR promotes, practices and protects universally accepted standards of human rights throughout Australia and overseas.

We make the following observations in response to the Department of Health's discussion paper issued in December 2016.

1. Summary

1.1 ALHR strongly supports the government's proposal to:
- repeal section 11 of the *Medical Services Act*;
- introduce a new Act regarding abortion; and
- amend the *Criminal Code Act*.

1.2 The existing legislative framework governing abortion in the Northern Territory makes an abortion a criminal offence except in very limited circumstances, as specified in the *Medical Services Act*. The effect of these laws is that many women are prevented from seeking early termination of unwanted pregnancies. The requirement for abortions to occur in a hospital in practical terms prevents women from accessing a medical termination, such as the drug RU486, as an additional option to surgical termination.

1.3 ALHR supports reforms that uphold sexual and reproductive health rights, and allow women and girls autonomy over their own bodies and health. In response to the discussion paper, ALHR specifically supports:
- broadening the circumstances in which abortion services can be provided;
- enabling women's access to medical termination, such as through RU486;
- the creation of safe access zones;
- enabling girls under the age 18, who have sufficient capacity, providing their consent to an abortion, without the requirement for consent necessarily defaulting to an adult; and
- thorough consideration of the remoteness of the Northern Territory and accessibility of services for Aboriginal women in the development of any guidelines in support of the new legislation.

1.4 ALHR endorses the Human Rights Law Centre's submissions on the discussion paper dated 18 January 2017.

1.5 UN Human Rights Bodies have provided States with clear guidance on when there is a need to decriminialise abortion and have emphasised that ensuring access to safe and legal abortion services in accordance with human rights standards is part of State obligations to eliminate discrimination against women and girls and ensure their right to health as well as other fundamental human rights.

2. International Human Rights Law

2.1 The United Nations Human Rights Committee has stated that the denial of access to safe and legal abortion is a breach of the fundamental human rights of women and girls, specifically under several articles of the *International Covenant on Civil and Political Rights* ("**ICCPR**")[1] including the right to an effective remedy, prohibition on torture and cruel, inhuman and degrading treatment, right to private life and right of minors to measures of protection.

2.2 The Committee on the Elimination of Discrimination Against Women has specified that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women".[2] The Committee has also more recently requested that States "remove punitive measures for women who undergo abortion" and has stated that the criminalisation of practitioners who provide abortion services also violates women's rights.[3]

2.3 Similarly, the Special Rapporteur on the right to health has argued that laws criminalising abortion "infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health". The Rapporteur has called on States to decriminalise abortion.[4]

2.4 The United Nations Committee on Economic, Social and Cultural Rights has also established that the right to health – which comprises reproductive and sexual health –

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1 *International Covenant on Civil and Political Rights*, 16 December 1966, 999 U.N.T.S. 171 (entered into force 23 March 1976).

2 Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, A/54/38/Rev 1 (1999) [11].

3 Concluding Observations on Peru, CEDAW/C/PER/CO/7-8 (2014), para. 36; Statement on sexual and reproductive health and rights: Beyond 2014 ICPD Review (2014).

4 UN Secretary-General, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/66/254 (2011), para. 21.

requires health services, including legal abortion services, which are available, accessible, acceptable and of good quality.[5]

2.5 The Committee on the Rights of the Child has recommended that "States ensure access to safe abortion and post abortion care services irrespective of whether abortion itself is legal".[6]

2.6 There is significant and consistent domestic and international jurisprudence that establishes that the right to life is not inconsistent with the provision of abortion services. Indeed, the view of the Australian Government is 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".[7]

3. Criteria for providing treatment

3.1 ALHR notes the proposal in the discussion paper that an abortion may be performed where each of the following criteria is met:

- informed consent is given by the woman (or other appropriate person in law);
- information and counselling are provided about current choices and future contraceptive options;
- consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances regardless of gestation; and
- decision making is based on a holistic assessment of the woman involving formation of an opinion by:
  - one suitably qualified medical practitioner for gestations of not more than 14 weeks; and
  - two suitably qualified medical practitioners for gestations of more than 14 weeks and up to but not more than 23 weeks, where an obstetrician or gynaecologist is recommended as one of the two suitably qualified medical practitioners.

3.2 ALHR has the following concerns about this proposal, outlined below:

- it does not give proper effect to the woman's choice;
- mandated counselling is redundant and, in some cases, inappropriate; and
- specifying criteria for termination according to different gestation periods is arbitrary, and fails to consider the circumstances of each case.

3.3 The requirement for medical practitioners to consider psychosocial matters and complete a holistic assessment is not problematic in itself, but when such an assessment empowers a practitioner to effectively override a woman's wishes, it is not supported by ALHR. The proposed decision making process by a practitioner usurps a woman's decision making capacity. Allowing practitioners to have a right of veto in respect of a woman's choice to terminate undermines a women's right to make a decision about her own body. Interference with these rights should – as is the case with any proposed limitation on a human right – be contextual and proportionate. It is a disproportionate limitation on the human rights of the woman concerned to allow such an interference on the basis of satisfaction of psychosocial criteria as assessed by another person or persons.

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5 General Comment 14 (2000) on the right to the highest attainable standard of health, paras. 8, 12. 27.

6 General Comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 70.

7 Mr Peter Arnaudo, Attorney–General's Department, Hansard - Joint Standing Committee on Treaties Reference: Treaties tabled on 14 May and 4 June 2008 16 June 2008, p.7. http://www.aph.gov.au/hansard/joint/commttee/J10940.pdf.

3.4 ALHR considers the requirements for the approval of up to two medical practitioners, including a specialist, to be excessive. We note that medical practitioners have a duty of care to their patients and are bound by professional medical obligations. Medical practitioners must refer to specialists in certain circumstances, for example for reasons such as level of expertise and complexity of a case. Mandating assessment by two practitioners presents additional hurdles for women – not only is one health professional able to override the choice of the woman, but two, because if either practitioner does not support a woman's desire to terminate her pregnancy, under the proposed legislation their veto will override her wishes.

3.5 ALHR is very concerned that there is no provision for abortion after 23 weeks pregnancy. Therefore as it stands, the current law will continue to apply, which only permits abortion after 23 weeks in order to save a woman's life. Foetal abnormalities account for a small but important proportion of abortion requests. Indeed, modern prenatal diagnosis is predicated on the availability of legal abortion should an abnormality be detected. Very few pregnancies are terminated after 20 weeks, but when they are, the circumstances are more likely to be distressing. The current law would force a woman to continue with a pregnancy where she is 24 weeks pregnant and has been told the foetus has a serious or fatal foetal abnormality, or where she is pregnant because of rape. ALHR strongly supports the Human Rights Law Centre's recommendation that the new laws must therefore allow abortion after 23 weeks in a broad range of circumstances, similar to the *Abortion Law Reform Act 2008* (Vic).

3.6 ALHR submits that there should not be a prescribed approach for different gestation periods. It should be a matter for medical practitioners to assess each case according to its circumstances, best practice and clinical guidelines.

3.7 ALHR recommends that there be no requirement for one or more medical practitioners to approve a woman's choice to have an abortion. If a medical practitioner must approve a woman's choice, that requirement should not apply to gestations under 24 weeks.

3.8 ALHR objects to the proposal concerning mandatory counselling on choices and contraceptive options. Medical practitioners already have a duty to provide advice on current options and risks because informed consent is a requirement of medical treatment. There are also situations where such counselling may be irrelevant and/or inappropriate, for example where a woman has used contraception but it has failed, or where a pregnancy has occurred as a result of rape. Specifically legislating for counselling is redundant. ALHR recommends that this criterion be removed. This approach will also account for possible evolution of the definition of informed consent, as best practice in the medical profession continues to strengthen.

4. Suitably qualified medical practitioner

4.1 ALHR agrees with the proposed definition of suitably qualified medical practitioner as it requires the practitioner to have appropriate knowledge of abortion services without being overly prescriptive. The government should consider referring to the *Therapeutic Goods Administration Act* and the Pharmaceutical Benefits Scheme in the regulations so that suitability can also be established where existing legislation authorises a practitioner to administer abortion-inducing medication.

5. Prescribing, supplying and administering drugs that induce medical termination

5.1 ALHR supports any changes to legislation that protect practitioners and health professionals from criminal charges for lawfully supplying and administering abortion-inducing drugs. This increases safe access to abortion. We support the wording recommended in the discussion paper for a provision authorising the prescription, supply

and administration of termination drugs.

6. Criteria for the most appropriate location of treatment and care

6.1 ALHR proposes that termination both within and outside hospitals be specifically authorised in the new legislation. However, due to the remoteness of the Northern Territory, we recommend against hospitalisation being required for certain gestation periods. Instead, we recommend that the circumstances of the woman and the pregnancy be taken into account so that if it is deemed safe by a suitably qualified medical practitioner, any termination can occur in a non-hospital setting. If the government does not adopt this approach, ALHR would support a legislative presumption that for gestation periods from 24 weeks a hospital setting is preferred, where the presumption can be rebutted after considering the time and cost of travelling to a hospital, the effect of travel on the woman and any risks for the woman if she receives abortion services in a non-hospital setting.

6.2 We note the Australian Medical Association NT's advice that the woman be within two hours of a hospital when she takes medication to terminate a pregnancy. To manage this requirement in a jurisdiction as vast as the Northern Territory, ALHR supports the proposal in the discussion paper requiring practitioners effecting termination to follow professional standards and guidelines. We support the development of these guidelines, as recommended, because this would increase safe access to abortions by providing valid options for women in remote areas.

6.3 ALHR supports the development of plain English and culturally appropriate resources to inform women of available services.

6.4 ALHR supports an evaluation and monitoring strategy, including the collection of data, as this will assist the government to strengthen the proposed framework over time. There should be guidelines regarding the collection of data and privacy, so that only relevant data is collected and women's identities are protected.

7. Provision of services

7.1 All abortion services must be accessible. As previously outlined, geographic accessibility is one component of this. However, consideration must also be given to affordability. ALHR agrees that the Top End Health Service and Central Australia Health Services should retain responsibility for abortion services. Where a woman is permitted by law to have an abortion, cost should not be a barrier to her having one. For these reasons ALHR believes that all abortion services should be publicly available.

8. Conscientious objection

8.1 ALHR supports the provision for persons involved in decision-making about abortion or treatment itself to conscientiously object and be relieved of any duty to terminate a pregnancy. ALHR supports the proposed wording which requires the objecting practitioner to refer to another practitioner who the practitioner knows does not hold the same objection. However, ALHR recommends that a timeframe be specified and that immediate referral is an appropriate timeframe.

8.2 ALHR also endorses the Human Rights Law Centre's recommendation that the law ensure that in medical emergencies, where an abortion is required to save a woman's life or prevent serious harm, doctors and nurses with a conscientious objection are still compelled to perform or assist with an abortion. We share their view that such an approach balances the right of health professionals to act in accordance with their

conscience and religious beliefs with the right of women to life, health and autonomy.

9. Safe access zones

9.1 ALHR supports safe access zones around abortion clinics as a way of protecting and promoting human rights and women's safety, and minimising opportunities for antisocial behaviours. This reference to human rights includes the right to non-discrimination (on the basis of gender, property or other status), not be submitted to cruel, inhuman or degrading treatment, privacy, personal autonomy and the highest attainable standard of physical and mental health. ALHR supports a penalty to give greater effect to safe access zone provisions.

10. Informed consent to treatment

10.1 ALHR agrees with informed consent being a criterion for providing treatment, and for the definition of informed consent to be in line with current practice such as the guidelines for obtaining informed consent used by the Health and Community Services Complaints Commission.

10.2 ALHR strongly supports application of the *Gillick* principle so that whether girls under 18 can give informed consent is determined by establishing a certain level of understanding. If this principle is not applied, girls will have to seek consent from their parents or legal guardians to have an abortion. This undermines their ability to make decisions about their own health, and can also put both their mental and physical health at risk.

11. Other

Decriminalisation

11.1 ALHR supports the Human Rights Law Centre's submissions about changes to the *Criminal Code Act*. ALHR agrees that the complete decriminalisation of termination of pregnancy affecting a health professional is important in order to avoid unsafe abortion. We endorse the Human Rights Law Centre's recommendation to:

- repeal sections 170 and 208A-C of the *Criminal Code Act* and replace them with a provision that makes it an offence for an unqualified person (but not the pregnant woman) to perform an abortion; and
- insert *the destruction of a foetus of a pregnant woman other than in the course of a medical procedure* into the definition of "serious harm".

Aboriginal women

11.2 ALHR notes that Aboriginal women are disproportionately affected in accessing health services given the number of Aboriginal women that live in remote and very remote communities vis-à-vis non-Aboriginal women. When developing guidelines to support the new legislative framework, such as guidelines for practitioners, the government must specifically consider the nature of the barriers that Aboriginal women face in accessing services, and work towards minimising the burden of those barriers to Aboriginal women.

Geographic location

11.3 Similarly, when developing guidelines to support the new legislative framework, the government must specifically consider the impact of the guidelines on all women who live in remote areas, and how to eliminate any barriers to them accessing abortion services.

Funding

11.4 To enable reform of abortion legislation, adequate funding needs to be provided to the health portfolio. We note that the new legislation is intended to commence on 1 July

2017. However, the only existing abortion services in the Northern Territory are in Darwin and Alice Springs. There are no services available in Katherine or remote areas and communities. It is critical to ensure that women are not prevented from seeking abortions due to geographical location, unaffordable transport to a hospital, lack of services or long wait times. Implementation of the new legislation will need to be properly resourced.

12. Conclusion

12.1 ALHR welcomes the Northern Territory's decision to review the law on abortion. This is an opportunity for the government to create a strong framework that upholds human rights, respects a woman's right to make decisions about her own health, is in line with evidence-based policy and considers best practice in other jurisdictions, such as Victoria.

12.2 If you would like to discuss any aspect of this submission, please contact ALHR at nt@alhr.org.au.

Yours sincerely

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