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Queensland Parliament Submission to Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Termination of Pregnancy Bill 2018 (draft)

Women's Electoral Lobby (NSW)

September 2018

Women's Electoral Lobby, established in 1972, is an independent, non-party political lobby group dedicated to creating a society where women's participation and their ability to fulfill their potential are unrestricted, acknowledged and respected and where women and men share equally in society's responsibilities and rewards.

The Women's Electoral Lobby has worked tirelessly for over 45 years to improve the position of women in society.

WEL applies a feminist approach to all its work, from policy analysis and development to campaigning. WEL has developed a Feminist Policy Framework, which sets out the values, which we use to measure fairness for women and fairness for society. WEL believes that good policies should address these indicators and work with governments at all levels on achieving better and fairer policy outcomes.

Our current strategic focus areas include:

- Violence against women including securing crucial funding for women's refuges
- Financial security for women
- Women's reproductive rights

WEL supports the draft Termination of Pregnancy Bill 2018

NSW and Queensland are the only states to wholly retain abortion in their criminal codes and to rely on uncertain judicial precedents to enable the health system to provide abortion services.

That abortion remains in these states' criminal codes is an anachronism from 19th century English criminal law. It also contravenes our international obligations under the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The recent CEDAW Committee review of Australia's domestic and international performance on rights for women noted that while abortion is covered under Medicare and the Pharmaceutical Benefits Scheme, it is still criminalized in NSW and QLD.

Retention of Abortion in the criminal code shames and criminalises women as this procedure is uniquely accessed by women. In this context WEL strongly supports the determination in the draft Bill that 'any woman who consents to, assists in or performs a termination on herself does not commit an offence.'

Reputable medical consensus is that abortion is a normal component of modern reproductive health care for women.

Abortion is regulated via policies administered by the Departments of Health in NSW and in Queensland. Notes to the Termination of Pregnancy Bill indicate that its provisions are consistent with those in Queensland Health Policy and regulation.

The Bill treats abortion as a health issue, rather than a criminal matter. This is a significant step forward for Queensland women and all consumers of reproductive health care in that state.

Abortion is one of the safest medical procedures. Research in jurisdictions where abortion is decriminalized and accessible show that the rates of abortion are less than in jurisdictions where access is restricted and that maternal health indicators are superior.

WEL is confident that once legislated, this Bill will enable the Queensland health system to confidently adopt a modern approach to abortion which creates certainty for women and practitioners, reflects current clinical practices and recognizes women's capacities to make personal and private health decisions in consultation with their doctor and others they choose to include.

WEL acknowledges that the Bill is the fruit of extensive consultation and research by the Queensland Law Reform Commission and inquiries conducted by Committees of the Queensland Parliament. We are impressed by the weight the Law Reform Commission Report has given to expert medical and health practitioner perspectives, along with those of health providers and community organisations with direct experience in the delivery of reproductive health care services, especially in regional, rural and remote settings**.**

Q1. *Do you agree terminations should be lawful on request up to 22 weeks?*

WEL understands that the decision to end a pregnancy is a profoundly personal one which arises from complex individual circumstances. The person who is pregnant is best placed to make the decision that is best for them and their family and the law should allow them to do so.

WEL supports a provision that allows a woman to make this very personal decision until 22 weeks in pregnancy. We are aware that screening for foetal health is generally recommended to take place at 18-20 weeks in pregnancy; and believe it's important that someone who receives an unexpected or negative diagnosis after this test has time to access relevant information, and doesn't feel rushed to make a decision.

There are a number of reasons that a pregnant person might not be able to access the abortion care they need until later in pregnancy - including delays because of their geographical location and limited health services in their region; and the violence and control of an abusive partner. We need a compassionate healthcare system that recognises that and minimises barriers to healthcare access.

WEL understands that the proposed 22 week provision is consistent with Queensland Clinic Guidelines for Perinatal Care at the Threshold of Viability, which advise that the threshold of viability is considered to be between 23 weeks and 0 days and 25 weeks and 6 days gestational age. The same guidelines recommend that obstetric management should be maternally focused until 22 weeks in pregnancy. A very similar law has been in place in Victoria for the past 10 years.

Q2. ***Do you agree that terminations should be lawful beyond 22 weeks with the agreement of two medical practitioners?***

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the leading standards body in women's health in Australia. Its members care for pregnant people, and are the doctors involved in performing abortions later in pregnancy. RANZCOG has stated that : *"The College supports the availability of late termination of pregnancy in rare situations where both managing clinicians and the patient believe it to be the most suitable option... The non-availability of late termination of pregnancy may place these women in an untenable position of having to make decisions at times when information is not available or a healthy co-twin is potentially endangered."*

WEL understands that patients seeking care in these circumstances often face complex, deeply personal and difficult circumstances - including women who may have just received a devastating diagnosis about the health of their foetus, or themselves. The proposed provision would mean a patient needing care would first have to obtain approval from two medical practitioners who have to agree that "in all the circumstances, the termination should be performed."

We know that women can also delay decisions on terminations because of personal circumstances, including family violence and because they are uncertain or misinformed about the confidentiality, legality, affordability and availability of reproductive health services.

WEL supports a requirement of consultation with two doctors and satisfaction of a broad common ground as specified in the draft bill. We would prefer that that this be required at 24 weeks to give women more decision making time, especially those in rural and remote areas, women suffering trauma and marginalised communities.

Nevertheless we accept that this proposed limit of 22 weeks, beyond which two doctors must approve termination, is a reasonable and pragmatic provision in the Bill. It is consistent with the current regulatory framework governing abortion in the Queensland health system, in particular the Clinical Services Capability Framework for Public and Licensed Private Health Facilities. A similar regulatory framework applies in NSW Public hospitals.

The well - established Victorian legislation on abortion includes similar requirements and broad decision-making criteria, with the exception that Victoria allows a 24 week window before the criterial apply.

WEL therefore supports the decision-making criteria in the draft Bill, as they stand.

WEL also strongly advises against any changes to this provision that would impact on the timely healthcare access of rural Queenslanders; including any requirement that the second consulting doctor must physically examine the patient.

Q3. *Do you agree that terminations beyond 22 weeks should be allowed in an emergency?*

WEL strongly supports this provision which is consistent with modern medical practice and ethics.

Q4. *Do you agree with allowing a health practitioner to conscientiously object to the performance of a termination, except in emergencies?*

WEL supports this provision and the exemption of administrative, managerial and other ancillary tasks associated with termination of pregnancy from the conscientious objection provision of the draft Bill.

Health professionals should be able to hold and practice their own beliefs, but those beliefs should not be allowed to interfere with the healthcare of their patients.

Therefore any provision for a doctor to personally object to providing abortion must also provide their patient with the right to be told where they can get unbiased advice.

Q5. *Do you agree with the establishment of safe access zones within 150m of the entrance of termination service premises and associated penalties for prohibited conduct or restricted recording?*

WEL supports the establishment of safe access zones under the conditions specified in the Bill.

We believe that pregnant people have the right to access medical treatment in privacy without prejudice or harassment, and that people who work at services that provide terminations have the right to attend their workplace without harassment, intimidation or obstruction.

Q7. Other issues

WEL would like to register our opposition to any provision for mandatory counselling being included in the Bill.

No state in Australia includes mandatory counselling as a legislated condition for a lawful abortion. Internationally, mandatory counselling is not a legislated requirement for lawful abortion in Canada, the UK or New Zealand. Mandatory counselling is typically a feature of legislation designed to restrict abortion access, such as in some US states.

In this context, “counselling services” are separate from the best clinical practice and knowledge provided by a woman’s doctor and/or medical personnel, and refers to a service provided by someone (who may or may not be qualified in a relevant discipline) to a pregnant woman, prior to her being granted access to the abortion care she seeks.

The Victorian Law Reform Commission examined the issue of mandatory counselling in its inquiry into the state's abortion laws in 2007 and found that mandated counselling would be unnecessary and ineffective. The Commission's report concluded that:

> *"Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm. Mandating counselling may result in women having to travel long distances for multiple medical assessments and counselling sessions before they can proceed. This would exacerbate existing inequities.*
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> *Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling."*

Reputable scientific studies conducted internationally and in Australia indicate that abortion is experienced as a personally based decision and as a safe medical procedure by most women and that the vast majority do not wish to speak to a counsellor prior to making their decision.[1]

From a professional perspective, the option of offering and referring a patient to counselling from a qualified, registered and impartial psychologist is considered part of the provision of a suite of termination services. RANZCOG's policy on termination recommends that counselling be available if desired, but not required. Similarly the NSW Health directive "Framework for Terminations in NSW Public Health Organisations" recommends that women be offered counselling.

[1] Trine Munk-Olsen, Ph.D., Thomas Munk Laursen, Ph.D., Carsten B. Pedersen, Dr.Med.Sc., Øjvind Lidegaard, Dr.Med.Sc., and Preben Bo Mortensen, Dr.Med.Sc. 'Induced First-Trimester Abortion and Risk of Mental Disorder' *New England Journal of Medicine* 2011; 364:332-339; RANZOOG 'Termination of Pregnancy. A Resource for Health Professionals',2005:4.