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Abortion Law Reform: An Overview of Current Issues

The law governing abortion varies, not only across the globe, but also throughout Australia. Some jurisdictions, such as Western Australia, have very liberal laws specifically set out by statute whereas, in jurisdictions such as Queensland, New South Wales and Victoria, the legal position is somewhat ambiguous, being reliant upon common law interpretations of the relevant criminal legislation. The Australian Capital Territory has decriminalised the procedure altogether. The position in Queensland appears to be that an abortion will be lawful if it is performed to preserve the life or the physical or mental health of the mother. Some organisations claim that the prevailing uncertainty has presented difficulties for women and the medical profession alike, particularly in terms of access to safe termination services.

This Brief seeks to compare abortion laws across all Australian jurisdictions and to then consider a select number of other countries, particularly those in which reforms have recently occurred or been proposed. Finally, it will discuss a more recent concept being debated among organisations, medical practitioners, women's groups and many other diverse persons and groups, including politicians – abortion as a health issue.

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1 INTRODUCTION

The law governing abortion varies, not only across the globe, but also throughout Australia. Some jurisdictions, such as Western Australia, have very liberal laws specifically set out by statute whereas, in jurisdictions such as Queensland, New South Wales and Victoria, the legal position is somewhat ambiguous, being reliant upon common law interpretations of the relevant criminal legislation. The Australian Capital Territory has decriminalised the procedure altogether. The position in Queensland appears to be that an abortion will be lawful if it is performed to preserve the life or the physical or mental health of the mother. Some organisations claim that the prevailing uncertainty has presented difficulties for women and the medical profession alike, particularly in terms of access to safe termination services.

This Brief seeks to compare abortion laws across all Australian jurisdictions and to then consider a select number of other countries, particularly those in which reforms have recently occurred or been proposed. Finally, it will discuss a more recent concept being debated among organisations, medical practitioners, women's groups and many other diverse persons and groups, including politicians – abortion as a health issue. The Brief does not seek to canvass the moral issues of abortion nor the views held by 'anti-abortion'/'pro-life' organisations that advocate the preservation of the unborn child believed to have commenced living at the moment of conception, and those held by 'pro-choice' groups who believe that each woman has a fundamental right to choose whether to carry the pregnancy to full term or to seek a termination.

Throughout this Brief, considerable reference has been made to a Research Paper published by the Commonwealth Parliamentary Library – *Abortion Law in Australia*.¹

2 SOME BACKGROUND DEFINITIONS AND EXPLANATIONS

An abortion is the expulsion or removal of a foetus from the uterus of a pregnant woman. It can be spontaneous or it may be induced. This Brief concentrates on

¹ Natasha Cica, 'Abortion Law in Australia', Research Paper 1 1998-99, Law and Bills Digest Group, Australian Parliamentary Library *Research Papers*, 31 August 1998, (Abortion Law in Australia Research Paper 1 1998-99).

induced or therapeutic abortions, which occur when the pregnancy is ended by surgical or other measures.²

Around 80,000 abortion procedures are carried out in Australia every year (and 70,500 women had undergone a specific termination procedure between July 2001 and May 2002).³ It appears that in Queensland, around 14,000 terminations are performed each year.⁴ Most take place in private clinics. They are usually performed where gestation is under 12 weeks (ie within 12 weeks of conception) as this first trimester period is the safest and more termination options are available. There are greater risks of complication in the second trimester (after the twelfth week). A pregnancy usually lasts for 40 weeks.

It is understood that Australia has a comparatively low abortion rate but that around one third of Australian women are affected by the experience.⁵ Rates appear highest for women in the 25-34 age group and among teenage women. All socio-economic backgrounds, religions, races, levels of education and occupations are represented, although there is a greater prevalence of younger, unmarried women.⁶

2.1 ABORTION PROCEDURES

The method used to procure the termination of the pregnancy depends upon the stage of the pregnancy and, therefore, the risk of complications to the mother. In Australia, surgical terminations are the norm, given the restricted availability of medical abortions (ie taking of medication) such as Mifepristone (RU-486).

² Family Planning Queensland, 'Abortion', *Information Sheet*, October 2000, at <http://www.fpq.asn.au>.

³ Statistics downloaded from the Medicare Benefits Schedule Item Statistics page on the Health Insurance Commission's website at <http://www.hic.gov.au>.

⁴ Queensland. *Report of the Taskforce on Women and the Criminal Code*, March 2000, p 353, citing Children by Choice, Information on Termination of Pregnancy for Queensland Women, May 1999.

⁵ Commonwealth, National Health and Medical Research Council, Expert Panel, *An Information Paper on Termination of Pregnancy in Australia*, AGPS, 1997, pp 36-38.

⁶ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Ch 4.

The approximate cost of a first trimester termination is around \$220 (in and around Brisbane) to \$480 (in regional areas such as Cairns and Townsville)⁷, some of which is refundable by way of a Medicare rebate (approximately \$127-\$145).⁸ Some clinics give student health care card and pension card concessions.

2.1.1 Surgical Terminations

Interception is the general process used for abortion in its very early stages (up to two weeks). A hand syringe and tube are used to empty the contents of the uterus. It is a quick and reasonably safe method.

The **Vacuum or Suction Aspiration** method is used in around 98% of first trimester termination procedures in Australia. A vacuum pump is inserted through the cervix to create a suction to remove the foetus and uterine lining, followed by a curette to check that the uterus is empty. It can be performed under local or general anaesthetic and the woman can leave after a few hours with no complications.

In the more uncommon cases, where the pregnancy exceeds 12 weeks and the foetus has become large, **dilation and evacuation (D&E)** must be performed with the woman placed under general anaesthetic. Once the cervix is dilated, the contents of the uterus can then be removed. Some side effects may be experienced such as heavy bleeding.

2.1.2 Abortion Pill RU-486 (Mifepristone)

In some countries, such as the United States, the drug Mifepristone, also known as RU-486, can be lawfully administered to women by their doctors under an approved treatment regime. This is a 'medical' abortion rather than a surgical one. Mifepristone, sometimes called the 'abortion pill', is used to terminate pregnancies up to around 40-63 days gestation. The woman initially takes a specified quantity of the drug then, in a further appointment two days later, prostaglandin is administered and an abortion will follow. There is generally a follow-up appointment after two weeks to ensure that the pregnancy has been successfully terminated.

⁷ Information from Children by Choice Association at <http://www.childrenbychoice.org.au/referral> and updated by e-mail information.

⁸ HIC, Medicare Benefits Schedule Item Statistics at <http://www.hic.gov.au>.

Mifepristone was developed by a French pharmaceutical firm and was first approved for use by French women in 1988. Its use has spread across a number of European countries and the United Kingdom and it was approved for use by US women by the Food and Drug Administration in September 2000.⁹ Trials of the drug have been conducted in Australia but it is yet to be approved for use in this country. In 1996, Federal Parliament supported a motion by Independent Senator, Brian Harradine MP, to restrict the importation of Mifepristone. However, it appears that doctors can apply to the Therapeutic Goods Administration to import it for a patient in certain situations.¹⁰

Most women will experience some side effects such as cramping and bleeding for up to two weeks afterwards. It appears that over the 12 years that Mifepristone has been used in Europe, serious side effects from its use have been rare.¹¹ Mifepristone is not suitable for women with certain conditions such as bleeding disorders or ectopic pregnancy. In April 2002, the drug manufacturers sent letters to doctors informing them that six women had developed serious illnesses after using Mifepristone although there was no way to tell whether the drug was the cause. Those numbers included three women who had ruptured ectopic pregnancies, one of whom died. It was believed that these complications were due to the women having delayed seeking treatment thinking that the pain they were experiencing (actually caused by the rupture) was merely a side effect of the abortion pill.¹²

2.1.3 'Morning-After' Pill

This method is one that can be used within 72 hours of intercourse where a woman takes two doses of medication 12 hours apart. It will not cause a termination of an implanted foetus but can reduce the risk of implantation occurring. It tends to be regarded as an emergency contraceptive drug. Adverse side-effects are rare and several types of medication are approved and used regularly in the United Kingdom, Europe and New Zealand. In Australia it is available only on prescription from doctors, family planning clinics and some hospitals. There

⁹ USA. FDA News Release, 'FDA approves Mifepristone for the termination of early pregnancy', *Washington Post*, 28 September 2000. Downloaded from <http://www.washingtonpost.com>.

¹⁰ Association for the Legal Right to Abortion (WA) Inc, *ALRA News*, November 2001, p 8.

¹¹ USA. 'Reports posted on abortion pill', *Heart Disease Weekly*, 26 May 2002. Downloaded from Queensland Parliamentary Library InfoTrac OneFile.

¹² 'Reports posted on abortion pill', *Heart Disease Weekly*.

appears to be a high rate of ignorance among women of this form of protection, with only a small number using it, possibly due to difficulties of access within the 72 hour timeframe. It is reported to be 95% effective if taken within 24 hours of intercourse, dropping to 86% by 72 hours.¹³ Its use is supported particularly by FPA Health (formerly the Family Planning Association of Australia) which hopes that it will reduce the annual abortion rate.

The maker of one ‘morning-after’ pill has said that a reason why it is by prescription only in Australia is so that doctors can regulate how patients use it and there are no plans to make it more widely available in Australia.¹⁴ While over the counter availability is supported by bodies such as Family Planning Queensland, family groups and doctors oppose it on the basis that it could take away parents’ right to counsel teenagers.¹⁵ The emergency contraceptive is available without a prescription in England, New Zealand, France, Israel, Canada, and Scandinavia.

3 ABORTION LAWS IN AUSTRALIA

In all Australian states and territories, except the Australian Capital Territory, criminal legislation provides sanctions for ‘unlawful’ abortions. The laws vary regarding what constitutes an ‘unlawful’ abortion with the most liberal regime being in WA. The ACT decriminalised abortion in laws passed in August 2002.

The relevant legislation governing the position on abortion in each jurisdiction is –

- **Queensland:** *Criminal Code*, ss 224-225, 282;
- **Victoria:** *Crimes Act 1958*, ss 65-66;
- **New South Wales:** *Crimes Act 1900*, ss 82-84;
- **Australian Capital Territory:** *Medical Practitioners (Maternal Health) Act 2002*;
- **Tasmania:** *Criminal Code*, ss 134, 135, 164, 165;
- **South Australia:** *Criminal Law Consolidation Act 1935*, ss 81-82A;
- **Northern Territory:** *Criminal Code*, ss 172-174;
- **Western Australia:** *Criminal Code*, s 199; *Health Act 1911*, s 334.

The common elements in the criminal statutory provisions, except in the ACT and WA, are –

¹³ ‘Sarah Bryden-Brown, ‘Morning-after pill on sale’, *Australian*, 1 July 2002, p 3.

¹⁴ ‘Sarah Bryden-Brown, ‘Morning-after pill on sale’.

¹⁵ Renee Mickelburgh, ‘Access row over ‘morning after’ pill, *Sunday Mail*, 7 July 2002, p 18.

- it is an offence to ‘unlawfully’ administer any poison or noxious thing, or use any instrument or other means, with intent to procure a miscarriage;
- it is an offence for the woman to procure or attempt to procure her own miscarriage (in some jurisdictions, including in Queensland, whether pregnant or not);
- it is also an offence to supply the means to procure the miscarriage (eg a drug or instrument).

However, there is no consistency between the state and territory laws in what constitutes an ‘unlawful’ abortion. In Victoria and New South Wales the answer is provided (although somewhat ambiguously) by the common law interpretation of the relevant criminal statutory provisions. Queensland has a *Criminal Code* and the interpretation of the abortion offence provisions has, to some extent, relied on common law interpretations from ‘non-code’ jurisdictions of Victoria and NSW.

Statutory reform has occurred over the past few decades in South Australia and the Northern Territory and, more recently, in WA and Tasmania, to specifically set out the situations in which a termination will be lawful despite the criminal laws. In August 2002, the ACT Parliament passed legislation to completely remove abortion from the *Crimes Act*.

The legislatures have been inconsistent in the penalties that attach to an offence, ranging from a fine of \$50,000 for the medical practitioner in WA to life imprisonment for both the doctor and the woman concerned in SA.

A committee appointed by State, Territory and Federal Attorneys-General to draft a national Model Criminal Code for uniform criminal laws, able to be adopted in all jurisdictions, released a number of discussion papers on different aspects of the criminal law. In September 1998, the Committee suggested that women should have free access to abortion on request up to ‘foetal viability’ (around 20 weeks), similar to the Western Australian position. After 20 weeks, abortion would be allowed only to save the life of, or prevent serious harm to, the woman or in cases of severe foetal abnormality. The Committee, however, declined to make firm recommendations for abortion law reform.¹⁶

While the offence of ‘child destruction’ also exists in most jurisdictions, it will not be dealt with in detail in this Brief. The term applies to very late abortions. Under s 313 of the Queensland *Criminal Code*, the offence is committed where a female is about to ‘be delivered of a child’ and a person 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. The penalty is imprisonment for life. The termination of a 32 week foetus with

¹⁶ Natasha Bitá, ‘Law-makers back early abortions’, *Australian*, 13 October 1998, p 3. Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, ‘Model Criminal Code, Ch 5, Non-Fatal Offences Against the Person’, *Discussion Paper*, June 1998.

dwarfism in a Melbourne hospital in 2000 has led to calls for the laws in this area to be clarified to enable the weighing up of the severity of abnormality to the foetus and the welfare of the mother.¹⁷

3.1 EARLY INTERPRETATION OF ‘UNLAWFUL’ ABORTION – *R v BOURNE*

At first, the only ground upon which an abortion would not be ‘unlawful’ was if it was performed to save the life of the mother – ie where there was imminent danger to the life of the mother.

The criminal law provisions creating the abortion related offences in Australia were modelled on the now superseded UK legislation, the *Offences Against the Person Act 1861*. Under ss 58-59 a person committed an offence by ‘unlawfully’ using an instrument with the intent to cause a miscarriage. The *Infant Life (Preservation) Act 1929* provided an exemption if a doctor could show that he or she acted ‘in good faith for the purpose only of preserving the life of the mother’.

Until 1969, it was assumed that abortion law in Australia was guided by the 1938 English case of *R v Bourne* concerning the trial of an eminent British doctor who had carried out the procedure on a 14 year old rape victim.¹⁸ Until legislative reform in the UK with the *Abortion Act 1967*, this decision provided guidance for English practitioners about when an abortion would not be ‘unlawful’.

MacNaghten J held that the abortion would not be ‘unlawful’ if the operation was performed for the purpose of preserving the pregnant woman’s life. He directed the jury that if it could find that the doctor had held the honest belief, on reasonable grounds and with adequate knowledge, that the probable consequence of the pregnancy would be to make the woman a ‘physical or mental wreck’, it was entitled to take the view that the doctor had acted for the purpose of preserving the mother’s life.¹⁹ His Honour said it was for the prosecution to satisfy the jury beyond reasonable doubt that the doctor did not hold the required honest belief about the possible consequences. The doctor was subsequently acquitted.

Some commentators have regarded the finding in *R v Bourne* as being based on the defence of ‘necessity’.²⁰ This defence is made out if a person honestly and

¹⁷ Louise Milligan, ‘Push to ease law for late abortion’, *Australian*, 25 October 2001, p 3.

¹⁸ [1938] 3 All ER 615.

¹⁹ [1938] 3 All ER 615 at 619.

²⁰ See *Abortion Law in Australia* Research Paper 1 1998-99, pp 4-5, citing G Williams, *The Sanctity of Life and the Criminal Law*, Knopf, New York, 1957, p 152.

reasonably believes that his or her action is necessary to prevent the relevant mischief and that it was not disproportionate to the mischief to be prevented.

As will be seen In Section 4 of this Brief, the *Abortion Act 1967* (UK) has liberalised abortion law in England, Wales and Scotland.

3.2 THE 1969 ‘MENNENITT RULING’

The law as provided by the English case of *R v Bourne* was adopted and extended by the Victorian Supreme Court judgement of Menhennitt J in *R v Davidson* in 1969.²¹ Justice Menhennitt’s ruling in that case (the ‘Menhennitt ruling’) forms the basis of the current law on abortion in Victoria and has been applied in Queensland.

Prior to that ruling, prosecutions for abortion under the criminal statutory provisions tended to be unsuccessful, as it was difficult to obtain evidence from doctors implicating their colleagues charged with the offence, and courts appeared unwilling to convict or impose harsh sentences.²²

Uncertainty regarding ‘unlawful’ abortion in Victoria resulted in the Victorian branch of the Australian Medical Association and the Attorney-General’s Department setting up a test case to allow the trial judge to thoroughly prepare his address to the jury so that it was more authoritative than a normal trial direction.²³

The case concerned a doctor who was charged on four counts of unlawfully using an instrument with intent to procure the miscarriage of a woman and one count of conspiring to do so. The relevant statutory provision (s 65 of the *Crimes Act 1958*) is similar to s 224 of the Queensland *Criminal Code*.

Justice Menhennitt noted that the use of the word ‘unlawful’ in s 65 suggests that there are certain situations where the abortion can be ‘lawful’ and that the only decision he could find concerning the meaning of ‘unlawful’ was *R v Bourne*. Menhennitt J was of the view that the legal principle espoused in that case was based on the defence of necessity and this defence was imported into s 65 of the *Crimes Act* by the term ‘unlawfully’. His Honour stated that –

²¹ [1969] VR 667.

²² L Crowley-Cyr, ‘A Century of Remodelling: The Law of Abortion in Review’, *Journal of Law and Medicine*, 7(3), 2000, pp 252-266, at p 254, citing a number of cases including *R v Walker (No 2)* [1915] St R Qd 143.

²³ E Edwards, RW Harding & IG Campbell, *The Criminal Codes: Commentary and Materials*, 4th ed, The Law Book Company Limited, Sydney, 1992, p 338.

...for... therapeutic abortion to be lawful, I think that the accused must have honestly believed on reasonable grounds that the act done by him was necessary to preserve the woman from some serious danger. As to this element of danger, it appears ... in principle that it should not be confined to danger to life, this would apply equally to **danger to physical or mental health provided it is a serious danger not being merely the normal dangers of pregnancy and childbirth** [emphasis added].²⁴

Justice Menhennitt stated that for an abortion to be lawful, the person procuring the miscarriage must have honestly believed on reasonable grounds –

- that the act done was necessary to preserve the woman from a serious danger to her life or her physical or mental health (beyond the normal dangers of pregnancy and childbirth); and
- that in the circumstances, the action was not out of proportion to the danger to be averted.

The onus was on the Crown to prove the absence of honest belief, on the part of the accused, of either of the above matters. The question of good faith must be decided not by the evidence of any member of the medical profession but by the jury on all of the evidence. It has been commented that without evidence about professional practice and medical probabilities, it is unlikely that a jury would deliver a guilty verdict against a doctor.²⁵ The outcome of *Davidson*, applying the Menhennitt ruling, was the acquittal of the doctor concerned.

The Menhennitt ruling liberalised the previous legal position. It did not require extreme danger or imminent death but ‘serious danger’ to life or physical or mental health. Note, however, that it is unlikely to extend to allowing abortions ‘on request’.²⁶ It appears that *R v Davidson* has been accepted and applied in Victoria, New South Wales and Queensland to govern what is ‘unlawful’ abortion.

3.3 R v WALD

The Menhennitt ruling was applied and extended by Levine DCJ in the New South Wales case of *R v Wald*. This 1971 case in the NSW District Court concerned whether a doctor and an anaesthetist who performed abortions in a Sydney clinic had done so ‘unlawfully’, contrary to s 83 of the *Crimes Act 1900* (NSW). Levine J set out the law, as expressed by the Menhennitt ruling but added the following liberalising statement –

²⁴ *R v Davidson*, extracted in E Edwards et al, p 340.

²⁵ RF Carter, *Criminal Law of Queensland*, (Looseleaf Service), para [s 282.15].

²⁶ *Abortion Law in Australia* Research Paper 1 1998-99.

*It would be for the jury to decide whether there existed in the case of each woman any **economic, social or medical ground or reason** which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical or mental health [emphasis added].*²⁷

Thus, under this more generous approach, an abortion would be lawful in NSW if the doctor has an honest and reasonable belief that an abortion would avoid a serious risk of danger to the woman's life or physical or mental health based on 'economic, social or medical grounds or reasons'. It would also be sufficient if such serious danger to mental health was not present at the time of the interview but the accused honestly believed that it could reasonably be expected to be seriously endangered at a later stage of the pregnancy.²⁸

Again, while the approach in NSW appears more liberal than even the Menhennitt ruling, abortion on request is not permitted. Levine J was careful to reject counsel's submission that provided the operation is performed properly, with the woman's consent, and without any recklessness or lack of skill, it would be lawful.

3.4 CES v SUPERCLINICS

CES and Anor v Superclinics (Australia) Pty Ltd and Ors was a civil action in which Kirby A-CJ extended further the circumstances in which an abortion would be lawful.²⁹ This case was an appeal from a primary judge who denied the plaintiff damages for being deprived, through the defendant's negligence, of the opportunity to abort a healthy foetus. That was because the primary judge found that to terminate the pregnancy would have been an unlawful act. On appeal, a 2:1 majority of the NSW Court of Appeal overruled the primary judge. It was held that that the evidence did not justify a finding that the abortion, if sought, would have been unlawful under the interpretation of the law provided in *R v Wald*.

The *R v Wald* interpretation was analysed by Kirby A-CJ, extending it further than previously. His Honour –

- confirmed that the practitioner's honestly held belief that a woman's mental health was in serious danger could be founded upon economic and social grounds;

²⁷ [1971] 3 NSWDCR 25 at 29.

²⁸ See also *K v Minister for Youth and Community Services and Anor* [1982] 1 NSWLR 311.

²⁹ (1995) 38 NSWLR 47.

- took the view that the belief regarding serious danger to mental health was not limited to that arising during the pregnancy but extended to threats to the woman's mental state **after the birth** of the child (eg due to the very economic and social circumstances in which she will then probably find herself, combined with the fact of the unwanted pregnancy). Kirby A-CJ considered that this view was supported by de Jersey J in the Queensland case of *Veivers v Connolly* (where a woman gave birth to a child with severe abnormalities after contracting rubella that was not detected in time);
- said that the honest and reasonable belief of the danger to the woman's physical or mental health is subjective and based on an assessment of the risk to the future mental health of the woman. It must be negated, beyond reasonable doubt, to show unlawfulness.

Kirby A-CJ considered that, in the case before him, there was evidence that the woman's mental health had been seriously affected by the birth of the child, due to the combined pressure of an unwanted baby in an unstable emotional relationship which had, in turn, forced her to give up her studies and prevented her from obtaining full time employment in her chosen discipline (photography). The woman was just 21 at the time of discovery and a student with limited financial means. His Honour considered that there was evidence to suggest that a practitioner could honestly and reasonably have believed that there was a serious threat to the woman's mental health that would have crystallised on the birth of the child if the pregnancy was not terminated earlier.

Some commentators have suggested that Kirby A-CJ's approach arguably legitimises abortion on request, provided that the doctor consulted by the woman considers that it should be performed because forcing the woman to continue with the pregnancy would pose a serious risk to her mental health, having regard to social or economic grounds. Social or economic factors going to establishing such belief on the part of the doctor may, on this approach, include that the woman may suffer great strain about having the child and bringing it up.³⁰

However, even this more generous approach would still not appear to enable women in NSW to have an abortion just because they wish to and the doctor is willing to perform it. For an abortion to be lawful there is still a level of 'serious danger' to physical or mental health that is required, and the relevant belief about that must be formed by the practitioner being consulted.³¹ Thus, 'health' grounds still apply in NSW, liberal though they might be.

³⁰ See *Abortion Law in Australia* Research Paper 1 1998-99, p 19, citing G Williams, 'The Law of Abortion', *Current Legal Problems*, vol 5, 1952.

³¹ *Abortion Law in Australia* Research Paper 1 1998-99, pp 19-20.

The High Court granted special leave to appeal against the Court of Appeal's decision in *Superclinics* but the case was settled before it was heard. For a short time in 1996, there was the possibility that the highest judicial body in the country would determine either that the very liberal interpretation of the NSW law adopted by Kirby A-CJ was correct (in which case it would have been influential in shaping abortion laws in Queensland and Victoria), or it could have reverted to a strict view that abortion was lawful only to preserve the life of the mother. The precarious position of the law in Queensland and Victoria is highlighted by the fact that just one judgement of a higher court than those which have provided guidance on abortion law to date (most of which have been District Court level), can alter that law completely.

3.5 QUEENSLAND POSITION ON ABORTION

The Queensland legal position is somewhat unclear although around 14,000 abortions occur every year in this State. Technically, all terminations are criminal offences unless they are to preserve the life of the mother but it appears to have been accepted that the Menhennitt ruling in *R v Davidson* applies to allow termination where the medical practitioner honestly and reasonably believes it is necessary to preserve the woman from a serious danger to her life or her physical or mental health (beyond the normal dangers of pregnancy and childbirth). The law is, however, susceptible to being overturned by a higher court or altered by legislation.

3.5.1 Legal Position

The Queensland *Criminal Code* specifically makes abortion a criminal offence. It appears that the murder or manslaughter provisions would not apply as s 292 provides that –

A child becomes a person capable of being killed when it has completely proceeded in a living state from 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.

Doctors or health workers who perform an abortion are liable to prosecution and imprisonment. **Section 224** of the *Criminal Code* provides –

Any person who, with intent to procure the miscarriage of a woman ... 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 states that a woman who intends to procure her own miscarriage by the same means, whether pregnant or not, is guilty of a crime and can be sent to prison for seven years.

However, s 282 provides –

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

Section 282 appears to have been mainly intended to protect doctors in situations where a patient is unconscious or otherwise unable to give consent to an operation where an assault would have otherwise been committed.³²

However, the inclusion of the phrase 'upon an unborn child for the preservation of the mother's life', has allowed s 282 to be treated as providing a defence to an abortion prosecution under s 224, provided all of the elements are satisfied. The words 'unlawfully administers' in s 224 indicate that the action may be lawful or may fall within the medical justification exception in s 282.

Where s 282 is applicable, the onus is on the Crown to negative its operation: *R v Ross, McCarthy and McCarthy*.³³ In *McCarthy*, only a passing reference was made to s 282 as a defence to abortion, with the appeal being upheld mainly on evidentiary grounds regarding the law of corroboration. However, Mansfield SPJ stated that it was clearly the duty of the Crown to negative the application of s 282.

It was also contended that there had been a misdirection by the trial judge in not explaining to the jury the meaning of 'preservation of the mother's life,' although he had read out the provision to them. However, Mansfield SPJ commented that a reading out of the words was sufficient as they had no technical meaning.³⁴ Other than the foregoing comments, there was no clarification provided about when an abortion would be protected by the operation of s 282.

There were some indications by Queensland judges during the 1980s that s 282 provided a defence to a charge of an 'unlawful' abortion, provided it met the requirements of the Menhennitt ruling. In *K v T*, Williams J considered that *R v Davidson* applied in Queensland.³⁵

³² E Colvin, S Linden & L Bunney, *Criminal Law in Queensland and Western Australia*, 2nd ed, Butterworths, Sydney, 1998, para 18.20.

³³ [1955] St R Qd 48.

³⁴ [1955] St R Qd 48 at 80-81. Mack J agreed with the reasons of Mansfield SPJ.

³⁵ [1983] 1 Qd R 396 at 398. See also *Re Bayliss* (unreported, Supreme Court of Queensland, McPherson J, 24 May 1985).

Doubts continued until elucidation was provided by McGuire DCJ's judgement in the Queensland District Court in *R v Bayliss and Cullen*. Justice McGuire approved the position taken by Menhennitt J in *Re Davidson* but was not inclined towards the liberal approach of Levine DCJ in *R v Wald*.

R v Bayliss and Cullen

The first real opportunity for the Queensland courts to clarify the law on abortion came in 1986 with the District Court case of *R v Bayliss and Cullen*. The matter involved the trial of medical practitioners who had been running an abortion clinic.³⁶ The prosecution led evidence to suggest that many abortions at the clinic were being performed on economic grounds.

The judgement of McGuire DCJ referred to *Bourne* and *Davidson* as substantially representing the law in Queensland and considered that ss 224 and 282 should be interpreted accordingly. It is not clear whether His Honour accepted the more liberal interpretation of the law enounced by Levine J in *R v Wald* because His Honour expressly approved only the Menhennitt ruling in *Davidson*. It has, however, been argued that *R v Wald* can be taken as applying in Queensland as the current interpretation for the purposes of the *Criminal Code* because the *Criminal Code* incorporates the modern common law as expounded from time to time.³⁷

In any event, His Honour believed it wrong to consider that the *Bourne* approach equated to *carte blanche* when it is only in exceptional cases that the doctrine can lawfully apply.³⁸ His Honour noted that the legislation indicated Parliament's view that the desire of the woman herself to be relieved of her pregnancy is not, of itself, justification for performing an abortion on demand³⁹ and stated –

*The law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on whim or caprice does not insidiously filter into our society. There is no legal justification for abortion on demand.*⁴⁰

It is clear from the decision that abortion on request is not permitted in Queensland. The practitioners in *Bayliss* were, however, acquitted of the charges.

³⁶ (1986) 9 Qld Lawyer Reports 8.

³⁷ *R v Johnson* [1964] Qd R 1.

³⁸ (1986) 9 Qld Lawyer Reports 8 at 45.

³⁹ (1986) 9 Qld Lawyer Reports 8 at 10.

⁴⁰ (1986) 9 Qld Lawyer Reports 8 at 45.

His Honour commented that the Menhennitt ruling lacked sufficient certainty and clarity but it was for Parliament or a higher court to make any definitive ruling about the law of abortion in Queensland.⁴¹

Veivers v Connolly

Some clarity was provided in the 1994 decision of de Jersey J in *Veivers v Connolly*, although it concerned a civil damages proceeding rather than a prosecution under the *Criminal Code*. In that case, de Jersey J affirmed that the test as provided in *Davidson* – that abortion is not unlawful if necessary to preserve the woman from a serious danger to her mental health which would occur if the pregnancy were to continue – applied to the circumstances of the case before him. His Honour also indicated that the danger did not have to arise during the pregnancy but could arise after the birth.⁴²

Conclusion

It would appear that to obtain a conviction of a medical practitioner, the prosecution would have to prove the following beyond reasonable doubt –

1. the doctor did not hold a reasonable belief that the procedure was necessary to preserve the woman from serious danger to her life, or serious danger to her physical or mental health (which, in NSW, but probably not in Queensland, would allow consideration of economic or social factors as well as health factors) which may operate throughout the pregnancy or after the birth of the child; or
2. the doctor did not hold a reasonable belief that the procedure was proportionate in the circumstances to the need to preserve the woman from the aforementioned serious danger.

Note that it has been held that a foetus has no right of its own until it is born and has a separate existence from its mother: *A-G ((Qld) (Ex rel Kerr) v T*.⁴³

⁴¹ (1986) 9 Qld Lawyer Reports 8 at 45- 46.

⁴² [1995] 2 Qd R 326 at 329.

⁴³ (1983) 57 ALJR 285 at 286.

3.5.2 Practice of Abortion in Queensland

It has been noted that the consequences of *Davidson* and *Wald* have been that abortions are available in Victoria and NSW in clinics and private and public hospitals.⁴⁴ However, availability in Queensland public hospitals is more restricted. One reason may be because the law, as interpreted in *Bayliss*, is more uncertain.⁴⁵

Nevertheless, around 14,000 abortions are performed in Queensland each year. Health Insurance Commission statistics suggest that there were 13,447 claims for Medicare rebates for one specific abortion procedure in Queensland between July 2001 and May 2002. It appears that the largest group seeking the procedure was 25-34 year old women (5,600), a figure reflected in other jurisdictions.⁴⁶ The data does not include services provided by hospital doctors to public patients in public hospitals. It appears that the abortion rate in Queensland for that period was higher than that in SA/NT and in WA. It has been reported that 300 abortions were performed in Queensland public hospitals in 2001 but, in all cases, the women's lives would have been at risk without the procedure.⁴⁷

In Queensland, around 99% of abortions are performed by the private health sector – mainly in free-standing clinics located in Brisbane, Townsville, Cairns and Rockhampton (around 18 in every 1000 were performed in private clinics in 2001-2002). Some women go to Tweed Heads in NSW. Public facilities perform terminations in more limited cases to save the woman's life or where the foetus has been diagnosed as having a genetic abnormality.

The Children by Choice Association has estimated that, as of March 2002, the approximate cost of a first trimester termination is around \$220 (in and around Brisbane) to \$480 (in regional areas such as Cairns and Townsville) for holders of Medicare cards.⁴⁸ The cost increases after the first 12 weeks. A Medicare rebate (around \$130-\$145) is available in most cases. However, city women are better off in terms of cost and access than rural women who must generally travel vast

⁴⁴ Queensland. *Report of the Taskforce on Women and the Criminal Code*, March 2000, p 357, citing a Submission from Children by Choice Incorporated, Information on Termination of Pregnancy for Queensland Women, May 1999, p 28.

⁴⁵ Queensland. *Report of the Taskforce on Women and the Criminal Code*, March 2000, p 357.

⁴⁶ Statistics downloaded from the HIC Medicare Benefits Schedule Item Statistics webpage.

⁴⁷ Matthew Franklin & Chris Jones, 'Pressure builds for abortion reform', *Courier Mail*, 3 May 2002, p 3, quoting Queensland Health sources.

⁴⁸ Information from Children by Choice Association at <http://www.childrenbychoice.org.au/referral>.

distances to access services. Lack of information, access and the attendant expenses are most disadvantageous for Aboriginal women and those from lower socio-economic backgrounds.⁴⁹ These issues are dealt with later in this Brief.

3.6 ABORTION LAW REFORM – QUEENSLAND

The legal position of abortion and its practice appear to be at odds. A woman can obtain an abortion after consulting a doctor and formally fulfilling the legal requirements set out in either the judicial authorities previously referred to, or any relevant statutory conditions. Few prosecutions have been successful against practitioners or women for ‘unlawful’ abortion. However, it cannot be said that a state or territory government would never use the technical abortion offence provisions to sanction doctors and women. As will be discussed below, substantial reform to abortion laws in WA and Tasmania were precipitated by sudden and unanticipated prosecutions of doctors performing abortion procedures, and, in the case of WA, a change of policy by the Director of Public Prosecutions. Indeed, as noted above, the High Court appeal in the case *CES v Superclinics*⁵⁰ demonstrates the precarious state of the common law when all of the current interpretations of the abortion provisions of criminal legislation in Victoria, NSW and Queensland could have been overturned had the case not settled earlier.⁵¹ This state of affairs can be unsettling for doctors and women alike, particularly when the offence carries the possibility of imprisonment.

More restricted availability of abortion services in Queensland may be partially attributable to a perception that the legal position is less certain than in NSW and Victoria.⁵²

A Pregnancy Termination Control Bill, introduced by the then Minister for Health, was defeated in the Queensland Parliament in May 1980.⁵³ Since then, there would

⁴⁹ *Women’s Taskforce Report*, p 359, citing Children by Choice, Information on Termination of Pregnancy for Queensland Women, May 1999.

⁵⁰ (1995) 38 NSWLR 47.

⁵¹ See also S Kift & L Willmott, ‘Abortion Law Reform: Will Someone Decide Who Decides?’, *Queensland Lawyer*, v 21(2), October 2000, pp 65-73, at pp 68ff.

⁵² *Women’s Taskforce Report*, p 357.

⁵³ Hon Sir William Knox MLA, Minister for Health, Pregnancy Termination Control Bill, Second Reading Speech, *Queensland Parliamentary Debates*, 29 April 1980, pp 3585-3657; 20 May 1980, pp 3689-3753; 21 May 1980, pp 3779-3783, pp 3783-3847.

appear to have been no significant legislative measures introduced dealing with the issue.

Prior to the establishment of the Taskforce on Women and the *Criminal Code* in 1998, two reviews of the Queensland *Criminal Code* by-passed the abortion provisions despite agitation by women's groups calling for legislative change.⁵⁴

Both Labor and Coalition Governments over the past decade have stated that the procedure is already allowed by the common law in proper circumstances. Similarly to the state and territory branches of the major parties in other jurisdictions, the Queensland Labor Party allows the issue to be dealt with by a conscience vote rather than along party lines. The Queensland Premier, the Hon Peter Beattie MP has been reported as stating that the Government will not resile from its State election promise in 2001 not to change the existing law.⁵⁵

An independent survey, conducted in Queensland on behalf of the Children by Choice Association in 1990, found that two thirds of respondents were in favour of amending abortion laws to make it a recognised medical procedure as a result of doctor and patient choice.⁵⁶ That support appears to have increased, with an AC Nielsen survey of 800 people conducted in May 1999 finding that 84% of respondents agreed that the decision should be left up to the individual and her doctor.⁵⁷

3.6.1 Taskforce on Women and the Criminal Code

The Taskforce on Women and the *Criminal Code* was established by the former Minister for Justice and Attorney-General, the Hon Matt Foley MLA and Minister for Women's Policy, the Hon Judy Spence MLA in November 1998 to report and make recommendations on the operation of the Queensland *Criminal Code* and its impacts on women. While abortion was not included in the Terms of Reference, the Taskforce determined that it was an issue upon which it would report because it was an offence under the *Criminal Code* and impacts upon women.⁵⁸ Two previous

⁵⁴ Matthew Franklin, 'It's their party and they'll cry if they want to...', *Courier Mail*, 27 April 2002, p 23.

⁵⁵ Matthew Franklin & Rosemary Odgers, 'Labor Left seeks legalised abortion', *Courier Mail*, 30 May 2002, p 6.

⁵⁶ 'A survey of community attitudes towards abortion', Brisbane, AGB:McNair for Children by Choice Association Inc, 1990.

⁵⁷ Lachlan Heywood, 'Support soars for legal abortions', *Courier Mail*, 9 August 1999, p 9.

⁵⁸ *Women's Taskforce Report*, p 351.

government reviews of the *Criminal Code* had not included the abortion provisions within the terms of reference.⁵⁹

The *Report on the Taskforce on Women and the Criminal Code (Women's Taskforce Report)* was delivered in March 2000. Chapter 9 deals with abortion, surrogacy and female genital mutilation. The Taskforce considered that the range of submissions it received indicated the strength of the debate but that it was impossible to reconcile such polarised opinions and would not attempt to do so. Instead it endeavoured to adopt a pragmatic approach. For most members of the Taskforce, the issue of equity of access was the most important factor.

The overall recommendation by the Taskforce was that ss 224-226 of the Queensland *Criminal Code* should be repealed.⁶⁰

The *Women's Taskforce Report* noted that the trend in community attitude was towards decriminalising abortion, supported by a number of surveys over recent years. It noted also the position taken by many bodies, including the Public Health Association of Australia,⁶¹ that abortion should be taken out of the criminal laws in Australia and regulated within medical practitioners' legislation (eg *Medical Practitioners Act 2001 (Qld)*) and a similar suggestion made in an *Information Paper* of an expert panel of the National Health and Medical Research Council in 1996 (further discussed below). The expert panel of the NHMRC found that the problems of access, information, quality of services and lack of trained service providers and support staff identified in its study were impacted upon by the uncertain legal position of abortion.⁶²

The Report observed that, arguably, it is Australia's participation in the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) (discussed later) which provides the political and legal imperative to amend legislation concerning termination of pregnancies.⁶³

⁵⁹ Children by Choice Association Inc, 'Law and practice of abortion in Australia', from the 'law' page at <http://www.childrenbychoice.org.au/frameset.html>, citing 'Goss criticises abortion law but refuses to act', *Australian*, 17 May 1993, pp 1-2 and P Morely & M Thomas, 'Abortion law not on the agenda – government', *Courier Mail*, 15 August 1996, p 5.

⁶⁰ *Women's Taskforce Report*, p 366, Recommendation 81.

⁶¹ The Public Health Association of Australia (PHA) is a body which provides information, research and a forum for discussion of public health issues and is represented on a number of government boards etc.

⁶² As will be explained later, the *Information Paper* was not endorsed by the NHMRC as a full Report but was put out instead as an *Information Paper*.

⁶³ *Women's Taskforce Report*, p 253.

However, the Taskforce was reluctant to determine in advance what rules should apply once the *Criminal Code* provisions were repealed.⁶⁴ A regulatory framework similar to that in South Australia, the Northern Territory or Western Australia was considered. However, this was ultimately rejected by the Taskforce out of concern that regulatory frameworks might operate against those women most in need of help by creating more hurdles and bureaucracy. For example, by requiring specially approved facilities, access for women in rural areas may become more difficult. In addition, one submission to the Taskforce argued that the WA provisions (considered below) governing consent for minors and court orders in lieu of consent had caused confusion and concerns.⁶⁵ It commented, however, that if any changes to regulations were made, ensuring access to services of all types for rural women should be considered.

The *Women's Taskforce Report* noted that the Children by Choice submission suggested that a panel be established (with widely representative membership, including Aboriginal women, young women, and government representatives) to consider, plan, and oversee a process for abortion services to become more accessible throughout Queensland as an urgent health and social justice goal.

As yet, the Queensland Government has not adopted the recommendation of the *Women's Taskforce Report* to remove abortion from the *Criminal Code*.

3.6.2 Recent Developments

Mr Beattie is reported to have said, in May 2002, that the figures show that women wanting abortions can, in fact, access them in consultation with their doctor.⁶⁶ The then Opposition Leader, Mike Horan, also agreed that there was no need for reform as the current law was the best way of ensuring that doctors abide by the law and respect human life.⁶⁷ In response to the passing of laws in the ACT to decriminalise abortion in August 2002, the Premier is reported to have said that there would be no changes to Queensland laws and the Government will be adhering to that position.⁶⁸

⁶⁴ *Women's Taskforce Report*, p 366.

⁶⁵ *Women's Taskforce Report*, p 362 citing the Children by Choice Submission, p 19.

⁶⁶ Matthew Franklin & Chris Jones, 'Pressure builds for abortion reform', *Courier Mail*, 3 May 2002, p 3.

⁶⁷ Matthew Franklin & Chris Jones, 'Pressure builds for abortion reform'.

⁶⁸ Maria Moscaritolo, Rosemary Odgers, ACT laws first to legalise abortion, *Courier Mail*, 22 August 2002, p 5.

At the June 2002 Labor Party State conference, the issue was raised by the Labor Party's left wing and the conference delegates passed a motion to provide publicly funded fertility procedures, including terminations on request for all Queensland women. The platform proposed was to stress that abortion is a health issue, not a legal one and that it was for women to decide if they wish to face risks involved with pregnancy and childbirth.⁶⁹

3.7 VICTORIA

Sections 65-66 of the *Crimes Act 1958* (Vic) are virtually identical to ss 224-225 of the Queensland Code and contain the common elements of most of the statutory criminal provisions concerning abortion, referred to above.

As noted earlier, the interpretation of 'unlawful' abortion provided by the Menhennitt ruling in *R v Davidson* continues to represent the position in Victoria. Thus, a pregnancy may be lawfully terminated if the person conducting the termination honestly believes on reasonable grounds that to do so is necessary to preserve the woman from a serious danger to her life or her physical or mental health (beyond the normal dangers of pregnancy and childbirth); and that, in the circumstances, the action was not out of proportion to the danger to be averted.

The private sector provides therapeutic abortions up to 18 weeks gestation, mainly in free-standing clinics or by private gynaecologists. Public sector services are available up to 20 weeks gestation or up to 22 weeks for foetal abnormality.⁷⁰

3.8 NEW SOUTH WALES

The law in NSW is governed by ss 82-84 of the *Crimes Act 1900* (NSW) which, again, are similar to the Queensland *Criminal Code* provisions.

In NSW, an abortion is not 'unlawful' if the accused has an honest and reasonable belief that an abortion would avoid a serious risk of danger to the woman's life or physical or mental health based on 'economic, social or medical grounds or reasons'. That 'serious danger' could be at any stage of the pregnancy: *R v Wald*. As noted earlier, Kirby A-CJ in *CES and Anor v Superclinics* expanded the grounds to embrace threats to the woman's mental state *after* the birth of the child,

⁶⁹ See Matthew Franklin & Rosemary Odgers, 'Labor Left seeks legalised abortion'; 'Labor votes to change abortion laws', *ABC NewsOnline*, 2 June 2002. At <http://www.abc.net.au/news>.

⁷⁰ Children by Choice Association Incorporated, 'Law and Practice of Abortion in Australia'.

for example, due to the very economic and social circumstances in which she will then probably find herself, combined with the fact of the unwanted pregnancy.⁷¹

As mentioned earlier, even this more generous approach would still not allow abortion on request and 'health' grounds (albeit generously interpreted) apply.⁷²

Following the introduction of liberal abortion laws in Western Australia (considered below), a number of Members of Parliament indicated that they would 'test the waters' to determine if there is parliamentary support for decriminalising abortion by removing it from the *Crimes Act*. The NSW Premier and the then Opposition Leader are reported to have said that abortion was an issue 'of MPs' individual consciences and the main political parties would not dictate a voting position'.⁷³

3.9 SOUTH AUSTRALIA

Sections 81 and 82 of the *Criminal Law Consolidation Act 1935* (SA) make unlawful abortion an offence. Contravention can result in life imprisonment for the woman or the doctor. In 1969, at approximately the same time as the decision in *R v Davidson*, a new s 82A was inserted into the Act to legalise abortion in certain circumstances ie it would not be 'unlawful' under ss 81-82. In essence, s 82A permits an abortion in two types of situations.

The **first** situation applies in the period before the foetus has become 'a child capable of being born alive' (which s 82A(8) sets at **28 weeks**). That is, if a qualified medical practitioner and one other qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman, that –

- the continuation of the pregnancy involves greater risk to the woman's life or of injury to physical or mental health than if the pregnancy were terminated; or
- there is a substantial risk that, if the pregnancy were not terminated, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.

It appears that there has been no judicial interpretation of s 82A but it has been suggested that, in cases of pregnancies of less than 28 weeks, the position is similar

⁷¹ (1995) 38 NSWLR 47.

⁷² *Abortion Law in Australia* Research Paper 1 1998-99.

⁷³ David Humphries, 'MPs to test support for abortion law reform', *Sydney Morning Herald*, 15 April 1998, p 3.

to that in NSW under the generous interpretation of the law by Kirby A-CJ in *Superclinics* (ie risk of injury to physical or mental health taking into account the woman's actual or reasonably foreseeable environment). However, again, it appears that abortion on mere request is not allowed because of the requirement that there be a risk to physical or mental health in continuing with the pregnancy that is greater than if it were terminated.⁷⁴

However, there are additional requirements that must be met that do not appear to exist for women in NSW. Those are that, unless it is an emergency –

- two qualified medical practitioners, after having personally examined the woman, must believe that the abortion is necessary; and
- the abortion must take place in a prescribed hospital or clinic; and
- the woman must have been resident in SA for at least two months.

The **second** situation is where, at any stage of the pregnancy (including **over 28 weeks**), the termination is immediately necessary to save the woman's life, or prevent grave injury to her physical or mental health. The abovementioned procedural requirements do not apply in these circumstances.

The provision also makes it clear that no person is under a duty to participate in any such termination operation to which he or she has a conscientious objection.

A regulation requires that practitioners involved in the abortion sign a certificate stating the legal ground under which the abortion was performed and complete a notice providing information about each termination including details about the woman, methods used, and more details about the grounds for the abortion.⁷⁵

Abortions are available at the Pregnancy Advisory Centre, a publicly funded free-standing clinic, and at a number of public hospitals at no charge. They are also available through the private health system at varying charges.

3.10 NORTHERN TERRITORY

The law on abortion in the Northern Territory is governed by the Northern Territory's *Criminal Code*, ss 172-173, which operate in a similar way to abortion provisions in other jurisdictions. The penalty for breach is seven years imprisonment. Those provisions are subject to s 174 which sets out the circumstances in which an abortion is lawful in terms quite similar to the SA provision. Note that, in every case, consent of the woman is a requirement.

⁷⁴ *Abortion Law in Australia* Research Paper 1 1998-99.

⁷⁵ Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 1996, reg 5.

First, for pregnancies up to **14 weeks**, the termination may be performed by a gynaecologist or obstetrician in hospital, if he or she and another medical practitioner are both of the opinion, formed in good faith, after medical examination of the woman, that –

- the continuation of the pregnancy involves greater risk to the woman’s life or greater risk of injury to physical or mental health, than if the pregnancy were terminated; or
- there is a substantial risk that, if the pregnancy were not terminated, the child would suffer from such physical or mental abnormalities as to be seriously handicapped.

There are some inbuilt safeguards –

- the grounds apply only up to 14 weeks gestation (compared with up to 28 weeks in SA);
- abortions must be performed by a gynaecologist or obstetrician in a hospital (although in other situations, they can be performed by any medical practitioner) whereas the SA provision allows a ‘qualified medical practitioner’ to perform the termination. In both jurisdictions, the decision must be supported by the opinion of another medical practitioner.

Unlike the case in SA, there is **no residency** requirement.

Secondly, if the pregnancy is between **14-23 weeks**, the abortion may be performed by a **medical practitioner** if he or she is of the opinion, after a medical examination of the woman, that termination is immediately necessary to prevent grave injury to the woman’s physical or mental health.

Thirdly, a termination can be carried out by a **medical practitioner** at any time in the pregnancy, including **over 23 weeks**, for the purpose only of preserving the woman’s life.

Again, persons with a conscientious objection to abortions do not have to involve themselves in procuring one or assisting in disposing of the foetus.

In each case above, if the woman is **under the age of 16** or otherwise incapable in law of giving the requisite consent, such consent must be obtained from an authorised person (eg a parent).

Again, there is no case law on the provisions that legalise abortion in the NT.

For pregnancies up to 23 weeks, it is possible to seek a termination in both public and private facilities, with services being more limited in the latter.

3.11 WESTERN AUSTRALIA

Prior to May 1998, ss 199-201 of the Western Australian *Criminal Code* were almost identical to the abortion provisions in the Queensland *Criminal Code*. Section 259 set out a 'defence' similar to s 282 in the Queensland Code. There had been no judicial interpretation of the abortion provisions of the Code. While there was uncertainty, it was assumed that the circumstances in which abortion could be performed were the same as in Queensland where the courts applied the Menhennitt ruling.

In practice, doctors performed a number of abortions and, for over 30 years, nobody had been prosecuted. Then, in February 1998, two Perth doctors were charged with attempting to procure an unlawful abortion after a foetus was found in a Maori lady's refrigerator pending a traditional burial. One of her children had told his classmates about the 'baby in the fridge' during a 'show and tell' session at school. The immediate reaction was that hospitals and clinics stopped performing abortions and women were advised to travel interstate for the procedure.

The prosecution of the two doctors was followed by calls for review of the law from some members of the medical profession and the Law Society. It was feared that most of the estimated 9000 abortions being performed in WA each year were not within the terms of the 'defence' of only being done to 'preserve the woman's life' and that doctors, and nurses assisting them, could be exposed by a change in prosecution policy.⁷⁶ The State Director of Public Prosecutions is reported to have indicated that the words of the defence remove criminality only when the procedure is for the preservation of the mother's life.⁷⁷ Government Ministers held a 'crisis' meeting with legal and medical representatives in the days following the charges, but uncertainty continued to reign.

On 27 May 1998, amendments to both the *Criminal Code* and the *Health Act 1911* were passed enabling women access to safe abortions on the basis of 'informed consent'. These extremely liberal laws did not come without considerable public and political debate, including intense campaigns by pro-choice and anti-abortion groups. The eventual legislation, the *Acts Amendment (Abortion) Act 1998*, was a product of two separate Bills introduced in March 1998. The first was a Private Member's Bill brought into the Legislative Council by ALP member, the Hon Cheryl Davenport MP, which sought to remove abortion from the *Criminal Code* and insert safeguards into the *Health Act 1911*.⁷⁸ The other, Government Bill,

⁷⁶ Natalie O'Brien, 'AMA tells doctors to refuse abortions', *Australian*, 10 February 1998, p 5.

⁷⁷ Matt Price, 'Body of Evidence', *Australian*, 14 February 1998, p 26.

⁷⁸ Hon C Davenport MLC, Criminal Code Amendment (Abortion) Bill, 10 March 1998, Second Reading Speech, *WA Legislative Council Hansard*, pp 8-17.

introduced into the Legislative Assembly by the State Attorney-General, sought to leave abortion in the *Criminal Code* but provide four situations when an abortion would be lawful, with informed consent being the minimal requirement.⁷⁹

The outcome is that WA women can legally obtain an abortion without the threat of prosecution. The existing ss 199-201 of the *Criminal Code* were repealed and replaced with one provision – s 199.⁸⁰

Pursuant to the new s 199 of the *Criminal Code*, it is unlawful to perform an abortion unless it is performed by a duly qualified and registered medical practitioner in good faith and with reasonable care and skill and it is justified under s 334 of the *Health Act 1911*.

Section 334 of the *Health Act 1911* sets out the four alternative grounds upon which the performance of the abortion is justified and includes where a woman provides ‘informed consent’, effectively allowing WA women abortion on request.

Where the pregnancy is **under 20 weeks**, the four grounds on which abortion is justified are –

- (a) the woman has given informed consent. In this context, ‘informed consent’ means consent freely given by the woman after a medical practitioner, completely independent of the doctor performing the abortion, has –
 - given her appropriate counselling about the medical risk of termination and of carrying the pregnancy to term;
 - offered her the opportunity of referral to counselling about her options;
 - informed her that counselling will be available following the termination or after the birth;
- (b) the woman will suffer serious personal, family or social consequences if the abortion is not performed and she has given informed consent;
- (c) serious danger to the physical or mental health of the woman will result if the abortion is not performed and she has given informed consent;
- (d) the pregnancy of the woman is causing serious danger to her physical or mental health and she has given informed consent.

In the last two situations, ‘informed consent’ is not necessary if it is impracticable for the woman to provide it.

⁷⁹ Hon C J Barnett MLA, Leader of the House, Criminal Code Amendment Bill, 10 March 1998, Second Reading Speech, *WA Legislative Assembly Hansard*, pp 135-137.

⁸⁰ The abovementioned charges against the two doctors for the procurement of an abortion were dropped by the Director of Public Prosecutions after the new laws were passed.

A woman **under 16 years of age** who is a dependant minor cannot give ‘informed consent’ unless her custodial parent or legal guardian has been informed and given the opportunity to participate in counselling and consultations with the doctor. A dependant minor can also apply to the Children’s Court for an order that she be allowed to provide consent without parental involvement.

If the pregnancy is **20 weeks or more** when the abortion is to be performed, the procedure is not justified unless –

- two medical practitioners, who are members of a Government appointed panel of medical practitioners, have agreed that the mother or unborn child has a severe medical condition that justifies the procedures; and
- the abortion is performed in an approved facility.

While the woman concerned no longer faces criminal sanctions, there are still some instances where performing abortion will be unlawful. A person performing the procedure (usually the medical practitioner) commits an offence against the *Criminal Code* if –

- the abortion is not justified under s 334 of the *Health Act 1911* (exposing the medical practitioner to a fine rather than imprisonment); and/or
- the person is not a registered, qualified medical practitioner, in which case he or she can be imprisoned for five years.

Western Australia’s abortion facilities comprise mainly free-standing clinics. In cases where the pregnancies is less than 20 weeks, women will be asked to sign a consent form and indicate that they have been offered counselling. It appears that terminations over 20 weeks can only be performed at one public hospital in Perth and only if the foetus or woman has a severe medical condition that the doctor believes warrants termination. However, women previously had to travel interstate for late abortions.

In November 2001, the Department of Health distributed a booklet to clarify the counselling requirements under the *Health Act*.

In accordance with the review requirements of the Act, the *Report of the Review of Provisions of the Health Act 1911* was tabled in the WA Legislative Assembly on 27 June 2002. The purpose was to examine the operation and effectiveness of the provisions. The Review Committee found that while the legislation was achieving the aim of making safe abortions available to WA women, a number of improvements could be made in the operation and delivery of abortion support services, and educational services relating to pregnancy. It recommended that the Department of Health take responsibility for undertaking and implementing these.⁸¹

⁸¹ WA. *Review of Provisions of the Health Act 1911 and the Criminal Code Relating to Abortion as Introduced by the Acts Amendment (Abortion) Act 1998*, June 2002.

The recommendations included monitoring of health information to ensure that it is comprehensive, current and effective and that it is culturally appropriate and inclusive of special needs. It was also recommended that service quality should be monitored, assessed and maintained and that the Department establish a mechanism to monitor practitioners in keeping abreast of legal requirements regarding informed consent and the information to be provided to women. The Review noted that there were still gaps in availability of services, particularly support services for women in remote areas and that this needed to be addressed. The importance of programs aimed at preventing unplanned pregnancies was also stressed in the recommendations.⁸²

3.11.1 Abortion as a Health Issue

In Western Australia, it appears that abortion is regarded essentially as a health issue rather than a criminal one, although it still remains in the *Criminal Code*. Some MPs argued, when debating the new laws, that any effort to reduce the large number of abortions in Australia required that it be removed from the criminal arena.⁸³ In this way, argued the head of gynaecology at one Perth public hospital, abortion can be dealt with by Government as it would deal with other health services. By regulating terminations through information provision and notification requirements regarding abortions being included in the *Health Act*, it was considered that greater knowledge about the incidence and profile of abortion in Australia would assist governments and others in tackling the issue. More detailed information would enable health bodies to plan services and governments to reduce demand for abortion through carefully targeted education campaigns.⁸⁴

When introducing her Private Member's Bill, the Hon Cheryl Davenport MP argued that women who choose termination need to have access to legal, safe, clean and professional services and access to counselling without fear of the law.⁸⁵

⁸² The Review Committee made 23 Recommendations dealing with operational and administrative matters such as reporting and auditing requirements; information provision; training of practitioners about the legal requirements etc. See pp 12-14.

⁸³ Chip Le Grand, 'Victory at midnight', *Australian*, 23 May 1998, p 29.

⁸⁴ Chip Le Grand, 'Victory at midnight', quoting Dr Harry Cohen, Head of Gynaecology at King Edward Hospital and Ms Judith Straton, Associate Professor of Public Health at the University of Western Australia.

⁸⁵ Hon C Davenport MP, Member for South Metropolitan, Criminal Code Amendment (Abortion) Bill 1998 (WA), Second Reading Speech, Legislative Council, *Hansard*, 10 March 1998, p 8.

A year after the legislation commenced, it was argued that access for girls under 16 years was a cause for concern. This was because there were high numbers of women in this age group represented in the abortion statistics yet only four had sought a court order exempting them from seeking parental consent, indicating that others may have undergone unsafe and/or illegal abortions.⁸⁶ The *Review of Provisions of the Health Act 1911 and the Criminal Code* did not address the foregoing point but did recommend that the Attorney-General review the appropriateness of the Children's Court to hear applications and to recommend ways that difficulties faced in rural and remote areas may be addressed.⁸⁷

3.12 TASMANIA

Prior to December 2001, the legislation governing abortion in Tasmania (ss 134-135 of the *Criminal Code*) was similar to that in Queensland. Section 51 was similarly worded to the 'defence' provision contained in s 282 of the Queensland *Criminal Code* but did not include the phrase 'or upon an unborn child for the preservation of the mother's life' which has enabled the Queensland courts to interpret the provision as allowing an abortion if it fell within the Menhennitt ruling.

Up to December 2001, there had not been any substantive judicial interpretation or clarification of the legal position for Tasmanian women contemplating an abortion. However, it appears to have been the practice for doctors to perform abortions under liberal interpretations of the *Criminal Code* if two doctors agreed that there was serious risk to the woman's physical or mental health or to the foetus. Tasmania's only free-standing clinic performing abortions closed in March 2001, meaning that only hospitals performed the procedures from that time.

The situation was abruptly changed when, in November 2001, a medical student asked the police to investigate the abortion practices at the Royal Hobart Hospital where abortions had been performed for over 30 years. Tasmanian doctors argued that they were not prepared to risk prosecution under unclear laws and refused to perform any further terminations. The Government brought in a doctor from Melbourne to take over the procedures.⁸⁸ The medical profession's fears were reinforced by advice from the Director of Public Prosecutions that the usual current

⁸⁶ S Stephen, 'WA abortion access one year on', *Green Left*, 1999. At <http://www.greenleft.org.au>.

⁸⁷ *Review of Provisions of the Health Act 1911 and the Criminal Code*, p 26.

⁸⁸ Bruce Montgomery, '“Dark Ages” abortion law under review', *Australian*, 12 December 2001, p 2.

practice (at least until the past few weeks) might not be covered by the *Code* and that the Government might now be aiding and abetting a crime.⁸⁹ Many women travelled interstate to have an abortion, financially assisted by the Government's patient transport assistance scheme. Some procedures continued at two private hospitals in the State.

The Tasmanian Premier, the Hon Jim Bacon MHA, recalled Parliament on 19 December 2001 to allow Health Minister, the Hon Judy Jackson MHA, to introduce a Private Member's Bill to provide specifically for the circumstances in which abortions could be legally performed, thereby creating certainty. Members of Parliament were given a conscience vote on the Criminal Code Amendment Bill (No 2) 2001, which was passed by both Houses on 20 December 2002 and assented to on 24 December 2001.

The disparity of views, even among Government members, was apparent from some of the comments made. The Premier is reported to have said that his primary concern was women's rights and his secondary concern was their access to the highest standard of care. Similar sentiments were echoed by the Health Minister who is reported to have stated that women would be 'condemned to the dark days of backyard abortions if the law were not clarified'. The Attorney-General has indicated that Tasmania needed to update its laws so that it was not in the same position as Ireland, which 'exports its problems'. On the other hand, the Deputy Premier is reported as being morally opposed to abortion and had commented that it was the only area of the law where destruction of life was allowed because someone is financially stretched.⁹⁰

The *Criminal Code Amendment Act (No 2) 2001* inserts a new s 164 into the *Criminal Code* which states that no crime is committed despite ss 134, 135 or 165 (causing death of a child before birth) if the abortion is 'legally justified'. Thus, abortion is retained under the *Code*.

Under s 165, a termination is 'legally justified' if two registered medical practitioners, at least one being a gynaecologist or obstetrician, have provided written certification that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the woman (taking account of any relevant matters) than if the pregnancy were terminated, and the woman has given informed consent, unless it is impracticable for her to do so.

'Informed consent' is given only if the medical practitioner has provided the woman with counselling about the medical risks of the abortion and the alternatives, and referred her to counselling about other related matters. If

⁸⁹ Bruce Montgomery, 'State flies women out for abortions', *Australian*, 13 December 2001, p 1.

⁹⁰ Bruce Montgomery, 'MPs sit late to legalise abortion', *Australian*, 20 December 2001, p 5.

obtaining consent is impracticable, both doctors must make a declaration detailing the reasons why.

It appears that there is no minimum age requirement for the woman undergoing the procedure as exists in WA and the NT. Again, persons with a conscientious objection to abortions do not have to involve themselves in the treatment, including counselling.

The laws operate retrospectively to provide that no prosecution lies against any person in relation to a termination of pregnancy performed before the laws commenced provided that they were performed by a registered medical practitioner at a public hospital or private medical establishment.

The grounds of legal justification are similar to those in SA and the NT. It appears that Tasmanian abortion laws have been statutorily placed on a similar footing to those in NSW. That is because, in assessing the risk to physical or mental health, the doctor can consider all relevant matters.

A private clinic providing termination procedures commenced operating in 2002.⁹¹

3.13 AUSTRALIAN CAPITAL TERRITORY

In August 2002, the ACT became the first Australian jurisdiction to totally decriminalise abortion by removing the abortion provisions (ss 42, 43 and 44) from the *Crimes Act 1900*. Those provisions were identical to the NSW *Crimes Act* provisions. It had been assumed that the legal position on abortion in NSW applied equally in the ACT but that was not ever tested by a court case.⁹² Many 'pro-choice' activists considered that the battle for abortion rights had been won in 1992 when some restrictive legislation was repealed and the Reproductive Health Service clinic was established.⁹³

⁹¹ 'Abortion in Tasmania: Recent Events and Changes in the Politics of Abortion', Women's Studies Seminar Series, 2002 Forum. At http://www.utas.edu.au/docs/humsoc/philosophy/pdf/Abortion_forum.pdf.pdf

⁹² *Abortion Law in Australia* Research Paper 1 1998-99.

⁹³ L Cannold with C Calcutt, 'The Australian Pro-Choice Movement and the Struggle for Legal Clarity, Liberal Laws and Liberal Access: Two Case Studies', Paper prepared on behalf of Children by Choice and the Australian Reproductive Health Alliance pp 1-16, p 9. At <http://www.arha.org.au/occasionalpapers/OP%203%20-%20Aust%20Abortion.pdf>

In 1998, the ACT passed the *Health Regulation (Maternal Health Information) Act 1998 (ACT)* (1998 Act) amid some controversy.⁹⁴ The legislation, introduced as a Private Member's Bill by a 'pro-life' Independent Member, was a somewhat watered-down version of an earlier Bill which sought to outlaw all abortions except in cases of 'grave medical or psychiatric risk'.

The 1998 Act appeared to restrict abortion for ACT women by imposing additional requirements that the common law, as applied in NSW, Victoria and Queensland, did not. The Act said that neither complying nor failing to comply with the requirements set out in the Act affected the determination of whether or not an abortion was lawful under the *Crimes Act*. In the debate on the legislation, a number of speakers focused on the fact that the new legislation reinforced the relevance of the *Crimes Act* and the sanctions imposed thereunder (10 years imprisonment for women and doctors).⁹⁵

The main features of the legislation were that abortions had to be performed by a registered medical practitioner in an approved facility. The woman had to be offered the choice of seeking counselling. An abortion could not be performed unless the woman was given information about risks of abortion and risks of continuing with the pregnancy, as well as other information specified in the Act, including the probable age of the foetus. In addition, it was an offence not to allow at least a 72-hour 'cooling off' period after that information session before performing the abortion. A Regulation required pamphlets containing pictures of foetuses at various stages of development to be shown to women. This 'information' provision was one of the most controversial aspects of the legislation. The Regulation was repealed by the new Government after coming to power in November 2001.

The 1998 Act was opposed by many ACT residents and leading doctors. Polling after it was passed indicated that 65% of respondents favoured abortion on request.⁹⁶

In December 2001, when the new Government came to power, Speaker Wayne Berry MLA introduced a Bill to repeal the 1998 Act along with the Crimes (Abolition of the Offence of Abortion) Bill 2001 to repeal ss 42-44 of the *Crimes Act 1900*. It was argued that the 1998 Act had been controversial and the

⁹⁴ See eg Stephanie Peatling, 'Women to be supplied with photographs of foetuses under new ACT abortion law', *Sydney Morning Herald*, 27 November 1998, p 6.

⁹⁵ See, for example, Ms K Tucker MLA, 'Postponement of Order of the Day', ACT Legislative Assembly, *Hansard Online*, 25 November 1998, p 2839.

⁹⁶ Natasha Cica, 'Just When You Thought it was Safe to go Back in the Water...', *Inkwell 1999/1*, 4 January 1999.

protection to women it purportedly sought to provide was no different to that provided in other laws, including the *Medical Practitioners Act 1930* and those governing approvals of health facilities.⁹⁷

Mr Wayne Berry MLA, when introducing the Bill, stated that the required three day ‘cooling off’ period was offensive to women as it presumed that they had not already given the matter thorough consideration and that the provisions governing the adequacy of relevant health facilities were passed in ignorance of the careful practices already in place. It was also prejudicial to rural women who may have to wait longer to have the abortion, thus increasing the risk of complication. That argument appears to have been borne out in practice with rural women finding it expensive and difficult to make two trips to the city.⁹⁸ Mr Berry considered that the repeal of the Act would restore the standing of the Parliament in the community in relation to women’s issues and put a rest to the disquiet and anger that it had caused.⁹⁹

On 21 August 2002, both Bills were passed on a conscience vote by the narrowest of margins – nine votes to eight. To improve support for the two Bills, amendments were made to the *Medical Practitioners Act 1930* to ensure that abortion would only be carried out by medical practitioners in registered facilities and that health workers with a conscientious objection to the procedure would not have to take part in them. When introducing the amendments Ms K Gallagher MLA said that they had minimal impact on the *Medical Practitioners Act* and merely addressed concerns that repealing the 1998 Act would leave women without specific protection regarding the quality and safety of the procedure. The result would be, however, that abortion would be treated like any other medical procedure.¹⁰⁰

Under the new regime, abortion is no longer unlawful and women up to 12 weeks pregnant can have an abortion at public clinics. After 12 weeks an ethics panel of doctors must review the case.¹⁰¹

⁹⁷ Mr W Berry MLA, Health Regulation (Maternal Health Information) Repeal Bill 2001 (ACT), Second Reading Speech, ACT Legislative Assembly, 12 December 2001, *Hansard*, pp 109-112, p 111.

⁹⁸ L Cannold with C Calcutt, ‘The Australian Pro-Choice Movement and the Struggle for Legal Clarity, Liberal Laws and Liberal Access: Two Case Studies’.

⁹⁹ Mr W Berry MLA, Second Reading Speech, p 112.

¹⁰⁰ Ms K Gallagher MLA, Medical Practitioners (Maternal Health) Amendment Bill 2002 (ACT), Second Reading Debate, *Hansard*, 15 May 2002, pp 1595-1596.

¹⁰¹ Sophie Douez, Liberal votes for abortion to be legal in the ACT’, *Age Online*, 23 August 2002. At <http://www.theage.com.au>.

4 INTERNATIONAL COMPARISONS

Since the 1950s there has been a global trend towards the liberalisation of abortion laws, with the focus moving away from abortion as a crime towards a concern for women's health and family well-being.¹⁰² However, 38% of the world's population live in countries where abortion is completely illegal or allowed only to protect life or health. Many developing countries have laws falling into those categories.¹⁰³

While most developed countries and a number of developing countries have relaxed restrictions, the legal status of abortion varies considerably throughout the world. Abortion laws tend to fall into one of the following categories (from the most to least restrictive) –

- prohibited totally or allowed only to save the woman's life (eg Mexico, Iran, Iraq, Nigeria);
- permitted to save the woman's life or protect her physical health (eg Poland, Ethiopia, Saudi Arabia, Peru, Pakistan, Zimbabwe);
- permitted to save the woman's life or protect her physical or mental health (eg Jamaica, Spain; Israel);
- permitted on all of the above grounds and also on socio-economic grounds (eg India; Japan, Taiwan, United Kingdom, Guyana after eight weeks, before which it is 'on request');
- permitted 'on request' (eg many European countries, Russian Federation, South Africa).¹⁰⁴

Many European countries have very liberal abortion laws. Around 10 European Union countries offer abortion 'on request' including Austria, France, Norway, the Netherlands and Sweden. Other countries such as Albania, Canada, Singapore, Cambodia and Vietnam take a similar approach.

However, even in countries with very liberal laws, some requirements do apply, such as parental consent for minors, the need for the procedure be undertaken in

¹⁰² Public Health Association of Australia, 'Fact Sheet 1 – The Global Context of Abortion' taken from *The Regulation of Abortion in Australia: Public Health Perspectives*, 2nd ed, 1998, citing R J Cook, 'Abortion laws and policies: challenges and opportunities', *Supplement to International Journal of Gynaecology & Obstetrics* 3, 1989, pp 61-87. All PHA fact sheets referred to in this Brief are from *The Regulation of Abortion in Australia* at <http://www.pha.org.au>.

¹⁰³ USA. Alan Guttmacher Institute, *Sharing Responsibility: Women, Society and Abortion Worldwide*, 1999, pp 21-22.

¹⁰⁴ USA. Centre for Reproductive Law and Policy (CRLP), *Reproductive Rights 2000: Moving Forward*, Electronic Edition, Ch 3, pp 29ff.

authorised facilities by relevantly qualified medical practitioners, the need for the recommendation of two doctors, compulsory counselling, ‘cooling off’ or waiting periods, and maximum stage of pregnancy at which the procedure will be performed. Those requirements can be viewed either as protecting women from unsafe practices or as imposing more barriers on choosing a safe procedure.

Below is a brief overview of the legal status of abortion in selected countries as it is not possible in this Brief to canvass the situation in all countries. More information, as at June 1999, can be found at the [International Planned Parenthood website](#).¹⁰⁵

4.1 UNITED KINGDOM

The *Abortion Act 1967* legalised abortion for UK women. The legislation was prompted by the ‘thalidomide babies’ incident, where mothers who took drugs for morning sickness gave birth to badly deformed children.

As noted earlier, the *Offences Against the Person Act 1861* made abortion illegal, unless performed for the sole purpose of preserving the life of the mother. During the 1930s, the law was tested in *R v Bourne* but the legal position was unclear until legislative reform in the late 1960s. However, many termination procedures were performed before that time without prosecution. Thus, many women had ‘unlawful’ abortions, with a number of poorer women having ‘backyard’ terminations. In the private sector, the procedure was a lucrative source of income for doctors exploiting the dubious legal situation by charging high fees.¹⁰⁶

The *Abortion Act 1967* made abortion lawful in England, Scotland and Wales (but not Northern Ireland, the Isle of Man or the Channel Islands) under clearly specified criteria that have some similarities to legislation in South Australia, Tasmania, and the Northern Territory. The Act was reviewed by a committee of inquiry (the Lane Committee) in 1974 which reported favourably on its operation. In 1990, the *Human Fertilisation and Embryology Act* was passed to insert into the *Abortion Act* a maximum time of 24 weeks up to which abortion would be lawful.

Relevant features of the *Abortion Act* are –

- up to 24 weeks, abortion with the woman’s consent is lawful provided that two doctors certify that a woman’s mental or physical health, or that of her

¹⁰⁵ At http://ippfnet.ippf.org/pub/IPPF_Regions/IPPF_CountryProfileList.ASP.

¹⁰⁶ J Greenwood, Chair of the British Pregnancy Advisory Service, London, ‘The New Ethics of Abortion’, *Journal of Medical Ethics*, 27(15), October 2001. Downloaded from InfoTrac.

children, is at greater risk if she continues with the pregnancy than if she terminates it;

- abortion is lawful at any stage of the pregnancy if the foetus is abnormal or if there is a risk of permanent injury to a woman's life or health.

Despite the liberalisation of abortion laws in the UK, some organisations are concerned that the law does not permit abortion 'on request' and believe that women are still having difficulty accessing the free National Health Service abortion services.

The UK [Abortion Law Reform Association \(ALRA\)](#) was established in 1936. It seeks to promote women's right to safe, free and legal abortion based on informed choice.¹⁰⁷ In particular, it believes that the current law giving doctors rather than women the power to determine whether or not to perform an abortion is not justified because it burdens doctors with making a decision that they are not really trained or suited to make.¹⁰⁸ The main change to the *Abortion Act* sought by the ALRA is to allow abortion 'on request' in the first three months of pregnancy and, from 15-24 weeks, if a doctor approves it. At the moment, the practitioner has to find that the woman's mental or physical health, or that of her children, is at greater risk if she continues with the pregnancy than if she terminates it (taking into account the woman's actual or reasonably foreseeable environment).

Other bodies, on the other hand, consider that the legislation has served women reasonably well and any difficulties are due to organisation and funding of services rather than the law itself, although some aspects of the law are anachronistic and obtrusive (eg the need for certification by two doctors).¹⁰⁹ In particular, some health professionals and managers do not regard abortion as an essential service that should be available within the public system.

Medical abortion is common for early term pregnancies, particularly through the use of Mifepristone, currently available only at hospitals and special outpatient units. There are now plans to offer it at family planning clinics as part of a pilot program to reduce the waiting time for termination.¹¹⁰ The 'morning after pill', available over the counter at pharmacies, is a common emergency contraceptive.

¹⁰⁷ The ALRA website is <http://www.alra.org.uk>. It carries out research and collects information to produce reports and other material. It is also a lobby group.

¹⁰⁸ ALRA, 'A more liberal abortion law', on the ALRA Law Reform homepage at <http://www.alra.org.uk/whychan.html>.

¹⁰⁹ J Greenwood, 'The New Ethics of Abortion'.

¹¹⁰ 'Britain to widen availability of abortion pill', *Sydney Morning Herald* Online, 8 July 2002. Downloaded from <http://www.theage.com.au>.

It has recently been reported that Britain's rate of teenage pregnancies is the highest in Western Europe and the second highest in the developed world, with 38,690 girls under 18 falling pregnant in 2000. The Health Department has responded by introducing a program under which students will be given free contraceptives at school clinics and provided with guidance on sexual matters.¹¹¹

4.2 NORTHERN IRELAND

The *Abortion Act 1967* does not extend to Northern Ireland. The Government chose not to debate the matter at the time the Act was passed because it was considered that it would not have the support of the population.¹¹² The law is therefore governed by the *R v Bourne* interpretation of the UK *Offences Against the Person Act 1861* ie abortion being allowed to avoid serious harm to the woman's life or her physical or mental health. Judgements of the Northern Ireland courts during the 1990s indicate that a real and serious risk that the mother will commit suicide if the pregnancy was to continue is a ground permitting abortion.

The ALRA notes that statistics on abortion in Northern Ireland began to be collated only recently, making it difficult to assess matters such as accessibility and reasons for termination. It found, however, that abortion may be available if the woman has a serious medical or psychological problem which would pose a risk to her life or health if the pregnancy were to continue; or if the woman has severe learning difficulties; or the foetus is abnormal.

As the legality of abortion is shrouded in some uncertainty, doctors are cautious about undertaking the procedure. A 1992 survey of gynaecologists in Northern Ireland found that around half had a conscientious objection to performing abortions but 95% did, in fact, carry out the procedure.¹¹³ However, there are vast inconsistencies in the practice because the law is such that doctors exercise their own judgements about whether or not the abortion is legal in a particular instance. For example, one doctor indicated that he would perform the procedure only if rape had caused the pregnancy while another said he would do so for foetal abnormality only.¹¹⁴

¹¹¹ Celia Hall, 'School contraceptives a bitter pill for Tories to take', *Age Online*, 29 June 2002.

¹¹² ALRA, 'Abortion in Northern Ireland', on the ALRA Law Reform homepage. At <http://www.alra.org.uk/northire.html>.

¹¹³ ALRA, 'Abortion in Northern Ireland', citing Dr C Francome, Middlesex University, *Journal Bisosic. Sci* (1994) 26, pp 389-394.

¹¹⁴ ALRA, 'Abortion in Northern Ireland', citing Dr C Francome, pp 389-394.

Many women travel to England to undergo the procedure and the official figure of over 40,000 since the *Abortion Act* was passed may, in fact, be higher because many women give false addresses to avoid detection. The cost of the procedure in a private clinic in England and the attendant travel and accommodation costs can be significant and often cause a delay in women undergoing the procedure.¹¹⁵

4.3 IRISH REPUBLIC

On 7 March 2002, Irish voters narrowly rejected a proposal by the Prime Minister to amend the Irish Constitution to toughen Ireland's already restrictive abortion laws. Ireland has had five referenda in 20 years on abortion, an issue of huge sensitivity in that predominantly Catholic country.

Abortion in Ireland was governed by the *Offences Against the Person Act 1861* but in 1983, following a referendum, amendments were made to the Constitution to make abortion illegal except to save a woman's life.

The current position of the law in Ireland is that abortions are unlawful unless it is to avert a real and substantial risk to life, as distinct from health, of the woman. However, the risk to life can be a real danger that the woman will commit suicide if she continues with the pregnancy. Suicide as a ground was established in the 1992 Supreme Court decision in *Attorney-General v X*. The case involved a young girl whose pregnancy resulted from a sexual assault and both she and her parents wanted her to have an abortion in England.¹¹⁶ Around the same time, the European Court of Human Rights doubted whether Ireland's abortion laws were well founded.

Also, in 1992, a referendum approved allowing women to obtain information about abortions that were lawful in other countries and to travel to those countries to procure them. Legislation was passed in 1995 to give effect to the constitutional amendment regarding provision of information. It is reported that around 7000 Irish women travel to England each year for an abortion.¹¹⁷

The March 2002 referendum proposal sought to overturn the decision in *Attorney-General v X* (likelihood of suicide as a ground for abortion) but it was defeated, albeit narrowly. Had the referendum proposal been successful, the Constitution

¹¹⁵ ALRA, 'Abortion in Northern Ireland', citing House of Commons Written Answer Vol 307 No 129 col 455, 2 March 1998.

¹¹⁶ For a discussion of this case, see Ireland, The Department of the Taoiseach, *Green Paper on Abortion*, September 1999, Ch 2.

¹¹⁷ 'Voters reject stricter abortion ban', *New York Times*, 6 March 2002.

would have been changed to prohibit the likelihood of the pregnant woman committing suicide if the pregnancy were to continue as being a ground for abortion. It also would have imposed greater penalties upon doctors who performed abortions in circumstances other than where a woman's life is at risk. The Prime Minister argued that the amendments were designed to protect the health of women and of the unborn child.¹¹⁸

4.4 UNITED STATES OF AMERICA

During the mid to late 1800s a number of US states began to pass laws to stop abortions. By 1910, all but one state had made it a criminal offence, unless the procedure was necessary to save the woman's life.¹¹⁹

The 1973 landmark case of *Roe v Wade* made abortion lawful in the USA.¹²⁰ Ms Roe was denied an abortion in Texas because her life was not directly at risk. She then challenged the constitutional validity of the Texan law. The US Supreme Court held that state criminal laws prohibiting abortion violated the 'due process' clause of the 14th Amendment of the US Constitution. The Court considered that that clause protected the right to privacy (which was found to create a realm of protection for the autonomy of the woman in respect of her body against the power of the State). This judgement had the effect of altering the law in 46 states. The practical effect of the decision in *Roe v Wade* for US women is –

- abortion 'on request' is legal up to the first 12 weeks of gestation. The Court said that during that period *the abortion decision and its effectuation must be left to the medical judgement of the pregnant woman's attending physician*;
- in the second trimester (up to 24 weeks) individual states may restrict abortion on grounds that are, as the Court said, *reasonably related to protecting the health of the woman*;
- in the third trimester, the Court said that a State *may, if it chooses, regulate, and even proscribe, abortion except where necessary, ... for the preservation of the life or health of the mother*. Subsequent court decisions have defined 'preservation of health' broadly to include suicidal depression about the pregnancy.

¹¹⁸ 'Irish to vote again on abortion rights', *AM ABC NewsOnline*, 6 March 2002. Downloaded from <http://www.abc.net.au/am>.

¹¹⁹ '29 Years After Roe v Wade, Legal Abortion at Risk', *PR Newswire*, 15 January 2002.

¹²⁰ 410 US 113 (1973).

By 1998, it appears that 31 states had moved to pass laws regulating abortion procedures through imposing various requirements. A number of states require that the woman undergo counselling or a 'cooling off' period before it is performed; many require parental consent for minors. Some others have, within the parameters of the *Roe v Wade* decision, prohibited abortions in the third trimester unless necessary to preserve the woman's life or health. In an important US Supreme Court decision, it was recognised that states had an interest in regulating the procedure to protect maternal health or foetal life, provided the regulation did not place an undue burden on the woman's decision about having an abortion.¹²¹ In addition, a 1989 decision upheld a State ban on the use of public facilities for abortion procedures.¹²²

However, in a significant breakthrough for women in September 2000, the Food and Drug Administration approved Mifepristone, also known as RU-486 (trading as Mifeprex), for the termination of early pregnancies (under 49 days). It is administered to women by their doctors under quite strict guidelines.

The focus has recently turned to whether or not to ban 'partial birth' abortions, ie late-term abortions where a foetus is partly delivered. A federal bill imposing such a ban was passed through Congress twice during the 1990s but was vetoed by the then President Clinton. The current President, George W Bush, is against abortion except in certain circumstances and supports the 'partial birth' ban.¹²³ In March 2002, Congress passed legislation imposing such a ban.¹²⁴ In March 2003, the United States Senate also passed legislation banning 'partial birth' abortion.¹²⁵

It is reported that the Bush administration has appointed anti-abortion activists to key positions on US delegations to United Nations conferences on global economic and social policy. It also helped to block an effort by some countries to include a reference to 'reproductive health services' in a UN special session on children document due to concern that such services would include abortion for minors.¹²⁶

¹²¹ *Planned Parenthood of Pennsylvania v Casey* 505 US 833 (1992).

¹²² *Webster v Reproductive Health Services*, 492 U.S. 490 (1989).

¹²³ S Hannett, 'The Regulation of Abortion in the United States', *Public Law*, Autumn 2001, pp 480-488, p 487.

¹²⁴ 'House votes to protect fetuses', *Washington Post*, 13 March 2002.

¹²⁵ Helen Dewar, 'Pro-choice lobby vows to fight abortion clamp', *Sydney Morning Herald Online*, 15 March 1993.

¹²⁶ Colum Lynch, 'Islamic Block, Christian Right team up to lobby UN', *Washington Post*, 17 June 2002, p A01.

The US Government has also reinstated a 'global gag rule' that restricts foreign non-governmental organisations that receive US family planning funds from using their own, non-US funds to provide legal abortion services, lobby their own governments for abortion law reform, or provide medical counselling or referrals regarding abortion.¹²⁷ In July 2002, the US Government withdrew \$US34 million (\$A62m) annual funding to the UN Population Program that runs programs for sexual and reproductive health in 142 countries, citing Chinese policies of 'coercive' family planning as a reason for the decision.¹²⁸

It is considered that since *Roe v Wade*, abortion has become a safe procedure. Women usually undergo an abortion within the first eight weeks of pregnancy and around 99% by 20 weeks. The risk of death from complications arising from abortion is now significantly lower than the risk of death as a result of pregnancy or childbirth (0.4 deaths per 100,000 procedures performed before eight weeks gestation).¹²⁹ However, there is virtually no publicly funded abortion.

It has been suggested that restrictions on US Federal funding for abortion may well have had their genesis in the argument that abortion is a woman's private decision because the Government can then take the view that if it should not intervene in the decision, then it has no duty to intervene to assist a woman to have the procedure.¹³⁰

4.5 CANADA

A 1988 decision of the Canadian Supreme Court held that s 251 of the *Criminal Code* (which restricted abortions) was in conflict with the *Charter of Rights and Freedoms* (which guaranteed women the right 'to life, liberty and security of the person') and was, therefore, unconstitutional.¹³¹ Attempts were made to pass abortion laws to fill the gap (including a gestationally based law) but were defeated. Thus, Canada does not presently have abortion laws and abortion is

¹²⁷ CRLP, 'The Global Gag Rule Could Stall Abortion Law Reform Worldwide', *CRLP Publications*, April 2001. Downloaded from the CLRP website at <http://www.crlp.org>.

¹²⁸ Harry Dunphy, 'Bush stirs abortion debate', *Courier Mail*, 24 July 2002, p 16.

¹²⁹ The Alan Guttmacher Institute, 'Abortion in Context United States and Worldwide', *Issues in Brief* at <http://www.agi-usa.org>.

¹³⁰ See R Graycar & J Morgan, *The Hidden Gender of Law*, 2nd ed, Federation Press, 2000, p 214, citing CA McKinnon, 'Privacy v Equality: Beyond Roe v Wade', *Feminism Unmodified: Discourses on Life and Law*, Harvard University Press, Cambridge, MA, 1987, p 96.

¹³¹ *Mortgentaler v The Queen* [1988] 1 SCR 30.

treated like any other medical procedure, governed by provincial and medical regulations.¹³²

The situation appears to be that in all provinces and territories (except Prince Edward Island) decisions about undergoing the procedure are between the woman and her treating doctor and the medical associations. In practice, abortions are readily available up to 20 weeks gestation in a number of hospitals and free-standing clinics in major cities but the gestational limit varies according to the facility where the procedure is undertaken. The requirement for parental consent for hospital-based procedures varies between jurisdictions also. A number of provincial governments fund the procedure undertaken in hospitals and clinics but in others, only those performed in hospitals are covered. Clinics require private payment. However, in some provinces and in rural areas, access is more restricted with more and more services being consolidated into a single service.

4.6 EUROPE

Until recently, **Eastern and Central Europe**, containing former Soviet Union countries, had some of the most liberal abortion laws in the world. Many countries allow abortion 'on request' up to 12 weeks gestation and up to 22 weeks for socio-economic and health reasons. Conversely, these same countries have a distinct lack of available contraception, which contributes to the very high rates of abortion. Government funding in a number of countries enables free or inexpensive access to abortion services in public facilities. Private facilities have much higher fees. Poland has the most restrictive laws in the region. Again, however, many countries impose requirements, intended to protect women's health, such as parental consent, counselling, and approvals from other doctors before the procedure may occur.¹³³ Over the past two years, countries such as Hungary and Russia have altered, or are seeking to change, their laws to make abortion harder to obtain.

Most countries in the **European Community** have liberal abortion laws with Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands and Sweden having abortion 'on request' in the early stages of pregnancy.

For example, in the **Netherlands**, legislation was passed in 1984 to allow abortion 'on request' up to 24 weeks gestation. It authorised the licensing of clinics and

¹³² Health Canada, Population and Public Health Branch, 'Induced Abortion', *Fact Sheet*, April 1998. At the Health Canada website at <http://www.hc-sc.gc.ca/pphb-dgspsp/rhs-ssg/factshts>.

¹³³ CRLP, *Women of the World: Laws and Policies Affecting Their Reproductive Lives – (East and Central Europe)*, October 2000.

hospitals but allowed only physicians to perform terminations. The main restrictions applying are the requirement for parental consent for girls under 18 years and a five day waiting period. The law also ensures the privacy of women and that women are not liable to any sanctions. No service provider is bound to perform an abortion if they have a conscientious objection.

It is understood that the rate of abortions in the Netherlands has fallen since the law was passed and it is around 6.5 per 100,000 women, making it the lowest in the Western world. Teenage pregnancy rates are also low. This may be due, in part, to widespread sex education in secondary school and to the general availability of a range of contraceptive options.¹³⁴

Until June 2002, in **Switzerland**, the Swiss Penal Code imposed the most stringent restrictions in Europe although, from 1981, legislation has ensured that counselling services are available and that lawful abortions are covered by health insurance.¹³⁵ Despite the restrictions, it appears that around 13,000 abortions were performed each year. Doctors acting in breach of the law could face five years' imprisonment (significant in Switzerland), although there were few prosecutions.¹³⁶

In June 2002, approximately 72% of Swiss voters approved a proposed law, to commence in October, to permit abortion 'on request' in the first 12 weeks of gestation, provided the woman provides written consent and agrees to counselling and medical advice. After 12 weeks, the abortion is lawful only for threat to life or physical health of the woman, or if she faces 'profound distress'. In practice, most abortions have been performed under 12 weeks.

Following the changes, it was reported that public hospitals in predominantly Catholic areas, which had previously sent women elsewhere for the procedure, would now have to offer it.¹³⁷

4.7 SOUTH AFRICA

Abortion was legalised in South Africa in 1975 but only on the grounds of rape, danger to the woman's life, or foetal impairment. Many poor and mainly black

¹³⁴ H Doppenberg, 'Contraception and sexually transmitted diseases: what can be done? Experiences and thoughts from the Netherlands', *British Journal of Family Planning*, vol 18, 1993, pp 123-125.

¹³⁵ Irish Government, *Green Paper on Abortion*, Appendix 3.

¹³⁶ Elizabeth Olson, 'Swiss ease abortion restrictions', *Age Online*, 4 June 2002.

¹³⁷ Elizabeth Olson, 'Swiss ease abortion restrictions'.

women went to backyard abortionists because the services were available only to the wealthy. There is much anecdotal evidence (despite lack of official statistics) that many women died or became sterile as a result.¹³⁸

In 1996, South Africa passed the *Choice of Termination of Pregnancy Act*, making South African abortion law one of the most liberal in the world. Abortion 'on request' is available up to 12 weeks gestation if the woman consents. It can be performed up to 20 weeks on a number of grounds, including socio-economic ones. There is no requirement for the consent of any person other than the woman concerned but the Act requires that a minor be advised to consult her parents or guardian. After 20 weeks, the grounds are limited to preserving the woman's life or if the foetus will be malformed. The opinion of two practitioners is required.

Midwives may perform terminations up to the first 12 weeks of gestation, but, thereafter, terminations must be performed by a medical practitioner. The Act provides for access to counselling, notification to relevant authorities, keeping records etc.

The commission of an offence relates only to performing the procedure without meeting the specified qualifications, exposing the person to a penalty of up to 10 years' imprisonment or a fine. Failing to maintain and provide records is also an offence, with lesser penalties attached but which include up to six months imprisonment. Interestingly, it is also an offence for anyone to prevent the abortion from occurring or to obstruct access to a facility for such procedure and this carries a penalty of a fine or imprisonment for up to 10 years.¹³⁹

The intention of the legislation was to protect women from backyard abortions and to ensure that all South African women had access to safe and clean medical abortions.

Shortly after the Act was passed, three religious bodies challenged its constitutionality under the 'right to life' clause of the Constitution. The Pretoria High Court upheld the validity of the Act and stated that there was no express provision in the Constitution affording the foetus legal personality or protection. The Court also strengthened the constitutional guarantees for protecting women's rights and considered the social and economic realities faced by women, particularly African women.¹⁴⁰

¹³⁸ Hon Cheryl Davenport MP, Criminal Code Amendment (Abortion) Bill 1998 (WA), Second Reading Speech, Legislative Council, *Hansard*, 10 March 1998, pp 8-12, 13-18, p 15.

¹³⁹ CRLP, *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Francophone Africa*, December 1999, pp 98-99.

¹⁴⁰ CLRP, *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Francophone Africa, 2001 Progress Report*, July 2001, pp 100-101.

It is understood that although there has been no Government advertising campaign to inform women about the new laws, the demand for abortions is outstripping what public facilities can provide. This is despite efforts by the Government to implement services, training for midwives, and supporting administrative structures. However, some areas, especially rural parts of the country, have no facilities available. In addition, there is a disparity of access between women on higher incomes and those from poorer families, with the former able to pay for private health care. It appears that second trimester abortions are difficult to obtain with many doctors lacking training or being unwilling to perform them. There is currently no regulation for referral procedures so health workers are not necessarily obliged by law to refer women to willing practitioners.¹⁴¹

5 ABORTION AS A HEALTH ISSUE

It has been noted that the *Re Davidson* and *Bayliss* judgements interpreted abortion law by having regard to the woman's 'physical and mental health'. Despite the apparent lawfulness of abortions performed within those parameters, confusion remains. It is uncertain whether, in Queensland, 'mental health' includes social and economic circumstances, as it has been interpreted in some jurisdictions.

Even in jurisdictions where legislation has specified situations in which abortion will be legal (eg South Australia, Tasmania, Western Australia), the fact that the criminal legislation continues to make it an offence concerns a number of organisations and others. The Queensland Children by Choice Association, among many other bodies, argues that because abortion remains a criminal offence in many Australian jurisdictions, including under Queensland's *Criminal Code*, women may feel reluctant to seek an abortion and criminally guilty if they do.¹⁴² However, it is often pointed out that neither restrictive laws nor lack of access to professional services stop women from seeking terminations, often by means which are dangerous to their health and their lives.¹⁴³ It has been suggested that the legal status of abortion correlates more with its safety than with its rate of occurrence.¹⁴⁴

¹⁴¹ CLRP, *2001 Progress Report*, pp 100-101, citing SJ Varkey & S Fonn, 'Termination of Pregnancy', *S.Afr Health Review*, 1999, ch. 26.

¹⁴² Queensland, *Women's Taskforce Report* p 355, citing Children by Choice Submission p 15.

¹⁴³ PHA, 'Fact Sheet 1 – The Global Context of Abortion' from *The Regulation of Abortion in Australia: Public Health Perspectives* from *The Regulation of Abortion in Australia: Public Health Perspectives*, at <http://www.pha.org.au>.

¹⁴⁴ Alan Guttmacher Institute (AGI), 'Abortion in Context United States and Worldwide', *Issues in Brief* at <http://www.agi-usa.org/>.

In 1997, the World Health Organisation (WHO) reported that around 13% of deaths related to pregnancy and childbirth are attributable to unsafe abortion.¹⁴⁵ Reporting on discussions held as part of the 1992 World Health Assembly, the WHO noted the contribution to maternal mortality and morbidity arising from unsafe abortion was *often because adequate family planning and other services are not accessible* and called on member countries to address the issue.

The Public Health Association of Australia (PHA) notes that abortions are very safe medical procedures when performed by qualified personnel under hygienic conditions. In Australia, deaths from abortion procedures have almost disappeared, yet before 1971, it was the major cause of maternal deaths. The PHA, along with much of the literature touching on this issue, cites the Romanian experience as evidence of the problems caused by restrictions on abortion. In 1966, to encourage childbearing, the Romanian Government made abortion and contraception illegal and while the birth rate rose for a short time, the maternal death rate also rose, but for a longer time. By 1989 it was around 10 times greater than any other country in Europe. In 1990, a new Government legalised abortion and the maternal death rate dropped to 40% of the 1989 level.¹⁴⁶

It has been found that the death rate from abortion is many times higher in developing countries, where it is usually illegal, than in developed countries – the worst incidence being Africa with almost 700 deaths per 100,000 procedures.¹⁴⁷ It has also been found that women in cities or from higher socio-economic backgrounds were usually able to obtain safe abortions, even in countries where it was illegal, and that the majority of deaths occur among women from rural areas and women on lower incomes. It has been reported that in Kenya, 30%-50% of maternal deaths are caused by unsafe abortions and a large portion of the Ministry of Health's budget is spent on managing complications arising from them. Most of the women resorting to unsafe procedures are poor and desperate and/or young girls willing to risk criminal prosecution and dangers to their lives and health. The

¹⁴⁵ PHA, Fact Sheet 1, citing World Health Organisation, *Maternal Health Around the World*, Maternal and Newborn Health/Safe Motherhood Unit, Division of Reproductive Health, Geneva, 1997.

¹⁴⁶ PHA 'Fact Sheet 1 – The Global Context of Abortion', citing World Bank, *World Development Report 1993: Investing in Health*, Oxford University Press for the World Bank, 1993. See also, A Duxbury & C Ward, 'The International Law Implications of Australian Abortion Law', *University of NSW Law Journal*, 23(2) (2000) p 1, p 26.

¹⁴⁷ AGI, *Sharing Responsibility: Women, Society and Abortion Worldwide*, p 35.

beneficiaries in this environment are the providers of safe services (who can charge exorbitant fees) and the ‘providers’ of backyard services.¹⁴⁸

Similar findings regarding the relationship between abortion and its legality and/or accessibility were made by the US based Alan Guttmacher Institute (AGI) in a major report in 1999. That report, *Sharing Responsibility: Women, Society and Abortion Worldwide*, collates research from around 60 countries about abortion law and other facts about abortion.¹⁴⁹ The findings indicated that the legality of abortion was not strongly related to the abortion rate of any particular country and that, in a number of countries where it is illegal (eg Latin American countries), there are high abortion rates. Conversely, in some countries where it is legal and widely available (countries in Western Europe), abortion rates are low.¹⁵⁰ The AGI argues that while legalising the procedures does not, of itself, guarantee safety, it does assist in reducing the number of unsafe abortions.

It has been suggested that governments in many parts of Africa are viewing the results of badly performed abortions as a major public health issue and are addressing the matter through reforms, particularly the provision of improved post-abortion care. It has been suggested that the large proportion of the health budget spent on treating Kenyan women in hospitals suffering from complications due to unsafe terminations (with 60% of acute gynaecological admissions in Nairobi being attributable to such) could be more usefully directed towards services that will save lives.¹⁵¹ It has been claimed, however, that the trend towards more liberalised abortion laws appears motivated by a concern for maternal mortality rather than recognition that access to safe abortion is a reproductive right.¹⁵²

A review of current literature published by health organisations, the legal and medical profession, academics and many other organisations involved in the abortion issue reveals a growing trend towards recognising abortion as a health issue rather than as a legal issue or as a ‘social issue’ or a ‘moral issue’. On this

¹⁴⁸ R Muganda (Executive Director, Centre for Study of Adolescence, Nairobi), ‘Abortion, a Grave Health Issue’, *Africa News Service*, 31 October 2001. Downloaded from Infotrac.

¹⁴⁹ AGI, ‘Abortion in Context United States and Worldwide’, drawing from data in AGI, *Sharing Responsibility: Women, Society and Abortion Worldwide*, 1999. The AGI is an independent US organisation established in 1968 to provide research, policy analysis and education in the fields of international reproductive health, reproductive rights and population.

¹⁵⁰ AGI, ‘Abortion in Context United States and Worldwide’.

¹⁵¹ R Muganda, ‘Abortion, a Grave Health Issue’.

¹⁵² CRLP, *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Francophone Africa 2001 Progress Report*, July 2001, p 161.

view, abortion would be dealt with as part of the health system and regulated like any other health service.

Such a health issue perspective is, of course, a controversial one in itself.¹⁵³ Those supporting this position argue that the practical reality, despite the legal reality, is that restrictive laws and unavailability of professional services will not stop women having abortions and the real issue is not whether or not the abortion should or should not occur but how safe and professional the conditions are under which they are performed.¹⁵⁴ Those who oppose abortion may find a review of health care aspects of abortion repugnant because it could be regarded as endorsing implicitly a positive moral or ethical value of available services.¹⁵⁵

Integral to the health issue viewpoint is the argument that no available contraceptive is totally foolproof and the provision of safe, accessible and affordable abortion services is vital to women's health.¹⁵⁶ In addition, it has been noted that there are other factors, apart from contraceptive usage, or lack thereof, that contribute to women wanting to have a termination. For example, some women cannot use contraceptives for medical reasons; some are victims of sexual assault; some suffer a drastic change of circumstances, such as death of a spouse or a divorce, that might make a previously wanted pregnancy an unwanted one.¹⁵⁷

5.1 RIGHT TO HEALTH IN INTERNATIONAL LAW

The preamble to the WHO Constitution (1946) states that 'health' is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

A number of international conventions refer to women's health issues. Australia is a signatory to the 1995 Beijing Declaration which calls for parties to consider reviewing laws containing punitive measures against women who have undergone illegal abortions. It contains a clause stating that –

¹⁵³ Catherine Armitage, 'Abortion: the new debate', *Australian* 17 December 1994, p 25.

¹⁵⁴ See, for example, Children by Choice Association, Public Health Association of Australia, Women's Electoral Lobby.

¹⁵⁵ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Foreword.

¹⁵⁶ Queensland Alliance for Legal Abortion, 'Join the Campaign to Reform Queensland Abortion Laws'.

¹⁵⁷ NHMRC, Expert Panel, *An Information Paper on Termination of Pregnancy in Australia*, Ch 4.

*A woman's health and the health of her children are affected by family planning issues. These include the age at which she begins and stops childbearing ... the total number of pregnancies and the socio-cultural and economic circumstances in which she lives and raises her children.*¹⁵⁸

It also states that unsafe abortions threaten the lives of a large number of women and that this represents a grave public health problem.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) prohibits all forms of discrimination against women in health care delivery and in marriage and family relations. The effect of **Article 12.1** is that countries must adopt measures to eliminate such discrimination to ensure that women have equal access to health care services, including those relating to family planning. **Article 12(2)** calls on parties to ensure that women have access to appropriate services for pregnancy, confinement and the post-natal period, with free services where necessary. Whether 'access to appropriate services' includes abortion services with the minimum of regulation imposed, has been a subject of some debate.¹⁵⁹

Australia is yet to ratify the Optional Protocol to CEDAW which enables persons to complain to the CEDAW Committee about possible breaches of CEDAW.

While many countries have passed legislation and adopted policies to prevent discrimination against women generally, most have avoided dealing with the issue of abortion in that context.¹⁶⁰

5.2 AUSTRALIAN PERSPECTIVE

With around 80,000 abortion procedures being performed each year in Australia, it has been suggested that, for many women, abortion will be part of their reproductive experience and, for this reason alone, abortion should be legalised and made safe and accessible.¹⁶¹ It appears also to be the only widely practised and

¹⁵⁸ United Nations, *Report of the Fourth World Conference on Women*, Ch 1: Declaration and Platform for Action, 1995.

¹⁵⁹ A Duxbury & C Ward, 'The International Law Implications of Australian Abortion Law', *University of NSW Law Journal*, 23(2) (2000), pp 1-34, p 26, citing doubts cast by Kingston in Conor Gearty & Adam Tomkins, *Understanding Human Rights*, Mansell, London, 1996, p 466.

¹⁶⁰ Queensland, *Report of the Taskforce on Women and the Criminal Code*, March 2000, p 353.

¹⁶¹ S Kift & L Willmott, 'Abortion Law Reform: Will Someone Decide Who Decides?' p 68.

publicly funded medical procedure that is criminalised.¹⁶² An anomalous situation is created by the fact that while abortion is technically illegal under the laws of most states, Medicare rebates are provided for most of the procedures.

Prior to the legislative changes to abortion law in WA, the *Report of the Chief Justice's Task Force on Gender Bias (WA)* noted that the then common law position created uncertainty and a fear that available services could be curtailed. It recommended that access to safe and legal abortion should be a right for all Australian women. It argued, as did the *Queensland Women's Taskforce Report*, that the current abortion provisions in the *Criminal Code* were in breach of international obligations under CEDAW to eliminate discrimination against women in the field of health care.¹⁶³

The dubious legality of abortion procedures in many Australian jurisdictions has consequences for the training and qualification of practitioners, discourages other health workers such as nurses, counsellors and social workers from seeking involvement, and impacts upon the provision of appropriate facilities for women.¹⁶⁴

In a study of women's experiences and attitudes to abortion in South Australia, Tasmania and Queensland, undertaken by three Adelaide researchers in 1994, many women reported finding the procedure itself, rather than the fact of having the abortion, the most traumatic. Many doctors' attitudes were poor and some refused to perform the procedure for discretionary reasons (eg the woman not using contraception), or routinely refused it but would not refer the woman to another practitioner who would perform an abortion. The researchers concluded that those practices would continue so long as abortion laws were unclear and doctors had control over the decision rather than the woman concerned.¹⁶⁵

The Public Health Association of Australia (PHA) is among a number of organisations that advocates access to safe, legal abortion as a human rights issue for women and claims also that the current legislative response is not capable of

¹⁶² L Teasdale, 'Confronting the Fear of Being 'Caught': Discourses on Abortion in Western Australia', *University of NSW Law Journal*, 22(1), 1999, pp 60-99, p 66.

¹⁶³ Excerpts from *Report of the Chief Justice's Task Force on Gender Bias (WA)*, excerpts 79-101, cited by the Children by Choice Association on its website <http://www.cbc.org.au>.

¹⁶⁴ Queensland, *Women's Taskforce Report* p 355, citing information from the Children by Choice Association's submission, p 17.

¹⁶⁵ L Ryan et al, 'We women decide: women's experience of seeking abortion in Queensland, South Australia and Tasmania 1985-1992', *Report of a Study Funded Through a Health and Community Services Research and Development Grant from the Commonwealth Department of Human Services and Health, Canberra*, Flinders University, Women's Studies Unit, 1994.

achieving public health goals.¹⁶⁶ It advocates that abortion be removed from criminal laws and that access to the procedure must be available through Medicare.¹⁶⁷

Justice Elizabeth Evatt has written –

*If equity and independence for women were highly valued, access to fertility control, to contraceptive and abortion services at reasonable cost, would also be a high priority. And yet it has been a constant struggle for women to gain and to keep the right to choose freely whether and when to have children.*¹⁶⁸

5.2.1 Accessibility

Abortion is now one of the safest and commonest medical procedures, particularly if performed in the early stages of gestation (5-14 weeks) where the risk of complication is around 1%. After 15 weeks, it rises to over 5%.¹⁶⁹ This demonstrates that women should not delay their decision about termination nor should they be impeded by administrative or financial requirements.¹⁷⁰ Interestingly, however, overseas studies have found that a large proportion of second trimester abortions are due to non-recognition of the pregnancy in its early stages rather than to factors such as long waiting periods, lack of access to facilities, or attitudes of doctors.¹⁷¹

Abortion services need to be accessible to women in terms of both availability and affordability. Even in countries where it is legalised, it might be too expensive and might not be covered by any public funding or private insurance such that women attempting to save for the procedure may wait too long or seek an abortion from an unauthorised person at a lower cost.¹⁷² India, for example, has liberal abortion laws

¹⁶⁶ PHA, Fact Sheet 4 – ‘The Health Impact of Criminal Codes on Abortion’.

¹⁶⁷ PHA Fact Sheet 7 – ‘Public Health Frameworks for Abortion’.

¹⁶⁸ Foreword by Justice Elizabeth Evatt in R Graycar & J Morgan, *The Hidden Gender of the Law*, 2nd ed, Federation Press, 2002, p viii. Justice Evatt is a former President of the ALRC, former Chief Justice of the Family Court and former member of member of CEDAW and of the United Nations Human Rights Committee.

¹⁶⁹ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*.

¹⁷⁰ PHA ‘Fact Sheet 3 – Abortion and Women’s Health.

¹⁷¹ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 47, citing a 1984 Royal College of Obstetricians and Gynaecologists (UK) study.

¹⁷² Alan Guttmacher Institute, ‘Abortion in Context United States and Worldwide’.

but many women are unaware of the availability of the procedure and few health services have authorised abortion facilities. It is also reported that in the early 1990s, many Australian women found that the issue of access to abortion services seemed to be determined by place of residence, access to information and financial means.¹⁷³ The more uncertain the legal position, the possibility of women from poorer backgrounds seeking unsafe abortions increases.

The PHA considers that the consequences of the current Australian legal position are that access to information about abortion services may be restricted and services are not readily accessible. In addition, ensuring that the procedure is performed by qualified and experienced health personnel can also be difficult. Finally, there is also a dearth of statistics about the incidence of abortion and the reasons why they occur, thus making education campaigns and services planning more difficult to target. The consequences, the PHA argues, impact more severely upon women from lower socio-economic backgrounds, or from rural areas, or with lower education standards that impair their capacity to navigate around the muddled arrangements that currently exist in many states and territories.¹⁷⁴ It considers that the current provision for abortion services across Australia does not meet stated goals for equity of access to health services as it is the most disadvantaged women who continue to suffer the most from reduced access to reliable information, counselling, and safe services for termination.

An Expert Panel of the National Health and Medical Research Council's findings, outlined in *An Information Paper on Termination of Pregnancy in Australia* (discussed below), found that termination of pregnancy services in public hospitals was generally inadequate, causing delays and forcing some women to pay for private services.¹⁷⁵ Inadequacy of services tended to be accompanied by a lack of accurate information and complex referral pathways. Because of concerns about legality, few women complain. The *Information Paper* noted the valuable role being played by the Children by Choice Association in Queensland which has provided information and referral for almost 100,000 Queensland women for over 20 years. It was suggested that the widespread underprovision of services for women reliant on the public health system could be reasonably regarded as having an indirect discriminatory effect against women in their access to health care.¹⁷⁶

¹⁷³ S Kift & L Willmott, 'Abortion Law Reform: Will Someone Decide Who Decides?' citing M Ripper & L Ryan, 'Women, Abortion and the State' (Special Edition: Women and the State: Australian Perspectives) (1995) 37 *J Aust Studies* 84, 86.

¹⁷⁴ PHA, Fact Sheet 4 – 'The Health Impact of Criminal Codes on Abortion'.

¹⁷⁵ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Introduction.

¹⁷⁶ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 10.

Accessibility was found to be better for private health services. The comment was made in the *Information Paper* that private specialised clinics in most jurisdictions provided prompt, good quality services. Planning and innovation of services has featured mostly in the free-standing clinics where there are dedicated and trained staff providing a safe, supportive environment for patients and there is also a sufficient caseload for the collective expertise and clinical skills to be maintained to high standards. However, the costs (even with the Medicare rebate and reduced rates for those unable to pay) were prohibitive for some women and these private facilities tend to be found mainly in major cities.

The *Information Paper* noted that while travel for other surgical procedures was generally assisted by government, travelling for an abortion was not usually covered (because terminations are usually provided by general practitioners, not by specialists on referral). Availability and affordability were, therefore, important factors in choosing to travel.

A Medicare rebate is provided for services performed by a registered provider other than in a public hospital to public patients (which have their own arrangements) but there are still out-of-pocket expenses that are incurred. It is also claimed that privacy fears held by some women means that around 10% do not claim the rebate.¹⁷⁷ Some women are dependent teenagers or women concealing rape.

In an AGB:McNair national community survey, undertaken for the Children by Choice Association, in August 1996, revealed that approximately 49% of respondents agreed that the cost of abortion should be met by Medicare and health insurance similar to the costs of other medical procedures.¹⁷⁸ A Newspoll survey of 1,200 people, commissioned by the *Weekend Australian* during September 1996, found that 65% supported the cost of an abortion being claimable under Medicare, with women being the strongest supporters (70%).¹⁷⁹

5.2.2 NHMRC Information Paper on Termination of Pregnancy in Australia

It has been suggested that, as at 1996, abortion, as an aspect of health care for women, had received little serious attention in health policy development, in planning and coordination in the delivery of services, or in the education of health

¹⁷⁷ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 5.

¹⁷⁸ AGB:McNair Survey Report for Family Planning Australia and Children by Choice, Melbourne, 1996.

¹⁷⁹ John Short, 'Strong majority supports Medicare funding for abortion', *Australian*, 28 September 1996, p 3.

professionals. The issue had not been the subject of national policy consideration since 1974, possibly due partly to its uncertain legal status regarding its circumstances, funding and organisation.¹⁸⁰

In 1996, the National Health and Medical Research Council (NHMRC) issued an *Information Paper on Termination of Pregnancy in Australia* (Information Paper). The NHMRC is a body within the Commonwealth Minister for Health portfolio, established to advise the community and governments on standards of individual and public health, provide advice on funding of research and training, and support medical advances.

The *Information Paper* began as a draft report prepared by an Expert Panel established to review the current arrangements for termination of pregnancy services, to recommend necessary improvements, and to consider methods of reducing the incidence of terminations. The NHMRC did not endorse the report but, instead, directed it be made available to the community and health bodies as an information paper.¹⁸¹ The NHMRC is not mentioned on the cover.

The Terms of Reference required the Panel, among other things, to review the available information on quality, availability and timeliness of services for the termination of pregnancy in Australia, and to recommend optimal arrangements for the provision of services, including counselling.

The Terms of Reference were, in keeping with the mandate of the NHMRC, structured to focus on health care aspects of abortion and the Expert Panel stated that it did not stray beyond those to address ethical issues. Therefore, the *Information Paper* takes, as its starting point, the fact that abortion services are provided to a significant number of Australian women each year; an accepted requirement that such health services should be of a high standard, with minimal complications and mortality rates; and that they be accessible on the basis of need as equitably as possible.¹⁸²

The *Information Paper* found that there was no evidence of any remaining demand for, or availability of, illegal services.¹⁸³ The majority of terminations are performed in private specialised clinics, day surgery units or by private practitioners in private or public hospitals. It found a low rate of procedures performed on public patients in public hospitals. However, at the time of reporting,

¹⁸⁰ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Introduction.

¹⁸¹ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Preface.

¹⁸² NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Foreword.

¹⁸³ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 5.

there were considerable differences in how and where abortions are performed, at what stage of pregnancy, by whom, and at what cost, with women in rural and remote areas faring poorly (as noted above). There was also similar variation in ease of access to good quality information, counselling and supporting care services.

The *Information Paper* suggested that the health system in Australia provides a significant level of service delivery to Australian women using a procedure that is defined and regulated under the criminal law. Of itself, abortion is a crime but there are exceptions that are stringently confined by requirements that vary between jurisdictions. The ambiguous legal status of abortions in many jurisdictions, such as Queensland, has a significant impact on the organisation, accessibility and timeliness of the services, particularly for women in rural areas. It was found that there was virtually no public hospital provision in Queensland except for serious foetal abnormality, with most services provided by private clinics in Brisbane, Townsville and Rockhampton. In jurisdictions where public facilities are available, it found that women face delays, particularly in jurisdictions where there is a legislative requirement for abortion to be performed at a hospital.¹⁸⁴

In terms of access and equity, the *Information Paper* found that rural women suffered disadvantage from the general undersupply of abortion services in the public sector and generally needed to travel to capital cities and (as noted above) without help from government travel assistance.

In a normal hospital setting, only a relatively small number of practitioners are inclined towards provision of abortion services. The reasons for this are many, including fear of harassment, remuneration disincentives, few well-trained teachers and training programs, and the uncertain legal situation exposing practitioners to potential prosecution and imprisonment.¹⁸⁵ It was noted that this situation required improvement through suitable training, support and remuneration.

It was found that women's decision making ability was hampered by the legal situation in most jurisdictions which requires the doctor to play a 'gatekeeping' role, which some doctors are not comfortable with. The practitioner must determine whether the woman's situation falls within the legal prerequisites allowing abortion. It was found that practitioners' interpretations of the relevant conditions can vary considerably and may well be influenced by personal opinions, with the claim made by many women's groups that the ambiguous laws give doctors power over the decision making process. Some doctors will neither

¹⁸⁴ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 7.

¹⁸⁵ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, pp 18-20.

perform the service nor provide a referral whereas other doctors will consider the woman as capable of deciding and perform the termination on that basis alone.

Conversely, many women find the necessary questioning (eg family, sexual, financial situation) to establish the requisite grounds intrusive and as establishing whether they 'deserve' an abortion. The same factors also impact on the access to and reliability of information provided to women.¹⁸⁶

The *Information Paper* found that the inconsistency between the law and the actual practice regarding abortion services has had an impact on access, information, training, recruitment and support of staff and quality of services. This has a counterproductive effect on woman's total health.¹⁸⁷

The NHMRC Expert Panel outlined a number of recommendations to improve abortion services which included –

- the need to maximise the autonomy women experience in decisions about their pregnancies, recognising that service providers must operate within the prevailing constraints of the legal system, including freedom from coercion from families and partners;
- the need to improve access to abortion services, particularly for rural women and those reliant on public health services, through arrangements with each regional health authority (to include a mix of public and private services);
- the need to improve the availability of information about abortion services, using existing roles and networks of service providers, family planning organisations etc;
- the need to ensure availability of appropriate non-directive and supportive counselling services at various stages in the experience, without coercion so that the final decision is always the woman's and ensuring that there is specific assistance to women who require the abortion due to foetal or maternal medical indications;
- that there be further efforts to provide supportive environments for staff of abortion services;
- that there be more efforts in education about sexuality, safe sex and contraception and improved access to reliable methods of contraception, including the 'morning-after' pill;

¹⁸⁶ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 28, also referring to previous studies of women's experiences eg Ryan et al.

¹⁸⁷ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, p 52.

- that upgrades be made to the provision of sex education in schools and similar settings, with attention being given to emotional and behavioural aspects as well as technical information;
- that there be further evaluation research which elicits women's experiences of abortion and unplanned pregnancy; and
- that findings of the *Information Paper* regarding the impact on service provision of the current legal position be referred to the ALRC for review.

5.3 SEX EDUCATION AND CONTRACEPTION

From July 2001 to May 2002, 9,874 Australian teenage women had an abortion.¹⁸⁸ The NHMRC Expert Panel's *Information Paper* also noted that there is a great need for further research and development in policy and programs to reduce unintended and unwanted pregnancy. It believed that it is unlikely there will be a significant reduction in the demand for abortion services without major change in sexual behaviour and/or major technical developments in other methods of fertility control.¹⁸⁹ Among its proposals were suggestions for improved sex education programs in schools and better access to emergency contraception, including allowing over the counter purchase of the 'morning-after pill'.

It is arguable that it is difficult to plan public health services, such as family planning organisations, without meaningful data and information about the need and use and relevancy of those services.¹⁹⁰

Family Planning Australia has indicated that available information relating to sexual and reproductive health, albeit limited, points to unmet needs and inequalities that require a public health focus to address those inequalities.¹⁹¹

The AGI, based in the USA, argues that rather than governments focusing on restricting abortion, it would be more appropriate to assist women in preventing unplanned pregnancies in the first place through improving access to

¹⁸⁸ Statistics downloaded from the Medicare Benefits Schedule Item Statistics page on the Health Insurance Commission's website at <http://www.hic.gov.au>.

¹⁸⁹ NHMRC, *An Information Paper on Termination of Pregnancy in Australia*, Introduction.

¹⁹⁰ Family Planning Australia Online, Rowling D, Medical Director, Family Planning Queensland, "Sexual and Reproductive Health is a Public Health Issue". At <http://www.fpa.net.au>.

¹⁹¹ Family Planning Queensland, 'Sexual and Reproductive Health is a Public Health Issue'.

comprehensive family planning services and promoting the effective use of contraceptives.¹⁹²

Despite the availability of the 'morning-after' emergency contraceptive pill to American women, the AGI has found that the rate of abortions among women in the USA (around 32.1 per 1000) was high compared with other developed countries. It believed that lack of access to effective and affordable contraceptives was a major factor contributing to unplanned pregnancies that resulted in abortion. Many American women do not have public or private insurance cover for contraceptives nor can they afford the high initial costs associated with many forms of the most reliable contraception methods. The AGI also advocated the need for the USA, as a leader in world affairs, to assist poorer nations in providing better contraceptive availability for women who might otherwise resolve unwanted pregnancies by turning to unsafe abortion.¹⁹³

It has been claimed that the South Australian experience has not realised the aim of reducing unwanted pregnancy through its reform of abortion law and channelling efforts into sex education programs and counselling. Since the passage of the amendments to the *Criminal Consolidation Act* in 1969, numbers of legal abortions have steadily increased, particularly in teenage girls. In 1998, teenage abortions accounted for 21.3% of the total number performed. That is despite school sex education programs and hospitals with abortion services offering counselling.¹⁹⁴

On the other hand, the Netherlands has some of the most liberal abortion laws and one of the lowest rates of abortions. It has been noted that contraceptive strategies and programs are widespread in that country and incorporate social, cultural, economic and religious factors and are targeted to community attitudes.¹⁹⁵

The high number of teenage abortions in Australia has prompted a leading university reproductive health expert to call for compulsory sex education in schools, with emphasis on safe sex programs which evidence apparently shows delays sexual experience. Professor Short claims that he had visited the Netherlands and Belgium which had the lowest teenage abortion rates because

¹⁹² AGI, 'Abortion in Context United States and Worldwide'.

¹⁹³ AGI, 'Abortion in Context United States and Worldwide'.

¹⁹⁴ M Bolling, 'Abortion Law Reform in South Australia: Have the Intentions Been Realised?', *History SA, the Newsletter of the Historical Society of SA*, March 2001, pp 14-16, p 15. downloaded from <http://www.history.sa.gov.au>.

¹⁹⁵ Western Australia. Department of Health, *Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion as introduced by the Acts Amendment (Abortion) Act 1998*, June 2002, p 41.

those countries do not perceive sex as a ‘sin’ and school nurses were allowed to distribute contraceptives to students.¹⁹⁶

5.4 SUGGESTED LEGISLATIVE REFORMS

There have been a number of proposals put forward by people and organisations in Australia concerning the legal means of achieving safety and equity of reproductive health services, including termination of pregnancy. As noted above, the *Women’s Taskforce Report* recommended repeal of the abortion provisions of the Queensland *Criminal Code* but made no recommendations about a new regulatory regime, concerned that any such framework might impose unduly restrictive requirements that impact on issues of equity and access.

The Public Health Association of Australia also urges repeal of legislative provisions criminalising abortion and believes that existing provisions in medical practitioners’ legislation in each Australian jurisdiction are adequate to ensure that abortion will only be performed by qualified medical practitioners and that their skill and competence are subject to peer review and community accountability. A number of states already have laws giving medical boards power to regulate and discipline practitioners (eg *Medical Practitioners Act 2001* (Qld)). Within this framework, the PHA considers that guidelines and standards for abortion procedures can be developed by bodies such as the Royal Australian College of Obstetricians and Gynaecologists, the Royal Australian College of General Practitioners and others. However, it believes that the system must ensure that the ultimate decision about abortion is the woman’s own but that a doctor needs to provide full disclosure of all material information, ensuring that the woman is aware of all the alternatives and is giving informed consent.¹⁹⁷

The approach taken in Western Australia, where regulation of abortion is governed by the *Health Act 1911* provisions, has been welcomed by a number of commentators. While abortion is still a criminal offence, that offence is committed only through non-compliance with the *Health Act 1911* and there is no sanction imposed on the woman concerned.¹⁹⁸ No doubt the recent changes to totally decriminalise abortion in the ACT will provide impetus for those seeking decriminalisation of abortion in other jurisdictions to pursue the matter with state and territory governments with greater determination.

¹⁹⁶ Erica Cervini, ‘Sex education call as teen abortion soars’, *AgeOnline*, 23 July 2002, at <http://www.theage.com.au>.

¹⁹⁷ Fact Sheet 7 – ‘Public Health Frameworks for Abortion’.

¹⁹⁸ A Duxbury & C Ward, ‘The International Law Implications of Australian Abortion Law’, p 27.

The issue has also become embroiled in the ‘stem cell’ debate. The Commonwealth *Research Involving Human Embryos Act 2002*, which provides a national framework for research on embryos and embryonic stem cells, was assented to on 19 December 2002.¹⁹⁹ Complementary Queensland legislation was passed in March 2003.

¹⁹⁹ Laura Tingle, ‘Senate passes embryo Bill’, *Australian Financial Review*, 6 December 2002, p 15.

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