

Women's Health West

Submission in response to 'The Law of Abortion: Information Paper'

Preamble

Without the ability and means to control their fertility and to be self-determined, experience pleasure, and be free from abuse in their sexual lives, women and girls cannot function as responsible, fully participating members of their families and communities – they cannot exercise citizenship (Petchesky, 2003: 10).

The Victorian government has a responsibility to act in the interests and according to the will of its citizens, who are overwhelmingly in favour of both the provision of safe and accessible abortion and women's right to choose an abortion for a range of reasons. The Menhennitt Ruling came in the wake of the state Liberal government being increasingly squeezed between its need for DLP preferences for re-election on the one hand and a community overwhelmingly in favour of liberalisation of abortion laws on the other. While the ruling provided a common law defence for medical practitioners acting in good faith, it also gave the government an excuse to avoid the 'hot potato' of abortion legislation. Nearly 40 years later, abortion remains a crime, while:

- over 80 percent of the community support women's choice in relation to abortion (Wilson et al, 2003)
- abortion is the most commonly performed surgical procedure in developed countries
- and abortion is a safe option for women when performed by a competent well-trained provider

Retaining an outdated law with the potential to require police officers to enforce a law that much of the community, including the police themselves, do not want enforced, aimed at imposing a specific moral code, and which, in the context of scarce resources and high 'crime' rates, is unenforceable, makes a mockery of the law. Women's Health West applauds the Victorian government's attempt to modernise the law in line with community sentiment and agreed upon practices and welcomes the opportunity to comment on the information paper.

Our submission is based on extensive research, direct service provision and policy development in the area of women's sexual and reproductive health. This includes the writer's role in providing pregnancy counselling and as coordinator of the Pregnancy Advisory Service at the Royal Women's Hospital for three years from 1990-93, and the completion of a PhD dissertation on the history of abortion law reform in Victoria, in 2004. We are happy to provide further information or clarification on request. Please contact Dr Robyn Gregory by email to robyng@whwest.org.au or by telephone on 9689 9588.

Discussion Questions

1. What ethical and legal principles should inform the law of abortion in Victoria?

There are a number of ethical and legal principles that should inform the law of abortion in Victoria. These are set out below.

First, women should have access to safe and legal abortions. This means that both women, and the medical practitioners carrying out their role in providing safe and competent reproductive health services, should be protected from prosecution by repealing the relevant sections of the *Crimes Act 1958*. Legal and unrestricted abortion allows for professional development, improvements in service quality, lower costs, more accessible services and the opportunity for women to explore whether or not abortion is the right decision for them.

Second, safe and legal abortion services should be developed and implemented with the explicit aim of promoting women's health and reproductive freedom, not as a method for controlling and regulating populations, or avoiding engaging with social issues of poverty and inequality.

Third, in order to do so, control over decision-making should lie with the pregnant woman, without pressure, or judgement as to the assumed validity of the reasons for her decision. It is the responsibility of the law to reflect the rights and responsibilities of citizenship. The right to choose abortion or motherhood is intrinsic to the citizenship status of women as a key indicator of autonomy and freedom (Gregory, 2004).

Fourth, Australia has an obligation, as a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), to ensure equity in access to health care services, including those related to family planning. However, some groups of women currently experience great difficulty in accessing safe and affordable services, for instance as a result of their age, the opinion of their medical practitioner or their geographical location.

Fifth, health professionals have an ethical and a legal obligation to respect women's rights, provide women with the full range of information available to assist in decision-making, protect the privacy of women who access their services, and provide a standard of best-practice care as agreed across the sector. Where a medical practitioner has a conscientious objection to providing abortion services or information, he or she must ensure appropriate and timely referrals to health professionals who do not share that objection.

Sixth, health professionals have the right to engage in provision of a range of services, and women to access those services, free from intimidation, harassment and/or harm. The current practice of allowing anti-abortion groups to picket women's reproductive health services must stop.

Finally, there is a legal and an ethical obligation to ensure transparency in advertising of 'false' providers.

2. What should be the policy objectives of any law of abortion? Are these currently met in Victoria?

Women's Health West do not believe that a law is required to control abortion. The policy objectives in terms of repealing abortion laws should be two-fold – to ensure safe, equitable, accessible and legal abortion for all Victorian women, and to institutionalise women's autonomy over reproductive decision-making.

In order to achieve this, abortion policy should aim to shape improvements to women's reproductive health services and to impact positively on the status of women, by including:

- Quality sexual and reproductive health services, including abortion, as core components of the Victorian health care system
- Access to the full range of reproductive health services, including abortion, regardless of women's geographical location
- Planning and provision of abortion services within a woman-centred care model that recognises and respects the rights of women to control their reproductive lives and to make decisions that are based on their personal knowledge and experiences
- Access to accurate and unbiased information to facilitate women making informed decisions
- The removal of barriers to timely provision of services to improve safety of outcomes for women (see comments in question 5 in relation to later terminations)
- Supportive non-compulsory counselling where requested
- Trained and properly equipped health service providers, working within guidelines of best-practice standards of care
- A statewide sexual and reproductive health policy geared to achieving positive health outcomes for women, including provision of good-quality family planning information and services to meet the diverse needs of groups of women, including adolescents, survivors of sexual assault and HIV-infected women

Few of these policy objectives are currently met in Victoria.

3. What factors should be taken into account in deciding if a termination is lawful?

- Consent of the pregnant woman?
- Threat to the life of the pregnant woman?
- Her physical and mental health?
- Social and economic factors when considering the physical and mental health of the woman?
- Other factors?

Women's Health West believe that the consent of the pregnant woman and the competence of the service provider are the only factors to take into account in deciding if a termination is lawful. It is each woman's circumstances and her knowledge of her own capacity and that of those around her that already guide her decision-making. Women make their decisions by consulting with those affected by the pregnancy, reviewing their own moral views and religious convictions, examining their physical, mental, social and economic capacity to bear and rear a child, examining the impact of a child on their existing children, partner or parents, the impact on their career or education, their – and the rest of their family's – capacity to support and care for a child with a disability, their age, marital status, citizenship and any other factors that influence the quality of life they could offer a child, or that makes parenting possible at that time.

There are a number of existing documents that could support the determination of informed consent. One excellent example is available from the Health Association of British Columbia at <http://www.whv.org.au/Articles/BC-abortion-care.pdf>.

4. South Australian legislation includes specific grounds for termination if the foetus is at risk of 'serious handicap'. How should this issue be considered in Victoria?

Women's Health West believes that women must be able to decide for themselves whether they are capable of caring for and supporting a child with a disability and that access to abortion must therefore cover the multitude of grounds upon which women will make their decision. Similarly, abortion should not be automatic and women should not be pressured into having an abortion where the foetus is identified as having a disability. Instead, women must be given every option to make an informed decision. This, rather than specifying particular grounds for termination, should be the key principle behind abortion provision.

We also recognise that while for most women in Australia abortion is conceptualised in liberal terms as a 'right', marginalised women can have a different experience of abortion and other birth-limiting technologies. This results largely from the introduction of oppressive policies that deny access to, or force poor, disabled or non-white women to use these technologies for eugenic or cost-saving purposes. Ample evidence is available to support claims that Aboriginal women in Australia had easy access to abortion and contraception at a time when white women's 'choice' in this regard was limited. Further, women with a disability, and

Aboriginal women particularly in the Northern Territory and Queensland, were regularly sterilised without their consent or knowledge. As a result, it is understandable that some oppressed groups, who have struggled to ensure that governments engage with social issues of poverty and inequality, are ambivalent about abortion. Just because abortion is legal does not necessarily mean that it will be safe and accessible. Just because abortion is widely available, does not necessarily mean that women have autonomy over sexuality or reproductive decision-making. Abortion does not, in itself, create reproductive freedom, but it is one of the conditions necessary for achieving that and improving the status of women.

It is specifically for these reasons that Women's Health West emphasise the importance of enshrining women's control over reproductive decision-making as key in the repeal of the relevant sections of the *Crimes Act 1958*. Women must have the right to choose or refuse an abortion – not to have access to abortion conditional upon government policies for controlling and regulating populations, or avoiding engaging with social issues of poverty and inequality.

5. In some jurisdictions, legislation contains different conditions for lawful termination, depending on the stage of the pregnancy. What are the advantages and disadvantages of this approach? Should Victoria take this approach?

Women's Health West does not support legislation setting out different conditions for lawful termination depending on the stage of the pregnancy. This is partly because the reasons for women seeking a termination in the second or third trimester are similar to the reasons women seek abortions in the first trimester, and partly because advances in medical technology – in terms of our capacity for foetal screening at later stages of gestation and for maintaining the life of babies born prematurely – are constantly changing, making the specification of timelines impractical. These difficulties will not be resolved by legislating to prevent termination at a particular stage.

The majority of Australian women who seek an abortion do so within the first trimester of their pregnancy, and those who do not would have preferred to have done so, given that a termination between 8-12 weeks gestation carries fewest medical complications. While data collection processes in Victoria make it difficult to identify the exact numbers of terminations carried out post 20-weeks gestation, data available indicates that a small number of women seek a second trimester abortion – 1.1 percent – either for psycho-social reasons or ones of foetal abnormality, and an even smaller number – 0.01 percent – seek a third trimester abortion largely for reasons of foetal abnormality that were not able to be picked up earlier in the pregnancy (DHS, 2004).

A UK study of 883 women who underwent an abortion between 13-24 weeks gestation, found three main reasons for the delay (Lee, 2004). The first was that women did not recognise that they were pregnant, generally because of irregular or continuing periods, coupled with the use of contraception. The second resulted from delays in accessing services after requesting a

referral from a general practitioner. This is a particularly pertinent point in Victoria, where the delays associated with accessing services for young women or women from rural or regional areas are well documented. The third, affecting 41 percent of women, revolved around various aspects of their relationships with their partner or parents, with 23 percent stating that their relationship with their partner had broken down or changed after they discovered the pregnancy, leading them to rethink their capacity to parent a child. This suggests that some women will seek second trimester abortions for the same reasons that women seek abortion in the first trimester – failure of contraception, difficulty negotiating an equitable relationship and so on – coupled with misidentification of pregnancy symptoms. Increasing access to safe and affordable abortion services, coupled with universally available sexual and reproductive health education, will have a major impact on reducing the numbers of second trimester abortions carried out in Victoria. Restricting services through legislation will simply increase the costs and reduce the safety of later term abortions, as women access clandestine or interstate services.

Where an abortion is requested in the third trimester – most likely as a result of advances in foetal screening and so the provision of greater information about the health status of the foetus, coupled with the increasing age of women having children and the higher risk of foetal abnormality – best practice standards adopted for provision of services at different gestational stages, not legislation, will be most effective for guiding both service provision and decision-making requirements.

6. If a staged approach is taken, on what basis do you determine a point in time in the pregnancy?

As outlined above, Women's Health West does not recommend nominating legislative conditions based on gestational stage. The decision of whether and when to seek a termination of pregnancy should be determined by the woman, in consultation with her medical practitioner and the various supports and procedures available through the adoption of best-practice standards of care.

7. What should be the role of the medical practitioner in deciding whether a termination is lawful and can proceed?

- Should these decisions be made by one or more practitioners?
- What sort of practitioners? GPs? Obstetricians and gynaecologists?
- Should the practitioner be required to notify the health department or similar body that the procedure has taken place?

One of the most positive aspects of Candy Broad's Crimes (Decriminalisation of Abortion) Bill 2007 was that she framed it in terms of *women's* control over reproductive decision-making *and* the right of the medical profession to exercise clinical judgement. These two principles – of women's autonomy and clinical judgement – should inform the role of the medical practitioner in recommending whether a termination of pregnancy is safe to proceed. This

includes the medical practitioner confirming whether or not a woman has consented freely to the procedure. Only one practitioner is required for this process – either a general practitioner or an obstetrician/gynaecologist. An inclusive approach is particularly important given the likely increased role of general practitioners in administering RU486 as it becomes more readily available, and to ensure geographical and economic equity for women who seek abortion services.

Advances in science and medical technology over the last century have come so fast that our ability to recognise the essentially moral decisions underpinning many medical procedures is sometimes limited (Albury, 1993). This has led to medical practitioners being handed the right to, in effect, exercise a social control as well as a public health function – including in the provision and regulation of abortion. With control over decision-making confirmed as the professional province of the physician in 1969, women have been in the position of having to appeal to the sympathy of their doctor in order to secure an abortion. This has an enormous impact on women's sense of self and autonomy and has also led to inequity in service provision and service outcome.

The essentially political nature of much of this decision-making process – particularly the role it might play in regulating women's sexuality and demanding that women behave 'morally' within a conservative Judeo-Christian framework – is masked by this largely unquestioning faith in the expertise of medical practitioners to control moral as well as medical decisions. In clarifying the role of the medical practitioner, it is timely to acknowledge that women are the best experts on their ability to bear and rear a child. Abortion policy and practice increasingly recognises this point and the law must change to stay in step with community attitudes.

The rules governing the notification of the procedure of abortion should mirror those required for the notification of other medical procedures, and should be limited to non-identifiable information to inform service planning and delivery.

8. Who should have the final say in deciding if a termination will take place?

The pregnant woman, free of coercion by others, should have the final say in deciding whether a termination will take place.

9. Should access to lawful termination be conditional upon attendance at counselling and information sessions? If so, what sort of counselling and information?

Access to termination should not be conditional upon attendance at counselling and information sessions. It is essential, however, that each woman is provided with the level of information and/or counselling that she requires, from information about the medical procedure, to timely, supportive and all-options counselling on request. This should be made available through hospitals, general practitioners, medical specialists, community health

centres, and other agencies that women are likely to attend for support in regard to an unplanned pregnancy.

The reasons for rejecting compulsory counselling are based on the experiences of the writer, who worked in a pregnancy advisory service for three years, where counselling prior to an abortion was compulsory regardless of the woman's circumstances, her reasons for seeking an abortion, or whether she wanted to see a counsellor. This largely bureaucratic procedure had developed, in part, in response to the lack of legal clarity offered by the Menhennitt Ruling.

Our aim as counsellors was to assist a woman through the crisis of an unplanned pregnancy without furthering the loss of control over her life already experienced as a result of that pregnancy. We found that compulsory counselling not only reinforced a lack of control, it sparked anger among women that they were assumed to be incapable of making a considered decision. Further, we understood that placing control over decision-making with the woman was crucial to effective counselling and a necessary adjunct to a woman's ability to take responsibility for her decision, particularly given that women who felt pressured into either continuing or terminating an unplanned pregnancy were more likely to experience regret. It also seemed that participating in a counselling process that compelled women to justify their decision as sound, unselfish and moral colluded in the oppression of women.

For the majority of women, the process of decision-making had positive consequences, perhaps all the more so for elucidating what was, and what was not, within each woman's ambit of control, including identifying the need for support in relation to sexual assault, violence in the home, addiction, mental health, and so on. Further, while a number of women grieved for the circumstances that might have allowed them to continue a pregnancy, such as a loving and supportive partner, good health or financial independence – feelings that are regularly exploited by anti-abortion 'counsellors' – these are not cases for compulsory counselling. In fact, while abortion is illegal, it might actually be the taboo of abortion, coupled with propaganda about long-term psychological problems and physical danger, which actually leads to some of the difficulties that women express. The percentage of women who found it difficult to make a decision was small compared with the overall rate of abortion, and usually centred on women who did not feel that they had the power to make a decision because of the circumstances of their lives. Abortion policy and practice should be to direct scarce resources towards those with the greatest need for support in decision-making, while reflecting women's autonomy in decision-making.

10. Should the law state that a medical practitioner has no duty to perform or assist a termination unless a woman's life is at risk?

The right of medical professionals to conscientiously object to the provision of some medical services is well established and there is a need for flexibility in the accommodation of a health care provider's choice not to participate in abortion procedures. It is equally important to

recognise the ethical and legal obligation of health care providers to provide appropriate care in emergency situations and to provide timely access to information about abortion and abortion services, including referral to a practitioner who does not hold similar views. Where a medical practitioner does object to providing a particular service, they should be required to notify their patients of this through appropriate material, such as a sign in the waiting room. The state government has a responsibility for ensuring that women are able to access the full range of reproductive health services, including abortion, regardless of their geographical location. This is particularly important in situations where women have access to only one service provider.

There is ample evidence that changes in abortion laws leading to more restrictive services result in a disastrous increase in abortion-related death and injury (Sachdev, 1988; WHO, 2003) and increases inequity in access to services. While personal values can be accommodated through recourse to best-practice health care standards and protocols, legislating to enshrine conscientious objection has the potential to negatively impact on equitable abortion provision. One of the strategies of anti-abortion groups to reduce or prevent abortion is to place pressure on medical practitioners not to provide services. This pressure is likely to have a greater impact on isolated practitioners in small communities, where women's access to reproductive health care services is already limited. Legislation – as opposed to using well-established practices – would provide a target for continued pressure, thereby reducing practitioners' protection from harassment and intimidation.

11. Does the offence of child destruction need to be changed in any way? If so, how?

The intent of section 10 of the Crimes Act is not currently clear. It appears to have been designed to respond to either an attack on a woman in the later stages of her pregnancy, where the assailant intended to harm the foetus, or instances where the foetus was killed in the process of delivery. Recourse in such circumstances is warranted. However, section 10 requires clarification of the intention of the law and must reflect that the offence of child destruction is not related to abortion where it is undertaken by a competent provider with the woman's consent.

12. Having considered the questions above, what are the key elements you would like to see in any new law of abortion in Victoria?

Women's Health West sees the removal of sections 65 and 66 of the *Crimes Act 1958* as the key element of change to abortion law in Victoria. Victoria does not require either a specific abortion law, or Menhennitt-style regulation under the *Health Act* (see below). The two principles of women's autonomy and clinical judgement should form the key elements of abortion policy and practice in Victoria. This reflects the requirement of both a right in law *and*

resources to enable those rights to be translated into reality by social provision of services to all women.

13. Is there anything else you would like to tell us?

It is rumoured that one of the options for removing abortion offences from the *Crimes Act 1958*, favoured by politicians, is to regulate abortion via the *Health Act* instead. This option might protect medical practitioners – and be seen to appease opponents of abortion – but it does not tackle the question of women’s right to control over reproductive decision-making. While women have greater access to abortion than in the 1960s, they are no closer to gaining real control over their bodies – with actions such as China’s one-child policy and reports of forced abortion demonstrating that it is not the availability of abortion alone, but control over reproductive decision-making, that is crucial to women’s equality within any society, making the ‘right to decide’ an important aspect of social, political and economic freedom (Gregory, 2004: 319).

Regulating abortion under the *Health Act* would shift control over reproductive decision-making from individual doctors to an expensive and bureaucratic state-sanctioned body. It does not acknowledge women as autonomous political and moral agents, does not question access to real social power and does not challenge the social relations between women and men. As a result, it will not impact on abortion rates for those who see this as the main policy objective of the law. The greatest method for reducing the rate of abortion remains improving the status of women. When women have – and believe they have – control over when and whether to engage in sexual intercourse; control over when to use, or demand that their partner use, contraception; freedom from discrimination and violence; and access to the material and social conditions that currently constrain individual women’s ability to bear and rear children; then, the rate of abortion will decrease. Legislating to remove barriers to women’s control, is a first step in affecting real change and a significant step towards improving the status of all women.

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