Respecting women’s autonomy and health

Termination of pregnancy law reform in the Northern Territory: Human Rights Law Centre’s submission to the Department of Health Discussion Paper

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1. Introduction

1. In December 2016, the Northern Territory Government published a Discussion Paper that contains various proposals to reform abortion laws in the Territory (the **proposed reforms**). The Human Rights Law Centre (**HRLC**) welcomes this opportunity to comment on the proposed reforms.

2. The HRLC is a national human rights organisations whose mandate includes the protection and promotion of women's reproductive rights. We have worked closely with Family Planning NT and What RU4 NT in relation to the proposed reforms.

3. Across Australia, the HRLC has advocated for the successful decriminalisation of abortion in Tasmania and Victoria, and for the current proposals to reform abortion law in Queensland. We also support safe access to abortion clinics. In 2015, we acted for the East Melbourne Fertility Control Clinic in its legal bid to end decades-long harassment by anti-abortionists out the front of its premises. We strongly supported safe access zone legislation in Victoria and the ACT.

2. Executive Summary

4. The Northern Territory Government has a unique opportunity to demonstrate its commitment to women's health and equality by comprehensively reforming the Territory's outdated abortion laws. Currently, the Territory's abortion laws are hopelessly out of step with community standards and clinical practice.

5. The Government should ensure that the new abortion law provides for safe and equitable access to abortion services for years to come, while also respecting women as competent decision-makers.

6. Laws that criminalise or restrict medical procedures only needed by women are a form of discrimination against women. Restrictive abortion laws don't prevent abortions; they lead to worse health outcomes for women and they threaten women's basic rights to life, health, equality and bodily autonomy. They also create uncertainty and fear for the medical profession and for women, making it harder to access services. Such laws also perpetuate wrongful stereotypes of women as incapable of making decisions about their own bodies.

7. As a result of restrictive abortion laws, women may be forced to carry an unwanted pregnancy to term, delayed in obtaining an abortion or seek out unsafe clandestine options, all of which can have deleterious impacts on women's health. These risks are heightened for those whose circumstances make accessing health services more difficult, including young women and girls, women living remotely, women with a disability, Aboriginal women, women of culturally

or linguistically diverse backgrounds and women who cannot afford to travel to jurisdictions with more liberal abortion laws.

8. The HRLC commends the Government's commitment to reforming abortion laws, guidelines and services in the Northern Territory. In particular, we are supportive of proposals that would:

   (a) improve access to medical abortion;

   (b) provide safe access zones around abortion services;

   (c) impose an obligation on health practitioners to refer where a conscientious objection is held; and

   (d) remove the requirement for parental consent for girls who are competent to provide consent.

9. It is encouraging that the Discussion Paper indicates a desire by the Government to bring the Territory's abortion legislation into line with contemporary standards and laws in other jurisdictions. There are however, serious shortcomings in the Government's proposals, which will significantly impair women's access to abortion services. In particular:

   (a) **There is a lack of clarity as to the extent to which abortion will be decriminalised**. The use of criminal law to regulate abortion creates fear for women and doctors and is a barrier to accessing an essential reproductive health service. In criminalising a service that only women need, the Northern Territory discriminates against women. The HRLC considers that reference to abortion in the *Criminal Code* (NT) should be repealed, including section 170, and replaced by:

      (i) a provision that makes it an offence for an unqualified person (but not a pregnant woman) to perform an abortion; and

      (ii) inserting into the definition of 'serious harm', the destruction of a pregnant woman's foetus, except during a medical procedure.

   (b) **Women will still be required to seek approval from doctors for their decision to have an abortion and ground their decision-making in psycho-social considerations**. What this means in practice is that doctors take on the role of gatekeeper and woman are viewed as incapable of making decisions about their bodies – they must seek approval for treatment, rather than making the decision themselves after receiving information and advice from their doctor. The NT government should reform the law to ensure that women have the right to choose to have an abortion at any stage of their pregnancy, without requiring a doctor to approve their decision. If the government wishes to place gestational limits on when a woman has the right to choose, such limits should not apply before 24 weeks.

(c) **There is no provision for abortion after 23 weeks pregnancy.** It is understood that the current law will apply after 23 weeks gestation, which only permits abortion to save a woman's life. Very few pregnancies are terminated after 20 weeks, but when they are, the circumstances are more likely to be distressing. The current law would force a woman to continue with a pregnancy where she is 24 weeks pregnant and has been told the foetus has a serious or fatal foetal abnormality, or where she is pregnant because of rape. The new abortion law must therefore allow abortion after 23 weeks in a broad range of circumstances, similar to the *Abortion Law Reform Act 2008* (Vic).

(d) **The proposal states that the provision of counselling will be a requirement before an abortion can be performed.** No evidence is provided by the Government to suggest that forcing women into counselling is beneficial for them. The new abortion law should not mandate counselling or a referral to counselling.

(e) **While doctors who hold a conscientious objection will have a duty to refer a woman to a doctor who does not hold such an objection, further reform is required.** First, the duty to refer should be extended to other health professionals, including counsellors, who might be a woman's first point of contact for information about her options. Second, the law must ensure that in medical emergencies, where an abortion is required to save a woman's life or prevent serious harm, doctors and nurses with a conscientious objection are still compelled to perform or assist with an abortion. This approach balances the right of health professionals to act in accordance with their conscience and religious beliefs with the right of women to life, health and autonomy.

10. The HRLC is aware of the unique demographics of the Northern Territory, in particular the relatively high proportion of the population living in remote Aboriginal communities. This clearly poses challenges in terms of equitable access to culturally appropriate reproductive health services, which this submission does not address. Further, this submission does not address the development of guidelines that are need to complement the law and ensure abortion services are delivered safely. Our recommendations are aimed at ensuring that *the law* does not stop any woman in the Territory from accessing the information and support she needs to help her make an informed decision in the event of an unintended pregnancy, or the medical treatment she requires should she decide to terminate her pregnancy.

3. Summary of recommendations

Recommendation 1: Sections 170 and 208A-C of the *Criminal Code* (NT) should be repealed and replaced with:

a. a provision that makes it an offence for an unqualified person to perform an abortion on a woman (without criminalising the conduct of the woman seeking an abortion); and

b. an amendment to the definition of 'serious harm' in section 1 of the *Criminal Code* (NT) to include 'the destruction of a foetus of a pregnant woman, other than in the course of a medical procedure'.

Recommendation 2: The Northern Territory Government should reform the law to ensure women have the right to choose to have an abortion, without requiring approval from a medical practitioner. If the Government wishes to place gestational limits on when a woman has the right to choose, such limits should not apply before 24 weeks gestation.

Recommendation 3: For pregnancies of more than 24 weeks gestation, if the approval of two doctors is considered necessary by the Northern Territory Government, then the law should permit abortion where it is considered appropriate, taking into account a woman's medical circumstances, and her current and future physical, psychological and social circumstances.

Recommendation 4: The new abortion law should not require counselling or a referral to counselling.

Recommendation 5: The duty proposed in the Discussion Paper – for medical practitioners who hold a conscientious objection to abortion to refer a woman to a medical practitioner known not to hold such an objection – should extend to all health practitioners, including counsellors.

Recommendation 6: The law should state, as an exception to the right to conscientiously object, that medical practitioners, nurses and midwives, have an obligation to perform or assist with the termination of a pregnancy in cases of emergency where it is necessary to save a women's life or prevent serious physical harm.

4. Human rights law and abortion

Decriminalising abortion and improving access is consistent with human rights law

11. The Northern Territory has a duty to guarantee all women and girls safe access to abortion services and post-abortion care.[1]

12. Laws that criminalise or restrict medical procedures only needed by women are recognised as a form of discrimination against women.[2] They threaten women's basic rights to life, health, equality and bodily autonomy. They are associated with poor health outcomes because women may be forced to carry an unwanted pregnancy to term, delayed in obtaining an abortion or seek out unsafe clandestine options.[3] Such laws also perpetuate wrongful stereotypes of women as incapable of making decisions about their own bodies.

The limited rights of a foetus

13. The fundamental principles of equality and non-discrimination require that the rights of a pregnant woman be given priority over an interest in prenatal life. Under international human rights law, although a foetus has some rights as a potential person, it has not been found to have a right to life. This is because protecting a right to life before birth could conflict with human rights protections for women. Or as the European Court of Human Rights put it: "the unborn child is not regarded as a 'person' directly by Article 2 of the Convention [right to life] and that if the unborn do have a 'right' to 'life' it is implicitly limited by the mother's rights and interests", including her rights to life, health and privacy.[4]

14. The view of the Australian Government is that the right to life under the *International Covenant on Civil and Political Rights*[5] was 'not intended to protect life from the point of conception but only from the point of birth.'[6]

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[1] Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health* E/C.12/GC/22 (2016) [28]. Australia is a party to the key international human rights treaties. The treaties apply throughout the states and territories and apply to the Northern Territory government under international law.

[2] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, A/54/38/Rev 1 (1999) [11]; United Nations Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication no. 2324/2013*, CCPR/C/116/D/2324/2013 (9 June 2016) [7.9]-[7.11].

[3] Juan Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment*, A/HRC/31/57 (5 January 2016) [43]; Anand Grover, *Report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health*, A/66/254 (3 August 2011) [21].

[4] *Vo v France*, App No 53924/00, Eur. Ct HR, 80 (2004); *A, B and C v Ireland*, App No 25579/05, Eur Ct HR 237-238 (2010).

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

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

5. Responses to the Discussion Paper

Decriminalisation of abortion

15. The criminal law is an inappropriate and harmful tool for the regulation of abortion. The use of criminal law to regulate access to an essential reproductive health service is archaic and discriminatory. It compromises the physical and mental health of women and girls and is inconsistent with community values and current clinical practice.

16. The Northern Territory should follow the example of other jurisdictions that have recently reformed their abortion laws, and completely decriminalise abortion where it is performed or directed by a qualified practitioner with a woman's consent. Such action is required for the Northern Territory's laws to be consistent with its human rights obligations towards women.[7]

The current law in the Northern Territory

17. Access to an abortion by women in the Northern Territory is currently only lawful in circumstances set out in section 11 of the *Medical Services Act* (NT) (**MSA**). Outside of section 11, the procuring of an abortion, or the supply of things to procure an abortion, is an offence under sections 208A-C of the *Criminal Code* (NT).

18. Section 170 of the Criminal Code criminalises 'killing an unborn child' and could apply to abortions where the foetus is capable of being 'born alive' (sometimes referred to as a 'late term abortion'). Section 170 is worded in such a way as to create uncertainty about the circumstances in which a late-term abortion performed with a woman's consent by a qualified practitioner could be the subject of a criminal prosecution.[8]

Proposed reform

19. While the Discussion Paper refers to the decriminalisation of abortion where performed by a suitably qualified medical practitioner, it also states that abortion will remain a criminal offence 'under other circumstances'.[9] There is also reference to the need to 'distinguish termination of pregnancy and unlawful termination of pregnancy'.[10]

20. There is insufficient clarity in the Discussion Paper to assess the extent to which abortion will be decriminalised.

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[7] Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health* E/C.12/GC/22 (2016) [40].
[8] For discussion of this issue in relation to a similarly worded provision that used to exist in Victorian law see Victorian Law Reform Commission, *Law of Abortion* (Final Report, 2008), ch 7.
[9] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016), Attachment 3.
[10] Ibid, 3.

HRLC's position

21. The use of criminal law to regulate access to abortion creates uncertainty and fear for the medical profession and for women. It makes it harder for women and girls to access an important reproductive health service. It compounds the barriers to access experienced by young women and girls, and those who live regionally or remotely, who speak English as a second language or who lack the financial means to travel.[11]

22. In 2005, the Public Health Association of Australia observed that the legal status of abortion directly affects the planning, safety and quality of reproductive health services and called for all state and territory governments to remove abortion from criminal laws.[12]

23. More recently, a Parliamentary inquiry in Queensland observed that since the decriminalisation and reform of abortion laws in Victoria in 2008, medical practitioners "can now focus on practicing in accordance with evidence based clinical standards to address women's health care needs, free of the threat of criminal proceedings".[13]

24. The HRLC considers the criminal law to be an inappropriate tool to regulate abortion, except to deter unqualified persons from performing abortions on women, or to deter people from attempting to destroy a woman's foetus without her consent. Performing a procedure on a woman without her consent would of course already constitute a criminal offence.

25. Any criminal provisions that seek to prevent the destruction of a foetus by an unqualified person or to ensure appropriate punishment where a criminal act results in the destruction of a foetus, must be appropriately adapted to this purpose and not capable of extending to late-term consensual abortions performed by qualified practitioners.

26. The Northern Territory Government should adopt the approach taken in Victoria in 2008, which followed an extensive inquiry by the Victorian Law Reform Commission:

    (a) repeal provisions relating to abortion from the *Criminal Code* (NT);

    (b) create an offence making it unlawful for an unqualified person to perform an abortion (but without criminalising the conduct of a woman in seeking the abortion); and

    (c) amend the definition of serious harm in section 1 of the *Criminal Code* (NT) to include the destruction of a pregnant woman's foetus other than in the course of a medical procedure.[14]

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[11] Public Health Association of Australia, *Abortion in Australia: Public Health Perspectives* (2005) 12.
[12] Ibid.
[13] Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into Law Governing Termination of Pregnancy in Queensland* (Report No 24, August 2016) 63.
[14] This is similar to the approach in New South Wales where the *Crimes Act 1900* (NSW) includes the destruction of a foetus of a pregnant woman in the definition of 'grievous bodily harm: s 4.

Recommendation 1

Sections 170 and 208A-C of the *Criminal Code* (NT) should be repealed and replaced with:

a. a provision that makes it an offence for an unqualified person to perform an abortion on a woman (without criminalising the conduct of the woman seeking an abortion); and

b. an amendment to the definition of 'serious harm' in section 1 of the *Criminal Code* (NT) to include 'the destruction of a foetus of a pregnant woman, other than in the course of a medical procedure'.

Gestational limits and third party approval

27. Currently, the law in the Northern Territory puts doctors in the position of gate keeper over women's access to abortion services by requiring women to obtain approval from doctors. In doing so, women are being told that they cannot be trusted to make decisions about what is right for their body, their families, their lives. The Government's proposal fails to redress this dynamic. The new law should framed in a way that respects the autonomy and decision-making capacity of women and their right to control what happens to their health and body.[15]

The current law in the Northern Territory

28. Currently, section 11 of the MSA outlines different criteria that must be met before an abortion can be performed based on the duration of a woman's pregnancy. Different rules apply to pregnancies of not more than 14 weeks and pregnancies up to 23 weeks.[16] Pregnancies over 23 weeks may only be terminated 'for the sole purpose of preserving' a woman's life.[17]

29. There is no clear rationale for the differing criteria based on 14 weeks and 23 weeks gestation. Certainly, the differing criteria is not justified by current medical evidence, nor is it consistent with clinical practice in other jurisdictions.

Proposed reform

30. The changes proposed in the Discussion Paper broaden, albeit to a limited extent, a woman's eligibility for an abortion. However, the 14 week and 23 week gestational periods are maintained as arbitrary points at which eligibility for an abortion changes. Alarmingly, there is no reference to abortion after 23 weeks of pregnancy.

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[15] Consistent with the requirements of the right to health in the *International Covenant on Economic, Social and Cultural Rights*: Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health* E/C.12/GC/22 (2016) [28]. See also see Centre for Reproductive Rights, *Safe and Legal Abortion is a Woman's Human Right* (Briefing Paper, 2011).

[16] *Medical Services Act* (NT) ss 11(1)-(2) in relation to pregnancies not more than 14 weeks; s 11(3) in relation to pregnancies not more than 23 weeks.

[17] Ibid s 11(4). Abortion to save a woman's life is permitted at any stage of pregnancy, but is the only circumstance in which it is permitted after 23 weeks gestation.

31. The proposal set out in the Discussion Paper requires women to seek the approval of one doctor up to 14 weeks pregnancy, and two doctors (including a gynaecologist or obstetrician) up to 23 weeks. In all pregnancies up to 23 weeks, medical approval for an abortion would be subject to a practitioner considering all relevant clinical and psycho-social matters, including the woman's current and future physical, psychological and social circumstances.

32. Of further concern, is that the proposal inserts a requirement for the provision of counselling. Counselling is discussed further below.

33. The Government has not provided any medical evidence or referred to any clinical necessity for such restrictive reform proposals.

HRLC's position – pregnancies up to 24 weeks gestation

34. The proposed changes relating to pregnancies of up to 23 weeks gestation fail to respect women's autonomy and promote women's health because they:

    (a) require the approval of one or two doctors (including a gynaecologist or obstetrician, between 14 and 23 weeks of pregnancy);

    (b) require women and doctors to medicalise a woman's decision-making to terminate an unwanted pregnancy by pointing to clinical and psycho-social issues; and

    (c) require women to undergo counselling.

35. The Discussion Paper frames the proposed reforms in terms of medical practitioners forming an 'opinion about eligibility'[18] for abortion after considering 'all relevant clinical and psycho-social matters'.[19] While the proposed reforms are an improvement on the current law, it is troubling that access to abortion is framed as a question of eligibility, determined by one or two medical practitioners. This places doctors in the position of ultimate gate keeper to abortion services, which is of particular concern in light of the small number of practitioners in the Northern Territory willing and qualified to provide abortion services.[20]

36. The Northern Territory has an obligation to eliminate practices that are based on inferiority or superiority of women or men and practices based on stereotyped roles.[21]

37. The requirement for one or two medical practitioners to approve a woman's decision based on psycho-social circumstances is inconsistent with adults' usual role as primary decision-maker

[18] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016), 4.
[19] Ibid, 3.
[20] The resignation of the only permanent doctor at the Royal Darwin Hospital willing and qualified to provide abortion services caused concern about access to abortion in 2015: see Alyssa Betts, 'Push to Improve Access to Abortion Services by Northern Territory Doctors', *Australian Broadcasting Corporation* (online), 27 January 2015) <http://www.abc.net.au/news/2015-01-27/nt-doctors-call-for-abortion-law-reform-to-improve-access/6048070>.
[21] *Convention on the Elimination of All Forms of Discrimination Against Women*, arts 2(f), 5(a) and 12.

about their own medical procedures. It situates women as incompetent decision-makers and in need of protection. As Rebecca Cook and Simone Cusack explain:

> The false stereotype of women as incapable of making rational decisions is persistent in the health sector… Gender-paternalistic stereotypes have enabled the development of a women-protective rationale for limiting access to therapeutic abortion.[22]

38. The Northern Territory does not need to reinvent the wheel. Victoria's abortion laws were reformed in 2008 following a comprehensive review by the Victorian Law Reform Commission. In Queensland, a parliamentary committee is currently considering two abortion law reform bills that would result in similar laws to those in Victoria.[23]

39. The Victorian reforms respect the autonomy of women by allowing a woman to seek an abortion without having to justify her decision or seek out approval up to 24 weeks gestation.[24] A similar law exists in Tasmania, but is unnecessarily limited to pregnancies up to 16 weeks gestation.[25] If the Northern Territory intends to impose a gestational limit, it should follow Victoria's example, as it gives greater autonomy to women for a longer period that is, to some extent, reflective of the period at which a foetus is viable.

40. In the Australian Capital Territory, abortion is regulated no differently in law to other medical procedures, except that medical facilities must be approved to provide abortion services.[26] There are no gestational limits in law, nor any requirement for two doctors to approve an abortion.

41. Against this backdrop, it can be seen that the proposal in the Discussion Paper for pregnancies of up to 23 weeks is unduly restrictive. It is not appropriate to give doctors the final say about whether an abortion is right for a woman based on 'psycho-social circumstances' and it is not necessary to have two doctors approve what is a relatively straightforward and safe medical procedure.

42. Framing the law in a way that positions medical professionals as the ultimate authority over women's decision-making should be avoided. As with other medical procedures, it should be a woman's decision as to whether she has an abortion, made in consultation with her doctor.

43. The Northern Territory should either entirely remove gestational limits on a woman's right to choose to have an abortion; or it should it at least allow women to choose to have an abortion without having to justify their decision or seek third party approval up to 24 weeks gestation.

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[22] Rebecca Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press, 2010) 86-87.
[23] Health (Abortion Law Reform) Amendment Bill 2016 (Qld) cl 4.
[24] *Abortion Law Reform Act 2008* (Vic) s 4.
[25] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4. Third party consent requirements at 16 weeks operate as an impermissible barrier to reproductive health services.
[26] *Health Act 1993* (ACT) pt 6.

Not only would this communicate to women that their autonomy and health is respected, it would simplify the law and provide much needed clarity to the health profession and women.

Recommendation 2

The Northern Territory Government should reform the law to ensure women have the right to choose to have an abortion, without requiring approval from a medical practitioner. If the Government wishes to place gestational limits on when a woman has the right to choose, such limits should not apply before 24 weeks gestation.

HRLC's position – pregnancies of more than 24 weeks

44. Very few abortions occur after 20 weeks pregnancy – approximately one to two percent.[27] The circumstances in which these abortion occur are typically distressing. For example, a serious or fatal foetal abnormality or a serious health condition in the pregnant woman which means she cannot carry the pregnancy to term without risking her life.

45. There is no proposal in the Discussion Paper that relates to pregnancies of more than 23 weeks. We understand however, that it is the Government's intention to incorporate the current provisions into the new law.

46. The law currently prohibits abortion after 23 weeks gestation except to save a woman's life. This is too narrow. It would for example, require a woman who has been told that her foetus has a fatal chromosomal abnormality to continue with her pregnancy. Such a situation was recently found by the United Nations Human Rights Committee to amount to cruel, inhuman and degrading treatment.[28] It would also require a woman pregnant as a result of rape to continue with her pregnancy. These outcomes are unacceptable and woefully out of step with community values.

47. If the approval of two doctors is considered necessary by the Government for pregnancies of more than 24 weeks pregnancy, the circumstances in which the law permits abortion after 24 weeks should be broadly worded to take into account the range of circumstances in which woman may need to seek an abortion. We recommend a provision similar to section 5 of the *Abortion Law Reform Act 2008* (Vic). This requires two doctors to take into account a woman's full circumstances, including medical, physical, psychological and social circumstances, in determining whether an abortion is appropriate.

[27] See SA Health, *Pregnancy Outcome in South Australia 2014* (2016), 12. Only South Australia publishes data on induced abortion and the most recent analysis nationwide data that could be found was Narelle Grayson et al, 'Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia' (Australian Institute of Health and Welfare, 2005) 51. As Grayson et al discuss, the analysis of abortion data is complicated because there is no single national data collection about induced abortions.

[28] This case concerned restrictive abortion laws in Ireland. See United Nations Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication no. 2324/2013*, CCPR/C/116/D/2324/2013 (9 June 2016) [7.3]-[7.5].

Recommendation 3

For pregnancies of more than 24 weeks gestation, if the approval of two doctors is considered necessary by the Northern Territory Government, then the law should permit abortion where it is considered appropriate, taking into account a woman's medical circumstances, and her current and future physical, psychological and social circumstances.

A requirement for counselling

48. The Government's proposal inserts a requirement for information and counselling to be provided to a pregnant woman, about her 'current choices and future contraceptive options'.[29]

49. In its extensive review of abortion laws, the Victorian Law Reform Commission considered the question of whether counselling should be mandated. The Commission found that the provision of counselling is a 'clinical matter best left to professional judgment based on a woman's circumstances'.[30]

50. The Commission 'did not find evidence that forcing women into counselling is necessary or advisable.'[31] It recommended that abortion laws not include a requirement for counselling or a referral to counselling.[32] The Northern Territory should take heed of these findings and not include a requirement for counselling in the new abortion law.

Recommendation 4

The new Northern Territory abortion law should not require counselling or a referral to counselling.

Access to medical abortion

51. We are encouraged that the Northern Territory Government intends to ensure that women with an unwanted pregnancy will have the choice of a medical abortion (taking the drugs mifepristone and misoprostol), rather than a surgical abortion, in the first 9 weeks of pregnancy, consistent with all other jurisdictions in Australia.[33]

52. Medical abortions can be undertaken outside of hospital settings by healthcare professionals who have been trained and registered through the MS 2 Step program. The reforms would allow for a qualified doctor to direct registered pharmacists, nurses and nurse practitioners to

[29] Department of Health (NT), *Termination of Pregnancy Law Reform; Improving Access by Northern Territory Women to Safe Termination of Pregnancy Services* (Discussion Paper, 2016), 3.
[30] Victorian Law Reform Commission, *Law of Abortion* (Final Report, 2008) [8.139].
[31] Ibid [8.122].
[32] Ibid, recommendation 5.
[33] A medical abortion involves taking the drugs mifepristone and misoprostol, which have been listed on Australia's Pharmaceutical Benefits Scheme for use in terminating pregnancies since 2013.

prescribe, supply or administer the medicines. The approach suggested in the Discussion Paper to managing risks by requiring medical practitioners to act in accordance with professional standards and guidelines appears sensible.

Conscientious objection

53. Current law in the Northern Territory unjustifiably prioritises a health professional's right to religious expression over a woman's rights to bodily autonomy and health. Section 11(6) of the MSA allows a person to object to any involvement in a termination of a pregnancy where that person holds a conscientious objection. There is no obligation to refer a woman to a health professional without such an objection. Further, the MSA does not make it clear that despite holding a conscientious objection, doctors and nurses must, in cases of medical emergency, assist with an abortion where required to save a woman's life or prevent serious harm.

54. We support the proposal in the Discussion Paper to introduce a duty for a medical practitioner with a conscientious objection to refer a woman to another practitioner who is known not have a conscientious objection.

55. The HRLC considers it important that the duty to refer extends beyond medical practitioners and include all health practitioners, including counsellors. Counsellors may be the first service that a woman contacts for assistance. The religious or moral values of a counsellor, or any other health professional, should not impede a woman from accessing information about all her treatment options.[34]

56. It is also critical that the law expressly states that in cases of medical emergency, where an abortion is necessary to save a woman's life or prevent serious physical harm, medical practitioners, nurses and midwives have an obligation to perform, or assist in, the termination of a pregnancy. This is in line with the approach taken in Tasmania[35] and proposed reforms in Queensland.[36]

57. Such an approach strikes the appropriate balance between the right of the health professional to freedom of conscience and religion and women's rights to life, health, non-discrimination and bodily autonomy.[37]

[34] This is consistent with Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* A/54/38/Rev 1 (1999) [11].
[35] *Reproductive Health (Access to Terminations) Act 2013* (Tas). A similar provision exists in Victoria but only compels a doctor or nurse to participate in an abortion where a woman's life is at risk (not where she is at risk of serious physical harm): *Abortion Law Reform Act 2008* (Vic) s 8(3)-(4).
[36] Health (Abortion Law Reform) Amendment Bill 2016 cl 4.
[37] Note that the right to freedom of religion can be limited in certain circumstances, including to protect health and to protect the rights and freedoms of others: *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 (entered into force 23 March 1976) art 18(3).

Recommendation 5

The duty proposed in the Discussion Paper – for medical practitioners who hold a conscientious objection to abortion to refer a woman to a medical practitioner known not to hold such an objection – should extend to all health practitioners, including counsellors.

Recommendation 6

The law should state, as an exception to the right to conscientiously object, that medical practitioners, nurses and midwives, have an obligation to perform or assist with the termination of a pregnancy in cases of emergency where it is necessary to save a women's life or prevent serious physical harm.

Safe access zones

58. Experience in Victoria and other jurisdictions shows that women seeking abortions and staff at clinics providing abortion services may be severely affected by the intimidating and abusive behaviour of some anti-abortion protestors outside abortion clinics.[38]

59. We are therefore supportive of the proposal to introduce safe access zones around clinics or hospitals that provide abortion services in the Northern Territory. This is consistent with developments in Tasmania, Victoria and the ACT[39] and a current proposal in Queensland.[40]

60. Safe access zones engage the right to freedom of expression of anti-abortionists. However, that right is not absolute and may be limited.[41] Sensible safe access zones, enacted for a legitimate purpose of protecting women's right to privacy and dignity whilst seeing their doctor, and in a form that is proportionate, are consistent with human rights.

The rights of girls under 16 years of age

61. Section 11(5)(b) of the MSA requires the consent of 'each person having authority in law' before an abortion can be performed on a girl under 16 years of age. Requiring the consent or notification of a parent may act as a deterrent to a young person seeking help, result in delayed treatment and ultimately lead to adverse health consequences and resort to unsafe clandestine abortion. These risks are heightened when two parents are required to consent. Further, a girl may be forced to seek the consent of an estranged or abusive parent.

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[38] See discussion in Victorian Parliament, 2 September 2015, referencing the evidence put before the Supreme Court by East Melbourne's Fertility Control Clinic: <http://www.parliament.vic.gov.au/images/stories/daily-hansard/Council_2015/Council_AugDec_2015_Daily_2_September_2015.pdf>. In some jurisdictions, protest outside clinics has led to violence against patients or staff, for example, the murder of security guard Steve Rogers at the East Melbourne Fertility Control Clinic in 2001.
[39] *Reproductive Health (Access to Terminations) Act 2013* (Tas); *Public Health and Wellbeing (Safe Access Zone) Amendment Act 2015* (Vic); *Health (Patient Privacy) Amendment Act 2015* (ACT).
[40] Health (Abortion Law Reform) Amendment Bill 2016 (Qld) cl 4.
[41] *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 (entered into force 23 March 1976) art 19(3).

62. We support the proposal put forward in the Discussion Paper to remove any requirement in the statute for parental or guardian consent for girls of a certain age. This is the approach in Victoria and Tasmania and also reflects the approach taken to other medical procedures required by persons under 16 years in the Northern Territory. In practice, it requires medical professionals to assess the competency of the child to provide informed consent.[42]

63. Such an approach enables medical professionals to act in a child's best interests, where they are competent to give consent and the notification of a parent is likely to cause them harm.[43]

[42] This is consistent with the common law position, as first articulated in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
[43] Article 3 of the *Convention on the Rights of the Child* requires that the best interests of the child be the primary consideration in all actions concerning children.