Submission to the Queensland Law Reform Commission review of termination of pregnancy laws consultation paper

February 2018

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Introduction
1. In December 2017, the Queensland Law Reform Commission (QLRC) released a consultation paper regarding the review of termination of pregnancy laws (in QLD).

2. Marie Stopes Australia thanks the QLRC or the opportunity to make a submission in response to the questions outlined in the QLRC consultation paper.

3. Marie Stopes Australia (MSA) provided the QLRC with data in November 2017 to assist them in the development of the consultation paper.

4. Failure to reform termination of pregnancy laws in Queensland will continue to discriminate against QLD women in how, where and what they are able to access in regards to essential sexual and reproductive health services.

5. Queensland women are not afforded the same reproductive rights as women who live in other States/Territories throughout Australia.

6. Termination of pregnancy (medical or surgical) is a health issue not a legal issue.

Background
7. MSA is the only national, not-for-profit provider of sexual and reproductive health services in Australia. Through our 14 clinics and telehealth we currently provide services 6 days per week, 24 hour aftercare and counselling supports.

8. Working across private and public sectors, our profits are returned to our social enterprise to enable vulnerable women in Australia and the Asia Pacific region access to abortion and contraception where they would not normally be able to.

9. Our National support centre (NSC) allows access to a one-stop-shop for women and men’s sexual and reproductive health needs, with the ability to make same day bookings or access to services generally within 24 - 48hrs regardless of where they live. The NSC supports over 110,000 callers confidentially and in a non-judgemental way annually.

10. MS Health, a pharmaceutical subsidiary of MSA is the sponsor and sole importer of medication abortion in Australia, supporting around 1,400 prescribers and 3,300 dispensers nationally. MSA invested over $6.0 million privately to ensure women in Australia are afforded choice when seeking a termination of pregnancy through the registration of Mifepristone in Australia.

11. As a demonstrated leader in the provision of safe and high quality SRH care, MSA:
   - Is fully accredited against the Australian Council of Health Care Standards and successfully gained seven (7) met with merit evaluations;
   - Identifies service system gaps and works with government and partners to develop local sexual and reproductive health (SRH) capacity, strategically ensuring SRH services are best placed to meet future needs and demands, where people live;
   - Values education and integrated health promotion in meeting the impact of social and environmental determinants of health as a cause of sexual and reproductive health inequity;
   - Employs a trauma-informed response to our service delivery, particularly in the area of abortion counselling;
   - Identifies and supports meaningful opportunities for consumers, carers and other stakeholders to both partner with MSA in the design and delivery of SRH throughout Australia and participate in local policy and practice discussions; and
   - Models and trials new and innovative SRH infrastructure and service delivery models throughout Australia.

12. Where a woman lives greatly influences her ability to access or exercise choice in accessing and using SRH services. This creates a tiered health care system favouring access to SRH services by socioeconomic status and victimising women by place of residence. MSA has established a philanthropic fund in an attempt to address this issue. However more needs to be done to address this issue, particularly in QLD where this is particularly acute.
MSA SUBMISSION

Consultation questions

Who should be permitted to perform or assist in performing terminations?

Q1. Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

13. Throughout Australia and including Queensland, only medical practitioners (general practitioners and Obstetrician/Gynaecologists) that are registered with AHPRA and that have completed specialised training in the provision of surgical terminations of pregnancy conduct surgical abortions. There is no reason why this should change in Queensland.

14. Currently throughout Australia including Queensland, only medical practitioners (general practitioners and Obstetrician/Gynaecologists) that meet the certification requirements as determined by MS Health and the TGA can prescribe the medications for medical termination of pregnancy. This could be extended to suitably qualified and experienced Nurse practitioners.

15. Medical practitioners including General Practitioners, Obstetrician/Gynaecologists and Nurse Practitioners should be permitted to assist women in performing a medical termination of pregnancy.

16. Pharmacists that meet the registration requirements as determined by MS Health and the TGA can dispense the pharmaceuticals that facilitate medical abortions. There is no reason why this should change in Queensland.

17. Women should be able to access a surgical termination at their choice of accredited facility that includes public hospitals and private day surgery providers. Currently there are no artificial restrictions regarding type of accredited facility that can conduct terminations in Queensland. This must not change as women deserve choice when accessing a health care service.

Q2. Should a woman be criminally responsible for the termination of her own pregnancy?

18. NO. It is unacceptable that women could be criminally responsible for accessing a health services that is covered by Medicare or the PBS and therefore recognised as a legal health service or an approved Pharmaceutical product in Australia.

19. NO. The Queensland abortion laws were written in 1899 and in no way reflects the health needs of women in 2018.

20. NO. Criminalising medical procedures that are needed only by women, and that punish women who undergo these procedures reinforces that the Queensland Government do not recognise women as being equal to men, nor are they to be afforded the same human rights as men.

21. NO. The safety, efficacy and health outcomes of women being able to legally and safely access pregnancy termination services are well documented, both in Australia and internationally. The Queensland Government should make every effort to ensure that women do not have to undergo life-threatening clandestine abortions and that abortion should be legal.

22. NO. The Queensland Government should ensure timely and affordable access to safe, high-quality health services, which should be delivered in a way that ensures that a woman gives her informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives.

23. NO. Making an Australian woman criminally responsible for the termination of her own pregnancy based on where she lives is unnecessary and discriminatory. Women in Victoria, the Northern Territory, Western Australia, Tasmania and the ACT can all legally access pregnancy termination without fear of persecution. There is no reason why women that reside in Queensland, NSW and South Australia should not be afforded the same access to health services as all other Australians.

24. NO. Over 4100 pregnancy termination health services are delivered in Queensland each year, demonstrating the need for this essential health service to be legalised.

25. NO. Criminalising abortion increases the risk that a woman may seek to access an abortion in an unsafe way. Where there are few restrictions on access to abortion, abortion-related mortality and morbidity are reduced (see https://www.guttmacher.org/gpr/2009/11/facts-and-consequences-legality-incidence-and-safety-abortion-worldwide).
Gestational Limits and grounds

Q3. Should there be a gestational limit or limits for a lawful termination of pregnancy?

26. NO. Medical practitioners already assess whether a procedure is medically safe to perform for each woman, pregnancy termination should not be the exception to the rule.

27. NO. There is no evidence to suggest that open gestation limits result in more women seeking late term abortions. For instance, the ACT has an open gestation limit and this has not increased the number of women seeking late term abortions.

28. NO. In other States where artificial gestation limits are applied access is impaired and women are forced to travel to access the service elsewhere (mainly Victoria for gestations in excess of 20 weeks). Artificial limits placed on supply will NOT affect demand.

Q5. Should there be a specific ground or grounds for a lawful termination of pregnancy?

29. NO. The application of any artificial and arbitrary non-medical grounds act to deter women from seeking health care and providers from delivering services within the formal health system. This can result in: a woman delaying/or being delayed access to health services, which may result in denial of services; the creation of complex and burdensome administrative procedures; unnecessary increases in the costs of accessing abortion services; and limiting the availability of services and their equitable geographic distribution due to other factors such as workforce shortages.

30. YES. National laws regarding the need to obtain informed consent from the woman to proceed with a procedure should apply, as it does for all other health services. If the woman gives consent, regardless of age, and is not being coerced, she must be afforded access to a lawful termination of pregnancy.

Consultation by the medical practitioner

Q8. Should a medical practitioner be required to consult with one or more others or refer to a committee, before performing a termination of pregnancy?

31. NO. A woman should only have to consult with one practitioner (the one doing the procedure) and not obtain a referral to access termination of pregnancy services. There is no medical reason why a woman would need to be referred by a medical practitioner (in most States) to obtain a pregnancy termination (surgical or medical). In all States (except WA) women can access a medical termination without a referral either in clinic or via telehealth.

32. NO. Medical practitioners are adept at seeking a second opinion for any medical procedure if the safety of the patient (woman) is at risk.

33. NO. The creation of complex and burdensome administrative procedures delays timely access and often causes more distress to the woman than the termination. There is no evidence to support the notion that additional consultation requirements improve health outcomes for women.

34. NO. Termination of pregnancy is time-sensitive (medical versus surgical termination). As risk associated with the procedure increases with increased gestation, barriers such as multiple consultations and panels or committee reviews add unnecessary time delays and possible health and mental health risks.

Conscientious objection

Q11. Should there be provision for conscientious objection?

35. NO. Pregnancy termination is an essential health service. At a minimum, all medical practitioners must provide an immediate referral to a suitably qualified health professional or service provider. Practitioners that refuse to refer should be penalised.

36. NO. Public health services, such as hospitals that receive government funding regardless of their affiliation (religious or otherwise), should not be able to object to the provision of essential health services.

37. NO. However, medical practitioner should be afforded the ability to choose what they specialise in. They do not have to become an abortion provider, BUT they must refer.
Counselling

Q13. Should there be any requirements in relation to offering counselling for a woman?

38. NO. Counselling services should not be a mandated requirement. They MUST remain the woman’s choice. MSA data show that 1 in 10 women that subsequently choose an abortion access counselling to assist in decision making. Fewer access post counselling supports.

39. YES. All women should be offered counselling pre and post procedure. The psychosocial impact some women experience when choosing a pregnancy termination means that all women should be offered counselling options.

40. YES. Counselling must be non-judgemental and trauma-informed. This will ensure that the woman can make informed decisions based on her needs and mental health.

41. YES. Only counsellors that are members of the National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC) should be permitted to provide and advertise that they provide counselling. This will ensure that counselling services that are anti-choice are not able to engage in reproductive coercion.

Protection of women and service providers and safe access zones

Q14. Should it be unlawful to harass, intimidate or obstruct:

a. A women who is considering, or who has undergone, a termination of pregnancy;

b. A person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

42. YES. Access to pregnancy termination is the only health service that is subject to legal protest or religious picketers in Australia. Allowing picketers interferes with a woman’s human right to access health care.

43. YES. In all other professions, picketing (or strike action) must be approved by the courts. Allowing picketing outside health services fails to protect health care workers, patients and their families accessing the health service or the general public.

44. YES. Multiple other laws exist that prohibit harassment and intimidation and other acts of violence. The right to picket, harass, intimidate, or obstruct women when accessing health care must be included under the Queensland Governments commitment to end Violence against Women. Failure to protect women when accessing a health service, affirms that the Queensland Government condones Violence against Women.

45. YES. Propaganda used by picketers and proponents of pregnancy termination to harass, intimidate and obstruct access are health services are usually contain graphic images, religious messages and false information. The use of prominent signage and placards should be subject to the same legislation advertising and marketing materials are subject to e.g. they must not deliberatively mislead the public or falsely advertise a product or cause distress to viewers.

46. YES. All workers are under work health and safety legislation are entitled to a safe workplace. Harassment, intimidation and other forms of violence in addition to obstructing access to a work site are illegal. Failure to protect the health and safety of workers is a direct challenge to the Queensland Government’s response to the Occupational Violence Taskforce and condones violence and harassment towards healthcare workers.

Q15. Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

47. YES. Safe access zones, have in the past, unfortunately been created in response to acts of violence that have resulted in the loss of life. Surely the Queensland Government would rather be proactive and prevent such acts of violence being committed in Queensland?

48. YES. Pregnancy terminations are commonly conducted in private premises. Picketers should not be permitted to enter private property or restrict access to private property based on their religious views.
Q16. Should the provision of safe access zones automatically establish an area around the premises as a safe access zone? What should the area be or should the Minister be responsible for making a declaration establishing an area of each safe access zone?

49. YES. An automatic safety zone of 150 meters as is in place in other states, removes ambiguity and the need for the Minister to be arbitrarily designate areas for each service. This will save Government resources and provide legal clarity.

Q17. What behaviours should be prohibited in a safe access zone?

50. The prohibition of behaviours within safe access zones should be nationally consistent. These include prohibiting:
   a) harassing and intimidating behaviour;
   b) communicating about abortion, in a manner that could be seen or heard by a person accessing or leaving premises providing abortions, where the communication is reasonably likely to cause distress or anxiety;
   c) impeding a footpath, road or vehicle without reasonable excuse; and
   d) intentionally recording a person accessing or leaving premises providing abortions, without consent or reasonable excuse.

51. Picketers that attempt to communicate with women about abortion should also be restricted from communication that is religiously-motivated or based on false information.

Q18. Should the prohibition on behaviours in safe access zone apply only during a particular time period?

52. NO. No time restrictions should be placed.

Q19. Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

53. YES. The reason picketers currently film women is solely for the purpose of seeking to shame, stigmatise, humiliate or cause distress to women.

54. YES. All Australians should be free to access health services confidentially and have a right to privacy.

55. YES. Publishing or distributing a recording of a person accessing or leaving premises providing abortions, without that person’s consent or without a reasonable excuse, should be an offence if the recording:
   a) identifies the person; and
   b) identifies them as a person accessing a premises providing abortions.

Collection of data about terminations of pregnancy?

Q20. Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

56. YES. However, this is best achieved at the Federal level. New Medicare item numbers should be created that specifically identify surgical termination of pregnancy and medical termination of pregnancy.