

Australia: Abortion and Human Rights

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Abstract

This article adopts a human rights lens to consider Australian law and practice regarding elective abortion. As such, it considers Australian laws within the context of the right to equality, right to privacy, right to health, and right to life. After setting out the human rights framework and noting the connected nature of many of the rights (and their corresponding violations), the article shifts its focus to analyzing Australian law and practice within the framework of these rights. It considers the importance of decriminalizing abortion and regulating it as a standard medical procedure. It discusses the need to remove legal and practical restrictions on access to abortion, including financial obstacles and anti-abortion protestors. Further, it comments on the importance of facilitating access; for example, by keeping accurate health data, securing continuity of health care, increasing the availability of medical abortion, and ensuring appropriate care is provided to the most marginalized and vulnerable women.

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Introduction: Human rights and a “fair go”

In Australian vernacular, a “fair go” is about equality and non-discrimination, and is part of the Australian ethos. Australia is signatory to many international conventions that embody the concept of giving everyone a “fair go.” We argue that Australian women do not receive a “fair go” regarding elective abortion.

International human rights law does not recognize a stand-alone right to abortion. However, the right to terminate a pregnancy falls within many recognized human rights; for example, depending on the circumstances, restrictions on abortion may be viewed as violating the: right to life; right to health; right to privacy/autonomy; right to equality/freedom from discrimination; and right to be free from torture or cruel, inhuman, or degrading treatment or punishment.¹ The relationship between unsafe abortion and maternal mortality underpins the argument that restrictions on abortion violate the right to life.² We argue that a woman’s right to decide matters relating to her own body (such as the right to elective abortion) form an integral part of the right to: privacy, autonomy, liberty, and physical integrity, as well as the right to decide the number and spacing of one’s children.³ The view that laws restricting abortion services violate a woman’s right to be free from gender-based discrimination is often based on the assessment that laws restricting access to abortion are informed by discriminatory assumptions about women and that the effect of such laws is to further entrench women’s unequal status in society.⁴ In addition, the argument that restrictions on abortion constitute torture or cruel, inhuman, or degrading treatment is based on the suffering that some women may experience if they are denied access to abortion services or access unsafe abortion services.⁵ Many of these arguments are interrelated. Accordingly, while the international human rights law relating to abortion is not clear-cut, it recognizes, at least in certain circumstances, the importance of decriminalizing abortion as well as the need to both remove barriers to the accessibility of abortion and to ensure that

access is provided.⁶ Further, it should be noted that Australia has ratified the majority of international human rights treaties, thereby binding itself to their terms under international law (though not necessarily incorporating them into domestic law).

In Australia, elective abortion is regulated at the state and territory levels, though it should be noted that certain issues, such as Medicare funding for abortion and the inclusion of mifepristone and misoprostol on the Pharmaceutical Benefits Scheme, are regulated at the federal level.⁷ The Australian government subsidizes many medicines to make them affordable to citizens through the Pharmaceutical Benefits Scheme (PBS) and this scheme is used by both private and public patients. One of the consequences of abortion being regulated predominantly at the local state level is that the following issues, which are engaged by the human rights norms discussed above, are addressed differently between the jurisdictions:

- decriminalization of abortion;
- removal of barriers to the accessibility of abortion, including “safe access zones” around clinics and the obligation on doctors to refer; and
- impediments to access, such as access for marginalized women, availability of medical (as opposed to surgical) abortion, prescribed settings where abortions may occur, and consent requirements.

These issues are discussed and related to the following four rights which they engage most relevantly within the Australian landscape: right to equality, right to privacy, right to health, and right to life. It should be noted that many issues may fall within several categories. For example, safe access zones protect women’s right to health, right to privacy, and possibly their right to equality. Therefore, while this article discusses the different issues in the context of (what the authors view as) the most “relevant” right, other human rights may also be applicable.

Right to equality and to be free from discrimination

Regulating abortion as a standard medical procedure

In Australia, a number of jurisdictions have decriminalized abortion. The most recent reform occurred on March 21, 2017, when the Northern Territory Parliament voted to repeal Section 11 of the Medical Services Act 1982 and replace it with the Termination of Pregnancy Law Reform Bill 2017, a more progressive piece of legislation.⁸ When this law comes into force, abortion will be decriminalized up to 23 weeks' gestation. Abortion was decriminalized in the Australian Capital Territory in 2002, Victoria in 2008, and Tasmania in 2013.⁹ Abortion remains a crime in South Australia, New South Wales, and Queensland.¹⁰ Where abortion has been decriminalized, it may nevertheless be subject to certain requirements, such as temporal requirements, but breaches of such temporal requirements do not carry the risk of criminal sanction. Western Australia is an anomaly in that elective abortion remains a crime technically but is available legally on request up to 20 weeks' gestation.¹¹ Thus in Northern Territory, Victoria, Tasmania, and Western Australia, abortion is legally available up to a certain stage of gestation without the need for a specific justification. Only the Australian Capital Territory does not prescribe such a temporal limitation on the legal availability of abortion services. This is significant for a number of reasons.

First, it means that only the Australian Capital Territory regulates abortion in the same way as any other medical procedure. All other jurisdictions, even those that have decriminalized abortion, nevertheless treat it differently to other medical procedures, where the requirements are a patient's informed consent and the clinicians' professional willingness. Accordingly, aside from the Australian Capital Territory, even in those jurisdictions where abortion has been decriminalized there remains a discriminatory component to the regulation which is inherent in the reality that

elective abortion is deemed to be different from other medical procedures. This also reinforces the stigma attached to abortion (and the negative health sequelae that may flow from such stigmatization).¹² Differential regulation between an aspect of health care needed only by women and all other forms of health care, and its related stigmatization, is itself a form of discrimination against women.

Secondly, the fact that only the Australian Capital Territory does not prescribe a temporal limitation on the legal availability of abortion services without the need for a specific justification is also significant because such regulation means that there is no need for a "health exception." In all Australian jurisdictions, elective abortion is available where the pregnancy poses a risk to the physical or mental health of the woman, though the permissibility of abortion in broader circumstances varies between jurisdictions. From one perspective, the availability of elective abortion where continuation of the pregnancy is deemed harmful to the woman's health is positive for women, as it provides an avenue for access to legal abortion where it may otherwise be a crime. Such a position is, however, problematic in that it empowers doctors to determine whether a woman should be permitted to terminate her pregnancy thereby, enabling doctors to become the gatekeepers to legal abortion and concomitantly rendering women vulnerable to doctors who hold beliefs that demonize abortion. This conflicts with general medical practice where the ultimate decision maker is the patient, not the doctor. Such a discriminatory approach deprives women of their agency and autonomy and constructs them as incapable of making important and rational decisions.¹³ This is particularly the case given that in most circumstances doctors rely on the *mental* health exception to enable their patients to access abortion services, which may lead to women being required to engage in unnecessary counselling from psychologists or referrals to psychiatrists.¹⁴ Australian doctors are aware of this antiquated and non-evidence-based practice and note the complex decision-making processes that

doctors go through when deciding whether women are eligible for a lawful termination.¹⁵ The manufacturing of existing or potential mental distress in order to stay within the limits of the law is commonplace for doctors in Queensland and New South Wales and means that they practice defensively in order to avoid prosecution from vague laws.¹⁶

Furthermore, there are very few instances where *two* doctors are required by law to make medical decisions; the only other area of health with this requirement is when the patient is mentally incompetent. Two doctors are required by law to certify mentally ill or mentally impaired patients and detain, restrain, or administer treatments. In the same vein, in the context of abortion the authorization of two medical practitioners is required in certain circumstances in Victoria, South Australia, West Australia, the Northern Territory and Tasmania.¹⁷ These laws are inconsistent throughout the country and out of step with contemporary health care, and the established laws and procedures of consent that exist in Australia in relation to other aspects of health care. Once again, this phenomena of treating abortion differently to other forms of health care is inherently discriminatory.

Another area where elective abortion is treated differentially from other types of medical procedures is the need for hyper-observation. By this we mean that the patient is regarded as unreliable or incompetent in some respect. Generally, patients are prescribed medications and given the autonomy to take them at will; the health practitioner rarely stands over to observe. In early medical abortion up to nine weeks, the initial Royal Australian and New Zealand College of Obstetricians and Gynaecologist (RANZCO&G) guidelines for 2012 to 2015 included the recommendation to directly observe the patient take mifepristone and misoprostol.¹⁸ This required the woman to make several visits to the doctor's practice with the associated inconvenience, increased cost, and risk of miscarriage during travel. The current RANZCO&G guidelines have removed the requirement that misoprostol be administered in the presence of the doctor as it had no evidence base but remain silent on whether mifepristone should be administered with a doctor

watching.¹⁹ With the requirements in some jurisdictions that abortion procedures occur only in a special facility hospital setting, this has led to confusion about the timing and location of treatments. For example, women have been required to travel to specific locations at specific times to be observed swallowing the medication(s). Misoprostol and mifepristone are not toxic substances to adults and are not dangerous or addictive medications that require a doctor to observe ingestion.²⁰ There are very few occasions where Australian patients are not entrusted to manage their own medications responsibly; these include pediatric patients, and patients who are mentally unwell, intellectually impaired, or addicted to drugs. There is no recorded case in Australia of a woman misusing her abortion medications that would suggest a need for hyper-observation. The requirement that abortions be carried out in an approved medical facility is one which was presumably intended to protect women undergoing surgical abortions, but is outdated and potentially harmful in the context of the availability of medical abortion.

The above discussion provides numerous examples of the differential treatment that the law accords to abortion as against other forms of medical treatment. Given that abortion is an aspect of health care required only by women, such differential treatment constitutes a form of discrimination against women. Only when abortion is regulated as a standard medical procedure will women achieve true equality in the context of access to health care.

Financial obstacles to health care

Each year in Australia, there are an estimated 85,000 abortions for a population of 23 million people or, put another way, an abortion rate of 19 per 1000 women; these numbers are declining slowly.²¹ The 1970s saw significant social change and the implementation of safe, hygienic abortion procedures through the provision of universal health insurance (formerly Medibank and now Medicare) for the clinical cost of abortion services. However, the supply of public health clinics does not meet demand for elective abortions, which is met by private clinics charging fees well above that of the univer-

sal insurance rebate. Therefore, abortion services in Australia are provided by both the public and private health systems. In South Australia and the Northern Territory, the public health system provides the majority of elective abortions but these jurisdictions account for only a small percentage of the Australian population. Most abortions in Australia are performed in the private sector for profit with patients still paying above private insurance fees; with prices ranging from A\$4400 to A\$800 for a first-trimester termination and significantly more with later gestation.²² This means that despite Medicare rebates and private insurance rebates women are left to cover the gap in health fees which may be hundreds of dollars. Consequently, there is a gradient of socio-economic access to reproductive health services that is inequitable and thus breaches the right to equality (as well as the right to health).²³ The price of a combined packet of mifepristone and misoprostol obtained through the Pharmaceutical Benefits Scheme is currently A\$38, but the fees charged by health providers often range from A\$250 to A\$580.²⁴ These fees may be for screening tests, analgesics, anti-emetics, and information and counselling, which are time consuming. Thus, cost may pose a barrier to access, particularly for the most vulnerable women, thereby calling into question the extent to which abortion services are equally available to all Australian women.

Right to privacy

In Australia, jurisdictions have begun to recognize the importance of protecting the privacy of women seeking to enter clinics and of safeguarding them from harassment and intimidation. Accordingly, since 2013, Tasmania, the Australian Capital Territory and Victoria have introduced legislation providing for safe access zones around clinics providing reproductive health services.²⁵ The newest Northern Territory Termination of Pregnancy Bill (2017) includes similar provisions.²⁶

Drawing on Victoria's 2008 abortion law reform efforts, Tasmania in 2013 also decriminalized abortion and became the first Australian jurisdiction to introduce safe access zones. The Tasmanian

legislation prohibits protesters from harassing patients within 150 meters of a clinic providing abortion services. The Australian Capital Territory, as the next Australian jurisdiction to take up this mantle, passed legislation in 2015 which, according to the explanatory statement, aims to ensure that "women can access the health facilities in privacy, and free from intimidating conduct."²⁷ Thus the desirability of protecting the privacy of patients entering and leaving these clinics was at the forefront of Parliament's intent in passing this legislation. Shortly thereafter, in November 2015, Victoria also passed legislation establishing "safe access zones" of 150 meters around a clinic at which abortion services are provided, in order to "protect the safety and wellbeing and respect the privacy and dignity of" people accessing those services as well as employees and others who enter the premises.²⁸ Once again, the need to safeguard women's privacy was an explicit motivation for the passage of this type of legislation. Most recently, in March 2017, the Northern Territory Parliament also established safe access zones of 150 meters.

The Fertility Control Clinic in East Melbourne, Victoria, provides a useful example of why the introduction of safe access zones in some jurisdictions constitutes an important step in protecting the privacy of women seeking to terminate a pregnancy. The Fertility Control Clinic was established in 1973 by Dr. Bertram Wainer, a doctor and advocate of the decriminalization of abortion. It provides a range of reproductive health services, including contraception, pap smears, sexually transmitted infection testing, treatment of miscarriages and abortion (medical and surgical). Once it became apparent that women could have an abortion without further harm, anti-abortion protesting in front of the clinic became commonplace. It has taken the form of verbal insults, offensive posters, dispensing of anti-abortion pamphlets, attempts to close clinics by surrounding premises and supergluing locks, as well as physical obstacles preventing women from entering the clinic. Further, the impediments to accessing legal remedies have meant that anti-abortion protesting has caused harm with impunity.²⁹ In 2015, the Fertility Control Clinic, frustrated by

Melbourne City Council's failure to act to prevent this harassment, initiated legal action against the council on the basis that the activities of the protesters constituted a nuisance and that the council is obligated to remedy such a nuisance. The action was unsuccessful as the court decided that the council had the power to decide not to act to bring an end to the protesting.³⁰ It is against this backdrop that the Victorian State Parliament passed legislation preventing anti-abortion protesting from taking place within 150 meters of a clinic providing abortion services. Thus, when introducing the bill into Parliament, the Minister for Health noted that "This bill acknowledges that Victorian women have a right to access legal reproductive services without fear, intimidation or harassment. Women also have a right to access these services without having their privacy compromised."³¹

There are those who argue that the access zone laws should be struck down because they infringe the protestors' right to free speech.³² It should be noted that in Australia there is no constitutionally entrenched right to free speech. However, the possibility of a High Court challenge has been raised on the basis that the access zones infringe the freedom of political communication that the High Court has held to be an implied right in the Australian Constitution.³³ This is highly debatable; in order to make a case for constitutional invalidity it would need to be established that the laws both impose a burden on political communication and fail the "compatibility testing" and "proportionality testing" requirements.³⁴ Unless such a challenge is mounted, it is not possible to predict precisely what approach the High Court would take, particularly given the subjectivity inherent in the test for constitutional validity. At the international level, the International Covenant on Civil and Political Rights (ICCPR) enshrines the right to free speech but provides that this right may be limited to respect the rights of others or to protect public health.³⁵ Similar provisions exist in Victoria, where the Charter of Rights provides for freedom of expression but allows it to be limited for the "protection of public health," and in the Australian Capital Territory, where the Human Rights Act stipulates that rights may be

subject to reasonable limits.³⁶

We believe that safe access zones play an important role in securing women's right to health/right to access appropriate health care. When discussing the effects of anti-abortion protests, Dean and Allanson, for example, observe that "such intimidation, harassment and intrusion of privacy can cause psychological or physical harm, especially when those targeted may already be under stress or anxious about an impending operation, an unplanned pregnancy, or a health-related medical or counselling appointment."³⁷ Safe access zones therefore play a significant role in protecting women's right to privacy and right to health.

Right to health

On March 4, 2016, the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) released General Comment 22, focusing on the right to sexual and reproductive health.³⁸ In this comment, the committee recognized that the "right to sexual and reproductive health is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights" (as well as other international human rights instruments).³⁹ The inclusion of the right to reproductive health as part of the general right to health is not particularly ground-breaking. However, UNCESCR's explicit inclusion of the right to elective abortion as forming a part of the right to reproductive health and consequently the broader right to health, is representative of a gradual willingness to acknowledge the importance of securing a woman's access to safe and legal abortion services as a core component of her right to attain the highest attainable standard of health. The tenor of General Comment 22 makes it clear that the decriminalization of abortion is not on its own enough to ensure that women's right to health is adequately safeguarded; the provision of access to services and the removal of impediments to access are also essential to securing the protection of women's right to reproductive health.

In Australia, 30% of Australians live in rural or remote locations with limited access to, and op-

tions for, health services. Some additional barriers to reproductive autonomy are: moral opposition and harassment; lack of special medical training; insufficient staff and hospital workforce; geographical distance to services; stigma and financial costs.⁴⁰ While legislation cannot ameliorate many of these barriers, it should not enable the infringement of human rights. Novel approaches such as telehealth overcome the barriers of distance, costs associated with traveling to services, finding a specialized abortion provider, avoiding conscientious objectors, and curbside harassment.⁴¹ Telehealth is the provision of health services when the doctor and patient are not in the same room, often by way of telephone or videolink. Yet some Australian legislation (such as the laws in South Australia) is interpreted to bar the provision of abortion services via telehealth. The below discussion considers some of the difficulties as well as positive aspects of Australia's approach to facilitating women's access to abortion services.

Access to accurate health data

In Australia, a lack of health data stymies the making of evidence-based clinical guidelines or health policies regarding elective abortion.⁴² There is no systematic collection of health data at a federal level or policy directive regarding abortion, as there is for blood borne diseases or cervical pap screening for example, where national level health directives are implemented at the state level using state level data analyzed with a nationwide focus.⁴³ Only two jurisdictions, South Australia and Western Australia, collect data on elective abortion systematically, through acts of parliament reporting for about 18% of the population.⁴⁴ Abortion data can be useful as it is an indicator of women's health at a population level. It informs public health planners about the effectiveness of sexuality education and the accessibility and acceptability of contraception coverage and potentially the fertility outcomes of a population.⁴⁵ This theme recurred during the Northern Territory abortion law reform process, where various stakeholders called for public health data in order to understand the magnitude of need, or indeed denounce that there was a need, for better

access to health services.⁴⁶ The Northern Territory data was outdated and lacked the nuances sought by stakeholders for decision-making during the legislative reform process.⁴⁷ The reformed law now has a provision which requires that abortions be reported to the chief health officer; this may go some way to the collection of relevant health data and the achievement of the right to the highest standard of health care.

The data and policy vacuum means that conservative forces can incite moral indignation with impunity. Australian experience with neo-conservatives during the 2000s exemplified this; certain politicians publicly suggested that there were too many abortions of convenience with the inevitable tropes against irresponsible and selfish women.⁴⁸ It is difficult to mount a rebuttal when the exact numbers are simply unknown and inferred through complex guessing. The *Sydney Morning Herald* reported, for example:

*Deputy Prime Minister John Anderson says he agrees that too many abortions are carried out each year. "Many of us think that they (fetuses) are potential fellow Australians and that some people don't think through carefully enough their responsibilities before they fall pregnant, frankly."*⁴⁹

As data is not collected systematically or analyzed, a parliamentary research brief in 2005 was unable to enumerate an accurate incidence of elective abortion; it found an imperfect system of information collection and pointed to better ways to obtain information—none of which have been implemented.⁵⁰

Health providers as barriers to appropriate health care: conscientious objection

The emphasis on securing access to safe and legal abortion services is reflected in Australian laws requiring doctors with a conscientious objection to abortion to refer the patient to another practitioner who does not hold a conscientious objection. In Tasmania, Victoria, and now the Northern Territory, the legislation includes a provision for doctors to conscientiously object to participating in an elective abortion, outside of an emergency.⁵¹ However, the law in these jurisdictions stipulates

that a doctor must provide a woman who might be considering a termination with information about where she can go to receive unbiased information about her options.⁵² These provisions have been controversial, particularly because of outsourcing of health services and medical training to religious organizations, especially Roman Catholicism. Medical and nursing students trained in Catholic universities and hospitals, both private and public, require their staff to turn away women seeking abortion; this is both discriminatory and a violation of the right to health.

Further, at the time of the Victorian law reform, the archbishop of Melbourne threatened to close the maternity departments in Catholic hospitals should these provisions remain in the legislation; this threat was not carried out.⁵³ Others have argued that doctors should be compelled to provide abortion services as part of their professional obligations. For example, Fiala and Arthur argue that refusal to provide a key medical service should be characterized as “dishonourable disobedience” rather than “conscientious objection.”⁵⁴ Further, the obligation to refer does not in practice necessarily translate into an obligation to refer without delay, a key consideration in circumstances like abortion where time is imperative. The importance of ensuring continuity of health care is demonstrated by the position adopted in a number of the medical profession’s ethical codes and guidelines, such as the International Federation of Gynecology and Obstetrics, the World Medical Association, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Australian Medical Association, though interestingly, similar provisions are not found in Australian nursing or midwifery position statements.⁵⁵ Finally, it is notable that while the legislative requirement on doctors is an important step, it is unclear whether (and if so to what extent) it operates on the ground.

Availability of medical abortion

Medical abortion with mifepristone and misoprostol has had a convoluted, politicized, and overly bureaucratic entry into Australia.⁵⁶ These cheaper, effective, safe medications should theoretically be

available to women at a primary health care level from doctors in general practice, but PBS data reveal very few prescriptions for mifepristone/misoprostol for terminations. For example, in 2015, there were 11,332 recorded prescriptions for medical abortion; given that there are approximately 85,000 terminations annually, this means that only an estimated 13% of all terminations were performed primarily using medications and not surgical methods.

Despite elective abortion being lawfully available for decades, the failure of laws to keep pace with medical and scientific developments inhibits women’s equitable access to the highest possible standard of health care. Of particular concern is South Australian law, which restricts the prescription of medical abortion.⁵⁷ The Northern Territory, which voted to reform its law in March 2017, had previously criminalized and restricted access to medical abortion.⁵⁸ That said, section 11 of the Medical Services Act (MSA) provided that it was lawful for a medical practitioner “to give medical treatment with the intention of terminating a woman’s pregnancy” in certain circumstances.⁵⁹ The problem, however, was that in the 1974 bill, “medical treatment” was defined to include all forms of surgery, but not medications. The MSA also specifically provided that the treatment was given in a hospital and included other restrictive provisions relating to consent and that opinions for treatment be formed by a gynecologist/obstetrician, thus limiting clinical treatment and type of provider and location. Similarly, South Australian law restricts abortion ‘treatment’ to prescribed hospitals, only five of which have established medical abortion services.⁶⁰ These differences in clinical practice do not directly relate to the vintage of the legislation in each jurisdiction, rather the overly prescriptive definitions and interpretation of law that is out of step with clinical practice. For example, Queensland has the oldest unreformed law, yet medical abortion is prescribed in this jurisdiction (though it should be noted that the 2010 case of *R v Brennan and Leach* involved a prosecution for medical abortion).⁶¹ These health care services are funded by federal health insurance and medications are subsidized as previously explained. Nevertheless, an increasing

number of women fall outside the safety net of the public health system due to limited space, and pay high prices for either medical or surgical abortions, which breaches the right to equality and freedom from discrimination as well as the right to health.⁶²

Right to life

The right to life in this context refers to women's rights to survive pregnancy, childbirth, and motherhood. It is beyond the scope of this article to consider arguments related to the right to life of the fetus. Australia has very low rates of maternal mortality and morbidity due to a generally wealthy and healthy population, access to comprehensive skilled maternity care, and small-sized families stemming from high acceptance of contraception. The ability to not be pregnant and or have an abortion prevents maternal mortality by the fact that vulnerable women do not get pregnant or give birth in the first instance. Fertility management in the form of modern contraception, backed up by elective abortion, is a key way to reduce maternal mortality by preventing pregnancy and birth and hence deaths related to reproduction. Pregnancy and birth are a greater risk to women's lives than elective abortion.

Maternal deaths are recorded well in Australia and the following information is drawn from a national report over five years.⁶³ On average, 21 women die each year due to pregnancy and childbirth in Australia. From 2008 to 2012, there were 105 deaths resulting from complications from pregnancy and childbirth; 16 indirect maternal deaths were due to psychosocial reasons, including suicide.⁶⁴ That mental health and social problems have led to the deaths of Australian women means that some women are particularly vulnerable during pregnancy. One example is the link between domestic violence and poor reproductive health outcomes.⁶⁵ The lack of reproductive autonomy experienced by Australian women is unknown, but one study found that intimate partner violence is a strong predictor of termination of pregnancy among young Australian women and proposed that prevention and reduction of partner violence may reduce the

rate of unwanted pregnancy.⁶⁶ The authors of the maternal deaths report note that psychological screening is equally important in antenatal and postnatal care.⁶⁷ Deaths during the first 14 weeks of pregnancy are not well recorded in Australia; however, the national report records 15 maternal deaths in the first trimester and found these were largely due to ectopic pregnancies, thromboembolisms, and cardiac and psychosocial events. No woman died as a direct result of an elective abortion.⁶⁸

Indigenous women have higher rates of maternal morbidity and mortality than non-indigenous women, reflecting the gradient of inequity in health care and the burden of background illness. The indigenous maternal mortality ratio was 14/100,000 women who gave birth, as compared with 2/100,000 for non-indigenous women. During the same period 2008 to 2012, 12 indigenous women died due to direct or indirect causes related to pregnancy and childbirth and none directly due to an elective abortion.⁶⁹ Indigenous women often do not have the same access to reproductive health services as other Australian women, and they suffer from relative social disadvantage and poverty that impacts on their health outcomes. Access to fertility management and abortion services are therefore important to women's health.⁷⁰ For some Australian women, access to termination of pregnancy will save their lives.

Conclusion

This article considers Australian abortion laws in the context of human rights law and uses examples from clinical practice. Specifically, it considers the extent to which Australian laws may violate or protect the right to equality, right to privacy, right to health, and right to life of a woman faced with a problematic pregnancy. The first step towards protecting the rights of such women is the decriminalization of abortion, which has occurred in a number of Australian jurisdictions. As illustrated by the situation in New South Wales, South Australia, and Queensland, while abortion remains a crime, other protective measures remain out of reach. Accordingly, measures such as safe access

zones or provisions requiring doctors with a conscientious objection to ensure continuity of care have only been enacted in jurisdictions which have decriminalized abortion (at least to some extent). Therefore, the authors submit that as a first step to safeguarding the human rights of Australian women, all Australian jurisdictions must decriminalize abortion. Other significant steps (which have already been initiated in some jurisdictions) include: regulating abortion as a standard medical procedure and removing restrictions on access to abortion; removing financial obstacles to access; establishing safe access zones; ensuring the collection and analysis of accurate health data; securing continuity of health care; increasing the availability and affordability of medical abortion; and ensuring that appropriate care is provided to the most marginalized and vulnerable women.

References

1. For “right to life” see for example: Human Rights Committee, *General Comment No 28: Article 3 (Equality of Rights between Men and Women)*, UN Doc CCPR/C/21/Rev.1/Add.10 (2000). For “right to health” see for example: Committee on Economic, Social and Cultural Rights, *General Comment No 22 on the right to sexual and reproductive health*, UN Doc E/C.12/GC/22 (2016). For an in-depth discussion of restrictions on abortion as a violation of the right to health see also: R. Sifris, “Restrictive regulation of abortion and the right to health” *Medical Law Review* 18 (2010) 185 - 212. For “right to privacy” see for example *Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005); *Mellet v Ireland*, Human Rights Committee, Communication No 2324/2013, UN Doc CCPR/C/116/2324/2013 (9 June 2016). For “right to equality” see for example See for example *L.C. v Peru*, Committee on the Elimination of Discrimination against Women, *Communication No 22/2009*, UN Doc CEDAW/C/50/D/22/2009 (25 November 2011); *Mellet v Ireland*, Human Rights Committee, Communication No 2324/2013, UN Doc CCPR/C/116/2324/2013 (9 June 2016). For “right to be free from torture” see for example See for example *Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005); *LMR v Argentina*, Human Rights Committee, *Communication No 1608/2007*, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011); *Mellet v Ireland*, Human Rights Committee, Communication No 2324/2013, UN Doc CCPR/C/116/2324/2013 (9 June 2016). For an in-depth discussion see R. Sifris, *Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinisation of Torture* (London and New York: Routledge, 2016).
2. C. Zampas and J. M. Gher, “Abortion as a human right - international and regional standards” *Human Rights Law Review* 8 (2008) 249, pp. 255-256; R. J. Cook and M. F. Fathalla, “Advancing reproductive rights beyond Cairo and Beijing” in K. D. Askin and D. M. Koenig (eds), *Women and International Human Rights Law (Volume 3)* (New York: Transnational Publishers Inc, 2001) pp. 78-80.
3. Center for Reproductive Rights, “Safe and legal abortion is a woman’s human right” (August 2004) p. 3; R. J. Cook and M. F. Fathalla, “Advancing reproductive rights beyond Cairo and Beijing” in K. D. Askin and D. M. Koenig (eds), *Women and International Human Rights Law (Volume 3)* (New York: Transnational Publishers Inc, 2001) pp. 80-82.
4. Center for Reproductive Rights, “Safe and legal abortion is a woman’s human right” (August 2004) p. 3; R. Siegel, “Reasoning from the body: A historical perspective on abortion regulation and questions of equal protection” *Stanford Law Review* 44 (1992) p. 261; C. A. MacKinnon, “Reflections on sex equality under law” *Yale Law Journal* (1991) 100 p. 1281.
5. See for example: *Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005).
6. Space precludes an in-depth discussion of the specific circumstances that the various treaty bodies have regarded as engaged by the various rights.
7. Pharmaceutical Benefits Scheme (2017) ‘MIFEPRISTONE (&) MISOPROSTOL’, available at <https://www.pbs.gov.au/medicine/item/10211K>.
8. Northern Territory Government (2017) *Termination of Pregnancy Bill 2017*, available at <http://www.austlii.edu.au/au/legis/nt/bill/toplrb2017373/>.
9. See *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT); *Abortion Law Reform Act 2008* (Vic); *Reproductive Health (Access to Terminations) Act 2013* (Tas).
10. For a discussion of some of the recent cases demonstrating the problems inherent in Queensland’s law, see H. Douglas and C. M. de Costa, “Time to repeal outdated abortion laws in New South Wales and Queensland” *Medical Journal of Australia* (2016) 205(8) (online).
11. See *Criminal Code Act Compilation Act 1913* (WA) s 199; *Health Act 1911* (WA) s 334.
12. See R. Sifris, “A woman’s right to choose: human rights and abortion in Australia” in P. Gerber and M. Castan (eds), *Contemporary Human Rights Issues in Australia* (Thomson Reuters, 2013) pp. 255-258.
13. M. Boyle, *Re-thinking Abortion* (London / New York, Routledge, 1997) p. 71.
14. H. Douglas, K. Black, and C. de Costa. “Manufactur-

ing mental illness (and lawful abortion): Doctors' attitudes to abortion law and practice in New South Wales and Queensland" *Journal of Law and Medicine* (2013) 20(3) pp. 560-76.

15. C. de Costa, H. Douglas, and K. Black, "Making it legal: abortion providers' knowledge and use of abortion law in New South Wales and Queensland" *Australian and New Zealand Journal of Obstetrics and Gynaecology* (2013) 53(2) 184-89.

16. H. Douglas, K. Black and C. de Costa, "Manufacturing mental illness (and lawful abortion): doctors' attitudes to abortion law and practice in New South Wales and Queensland" *Journal of Law and Medicine* (2013) 20 (3) pp. 560-76.

17. Victoria, South Australia, Western Australia, the Northern Territory and Tasmania. *Abortion Law Reform Act 2008* (Vic) s 5; *Criminal Law Consolidation Act 1935* (SA) s 82A(1); *Health Act 1911* (WA) s 334(7); Termination of Pregnancy Law Reform Bill 2017 (NT) s 9; *Reproductive Health (Access to Terminations Act) 2013* (Tas) s 5.

18. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. "The use of mifepristone for medical termination of pregnancy." In College Statement, 5, 2012.

19. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. "The use of mifepristone for medical termination of pregnancy." In College Statement, 12, 2016.

20. A. O'Rourke, S. Belton, and E. Mulligan, "Medical abortion in Australia: What are the legal and clinical risks? Is medical abortion over-regulated?" *Journal of Law and Medicine* Sept (2016). See also *R v Brennan and Leach* (2010) (unrep, Dist Ct Qld, Criminal Jurisdiction, Indictment 74 of 2010).

21. Family Planning NSW, "Reproductive and Sexual Health in Australia." Ashfield, Sydney: FPNSW, 2013.

22. Children by Choice Association (2016) 'How much will an abortion cost?' Available at <https://www.childrenbychoice.org.au/forwomen/abortion/abortioncosts>.

23. M. Shankar et al (2017), "Access, equity and costs of induced abortion services in Australia: a cross-sectional study," *Australia and New Zealand Journal of Public Health*.

24. Mridula Shankar et al (2017) 'Access, equity and costs of induced abortion services in Australia: a cross-sectional study' *Australia and New Zealand Journal of Public Health* n/a. Available at <http://dx.doi.org/10.1111/1753-6405.12641>.

25. See *Reproductive Health (Access to Terminations) Act 2013* (Tas), *Health (Patient Privacy) Amendment Act 2015* (ACT), *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic).

26. Northern Territory Government (2017) *Termination of Pregnancy Bill 2017*, available at <http://www.austlii.edu.au/au/legis/nt/bill/toplrb2017373/>.

27. *Health (Patient Privacy) Amendment Act 2015* (ACT) (Explanatory Statement).

28. *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s. 5.

29. S. Allanson, "Abortion access versus anti-choice nuisance: Supreme Court action update (presentation at Second National Sexual & Reproductive Health Conference, Melbourne, November 18, 2014).

30. See *Fertility Control Clinic v Melbourne City Council* [2015] VSC 424.

31. Public Health and Wellbeing Amendment (Safe Access Zones) Bill 2015 (Vic) (second reading).

32. For a discussion on the right to access abortion services versus freedom of speech and freedom to protest against such services, see, for example, R.E. Dean and S. Allanson, "Abortion in Australia: access versus protest" *Journal of Law and Medicine* (2004) 11 510-515.

33. M. Stokes, "Tasmanian ban on abortion clinic protests may not be constitutionally valid," *The Conversation* (25 November 2013).

34. *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *McCloy v New South Wales* [2015] HCA 34.

35. *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976), Art 19.

36. See *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 15; *Human Rights Act 2004* (ACT) s 28.

37. R.E. Dean and S. Allanson, "Abortion in Australia: access versus protest" *Journal of Law and Medicine* (2004) p. 512.

38. Committee on Economic, Social and Cultural Rights, *General Comment 22 on the Right to sexual and reproductive health*, UN Doc E/C.12/GC/22 (2016).

39. Committee on Economic, Social and Cultural Rights, *General Comment 22 on the Right to sexual and reproductive health*, UN Doc E/C.12/GC/22 (2016) para. 1.

40. F. Doran and S. Nancarrow, "Barriers and facilitators of access to first-trimester abortion services for women in the developed world: A systematic review." [In eng]. *Journal of Family Planning and Reproductive Health Care* (Jul 2015) 41(3) pp. 170-80.

41. F. Doran and J. Hornibrook. "Barriers around access to abortion experienced by rural women in New South Wales, Australia." *Rural and Remote Health* (2016) 16, no. 3538: online.

42. C.M. de Costa, D.B. Russell, and M. Carrette. "Abortion in Australia: still to emerge from the 19th century" *The Lancet* (2010) 375, no. 9717 804-05.

43. A. Chan and L.C. Sage, "Estimating Australia's abortion rates 1985-2003" *Medical Journal of Australia* (2005) 182, no. 9 447-52.

44. M. Hutchinson, A. Joyce and M. Cheong, "Induced abortions in Western Australia 2010-2012. 4th Report of the Western Australian abortion notification system." In

Statistical series number 96, edited by Western Australia Department of Health, 72, 2013.

45. Government of South Australia, "Pregnancy Outcome Statistics" <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics/pregnancy+outcome+statistics>.

46. Northern Territory Government (2017) 'Debates 21 March 2017 Termination of Pregnancy Law Reform Serial 15', available at <https://parliament.nt.gov.au/parliamentary-business/hansard-debates-and-minutes-of-proceedings/draft-daily-hansard,-questions-and-minutes/DEBATES-DAY-4-21-MARCH-2017.pdf>.

47. X. Zhang et al (2010) *Trends in the health of mothers and babies, Northern Territory 1986-2005*, Department of Health and Families.

48. E. Millar, "'Too many'" anxious white nationalism and the biopolitics of Abortion *Australian Feminist Studies* 30, no. 83 (2015/01/02 2015): 82-98.

49. Australian Associated Press, "Church demands abortion enquiry" *The Sydney Morning Herald*, 1 November 2004.

50. A. Pratt, A. Biggs and L. Buckmaster, "How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection." In Research Brief, edited by Parliamentary Library, 22. Canberra: Parliament of Australia, 2005.

51. *Reproductive Health (Access to Terminations) Act 2013* (Tas) s. 6, *Abortion Law Reform Act 2008* (Vic), s. 8.

52. *Reproductive Health (Access to Terminations) Act 2013* (Tas) s. 7, *Abortion Law Reform Act 2008* (Vic), s. 8.

53. B. Zwartz, "Archbishop in abortion law threat" *The Age* (September 23, 2008).

54. C. Fiala and J.H. Arthur, "Dishonourable disobedience – why refusal to treat in reproductive healthcare is not conscientious objection" *Woman – Psychosomatic Gynaecology and Obstetrics* (2014) 1-12.

55. International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003) available at http://www.figo.org/sites/default/files/uploads/wg-publications/wsr/Rights-Based_%20Code_of_Ethics_October%202003%20-%20Copy%20-%20Copy.pdf; World Medical Association, *Declaration on Therapeutic Abortion, adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970 (amended by the 35th World Medical Assembly, Venice, Italy, October 1983; 57th WMA General Assembly, Pilanesberg, South Africa, October 2006)* available at <http://www.wma.net/en/30publications/10policies/a1/>; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Code of Ethical Practice* (2006) p. 6; Australian Medical Association, *Position Statement on Conscientious Objection* (2013) available at <https://ama.com.au/position-statement/conscientious-objection-2013>

56. B. Baird, "Medical abortion in Australia: a short history" *Reproductive Health Matters* 23, no. 46 (11// 2015): 169-76.

57. A. O'Rourke et al (2016) 'Medical abortion in Australia: What are the legal and clinical risks? Is medical abortion over-regulated?' 24 *Journal of Law and Medicine* 221.

58. *Criminal Code Act 1983* (NT) s 208B.

59. *Medical Services Act 1982* (NT) s 11.

60. *Criminal Law Consolidation Act 1935* (SA) s 82A.

61. *R v Brennan and Leach* (2010) (unrep, Dist Ct Qld, Criminal Jurisdiction, Indictment 74 of 2010).

62. F. Gerry, S. Belton, and J. Yogaratnam, "Reproductive health and rights in the Northern Territory: reforming the Medical Services Act 1974." 32. eSpace <http://espace.cdu.edu.au/view/cdu:52966>: Charles Darwin University, 2015.

63. AIHW, M.D. Humphrey, M.R. Bonello, A. Chughtai, A. Macaldie, K. Harris, and G.M. Chambers, "Maternal deaths in Australia 2008-2012." In *Maternal deaths services no.5 Cat. no. PER 70*. Canberra: AIHW, 2015.

64. AIHW, M.D. Humphrey, M.R. Bonello, A. Chughtai, A. Macaldie, K. Harris, and G.M. Chambers, "Maternal Deaths in Australia 2008-2012." In *Maternal deaths services no.5 Cat. no. PER 70*, Canberra: AIHW, 2015.

65. L. Meuleners et al (2011) 'Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence: A population based study in Western Australia, 2002-2008' 11 *BMC Pregnancy Childbirth* 70. available at <http://dx.doi.org/10.1186/1471-2393-11-70>.

66. A. Taft and L. Watson (2007) 'Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women' 31 *Australia and New Zealand Journal of Public Health* 135 available at <http://dx.doi.org/10.1111/j.1753-6405.2007.00031.x>.

67. AIHW, M.D. Humphrey, M.R. Bonello, A. Chughtai, A. Macaldie, K. Harris, and G.M. Chambers. "Maternal Deaths in Australia 2008-2012." In *Maternal deaths services no.5 Cat. no. PER 70*, Canberra: AIHW, 2015.

68. *Ibid.*

69. *Ibid.*

70. J. Boyle and S. Eades, "Closing the gap in Aboriginal women's reproductive health: some progress, but still a long way to go." *Australian and New Zealand Journal of Obstetrics and Gynaecology* (2016) 56(3) pp. 223-24.