NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF HEALTH

The Discussion Paper, Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services, was released by the Department of Health on 9 December 2016 and submissions closed on the 27 January 2017.

With consent to publish, below are submissions received.

Submission #002

To whom it may concern,

I am a medical practitioner, practicing in the field of emergency medicine. I have been living and working in the Territory for the past 9 years. I welcome this initiative, and feel it will make women safer and allow them more autonomy and control over their own health.

Submission #004

Hi,
I am writing to express my wholehearted support for the proposed legislation and will be present in the gallery for debates regarding this bill. As a woman of reproductive age and who has spent countless hours, appointments and a significant amount of mine and taxpayer's money on my reproductive choices and health, I think this legislation epitomizes equality for women, and is reasonable and necessary and finally brings the NT in line with other Australian states and territories.

Submission #006

To Whom It May Concern,

My name is xxxxxxxxxx and I live in the NT and I support the right for a woman to have an abortion as long as she is healthy and fit for the procedure.

Thank you for drafting this legislation and helping it get through.

Thank you

Submission #010

Hi DOH,

I live in the NT and support the introduction of legislation that makes RU486 available to women in all parts of the NT.

It is important to empower women and broaden the availability of health and life options, including safe chemical abortion, to women everywhere. I believe RU486 should be available for women everywhere if it suits their circumstances.

I do not support the requirement that two medical doctors, one a 'specialist', are required to examine a woman who requires this arrangement. This is utterly ridiculous for remote people who I believe should also be able to access this under other types of less restrictive medical supervision. Where are all these proposed specialists to be found?

I trust that we have plenty of smart people over at DOH who are specialised and smart when it comes to health policy who can work out ways to remove unnecessary and unreasonable obstacles to access to this technology. Risk management is about management of risk and not aversion of risk. There will be some risk and this will be acceptable. I believe that it is better to make this available and take on some of that risk than to make it impossible to access and further disadvantage people who could use some control over their lives.

Please add my vote of support to the consultation, and thank you for your time and the work you do for our community, it is very important.

Thank you

Submission #012

Dear Sir/Madam,

It's come to my attention that our government is proposing changes to the laws around the termination of pregnancies and I am quite concerned about this.

I'm writing to you as the feedback email at the end of the discussion paper.

Having read the press release, and also the discussion paper, I feel like there are a number of shortcomings to the discussion.

1. The major premise seems to be keeping up with the rest of the country. However, there was very little evidence given about the contrast between Northern Territory legislation and the other states and territories.

2. It seems there are no provisions for counselling to be given as part of the termination process. Only comments about counselling regarding future pregnancies and contraception.

3. Significant consideration is given to RU486, though this is only allowed for pregnancies up to 9 weeks. All other pregnancies, even up to 23 weeks as mentioned, presumably could not be done in remote locations without the appropriate instruments.

4. It is disappointing that there is no consideration given to the 'right' of the father, or the child, in this situation.

5. There were a few times when different options were presented, and then the least rigorous seems to be proposed. For example:
- a very broad definition of termination of pregnancy;
- how to define 'suitably qualified medical practitioner';
- deciding on locations, which isn't actually a decision about location at all, but putting the responsibility on the practitioner.
- what level of consent is needed

6. The conscientious objection section doesn't allow a conscientious objector to object, but to abstain from further involvement.

7. There is no research into the impact of abortion on women who have had them. I only have anecdotal comments from my role as a minister in the Anglican church and the times I've spoken with women who have had abortions, even if it is a long time ago, it still weighs on them, and impacts them.

8. Overall the whole discussion paper is built around a presumption that it is a good thing 'to allow women better access to termination of pregnancy services including medical termination'.

My greatest concern is as a Christian minister convinced that a creator God gives life to all from conception, and that to abort any pregnancy based solely on the consent of the mother is a bad thing for the child, the mother, and our community's attitude to life.

Submission #014

Thank you for the opportunity to provide feedback on the discussion paper proposing legislative reform aimed at improving access for Northern Territory women to safe termination of pregnancy service.

My concern is about the extremely low number of adoptions that take place in the NT, this supports the view that inadequate information and counselling is provided about current choices. Women need to be better informed about the adoptive process (open adoption and quality prospective parents) so they are aware of alternative choices to termination. They also need to be aware of available government support to continue their pregnancy.

All health professions need to be educated about these other options so women feel they have other realistic choices.

thank you

Submission #015

I support the proposed changes to the abortion laws in the NT. Prior to moving to the NT I worked at xxxxxx Women's Health Centre where we actively supported modernising abortion legislation in that state and removing it from the criminal code. As someone who holds a social view of health, I know unwanted pregnancy can have many negative, long term effects on women including lack of educational and employment opportunities, ongoing poverty which has health ramifications including depression. Women should not be at risk of criminal consequences for taking control of their own reproductive health and making life choices that suit them and their circumstances.
Please act to ensure women's rights to make decisions about their own bodies are protected, not criminalised.

Submission #018

To whom it may concern,

As a woman I'd like to contribute to the consultation on pregnancy termination law reform. I was shocked to read the ridiculous hoops women have to go through to terminate a pregnancy in the Northern Territory. The law is archaic and puts enormous unnecessary additional stress onto people already going through one of the most distressing times in their lives. Whether or not to continue a pregnancy has to be a woman's choice and they should not be made to feel worse when circumstances mean having a child at that time or to that person is not an option or in their best interests.

Submission #019

As per the CE broadcast I am responding as an interested clinician
I have read the discussion paper and find a well presented, thoughtful well prepared discussion
I agree with its proposal

Submission #021

Dear Minister Fyles

Re: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

I am a supporter of WHAT RU4 NT? and write to provide feedback on the above mentioned discussion paper.

I support the proposed reforms as detailed in the paper, including:

- Decriminalisation of abortion
- Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
- Ensuring women are provided with supportive care from health professionals about future contraceptive options
- Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
- Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
- Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
- Removing the need for women to justify the reason they seek an abortion
- Enabling minors who satisfy the relevant competency test to consent to treatment
- Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them
- Establishing safe access zones around places where terminations are performed.

I also seek that the following be considered:

- Women be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.

I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.

Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #022

Dear Minister Fyles,

Re: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services
I am writing to provide feedback on the above mentioned paper.
I am a supporter of *WHAT RU4 NT?* and write to provide the proposed reforms as detailed in the paper, including:

1. Decriminalisation of abortion
2. Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
3. Ensuring women are provided with supportive care from health professionals about future contraceptive options
4. Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
5. Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
6. Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
7. Removing the need for women to justify the reason they seek an abortion
8. Enabling minors who satisfy the relevant competency test to consent to treatment
9. Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them

I also seek that the following be considered:

1. Women be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in pregnancy
2. I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.

For me, legislation that supports equity of access to health services – including termination of pregnancy services – for women across the NT is an absolute priority. In addition, ensuring that women in the NT have access to pregnancy termination services in line with those in other states is of high importance to me.
Furthermore, I have full confidence in the NT's highly skilled medical practitioners to be fully capable of adhering to the relevant, evidence-based medical standards and guidelines that govern the administering of medications such as RU486. Such medical

guidelines are constantly reviewed and updated based on contemporary medical evidence.
Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #024

Dear Minister Fyles
Re: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services
I am a supporter of WHAT RU4 NT? and write to provide feedback on the above mentioned discussion paper.
I support the proposed reforms as detailed in the paper, including:
• Decriminalisation of abortion
• Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
• Ensuring women are provided with supportive care from health professionals about future contraceptive options
• Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
• Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
• Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
• Removing the need for women to justify the reason they seek an abortion
• Enabling minors who satisfy the relevant competency test to consent to treatment
• Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them
• Establishing safe access zones around places where terminations are performed.
I also seek that the following be considered:
• Women be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.
I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.
Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #027

1/14/2017

WHAT RU4 NT?

Response to government on Termination of Pregnancy Law Reform

WHAT RU4 NT?

Response to government on Termination of Pregnancy Law Reform

WHAT RU4 NT? is an advocacy group formed in 2014 in order to improve the quality of reproductive health care provided to Northern Territory (NT) women and specifically termination of pregnancy. WHAT RU4 NT? is formed by clinicians, lawyers, consumers and the NT community who wish to encourage change and implement reproductive health rights enshrined in international conventions that Australia is a signatory. WHAT RU4 NT? has strong support in the NT with over 1200 followers on Facebook and media coverage in popular press and radio outlets. WHAT RU4 NT? has consistently called for contemporary legislation in line with current medical practice that recognizes termination of pregnancy as a health event and not a criminal event. WHAT RU4 NT? garnered over 1000 signatures in a petition presented to parliament calling for law reform plus several hundred letters of support supplied to the previous Ministers of Health and Attorney General. WHAT RU4 NT? welcomes this Discussion Paper from the present government.

One in four pregnancies are terminated in the NT and each year around 1000 women end their pregnancies. Indigenous women and non-Indigenous women end their pregnancies at the same rate. In some cases NT women are forced to travel interstate to seek termination services that are not available in the NT. Access to services and the quality of services has been deficient, in part due to legal constraints. The Medical Services Act Section 11 needs urgent reform to reflect current medical standards of care and social changes since 1974 when the 'abortion law' was first legislated. WHAT RU4 NT? supports the repeal of Section 11. WHAT RU4 NT? will not support any legislation that discriminates against girls and women or adds financial burdens to managing fertility and reproduction.

1 Criminality and health care

WHAT RU4 NT? endorses the complete decriminalisation of termination of pregnancy affecting a health professional. Unsafe abortion by unskilled or underground methods is best avoided by providing access to legal and safe methods of termination of pregnancy. This is recommended by the World Health Organization.[1]

2 Treatment options

Medicine continually advances and it is not wise to legislate prescriptively on the manner in which a termination of pregnancy is managed. Including surgical and medical methods of abortion as well as 'other means that are medically approved' is appropriate. Referring to standard treatment options and preparing clinical guidelines that are approved by the relevant health experts is recommended.

3 Criteria for providing treatment

- Many of the subsections regarding consent, information, counseling, and paying attention to a patient's psycho-social situation are redundant as these are requirements of standard medical care. Termination of pregnancy is no different. Wording within the legislation should not imply

that any of this health care is mandatory but rather in line with evolving 'best practice' guidelines for the care of women seeking a termination of pregnancy.

- WHAT RU4 NT?'s position is that there is no need to state the number of doctors required. WHAT RU4 NT? accepts that one doctor should be involved in all cases; with later gestations and more complex cases two or more doctors may or may not be required to be involved. This is an issue of professional assessment, not law.
- WHAT RU4 NT? submits that it is potentially restrictive to include a definition of 'suitably qualified medical practitioner' in the legislation. Any definition runs the risk of being overly prescriptive in the future, given the potential development of new technology and medications. Currently, the Therapeutic Goods Administration and the Pharmaceutical Benefits Scheme restrict the prescription of MS2-Step to medical practitioners who are certified (through being a FRANZCOG or having completed additional online training). This is the level at which 'suitably qualified medical practitioner' should be defined. In the future, medications or other procedures that induce an abortion may be even safer and more efficacious, and may be very straightforward to prescribe or perform. If this were to occur, the medications or procedures would be taught at medical school and during general practice training as per the way medical practitioners are taught to prescribe other drugs and to perform other procedures. Additional 'recognised training courses' or registration as certified prescribers would not be required, just as they are not for other drugs prescribed by general practitioners (including drugs with dangerous side effect profiles such as warfarin, methotrexate and prednisolone).
- The gestational limit of 23 weeks does not take into account foetal abnormality. This seems a pressing omission. Foetal abnormalities are diagnosed at 18 weeks and beyond. Diagnosing and managing fetal abnormalities raise ethical, legal and medical complexity but the proposed limit ignores real issues for women and their families. Several Australian studies are worth looking at in detail on this point.

  Dr Dickinson examined late terminations of pregnancy in WA from 1998-2004. Dr Dickinson found that 219 women underwent abortions ≥20 weeks' gestation during this period, representing 0.5% of all abortions in the state. The vast majority of these were performed between 20 and 24 weeks with only 29 performed after 24 weeks. The principal indications for terminations ≥20 weeks were: karyotypic (28.8%); cardiac anomalies (15.5%) and neural tube defects (11.9%). [2]

  Professors de Costa, Douglas and Black wrote on this subject in 2015, stating:

  > *'Induced abortions after 20 weeks' gestation comprise around one per cent of all terminations in Australia and mostly occur following the diagnosis of a foetal anomaly. However, these abortions are overly represented in legal cases against doctors and challenging to organise in those states where abortion remains in the criminal code and health department directives impose regulations... Ethics committee involvement for late-term abortions is required by state health policy in NSW and Queensland, where abortion is still a criminal offence. This process is seen by abortion providers to hinder timely access to services and excludes women from the decision-making process.'[3]*

  This is a small number of women but their requirements must be considered. Legal barriers disrupt the therapeutic relationship and compound trauma for these women. Further, a study in the United States by Professor Green Foster found that 'banning' or limiting gestation disproportionally affects young and financially disadvantaged women, particularly those living

with domestic violence or substance abuse. [4] Writing limits to gestation into legislation on a medical issue is harmful and should be a clinical matter lead by current medical guidelines.

4 Prescribing, supplying and administering medicines

WHAT RU4 NT? endorses a wide range of health professionals, including pharmacists, nurses, midwives and doctors who are legislated to prescribe, supply and administer various medicines that induce termination of pregnancy. Health professionals are often in short supply in the NT and this leads to crises of care.[5] This is in step with World Health Organization guidelines.[1] Ensuring that health professionals have legal authority if they abide by best practice guidelines and current medical evidence is endorsed by WHAT RU4 NT? There is a case to answer in the over-regulation of mifepristone and misoprostol, non-toxic medications that are less dangerous than many other medications available in supermarkets.[6]

WHAT RU4 NT? members would be pleased to assist with the development of any new guidelines or participate in the expert group for the safe provision of termination of pregnancy in the NT.

5 Location of health care

WHAT RU4 NT? supports the provision of termination of pregnancy within and beyond hospital settings. The location of the termination of pregnancy should be determined by the needs of the woman with the advice of her doctor and prevailing local conditions. Many factors will influence the choice of setting and the most appropriate response in the circumstances. Early medical abortion is specifically valuable for those women who wish to remain in a home setting. The development of some guidelines to assist decision making will be beneficial. We recommend that these guidelines are similar to the Women's Business Manual [7]

As the NT government states, there are a proliferation of guidelines from expert groups available to health professionals on the topic of termination of pregnancy. The NT Department of Health should develop their own which would take into account local specifics and options which can be regularly updated. From the options to reducing risks arising from remoteness listed in the Department's discussion paper, WHAT RU4 NT? agrees with the Department in supporting option 3, 'the adoption of professional standards and guidelines by the practitioner'.

6 Data

Data collection on termination of pregnancy in Australia is inadequate. We recommend that government now consider how systems will be implemented both within the public hospital and private clinic settings including GP practices, to capture important statistical information about women's health outcomes in the Northern Territory. WHAT RU4 NT? recommends the mandatory collection of deidentified data from doctors who manage termination of pregnancy including where RU486 is prescribed regardless of location or type of abortion in a similar way that Western Australia, New Zealand and South Australia collect data.

7 Conscientious objection

WHAT RU4 NT? supports the Department of Health's proposal for a clause similar to Victorian legislation section 8 which proposes that health practitioners with an objection inform the woman and refer her to another colleague who does not hold an objection immediately to ensure meaningfully timed referrals.

8 Safe access zones

WHAT RU4 NT? supports the creation of Safe Access Zones around pharmacies, general practices, hospitals, and clinics where any termination of pregnancy services are provided. The government's position of a penalty for those who infringe the right of privacy or harass patients or staff is also supported.

9 Informed consent

Informed consent is part of normal standard care and adult women who consult their doctor require no further legislation apart from normal medical standards of best practice.

Minors seeking a termination of pregnancy should be handled according to 'best practice' guidelines for care of teenagers and provided with standard care. WHATRU4NT? supports the use of the principle of Gillick competence in determining a minor's capacity to consent. Intellectually impaired women and women requiring guardianship should not be impeded in requesting termination of pregnancy. Usual consent processes should apply in these cases.

Vulnerable women, women with disabilities, children in state care require special assistance and particularly support from government. The provision of some termination of pregnancy services within public hospitals is one way to ensure that access is possible for disadvantaged women. We recommend that Territory Families and Department of Health (Adult Guardianship) create policy detailing the factors service providers must consider in supporting women and girls who are in care to make an informed decision that is in their best interests.

Final words

WHAT RU4 NT? is comprised of women from a diverse range of backgrounds, including Indigenous women and Culturally and Linguistically Diverse women and women from same sex and gender diverse identities. We acknowledge that there are added barriers that women from certain groups experience which can make them reluctant to access mainstream health services. We recommend that women from a diverse range of backgrounds are consulted and included in expert advisory groups.

WHAT RU4 NT? endorses Family Planning Welfare Association of NT's submission in full. We appreciate the opportunity to comment on the government's discussion paper. We commend the government for their prompt response and commitment to reforming the Medical Services Act as a legislative priority and for the comprehensive Consultation Paper and public inquiry government has committed to and implemented. We look forward to contemporary legislation that does not discriminate against women and upholds the best reproductive health care standards.

References

1. World Health Organization, *Safe abortion: technical and policy guidance for health systems* Department of Reproductive Health and Research, Editor. 2012: Geneva. p. 134.
2. Dickinson, J.E., *Late pregnancy termination within a legislated medical environment.* Australian and New Zealand Journal of Obstetrics and Gynaecology, 2004. **44**(4): p. 337-341.
3. Black, K.I., H. Douglas, and C. de Costa, *Women's access to abortion after 20 weeks' gestation for fetal chromosomal abnormalities: Views and experiences of doctors in New South Wales and Queensland.* Australian and New Zealand Journal of Obstetrics and Gynaecology, 2015: p. n/a-n/a.
4. Greene Foster, D. and K. Kimport, *Who seeks abortions at or after 20 weeks?* Perspectives on Sexual and Reproductive Health, 2013. **45**(4): p. 210-218.
5. Belton, S., C. de Costa, and A. Whittaker, *Termination of Pregnancy: a long way to go in the Northern Territory*, in *Medical Journal of Australia*. 2015: Letter to the Editor.
6. O'Rourke, A., 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, 2016. **24**: p. 221-238.
7. *Minymaku Kutju Tjukurpa Women's Business Manual, 4th Edition*. Standard Treatment Manual for Women's Business in Central Australia and Top end of the Northern Territory. 2008, Congress Alukura and Nganampa Health Council Alice Springs.



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

18 January 2017

www.hrlc.org.au

Freedom. Respect. Equality. Dignity. Action.

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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.

[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]

[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.

[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.

[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.

Submission #032

19 January '017

Enquiry on Termination of Pregnancy Law Reform
Department of Health
Northern Territory Government, NT.

Email : doh.consultation@nt.gov.au

Dear Madam/Sir,

Re: Enquiry on Termination of Pregnancy Law Reform by the Northern Territory Government.

I am writing to you to tell you of the Jewish perspective on abortion and to appeal to you to make abortion illegal except for certain exceptions which are outlined below.

1) The Seven Noachide Laws for all humanity makes any abortion which is performed after forty (40) days' gestation of the foetus an act of murder, except when the mother's life is in danger, in which case it is allowed at any time at all, but only if no part of the foetus has protruded outside the birth canal. Abortion up to forty (40) days is allowed for any reason at all.

2) It is only in the event that a mother's life is endangered that an abortion can be performed at any time at all but only before any part of the foetus appears outside the entrance of the birth canal - even at nine (9) months of gestation an abortion can be performed to save a mother's life in the above circumstances.

As you can see from the above, the criteria under the Seven Noachide Laws for which abortion may or may not be performed are very specific.

I urge you to make abortion illegal in a way which is consistent with the Seven Noachide Laws, and equally, urge you to legislate all laws in accordance with the Seven Noachide Laws.
Thank you for accepting this submission.

Submission #033 Tabbot Foundation

Submission to the Northern Territory Government

Department of Health regarding Termination of Pregnancy Law reform

The Tabbot Foundation

The Tabbot Foundation provides an Australia-wide telephone consultation home medical termination of pregnancy service. Abortion has been revolutionised by medication abortion which has been available throughout the world for more than a decade but has been restricted for use in Australia until more recently. The method has been used by millions of women in more than 50 countries who have had access to it for several years. In Australia in 2015, more than 23% of abortions were performed medically and this is increasing rapidly now that women are aware of the alternative and preference. Medical abortion is now accounts for 46% in USA, 66% in UK, Scandinavian countries more than 85% and almost 100% in Norway.

The Tabbot Foundation at present provides about 15% of its services to women in RA4 and RA 5 areas in other states. The safety of service provision is assessed individually based on the location of the patient and proximity to emergency facilities. In addition, we supply extra misoprostol to all patients to manage excessive bleeding that may occur days after the abortion. In doing so, we believe that home based medical abortion by telephone consultation can be safely provided if the woman is resident within 1 hour of Darwin, Katherine or Alice Springs thus serving more than 70% of women.

Responses to the discussion paper are only in relation to the provision of home based medical abortion services at a gestation less than 9 weeks.

Criteria for providing treatment

Note that no woman can be one week pregnant.

Criteria for the most appropriate location of treatment and safe care

1) Mifepristone not under direct supervision

The RANZCOG Guidelines July 2013 restricted the use of mifepristone to under the direct vision of the medical practitioner:

"*Elements of clinical care may be delivered by another suitably qualified and experienced clinician or service; where more than one service or facility is involved there must be explicit agreed arrangements for sharing of relevant clinical information and for the provision of care which may be necessary, possibly with shared protocols. However, the administration of mifepristone must take place under the direct vision of the medical practitioner (or a health professional under their supervision), as this ensures that it is the woman who has requested the abortion who is taking the drug and at the gestation expected".*

This constraint was removed in the latest guidelines C-21 2016 because it did not allow for the woman ever to be handed a prescription, mistrusted like methadone addicts, or to allow the woman to choose the day that the abortion would take place; most prefer the weekend so it meant the woman had to be seen to swallow the tablet on a Thursday or Friday. Instead the guidelines are now:

"3.2 Mifepristone use in Medical Termination of Pregnancy
Termination of pregnancy by any method should be conducted in accordance with the legal and regulatory requirements of the jurisdiction within which it occurs. Clinicians should be familiar with local requirements, which in some jurisdictions determine where the relevant drugs may be administered and by whom, and may preclude home administration of misoprostol."

And the guidelines support the use of misoprostol at home:

"There is abundant evidence to support the option of misoprostol being self-administered at home by
women at less than 63 days gestation who prefer this; the woman must be advised to have an

accompanying support person present at least until the conceptus is passed, who should be able to
assist in contacting and accessing support and/or emergency care if needed."

2) MS Health

No reference is made of MS Health in the TGA requirements. MS Health licence expires in 2018 and other sponsors of the drug may then be available.

"The Therapeutic Goods Administration (TGA) requires that both practitioners and pharmacies are registered with the sponsoring company, before mifepristone is supplied. Holders of FRANZCOG or Advanced DRANZCOG will need to provide evidence of this qualification or complete the online training, offered by the sponsoring company in order to register."

Paul Hyland MB BS FRCS FRCOG FRANZCOG
Medical Director
The Tabbot Foundation

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Dr Virginia Skinner
Northern Territory Government
Email: DOH.consultation@nt.gov.au

Dear Dr Skinner

Subject: Termination of Pregnancy Law Reform

Thank you for the opportunity to provide feedback on the revision of termination of pregnancy legislation in the Northern Territory. Please find below our comments:

1 Repealing the sections of the Criminal Code referring to termination of pregnancy is consistent with the situation in Tasmania. This is also consistent with legislative changes in other jurisdictions (as identified in the document) as well as changes in social expectations regarding access to termination of pregnancy.

2 A legislative instrument may not be the best place to identify the practices involved in the termination of pregnancy. Perhaps, the use of the term "through any medical intervention" covers all current and future possibilities without listing 'surgical', 'prescription' etc. However, the proposed legislation does make reference to 'other means' which does also cover any future developments.

3 Pre-termination counselling has been shown to have benefits for women including improvements in psychological coping post-termination (Vandamme et al. 2013) and may assist women to make an informed decision about terminating a pregnancy (Strydom & Humpel 2009). However, Baron et. al (2015) demonstrated that a majority of their cohort of women seeking termination of pregnancy either did not want or did not believe they needed counselling. In another study cohort it was shown that many women preferred not to receive pre-termination counselling from their usual gynaecology provider (Chor et al. 2016).

4 We believe it is essential for women to be offered counselling prior to termination of pregnancy, due to the benefits it may provide, and that appropriate individuals are available to deliver that counselling in both urban and regional settings. Investigating telehealth options may also be possible as a means of providing counselling in remote areas. We are also of the view that access to termination of pregnancy should not be contingent upon a woman receiving mandatory pre-abortion counselling. The right to decline the offer of counselling should be respected in the interests of supporting a woman's autonomy.

5 The question of whether assessment can be safely performed at a specific site is different to the question of whether a termination can be safely performed at a specific site. There are two questions that arise from the proposed changes to legislation:

a) Firstly, is the recommended number of assessing doctors (i.e. one up to 14 weeks gestation and two post 14 weeks gestation) adequate given the risks involved, particularly in remote areas? It is likely that the risks associated with assessment are no greater in remote areas when compared to urban ones. In Tasmanian legislation, one doctor may undertake assessment up to 16 weeks gestation.

b) Secondly, if there are no contraindications to termination of pregnancy discovered upon patient assessment, are the risks associated with performing a termination of pregnancy in a remote area, via prescription of medication or other means, acceptable? The paper identifies that termination of pregnancy through medication is considered safe and relatively risk free. We would suggest some form of risk assessment be undertaken in relation to the frequency and type of complications that may arise and how remoteness may impact upon patient outcomes.

6 Where a doctor or doctors, as the case may be, assess a woman and decide that termination of pregnancy is contraindicated in a remote setting, patient safety must take a higher priority than the ability to access a local service. In practice, where the assessing doctor or doctors, as the case may be, believe that there is a contraindication to performing a termination of pregnancy in a remote setting, a referral will be made to a less remote centre and/or a more specialized provider.

7 Informed consent requires a doctor to discuss the material risks associated with a proposed medical intervention. Material risks include those to which a reasonable person in the patient's position, if warned of the risk would likely attach significance, or where the doctor should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (NHMRC 2004). Good medical practice requires that doctors make genuine efforts to understand a patient's context, including cultural context, acknowledge the social, economic, cultural and behavioural factors that influence health, and adapt their practice to improve patient engagement (Medical Board of Australia 2014). Thus, good practice would require a doctor to acknowledge the material risks relevant to individual patients within the informed consent process.

8 It seems that the intention of the proposed legislation is to support individuals with capacity to make their own health care decisions regardless of age. Inclusion of wording such as that in Attachment 2 is probably not enough to ensure that Gillick competence in young people is respected. It is understood that the Northern Territory has no statutory definition of capacity. The proposed legislation may be a vehicle through which to provide such a definition, supported by a statement that capacity to consent to medical treatment may be present in young people.

9 Some doctors may have a conscientious objection to making a referral of a patient for termination of pregnancy. It is, however, a duty to ensure patient non-abandonment. Thus, there should be some mandate to ensure the patient is not abandoned and is given sufficient information or linked with services that can provide her with assistance. In Tasmania, as identified in the document, legislation does mandate that doctors who object to performing termination of pregnancy refer their patients to another provider. This has been a contentious issue in some Western jurisdictions and it is one worth considering thoroughly. Would the right to conscientious objection be important, for example, to Aboriginal doctors working in remote areas? How might any conscientious objection be dealt with in a manner that is acceptable to the doctor and does not involve patient abandonment? Traditionally all health care providers have had a right to conscientious objection and legislating mandatory referral necessarily interferes with that right.

10 We agree that those exercising their rights under the law should not be harassed or impeded in doing so. Thus, we would support the introduction of a proposed exclusion zone.

We would be happy to review any policies that may be produced in response to the legislation.

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Yours sincerely

Professor Anthony Lawler
Director Acute Planning and Strategy & Principal Medical Advisor
19th January 2017

Submission #035

Doh.consultation@nt.gov.au

Dear Minister Fyles

Re: Termination of Pregnancy Law Reform; improving access by Northern Territory women to safe termination of pregnancy services

I am a supporter of WHAT RU4 NT? and write to provide feedback on the above mentioned discussion paper.

I support the proposed reforms as detailed in the paper, including:

1. Decriminalisation of abortion
2. Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
3. Ensuring women are provided with supportive care from health professionals about future contraceptive options
4. Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
5. Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
6. Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
7. Removing the need for women to justify the reason they seek an abortion
8. Enabling minors who satisfy the relevant competency test to consent to treatment
9. Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them
10. Establishing safe access zones around places where terminations are performed.

I also seek that the following be considered

1. Women have the right to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.
2. I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.

Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #036

Submission to TOP law reform

I would like to draw attention to the following issues

1. The 23 week upper limit of gestation at which a termination may be undertaken is entirely arbitrary, and I believe that an upper limit should be scrapped. While terminations beyond this gestation are extremely uncommon, other than for the purpose of saving the woman's life, occasionally they need to be considered. Especially in the case of late diagnosis of severe fetal abnormality not compatible with life. For example, 2 weeks a young woman from our service was diagnosed with a chromosomal abnormality at 27 weeks. This abnormality is not compatible with life. My only option in the NT is to say to her that she has to continue carrying that pregnancy to term , then deliver a baby who will not survive. Obviously this is distressing to her.
   I am not against the idea of some sort of independent review of individual cases beyond 23 weeks (as in other states), as this can provide transparency in the decision making in these difficult cases and provide support to the obstetrician involved, when a maternal request places undue pressure on the clinician involved.

2. There is no reference to a termination register in the discussion paper, however, it seemed clear from a recent meeting that it is a legislative objective. I am absolutely opposed to this for 2 reasons. Firstly it is an unnecessary burden on the clinician (remember that if we remove the need for a primary referral from a medical practitioner then the full burden of counselling and mandatory reporting falls to that sole clinician, as well as all the necessary work involved in undertaking the termination). Secondly, I fail to see why this particular procedure has to be monitored. No case was made to me regarding the purpose of a register. If it is to keep track of numbers of terminations being performed then I maintain that there are other methods of data collection (eg. Surgical termination numbers can be reported by each facility undertaking them, medical termination numbers can be monitored with pbs data). If it is to monitor complications then this can be done using hospital coding data (if a complication is serious enough then it will warrant hospital admission). I do not see what makes this medical procedure different to any other; every procedure can have complications.
   Registers are prone to errors if not maintained properly; this will incur significant monetary cost on a permanent basis if legislated for.
   In addition, from a consumer point of view it seems to me to be unnecessary and intrusive monitoring of personal health choices.

3. Given that women who live in remote areas will still have to travel to an urban centre for termination (often to access ultrasound for dating) then medical termination has to remain an option for them. Current access to no cost pbs medications (the S100 scheme) is restricted to non hospital services registered with this scheme. Alice Springs hospital currently undertakes all terminations in central Australia, and it is likely that the hospital will remain the main provider of termination services. At present I cannot write a no cost pbs script for a woman living in a remote area due to prescribing restrictions of the S100 scheme. The NT dept health will have to provide a solution to this barrier to access.

4. I am in favour of the consent changes proposed in relation to young people. If a young person is “Gillick” competent then the decision to terminate the pregnancy is between herself and the medical practitioner (and should not necessarily require notification to Dept Children and Families if the young person is under their care). Sometimes we have to deal with very young people, ie, 11 and 12 years of age presenting for termination of pregnancy. These can be difficult and delicate and time consuming to deal with. The current situation in regard to availability of counselling (apart from the medical practitioner) in central Australia is extremely poor. The Alice Springs hospital does not have an outpatient social work service . The law reform process and formulation of an NT guideline provides an opportunity to improve counselling services in central Australia. Most people requesting termination do not require counselling, but for the minority who do, especially the very young people that we sometimes have to care for, we need to be able to offer a clear pathway to a real service.

Submission #040

G'day
Just to let you know that my view on abortion is ...
Rape or incest.
Anything else is murder.
Have YOU asked the creator, Jesus Christ what His viewpoint is, after all ,you answer to Him on your choices and what you enforce.

Cheers

Submission #042

Dear Minister Fyles

Re: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

I am a supporter of WHAT RU4 NT? and write to provide feedback on the above-mentioned discussion paper.

I support the proposed reforms as detailed in the paper, including:
- Decriminalisation of abortion
- Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
- Ensuring women are provided with supportive care from health professionals about future contraceptive options
- Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
- Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
- Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
- Removing the need for women to justify the reason they seek an abortion
- Enabling minors who satisfy the relevant competency test to consent to treatment
- Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them
- Establishing safe access zones around places where terminations are performed.

I also seek that the following be considered:
- Women be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.
- I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.

Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #043

Dear Sir/Madam,

I would like to make comments on the proposed changes with ToP as below.

1. If we were to allow abortion in NT, do we have enough remote clinics to deal with ToP? I have been in NT for almost five years now and have been traveling nearly every place. I just do not see NT is ready for the proposed changes.

2. If we were to legalised abortion, are there any plan to enforce pre- and post-abortion counseling including alternatives to medical and surgical facilities.

3. Given the potential lack of literacy or access to technology including email, are there any plan to ensure the locals' opinions on this matter are properly heard before making any changes?

Submission #044

Dear Minister Fyles

Re: Abortion Law Reform in the Northern Territory

As a resident of the Northern Territory, I applaud the government for acknowledging the archaic abortion laws confronting women in the Territory and for inviting public input about the legislative reforms required to prioritise the health and happiness of women. As a 20 something year old sexually active woman, the right to terminate an unwanted pregnancy is a right integral to my mental and physical wellbeing.

I propose the following reforms:

Decriminalisation of Abortion

The government proposal decriminalises abortion when performed by a suitably qualified medical practitioner but maintains that the procedure will remain a criminal offence under other circumstances.

I respectfully submit that the proposal for abortion to remain a criminal offence "under other circumstances" may impact on the ability and willingness of qualified practitioners to perform the procedure. Failing to define the circumstances under which abortion remains a criminal offence means that practitioners lack clarity about when they are providing a medical service as opposed to engaging in criminal conduct. The circumstances under which abortion is a criminal offence need to be certain and limited. The circumstance should be the performance of the abortion by an unqualified person excluding the woman undergoing the procedure.

Gestational Limits and Third Party Approval

The government proposal requires women to obtain the approval of one doctor for a pregnancy up to a gestational period of up to 14 weeks and two doctors including a gynaecologist or obstetrician for a pregnancy up to a gestational period of up to 23 weeks. The proposal is silent on the treatment to be afforded to women who want to undergo an abortion after becoming aware that the foetus has a foetal abnormality.

I respectfully submit that the proposal promotes a paternalistic view of women that presumes they are incapable of making decisions for themselves. Leaving doctors the ultimate decision makers over the right of women to undergo abortions is also dangerous given the relatively small pool of doctors available to women in the Northern Territory compared to other Australian jurisdictions. This problem is exacerbated for women in remote communities who may not have daily access to a single doctor. In such circumstances, the doctor refusing to approve an abortion or being unqualified to do because they are not an obstetrician, gynaecologist or GP who has undertaken accredited qualification to administer RU486 may result in the woman having no other way of terminating the pregnancy. The gestational limit of 23 weeks also does not account for foetal abnormality. Foetal abnormalities are

diagnosed at 18 weeks and beyond and consequently a gestational limit of 23 weeks may result in a woman finding out about a foetal abnormality after the right to undergo an abortion has expired or otherwise may result in a woman not having adequate time to consider her options. There should accordingly be no gestational limit on the right to an abortion nor should there be a requirement for doctors to approve the procedure. This would bring the law into line with the approach afforded to other medical procedures.

Counselling

The government proposal requires information and counselling to be provided to a pregnant woman about her current choices and future contraceptive options.

I respectfully submit that counselling is offered rather than mandated to women seeking an abortion. It is offensive in the extreme to assume that every woman seeking an abortion is suffering from psychological turmoil requiring professional assistance. On the contrary, in its recommendations to the Victorian government pursuing abortion law reform in 2008, the Victorian Law Reform Commission noted the consensus amongst abortion providers that "the majority of women who seek an abortion are informed, have considered their decision thoughtfully and for some time, and are clear in their decision not to continue this particular pregnancy at this particular time in their life for a set of unique and individual reasons."

Conscientious objection

The government proposal requires a medical practitioner with a conscientious objection to abortion to refer to the woman seeking an abortion to another practitioner.

I respectfully submit that the duty to refer should extend to all professionals that a woman may encounter when seeking to terminate a pregnancy. The right to exercise a conscientious objection should also be second to the right of a woman to an abortion in circumstances where it is necessary to preserve the life of a pregnant woman or to prevent serious harm to the pregnant woman. Serious harm should be defined as circumstances where an abortion is necessary to prevent grave injury to the physical or mental health of a woman or to prevent a woman from carrying a foetus with foetal abnormalities to term.

Summary

I reiterate my praise for the government in agreeing to reform abortion laws in the Territory and look forward to the day when the health and wellbeing of women is prioritised in the legislation.

Submission #046

To Whom it May Concern,

I am writing to inform you of my opinion on the proposed changes to the abortion laws in the NT.

Medical advances are not always advances. Creating easier ways for women to end the life of a child is not an advance. Each life is sacred. Yes, the health and well being of women is important, but we are called to protect the most vulnerable in society, and there is none more vulnerable than a child still in the womb.

I recently miscarried at 9 weeks. I was able to hold my child when he was born. He only grew til around 7 and a half weeks. A little over the size of my thumb nail. He was perfectly formed. He had a head, body, arms and legs. Even at this early stage of pregnancy, his fingers were distinguishable.

I am peace with what I have been through. What I am not at peace with though is that thousands of children are disposed of each year for conveniences sake. Yes, the situation that a women may be in may not be ideal, but there are better solutions than terminating the most vulnerable.

I implore you to reconsider these changes. Let us instead look at solutions that protect women and their unborn babies.

Submission #047

To Whom It May Concern,

I am writing a response to the proposed changes on Abortion.

War
Australia looks up to our 'older brother' America in many things. We share common interests in music, culture, and common interests in who we go to war with. The continuing war on terror has lead to a renewed national consciousness of the high price of war, and, for many, a heightened desire for peace. Yet, despite all this concern, the most horrible war of all has gone all but unnoticed. Australia's statistics on abortion are less than desirable, however in America it has claimed 57 million American lives in the last 43 years.
This scourge is as horrible as anything terrorists can fathom, because it strikes at the very core of humanity and our country: the family. By destroying the most basic human bond of all—that between mother and child—abortion dissolves the precious glue that binds our nation together.
While mother and child are the first victims, there is not a single element of society that is not affected by abortion. Mother, child, father, husband, aunt, uncle, friend, sibling and grandparent alike suffer the scars of the abortionist's scalpel. Peace abroad is meaningless without peace at home.

Life Starts at Conception
This is the definition given in any respectable medical textbook. To declare a beginning of life at any point after the fusing of a wife's egg and a husband's contribution is irrational and an exercise in sophistical chicanery.
Only machines such as clocks and cars come into existence part by part. Living beings come into existence all at once and gradually unfold their world of innate potential. A living human person begins to exist at the moment of conception, even though only as a cell. What is important is not the accident of size or weight but the essence – which is fully human. The unborn baby has a distinct, unchanging and unrepeatable genetic code, unique in all of history, from the moment of conception till death.

As a Christian, along with 61.1% of Australians, I believe we are made in the image of God. From the very beginning of the Bible we learn that God is the author of life. Human beings have incredible dignity because we are made in God's image. "Let Us make man in Our image, according to Our likeness," the Creator says. "Let them have dominion over the fish of the sea, over the birds of the air, and over the cattle, over all the earth and over every creeping thing that creeps on the earth" (Genesis 1:26).

In giving man dominion over animals God revealed that humanity is in a totally different class from animals. Genesis reveals that God creates human beings with a soul, moral choice, and self-conscious intelligence. We read of God breathing a soul (possessing free will and reason) into a human being in Genesis 2:7 when He "breathed into his nostrils the breath of life; and man became a living being."

Beliefs, Morals and Ethics
The Bible undergirds the scientific data. As we look to God's Word, the ultimate source of truth, we see that God, the Creator of life, tells us when personhood begins.

Formed in the womb—There are over seventy references to "the womb" in the Bible. One of these is Jeremiah 1:5: "Before I formed you in the womb I knew you." Catch the wording of

this sentence: God forms us in the womb. He is intimately involved in creating and developing the little ones growing within their mothers.

Unique and Individual—"You formed my inward parts; you covered me in my mother's womb. I will praise You, for I am fearfully and wonderfully made; marvelous are Your works, and that my soul knows very well. My frame was not hidden from You, when I was made in secret, and skillfully wrought in the lowest parts of the earth. (Psalm 139:13–15)"

Final Comments
I am strongly against the Law Reform to accept Abortion in the Northern Territory.
Please do not be swayed by the loudest talkers, but be swayed by the word of God and of Common Sense.
Think of all you have achieved in your life, the ups and the downs. This opportunity at life could be snuffed out for another person if this Law Reform goes through.

Thank you for your consideration,

Submission #048

My name is xxxxxxxxxxx and as a permanent resident of the NT I would like to submit some feedback on the proposed legislation changes without prejudice.

My concern covers two matters- one is the timeframe given for choosing termination and two the age of a child to make the request for termination.

Why do we offer termination up to 23 weeks? I agree that should the pregnancy fall under the following two criteria then it is deemed necessary ie The continuance of the pregnancy would involve greater risk to the woman's life or greater risk of harm to her physical or mental health than if the pregnancy were terminated; or

(ii) there is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities

However the right to choose termination other than the above should be limited to 20 weeks. The development of the foetus is such at 23 weeks that lungs are being developed to set them up to breathe and they sense movement externally. I think we need to consider a woman's right to choose and the safety and rights of the baby. It seems an excessive play out unless the above criteria are met for the mother.

Again the right of the mother deemed emotionally and intellectually able at 16 yrs makes little regard for reality. A child unable to vote yet making a decision as big as this one if not meeting the above criteria, she needs to have the advice and support of an adult and medical practitioners to explain many options open to her. Ultimately the decision should be a joint one with an adult. There is no shame now in carrying a child full term when families are longing for a child to adopt.

While opinions shared by myself may not stand up to the rigour of contemporary Australia I thank you for the opportunity to respond.

Submission #049

Feedback to the discussion paper: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services.
The National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC)
20/01/2017

NAAPOC *pays our respects to the traditional owners of country throughout the Northern Territory and Australia and their continued connection to land and community, and we pay our respects to elders past, present and emerging.*

This submission primarily addresses the counselling component of abortion access and care. *NAAPOC* asserts that women regardless of age or geographical location should be the primary decision makers regarding their own pregnancies and that they should be able to seek treatment for abortion care via the medical assistance of one appropriate medical professional. *NAAPOC* thanks the Northern Territory Government for the opportunity to contribute to the discussion regarding abortion law and access in the Northern Territory. We further congratulate the Northern Territory Government on taking positive steps forward to address legislative restrictions and reform in the area of abortion care. Various states in Australia have already undertaken law reform in the last decade including Western Australia and Victoria, and both Queensland and New South Wales are considering law reform in this area.

NAAPOC

NAAPOC was formally established in 2014 as an alliance of counsellors who have joint expertise and interest in unplanned or unwanted pregnancy and pregnancy options counselling and the provision of pro-choice information, women-centred counselling and referral services. *NAAPOC* has four founding organisations comprised of Pregnancy Advisory Service (PAS; Royal Women's Hospital, Victoria), Marie Stopes International Australia (MSIA; national), Children by Choice (Queensland) and Pregnancy Advisory Centre (PAC; SA Health, South Australia). MSIA provides a range of reproductive health services across Australia, including abortion services. Pro-choice counselling is an important part of the service they offer. Children by Choice is Queensland's only standalone pro-choice pregnancy counselling, information and referral service. The Pregnancy Advisory Centre in South Australia and the Pregnancy Advisory Service in Victoria are both public health care settings. All of these services have at various times provided advocacy and support to Northern Territory women and health care professionals when women have been unable to access services related to pregnancy options and abortion care in their home territory. Women in rural and remote areas within the Territory have reported their geographical location as a key barrier to accessing reproductive health care, including abortion services. All counsellors employed by these services and in *NAAPOC* hold tertiary qualifications in relevant fields including social work, psychology and counselling and have extensive experience in providing pregnancy options counselling to Australian women.

Abortion and Reproductive Justice: A National and International Context

NAAPOC believes that women should have the right to freely determine their reproductive health choices. Women's rights to access comprehensive reproductive health services, including abortion, are recognised by the United Nations Committee on the Elimination of Discrimination of Against Women, drawing upon the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (1979) (1). In a 2016 judgment,

the United Nations assessed the criminalisation of abortion by a state to be “a breach of women’s human rights” (1.1). *NAAPOC* believes that advocating for women to have access to their full range of reproductive rights is fundamental to ensuring women can enact their full claims to citizenship and human rights.

Unplanned and unwanted pregnancies are the primary reason women choose abortion. Among the 208 million women estimated to become pregnant each year worldwide, approximately 41% (or 85 million) of pregnancies are unintended (2). In Australia approximately 50% of pregnancies are unplanned (6). Some women are able to incorporate an unplanned pregnancy into their lives; others require a range of supports, such as family, friends, and partner support or pregnancy options counselling to support them to make a decision. It is estimated that just under one in four women in Australia will have a termination of pregnancy during their reproductive lifetimes (3). Some women face additional barriers to abortion access when that is their choice, including but not limited to young women, women living in rural and remote areas, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, women experiencing violence, and women experiencing financial distress and poverty. It is important to note that many women face simultaneous multiple barriers to abortion access which are related to issues including but not limited to socioeconomic status, geography and discrimination.

Abortion in Australia and in other developed countries has for many years been established as a safe and common procedure. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG*)* conclude in their publication, Termination of Pregnancy: A Resource for Health Workers:
*“*Abortion is safer than continuing a pregnancy to term and that complications are uncommon”*(3).*

Similarly, the World Health Organisation’s (WHO) position on abortion is clear**:**
“Whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same. Unsafe abortion and associated morbidity and mortality in women are avoidable. Safe abortion services therefore should be available and accessible for all women”(2).

More recently, the Australian Medical Association’s (AMA) 2013 position statement Ethical Issues in Reproductive Medicine stated the following (4):

- Access to reproductive medicine should be free from political or religious interference.
- All individuals have the right to make their own decisions about reproduction and the use of available reproductive medicine.
- Reproductive medicine includes services to manage fertility as well as infertility. Family planning services are used to control fertility and include contraception, termination of pregnancy, and sterilisation.
- A patient who seeks, or has undertaken any form of reproductive medicine, should not be subject to discrimination or stigmatisation.
- While a doctor may refuse to be clinically involved in a termination of pregnancy because of his or her personal convictions, such a refusal should not impede the patient’s access to care.

The extensive research available, as highlighted above, supports a universal right of women to access safe and legal abortion when that is the woman's choice. It is appropriate therefore that abortion be removed from Northern Territory's *Criminal Code Act* and oversight of abortion provision to be transferred to a robust evidenced based health regulation framework. Women do not make a criminal choice when they choose to have an abortion.

Reproductive justice for young women in the Northern Territory

NAAPOC strongly urges the Northern Territory Government (hereinafter referred to as the Government) to consider the reproductive rights of young women in the Northern Territory. As noted in the discussion paper, the use of *Gillick* competence in other jurisdictions provides for young women to consent to an abortion procedure if the assessing medical or allied health professional determines them to be competent to make that decision. Where it is determined that the young woman does not have capacity to make that decision, an application may be made to the relevant court to determine the best interests of the young woman.

NAAPOC counsellors have extensive experience providing pregnancy options counselling to young women aged 16 years and under. These young woman have just as much right to reproductive autonomy as older women in Australia, including in the Northern Territory. Many of the young woman who have received support from *NAAPOC* member organisations have been at risk of harm from their parents or carers, and it has not been safe for them to disclose their pregnancies to their parents or carers. It is essential to respect the dignity and autonomy of young women, and their right to safety, and allow them to make their own choices in consultation with a medical professional.

NAAPOC submits that the proposed legislation should provide clarification that a young woman aged 16 years or under is the appropriate person having authority in law to provide consent to the treatment where they are assessed to be competent.

Pregnancy options, abortion and counselling

NAAPOC supports contemporary evidence based and women-centred counselling practices and clinical services as identified and evidenced by the WHO, RANZCOG, United Kingdom Royal College Obstetrics and Gynaecologists (RCOG), Academy of Royal Medical Colleges Medicine (AORMC), and the American Psychological Association (APA). As such we support Australian women having voluntary access to comprehensive, evidence based counselling and support that places the woman as the expert in her life. This is turn supports the woman's full capacity to choose one of three pregnancy outcomes available: continuing the pregnancy to parent or adopt, or abortion.

Informed consent counselling vs therapeutic counselling

It is important to note the difference between therapeutic counselling and informed consent counselling in the context of pregnancy options and abortion counselling. Informed consent counselling supports women to understand the abortion procedure and any risks or side effects related to the procedure. Importantly, informed consent counselling confirms that the woman is independently making the choice to have an abortion.

The provision of informed consent counselling is a standard required of all health care services. MS Health, the licensed distributor of abortion medication in Australia, requires that general practitioners who prescribe the medication abortion obtain informed consent from their patients. Women seeking abortion care via surgical or medication methods are no different, and informed consent counselling is already provided in all states and territories of Australia, including the Northern Territory.

Therapeutic counselling in comparison provides women with the opportunity, where needed, to further explore their values, strengths and capacities in relation to their pregnancy decision. It may be that a woman requests counselling to assist her to navigate the decision-making path, or she may have already made a decision, for example, to have an abortion, and needs to discuss this decision with a supportive and non-judgemental counselling professional. For the majority of women, an unplanned or unwanted pregnancy comes as a shock and there may be challenging feelings and emotions associated with pregnancy decision-making. Women or couples with a wanted pregnancy may receive the news of a foetal abnormality and may be faced with a difficult decision-making process regarding the outcome of the pregnancy. Women have the capacity to reflect on their situation, determine what they want and to make informed choices about their course of action. They can either do this on their own or with the support of significant others in their lives including their health care providers. Thus it is not necessary that women receive pregnancy options counselling, however it is important that counselling be available to them if needed.

Effective support for women making these decisions should be based on several best practice key principles:

- Women are the experts in their own life.
- Women have the right to be treated in a respectful, non-judgemental way when discussing all of their reproductive options.
- Women require access to accurate and evidence-based information about all the reproductive options they are considering (15).

Mandatory counselling and cooling off periods

The discussion paper suggests that there be a requirement for counselling included in a new Act if Section 11 of the *Medical Services Act* is repealed. The wording suggested within the discussion paper is found on p. 3 “Information and counselling are provided about current choices and future contraceptive options” and on p. 15 “Information and counselling are to be provided about future contraceptive options regardless of gestation”. It is important to note that not all women need or want therapeutic counselling prior to making a decision about a pregnancy as demonstrated by Australian and international research. In a study commissioned by Marie Stopes International, the majority of women participants stated they did not need or want counselling, but wanted it to be available if required (6). A peer-reviewed qualitative study concluded that requiring women to undergo counselling would “delay the process and for most women would be an unnecessary burden, whilst also diverting resources from those women who require counselling” (7). Evidence shows the majority of women report emotional wellness after an abortion (12) which again indicates that counselling should not be mandatory, but instead women should be advised of services

available so they can make an informed choice regarding whether or not they access counselling. Risk factors for poor coping following abortion, such as pre-existing mental health issues have been identified (11,13) and it is important for these women in particular that voluntary, nonjudgmental therapeutic counselling be made available upon request . We are also concerned that if counselling is mandated, not all providers will respect the rights of women to reproductive choice and justice, which in turn may cause harm to those clients as they face a hidden anti-choice agenda. In the interests of women's dignity and autonomy, we strongly encourage the Government to reword this section of the proposed new Act to require that information about counselling services be made available to women rather than that the provision of counselling be a legislated requirement.

The practice standards and ethical guidelines of social work, counselling and psychological registration bodies in Australia also support the general principles of client self-determination, self-efficacy and client rights to autonomy over their decisions; these registration bodies include the Australian Association of Social Workers (AASW), the Australian Psychological Association (APA), the Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA). *NAAPOC* **<u>does not</u>** support any amendments of the Bill that propose compulsory counselling or mandatory waiting periods for women accessing abortion.

Women accessing abortion undertake a comprehensive medical assessment and the aforementioned informed consent process prior to abortion. Additionally women in many areas are subject to wait times for appointments which are often due to geographical barriers to abortion services and the inaccessibility of abortion services in many metropolitan, regional and rural areas of Australia. This is particularly so in the Northern Territory. The imposition of unnecessary mandatory counselling would further increase the waiting times and subsequently increase cumulative stressors for women. In the rigorous abortion law reform review process, the Victorian Abortion Law Reform Commission vetoed the recommendation of proposed legislation that sought to introduce compulsory counselling and mandatory cooling off periods prior to abortion(9). *NAAPOC* supports the introduction of consistent and simplified practices across all Australian jurisdictions.

Anti-choice individuals and groups opposed to abortion have argued false and distorted claims that mandatory counselling and cooling off periods will reduce the abortion rate. It is arguable that these groups aim to impose additional burdens on women to create barriers to abortion access, rather than offering an holistic range of supports for women no matter which pregnancy option they choose (15). There is no evidence that women take any decision about an unintended pregnancy in a rushed or unconsidered way. It is the experience of *NAAPOC* counsellors that women weighing up their pregnancy options do so in a considered and deeply thoughtful manner. *NAAPOC* draws the attention of the committee to peer-reviewed research that indicates that improved access to contraception and comprehensive sexual health education – rather than mandatory cooling off periods or mandatory counselling - is the key factor associated with reduced rates of abortions (10).

Whilst mandatory counselling is rarely implemented, there have been examples in the United States of America which have sought to restrict access to abortion by imposing this upon women. Researchers have concluded that mandatory laws related to counselling

directly correlated with making access to services more difficult which in turn resulted in interstate travel and later gestations for abortions (8). Mandatory counselling and mandatory cooling off periods undermine the expertise of medical and health professionals providing care for women and suggest that the state does not trust women as a specific group of the population to make responsible, autonomous and competent decisions.

NAAPOC believes that mandatory cooling off periods and mandatory counselling are offensive and discriminatory to women because they negate women's autonomy and competency to make their own decisions about their health and their life circumstances. Correspondingly, men are not required to undergo mandatory cooling off periods or mandatory counselling for male-specific medical procedures.

Professional counselling: Access and availability issues in Australia

It is important to note that Australian women have varying degrees of access to high quality, women-centred, evidence based counselling for pregnancy decision making and post abortion. There are a number of organisations that provide pregnancy counselling and support services to women throughout Australia. These include, but are not limited to, the Sexual Health and Family Planning Alliances in Australia, MSIA, Children by Choice, PAS, PAC, the Post and Antenatal Depression Association (PANDA) which includes the National Perinatal Depression helpline, SANDS Miscarriage, Stillbirth and Newborn Death Support, and the National Pregnancy Birth and Baby Helpline (PBBH).

Whilst there are differences between pregnancy counselling services across Australia in both the public and private settings, those services that operate from a woman-centred, pro-choice, evidence based framework are considered best practice services. These best practice services acknowledge a woman's capacity to make her own decision and provide her with the opportunity to access support via counselling that is informed and non-judgemental. These counselling services additionally provide support and referrals to access antenatal, parenting, abortion and adoption services as required.

It is a sad reality that the quality and availability of appropriate pregnancy options counselling in Australia is unreliable. This is largely due to the unregulated nature of counselling in Australia. A large range of people are legally able to call themselves counsellors without appropriate qualifications or training. This has consequences for anyone seeking counselling and undermines the profession for those counsellors who are trained appropriately, access clinical supervision, and who uphold and are guided by professional practice standards and ethics. *NAAPOC* counsellors set a high standard of excellence in pregnancy options counselling.

There are a number of organisations that purport to provide counselling services to women facing unplanned or unwanted pregnancy in Australia. Colloquially known as false-providers or anti-choice providers, the aim of these false pregnancy counselling providers is to talk women who prefer to have an abortion out of that option and to force those women to continue their pregnancies. Anti-choice providers do this by providing misleading, inaccurate or false information about the option of abortion and will not provide information about where a woman can obtain information about abortion access. They use tactics that seek to shame, scare and manipulate women who contact them seeking support

and information about abortion. *NAAPOC* counsellors have on numerous occasions provided counselling to women who have been left extremely distressed following interactions with anti-choice "counsellors", including women who have reported being labelled "murderers" and provided false information about fetal awareness and development by the aforementioned anti-choice "counsellors".

In the interests of client safety, autonomy and dignity, *NAAPOC* believes that anti-choice services should publicly state their anti-choice stance in all published materials so that any reasonable health consumer can make a choice about whether or not to access that service. As the national advertising law stands, there is no requirement for purported pregnancy options services to be transparent about their stance on abortion and this allows them to ambush women with their anti-choice agenda.

Australia is a modern, secular and inclusive society with a strong history of medical and scientific research. Australian women, including women in the Northern Territory, should have access to reproductive justice including the right to make their own health care decisions and to be trusted as experts in their own lives. Women should be able to trust that health professionals and counsellors will not subject them to non-evidence-based or personal anti-choice values when seeking professional support and counselling services regarding a private medical issue. *NAAPOC* urges the Government to be aware and mindful of the number of false counselling providers Australia wide which do not rely on medically sound, evidence based information to guide their information and practice.

Supports following an abortion

The following points are drawn from peer-reviewed publications by bodies such as RANZCOG, RCOG, APA, AORMC and WHO:

- The majority of women cope well emotionally following an abortion (11). Some women experience a range of emotions following abortion. Often this occurs because women are not given social and cultural permission to consider abortion as a legitimate option, resulting in a struggle with a pregnancy and related doubting of their own experiences. This lack of self-validation can lead to a range of complex feelings. The stigma and discrimination attached to the abortion choice perpetuates the idea that if you do choose to have a termination that it should be followed by a negative emotional response, in particular regret. However this is not the case for the majority of women (16,17).
- The best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy (11).
- The most reliable predictor of post abortion mental health problems was having a prior history of mental health problems (11).
- Research published in July 2015, the most robust longitudinal study of women and abortion in the US, which followed women over three years post their abortion showed that 99% of these women reported that abortion was the right decision at all time points over three years (12).

- The same study also demonstrated that both negative and positive emotions decline over time and that higher perceived community abortion stigma and lower social support were associated with more negative emotions (12).
- In 2011 a meta-review of studies showed the rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth (13).

Conclusion

NAAPOC supports the Government proposal to repeal abortion from the Northern Territory's *Criminal Code.* We encourage the Government to adopt the recommendations of reputable, peak bodies such as RANZCOG, RCOG, APA, the AMA, AOMRC and WHO and to refer to peer reviewed, methodologically sound evidence when making recommendations regarding the role of self-determined counselling and medical care in the provision of safe and legal abortion in the Northern Territory.

The anti-choice agenda claims to "represent both sides" of the debate regarding reproductive justice, using false equivalencies which effectively give equal value to the opinions of those who deliberately spread highly emotive misinformation. This technique has become a mainstay of the anti-choice agenda in debates and previous law reform efforts surrounding women's reproductive rights and abortion law reform. *NAAPOC* urges the Government not to consider the many false claims of anti-choice individuals and groups who oppose women's rights to access safe and legal abortion. These claims are not "equivalent" to the consensus of the medical and public health sector. Personal decision-making by women and their doctor should not be replaced by personal-political ideology (9).

NAAPOC supports the essential proposals contained within the discussion paper to include in the proposed Act safe access zones and conscientious objection clauses that require the conscientious objector to refer on to another medical professional who does not hold the same conscientious objection. This would bring Northern Territory legislation into line with similar Victorian legislation.

NAAPOC **does not** support mandatory counselling or mandatory cooling-off periods for women. *NAAPOC* **does** support the funding of pro-choice government funded and regulated state services for women to access quality, evidenced based pregnancy counselling services.

NAAPOC **does not** support the discussion paper's reference to a requirement for two doctors to *consent to a termination* of pregnancy greater than 14 weeks gestation. The requirement for two doctors may increase barriers to access for women in the Northern Territory, particularly those in rural and remote areas. It is important to note that abortions in the second trimester are rare in all states and territories of Australia. Whilst national Australian data is not kept, South Australian statistics show consistently that the majority of terminations of pregnancy (91.9%) occur within the first 14 weeks (18).This is also found to be consistent in countries such as the United Kingdom where national data is routinely collected (19). Published data from the Pregnancy Outcomes Unit in South Australia (18) further shows that a termination of pregnancy occurring at 20+ weeks gestation accounts for on average 1.9% of the total abortions. Reasons for abortion occurring later in pregnancy are commonly the result of a range of complex circumstances, including fetal anomaly,

which is commonly not conclusively diagnosable until later in pregnancy. Supports from a range of health professionals, for example, counsellors, nurses, midwives, doctors, experienced in these areas should be accessible, but not requirements that create further barriers.

NAAPOC supports the belief that a woman is the best placed person to make her own medical decisions about when it is the right time to be pregnant or not, and this should be supported by one medical professional who is experienced in the provision of abortion services or referral to another doctor who can provide this service. *NAAPOC* respectfully encourages the Government to seek further guidance regarding a second doctor provision from medical professionals experienced in abortion service provision, particularly those who offer services beyond 14 weeks gestation.

Submission written by Brooke Calo, Clinical Social Worker (Pregnancy Advisory Centre) and founding member of *NAAPOC*, Siân Tooker, Counsellor (Children by Choice) and member of *NAAPOC* and Trish Hayes, Counselling Coordinator (Marie Stopes International Australia) and founding member of *NAAPOC*.

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Submission #050

pro choice queensland

our choice. our voice.

Submission to the Norther Territory Government, Department of Health regarding Termination of Pregnancy Law reform

Who we are

Pro Choice Queensland is a grassroots group of organisations and individuals campaigning for the removal of abortion from Queensland's Criminal Code. We believe that laws criminalising abortion are the single biggest barrier to women's reproductive choice in this state. For further information please visit our website Pro Choice Queensland.

We seek changes to the law which would:

- maximise women's reproductive rights and freedoms,
- provide the legal certainty necessary for doctors to provide best patient care for Queensland women, and
- reflect advances in medical practice and community attitudes.

Termination of Pregnancy Law Reform: Responses to the key consideration points

Pro Choice Queensland strongly supports the decriminalisation of abortion and therefore supports the Northern Territory's Termination of Pregnancy Law Reform. We commend the government in advancing accessing for Northern Territory women to safe termination of pregnancy services.

While undertaking this review we would strongly recommend that the committee refer to the Victorian Law Reform Commission enquiry into abortion law reform from 2008. This inquiry and report resulted in the decriminalisation of abortion in Victoria and provided a comprehensive overview of issues including public opinion, clinical practice, mandatory counselling and related issues. This enquiry applied similar terms of reference and the report, *Law of Abortion: overview of inquiry and full documentatio*n – is available on the Victorian Law Reform Commission website.

1. Definition of Termination of Pregnancy

Pro Choice Queensland supports a definition which includes both surgical and medical termination of pregnancy.

2. Criteria for providing treatment

Pro Choice Queensland supports the majority of the criteria proposed for providing treatment with a number of suggestions and one exception. We commend the inclusion of information and counselling on future contraception options

Suggestion: In regards to the provision of information and counselling, we believe every women has the right to make their own decision about an unplanned pregnancy and should be provided with the supports they require to make that decision and to access their preferred option. These supports should include decision making support and most importantly accurate information about all of their options. The research tells us that the majority of women do not want counselling however they do want accurate information.[i] Services supporting women should clearly advertise what support they provide. Such services should not coerce women, provide misleading inaccurate information and delay the decision making process or impose their own moral or religious beliefs.

Suggestion: Pro Choice Queensland would ideally like no gestational limits imposed in legislation. However, we would support the introduction of the Victorian model: legal to 24 weeks on request and legal post-24 weeks with two doctors 'approval. The number of abortions performed at 20 weeks gestation or later makes up a very small proportion of all abortions. Statistics from the South Australian Department of Health (the only state with mandatory data collection and publicly available reports on abortion) show that over 90% of terminations are performed within the first trimester, and only around 2% or less are performed at 20 weeks gestation or later[ii] Women may be present later for abortion for a number of reasons. These include diagnosis of fetal abnormality in a wanted pregnancy, difficulty in accessing abortion, failure to recognise the pregnancy earlier (often due to extreme immaturity or maturity, mental disability, or incompetent medical care) or catastrophic changes in personal circumstances (including death or serious illness of partner or child, loss of a job, partner violence or desertion). The decision to abort in any of these circumstances is a difficult one, and often made more complex by the lack of available termination services for post-20 week abortion.For more information read Women's Health Victoria's Termination of Pregnancy Post 24 Weeks background paper seek later terminations.

Exception: Pro Choice Queensland does not support the requirement of two qualified doctors (one of whom is an Obstetrician/Gynaecologist) should assess the woman after 14 weeks is disproportionate of the risks and may impact access to services for women. Despite this being current practice in Northern Territory public hospitals, it would create barriers in other facilities such as private option clinics and is not necessary.

Although there is a lower risk to the woman in early pregnancy (up to 14 completed weeks) than in later pregnancies (up to, but not more than 23 weeks) this risk is outweighed by the continuation of the pregnancy. The risk of the medical treatment or surgical operation is out of proportion to the risk intended to be averted.

In Australia, where abortions are performed by highly qualified health care professionals in very hygienic conditions, a pregnancy termination is one of the safest medical procedures and complications are rare.[iii] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, or RANZCOG, states that serious complications after abortions are rare and that mortality and serious morbidity occur less commonly with abortions than with pregnancies carried to term. [iv]

In addition, the ability to access a termination of pregnancy less than 14 weeks may not be possible for many women due to barriers to access health care services which can delay presentation, example women in rural or remote communities and young women. [v]

3. Suitably qualified medical practitioner

Pro Choice Queensland supports this recommendation generally except for the two qualified doctors (one of whom is an Obstetrician/Gynaecologist) should assess the woman after 14 weeks, as discussed in section 2.

4. Prescribing, Supplying and Administering drugs that induce medical termination

Pro Choice Queensland supports this recommendation to protect medical practitioners but would not wish to see onerous guidelines implemented.

As this is a specialist area of health with limited numbers of practitioners this recommendation will support access to termination of pregnancy services and succession planning.

Abortion provision is highly regulated not only by states and territories but also by the TGA and professional bodies such as Australian Health Practitioner Regulation Agency (AHPRA) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). These regulations are very comprehensive and provide clear guidance for practitioners any additional guidelines should not create more complexity.

5. Criteria for the most appropriate location of treatment and safe care

Pro Choice Queensland welcomes changes to allow for termination of pregnancy services outside of the public hospital setting and believe that this will allow for a significant improvement especially access to medical abortion. However, as discussed above we believe the cut off at 14 weeks is too restrictive.

Surgical abortions post 14 weeks are provided safely in other jurisdictions outside the hospital setting up to 23 weeks and 6 days(Victoria) by private clinics, such as Dr. Marie.

Pro Choice Queensland supports the recommendation to adopt Option 3, in regards to the options proposed to reduce risks arising from remoteness.

Pro Choice Queensland supports the development of consumer-oriented resources and recommends these resources offered to women are non-bias and evidence based.

Pro Choice Queensland supports the development of an evaluation and monitoring strategy and would recommend the collection and publication of de- identified data to allow for a better understanding of women's experiences.

Currently, there is no standardised national data collection on unplanned pregnancy and abortion in Australia, and different states have different laws and regulations. Only South Australis records and reports their data. The ability to collect and analyse robust data will lead to improved health outcomes for women.

6. Provision of services

Pro Choice Queensland strongly supports this recommendation. We commend the NT Government for recognising the barriers to abortion services experienced by disadvantaged women and ensuring access for these women to safe abortion care.

7. Conscientious Objection

Pro Choice Queensland supports this clause and believes the current professional standards set out by bodies such as AHPRA are sufficient. We would support a publicly available register of conscientious objectors.

8. Safe Access Zones

Pro Choice Queensland supports recommendation and notes that safe zones not only protect women accessing services but also staff working at the facility.

9. Informed consent to treatment

Pro Choice Queensland supports the recommendation proposed and would suggest the inclusion of details regarding the process for women who are deemed not Gillick competent.

Conclusion

Every woman should be able to access an abortion if that is their preferred option when experiencing an unplanned pregnancy. There are detrimental outcomes for woman who cannot access this option, evident from the US longitudinal Turnaway Study. Early analyses suggest that women who carry unwanted pregnancies to term are more likely to be in poverty and experience domestic violence.

We acknowledge that this is a very contentious area of health however; we trust that the NT Government will not place undue merit to value based or religious arguments in this process. These arguments and opinions are often presented as fact in an attempt to influence public policy. Health law and regulation should be based on the best available evidence, not a values system which not everybody subscribes to. We encourage the NT Government to relay only on accurate up to date evidence based information, which is not misleading or emotive in this process.

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[v] Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland Report No. 24, 55th Parliament Health, Communities, Disability Services and Domestic Family Violence Prevention Committee August 2016(p.73-74)

Submission #055

I write as a medical practitioner in the Field of Anaesthetics. I have worked in the NT for more than ten years. I have seen multiple women have terminations. Even in the patients who have apparently been through counselling etc, nursing staff as well as medical staff who look after these women in the recovery room have seen the sometimes distressing sadness in them. They will very often wake up sobbing uncontrollably in significant emotional distress over the procedure that has just taken place.

Many will continue to live with devastating guilt of what they have chosen to do recognising that the termination of a child's life has occurred I feel the so called counselling offered is woefully inadequate and very often refused due to the belief the patient may know what is best for herself.

Does counselling ever offer the alternative, which is to consider carrying on the pregnancy ?

Does counselling or informed consent also talk about the foetus and whatever the so called gestational age the developments that have already occurred in the foetus, that causes the foetus to feel the procedure?

Who advocates on behalf of the foetus that has no voice?

Why are we making it easier and more convenient for anyone to have a termination just because it is not convenient to them?

I certainly do not support the present changes I feel more needs to be done to support services to help women who for what ever reason are at a point where they feel a termination is the only way out to see what other options there are

Submission #057

Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

Discussion paper

The essence of this discussion is excellent and at last NT women are getting close to sexual health equality. There are several points I wish to draw to your attention.

2. Criteria for providing treatment

The choice of 23 weeks gestation as the limit to accessing termination of pregnancy. Other jurisdictions in Australia go beyond this and once again women in NT will disadvantaged. As to where they should be performed and by whom is an operational matter and RANZCOG provide appropriate guidelines.

Need for the opinion of two suitability qualified medical practitioners for terminations beyond 14 weeks. There is no evidence to suggest that the opinion of two medical practitioners has a better outcome than the opinion of one medical practitioner. In fact this could be seen to be a value statement placing unnecessary obstacles in access to medical care.

5. Criteria for the most appropriate location of treatment and safe care

Professional standards and guidelines

AMA (NT) official position does not include *the woman is within two hours of a hospital when she takes the medication.*

I was involved in many discussions when I was a member of AMANT and the quoted position is only the personal view of a couple of the board members. Many AMA members do not agree with this stipulation. Once again it is placing unnecessary obstacles in NT women's access to safe, evidence-based practice. The RANZCOG and other organisations provide appropriate and adequate guidelines for after care for women having a termination.

Submission #059

Dear Sir/ Ma'am,

I'm writing to state that I don't support the proposed changes to legislation concerning the provision of RU486.

From my perspective, these changes make it easier to obtain an abortion in the NT, and go a step further in normalising the taking of human life in this manner.

I am thankful that the proposed legislation provides for doctors with a conscientious objection, but would like this aspect to be strengthened to better acknowledge the serious ethical concerns that a number of people hold over the taking of life in this manner.

Submission #061 Rise Up Australia Party

Dear Politician,

As the NT President of the Rise Up Australia Party (RUAP), I am writing on behalf of our local candidates, members and other concerned constituents.

We are totally opposed to the introduction of the RU486 Abortion Pill in the Northern Territory; the proposal to place an exclusion zone around the Royal Darwin Hospital and Darwin Private Hospital and the removal of a medical practitioner's right to conscientious objection.

We are very disappointed at the timing of your intention to push through the RU486 Pill in the Northern Territory with the cutoff date for submissions still being within the school holiday period.

We have read many evidenced based research papers on the disastrous side effects of taking this cocktail of drugs to procure an abortion. This evidence includes the research of pro-abortionist, Dr Renate Klein, Associate Professor in Women's Studies at Deakin University, an internationally renowned feminist, who also happens to be a biologist. Renate states that the RU486 abortion drug is "a modern version of backyard abortion: unsafe, painful and deeply scary".

Some of the many horror stories from women who have taken this unsafe RU486 drug include;

- Fever and flu like symptoms.
- Weeks of excessive bleeding with extreme pain or hemorrhage.
- Serious internal infections, some even becoming septic because of retained body parts.
- Necessity of hospitalization with 5% - 8% of women requiring further surgical abortion.
- Inability to fall pregnant afterwards.
- Onset of severe depression, mental health issues including suicide.
- Death of Mother.

During the 2016 Federal and local NT elections, RUAP Candidates had the opportunity to visit most of the Remote Aboriginal Communities between Darwin and Alice Springs, including the Tiwi Islands. As we engaged in discussions with Elders and many of the women in those communities one of the issues discussed was their position on the RU486 Abortion Pill. Most of these communities had no prior knowledge of the proposed introduction of this abortion drug. All of them without exception completely

rejected this type of termination of pregnancy, considering it to be fraught with dangers and serious risk implications, especially with regard to their remote locations.

We also totally reject the proposal to introduce exclusion zones around the Royal Darwin Hospital and Darwin Private Hospital as this would be a violation of freedom of speech. In Victoria and other States and Territories, protestors outside abortion clinics approach, speak with and offer pamphlets to women procuring abortions. NOTHING LIKE THIS HAPPENS IN DARWIN.

In Darwin, a small group of people stand on Rocklands Drive once a week (outside the hospital grounds), and pray silently. Hundreds of people enter and leave the hospital daily and it is impossible to know the purpose for any person's visit. How is this 'interfering with, threatening, harassing, intimidating, hindering or obstructing access to anyone entering or leaving the facility'?

The Department of Health is also proposing in this bill that all registered medical practitioners must either provide themselves or refer a patient to a practitioner who does provide abortions, even though that practitioner may have a conscientious objection to abortion. This is a grave violation of democratic rights and must always be rejected in the name of freedom of speech.

Every other State or Territory in Australia has a "Pregnancy Problem House", or similar, for mothers in difficult or threatening situations with their pregnancies. We need one of these here in the Northern Territory before we need RU486.

Yours Sincerely,

Jan Pile

President of the Rise Up Australia Party, NT Branch

Submission #0065(a) & (b)

Good Morning

I would like to have conscientious objection very clearly spelled out and there has to be no room for misinterpretation or ambiguity. It has to be made very clear that under no circumstances should any health care worker be forced/coerced/requested or even asked to be complicit in aborting a foetus if that HCW conscientious objection is known.

Thank you kindly

Good morning

Thank you for getting back to me. I know the input closes today, and I forgot to put into my previous mail another point. If this legislation goes through I would like some mention made that taxpayer money should NOT be used to pay for Termination if it is simply due to oops. Taxpayers should know that some of their money is going toward supporting termination of pregnancy. Miscarriage, incest, rape, statutory rape etc, is a completely different subject. But seeing the same customers for the same procedure (Termination) is not addressing the problem, it is just making it easier. I certainly don't want my tax money used for repeat offenders. There is certainly enough campaigns for safe sex etc.

If women still have unprotected, voluntary sex and does not plan to get pregnant, but does, they should pay for the termination. Not the general population.

Submission #68 Right to Life

RU 486 and the Northern Territory

HISTORY - Population control in third world countries

RU486 is a drug designed to kill preborn babies in third world countries to control their population. Many years ago when RU486 was developed in France by Professor Beaulieu, it was developed with the third world in mind. Our President, Mrs Margaret Tighe attended a U.N. conference on Population and Development in Cairo in 1994 at which American Right to Lifers were distributing copies of archival material released in the U.S. – as is allowed after so many years, in which Henry Kissenger, the U.S. Secretary of State, said it was a matter of National Security to control the population of African countries!

DANGERS - including death

The special danger of giving RU486 to indigenous mothers in rural and remote communities is that they do not have access to emergency medical care.

The *Australian* and *Herald Sun* reported the first death of a mother from the RU486 pill in Newcastel(attached). The mother died of sepsis, a very rare cause of death nowadays, but also the cause of death in American and Canadian mothers.

Complications listed in *The Australian* article, (attached) since the drug was approved to 2006 were:

- ongoing pregnancy (78 cases)
- significant post-partum haemorrhage requiring transfusion (18 cases)
- retained products of conception (442 cases)
- cervical tear following initial dilatation (5 cases)
- uterine perforation or rupture (2 cases)
- nausea and vomiting (10 cases)
- infection/ suspected infection/endometritis (18 cases)
- post partum haemorrhage not requiring transfusion (14 cases)
- abdominal pain (4 cases)
- fainting, dizziness, vomiting (1 case)
- dehiscence (opening) of caesarean section (2 cases)
- death – sepsis (1 case)

One in thirty women will have to have a surgical abortion after an RU486 abortion. The New York Times reported that medical abortions cause the death of the mother in one in 100 000 abortions, whilst surgical abortions cause the death of the mother in one in a million operations.[2] RU486 abortions are riskier and less certain.[3,4] The academic journals are full of articles warning about the health risks.[5]

Every abortion kills a baby and we do not support the killing of babies, particularly indigenous babies. RU486 abortions are riskier and less certain, but they are

purported, incorrectly, to be cheaper than surgical abortions. The RU 486 pill is heavily subsidised down to $12. However, in Melbourne RU486 abortions cost $1160 (Marie Stopes) and $1150 (Fertility Control Clinic) of which $659 is paid by the taxpayer. Additional services are provided, as these places are money-making businesses. They make money out of women's misery.

Because of these health concerns some leading feminists and pro-abortionists such as Dr Renate Klein of Deakin University are totally opposed to RU486. Even Germaine Greer is opposed to it. It is a debate about medical health and human rights. In the preface of *RU-486: Misconceptions, Myths and Morals* by Renate Klein, Janice Raymond and Lynetter Dumble, "Rose" from South Australia shares her experience,

> *'She told me it would be easy and quick. The worst part…was the sheer amount of time it took for me to 'terminate' my baby: every large clot of blood – which I could literally feel passing through my insides…was a reminder of the fact I was terminating a baby, for which i felt hugely saddened. It was 3 days of nausea, high temperature, sweating, cramping, lots of blood, distress and swirling emotions. I would never ever go through that again." Rose bled for another 3 weeks.*

RU486 is not the "safe" DIY method for women it is claimed to be. The rural and remote nature of indigenous women in the Northern Territory is precisely the reason that the Territory should not have RU486. This drug is especially provocative and inappropriate for women in rural and remote communities.

HELP NOT HARM OUR INDIGENOUS MOTHERS

We should be proud of our indigenous population and encourage them to continue their pregnancies, not to kill their babies. A growing population is one of hope and optimism for the future, but an abortion is an expression of despair and lack of support. Why not support our indigenous mothers who are pregnant? It may be more work, but it is the right thing to do. If they are homeless, why not refer them to an accommodation service? If they are in a domestic violence situation, why not refer them to counselling? If they are poor, why not refer them to financial counselling? Why not treat the problem, rather than kill their baby? Why not set up Pregnancy Support Centres, rather than supporting the multi-million dollar abortion businesses?

Indigenous mothers will never get social and economic justice if they are offered the death of their babies as a "solution" to their situation. A first world country like Australia should be able to offer these women something better- care and practical help to care for their children.

Do not be part of a program to eliminate indigenous children before they are born.

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Submission #069

YWCA Darwin's Response to *Termination of Pregnancy Law Reform; Improving access by Northern Territory Women to safe termination of pregnancy services Discussion Paper*

January 2017

YWCA Darwin

YWCA Darwin is a non-religious organisation that achieves positive change by providing advocacy, programs and services for women, families and young people in Darwin. Operating within a feminist and social justice framework, YWCA Darwin's vision is for empowered individuals, women and families in a safe and inclusive community.

YWCA Darwin is a strong advocate for women's rights, gender equality and raising awareness around domestic violence and does this through not just the programs, but also through involvement in steering committees, working groups and collaborative partnerships. The organisation is part of a larger national and international movement for women's rights.

YWCA advocates for programs and policies that support women's access to a responsive, respectful, affordable and appropriate health system. YWCA Australia advocates for health policy that promotes women's self-ownership, positive body image and positive sexuality. YWCA Australia's National Policy Platform states that one of the changes that YWCA Australia advocates for is the decriminalisation of abortion and increasing access to abortion for women in regional, rural and remote areas, as well as financially disadvantaged women.

YWCA Darwin and YWCA Australia are specifically pro-choice and advocates for the decriminalisation of abortion in all Australian jurisdictions in order to promote the well-being of all Territorian women and to protect medical practitioners from criminal liability. In addition, YWCA Darwin also advocates for the wide-ranging availability of the World Health Organisation approved Mifepristone (or RU-486).

Below is YWCA Darwin's response to the Northern Territory Government's *Termination of Pregnancy Law Reform; Improving access by Northern Territory Women to safe termination of pregnancy services Discussion Paper*. Please also refer to the YWCA Darwin Table of Responses to the Discussion Paper (Attachment A).

1. Definition of Termination of Pregnancy

YWCA Darwin agrees with the definition of 'termination of pregnancy' as stated in the discussion paper. YWCA Darwin advocates for the complete decriminalisation of termination of pregnancy affecting a health professional and agrees that the best method to avoid unsafe abortion is to provide access to safe and legal methods of termination of pregnancy. YWCA Darwin agrees with the Human Rights Law Centre submission 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 the 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.

2. Criteria for Providing Treatment

YWCA Darwin proposes the removal of gestation terms when a woman is seeking termination of pregnancy, taking into consideration the small number of women that require late term abortions. Gestational limits should not be in this legislation, but be a clinical matter led by the current medical guidelines.

YWCA Darwin further submits that there is no need to state the number of doctors required. Medical presence should not be legislated in this act, but based on other relevant legislation and professional medical assessment on a case-by-case basis.

3. Suitably Qualified Medical Practitioner

YWCA Darwin recommends the removal of the definition of 'suitably qualified medical practitioner' in the legislation. This definition is potentially limiting, with new technologies and medicine being developed every day. Suitability should be decided by other relevant legislation such as the *Therapeutic Goods Administration Act a*nd the *Pharmaceutical Benefits Scheme* to ensure that legislation remains current and relevant.

4. Prescribing, Supplying and Administering Drugs that induce medical termination

YWCA Darwin believes that medical professionals including registered nurses, midwives, pharmacists and doctors who are legislated should be able to issue and administer medications that can be used to terminate pregnancies. This is especially important because of the short supply of medical professionals in Northern Territory. Availing all these medical professionals the right to issue and administer medications is in line with the World Health Organisations' guidelines[1]. Medical professionals are required to follow the best practice guidelines as set out in the *Therapeutic Goods Administration Act* and the *Pharmaceutical Benefits Scheme*.

5. Criteria for the most appropriate location of treatment and safe care

YWCA Darwin supports the provision of termination of pregnancy both within and beyond hospital settings. The needs of the woman accessing termination of pregnancy should be used to determine the location of the treatment. YWCA Darwin endorses WHAT RU4 NT's suggestion of developing guidelines to assist decision making.

YWCA Darwin agrees with the Department of Health in recommending option 3. However, YWCA Darwin urges the removal of reference to counselling. This is medical best practice, and should be offered, not legislated.

6. Provision of services

YWCA Darwin strongly supports this recommendation. We strongly agree that all services need to be accessible through the Public Health System, with Private Services being additional to these. We advocate that the costs associated with services should not cause inability to access the services. We commend the NT Government for recognising the barriers to abortion services experienced by disadvantaged women and ensuring access for all women to safe medical services including termination.

7. Conscientious Objection

YWCA Darwin supports the clause to align with the Victorian legislation in regards to Conscientious Objection. This ensures that health practitioners will refer these women to their colleagues who do not conscientiously object immediately.

8. Safe Access Zones

YWCA Darwin strongly supports the recommendation and notes that safe zones not only protect women accessing services but also staff working at the facility. YWCA Darwin agrees and supports the NT Government's recommendation to apply a penalty to those who breach the safe access zone provisions.

[1] World Health Organisation. *Safe abortion: technical and policy guidelines for health systems.* http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1

9. Informed consent to treatment

YWCA Darwin supports the inclusion of the Gillick Competence approach to informed consent as the method to determine the capability for someone under the age of 16 to provide their own consent.

Conclusion

YWCA Darwin appreciates the Northern Territory Government's commitment and priority in reforming the Medical Services Act, and appreciates the opportunity to comment on the comprehensive discussion paper. YWCA Darwin further recommends that women from a diverse range of backgrounds are consulted and included in expert advisory groups in order to have a holistic review of the act.

YWCA Darwin recognises the responsibility of all levels of government to contribute to the realisation of the human right to health. As stated in Article 12 of The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), State parties have an obligation to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those relating to family planning". By making the amendments proposed above, the NT government will be complying with Article 12 of CEDAW, and furthermore, taking many steps forward in terms of eliminating discrimination against women. Every woman should be given the choice of accessing safe and affordable medical or surgical termination of pregnancy regardless of the situation.

YWCA Darwin believes that this review is the perfect opportunity for the Northern Territory Government to lead by example in providing safe, affordable and legal access to women seeking to terminate their pregnancy. We look forward to a leading edge legislation that employs the best practice and standards for women's reproductive health and does not discriminate against women.



Kate Presswell
President



Jessica Watkinson
Chief Executive Officer

Attachment A: YWCA Darwin Table of Recommendations

Point	YWCA Darwin Position	YWCA Darwin Recommendation
1. **Definition of Termination of Pregnancy**	Agree	● Complete decriminalisation of termination of pregnancy affecting a health professional
2. **Criteria for Providing Treatment**	Recommend amendments	● Removal of reference to gestation terms ● No need to state the number of doctors required
3. **Suitably Qualified Medical Practitioner**	Recommend amendments	● Removal of the definition of 'suitably qualified medical practitioner' in the legislation
4. **Prescribing, Supplying and Administering Drugs that induce medical termination**	Recommend amendments	● Any legislated medical professional should be able to issue and administer medications
5. **Criteria for the most appropriate location of treatment and safe care**	Agree with amendment	● YWCA Darwin supports the provision of termination of pregnancy both within and beyond hospital settings ● Agrees with the Department of Health in recommending option 3, but remove reference to counselling within legislation.
6. **Provision of services**	Agree	● All services need to be accessible through the Public Health System, with Private Services being additional to these. ● Costs associated with services should not cause inability to access the services.
7. **Conscientious Objection**	Agree	● Align with the Victorian legislation in regards to Conscientious Objection.
8. **Safe Access Zones**	Agree	● Establish a safe access zone extending 150 metres. ● Apply a penalty to those who breach the safe access zone provisions.
9. **Informed consent to treatment**	Agree	● Inclusion of the Gillick Competence approach to informed consent.

Submission #070

Thank you for the invitation to comment on proposed changes re abortion practice.

As a grandpa to three youngsters brought up / or now growing up in the Northern Territory, I feel obliged to express my heartfelt opposition to making abortion more easily available. Even the Clintons wanted it 'safe, legal, and rare'. We apparently want it everywhere! So I have to sound severe.

This week we heard the ABC broadcast reflections on the last death penalty administered in Victoria – and Australia. A terrible crash as the trapdoor flew back, then the rope swaying and an eerie strange silence. We had killed a human being.

We don't do that anymore. Except with every abortion. Silence again.

The silence in this document speaks loudly. Are the aborted ever even once mentioned? They obviously have no voice, no legitimacy... as if. The nameless unmentionable child... Is she nothing? We talk about 'pregnancy termination' as if it concerned only us adults. But that's the language of the victors with power, not so innocent - but of course never criminal! The victim must be guilty, and is reduced to zero.

The baby, child, foetus-victim, all reduced to nihil, as we move into the land of terror nullius, "no probs", *kein Piep*!

Reality however lies elsewhere.

Are the women seeking a termination to be shown clear images depicting the various stages of fetal development? Why not if not?

A pregnancy is only terminated by terminating a life, a helpless life. Every time. Or shouldn't this be mentioned?

With every abortion another fast-developing, heart-beating, fully d.n.a.-ed, once-only, unique human kid is grossly pushed off our planet. Scientifically this is surely beyond all nonsense; intelligence-insulting denialism. Is it not ethical nihilism, convenient for adult medical staff with self-serving power of legal cover. But what is actually happening, is it not simply pre-natal infanticide? Honestly! Hidden under the blind word abortion. Contra naturam.

And the emotional post-abortion memories, regrets, and trauma of the woman involved seem to rate very little if any mention. Who then will care? – out in remote regions – across the years to come!

And we are not to speak aloud of it within range of where it happens?! What a fine privilege, and relief! Thus does freedom of speech give way to something important, like… don't mention the war! And strictures on whom we communicate with, and where. Is this still Australia?

These Victorian laws are not good laws.

No signs, posters naming the reality of this tsunami of ***prenatal infanticide*** hitting our shores?!
6 to 23 weeks, to full term, to post-natal (with logical Peter Singer)? Are we to content ourselves with vague bureaucratic assurances and an occasional ‘don’t you worry about that’!

If this slope appears slippery, it does because it is. It’s a chasm, more than half hidden under cloud and fog.

Please step back from increasing accessibility to termination of pregnancy. Life requires love. And the courage – and optimism – to call things by name.

Respectfully if passionately submitted.

Submission #072

Dear Minister Fyles
Re: Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services
I am a supporter of WHAT RU4 NT? and write to provide feedback on the above mentioned discussion paper.
I support the proposed reforms as detailed in the paper, including:

- Decriminalisation of abortion
- Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
- Ensuring women are provided with supportive care from health professionals about future contraceptive options
- Providing that a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
- Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
- Removing the requirement for two doctors to examine a woman seeking an abortion under 14 weeks' gestation
- Removing the need for women to justify the reason they seek an abortion Enabling minors who satisfy the relevant competency test to consent to treatment
- Requiring doctors with a conscientious objection to refer a patient to another doctor who can help them
- Establishing safe access zones around places where terminations are performed.

I also seek that the following be considered:

- Women be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.
- I consider the Act should not require women to undergo counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options.

Thank you for providing the public with the opportunity to contribute to this important piece of legislation.

Submission #073

Department of Health
Re: Abortion Law Reform

I write to you as a Chaplain working in the NT. I am very concerned about the proposed law reform for abortion of babies. Too often I have been asked to come alongside women who have had abortions and then, in most cases, have lived with deep regret of aborting their babies.

In my experience, most women regret the fact that they have aborted their baby at some stage in their life.

This has led to emotional and mental trauma for these women; feelings of worthlessness and deep shame are not uncommon.

I understand that a women who's life is at risk during pregnancy may need to have her baby aborted.

Please seriously consider a woman's holistic health in your deliberations around Abortion Law.

Submission #074

Dear Sir/Madam

Please find our response to the proposed: "Termination of Pregnancy Law Reform;"

Why the Northern Territory Government ought to reconsider the proposed changes to the law;

Bias and assumptions are clearly evident in this proposal it makes evident that despite the "welcomed" feedback this proposal is intended to be carried out regardless of feedback received.

The timing of this proposal is a concern, as it comes at a time when many of our NT residents are on interstate holidays. This does not allow for proper discussion or feedback, therefore we request that the period for public submissions be extended so that all who desire to take part in this discussion have ample time to do so.

Decriminalising Abortion will say to society that abortion is good. Rather than having the mindset of "keeping up with the rest of the world" or 'so called', "medical advances", we should ask the question: "is it right?" A life is being taken (see last point). This "option" further divorces sex from procreation and so increases casual sexual activity and all the risks and complications associated.

Increased Rates of Abortion will inevitably occur when a message of, "implied good, and approval" is made through government legislation changes. Whenever a service or product is made more easily and readily available, consumption will increase. It defies logic to believe otherwise. Consider if the NT Government made sniffable petrol more readily available, would we see an increase in petrol-sniffing? Making abortion more readily available, as displayed in history (eg: Russia in 1920-1936) will significantly increase rates and have a negative effect on NT population growth.

"Safe Access Zones" will remove freedom of speech from our NT residents. Of course, aggressive behaviour should never be acceptable, however; expressing opinions, talking to people and holding protests are some of our basic rights as citizens of the NT. Soon "Safety Zones" could be implemented in many public places further restricting our rights?

Regarding Parental Consent, parents should be encouraged by government to know if their child is engaging in sexual behaviour and therefore desiring risky medical procedures and drugs. The parents of these young people grappling with 'parenthood' should be given opportunity to be involved in decision making. Legal backlash from parents and minors should be considered.

Biological Father's Consent in these law proposals has been completely missed.

Child in utero Consent never seems to be considered in these matters, a child who would be a future NT resident. Can we be different and think independently in the NT? Can we consider all our members?

Doctors who Conscientiously Object to Referring for abortion should not be stipulated by law to have to refer the woman to someone who will refer for abortion. This obviously goes against their 'freedom of conscience' which the law is also supposed to respect and protect. Why doesn't the proposal go both ways; that a doctor who does refer for abortion would also be required to first refer to one who doesn't? There are many legitimate concerns about the impacts on woman engaging in abortion. Women and their families may benefit from being informed by someone who believes there are indeed concerns and negative impacts.

The Hypocratic Oath has pivotally affected the way we carry out medical care and is important to consider, part of which states; "I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art."

Four Biological Reasons Why the Unborn is a Human Life to be Protected

1. ***Size*** *shouldn't matter* – the foetus is smaller than a new born, are large people more human than small people?

2. ***Level of development*** *shouldn't define our humanity* – Does self-awareness and level of intelligence define us as human beings? If that is true, it means that the more intelligent of us should have the right to exploit those who are less intelligent. The four year old who doesn't have her reproductive system developed yet is worth less than the fourteen year old girl, the elderly also would begin to lose their worth as they age. If we don't agree with this elitist view then why do we impose it on the unborn? Why do we rule out the foetus from being human simply because its development doesn't meet ours?

3. ***Environment and location*** *doesn't have a bearing on who you are* –When you change location do you change being you? Then how does the process of birth make us any more human? The birth canal is a journey of 8 inches, how does this "blob of tissue" suddenly in this simple journey become a valuable human being whom we should love, protect and respect?

4. ***Degree of dependency*** *does not define our humanity or value* – "Until its viable, it's not a human", if this statement defines our humanity this would mean that if we rely on anyone for anything we are less of a human. Many people are dependent on insulin, heart medication, pace makers and they would not survive without them. Are they less human due to their dependency?

We submit this response to you - our representatives in the NT Government and anticipate your thorough response to our concerns.

Submission #075

Dear Sir/Madam,

As an expatriate Australian working in bioethics in the UK, and the author of a book on the ethics of pregnancy,[1] I am writing to urge the Department of Health to reject recent proposals to amend the abortion law of the Northern Territory.

These proposals show scant recognition of the harm abortion can do to women, both physically and psychologically.[2] Even apart from this harm, pregnancy is not a disease, and abortion is not treatment.

That being the case, it seems particularly unreasonable to expect a doctor with a conscientious objection to refer the woman to another doctor for what the first doctor sees as a non-medical and indeed, a harmful intervention. Would we ask doctors to refer for any other harmful, non-medical intervention to which they had a conscientious objection – for example, writing a prescription for suicide pills or arranging a female circumcision? History has other examples of doctors being coerced to collude in non-medical activities by governments which did not respect good medical practice.

Far from being made easier (for example, by reducing the number of doctors legally required to be involved, as proposed), abortion should be strongly discouraged in favour of life-affirming alternatives for the woman and her baby. Many women will wish to keep their baby if supported through the pregnancy, while for those who do not, fostering and adoption are possible solutions which can respect the rights of all.

Note that the proposed changes do not clearly refer to any offer of help to the woman to have her baby – except that those who do make a last-minute offer of help outside the place where abortions are performed would be prohibited from doing so under the proposed law, which would ban "intentionally communicating in relation to treatment in a way that is seen or heard by another person" (would that include offering a leaflet with details of pregnancy support available?)

Finally, giving abortion pills to women to take outside a hospital setting is particularly inappropriate in the Northern Territory, for reasons which should be obvious. To rely on a woman from a remote rural community staying within reach of emergency services, and accessing these services as needed, seems hazardous and unrealistic. Apart from the physical hazards of medical abortion, the psychological impact on the woman of potentially seeing the foetus she has expelled, which causes some women severe distress, should not be underestimated.

With best wishes,

Dr Helen Watt

[1] *The Ethics of Pregnancy, Abortion and Childbirth: Exploring Moral Choices in Childbearing* (New York and Abingdon: Routledge, 2016).
[2] P.K. Coleman, "Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009", *British Journal of Psychiatry* 199 (2011): 180-6; D.M.Ferguson, L.J.Horwood, J.M. Boden, "Abortion and mental health disorders: Evidence from a 30 year longitudinal study", *British Journal of Psychiatry* 193 (2008): 444-51; David M.Ferguson, L. John Horwood, Joseph M.Boden, "Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A reappraisal of the evidence", *Australian and New Zealand Journal of Psychiatry*, found at: DOI: 10.1177/0004867413484597, published online 3 April 2013.

Submission #077

Thursday, 26 January 2017

Department of Health
Northern Territory Government
DOH.consultation@nt.gov.au

To whom it may concern:

RE: "Termination of Pregnancy Law Reform"

Thank-you for the invitation to respond to the Discussion Paper and F.A.Q. relating to "Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services".

The Need for Discussion

The topic of termination of pregnancy has important and far-reaching moral, social, cultural and, for some, spiritual dimensions. Therefore, changes to the way our legal system regulates termination of pregnancy must be publicly discussed. The release of a "discussion paper" on proposed changes to legislation on termination of pregnancy is, in itself, an acknowledgement of the need for discussion.

However, the timing of the release of the "discussion paper" and F.A.Q. and the nature of their contents significantly limit the opportunities for public discussion.

The timing of the discussion period has been very poor. The "discussion paper" was released on 8 December 2016, with a call for responses by 27 January 2017. This Christmas/New Year period is typically the quietest period in Australian public discourse, and even moreso in the Northern Territory, when many Territorians leave for cooler weather "down south". A cynical onlooker might suggest that the discussion period was timed to minimise public discussion.

Unfortunately, the "discussion paper" and accompanying F.A.Q. read like more opinion pieces or information bulletins. They contain no substantive argument, at all. In place of argument, the documents contain:

- the premise that other Australian jurisdictions are changing their termination of pregnancy laws;
  (Perhaps this is so, but should the NT always mimic other states/territories? If so, what is the point of having a Territory Government?)
- the assertion that women are seeking access to medical termination of pregnancy;
  (The paper contains no evidence to support this claim. How many women would be seeking this access? Is there sufficient demand to consider an overhaul of legislation? Even if there is a large demand for medical termination, this would only be an important factor, rather than a complete argument, for change.)
- the assertion that the proposed changes to the law would result in "better access" to services;
  (What is meant by "better access"? What is the evidence that these changes would achieve it?)
- statements that suggest the legal changes are a fait accompli, e.g. "Changes to legislation are proposed to take effect on 1 July 2017".

Just as a clear argument for change has not been made, neither has any counter-argument been presented or even acknowledged. As a GP with a range of experience across the NT, I have not encountered any problems with the current legislation and I find the discussion paper unconvincing.

I suggest that the NT Government promote further community discussion of the topic by:

1. making a complete argument for the changes that are proposed, addressing questions such as those I have raised above;
2. allowing more time for discussion;
3. using greater government resources to facilitate the discussion, e.g. referring the matter to a relevant parliamentary committee; and
4. not using language which suggests that Government's policy is already pre-determined.

Specific Concerns

In addition to my afore-mentioned concerns, I have several specific concerns about the proposed legal changes.

Firstly, I am worried about the safety of patients. A significant benefit of the current termination of pregnancy services is that they have a high degree of medical supervision in hospital. The use of RU-486, with its inherent risk of causing life-threatening haemorrhage, could lead to the deaths of women who can't access emergency care at the time of haemorrhage. Although the proposed legislation puts the onus on the medical practitioner to try and avoid this a situation like this, this onus is an unfair burden on many practitioners who already have to surmount significant geographical, resource and, in some cases, language and cultural barriers to provide care to patients in the NT.

Secondly, I am worried about the implications of formal "conscientious objection" clauses for a conscientious objector who works in remote communities. Sometimes there is only one medical practitioner in a remote community at any given time. What mechanisms would protect such a medical practitioner if they were a conscientious objector? Or would conscientious objectors be precluded from working in such remote contexts?

Thirdly, I am worried that the voices of Aboriginal and Torres Straight Islander communities may not be heard in this discussion. What provisions are being made for these voices to be heard?

I look forward to a response to these specific concerns, and I hope that the NT Government can facilitate a more fulsome discussion of the matter at hand.

Submission #079

To it may concern,

I write to you in earnest hope and prayer that you reconsider these new proposed laws regarding abortion. I think it unfathomable that we will potentially be able to terminate a baby at 23 weeks gestation! I know how well formed a baby is at just 12 weeks, let alone more than halfway through the pregnancy. This is just madness and it makes me sick. We have to be a voice to those without a voice. These little ones haven't even had a chance at life and we are going to give women more chance of ending these little ones lives for the sake of increasing her 'rights' and 'control of her own body'.

I am a woman and I want no such rights. If I decide to have sexual intercourse with someone, then I know that there is always every chance of falling pregnant, yes even with contraception, planned or unplanned. That baby was formed and is part of God's plan. Why should we keep interfering and taking control for ourselves? There is so much death surrounding us, everywhere we look, and medical professionals strive to preserve life.... but that the same time end it. It doesn't make sense. It's 'legally justified murder' if you ask me. But how can we justify it? Based on the woman's right to her own body? Because she isn't 'ready'? Because she isn't in the right relationship? Even if she was raped, which would be an understandably horrific experience to endure... that child can still have a chance at life despite the circumstances to which he or she were formed. Even if that woman can't or won't raise the child... at the very least adopt to someone who will. Or consider this. That woman who is demanding more rights and control over her own body may not be there to demand them if her own mother had those exclusive rights to end her child's life.

I urge you to please reconsider the passing of these new changes.
Please be a voice to the voiceless.

Submission #080

Dear Colleagues,

Response to the Termination of Pregnancy Law Reform in the Northern Territory discussion paper

I am pleased that feedback is being invited for this discussion paper.

I am a medical practitioner who has lived and worked in the NT since 2005, almost all in Central Australia, in Alice Springs Hospital (including in obstetrics and gynaecology), in public health and in primary care therefore I fully agree that there are "unique challenges to clinical care presented by the geographical and population profile of the NT" (page 1).

There are several issues raised in the discussion paper which I believe requires further consideration and even amendment before the legislation is tabled.

1. There is an important omission in the discussion paper, namely a basic epidemiological analysis regarding ToP in the NT. Knowing some basic demographic data, over time, of the ages, ethnicity, gestation, location of ToP, method of ToP, reason for ToP, and so on, would enable the readers to understand the context of the issue and hence give more informed comment. I am hoping that this information (presumably relatively easily obtainable from computerised hospital records) has been available to and considered by those who are advocating for these changes. Without basic epidemiological data, the proposed changes could be interpreted as being ideological and not based on fact.

2. Considering that Aboriginal patients have a disproportionate usage of health care services in the NT, and that Aboriginal women have higher fertility rates than other women in Australia, I would hope that Aboriginal stakeholders are adequately consulted regarding this proposed change in legislation. Noting that many of my Aboriginal patients of reproductive age have low health literacy and low literacy in general, I imagine that this discussion paper is not accessible to many (or even most of) them. What steps are being taken to ensure that the discussion is not biased towards people who have internet access and are highly literate?

3. "Specific areas of the Act have been identified as limiting access to ToP for women in the NT " (page 1). While this is a theoretical assertion, I would like to see some quantitative estimate of the limited access (see point 1 above), for example: How many and what proportion women declined to proceed with the ToP because it was a surgical and not medical procedure? How many and what proportion of women declined to proceed because they had to see a second medical practitioner? How many and what proportion women were declined for a ToP because they did not meet the criteria in the current legislation?

4. For the requirements for a ToP, I am pleased that there will be "information and counselling....about current choices and future contraceptive options" and a "holistic assessment" will be made (page 3).

4a. Effective contraception is highly important to preventing unplanned pregnancies, so I am pleased that a contraception discussion with the patient is part of the proposed legislation. Furthermore, in the interests of continuously improving clinical practice, regular audits should be done on what forms of contraception women were on, if any, when requesting ToP. Knowing the epidemiology of contraceptive failure and the epidemiology of not using contraception, would certainly assist in understanding the gaps in offering effective

contraception in the NT population. In fact, such an audit should be done regularly to improve clinical practice, regardless of the proposed legislation.

4bi. 'Counselling' is a very broad term that may mean different things to different people, so I recommend that the definition of 'counselling' is made clear in the legislation. In a situation of a woman who is distressed by an unplanned pregnancy, she should first be offered non-directive and supportive decision-making counselling which provides her with emotional support to make a confident and informed rather than panicked decision regarding her pregnancy, based on her values, the options available, and availability of other forms of support. If, after the non-directive, supportive decision-making counselling, she then makes the informed choice of having a ToP, she must then be given a second, different type of counselling, namely pre-procedure counselling, where she is informed and is given the opportunity to discuss what will happen to her before, during and after the medical or surgical procedure (which is what should be available to all patients before any procedure). It is imperative that both types of counselling are offered to every woman to ensure that she makes informed decisions regarding her own health, well-being and that of her baby.

4bii. While my experience is that information on contraception is relatively easily available in health facilities in Central Australia, I have seen few (if any) resources regarding women having access to counselling, financial, emotional and practical support for unplanned pregnancies, including how to go about giving a baby for adoption, should they choose to continue with the unplanned pregnancy. I strongly suggest that as part of this reform to ToP legislation and practices, serious attempts are made to provide that comprehensive information and counselling (as mentioned in point 4bi above). I suggest a working group that is specifically given this task, with deadlines and accountability structures, such that women amidst the turmoil of unplanned pregnancies are consistently offered a range of genuine choices.

4c. The prevalence of domestic violence in the NT is well known to be high. In my experience, termination of pregnancy requests are often related to domestic violence, and indeed this is a recognised correlation worldwide. I often wonder if a pregnant woman requesting a termination felt she could continue her pregnancy and raise her child without the threat of domestic violence, whether her choices would be different. Therefore I suggest that this proposed change in the legislation is a good opportunity to explore the links between ToP and domestic violence, for example, to do an audit of whether women requesting a ToP have been routinely asked about domestic violence, to quantify what proportion of ToP requests are associated with domestic violence, and hence estimate how many ToP procedures could be prevented with improved measures to deal with domestic violence (which would most likely give yet another good reason for increasing efforts to prevent and stop domestic violence).

4d. What are the plans for ensuring that women in the NT who request a ToP are indeed given appropriate counselling to "all relevant clinical and psycho-social matters including the women's current and future physical, psychological and social circumstances"? I suggest that as part of this reform, there are also associated quality assurance and improvement measures (eg. clinical audits) put into place to ensure that this will be done consistently according to the legislation.

5. I am concerned that only one medical practitioner's assessment is required for a woman requesting a ToP for gestations less than 14 weeks (page 4), for the reasons detailed below.

5a. For a comprehensive assessment and counselling, as proposed in this discussion paper, the consultation is necessarily long and complex if it is to be done properly. Having a second

medical practitioner, as the current legislation provides, helps ensure that women receive adequate assessment and counselling. There may be topics she may not wish to raise with one medical practitioner that she feels comfortable raising with a second; the first medical practitioner may raise new issues that the woman may go home to think about then ask the second medical practitioner. In short, a second medical practitioner's involvement should improve the quality of patient care in a complex clinical situation.

5b. For an important decision such as a ToP, seeing two medical practitioners theoretically provides the woman with a 'cooling-off period' to think through the information that the first medical practitioner has offered, and to discuss it with the second if she wishes. Other elective medical procedures are generally never done immediately to allow the patient time to think and discuss with family and friends. Even activities as important or mundane as purchasing a house or joining a gym have a cooling-off period, so I am concerned that the proposed change to the ToP legislation does not give that option for a decision that has long-term consequences. If the final consensus is that only one medical practitioner is required, then I would suggest that there should be a cooling-off period of even just 48 hours between the initial consultation and the start of the medical or surgical ToP procedure.

6. "There is anecdotal evidence that women travel interstate to access medical termination services" (page 5). I am concerned that the legislation is being proposed based on only anecdotal evidence (please refer to point 1). While I appreciate that accurate figures may be hard to obtain, I think more substantial attempts could be made to quantify this issue. In my experience in working both in Alice Springs Hospital and in primary care, ToP in Alice Springs Hospital is quite accessible; general practitioners in both Alice Springs and remote communities can refer women quite easily to Alice Springs Hospital for ToP, which are performed regularly at the hospital. (I am aware that, at least in the past, there have been guidelines on how to transfer pregnant women in more advanced gestation to Adelaide for ToP, but that was rarely done in my experience. Obtaining data on this surely cannot be difficult.)

7. "The AMA NT advice is that the woman is within two hours of a hospital when she takes the medication " (page 7). Having worked in many remote clinics, I support this recommendation, should the proposed legislation be passed.

7a. If medical ToP were to become more accessible after the legislation of the proposed changes, then I would strongly suggest that the 2 hours is strictly defined, for example, as follows: the two hours means two hours under actual circumstances, and not ideal circumstances. Two hours on a dry and recently-graded dirt road may turn into 3 hours on the same road after rain. While most RFDS retrievals will get a patient to hospital in less than two hours after the retrieval team arrives at the remote location, the reality of tasking planes, pilot hours, flying conditions and so on, mean that even Priority 1 retrieval flights take more than two hours between the initial phone call to request the plane to when the team arrives at the remote clinic, let alone safely delivering the patient to hospital.

7bi. I am acutely aware that remote clinics are often short staffed by overworked remote area nurses who often struggle to provide routine primary care services, hence adding medical ToP to their already long list of responsibilities seems unrealistic and irresponsible.

7bii. I have worked in at least one clinic staffed by only two nurses who both happened to have conscientious objections against ToP, so even if a two nurse-clinic could cope with the extra workload, legalising ToP in remote clinics may bring unnecessary ethical complexity to an already highly complex work environment.

7c. Considering that large proportions of our patient population in remote areas have low health literacy and are highly dependent on the clinic even for very minor health needs (for example, patients regularly come to the clinic purely for paracetamol tablets or management of very minor injuries, which in other most other places in Australia would be managed at home), then performing medical ToP in remote clinics where patients are expected to spend much of the duration of the medical procedure at home (where privacy and clean toilets may be rare) would seem less than ideal for the well-being of women who are already in difficult situations.

8. “It is also proposed that the Department of Health produced consumer-oriented resources to inform consumers of access to termination of pregnancy services” (page 8). While I agree that this would be helpful, it is also important to ensure that pregnant women are provided with information on how they can be supported during pregnancy, should they choose not to go ahead with the ToP, including how to be safe from domestic violence (please refer to point 4 above).

9. Safe access zones (page 8). I am very concerned about the proposed safe access zones. While I have limited experience in legal matters, surely there are existing laws that deal with people who harass, intimidate, interfere, threaten or obstruct others in public or private areas, and those existing laws would surely be applicable to anyone who demonstrates these anti-social behaviours against pregnant women. Furthermore, legislation to prevent “intentionally communicating in relation to treatment in a way that is seen or heard by another person” seems to me a draconian limitation on free speech. I do not wish to create a society where ordinary citizens cannot express their diverse opinions.

A parallel example is vaccination: as a public health physician who is a very enthusiastic supporter of vaccines, I am very frustrated by anti-vaccine campaigners who mislead parents of vulnerable children. At the same time, out of respect for free speech, anti-vaccinators have the right to distribute their mis-information (even though I would far prefer that they did not) I would not want a law enacted to prevent them for expressing their opinions (strange or wrong as they may be) nor from approaching vaccination clinics. Hence using a law to silence people who may have strong and differing views on ToP is very worrying to me.

I trust that all the points that I raise above will be given serious consideration, and I look forward to receiving a substantial response.

27 January 2017

Northern Territory Department of Health
DOH.consultation@nt.gov.au

Dear Committee Secretary

Reproductive Choice Australia is a coalition of organisations and individuals who are committed to ensuring women's reproductive rights are protected and enhanced in Australia. It is Australia's only dedicated pro-choice advocacy organisation, a non-partisan, not-for-profit organisation run by volunteers.

The association's purpose is to:

Promote women's reproductive rights, engage stakeholders, educate and inform the community and reduce stigma.

Advocate for the promotion, maintenance, extension and improvement of access to the full range of reproductive health care services, including but not limited to:

- *all forms of contraception including emergency contraception*
- *medical and surgical termination of pregnancy*
- *evidence based, unbiased information and counselling in relation to pregnancy options*
- *respect for women's bodily autonomy*
- *unhindered medical decision-making*
- *appropriate legal frameworks governing termination of pregnancy .*

We welcome this opportunity to make a submission in response to the discussion paper; *Termination of Pregnancy Law Reform.*

Yours sincerely

Jenny Ejlak
President
Reproductive Choice Australia

Termination of Pregnancy Law Reform: Discussion Paper
Northern Territory January 2017

Guiding principles and context

A key policy objective for the Northern Territory Government should be a comprehensive, statewide sexual and reproductive health strategy with a focus on promoting healthy sexuality and fertility, safe sex practices, respectful relationships and the prevention of unintended pregnancy, foetal alcohol syndrome disorder and sexually transmissible infections.

There is a strong link between domestic violence and reproductive coercion which can lead to repeat unwanted pregnancies and termination of pregnancy. Including the provision of reliable contraception within violence prevention and response services is crucial.

In addition to a prevention and health promotion focus, there needs to be adequate service planning for termination of pregnancy care services both in the public and private health sectors to ensure affordable and appropriate services are available to women at the earliest possible stage of their pregnancy. As a territory with a dispersed and mobile population, consideration also needs to be given to rural and remote access to termination of pregnancy services within health service planning.

Medico-legal context

Termination of pregnancy is one of the safest and most common procedures undertaken globally, when it is performed by qualified health professionals, with proper equipment, appropriate technique and training and in sanitary conditions, in an environment where the procedure is legal and accessible.

In their 2012 publication, *Safe Abortion: Technical and Policy Guidance for Health Systems 2nd edn*[1], the World Health Organisation (WHO) states: *"Regulatory, policy and programmatic barriers that hinder access to and timely provision of safe termination of pregnancy care should be removed."*

In the same publication the WHO also states: *"Additional barriers, that may or may not be codified in law, often impede women from reaching the services for which they are eligible and contribute to unsafe termination of pregnancy."* Some of the barriers listed include:

- requiring third-party authorisation from one or more medical professionals
- restricting available methods of termination of pregnancy, including surgical and medical methods
- restricting the type of health-care providers and facilities that can lawfully provide services
- failing to assure referral in case of conscientious objection
- requiring mandatory waiting periods
- failing to guarantee access to affordable services.

Reproductive Choice Australia endorses these WHO principles and statements. We believe that termination of pregnancy is a health issue not a criminal one and as such should be governed by the

[1] World Health Organization. (2012). *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed.). Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

existing health laws, professional registration criteria, standards and clinical and professional guidelines which cover all other medical and surgical procedures. No additional laws are required.

Ideal law reform outcomes would result in all references to termination of pregnancy in criminal law being removed, and termination of pregnancy being regulated like all other medical procedures through existing healthcare law and professional clinical guidelines. This would enable a more comprehensive consultation in which health professionals can consider the unique circumstances for their individual patients, rather than deciding whether each patient fits a narrow set of criteria as is currently the case.

Comments on specific parts of the discussion paper:

2. Criteria for providing treatment

The criteria proposed here are restrictive and unnecessary. If all references to termination of pregnancy are removed from criminal law there will be no need to distinguish what type of termination is 'lawful'.

Informed consent is a routine part of medical care and does not need to be spelt out separately for this procedure. The general standard of disclosure by a medical practitioner (informed consent) embodies the principle that doctors must provide all relevant information that a patient should consider before deciding whether to have a particular medical procedure. This includes the nature, risks, and benefits of any medical procedure and availability of alternatives. There is a plethora of information available to anyone on the internet including reputable sites such as medical college clinical guidelines and the consumer-oriented government website, Better Health Channel.

There are many reasons a woman may not recognise or acknowledge a pregnancy until the second trimester, and the small proportion of terminations beyond the first trimester often represents a personal tragedy: a sick or substance addicted woman, a woman who is a victim of violence, a woman with a wanted pregnancy affected by a catastrophic foetal abnormality.

The need for specialised and multi-disciplinary medical care to obtain a termination at this stage of pregnancy means that extensive scrutiny of the woman's circumstances already takes place.

It is the role of professional medical colleges to continually refine clinical and practice guidelines for such complex cases. It is not the role of members of parliament to determine clinical practice or to put legal impediments in place. Legal obstacles achieve nothing but increasing the stigma surrounding the procedures, and potentially increasing delays in finding a safe service.

Severe foetal abnormality can make later termination the most medically advisable option. Diagnosis of many foetal abnormalities is not possible until later gestation. Free screening for chromosomal abnormality does not happen until 18 weeks gestation or later, and the results may then take two weeks or more, delaying diagnosis until 22 weeks or later. Women living in regional and remote areas and those who can't afford to pay for early tests can be disadvantaged by this.

There is often uncertainty around diagnosis of foetal abnormality, which becomes clearer by waiting until a later stage of pregnancy. Setting gestational limits may lead to the termination of pregnancy of healthy, wanted foetuses because women with these uncertain diagnoses are afraid of having the option of late termination closed to them.

We advise against restrictions or cut-off points at any gestation, as this can lead to women feeling pressured to make important decisions without sufficient time to gather and review adequate medical information.

Requiring two doctors to authorise an abortion beyond 14 weeks gestation and a cut-off point of 23 weeks gestation create high-risk situations when a woman's life is at risk if a pregnancy is not terminated, or if through illness or injury, the foetus is no longer viable. There may only be one medical practitioner available in a remote area in an emergency, and if they oppose abortion or if they are concerned about the medico-legal risk of terminating a pregnancy without a second medical practitioner's authorisation, the woman may die.

Mandating that "Information and counselling are to be provided about future contraceptive options regardless of gestation" will be patronising, insulting and potentially harmful to women who have lost a planned, wanted pregnancy due to foetal abnormality, maternal health risk or foetal death in utero.

Every patient is different. Legally required information risks both under and over inclusiveness. Health professionals, rather than legislators, are best placed to determine the relevant information to be given to a patient bearing in mind the questions asked and concerns raised by each individual. The 2008 Victorian Law Reform Commission (VLRC) report recommended*: "Any new termination of pregnancy law should not contain mandated information provisions"* (p. 8).

We suggest instead that the Northern Territory government invest in a comprehensive sexual and reproductive health strategy with a focus on promoting healthy sexuality and fertility and prevention of unintended pregnancy via the accessible and affordable provision of the full range of contraceptive options for women and men. This strategy should be aimed at all Territorians of reproductive age, not just those seeking termination services.

3. Suitably qualified medical practitioner

Limiting the provision of termination services to medical practitioners, particularly medical specialists, is problematic in many ways and we strongly advise against it.

Access to medical practitioners, particularly those with specialist training, can be limited for both patients and health services. Women living in regional and remote areas currently bear significant costs associated with travelling to a prescribed hospital for surgical termination and if the only specialised practitioner who can prescribe medical abortion is in a major town then access will not improve. Any changes to law should promote equity of access to services, not create further barriers.

Social and professional stigma associated with termination of pregnancy already prevents more health professionals from providing this service. Creating additional barriers (such as costly and time consuming training) to doing so will only discourage health professionals further.

Since the advent of medical, as opposed to surgical termination of pregnancy, midwives, sexual and reproductive health nurses, nurse practitioners, pharmacists, and in some countries paramedics and non-clinician peer health workers are able to competently administer medication termination of pregnancy, supported by a World Health Organisation framework[2]. Changes in scope of practice for health professionals may see this happening in Australia before long. Limiting the provision of abortion services to one category of health professional is likely to create further barriers in the future.

Health practitioner, pharmaceutical and professional body clinical guidelines are the appropriate mechanisms to regulate health services, not stand-alone laws for individual procedures.

[2] World Health Organization. (2015). *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception.* Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/health-worker-roles-safe-abortion-1st-trimester-summary/en/

4. Prescribing, Supplying and Administering drugs that induce medical termination

The discussion paper states that the Therapeutic Goods Administration (TGA) already places restrictions on the prescription, dispensing and administering of abortifacient medication. This is their role across all medications, and further restrictions or duplication in Northern Territory law are unnecessary.

5. Criteria for the most appropriate location of treatment and safe care

Again, the TGA has already provided guidance on the responsible prescribing of abortifacient medication in relation to the location where the woman takes the medication and how close she needs to be to medical facilities. The Royal Australasian College of Obstetricians and Gynaecologists (RANZCOG) has produced similar guidelines. Further restrictions in NT law are unnecessary and may prove to be a barrier in the future if clinical or TGA guidelines are changed.

6. Provision of services

We applaud the Department's commitment to maintaining affordable and accessible surgical termination services in public hospitals to ensure all NT women have access to services.

7. Conscientious Objection

We support the Department's proposal to include a referral clause for conscientious objection similar to what is in Victorian legislation, however we note that while the body of the discussion paper quotes "health practitioner" the appendix refers only to "medical practitioner". We recommend that "health practitioner" (one registered by the Australian Health Practitioner Regulation Agency) is used in legislation so that nurses, midwives, pharmacists, psychologists and social workers are also required to notify women of an objection and refer them on.

We also note the absence of an exception to the conscientious objection clause for cases where the woman's life or health is at risk. This is an essential clause, particularly for regional or remote areas with a lack of choice of health professional. Victorian and Tasmanian law provide examples of such clauses.

8. Safe Access Zones

Evidence gathered in Victoria[3] as well as many jurisdictions overseas, shows significant distress caused to women and ongoing harassment of health professionals by anti-choice protesters outside termination of pregnancy clinics. Access zones have been successfully introduced in three Australian jurisdictions; Tasmania, Victoria and the Australian Capital Territory. We support the introduction of access zones around premises in the NT where termination of pregnancy may be provided.

9. Informed consent to treatment

We support the principle of using the existing Gillick competence measure, however this is another area that is the role of clinical guidelines and does not need to be spelt out in separate law.

Other issues

Drawing on our experience of law reform processes in other jurisdictions, we have prepared statements relating to common proposals by those opposed to, or unclear about, termination of

[3] Dean, R. E., & Allanson, S. J. (2004). Abortion in Australia: Access versus protest*, Law and Medicine, 11*(4), 510-515. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15214135

pregnancy related healthcare or access. Unless otherwise stated, references including page numbers are from the Victorian Law Reform Commission's *Law of Abortion: Final Report 2008.*

Panel of doctors to decide whether termination of pregnancy goes ahead
A mandatory panel at law is not reflective of current clinical practice.

Termination review panels are sometimes constructed by public hospitals. In the main they serve to mitigate legal risk and legal uncertainty that emanate from termination of pregnancy remaining in criminal law. There is no better example of this than the fact that the Termination Review Panel at the Royal Women's Hospital in Victoria (until decriminalisation in 2008) was chaired not by a clinician but by an administrator.

The VLRC Report states: "*The panel system leads to a loss of autonomy for the woman. Anecdotal information from Western Australia (where a panel exists for later term termination of pregnancy s) suggests 'women resent the ultimate decision of late pregnancy termination being removed from their direct control'*." (p. 38).

Restrictions related to the age of the pregnant woman
"The existing law governing consent and confidentiality for young people is adequate. No further legislative reform is required." (p. 8).

Current law relating to informed consent in healthcare provides that provided a young person can fully understand the nature of the treatment and its effect, they are able to give consent. There are well-adopted and longstanding tests that a clinician must satisfy him or herself of in order to deem that a patient has provided informed consent. That is not a function of age. That is a function of the person's ability to grasp both the outcome of proceeding and the outcome of not proceeding.

To involve the parents can often mean young women are ostracised from their families, face issues of violence, or may hide or be in denial of a pregnancy to avoid being forced to reveal it to their families.

In the case of a child who has been sexually abused by a parent or legal guardian, parental notification laws could compel health professionals to involve the abuser, who would then get to influence the decision about what would happen to the pregnancy resulting from that abuse. Government has an obligation to protect all young people who are victims of abuse, not exacerbate their abuse by involving the abuser in their healthcare decisions.

'Partial Birth' termination of pregnancy
This is terminology used by anti-choice groups in the USA, however this type of technique is not used in Australia. In any case, it is not the role of the parliament to dictate in law what procedural techniques doctors can and can't use. Medical technology will always outpace law and to outlaw any particular surgical technique would set a dangerous precedent. Determining appropriate medical procedures is the role of medical colleges and health professionals, not parliamentarians.

Compulsory counselling
The Victorian Law Reform Commission report states:
"Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling" (p.8). *"Abortion counselling is a clinical, service delivery issue rather than one to be directed by law"* (p.124 - 8.122).

The VLRC found that non-directive counselling was current practice in clinics. *"As well as providing details of the procedure and medical risk information, a counsellor discusses the termination of*

pregnancy decision with the woman to ensure she is clear in her decision and is giving free and informed consent" (p.35 - 3.30).

Forcing counselling can do more harm than good. There is consensus among providers that:
"…the majority of women who seek an termination of pregnancy are informed, have considered their decision thoughtfully and for some time, and are clear in their decision not to continue this particular pregnancy at this particular time in their life for a set of unique and individual reasons" (p.120 - 8.80).
"Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm" (p.125 - 8.125).

Women's Health West, noting personal experience of counselling in a mandatory setting stated: "*Compulsory counselling not only reinforced a lack of control, it sparked anger among women that they were assumed to be incapable of making a considered decision*" (p.123 - 8.106).

"Mandating counselling may result in women having to travel long distances for multiple medical assessments and counselling sessions before they can proceed. This would exacerbate existing inequities" (p.125 - 8.127).

Marie Stopes International[4] commissioned survey of women who experienced unplanned pregnancy. This 2006 survey found that 75% of women did not wish to speak to a counsellor before deciding how to proceed. Among survey participants, the most common place to obtain counselling was an termination of pregnancy clinic (45%). Of those women who obtained counselling, 46% said the most helpful thing was that counselling was nonjudgmental; 80% expressed satisfaction with the service provided.

There is no need for counselling to counter mental health concerns. The world's largest, most comprehensive and systematic review into the mental health outcomes of induced termination of pregnancy was published by the Academy of Medical Royal Colleges at the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists. Their review[5] of 44 published studies spanning over 20 years found that it's unplanned pregnancy, not termination of pregnancy, that is stressful for women.

Unbiased pregnancy options counselling should be adequately funded so as to be available to all women with a problem pregnancy, but counselling should not be mandated.

Cooling off periods
The concept of 'cooling off' periods is ignorant and patronising given the reality of women's lives, the urgency of a problem pregnancy and the barriers and time delays already experienced by women.

Imposed cooling-off periods may delay access to safe first trimester termination of pregnancy. This is of particular concern for rural and regional women who could face additional travel and accommodation costs.

VLRC Recommendation: *"6. Any new termination of pregnancy law should <u>not</u> contain a compulsory delay or cooling-off period before an abortion may be lawfully performed."*

[4] Marie Stopes International. (2006). *What Women Want: When Faced with an Unplanned Pregnancy.* Retrieved from http://www.mariestopes.org.au/wp-content/uploads/2014/07/KeyFindings.pdf
[5] National Collaborating Centre for Mental Health. (2011). *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors.* London: Academy of Medical Royal Colleges. Retrieved from http://www.aomrc.org.uk/wp-content/uploads/2016 /05/Induced_Abortion_Mental_Health_1211.pdf

The need for advance bookings in private clinics and waiting lists in public facilities, travel issues for women living outside the cities, and costs associated with private termination of pregnancy already create significant time delays between a woman deciding to seek an termination of pregnancy and actually receiving one.

Foetal Pain arguments

A systematic review of the literature on fetal pain in the Journal of the American Medical Association, 2005 (Vol 294, No. 8)[6] reported: *"Neither withdrawal reflexes not hormonal stress responses prove the existence of fetal pain, because they can be elicited by nonpainful stimuli and occur without conscious cortical processing. Fetal awareness of noxious stimuli requires functioning thalamocortical connections. Thalamocortical fibers begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks."*

The report concluded: *"Fetal anesthesia or analgesia should not be recommended or routinely offered for abortion because current experimental techniques provide unknown fetal benefit and may increase risks for the woman."*

Compulsory viewing of ultrasounds

Ultrasounds are routinely done to ensure the pregnancy is not ectopic and to confirm gestation. There is no reason for the woman to be forced to view this. Such measures are designed only to distress and punish women and to coerce them to continue a pregnancy.

Imagine compulsory viewing of ultrasound in a scenario where a woman who has been informed her planned, wanted pregnancy has resulted in catastrophic foetal abnormality, or that her own life is at stake if the pregnancy is not terminated. This is an already extremely distressing situation – tor force a woman already distressed at losing a wanted pregnancy to view an ultrasound would be cruel in the extreme.

[6] Lee, S. J., Ralston, H. J. P., Drey, E. A., Partridge, J. C., & Rosen, M. A. (2005). Fetal pain: A systematic multidisciplinary review of the evidence. *Journal of American Medical Association*, *294*(8), 947-954. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=201429

Submission #085

Submission for the bill: Termination of Pregnancy Law Reform; improving access by Northern Territory women to safe termination of pregnancy services

Dear Review Committee,
The general promotion of contraceptives under the guise of "safe sex" within State education and through the media in general, leaves our adolescents vulnerable to mutual use and self-abuse including abortion and its consequences. The provision of increased access to abortion can be understood to be at-best, a desperate effort to compensate for a failure to recognise the true nature of the person as sexual being called to exist in committed life-long-relationships that by nature are welcoming of the gift of human life.

The promotion of condom use among adolescents is facilitating an increase in irresponsible and non-committal sexual activity. Coupled with a real-failure-rate of 4 - 6 % - mainly due to misuse often associated with alcohol – condom use is contributing to many unwanted pregnancies and a consequential culture of abortion as well as the spread of disease including Chlamydia which causes infertility, has no symptoms, and the transmission of which is not obstructed by the use of condoms since Chlamydia is transferred by contact anywhere in the genital area.

Combined with an opportunistic abortion industry, our young women are falling victim to abortion. Statistics tell us that more than 60% of abortions in Australia are accounted for by the 16 to 24 year old age group, who often carry alone - the blame and guilt of abortion, believing that they have somehow 'failed-to-be-safe'. Their culpability however is greatly reduced considering that we have fed them the contraceptive "safe sex" lie from the outset.

The truth is that they have been set up for failure. Firstly with the sexually abusive: "safe sex" message, and then in addition to this they have often been taken advantage of by profiteer abortion providers. Adolescent girls are routinely issued low-dose contraceptive pills that unless taken at the exactly correct time each day, can result in pregnancy. Abortion providers operating under the guise of "Family-Planning and "Parenthood"
type services operate in this fashion, taking over the role of parent and becoming the sex expert in the lives of their clients who they know will return to them for a tax payer funded abortion.

If we are going to falsely educate our children about what is sexually responsible, then we are going to have a crisis in unwanted pregnancies.

The proposed *Termination of Pregnancy Law Reform* bill speaks of "safe"; a word that in the English language belongs to the realm of nurture and care often associated with the sphere of family. This is nothing less than a clever and pernicious manipulation of the public. However, as Saint Paul said: "For we are not contending against flesh and blood, but against the principalities, against the powers, against the world rulers of this present darkness, against the spiritual hosts of wickedness in the heavenly places" (Eph. 6:12).

Using coercive State power - in the form of the law courts - to force citizens and medical professionals alike to cooperate in killing the innocent will not serve the good of the Nation. Providing a deadly take-home-abortion pill: RU486, will serve only to further marginalise and isolate desperate and vulnerable young women. The medical experts confirm this for us. For the sake of sanity, let us tell them the truth about sex: and that is that sexual intimacy belongs in one committed life-long relationship as it was designed by God from the beginning. All the science, all the facts, all the medicine and all the statistics confirm this outright.

Do we want emotionally strong and responsible men, who are capable of commitment and the other-centred self-donation which is necessary for maintaining life-long-love relationships that brings peace to the human spirit? We can facilitate this somewhat through education, but never can this be achieved through "safe sex" ideology which only promotes irresponsibility and self-centeredness.

Yours Sincerely
Educator in Sexuality

Submission #086

Feedback on the discussion paper regarding Termination of Pregnancy Law Reform in NT

Provision No 2: Criteria for providing treatment:

Decision to provide MTP:

Consenting process –(including attachment 2)

Define emergency and non-emergency situations clearly as it says "in non- emergency situations, the criteria as in attachment 2 to be followed"

What minimum criteria for consent should be done in emergency?

Consent- Ensure all health related and non-health related consequences of MTP Vs other options are discussed and clearly documented. Document clearly what exactly was discussed rather than a statement that it was all discussed.

Counselling: who and where should this be offered- counselling in the same day clinics especially private abortion clinics could be pro- abortion? Document clearly the details of counselling.

Clause No 5: Criteria for most appropriate location and safe care :

"Ensure pre and post procedural counselling" ––must ensure that counselling is not only given by the counsellors in abortion clinics .

"DOH to provide consumer oriented resources to inform consumers of access to MTP services"-**discriminatory**- DOH should provide equal resources on alternate options and all counselling services, public, private, NGO's.

Clause no 7: Conscientious objection:

This is forcing doctors to ignore their medical knowledge and medical ethics.

It is breech of human rights: Australia is a signatory to the "International Covenant on Civil and Political Rights" (ICCPR). Under the ICCPR, "freedom of thought, conscience and religion " is a fundamental right and is also protected by the major human rights treaties, this is one of the human rights which cannot be suspended or limited , even in the time of public emergency which threatens the life of the nation". A law which forces a person to act contrary to their conscience or their religious believes is inconsistent with the fundamental right to freedom of religion and conscience.

If a medical personnel with conscientious objections to terminations are compelled to treat , or to refer which is indirectly participating in the act of termination, it may lay grounds for litigation against the state where psychological trauma results.

The AMA Code of Ethics only imposes a duty to inform so patients can seek care elsewhere.

Clause 8: Safe access Zones:*"safe access zones will prohibit a person from…….intentionally communicating in relation to treatment in such a way that it is seen or heard by another person…"*

This against freedom of speech and assembly

Even peaceful communication or offering of information about counselling, financial assistance, practical support or other options such as adoption or foster care is not permitted under this clause.

This is may be unconstitutional and invalid because of its interference with freedom of political communications as abortion is a controversial political issue as well.

As abortion clinics could be located anywhere, what if a church, mosque or public park is within the 150 m zone?

Other issues:

There is no clause in this law that protects women from Abortion providers whose treatment causes physical or emotional side effects

Nothing in this law prevents sex selection abortions or abortions for social reasons or even for medical experimentation purposes.

NT specifically has to be extremely careful in providing medical abortions to Indigenous women as access to emergency health care is limited and many of these women may receive inadequate counselling / information and may not report side effects from medical abortion- lives may be lost.

Submission #087

To whom this may concern,

I have read the proposed legislation concerning termination of pregnancy & would like to provide numerous points as to why I believe this proposal should be rejected.

1. As far as 'modernising' abortion goes, President Trump has just signed a bill to stop tax payer $ from supporting Planned Parenthood which Marie Stopes was a founder of & which was a major election promise that Trump was marginally successful in winning the Presidency with. As the other Australian states have previously followed the trends of USA they will no doubt want to follow this new realisation that abortion is nothing more than the murder of innocent babies so why move to make abortion easier when the modern world is choosing to revoke what is now being considered an inhumane act with long term consequences.

2. Marie Stopes is a proud self-confessed eugenicist, as was Adolf Hitler. Her beliefs & agenda are not in the best interest of all mankind & especially not for dark skinned people.

3. The purpose of the abortion drug is to starve the living, growing baby of nutrition until it dies & then the final pill brings on the birth of the baby's dead body. This is totally inhumane & even the worst criminal on death row is treated with more respect & compassion than an innocent baby with a beating heart who is living in what should be the safest place in the world- his or her mothers protective womb.

4. The paper talks of 'safe' termination but how can the word safe be used when at least one of the living beings involved ends up dying.

5. A mother under 16 not needing her parents' consent to abort. The parents should be involved in what could be the second biggest regret of their daughter's life & also for the wellbeing of their grandchild.

6. In the questions paper it is stated that the proposed bill is not expected to increase abortion rates as figures show that restrictions on abortion laws have not lowered abortion rates. This does not make sense & needs to be more specific. What does make sense is that if abortion was altogether illegal it may make women & even men more mindful or careful with their decisions to not be in an unplanned situation anyway & in the process it can also reduce the incredibly high STD rates & all the other psychological problems sexually active people seem to have as compared to committed married couples.

7. Has a study been done to see if there is a connection to the extremely high rates of depression in women & abortion?

8. When reading the discussion paper there is a link to a publication regarding reducing family domestic violence strategy. It stated that safety, regardless of age, is a basic human right. Well may I sugest that the unborn, even though many can & do live outside the womb pior to the proposed 23wk abortion proposal, but whatever stage they are in, they are considered by mothers & doctors alike as living beings but yet they are denied this right to safety. Is it any wonder domestic violence is what it is today when family members know that mothers are killing their babies through cruel inhumane deaths. Whether medical or surgical truth always comes out one way or another & really what is the difference between the deliberate planned death of the unborn or a 1yr old baby beaten in a fit of rage where the mother or father responsible is treated with utmost disdain in society & given a long gaol sentence?

Where really are we heading as a society? It is not about women's rights or health when a baby's rights & health are trampled on.

Thank you for the opportunity to speak for the voiceless & for the many women who suffer guilt in silence.

Submission #088

To whom this may concern,

My name is xxxxxxxxxx, and I have been a resident of Alice Springs since 2015. Below are my comments on the proposed changes to the administration of "termination of pregnancy" in the NT, and to the discussion paper titled "Termination of Pregnancy Reform; Improving access by Northern Territory women to safe termination of pregnancy services".

I am commenting because a) I am a citizen of the Northern Territory, and I want what is best for my community b) I have family and friends who are doctors, nurses, and social workers and work in the NT; and c) I work for an indigenous organisation, and I am concerned how this proposal will affect aboriginal women; particularly those living in town camps, or in the remote communities my organisation services.

As a general statement, I am against abortion on several grounds.

1) I am a practicing Christian; of which there are many in Alice Springs. The Bible says: "Children are a heritage from the Lord, offspring a reward from him" and "For you created my inmost being;

you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made." (Psalm 127:3 and 139:13-14)

2) "Safe termination" is a misnomer. Obviously, the child whose heart is beating, whose brain is functioning, whose limbs are moving, and whose muscles are twitching, is not "safe" when its life is terminated in the act of abortion. The methods and administration of abortion are also not safe to women, neither physically, psychologically, nor spiritually. There are significant risks.

3) The medical advancements of the 21st century are not the creation of the "french pill" (i.e. RU486) but are the antenatal and neonatal advancements that can be provided to families and their children. At any given time, at any given hospital, a child will be born premature, and will receive the greatest care 21st century medicine can provide; whilst simultaneously, in the same hospital a child of the same gestation will be aborted under the rhetoric of "advanced", "contemporary" or "21st century." This is a contradiction, and in my view, not right.

4) Our child was born premature at 36 weeks gestation, and my wife and I spent two to three weeks in the neonatal unit at Alice Springs hospital, and have profound appreciation for the work that is done there, and the care that is given to the most delicate and precious of children.

We are very aware of the developmental cycle of a child in the womb, and cannot think of any time during that cycle where an abortion is appropriate. We shared our news on facebook, and with family and friends, at 12 weeks gestation, and have never received more love and congratulations for anything we have ever done, expect perhaps when our son was actually born. On this basis, I do not agree with this papers concept of "societal expectations."

5) The whole vibe that I get from this paper is "remove safeguards, easier access, and more abortions" and I am concerned that in a very subtle way this will act as a form of racial

eugenics towards aboriginal people; similar to the way Planned Parenthood in America asymmetrically aborts black children.

Commenting specifically on the sections of the discussion paper, I will highlight the following areas:

- Point three of the paper seeks to a) remove the requirement of two practitioners to sign off on an abortion for terminations under 14 weeks, and b) expand the definition of "suitably qualified medical practitioner" to encompass those who are not obstetricians and gynecologists. The apparent intention behind point a) is to make approval for abortions easier, but point b) is particularly unwise. Nurses, or pharmacists, who are the likely "suitably qualified medical practitioners" in focus, are not equipped to make decisions on termination, and to provide the necessary medical counseling required by the proposed amendments. It is above their pay-grade. Abortifacients are not the same, by nature, as aspirin, and involve significant multifaceted risk. Anything less than a consultant, or a GP, is sub-optimal medical care.

- Point five of the discussion paper seeks to expand the setting for abortion beyond public and private hospitals, and allow for abortions to take place in "urban day surgery centres, family planning clinics, GP clinics, regional locations, and remote Primary Health Care Centres." Having reviewed the risks involved in RU486 in the following document (http://www.feministes-radicales.org/wp-content/uploads/2010/11/Janice-G.-Raymond-Renate-Klein-Lynette-J.-Dumble.-RU-486-Misconceptions-Myths-and-Morals.pdf), having a general appreciation for the third-world health conditions found in certain parts of the NT, and having experienced the living conditions of the remote communities and town camps; this proposal would be disastrous for our community, and I could not image a rural GP recommending this setting for an abortion to take place.

This proposal reads like a "big city" person, modelling their ideas from Victoria, and not considering the uniqueness of the NT, and that the reason why the safeguards are in place are for the protection of our women and children.

- Point seven is a very serious issue which I believe infringes on free speech, and freedom of conscience. Of the many Christian doctors and GPs that I know, I know for a fact that they will not, and do not, refer a woman seeking an abortion to "someone else who does not have a conscientious objection." This would limit their freedom and liberty to conscientiously object to terminating a potential and viable human infant, and bring the force of the law upon them. This is extreme left wing intolerant ideology attempting to make its way into our legislation, and it needs to be removed.

A friend of mine, who is a GP in Victoria, was asked by a patient for an abortion. The GP said to the patient "this is what the law says I should do, I am not doing it. You can sue me." And the patient said, "I think the law is wrong to require that of you, and there are plenty of GPs who will provide me what I ask for." (Thankfully, the patient was not actually pregnant).

Rural and remote GPs are generally male, conservative, and against abortion, so I can understand the motive behind these proposed changes to the legislation to a) limit their freedoms and b) expand those who can provide abortion services - but I do not think it is right, and the proposed changes are sub-optimal and dangerous.

To conclude, whilst I am against abortion, I acknowledge abortion is a part of life for the present time. Nevertheless, I do not wish for abortion to be easier, or more frequent, which is my primary motivation for my opposition to the proposed amendments outlined in the

discussion paper. In my survey of the paper, I have found proposals to be loose or deceptive with language, such as "*safe* termination", "contemporary", "advances", and make suggestions for sub-optimal care, which I do not believe would be tolerated in other medical fields, even in the NT. I believe some of the proposals would actually be dangerous and disastrous for aboriginal women, if they were to be carried out as this paper fancies. And this paper makes the usual omission of concern for the living, developing and viable infant growing inside its mother.

Thank you for the opportunity to share my comments.

Submission #089

To whom it may concern,
I am a final year medical student working at the Royal Darwin Hospital. I have just noticed the termination of pregnancy press release and discussion paper on the hospital intranet. I am very alarmed at the ambiguity of the recommendations and consider that these changes are certain to be dangerous for women and society. Below are my comments…

From the discussion paper
Medical
Definition of termination of pregnancy
- Intentionally causing the termination of a woman's pregnancy by "Any other means"- could mean a baseball bat to the belly. There needs to be an adjective like "safe"; "reasonable" or "medically appropriate" in place.

Definition of "Suitably qualified medical practitioner"
- Could b) *a medical practitioner who has completed a recognised training course within the last 2 years for the provision of advice, performing procedures and giving of treatment in the area of fertility control* be an intern doctor who learnt these skills as a recent medical student? An intern would not have the level of experience to cover the requirements listed below.
- Could c) *a medical practitioner who has a valid credential prescribed by regulation* be an orthopaedic surgeon who knows nothing about women's health?

Criteria for assessment of termination of pregnancy (TOP)
- The new legislation just "requires 1 suitably qualified medical practitioner". There are many medical practitioners (like the intern above or a bulk billing doctor) who would not have the time or experience to:
- counsel the woman appropriately between options with very different expected experiences (surgical abortion, medication abortion, adoption, continuation of pregnancy),
- assess the psychological state of the woman to determine whether she is likely to suffer post abortion stress syndrome,
- ultrasound the patient to exclude ectopic pregnancy,
- screen the patient for STI's,
- prescribe appropriate prophylactic antibiotics to prevent serious infection,
- do rhesus testing and alloimmunisation,
- remove any intrauterine devices in situ,
- screen the patient for any co-morbidities listed in the warnings section of the mifepristone MIMS guide such as cardiovascular disease, hypertension, hepatic disease, respiratory disease, renal disease, diabetes, anaemia, malnutrition and smoking status, all of which are highly prevalent in our local Aboriginal population.

Furthermore, where the legislation recommends "assessment" rather than "examination", to allow for telemedicine, a thorough assessment for TOP will not be undertaken.
The proposed legislation says a woman is eligible for TOP for current and future biopsychosocial reasons
- I consider biological reasons for TOP such as where the woman's life is immediately threatened (i.e. ectopic pregnancy) are reasonable.
- A woman's psychosocial situation can be changed by having a baby. We all know teenagers or friends who have had unplanned pregnancies and decided to keep the baby which changed their lives for the better. Often their changed status (to mother) causes them to feel more worthwhile. A major US study that collected data on approximately 19,000 adolescents

found girls who had been pregnant at least once had higher rates of delinquency than never-pregnant girls. But girls who kept their babies had delinquency rates the same as never-pregnant girls. (Hope LT, 2003)

- Other studies have proven that motherhood is good for the psychological state of women with mothers ½ as likely to commit suicide than a woman who has never conceived. In contrast, women who have had a TOP are 3 x more likely to commit suicide than women who have never conceived (Gissler M, 1996)
- A study looking at victims of rape who became pregnant found that 78% of the 30% of women who had abortions after their rapes felt that they'd made the wrong decision (Reardon D, 2000).
- A doctor cannot predict if a psychosocial situation is incompatible with parenting. Some of the most inspirational humans were born into *unfavourable* psychosocial conditions (Oprah Winfrey, Simone Biles, Jesus). The future is unable to be predicted.

Location of treatment for no more than 23 weeks
- "In accordance with professional standards and guidelines" – which ones? None are listed

Standards of care
- "In accordance with professional standards and guidelines" – which ones? None are listed

Conscientious objection
- If a medical practitioner considers that the woman or the foetus is likely to suffer physical or psychological harm from TOP, do they still have to send her to another practitioner who will refer for TOP?

Practical
Regulation
- The proposed method of legislation places a significantly new and increased burden on medical practitioners to unilaterally
- determine viability of pregnancy;
- determine the mother's situation;
- prioritise one life compared with another; and
- look into the future.
- Is there any regulatory body to support, monitor and control medical practitioners in this setting of a new responsibility over human life?
- In accordance with the new powers/ responsibilities /privileges bestowed on medical practitioners, is there a consideration of whether existing medical malpractice law and professional indemnity insurance covers these circumstances?

Logistics
Metropolitan clinics
- How will bulk billing practices (5 minute medicine) cover the requirements needed (see above *criteria for assessment for TOP)?*
- Do any Darwin clinics have capacity to become abortion facilities? And if so, who will regulate this?

Remote clinics
- Do they have access to emergency facilities (including ultrasound)?
- How will they obtain informed consent (language/ education barriers)?
- Is there access to counselling services?

- Is there the ability to follow-up patients? Medical abortion takes longer and requires further follow-up and is dangerous if follow-up is incomplete.
- Will anyone know if a mother delivered a dead or moving foetus at home, and how she coped?
- This legislation is bound to place remote doctors at risk of cumulative stress requiring only ONE doctors opinion PLUS remote healthcare stress putting patients at risk of an increased probability of error in judgement.

Reporting
- Is there any plan for monitoring the societal impact of this controversial legislation?
- How can this be monitored to gauge behavioural effect on society from legislation?

The department of health's priority should be about the prevention of unplanned pregnancies, not the reactive management.

The Government needs to consider the societal behavioural outcome as well as the societal demand. A legislator's role is not just to "keep pace with medical advances" but to appropriately guide medicine towards complimenting societal needs. The research conducted by Dr Meningle on human twins was inappropriate, and the Nazi Government involvement with his intentions was evil. If abortion is inappropriate, no matter how good the technology or pharmacology, the government should discourage it. If easier abortion has a behavioural effect of increasing societal promiscuity, then it increases, rather than decreases, the incidence of unplanned pregnancies, medical complications due to pregnancy or abortion, and long term psychosocial effects of unplanned pregnancies or abortion.

The MS 2 step program causes labour without anaesthesia and the birth of a recognisable fetus. This seems a step back from surgical abortion and various randomised controlled trials have indicated that satisfaction with medical abortion is much lower than surgical abortion (Rørbye C, 2005) (Robson SC, 2009). Has the department considered the psychological trauma this method of TOP is likely to cause? They might be inclined to argue that since other states have had it for a couple of years, with no public problems, this is a catastrophised view. How long does it take for PTSD to present publicly in other populations of people? (Vietnam war, WW1 & WW2, women speaking out about domestic violence).

Is the department of health also working on counselling and support services and alternative options for women who choose to continue with an unplanned pregnancy?

Legalising abortion doesn't do anything to solve the structural problems that drive women to seek abortion in the first place, or do anything to alleviate the consequences of terminating a pregnancy. Many women lack the resources that would allow them to combine work and child rearing or feel forced to choose between their education and their children. It doesn't have to be this way. The government can support women in a way that an unplanned pregnancy doesn't have to mean then end of work/education and quality of life. They can prioritise feminist policies which

- Stop objectifying women and promoting casual sex as not harmful to women's bodies; and

- Recognise the capacity for women to become pregnant and have in place policies which make this a positive rather than a negative experience for women.

Yours sincerely, A female medical student.

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Submission #090

Personal Submission into "Termination of Pregnancy Law Reform" Discussion Paper.

Dear Department of Health,

Thank you for the opportunity to submit feedback on the "Termination of Pregnancy Law Reform" discussion paper.

I wish to make my submission as a concerned husband, father and man. I strongly reject any opinion that abortion is exclusively about women's choice, and men should butt out. It takes a responsible man and a responsible woman to create a *wanted* pregnancy. Early term (<9weeks) abortion is overwhelmingly about *unwanted* pregnancy, a societal problem caused by the irresponsible sexual behaviors of both men and women

I was born and raised in Darwin and have witnessed a growing number friends and relatives involved in or exposed to tragic situations of family breakdown, family violence, serious sexually transmitted diseases, and suicide related to family stress items. I believe that *irresponsible sexual behavior* is a very significant underlying factor in these current and very concerning societal problems.

In making this submission I hope to clearly identify the concern that the *sexual behavior* of people in the Northern Territory is a severely neglected policy and planning area by the Northern Territory and Federal Governments. THIS ITEM IS NOT MENTIONED IN THE DISCUSSION PAPER.

I hope that the NT Government accepts that it's legislative responsibilities *exceed* the demands of "keeping up with modern medicine" and "satisfying community demands", and *extend* as far as the responsibility to *guide both modern medicine and society towards more responsible behavior*.

I am very concerned that the publicity attached to and promotion of RU486 as a "safe, easy to access and cheap" method of getting rid of unwanted pregnancies will substantially reduce one of the primary precautionary attitudes towards having sex, namely the risk of getting pregnant. This in turn may influence the sexual activity choices of young men and women, despite the RU486 regime offering no protective effect over the probabilities of getting pregnant, or contracting sexually transmissible diseases.

Overleaf I attach considered responses to the items mentioned in the discussion paper.

Yours Sincerely,

Response to particular Discussion Paper, Items of concern:

1. Definition Uncertainties: ☐ Does *medical practitioner* mean *any* qualified doctor (specialist, registrar or intern)?

- Does *medical practitioner* potentially include other allied health practitioners (e.g. nurses, Aboriginal Health Workers, etc)?

2. The Proposed Changes remove the existing right of a medical practitioner to have a FULL conscientious objection to involvement in an abortion procedure (Section 7: Conscientious Objection). ☐ Concerns in other jurisdictions have already been raised about the constitutional validity of this idea, and compatibility with several (signatory) international human rights items.

- The discussion paper isolates medical practitioners as the only group of people to have this restriction placed upon them.
  - The discussion paper does not outline any suggestion of consequence for a practitioner who does not comply with this requirement. **i. Is it a Criminal Offence?**
  - **ii. Would they be brought before the medical registration board?**
  - **iii.** Would they be fined?
  -
  -

3. The Proposed Changes would significantly alter the established Medicolegal Framework of the Northern Territory. ☐ This would be the first time that a medical practitioner (who was not an Obstetric Specialist) would carry both the power to and the responsibility of terminating a pregnancy.

- Is this new responsibility likely to impact on the insurance premiums attached to community medical practice?
- The Discussion Paper, under "Professional Standards and Guidelines" indicates that a practitioner-based level of responsibility would be preferred over clinic registration or clinic-based standards. i. Despite this, the discussion paper does not clearly indicate any method of ensuring the professional standards of an individual practitioner or professional consistency amongst practitioners.
- ii. The Discussion Paper also does not indicate any strategy for overseeing the responsible adherence to standards by individual practitioners.

In my opinion, any legislative approach will require a comprehensive regulatory framework, including a legislated set of regulations comprising professional standards, a designated tribunal body, and designated penalties for professional noncompliance, malpractice, neglect or failure to adhere to the cross-referral requirement.

4. The Proposed Changes do not comment on the need for the "informed consent" to endure the time-period across the administration of both medications. The discussion paper also does not clearly identify the implied "patient compliance" requirements of the treatment regime. ☐ Is there a procedural requirement if a mother returns shortly after taking the mifepristone pill having changed her mind?

- Is a reversal medication (i.e. progesterone) likely to be compulsorily available, and will the training for medical practitioners include this element?
- Is there a procedural allowance for if a mother refuses to take the misoprostol pill or absconds? Will a medical practitioner have anybody to report this to?

5. Section 9 "Informed Consent to Treatment".

☐ As a parent I am extremely concerned by the proposal to include the *Gillick* principle of competence for minors as a strategy to obtain "informed consent" from a person under the age of 16 in a situation of performing an abortion. **i.** One could argue that a pregnant child under the age of 16 has a demonstrated history of immature decision making.

ii. The minor has obviously been a victim or participant in illegal sexual activity. Does the medical practitioner have to report the offence? How are reporting requirmeents over such offences balanced against treatment requests? Are tissue samples taken as evidence?

iii. Is each "suitably qualified" medical practitioner going to become an expert on interpreting and applying the *Gillick* principle? A significant ethical and medicolegal burden is placed on a medical practitioner by this situation. How would a medical practitioner defend themselves if they conducted an abortion on a minor, and were subsequently accused by the minor of misconduct?

iv. The *Gillick* principle was not constructed for an extended medical intervention such as RU486. What is a minor going to do during the two-day period between administration of mifepristone and misoprostol? Would they go home, and try to hide any symptoms from parents? Would they avoid going home?

6. Concerns about the in-practice application of RU486

I do not consider myself adequately qualified to raise concerns about the medical safety of RU486.

As an experienced and practicing allied health professional, I am concerned by a number of practical challenges to performing medical abortion in the NT: **i.** Difficulty with obtaining properly informed consent from indigenous patients. (Language, culture, education barriers)
ii. Inconsistencies with compliance and follow-up attendance by indigenous patients.
iii. Remote Healthcare isolations including distance and weather-related threats to emergency access (limiting reliability of roads, air transport, phone and internet communication). Time to get to an emergency facility can vary significantly based on circumstances that are capable of changing rapidly over the treatment period required for the proposed procedure.

I have a sincere concern for the likelihood that a mother is going to see her aborted foetus (protocol encourages the mother to look for foetal material, to ensure that it is a fully completed process), and that she is most likely going to be alone when she sees this. During a surgical abortion the mother is sedated, does not see the products, and is accompanied by health professional staff throughout the entirety of the significantly shorter procedure.

Submission #091

In reading through the discussion paper on the proposed changes to legislation on abortion in the Territory, it strikes me that there tends to be too much of a focus on 'keeping up' with and staying 'in-line' with a contemporary and interstate model of legislation and practice. Let us be careful not to board the wrong train, that is; just because other states of Australia are doing something and doing it a certain way doesn't mean we necessarily follow suit. We need to check our destination ticket in order to choose our route.

The important questions should not be, "Is it contemporary? Is it modern? Is everyone else doing it?", but more importantly, "Is it good, helpful, necessary?" And, "What are the effects and consequences?"

If we approach our proposed legislative changes with the latter rather than the former mindset then it lends itself significantly to safer and better made decisions.

A few of my own concerns and objections:

First, This proposed change of legislation is designed to make abortion an even easier option, probably in some circumstances the easiest option. This is not in the best interest of the child in the womb, the mother, the father, or the community. Why not instead work on legislation that seeks to increase family support, the ability to adopt, etc.

Let's be honest, is anyone actually thinking of the child in the mothers womb? I doubt it since they are the ones who actually suffer and die due to these procedures and drugs. So many people quote human rights all over the place but are inconsistent because a baby in the womb is deprived of any rights.

Second, If a medical practitioner feels that they would be going against their conscience in performing or helping in any part of an abortion, they must not then be made to refer that person on to another medical practitioner whom they know would do what they them self have conscientiously objected to. This is a direct contradiction to the medical practitioner's conscientious objection.

A medical practitioner who has objected to aiding in an abortion for conscientious reasons who is then forced to refer a patient on to someone they know is going to do the work they do not agree with, is thereby forced to be aiding in the act, and therefore in reality has no option of conscientious objection. This is dangerous as it is denying an individual their freedom of thought, conscience, and speech.

Third, Setting up so called 'Safe Access Zones' around medical center's is another trespass upon freedom of speech as its aim is to stop anyone who may hold a different opinion from expressing such an opinion anywhere in the near vicinity of any premises offering reproductive health services. But not only that, the area recommended (150m radius) will very probably include private properties and will thus disallow private persons to express their own views within their own private premises! However this is very much out of character for the Australia that supposedly stands for freedom of speech, and expression, and religion, and has ratified the treaty of the Universal Declaration of Human Rights, the 18th Article of which states,

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

A lot more could be said on each of these few points, but I think the point is clear that I do not support these changes in legislation as they are neither good nor helpful, but actually the opposite..

Submission #093

Dear Health Minister,

I and my husband would like to raise our concerns regarding the recent termination of pregnancy law reform. We are a young family with three children, we are shocked with the statistics of abortion and the reason behind the need for pregnancy termination law reform. To cater increasing demand for abortion a new law needs to be formulated in order to save our women! This is just like treating the side effects after prescribing a wrong medication.

Our concerns with the new law is

1. Why the Government needs to formalize a law for legalized murder?

2. If our health professionals support killing how we can trust them that they will feel the same pain as we go through and do everything to save our life?

3. If I am referring a women to another professional who do not have conscientious objection will I be silently partaking in the crime? Does it mean that a health professional is also a professional killer?

4. Why do we have imprisonment and punishments for road accidents where people kill others unintentionally? If road accidents are considered as legal offences why this intentional killing of innocent babies needs to be legalized? It has scientifically proven that the fetus has all the features of a human being so it should be treated as a human being.

5. Is this 'safe access zone' will be really safe for human being where an innocent baby is brutally murdered within his/her mother's womb with mother's permission and by a health professional? Also it has proven that drugs such as RU486 will cause dangerous side effects to women's health.

No women in this world will get pregnant by chance. It will happen only through sexual intercourse either with consent or without consent. Whatever be the case, if a new life has created, that is a new human being and an individual. No one has the right to decide that individual's destiny. By making the law reform with an easy accessibility is actually allowing people to lead an immoral life with an awareness that law is in their favour. Do we reform the traffic laws and make it acceptable and legal to cross the red light if a few drunken people cross the red lights regularly?

Increased amount of Alcohol and drug usage is the major reason behind the sexual abuse and unwanted pregnancy. Without treating or dealing with the basic reasons no good is going to happen to our women and in our society. Instead, increased sexually transmitted diseases, hormonal imbalance, depression, physically and mentally challenged babies are awaiting our women.

Man is a social being hence we should follow laws for the betterment of the society not to destroy, we should respect people not to use them for individual benefits, we should help each other to live not to kill them for my safety.

Our opinion is, instead of making the pregnancy termination law reform by legalizing abortion, we need to create a law that will reduce unwanted pregnancies. NT Government should take a bold step in order to ban abortion in our hospitals and clinics and promote life.

We should restrict the alcohol and drug mafia not to spoil our society. We need to educate our women about their body, importance of healthy relationships, bad impacts of alcohol and drug usage, about natural family planning such as Billings ovulation method. Health clinics and GP clinics should give out leaflets about above services so that more women have access to these services.

Looking forward a government which respect its people, reduces crime, make policies and laws to save the next generation and earth.



RU4Life

A response to the Discussion Paper on Abortion released by the Department of Health - Christmas 2016

Gerry Wood - Independent Member for Nelson

January 2017

Comments on Discussion Paper re Termination of Pregnancy (Abortion) by the NT Department of Health

INTRODUCTION

At the outset can I say that I don't believe this Department of Health document is a true discussion paper but basically a paper which describes what the proposed changes to the Medical Services Act will be, as if those changes are going to happen regardless of what others think? To be a true discussion paper it should have included alternative views or even a section similar to a recent discussion paper released about an Independent Commission against Corruption headed *Particular Issues to Consider*.

So where you read the phrase 'discussion paper' please replace it with 'assertion paper' and you will be closer to the truth in describing what the Department of Health has written.

People do have different views to the views of the pro-abortion lobby – I am in contact with them regularly. Unfortunately those views are being suppressed because people are scared of the ridicule they may get in the pro RU486 press or from pro-abortion people or even in their job if they speak out.

So I will do my best to reflect not only my views but others when responding to this 'discussion paper'. I also reiterate that I do not support abortion as I believe that unborn human life should be protected by our Parliament not destroyed which is what this legislation supports. We are human from the day we are conceived to the day we die and carry our own individual DNA from the start to the finish. It is clear in this discussion paper that the authors do not accept that premise as nowhere in the paper are the rights of the unborn mentioned and of course nowhere in this discussion paper is the word 'abortion' used, just the euphemism 'termination of pregnancy'. Even worse is the phrase 'products of conception' a horrible and cowardly term that describes bits left over of an unborn human life during the abortion process.

The reality is, of course, that regardless of my views I know that abortion is lawful in the NT, but I still have a responsibility to look at the proposed changes in the hope that another way of destroying a human life using drugs does not succeed in our Parliament. Some may say what does it matter if abortion is already permitted, but I say if you don't support people dying by being hit by a car why would you support someone being hit by a bus? You still get the same sad outcome.

What this 'discussion paper' avoids is recognising that there are different views about what is being proposed. This 'discussion paper' is not just about legalising the use of RU486 of abortifacient, but also making abortion easier, restricting conscientious objection by doctors and health staff and restricting protest even silent protest.

For a person who reads the Department of Health discussion paper they will see no alternative views or concerns re these matters. A 'discussion paper' from the Department of Health should have included alternative views.

The way the 'discussion paper' and the accompanying FAQ (Frequently Asked Questions) paper are worded infer that these changes are inevitable. To call the changes 'contemporary', 'bringing us into the 21st Century' and then to say the legislation will be come into effect in July 2017 one can easily see why other views will be given token or zero consideration. Even the Minister's press release says

these changes will 'modernise' the legislation, obviously for the Minister modernise means an improvement. That may be something you would agree with if you support these changes, but not so if you don't. The Minister also states in her press release that this legislation will keep pace with medical advances in the future. I would argue this proposed legislation is a medical retreat and if we are really interested in medical advances we should be aiming as a priority to reduce the numbers of abortions not encourage more to occur by making abortions easier to obtain.

The 'discussion paper' basically copies most of the recommendations that NT Family Planning put to the Government in 2013 and the Review of Termination of Pregnancy Services in the Northern Territory, April 2014, undertaken by Prof Caroline de Costa (a pro-abortion advocate) at the request of Dr Sara Watson Medical Services, Royal Darwin Hospital. Victorian legislation was also used: the proposed restricted safe access zones and prevention of a conscientious objection clauses in the 'discussion paper' are similar to the Victorian model. In late 2015 in two stages, the Member for Goyder, Kezia Purick, introduced a private member's Bill which fortunately did not succeed because the NT general election in late 2016 ended any more debate on the subject. That Bill has now come back in the form of this 'discussion paper', hence my view that the 'discussion paper' is biased.

There is no room in the 'discussion paper' for a debate on programmes to reduce the number of abortions or the idea of promoting adoption as a real alternative to unwanted pregnancies. When it is estimated there are 600 to 900 abortions a year in the NT you have to ask why aren't we doing something to lower that terrible statistic? Note: accurate numbers of abortions are not kept and the figure quoted comes from the de Costa review authorised by the Department of Health. Why aren't accurate records kept and included in the annual report? Is this issue too sensitive and the Department would rather it was not publicised?

Is it time to question if there is too much emphasis of a safe sex culture promoted by Governments and family planning groups which seem to have failed when you look at the large numbers of abortions in the Territory? Should we be teaching and promoting to our youth about respect or is that old fashioned? You won't find these discussion points in the 'discussion paper' because it isn't a discussion paper.

I received a letter recently from Bishop Eugene Hurley, Catholic Bishop of Darwin and the NT. The Bishop has a post graduate qualification in counselling and 'practised' for many years. He says he *is acutely aware of the trauma experienced by many women who are faced with the reality of an abortion and/or having had an abortion.*

He says he said he had initiated a strategy called 'Walking with Love'. He says that 'this program was initiated in order to care for women contemplating abortion and providing them with real and safe alternatives'. He also goes onto say 'it also provides a safe place to talk about having an abortion without being judged'.

This 'discussion paper' does not talk about this and the author/s probably would have little time for the Bishop because he is a Catholic, or is it just that the author/s are one-eyed and refuse to debate it in case their ideology might be challenged by others. Of course in the eyes of some having a religious faith precludes you from having an opinion but of course strangely it doesn't preclude those with a non-religious belief from having an opinion. The idea that using reason to come to the biological conclusion that an unborn baby is a human being doesn't seem to matter to supporters of RU486.

Supporters of the proposed changes also argue that because other states have approved medical abortion so should we. The Territory is not Queensland nor Victoria and they don't run us. We might

study what they do but we pass our own laws based on our views and our circumstances. Who's to say those states are right – the treatment of the unborn in Victoria can only be described as medieval and I would be ashamed to use that State as an example we should follow.

CHANGES PROPOSED IN THE DISCUSSION PAPER

The changes proposed are intended to establish a new Act which the Government intends to introduce into Parliament soon. The intention of the Government is first to repeal Section 11 of the Medical Services Act which deals with abortions. It would be then replace that with a new Act based on the recommendations in this 'discussion paper' which as you will see, if passed, will have serious consequences for the unborn, doctors, nurses and even the public.

So we need to look carefully at what is in the existing Section 11 and what will be in the new Act.

As I said before surgical abortion is permitted in the NT and this new Bill will allow medical or chemical abortions to occur. This would mean the approval of RU486 as an abortifacient along with the second drug, a prostaglandin (Misoprostol), a drug used to complete the abortion process.

The changes will also allow abortions outside of hospitals, reduce the number of practitioners who have to give approval for some abortions from two to one, ease the restrictions on having an abortion, allow chemists, nurses and midwives to prescribe, supply and administer the drug RU486, change the consent laws for children under 16, stop any protests within 150 metres of an abortion clinic and remove the doctor's rights to have a conscientious objection to abortion.

Change 1

To allow these drugs to be used for abortion a new definition in the proposed new Act is required defining termination of pregnancy (abortion). Below is the definition the Government proposes;

> *termination of pregnancy means intentionally causing the termination of a woman's pregnancy by:*
> *(a) using an instrument; or*
> *(b) using a medicine or a combination of medicines; or*
> *(c) any other means*

In plain English this means that the new law will allow the destruction of a human life by using either (a), (b) or (c).

Part (a) using an instrument, is a description of a process used for a surgical abortion which is allowed under Northern Territory law today.

Part (b) is the change in the law which will allow RU486 and other drugs to be used to produce an abortion.

There is no mention of concerns about the safety of this drug nor a mention of the second drug used called prostaglandin and marketed under the trade name Cycotec. The manufacturer, by the way, has not approved this drug for use as an abortifacient, the drug is an anti-gastric ulcer treatment.

Renate Klein PhD/ Janice Raymond PhD/ Lynette Dumble PhD co-authors of the book *RU486,* query why certain women's groups are promoting the use of RU846. Their concerns are very relevant to

this debate. The authors are pro-abortion and feminists, but are strongly opposed to the use of RU486. They say a surgical abortion is safer and takes very little time whereas a chemical abortion can take up to 6 weeks and has side effects, haemorrhaging and bleeding and even death. They say:

> *After painstaking research for two years, we did not like what we found. We became convinced that not only was RU/PG abortion **not** a new panacea, but that in fact its potential widespread (and in many countries illegal) use might jeopardise women's lives and become the new DIY backyard abortion, 21st century style.*

The authors go on to query why certain women's groups are promoting putting an abortifacient drug in women's bodies but at the same time showing their concerns about chemically fed animals and plants.

They put these questions to the promoters of this drug:

- *Is RU486 a miracle drug for abortion that is safe and effective alternative to conventional abortion procedures?*
- *Does it privatise and de-medicalise the abortion experience?*
- *Is its availability a victory for women?*
- *Is RU486 safe for use in Third World countries and remote rural areas?*
- *Who benefits from chemical abortion and how does RU486 effect existing abortion services?*

(My question in relation to the last dot point – has the monopoly company (Marie Stopes International Australia) that sells RU486 been visiting the RDH recently to promote its product in the belief that the Government will introduce new laws which will allow RU486 to be used? Is that ethical?)

Of course there is no mention of those alternative views in the 'discussion paper". At least the authors of RU486 put their names to their opinions!

The safety of RU486 compared to a surgical abortion is also questioned. Dr David Gawler, who was the Director of General Surgery at RDH for over 12 years raises this in the following letter and raises other reasons why it is not safe to use this drug in the Northern Territory.

> *To whom it may concern*
>
> *I am writing to voice my medical concerns about the proposed use of RU486 (medical abortion) in the Northern Territory. I recently retired as Director of General Surgery at the Royal Darwin Hospital after working at RDH for over 12 years.*
>
> *The primary and most important consideration in assessing the suitability of a treatment, is patient safety. A "one-size fits all" policy is not appropriate in relation to the delivery of health services to "at risk" groups in the formulation of NT Health Policy. The Northern Territory Government has a very particular responsibility in ensuring the health and safety of Indigenous women in relation to the "Closing the Gap" Policy of the Federal Government.*
>
> *A South Australian Health Department audit of nearly 7,000 abortions performed in 2009 and 2010 compared the safety of RU486 with surgical abortion, (E.A. Mulligan, "Mifepristone in South Australia" published by "Australian Family Physician" Vol. 40, No.5, May 2011).*
>
> *The South Australian audit showed that, "1 in 18 patients who used RU486 (Mifepristone) had to be re-admitted to hospital i.e., (a total of 5.7% of first trimester medical abortions (women using RU486) vs. only 0.4% of surgical abortions). The same study revealed that as*

many as 33% of women who had second trimester RU486 abortions required some form of surgical intervention".

The findings of that South Australian audit were published in "The Australian" (May 7, 2011): Abortion pill 'less safe than surgery' reported by Jamie Walker. (http://www.theaustralian.com.au/national-affairs/abortion-pill-less-safe-than-surgery/story-fn59niix-1226051434394)

In the USA, the Food and Drug Administration (FDA) "Mifepristone U.S. Post marketing Adverse Events Reports Summary (since approval in the year 2000 until) 30/4/2011", revealed that at least 11 women have died as a result of complications related to taking RU486; 612 women were hospitalized after taking RU486; and of these, at least 339 women required blood transfusions as a result of serious blood loss. The report also indicates that 58 women were prescribed RU486 despite having an ectopic (tubal) pregnancy (which is a serious contraindication for using RU486, and entails a risk of death.

In a Statement: "The use of mifepristone for medical termination of pregnancy" (Reviewed February 2016), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists mandates:-

1. *"Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care ..... from the administration of mifepristone until the termination of pregnancy is complete."*

This is because there is a small but significant incidence of major haemorrhage which may be life-threatening, requiring hospitalisation; blood transfusion and surgery.

Serious and potentially life threatening complications which may occur are bacterial sepsis (for example, Clostridia sordellii); incomplete abortion (where parts of the baby and placenta remain in the womb), necessitating emergency surgery; and ectopic (tubal) pregnancy which may rupture and cause internal bleeding, which may cause rapid death without speedy interventions.

NB. In remote settings in the Northern Territory, air evacuation may not always be possible during the Wet Season; furthermore, even in good weather, because of the tyranny of distance, and because not every remote community has a plane sitting on the airstrip, there can be very prolonged aviation delays.

Moreover, in the USA, despite the mandatory requirement for the availability of rapid transport to close and adequately equipped facilities, fourteen deaths (up until 2012) have occurred as a result of using RU486 (Mifepristone).

2. *The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also stipulates that :*
   "Accurate gestational assessment is essential to selecting optimal treatment options and regimens. Ultrasound examination is mandatory prior to termination of pregnancy to confirm gestation and exclude ectopic pregnancy; a diagnosis of ectopic pregnancy can be very difficult after attempted medical or surgical abortion."

   N.B. Skilled ultrasound assessments are not usually available in rural and remote NT clinics; and so RU486 is an inappropriate drug.

3. *The RANZCOG also mandates three visits to the RU486 prescribing doctor. At the initial visit (before giving the patient RU486) arrangements must be made for diagnostic ultrasound to establish gestational dates and to exclude ectopic (tubal) pregnancy; blood group in case urgent transfusion is necessary; rhesus negative status must be established in case Rh Immune Globulin needs to be administered to the mother during the medical abortion, because of danger to subsequent pregnancies. These services must be available to the patient. Again, logistics for this may be challenging and patient co-operation is imperative.*

NB. Due to language difficulties (English not first language) and cultural reasons Indigenous people often do not comply with attendance at medical appointments and medical instructions, which may result in serious consequences for the patient.

In addition, any woman (Indigenous or non-Indigenous) who has issues with drugs, alcohol, homelessness or domestic violence, would be at a greater risk due to an uncertain lifestyle, and would be unsuitable candidates for a medical abortion (RU486).

4. *The RANZCOG also stipulates that as with all proposed medical procedures, a truly informed consent must be obtained. This can be extremely difficult to obtain with certainty due to language barriers (even with interpreters), and the (unfortunately) poor educational standards of many Northern Territory patients. In like manner, women discharged from a treatment facility need written instructions about "follow up" arrangements, symptoms of concern and lines of communication to access help and advice 24 hours/day. In that many Indigenous people have poor readings skills (through no fault of their own), such written advice is of little help to the patient. The RANZCOG also recommends that there should be another person with the patient until the abortion process is complete. This other person needs also to understand the written instructions, and again this may not be possible.*

5. *The RANZCOG recommends that the RU486 (Mifepristone)- (medical abortion) only be used in a treatment facility ie. as an inpatient in a hospital, if gestation is greater than 63 days.*

NB. During the medical abortion process, which may take 2 – 7 days or longer, there is a real risk that a patient may abscond from hospital, as often happens at Northern Territory. Such a patient could be at serious risk.

6. *Importantly, up to 90% of women undergoing RU486 –(medical) abortion experience very unpleasant side effects, such as severe abdominal cramps, nausea and vomiting, diarrhoea, headache and prolonged bleeding. Sometimes if the pregnancy continues after the administration of RU486, the viable baby will be damaged when born.*

NB. It is a well-established fact that the incidence of depression and suicide increases post abortion. A woman may see the baby in the toilet and even if it is tiny, this can be very unsettling. Especially this is so in the culture of an Indigenous woman, as the baby is a

person, no matter how small. The house where the 'baby died' may have to be vacated for cultural reasons.

Thus, in summary, medical (RU486) abortion is not a procedure that can be safely used. Especially in remote communities in the Northern Territory; or even in Darwin or other NT towns, there will be health risks to patients who are noncompliant or who abscond. Without doubt, there will also be deaths or serious complications among young women.

In the light of the RANZCOG statements, these deaths will be the result of negligence on the part of the authorities who sanction such use and the practitioners who ignore the advice of the foremost clinical authority in obstetrics and gynaecology in Australia.

Yours faithfully,

(Dr.) David M Gawler MB BS FRACS FRCS (Eng) FRCPS (Glas) FICS

3rd May, 2016

There are many good reasons as Dr Gawler has stated why we should not be approving RU486 for use in the NT. There are many good reasons, as Renate Klein has stated in her book *RU486*, why these drugs should not be approved.

Part (c) has no explanation as to what *any other means* means but obviously the Government wants to make sure that in the future that if there is a 'more improved' way of destroying a human life it will be available. The words 'any other means' will preclude debate on what those means will be. This clause should be scrapped as it is too open ended and will not allow for approval or non-approval by Parliament. Of course that may be deliberate as certainly there are some in the pro-abortion camp that believe politicians should stay out of a women's business. But in this case it is not just about the women, it's about a completely separate human being who has a right to live and it should be politician's right and responsibility to protect that life. We live in a democracy not a feminine autocracy.

I will look at what is RU486 and the risks in more detail under the section headed Change 3.

Change 2

The next new definition which is not defined in the present Act is:

suitably qualified medical practitioner means a medical practitioner who:

- *is an obstetrician or gynaecologist;*
- *or (b) has completed a recognised training course within the last 2 years for the provision of advice, performing procedures and giving of treatment in the area of fertility control;*
- *or (c) has a valid credential prescribed by regulation.*

Why is this broad definition required? Is this to avoid examination by a gynaecologists or obstetrician so as to make it easier to get an abortion because now there will need to only be one suitability qualified medical practitioner for approval of abortions up to 14 weeks? What is a valid credential prescribed by regulation in part (c)?

In 2013 Dr Peter Beaumont, the then President of the AMA NT, wrote:

I write to inform you that the Australian Medical Association Northern Territory (AMANT) would support changes to the law and/or regulations covering Termination of Pregnancy to allow termination out of hospital subject to the following restriction(s):

*3. That the termination process **is initiated, managed by an approved or licenced team consisting of appropriately trained and credentialed <u>doctors and nurses</u>** working within generally accepted Australian guidelines.*

How does this match (b) and (c) in the above definition of a *suitably qualified medical practitioner*? The above statement from the AMANT clearly states that there must consist of a team of 'appropriately trained and credentialed doctors **and** nurse's, it doesn't say **or** *nurses.*

But the Government proposed changes say this:

In the Northern Territory health care context it is not always possible for two medical practitioners to assess a woman, nor is it always possible for one of the two practitioners to have specialist qualifications in gynaecology or obstetrics. However, it is appropriate in certain circumstances for a single suitably qualified medical practitioner to be permitted to conduct the requisite assessments.
The Department of Health considers it is appropriate, for terminations of not more than 14 weeks' gestation, that a single, 'suitably qualified' medical practitioner performs the physical examination to determine the gestation of pregnancy, complete the decision making process with the woman concerned and form an opinion about eligibility for termination of pregnancy.
The Department of Health recommends that a definition of 'suitably qualified medical practitioner' be included in the legislation, but that it should not be overly prescriptive or expressed in a way that fixes the measures for this at a particular point in time. Rather, it should allow for the legislation to remain contemporary by from time to time referencing professional standards, qualifications or assessments set by health practitioner training organisations or Medical Colleges.

This is at odds with what Dr Beaumont is saying.

What is the Government trying to do when it says there need only be a single suitably qualified medical practitioner to 'perform(s) the physical examination to determine the gestation of pregnancy, complete the decision making process with the woman concerned and form an opinion about eligibility for termination of pregnancy'?

Does that mean the Government is trying to lower the standard of the person who does the assessment so that medical abortions (up to 9 weeks) can be done in remote parts of the Territory without the need for ***appropriately trained and credentialed doctors and nurses***? A doctor who is a supporter of RU486 may go out bush recommending RU486 without the need for a second opinion or even a third opinion where there may be language and cultural differences. We are not talking about minor surgery, we are talking about the safety of the mother and the safety of the unborn.

Abortion is a serious matter and according to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2016 the following need to be done before a medical abortion can be performed

General considerations prior to pregnancy termination

• All women should be given accurate information and appropriate counselling should be available.

• Clinical assessment should be undertaken including medical history and examination.
• Clinicians should consider any contraindications to mifepristone or misoprostol, any co morbidities, surgical risk factors and the woman's preference in choosing a method of abortion.
• Accurate gestational assessment is essential to selecting optimal treatment options and regimens. Ultrasound examination is mandatory prior to termination of pregnancy to confirm gestation and exclude ectopic pregnancy; a diagnosis of ectopic pregnancy can be very difficult after attempted medical or surgical abortion. The use of mifepristone for medical termination of pregnancy C-Gyn 21 6
• Consideration should be given to screening for STIs and/or antibiotic prophylaxis in accordance with published guidelines and considering local prevalences.
• Blood group and Rhesus status should be assessed if not known and anti-D given to non-sensitised Rh negative women within 72 hours of the termination in accordance with current local guidelines.

I look at this in more detail under **Change 3.**

As Dr David Gawler said in his letter

> *Due to language difficulties (English not first language) and cultural reasons Indigenous people often do not comply with attendance at medical appointments and medical instructions, which may result in serious consequences for the patient.*
>
> *In addition, any woman (Indigenous or non-Indigenous) who has issues with drugs, alcohol, homelessness or domestic violence, would be at a greater risk due to an uncertain lifestyle, and would be unsuitable candidates for a medical abortion (RU486).*

Will those the Government is trying to include in its new definition *of suitably qualified medical practitioners* be able to make all these judgements? The AMANT says one thing but the Government seems to be lowering the standards – why? Medical reasons or ideological reasons?

On top of that a *suitably qualified practitioner* must be responsible for making sure the following happens as the AMANT requests. That is:

> *(2) Medical terminations be initiated and managed out of hospitals, but only in locations where the patient has road access to registered surgical services capable of performing dilatation and curettage under general anaesthetic semi-urgently within 2 hours of this need being assessed as necessary.*

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommend

> *Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care (in a service accepting this responsibility) from administration of mifepristone until termination of pregnancy is complete.*

In a letter to a Senate hearing in 2005 Dr Gawler expressed his concerns about the supply of this drug in remote areas especially in the wet season when evacuation by air or road may be impossible.

If something goes wrong, who will be responsible if the Governments proposed changes means a person less qualified then what the AMA recommends makes a decision which results in a death or serious medical incident- who will be liable? – the Government or the *suitably qualified medical*

practitioner? Would a person who has a valid credential prescribed by regulation, be suitable to make decisions regarding terminations especially as there is no indication of what might be in the regulation? Part (c) should be removed from the definition of a suitably qualified medical practitioner but if passed the regulations should be in the Act so they can't be changed without Parliamentary approval.

Is all this just a way of easing the restraints and oversights on abortion?

Change 3

A new section is proposed which relates to the prescribing, supplying and administering of drugs that induce medical termination.

This is copied from Victorian legislation.

The change would mean that:

> *A registered medical practitioner may issue a prescription for a drug or drugs to cause termination of pregnancy for*
> *a. a registered pharmacist to supply; and*
> *b. a registered nurse, registered midwife or endorsed nurse practitioner to supply and administer*

In NZ the drug is not available through pharmacies but on a restricted basis to institutions licensed to carry out termination of pregnancy.

As mentioned by Dr Gawler:

> *Medical (RU486) abortion is not a procedure that can be safely used. Especially in remote communities in the Northern Territory; or even in Darwin or other NT towns, there will be health risks to patients who are noncompliant or who abscond. Without doubt, there will also be deaths or serious complications among young women.*
>
> *Nothing in this overcomes the evidence based concerns of Dr Gawler. This will inevitably lead to the Department of Health and every medical practitioner involved facing negligence and other legal action.*

The Government needs to clearly explain how this process will work so those people involved know what they are responsible for and the possible risks they may face.

A women living on a remote community goes to her local clinic and asks for an abortion. Will counselling be done at her community? Who will counsel her about alternatives to abortion? Who will counsel her about the differences between a surgical abortion and a medical abortion? Who will examine her and do an assessment? An examination requires an ultra sound and a blood check – where will that be done and who will be qualified to do an ultrasound? Who will make the decision about whether the women will be within 2 hours of driving to a surgery? Or will the women have to come to Darwin?

If the women is properly examined, counselled and assessed by a qualified medical practitioner and hopefully supported by another medical practitioner (as required by AMANT) and the first medical practitioner approves a medical abortion will that person be responsible if something goes wrong if

the person (a registered nurse, registered midwife or endorsed nurse practitioner) administering the drug makes a mistake causing death or injury?

The process for the supply and administration of RU486 especially in remote communities needs to be clearly explained. In the discussion paper the author/s make a case for changing the word *examination* to *assessment* so opening up the possibility of using telemedicine which hints that a doctor will be able to give approval for an abortion by looking from his/her desk and making a decision from their office. This would fly in face of Dr Robert Parker from the AMANT, who wrote on the 11 August last year:

> *that at least two medical practitioners should be involved in the counselling and decision making around pregnancy. At least one of these consultations need to be face to face.*

So how would counselling be done face to face? How would all those cultural and language difficulties be assessed on top of the medical assessments required to reduce any risk to the patient?

So that is why there is a new provision.

Change 4

The new provision on page 14 of the 'discussion paper' proposes a back door way of getting RU486 into communities without the need for a *suitably qualified medical practitioner* by adding a new classification *directed health practitioners*. This appears to be at odds (deliberately?) with Change 3.

The new provision states:

> *Registered pharmacist, nurse or nurse practitioners ("directed practitioner") may* ***prescribe, supply and administer medication in the performance of a medical termination of pregnancy of less than 14 weeks provided:*** *(a) the suitably qualified medical practitioner has assessed the woman in accordance with the relevant provisions and has directed the health practitioner to prescribe, supply or administer the medicines;*
>
> *(b) the directed practitioner acts in accordance with professional standards and guidelines applicable to the medical practitioner in relation to all aspects of the treatment/procedure, support and location/access to emergency services*

Is the Department of Health now saying that a registered pharmacist, nurse or nurse practitioner may prescribe, supply and administer MS-2Step (RU486 and Misoprostol) and not only supply the drugs but also supply them to a women up to 14 weeks gestation which is against the guidelines of 7 to 9 weeks gestation?

> *The PBAC recommended the listing of mifepristone and misoprostol for termination of an intra-uterine pregnancy of up to* ***49 days gestation*** *on the premise of non-inferior effectiveness against STOP. In making this decision, the PBAC took into account the Australian observational data provided, relevant to its consideration. The PBAC considered the observational data provided a reliable indication of the likely safety in Australian clinical practice*. (Dept of Health Commonwealth web page). – 49 days gestation or 63 days (7 to 9 weeks) needs clarification by the Department.

In a Public Summary Document – July 2014 at a Pharmaceutical Benefits Advisory Committee (PBAC) Meeting: Section 7: PBAC Outcome states:

> **The PBAC advised that mifepristone + misoprostol is <u>not suitable</u> for prescribing by nurse practitioners.**

Will the Government be breaking the law if it goes against this ruling?

How does this fit in with what is stated in Attachment 1 of the 'discussion paper' headed *Early medication termination; MS-2Step: Mifepristone (RU486) and Misoprostol*

These are the guidelines

- *The prescribing practitioner must take responsibility for arrangements for the entire process of termination of pregnancy, which must include 24 hour access to specific telephone advice and support, and to provision of emergency obstetric care including surgical uterine evacuation or other interventions required for the management of complications. Patient care remains the responsibility of the medical practitioner during the entire medical termination of pregnancy process.*
- *Patients must return for follow up to confirm that termination of pregnancy has been successful 14-21 days after taking MS-2Step.*
- *Follow up intervention must be scheduled by the medical practitioner when medical termination of pregnancy has not been successful.*

Note: there is no definition of *prescribing practitioner* – what does it mean?

So it appears that *directed health practitioners* will do the entire termination of pregnancy procedure by an assessment not examination directed by someone (perhaps a prescribing practitioner) somewhere far removed from the procedure using telemedicine. This might be suitable to fix a broken arm, but this abortion procedure is far more serious - this is about destroying an unborn human life involving also the life of a mother. This process cannot be supported – it is too dangerous and risky. It is bad law.

What is going on? How will a directed health practitioner know what to do? For instance, as the drug cannot be used later than 7 to 9 weeks and if the women doesn't know her gestation period how will the directed health practitioner know? If ultrasound is available who will be the qualified person to use it so a proper assessment of the mother can be made? If the person gives the drug to someone who's gestation period is over 9 weeks will that be against the law or if it is the case will someone try and fudge the gestation period to make it look like it is within the limits? And of course let's not forget all the other issues that need to be assessed!

Is the Department also breaking the laws when it says in the discussion paper?

> *Registered pharmacist, nurse or nurse practitioners ("directed practitioner") may* ***prescribe, supply and administer medication in the performance of a medical termination of pregnancy of less than <u>14 weeks</u> provided…….***

The drugs are not registered for use up to 14 weeks – a mistake or what is intended?

What will happen if a nurse on a community refuses to be part of this? Will she be allowed a conscientious objection without limitations? See section 12.

The argument for this discussion paper or any legislation to go to a committee couldn't be greater.

A matter not mentioned in the discussion paper is risk and these proposed changes will create risk. Government Departments are required to do risk audits before they approve something that may have potential risk. The use of the RU486 definitely carries risk and when you start to reduce controls over who prescribes and administers the drug and where it can happen then there will be risk. Can the Department of Health produce an independent risk assessment related to the introduction of the proposed new changes to abortion law? What is the risk to the patient for the Department to approve using telemedicine as the means to approve an abortion?

Why do I raise the issue of risk? Dr Gawler has already raised serious concerns about the safety of administering this drug especially in remote areas.

To highlight even more the detail a person administering this drug would have to be aware of all the contraindications and precautions related to this drug. Below is the abbreviated list of what a medical practitioner needs to know and check before approving the use of RU486.

MIMS Abbreviated Product Listing

MS-2 Step

It is very important that all patients receiving these medications are followed up by a medical practitioner, preferably the prescriber, to ensure that the medication has been effective. Even if no adverse events have occurred all patients must receive follow-up 14 to 21 days after taking mifepristone. Read the Special warnings and precautions for use carefully (see Precautions).

Generic Ingredients: misoprostol; mifepristone
Company MS Health Pty Ltd

Permitted in sport
ARTG: Registered medicine

Use: Antiprogestogen + prostaglandin. Medical termination of a developing intrauterine pregnancy, up to 63 days of gestation (confirm by ultrasound if poss)
Contra: Ectopic pregnancy, haemorrhagic disorders (incl suspected); uncertain gestational age; chronic adrenal failure; concurrent long-term corticosteroids (incl inhaled); IUD in place (remove preadmin); anticoagulant treatment; prostaglandin hypersensitivity
Prec: Suspected adrenal failure; ensure follow-up to confirm expulsion (within 14-21 days after mifepristone admin); rhesus determination nec; hypertensive, hepatic, respiratory, renal disease; diabetes; severe anaemia; malnutrition; asthma; CV disease, risk; inherited porphyria (no data); haemostatic disorder with hypocoagulability; monitor for infection, sepsis; heavy smokers (esp women > 35 yrs who smoke > 15 cigarettes/day); epilepsy history; ensure consent, treatment in accordance with appropriate state, territory legislation; avoid conception during next menstrual cycle (use reliable contraception as early as poss postadmin); lactation (avoid); women < 18 yrs (limited data)
Adverse: Vaginal bleed incl heavy, persistent; GI upset incl abdominal pain; asthma; dizziness; headache; uterine contractions, spasm; fatigue; chill; fever; breast tenderness, abscess; hypotension; fainting; infection; hot flush; rash; rare: toxic shock syndrome, epilepsy, intrauterine adhesion, ovarian cyst/ uterine rupture, haematosalpynx, SLE, MI, hepatic/ hepatorenal/ renal failure, severe skin reaction, anaphylaxis; septic shock (very rare); others, see full PI

SPECIAL WARNINGS AND PRECAUTIONS FOR USE (from TGA website 2014)
https://www.tga.gov.au/sites/default/.../auspar-mifepristone-misoprostol-141013-pi.do

- ***Populations not studied*:**

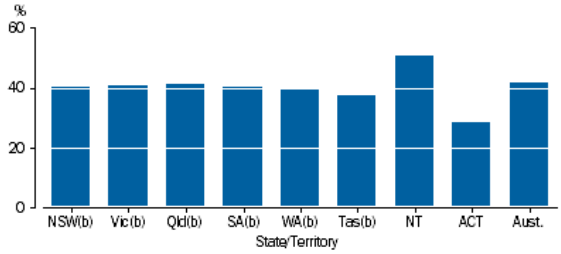
In the absence of specific studies, ***MS-2 Step™*** is not recommended in patients with:

- Cardiovascular disease
- Hypertensive disease
- Hepatic disease
- Respiratory disease
- Renal disease
- Diabetes
- Severe anaemia
- Malnutrition
- Heavy smokers

Women who are older than 35 years and who also smoke 15+ cigarettes per day should be treated with caution because such patients were generally excluded from clinical trials of mifepristone.

<u>Below are some statistics re the current state of Aboriginal health across Australia</u>.

CURRENT DAILY SMOKERS(a) BY STATE/TERRITORY, Aboriginal and Torres Strait Islander people—2012–13



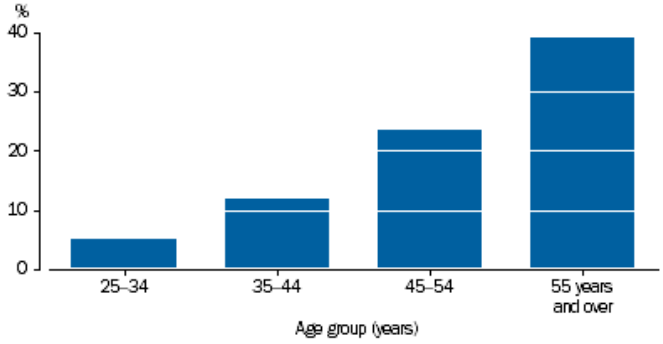
(a) Aged 15 years and over.
(b) Difference between State rate and national rate is not statistically significant.
Source: 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey

In 2012–13, 7.6% of Aboriginal and Torres Strait Islander adults were at risk of anaemia. After taking age differences into account, Aboriginal and Torres Strait Islander people were almost twice as likely as non-Indigenous people to be at risk (rate ratio of 1.9).

Overall, the risk of anaemia was higher for Aboriginal and Torres Strait Islander people living in remote areas compared with those living in non-remote areas (10.1% compared with 6.9%). Research suggests that poor nutrition and poor supply of healthy food contributes to chronic diseases such as anaemia, particularly in remote Australia.[2]

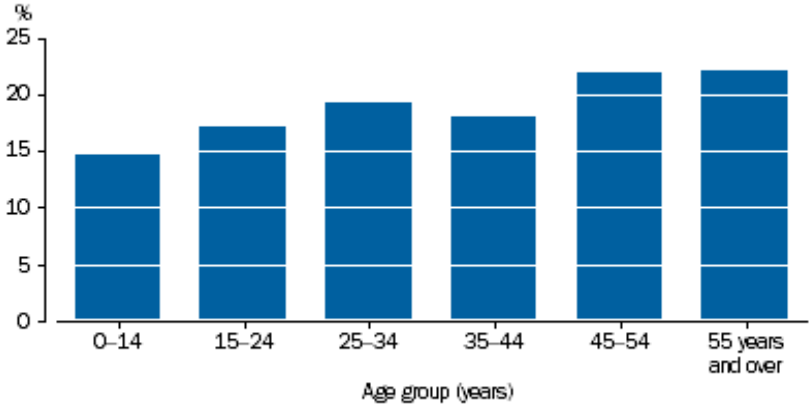
As was the case in the non-Indigenous population, Aboriginal and Torres Strait Islander women were more likely than men to be at risk of anaemia (10.3% compared with 4.8%). Although the overall age pattern for anaemia was similar for both the Aboriginal and Torres Strait Islander and non-Indigenous populations, Aboriginal and Torres Strait Islander people were at a higher risk of anaemia than their non-Indigenous counterparts in most age groups.

DIABETES/HIGH SUGAR LEVELS BY AGE, Aboriginal and Torres Strait Islander people aged 25 years and over—2012-13



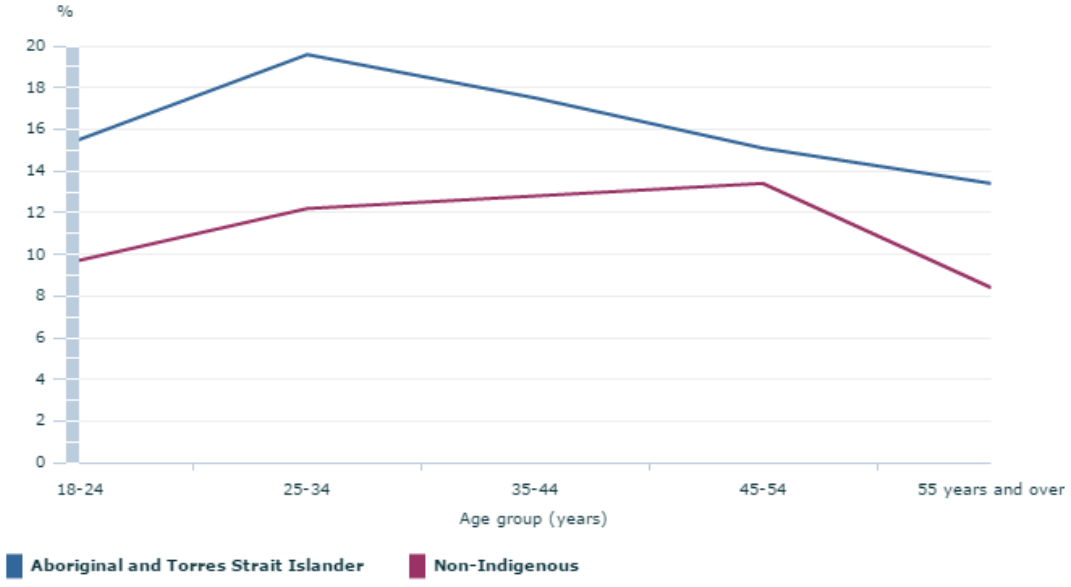
Source: 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey

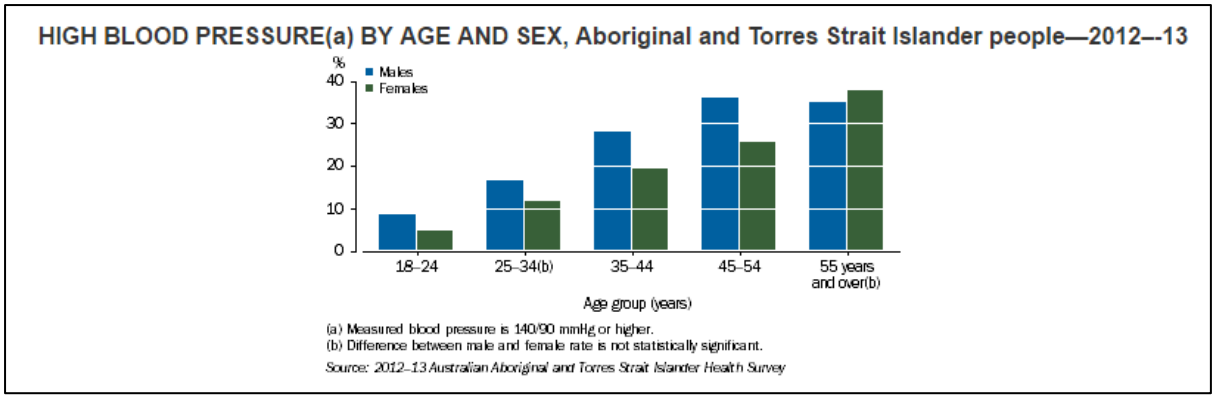
ASTHMA BY AGE, Aboriginal and Torres Strait Islander people—2012–13

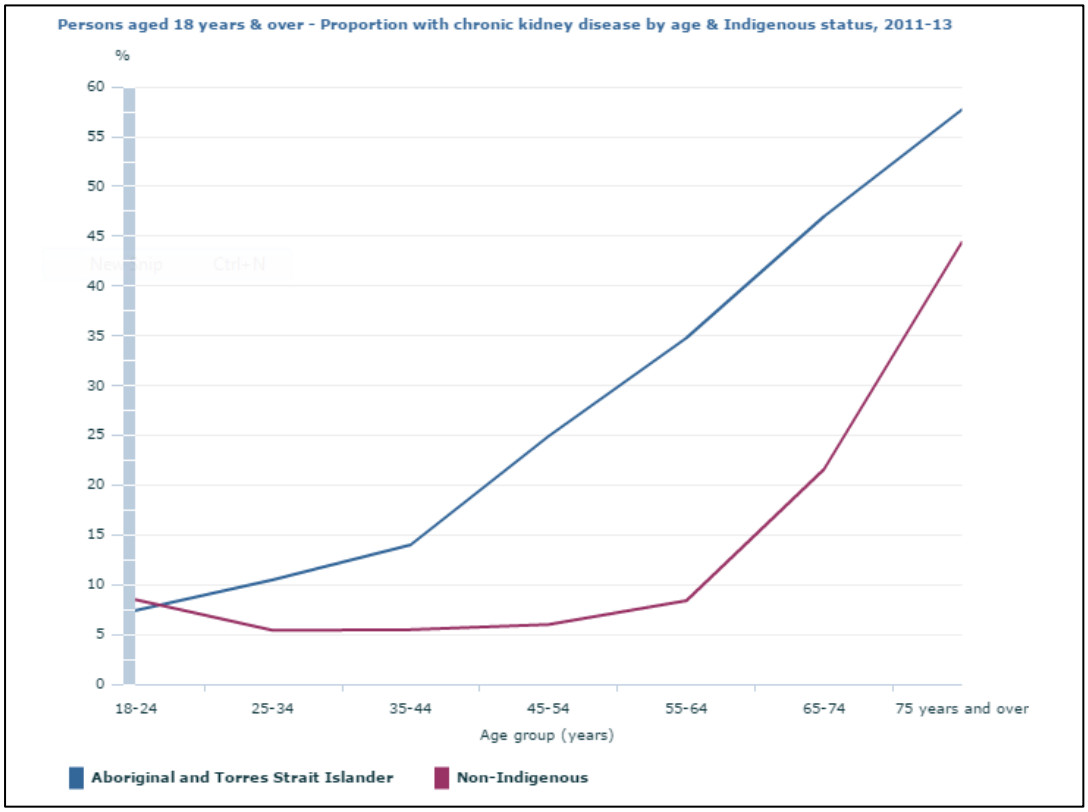


Source: 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey

Persons aged 18 years & over - Proportion with abnormal ALT levels by age & Indigenous status, 2011-13







I could include many more graphs and statistics but the point I am trying to emphasise is that many Aboriginal people have diseases and many Aboriginal people live in remote parts of Australia and many of the diseases they have are on the precautionary list of illnesses that must be checked before any consideration is given to prescribing RU486. Not only are they on the precautionary list but according to the TGA web page it says in relation to a list of illnesses and conditions shown above, ***in the absence of specific studies, MS-2 Step™ is <u>not recommended</u> in patients.***

Doctors or medical practitioners are going to have to be very sure the people they supply RU486 will have been thoroughly assessed before any approvals are given for the administration of this abortifacient. It is even scarier that this will be given to people who speak a different language and think differently because of their culture. On top of that only one medical practitioner will make a decision whereas before at least there was the safeguard of a second opinion: and all this could be done by telemedicine.

You get the impression that there is no ethics or medical concerns involved in this debate. Is the Health Department just wanting to cut costs by reducing the need for surgical abortions?

The Minister mentioned in her press release that AMSANT (the Aboriginal Medical Services Alliances NT) were being consulted. But that is not good enough. There needs to be some independent people, not NT Family Planning, or the Department of Health, who will talk to Aboriginal people, men and women, about what the Government is trying to bring into their communities and they should be able to have a say whether they want it or not. Aboriginal people may not have had time to understand or consider or want this drug, but some reckon, Health knows best and the legislation will pass anyway.

This is not like taking Panadol as one so called Health person described RU486 recently at an RDH forum. RU486 is a serious drug and if the pro-abortion lobby is going to push these proposed changes through Parliament based on so called women's rights rather than the medical, ethical, legal and social matters raised by these proposed changes and without a thorough risk assessment, then any incident that originates from the use of this drug surely would make the Government liable for negligence and lack of duty of care.

The Government and the Department needs to say if a risk assessment has occurred and if so it can be made public?

Change 5

This change is to remove the existing limitations on when an abortion can be performed and replacing with it a new control which is so wishy-washy it is really a cover for abortion on demand.

Dr Beaumont recommended this in his letter:

> *(1)That medical terminations be initiated subject to the same legal restraints that currently apply to terminations under 14 weeks gestation in the Northern Territory except that medical terminations could only be initiated in pregnancies up to 49 days gestation.*

One of those legal restraints is in the present Medical Services Act Sec 11 where it says:

> *(1) It is lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy if:*
>
> *(i) the continuance of the pregnancy would involve greater risk to her life or greater risk of harm to her physical or mental health than if the pregnancy were terminated; or*
>
> *(ii) there is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities;*

Theoretically this is the one section of the existing Act which restricts abortions. With 600 to 900 abortions a year in the NT and no public records kept it is difficult to verify if those abortions were done under the present legal requirements of the Act. The new changes will make it easier for abortions and the Department will hide that from public view. There should be detailed records kept similar to other statistics the Department releases in its Annual Report so the information is publicly accessible. Has there ever been an audit done of abortions in the NT?

But now the Government wishes to scrap those restrictions on abortion and introduce a new criteria which could be interpreted so broadly it looks very much like abortion on demand is the real object of this change.

This is the present criteria for an abortion to be performed on a women who is no more than 14 weeks pregnant:

> *(i) The continuance of the pregnancy would involve greater risk to the woman's life or greater risk of harm to her physical or mental health than if the pregnancy were terminated; or*
>
> *(ii) there is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities;*

The proposed change will remove the these clauses and introduce the following

> *Consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances*

So if this is the new guideline, a suitably qualified medical practitioner will have to be competent in assessing the above new assessment requirements. What training will that person have in psycho-social matters – whatever that means? Why will there be no second opinion from another medical practitioner as required by the AMANT?

By also now removing

> (ii) *there is a substantial risk that, if the pregnancy were not terminated and the child were born, the child would be seriously handicapped because of physical or mental abnormalities,*

the reason for having an abortion will not relate to the health of the unborn but solely relate to the mother. So there doesn't have to be a 'substantial risk etc.' from the unborn's perspective, there will simply be no protection under the law if this is passed.

This is abortion on demand.

The Government is also recommending:

> *that only one suitably qualified medical practitioner (will make a decision on abortion) for gestations of not more than 14 weeks.*

The present Act says

> *It is lawful for a medical practitioner to give <u>medical treatment</u> with the intention of terminating a <u>woman</u>'s pregnancy if:*
> *(b) after medically examining her, the practitioner and another medical practitioner are of the opinion, formed in good faith*

As quoted before the President of the AMANT wrote on the 11 August:

> *that at least two medical practitioners should be involved in the counselling and decision making around pregnancy. At least one of these consultations need to be face to face.*

Questions need to be asked – why is the Government proposing the change? Have they considered any risks to the patient, any liability to the doctors or this an ideological issue in attempt to reduce the number of people making a decision about a so-called women's right to have an abortion.

As mentioned before how will this work out bush? Who will double check to make sure the women whose second language is English fully understands and comprehends what is going to happen to her. Will GP's now be able to prescribe abortions without a second opinion and without knowing whether they have done all the prescribed checks?

Why wasn't Dr Parker's view on this matter included in the 'discussion paper'?

At the very least the existing requirements for an abortion to be approved should stay as they are.

Change 6

This deals with the criteria for the most appropriate location of safe treatment and safe care. The 'discussion paper' states the following:

> *There is evidence that medical terminations of not more than 9 weeks gestation, and surgical terminations of not more than 14 weeks gestation can be safely conducted outside a hospital setting, and in all jurisdictions except for the Northern Territory, this occurs.*

Under the existing law an abortion performed for someone not more than 14 weeks pregnant is required to get that treatment in a hospital.

In relation to someone who is not more than 23 weeks pregnant, the law is silent on where that abortion can take place.

In other parts of Australia abortions are performed in abortion clinics.

One of the reasons for the proposed changes is to allow abortion to occur in places other than in a hospital. Supporters would argue that all women no matter where they live should be able to access abortion or at least a medical abortion using RU486. To do that requires the present law relating to an abortion of a human life up to 14 weeks to be performed in a hospital. RU486 is only permitted for pregnancies up till 9 weeks and under our present laws therefore that could only be given in a hospital.

The proposed change in the discussion paper states:

> *Suitably qualified medical practitioner must act in accordance with professional standards and guidelines.* [1]
>
> [1] These include MS Health certification requirements, RANZCOG College Statements and product information guidelines

What does this mean? Who will make the decision on where an abortion can occur considering the dangers stated by Dr Gawler and the warnings by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and by Dr Beaumont. Ultrasound equipment is mandatory and blood groups should be assessed. Screening for STIs should be considered. What about language and cultural issues? Medical abortion should not be performed in an isolated or inaccessible setting.

The discussion paper puts out three options (below) but the Department prefers number 3.

1. a regulatory response whereby clinics and facilities are licensed or regulated. This would require an entirely regulatory framework and development of a system for assessment/approval, monitoring and enforcement which would in all likelihood be costly and resource intensive for little additional benefit;

2. setting of facility or clinic standards and role delineation. This has been the approach in South Australia, where a SA Health clinical advisory group has established minimal standards for the provision of termination of pregnancy services in facilities that are licensed and regulated;

3. adoption of professional standards and guidelines by the practitioner. This would require those issuing prescriptions to do so in compliance with the provisions of the Bill and following the professional standards and guidelines including MS Health certification requirements, RANZCOG College Statements and product information guidelines.

Whilst I am opposed to RU486, in the event that it is approved then I believe that Option 1 or 2 be the preferred option. Option 3 is open for interpretation whereas the other options are more definitive in their location and standards and as abortion is a very serious process matter both medically, ethically and socially then option 3 should **not** be considered.

Change 7

This relates to abortions up to 23 weeks pregnancies. Under the existing Act the law states in relation to abortions up to 23 weeks:

It is lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy if:

(ii) is of the opinion termination of the pregnancy is immediately necessary to prevent serious harm to her physical or mental health;

Under the new proposed changes it will simply say:

Consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances

That will be the basis for permission to have an abortion. It could be interpreted so broadly that it looks very much like abortion on demand dressed up in fancy language to disguise its true intent. After all that's what many abortion lobbyists want.

The existing law should remain with the addition that surgical abortions up to 23 weeks can only occur in hospitals. It should be made clear that medical abortions should only be allowed up to 9 weeks.

Change 8

Presently as stated before there is no mention of where an abortion can occur for pregnancies up to 23 weeks.

In the new Act it is proposed where that abortion could occur:

> *Suitably qualified medical practitioner must act in accordance with professional standards and guidelines*.

In this case it doesn't specify what the standards and guidelines are. Basically it says you will be able to have an abortion outside a hospital if you are no more than 23 weeks pregnant as long as it in accordance with professional standards and guidelines.

Once again I reaffirm my objections to abortions but if this legislation is passed then abortions this late should be performed in hospitals.

I expect that the Government like in Change 5 would prefer to use Option number 3 as mentioned above. It claims that this will allow provisions to remain contemporary into the future but as abortion is not about everyday surgery and has strong medical and ethical issues that need to be considered then I believe stronger options 1 and 2 should be the only alternatives if that's all the alternatives that the Government has offered. Strangely they haven't offered the option of only in hospitals but as I have said before this 'discussion paper' is not a discussion paper.

Change 9

This change has no explanation in the discussion paper. The paper states what is in the present act:

> *Consent for those aged 16 and over and deemed competent*

And states what will be in the new Act:

> *The appropriate person consents to the giving of treatment*

It appears there is no change in relation to this part of the existing Section 11 in the proposed new Act.

Change 10

The discussion paper says the following:

> *Section 11 of the Northern Territory Medical Services Act describes conditions relating to consent for women under the age of 16. These conditions require that consent of 'each person having authority in law' must be obtained before a lawful termination of pregnancy can be performed.*

For example, where there are two parents or joint guardians, both persons must provide consent. This requirement is not consistent with the consent requirements for other medical or surgical procedures and is viewed as potentially restrictive to young women accessing termination, with the potential for this vulnerable group to seek unsafe or unsupervised terminations.

To achieve this the new Act will include the following:

The appropriate person having authority in law provides informed consent to the treatment

Firstly to say *this requirement is not consistent with the consent requirements for other medical or surgical procedures* shows why the author does not accept that there is a difference between an abortion and getting your appendix out. The author doesn't believe the destruction of human life is then any different that removing an appendix. That sums up the basis of this 'discussion 'paper' – this is not about human life – the fundamental discussion about human life is ignored deliberately because this is about one single minded object – a women's right to do what she wants to do with her body and if the unborn is recognised as a human life that has rights, that would interfere with the ideology. A male parent or guardian's rights in relation to consent doesn't get a mention.

This change means that only one person would be required to give consent so in the case of parents only one would be required to give consent.

This would raise some serious questions.

- What if the women even though under 16 wanted to go through with the pregnancy, would she be forced to have an abortion?
- Which parent would be asked to give consent and on what basis would that occur?
- Could that be challenged by a parent who disagreed with the other parent?
- Has an offence occurred and therefore what is the responsibility of the medical practitioner?

The discussion paper skips around these issues. The paper mentions the word 'informed consent' and quotes guidelines used by the Northern Territory Health and Community and Community Services Complaints Commissioner as well as the Gillick competence standard test used in Queensland. Does the Gillick competence test apply to abortion?

This issue raises the rights of the parents or guardians, the rights of the child, the effect on the child, and the responsibility of the Government to protect the unborn. The change like the rest of the proposed changes is intended to make abortion easier.

This section of the present Act should stay as it is and if the Government wishes to look further into the matter that should be done through an inquiry where people can discuss this matter in depth and recommendations made back to the Government if necessary.

<u>Change 11</u>

This proposed change relates to the standard of care a medical practitioner must provide when providing an abortion.

The discussion paper says this:

The medical practitioner, in giving medical treatment with the intention of terminating a woman's pregnancy, must give the treatment

(a) with professional care; and
(b) otherwise according to law.

The current Act says something slightly different:

> *(7) This section does not relieve a medical practitioner, in giving medical treatment with the intention of terminating a woman's pregnancy, from liability to give the treatment:*
>
> *(a) with professional care; and (b) otherwise according to law.*

The proposed changes state:

> *Suitably qualified medical practitioner must act in accordance with professional standards and guidelines.*

The issue of liability that is mentioned in the present Act is not in the proposed changes – why? Is the Department trying to ignore liability? There needs to be clear reference to what standards and guidelines apply and whether they should be enforceable.

It is interesting to note that there is no reference to other care that should be provided to someone either contemplating or who just had an abortion.

Change 12

This change relates to a fundamental premise in a free society.

Under Section 11 (6) of the Medical Services Act it states:

> *A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so.*

The proposed changes state the following:

> *A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so*
>
> *A medical practitioner who conscientiously objects to performing a termination of pregnancy must refer the woman to a practitioner who is known not to hold such an objection.*

This new section will require a doctor or a nurse or anyone who fits under the definition of 'medical practitioner' who has conscientiously objects to abortion, to send a patient to another practitioner who does not object to abortion.

This shows the influence the pro-abortion lobby has over the Department of Health. No fair minded person would ever contemplate such an immoral and draconian piece of legislation in such a totalitarian manner. It forces medical practitioners to act contrary to the Hippocratic Oath, their

conscience, their professional values and professional standards by the AMA and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

This legislation threatens a doctor or a nurse with a criminal offence if they do not send someone to a pro-abortion practitioner. This is designed to force doctors to act against their conscience and to silence anyone in the medical fraternity who opposes abortion by threatening their livelihood by having those who offend against this law possibly deregistered. This is because when it comes to the issue of conscience the Australian Medical Council is weak when it says that doctors can be deregistered if they do not comply with maintaining standards in medicine. So if we approve a medical law that a Doctor cannot abide by, they may have their practice restricted or cancelled. Perhaps that is the intention behind this proposed change. It is one thing to change the laws about abortion but to change laws around conscientious objection is a form of totalitarianism.

A doctor or nurse who does not believe in abortion cannot send someone off to another practitioner who supports abortion. A person who wants to kill someone but sends a message off to someone else (a hit man) to do the killing is still guilty of murder. The same principle would apply to a conscientious objector against abortion.

Will this law apply to all doctors and nurses and Aboriginal Health Workers across the Territory?

Where is the ethics in this? Where is the discussion in the 'discussion paper'? None!

What next? Is the Government going to tell me as a local member with a conscientious objection to abortion, that if someone comes to my office and asks where they can get an abortion, I will have to tell them and if not I will be breaking the law? Would I go to gaol? Will the doctors and nurses go to gaol if they break the law? Why is the law just limited to medical people?

As Nicholas Tonti-Filippini* said in his book *About Bioethics* be Australia has signed the *International Covenant on Civil and Political Rights.*

> *Article 18*
>
> *1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.*
>
> *2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.*

The proposed changes clearly goes against Article 18 and this proposed changed should be scrapped.

Funnily enough this legislation mirrors the Victorian Legislation, the home of Emily's List which is an organisation co -founded by Joan Kirner, ex Labor Premier of Victoria. Emily's List promotes women's rights including abortion and funds some members our NT Parliament at election time.

It is isn't surprising that this law on conscientious objection has copied Victorian law and ends up in a discussion paper as something supported by the Department of Health. How many Department of Health medical practitioners did they consult with before this was put in the discussion paper?

Change 13

This change proposed is not in the old Act. It states:

> *Establish safe access zones extending 150 metres from a place at which termination of pregnancy may be performed.*

According to the discussion paper this law will be similar to laws established in Victoria, Tasmania and the ACT. The idea behind these laws is:

> *to establish a safe access zone extending 150 metres from a place at which termination of pregnancy may be performed. Safe access zone provisions will prohibit a person from causing distress by intentionally harassing, intimidating, interfering with, threatening, hindering, intentionally communicating in relation to treatment in a way that is seen or heard by another person, or obstructing access to a woman entering or leaving the facility.*
>
> *Consideration should be given to applying a penalty to those who breach the safe access zone provisions.*

No one should be allowed to harass or intimidate people who were entering a clinic and I certainly would not endorse that kind of behaviour. Section 47 of the Summary Offences Act already covers this under offensive conduct. So why is the Government promoting a new law. Has anyone been harassed going to the hospital in the Territory for an abortion? Will this mean if there is a silent prayer group within 150 metres, those people can be arrested? The law in Victoria states that a breach of this law would attract a punishment of $75,000 or 12 months imprisonment? The discussion paper recommends a penalty if there is a breach of the safe access zone. A direction to move on, under Victoria's Summary Offences Act, is $758!

Why doesn't this law apply to people who oppose frakking who might harass people working at an office for a gas company that does frakking? Or a greyhound trainer who might find someone from an animal rights group protesting outside his front door?

Why is ex-Senator Bob Brown challenging the anti-forest-laws- in Tasmania as stopping him from the right to political expression and claiming these laws are unconstitutional?

Why is this safe access zone only outside an abortion clinic, not other places?

He is an example of legislation which is unnecessary, there is no history of people being harassed in the NT and the law may even be unconstitutional.

I refer to two documents.

The first one is called *Protests Outside Abortion Clinics- constitutionally protected speech? By Mitchell Landrigan.*
The second one is the *58th Alert Digest written by the Victorian Scrutiny of Acts and Regulations Committee (No 10 of 2015) which looks at the Public Health and Wellbeing Amendment (Safe Access Bill) 2015.*

Both these documents are a good basis for a proper discussion around of whether should have access zones or not.

Summary

When discussing this issue we need to understand that although abortion is a complex issue that doesn't mean that it is right. If we believe that we are all human beings from conception to death then we cannot support a drug which will destroy that human life at the beginning of its existence. Some women say that they have the right to make decisions over their bodies and therefore argue that abortion is one of those rights, but the unborn human life is not her, it is separate human being with its own separate identity and own DNA. It lives within a women but biologically it is not part of a women like an arm or a leg. It therefore has a right to live even though it can't make that decision, no different than on the first day it is born, it still has a right to live even though it cannot tell you that and cannot survive without someone to care for it. In or out of the womb should make no difference when protecting that life.

Interesting to note that the European Court of Human Rights has ruled that there is 'no human right to abortion'.

Unfortunately some in society don't accept that view and so don't even question the morality of abortion. There is no ethical discussion included in the 'discussion paper' – it is avoided. It is written by a group of people who are driven by an ideology where a women's right over her body is paramount and men like me should butt out. I won't be doing that because women do not have an automatic right over whether an unborn human life should live or die.

We all, including the Department of Health, should be working towards reducing the need for abortions instead of encouraging abortions which is what the introduction of RU486 does. On some web sites it is even advocated as an online drug for at-home abortions. A DIY abortion drug.

Why don't we have a discussion paper on how to reduce abortions? Wouldn't it be good if the Department of Health released a paper on that but they won't? It is against their ideology which is centred on women's rights not the rights of the unborn.

Wouldn't it would be good if we had a Department of Health which promoted life and worked tirelessly looking for ways to encourage women through difficult times not to abort their unborn life.

I received this email from Dr Helen Watt which has some very relevant comments re the 'discussion paper'. She wrote:

> *As an expatriate Australian working in bioethics in the UK, and the author of a book on the ethics of pregnancy,[1] I am writing to urge you to reject recent proposals to amend the abortion law of the Northern Territory.*

These proposals show scant recognition of the harm abortion can do to women, both physically and psychologically.[2] Even apart from this harm, pregnancy is not a disease, and abortion is not treatment.

That being the case, it seems particularly unreasonable to expect a doctor with a conscientious objection to refer the woman to another doctor for what the first doctor sees as a non-medical and indeed, a harmful intervention. Would we ask doctors to refer for any other harmful, non-medical intervention to which they had a conscientious objection – for example, writing a prescription for suicide pills or arranging a female circumcision? History has other examples of doctors being coerced to collude in non-medical activities by governments which did not respect good medical practice.

Far from being made easier (for example, by reducing the number of doctors legally required to be involved, as proposed), abortion should be strongly discouraged in favour of life-affirming alternatives for the woman and her baby. Many women will wish to keep their baby if supported through the pregnancy, while for those who do not, fostering and adoption are possible solutions which can respect the rights of all.

Note that the proposed changes do not clearly refer to any offer of help to the woman to have her baby – except that those who do make a last-minute offer of help outside the place where abortions are performed would be prohibited from doing so under the proposed law, which would ban "intentionally communicating in relation to treatment in a way that is seen or heard by another person" (would that include offering a leaflet with details of pregnancy support available?)

Finally, giving abortion pills to women to take outside a hospital setting is particularly inappropriate in the Northern Territory, for reasons which should be obvious. To rely on a woman from a remote rural community staying within reach of emergency services, and accessing these services as needed, seems hazardous and unrealistic. Apart from the physical hazards of medical abortion, the psychological impact on the woman of potentially seeing the foetus she has expelled, which causes some women severe distress, should not be underestimated.

With best wishes,

Dr Helen Watt

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[1] The Ethics of Pregnancy, Abortion and Childbirth: Exploring Moral Choices in Childbearing (New York and Abingdon: Routledge, 2016).

[2] P.K. Coleman, "Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009", British Journal of Psychiatry 199 (2011): 180-6; D.M.Ferguson, L.J.Horwood, J.M. Boden, "Abortion and mental health disorders: Evidence from a 30 year longitudinal study", British Journal of Psychiatry 193 (2008): 444-51; David M.Ferguson, L. John Horwood, Joseph M.Boden, "Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A reappraisal of the evidence", Australian and New Zealand Journal of Psychiatry, found at: DOI: 10.1177/0004867413484597, published online 3 April 2013.

Wouldn't it be good for the Department of Health to recognise that men are part of this discussion too as they make up the other half of the unborn human life? But something tells me the feminists could never accept that. They are not even interested in sticking up for their unborn female sisters?

Norman J Ford* wrote in his book the PreNatal Person

> *The Foetus is defenceless and totally dependent on the mother for support and survival. Janet Podell, a former pro-choice feminist, changed her mind after her first child:*
>
> > *'It was impossible to ignore the plain fact that this baby was the same living being who had being kicking me in the ribs for months. His life was clearly an uninterruptible continuum that had begun long before I could feel him move…'*
>
> *Abortion derives a real person, not merely a potential person, of life and an opportunity to develop to the age of reason when free and morally responsible acts can be made. One should always treat illness and alleviate suffering of a pregnant women but not by direct abortion which is a breach of the duty of care owed to the foetus by the mothers and doctors.*

The Queensland Parliament, where a number of Territory Parliamentarians visited recently, sends all legislation to a committee, in fact an abortion Bill was recently looked at by one of those committees.

Parliamentarians should be fully informed of all views on this important issue before they debate these changes in Parliament and a committee or inquiry is one way to do that. I know that I have not touched on all the issues but a Parliamentary Committee would be able to do that.

Recently, I was contacted by a trainee doctor who wanted to practice in the NT. She does not support the changes but when she told someone in the Department that she was going to go public, she was warned of the consequences – that is, she would very unlikely get a job in the NT. A committee process would allow her to speak *in camera*. People like Norman J Ford and Helen Watt could also be asked to attend.

It saddens me that people today are frightened to express a view other than the official view in case they might lose their job.

It frightens me that people with RU486 views now dominate within the Department – a strategy perhaps? Is the Department a Department where alternative views can be freely expressed or debated without recriminations? Looking at the lack of alternative views within the 'discussion paper' I think the Department has a closed shop on other views.

Is there a bioethics section within the Department of Health and if so were they consulted in the production of this 'discussion paper'? And what are their views and will they be published?

These proposed changes need to be tested by experts before they go to Parliament so the community can be satisfied that they have not been given an automatic tick of approval as the 'discussion paper' suggests should happen.

This 'discussion paper' is simply a document about making abortion easier.

This 'discussion paper' is written by ideologues who are not interested in debate which is reflected in the style and bias of the 'discussion paper' and the complete lack of alternative views.

This ‘discussion paper’ should be seen for what it really is – an instruction manual on a new way to destroy an unborn human life.

Any thinking, caring Member of Parliament should reject this ‘discussion paper’ and support the establishment of a Parliamentary Committee similar to Queensland.

Abortion is not the way to go – we need to find other ways – RU486 is not one of them.

As a Catholic I believe human life is sacred.

As a human being I believe human life is sacred.

As a Member of the NT Legislative Assembly I believe human life is sacred

My very ‘me’ says the unborn is a human life therefore……

**Nicholas Tonti-Filippinni was the Associate Dean and Head of Bioethics at the St John Paul Institute for Marriage and Family in Melbourne. Professor Tonti-Filippinni was a philosopher who specialised in bioethics for the past 30 years including having been Australia’s first hospital ethicist and Director of Bioethics at St Vincent’s Hospital in Melbourne, 1982 -1990. Nicholas Tonti-Filippini died in Melbourne, aged 58, after living for nearly four decades with chronic auto-immune disease.*

**The Reverend Emeritus Professor Norman Michael Ford SDB has served the University of Divinity as an outstanding teacher and scholar for over forty years. He has led the development of the University’s curriculum in moral theology, moral philosophy and bioethics. He has served as chairman and member of hospital ethics committees, and he was the Foundation Director of the Caroline Chisholm Centre for Health Ethics, Melbourne (1995–2007). He has been widely sought after as a speaker on bioethical issues by universities, medical forums and community groups, both in Australia and overseas. Various government committees examining bioethical issues have also drawn on his expertise. (Google)*

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Submission #096

27 January 2017

Submission
Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

United Voice Northern Territory Branch welcomes the Northern Territory government's progressive policy in expanding section 11 of the *Medical Services Act*.

United Voice is the Union which represents Aboriginal Health Practitioners in the Northern Territory.

The clause regarding health practitioners does not include Aboriginal Health Practitioners in the proposed Act, United Voice are seeking clarification to this clause and are advocating that Aboriginal Health Practitioners be legislated like the other health professionals.

The Department of Health are fully aware of the vital role Aboriginal Health Practitioners play in the provision of health services to remote communities.

Aboriginal Health Practitioners in many locations are gazetted at the same level as nurses and administer medications in these locations.

United Voice is of the view that modifying the provision regarding directed health practitioners without including Aboriginal Health Practitioners will needlessly limit the access of Mifepristone to regional and remote centres.

While this will be a marked improvement on the current service provision United Voice believes that all communities serviced by Aboriginal Health Practitioners should be afforded the same right to access safe termination as those in regional centres and cities.

Thank you for your time

Erina Early
Branch Secretary
United Voice NT Branch

Submission #100

Submission

Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services

Discussion Paper

1. Introduction

The Northern Territory Department of Health has issued the *Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services Discussion Paper* ("**Discussion Paper**") and invited written submissions by 27 January 2017. The issues around medical services intended to terminate a pregnancy are politically sensitive due to the ideological clash between those who believe life begins at conception and those who consider the freedom of the mother to make such a decision to be an absolute right, however it should be remembered that when an individual woman considers this course of action, it is not a theoretical or academic decision. Rather, the decision is made in circumstances where the woman is often highly vulnerable, perhaps due to a lack of familial support, poor socio-economic position, pressure from the father or other family and/or the prospect of change to long term plans and priorities. Further, these pressures apply when a decision with lifelong consequences must be made in a relatively short period of time.

As will be submitted below, women in this situation must be afforded the best possible support at such a vulnerable time, especially if they are isolated from the usual supports in their lives. That support must include healthcare, guided by the latest and best available medical information, in fulfilment of the government's role to protect the people for whom it is responsible. Yet that support should also include a place for direct personal assistance as everyone takes responsibility for the most vulnerable in our community.

2. The Development of Information regarding Pregnancy and the Termination thereof since 1970

Under the heading "Background", the Discussion Paper describes the current regime dealing with the termination of pregnancy in the Northern Territory as "contemporary" at the time of its establishment in the 1970s.[1] Under the same heading, the Discussion Paper asserts that the current regime has not kept pace with the changing nature of best practice in medicine and societal expectations or legislation elsewhere in Australia.[2] It is submitted this assertion is accurate, and that significant information developed since that time must be considered prior to any modification of the legal regime dealing with the termination of pregnancies in the Northern Territory. Examples of relevant information are set out below.

2.1 The development of the child *in utero*

The advent of pre-natal scanning and pre-natal surgery has provided to modern medical science substantially more information regarding the development of an unborn child than was available in 1970. In short, it is now possible to identify with substantial accuracy numerous characteristics of an unborn child at various stages of development. Characteristics will be divided into the following categories:

[1] Discussion Paper, p 1.
[2] Ibid, p 2.

(a) 9 Weeks

Although there is always some variation with each child, the face of an unborn child at approximately 9 weeks since conception will be slowly forming.[3] The eyes of that child are developing and there will be some colour in them.[4] The mouth and tongue have developed, and the unborn child will have tiny taste buds.[5] Hands and feet will also develop, with ridges where fingers and toes will grow.[6] The development of the major internal organs, such as heart, brain, lungs, kidneys and gut has commenced.[7] Around this time, an unborn child is typically about 22 mm long from the head to the bottom.[8]

(b) 14 Weeks

At this stage of development the unborn child is, from head to bottom, about 85 mm in length and the child's ovaries or testes are fully developed within the body.[9] At the same time, external genitals are beginning to form and the identification of the unborn child's gender is usually possible.[10] The unborn child will also begin to swallow some amniotic fluid, which will progress through the stomach and kidney and be passed back into the amniotic fluid as urine.[11]

(c) 21 to 24 Weeks

At about 21 weeks, the unborn child will usually weight about 350 grams, and will soon move into a pattern of wakefulness and sleep, though that pattern may differ from the mother's sleeping pattern.[12] This leads to the sensation of the unborn child moving while the mother may be trying to sleep.[13] The unborn child's lungs do not yet work properly, however he or she will be practicing breathing movements in preparation for life after birth.[14]

2.2 The stage of development when an unborn child can be born alive

By the time of 24 weeks from conception, the unborn child has a change of survival if born.[15] It is rare for children born prior to this state of development to live due to limited development of their lungs, however improvements in neonatal care allows more premature births to survive.[16]

2.3 Recognition of personhood of unborn child

The Discussion Paper refers to changes in 'societal expectations' as they have developed since the enactment of the current legal regime in the Northern Territory. While there is a legal avenue to obtain a termination of a pregnancy in all Australian states and territories,

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[3] https://www.pregnancybirthbaby.org.au/pregnancy-9-to-12-weeks as viewed 26 January 2017.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] https://www.pregnancybirthbaby.org.au/pregnancy-13-to-16-weeks as viewed 26 January 2017.
[10] Ibid.
[11] Ibid.
[12] https://www.pregnancybirthbaby.org.au/pregnancy-21-to-24-weeks as view 26 January 2017.
[13] Ibid.

[14] Ibid.
[15] Ibid.
[16] Ibid.

other legislation represents a significant development of societal expectation in the unique treatment of unborn children. Examples are set out below.

(a) Unlawful killing of a human being

The criminal law of every Australian jurisdiction includes offences such as "murder" and "manslaughter", which prohibit the unlawful killing of a human being.[17] For the purpose of these laws, an unborn child is only capable of dying as a result of murder or manslaughter once he or she is 'born alive', that is completely extruded from the body of the pregnant woman, though it is not necessary for the umbilical cord, placenta or afterbirth to have fully extruded from the woman's body.[18] It is also unnecessary to establish that the child has the capacity to stay alive, though some jurisdictions require the child to have taken a breath before a murder charge could be brought.[19] Therefore no murder or manslaughter charge can be brought for a termination of a pregnancy *in utero*.[20]

However, it would be inaccurate to suggest that an unborn child is treated as either property or a mere appendage of the mother until he or she is born alive. In *R v Castles*, a woman injected warm water into her uterus with the intention of terminating her pregnancy.[21] The woman gave birth two days later and, as there was some suggestion that the child had taken a breath prior to death, the woman was charged with manslaughter. Lucas J conceded that based on the evidence presented, it was possible for a verdict of guilty to be returned, however the matter was eventually determined on the basis of reasonable doubt as to whether the child had taken a breath prior to dying.[22] Yet it would only be possible for a guilty verdict to be returned if it is accepted that a person can die from injuries inflicted before they are accepted as a person at law. If this position does not contradict the need to be 'born alive' before a child can die from murder or manslaughter, then it at least creates a unique legal recognition at law which applies only to unborn children.

Further support for the unique recognition is found in English case of *Attorney-General's Reference (No 3 of 1994)*, which dealt with a man who stabbed his girlfriend in the lower abdomen while she was between 24 and 26 weeks' pregnant and thus caused her to go into premature labour.[23] The woman gave birth to a child who lived for four months and then died as a result of injuries from the stab wounds received *in utero*.[24] The Court of Appeal held that both murder and manslaughter could be committed where a child's death resulted from injury to the mother during pregnancy.[25] The Court of Appeal did however state, though not as part of the judgment, that a doctor performing a termination of pregnancy would not be guilty of murder if the termination caused the unborn child to be born alive and then die, provided the procedure was otherwise lawfully performed.[26] A further example is found in *Martin v The Queen*, where the

[17] Natasha Cica, Law and Bills Digest Group, *Abortion Law in Australia*, No. 1 of 1998-99, p 38.
[18] Ibid, p 38.
[19] Ibid, p 38.
[20] Ibid, p 38.
[21] Ibid, p 39.
[22] Ibid, p 39.
[23] Ibid, p 39.
[24] Ibid, p 39.
[25] Ibid, p 39.
[26] Ibid, p 39.

appellant had stabbed his 28 week pregnant partner in the lower back, causing foetal brain damage which caused the child's death after he was born alive.[27] The appellant was convicted for manslaughter and the Western Australian Court of Criminal Appeal held that a prosecution could be brought in respect of injuries inflicted on a child before his or her birth which ultimately led to his or her death, provided the child were born alive.[28] In reaching this decision, the court relied upon section 271 of the *Criminal Code* (WA), which provides that:

> *When a child dies in consequence of an act done or omitted to be done by any person before or during its birth, the person who did or omitted to do such act is deemed to have killed the child.*[29]

Although the matter was not addressed, *Martin v R* suggests consistency with the proposition that liability for homicide can attach to the death of a child which results from injuries caused by an otherwise lawful termination of pregnancy.[30] This reasoning is consistent with decisions in other Australian jurisdictions that if a child is born alive, he or she can bring a civil action in respect of negligent actions which took place before his or her birth or her conception.[31]

The *Criminal Code* (NT) contains two provisions relevant to this discussion. The first is section 170, which provides that:

> *Any person who, when a woman or girl is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of an offence and is liable to imprisonment for life.*

The second is section 317, which provides that:

> *Upon an indictment charging a person with murder or manslaughter, if it appears that the person alleged to have been killed was a child of which a woman had recently been delivered, the accused person may be found guilty alternatively of the offence of preventing the child from being born alive by an act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, or of the offence of disposing of the dead body of a child with the intention of concealing the child's birth.*

Each of these offences point to a recognition of the humanity of the unborn child, which is distinct from the born child only in that there is a legal avenue for the termination of an unborn child. This is not a position unique to Australian law for, in addition to the English law set out above, the majority of the states of the United States of America have laws which allow for the possibility of an unborn child being the victim of a crime.

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[27] Ibid, p 39.
[28] Ibid, p 40.
[29] *The Criminal Code* (WA), s 271.
[30] Natasha Cica, Law and Bills Digest Group, *Abortion Law in Australia*, No. 1 of 1998-99, p 40.
[31] *Abortion Law in Australia*, 31 August 1998. Bills Digest, p40.

(b) Assault laws

The previous section dealt with laws regarding the taking of life, which are limited by the requirement that a child be born alive. However some Australian laws already grant a unique form a recognition to an unborn child for the purpose of assault law. An example is found in the definition of "*Grievous Bodily Harm*" in the *Crimes Act 1900* (NSW), which includes:

> *the destruction (other than in the course of a medical procedure) of the foetus of a pregnant woman, whether or not the woman suffers any other harm.*[32]

This definition creates a separate offence which deals with actions that result in the death of an unborn child. This law represents a societal expectation that the loss of an unborn child in certain circumstances be dealt with under the laws regarding an offence against a person. While this law does allow for the destruction of an unborn child in the course of a medical procedure, the New South Wales parliament has still elected to grant some unique recognition to an unborn child, apart from his or her mother. Further, the laws relating to destruction cannot be said to treat the unborn child as property, as the offence "*Grievous Bodily Harm*" is a species of assault, which is an unlawful interference with a person and not the destruction of property.

(c) Child protection law

Notwithstanding the limits upon recognition of an unborn child as a person, Victorian child protection legislation provides that a person can make a child protection report regarding an unborn child if that person had concerns for the child after his or her birth.[33] There are similar provisions in child protection legislation in New South Wales,[34] and the Queensland child protection department is specifically empowered to offer support to reduce the likelihood that an unborn child will be in need of protection after the child is born.[35]

(d) Registration of births

Each state and territory of Australia has legislation that deals with the registration of births, deaths and marriages, usually by the giving of a prescribed form of notice to the established Registrar or Registrar-General. In the Australian Capital Territory, that notice must be provided in relation to any child born alive, or any stillbirth,[36] and for the purpose of that legislation, "child" includes a "stillborn child".[37] Similar provisions are enacted by the *Births, Deaths and Marriages Registration Act 1995* (NSW).

In the Northern Territory, section 12 of the *Births, Deaths and Marriages Registration Act* (NT) provides that notice must be given to the Registrar in the event of any child born alive, or of any stillbirth. Section 12(3) of the same legislation provides that when notice of a stillbirth is given, that notice must include a doctor's certificate which certifies "*the cause of foetal death*".

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[32] *Crime Act 1900* (NSW), s 4.
[33] *Child, Youth and Families Act 2005* (Vic), s 29.
[34] *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 25.
[35] *Child Protection Act 1999* (Qld), s 21A.
[36] *Births, Deaths and Marriages Registration Act 1997* (ACT), s 5.
[37] Ibid, s 4.

(e) Summary

While an unborn child is not recognised as a person at law for the purposes of homicide laws, it would be inaccurate to suggest that the unborn child could be considered to be a mere appendage to the mother, else the homicide and assault laws could not operate as set out above. Further, the unborn child cannot be considered property, or those laws could not apply at all as they are concerned only with injury to a person.

These factors, taken together with the recognition of the unborn child for the purpose of child protection and registration laws demonstrate that, since the Northern Territory's termination of pregnancy services regime was enacted, there has been substantial development in the legal status of the unborn child. It is submitted that even if an unborn child is not recognised as a person at law until he or she has been 'born alive', the unique position that an unborn child occupies at law should be recognised and considered in any modification of the law dealing with termination of pregnancies in the Northern Territory.

3. **Treatment options for the termination of pregnancy**

Although treatments for medical termination of pregnancy, such as Mifepristone and Misoprostol, were unknown when the Northern Territory's current legal regime was enacted, the ease with which these treatments can be administered should not prompt expanded use without due consideration to the risks involved. As set out in the Discussion Paper, Therapeutic Goods Administration ("TGA") approved guidelines set out a number of requirements in relation to Mifepristone and Misoprostol, including that a woman being treated with those drugs must have access to 24-hour emergency care.[38] That position is supported by Royal Australian and New Zealand College of Obstetricians and Gynaecologists ("RANZCOG") which required that arrangements for the termination of pregnancy by way of Mifepristone and Misoprostol must include 24 hour access to telephone advice, and 24 hour access to surgical uterine evacuation, such as through on call arrangements or in an emergency department.[39] RANZCOG further directs that medical terminations should not be performed in remote places which lack access to suitable emergency care, which is supported by the advice of the Australian Medical Association Northern Territory ("AMA NT") that a woman be within two hours of a hospital she takes Mifepristone and Misoprostol.[40]

Each of the matters set out above points to risks associated with Mifepristone and Misoprostol, especially in the context of the Northern Territory where a large proportion of the population lives in remote areas. Further, the population of the Northern Territory is highly mobile,[41] which reduces the likelihood that patients will remain within the recommended distance of emergency care unless they are required to remain near a public hospital, as required by the current legal regime governing the termination of pregnancy in the Northern Territory. Even if a woman could reach a remote clinic in the event of a complication, it seems unlikely that the clinic would be equipped to provide sufficient treatment. On this basis, Mifepristone and Misoprostol cannot be used as recommended

[38] Discussion Paper, p 6.
[39] Ibid, p 6.
[40] Ibid, p 6.
[41] Ibid, p 7.

within the Northern Territory unless the current legal requirement that the termination of pregnancy take place within a hospital is maintained.[42]

4. Difficulties with changing the *Medical Services Act* to improve safe access to termination of pregnancy for NT women

For the reasons set out elsewhere within this paper, the contemplated changes should not be enacted and so the method of amendment is irrelevant.

4.1 Definition of Termination of Pregnancy

If the contemplated amendments proceed, it is submitted that it is undesirable to have a single definition for the term "termination of pregnancy", for the following reasons:

(a) If the proposed changes are enacted, then the term will encompass both medical and surgical terminations of unborn children.

(b) Each of those terms will require separate policy guidelines for government staff, and possibly private health care workers, who will be required to apply those guidelines in practical situations.

(c) If the distinction between the types of pregnancy termination is found in the definition, as is contemplated,[43] then the policy guidelines would need to identify, every time the definition is applied, whether particular guidelines apply to one type of pregnancy termination or another. Further, some provisions would presumably apply to both types and some to only one.

(d) Alternatively, if the distinction between the types of pregnancy termination is placed in the description of the concept, for example 'medical termination of pregnancy' and 'surgical termination of pregnancy', then separate policy frameworks could be easily developed for each type of pregnancy. For ease of use in a practical context, it is submitted that his is the preferred option.

4.2 Criteria for providing treatment

(a) Informed Consent

If termination of pregnancies is still to be available, then the availability of pregnancy termination services should not be made easier given the advances in medical information regarding the development of a child, as set out in section 2.1 above. Rather, women contemplating the termination of a pregnancy should be required to receive the following information before they are considered to have given informed consent.

(i) Information regarding the development of the unborn child *in utero* including, but not limited to, the information set out in section 2.1 above.

(ii) Information regarding the age at which an unborn child can survive outside the womb including, but not limited to, the information set out in section 2.2 above.

(iii) Information regarding any and all risks to mother as a result of the termination of a pregnancy.

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[42] *Medical Services Act* (NT) s 11(1)(c).
[43] Discussion Paper, p 3.

Given the information relevant to the termination of a pregnancy has grown so significantly since the implementation of the current legal regime which deals with this issue, a person could not be reasonably considered to have provided informed consent unless they are made aware of this information. This issue is of significant importance for the Department of Health in its position as employer of medical personal, which makes the department vicariously liable for injuries caused as a result of any failure to obtain informed consent by their employees.

(b) Approval by two medical practitioners

If termination of pregnancies is still to be available, then the current requirement for the agreement between two medical practitioners should be maintained. This requirement represents an important protection for the patient from the error or negligence of the medical professionals. Further, this requirement represents an important protection for the medical professionals who, along with the Department of Health who would be vicariously liable for their actions, may be subject to claims that appropriate assessments and informed consent were not obtained. Finally, if current guidelines in relation to medical termination of pregnancy are followed, then there should be no need to consider a scenario where it is not possible to obtain advice from two medical practitioners.

4.3 Suitably qualified medical practitioner

The Discussion Paper asserts "*it is appropriate in certain circumstances for a single suitably qualified medical practitioner to be permitted to conduct the requisite assessments*" and then proceeds to suggest that the 'certain circumstances' might relate to pregnancies that are within 14 weeks' of conception. The Discussion Paper offers no guidance as to why this change in circumstances might be considered appropriate, given that the current regime has presumably been deemed 'appropriate' since the mid-1970s. Rather, the Discussion Paper has merely cited that due to the context of health care in the Northern Territory, it may be difficult for two medical practitioners to assess a woman. This is a position based on convenience rather than evidence based medical care.

It is instead submitted, in order to provide women with the best possible healthcare, any medical professional should have the expertise to provide the information necessary to obtain informed consent, and to advise of any risks attached to any procedure for the termination of pregnancy. Unless that advice is provided from someone with the appropriate expertise, in all the relevant areas of medicine, the woman cannot possibly be considered to have been properly informed, and thus cannot provide informed consent. In the absence of informed consent, the medical practitioners, and their employers, are once again opened to civil liability in the event of injury.

4.4 Prescribing, Supplying and Administering drugs that induce medical termination

It is submitted that, for the reasons set out in section 3 above, no consideration should be given to expanding the suppliers of medical termination drugs, and that if such a method of pregnancy termination is available at all, it should be confined to hospitals where appropriate medical care is available.

4.5 Criteria for the most appropriate location of treatment and safe care

(a) Location

The Discussion Paper sets out that there is "*evidence that medical terminations of not more than 9 weeks gestation, and surgical terminations of not more than 14*

weeks gestation can be safely conducted outside a hospital setting, and in all jurisdictions except for the Northern Territory, this occurs."[44] However, the Discussion Paper also, as set out in section 3 above, sets out current guidelines which would prevent the provision of medical terminations of pregnancy save in or close to a hospital.

It is submitted if the evidence referred to in the Discussion Paper has not prompted amendment to guidelines approved by the TGA, or to RANZCOG or AMA NT guidelines, then it should not be relied upon in the formulation of policy or law in the Northern Territory.

(b) Professional standards and guidelines

The Discussion Paper notes that the population of the Northern Territory is uniquely geographically distributed and is highly mobile, before considering three options.[45] In relation to those three options, it is submitted:

(i) A regulatory response whereby clinics and facilities are licensed or regulated will not make available emergency care to women in remote areas, making the Department of Health non-compliant with the guidelines set out in section 3 above. Non-compliance might be raised as evidence in a proceeding for damages against the Department of Health for failing to provide medical care to the appropriate professional standard.

(ii) The setting of facility or clinic standards will likewise be unable to make available to Northern Territory women the recommended emergency after care as set out in section 3 above, with the legal risks set out in the previous section.

(iii) The third option refers to:

> *adoption of professional standards and guidelines by the practitioner. This would require those issuing prescriptions to do so in compliance with the provisions of the Bill and following the professional standards and guidelines including MS Health certification requirements, RANZCOG College Statements and product information guidelines.*[46]

The Discussion Paper prefers the third option, as set out in the following statement:

> *It is proposed that the Department of Health and a representative expert reference group develop appropriate best practice guidelines to be generally referred to by and accessible to health practitioners. These best practice guidelines would be applicable in all potential settings across the NT including public and private hospitals, urban day surgery centres, family planning clinics, GP clinics, regional locations, and remote Primary Health Care Centres. The guidelines would include best practice*

[44] Ibid, p 5-6.
[45] Ibid, p 7
[46] Ibid, p 7.

> *management of women living in remote areas of the NT, women with disabilities and children in state care.*[47]

Yet the third option raises a logical contradiction, specifically that it is not possible to "*develop appropriate best practice guidelines in all potential settings across the NT including … regional locations, and remote Primary Health Care Centres*" and also follow "*professional standards and guidelines including … RANZCOG College Statements and product information guidelines*". The former states an intention to allow for termination of pregnancy services in areas where women cannot access emergency after-care and the later are guidelines which require emergency after-care to be available.

It is submitted that compliance with the guidelines referred to in section 3 should be maintained, for the protection of pregnant women from injury, and for the protection of medical professionals and their employers from liability.

(c) Provision of Consumer-orientated Resources

The Discussion Paper contemplates that:

> *the Department of Health produces consumer-oriented resources to inform consumers of access to termination of pregnancy services, similar to the Victorian Better Health Channel website.*[48]

It is submitted that any such resources should provide the information required for a woman to be considered to have received informed consent, as set out in section 4.2(a) above.

(d) Rigorous Evaluation and Monitoring

The Discussion Paper contemplates that:

> *It is also proposed that a rigorous evaluation and monitoring strategy be developed, including submission and analysis of data relating to women's safety.*[49]

It is submitted that section 3 above already sets out significant data in relation to women's safety as a result of engaging a service to terminate a pregnancy. However the best healthcare requires that information is continually updated, so rigorous evaluation and monitoring is desirable. It is however submitted that the collected data, de-identified to protect privacy, should be made publicly available so that any conclusions based upon that data can be widely reviewed become part of the body of medical knowledge.

4.6 Provision of services

For the reasons set out in section 3 above, it is submitted that there should be no expansion of termination of pregnancy services such that women who undergo those procedures are unable to access emergency after-care in a timely manner.

Further since, as set out in section 4.5(b), the Department of Health is at least contemplating a departure from the current guidelines in relation to medical pregnancy terminations, the

[47] Ibid, p 7-8.
[48] Ibid, p 8
[49] Ibid, p 8.

risk of legal liability for the medical practitioners and the for the Department is increased. Given the concern expressed in the Discussion Paper regarding access to pregnancy termination services to women irrespective of their ability to pay, it is submitted that the NT government should also ensure that women who are harmed as a result of a termination of pregnancy are funded to seek compensation, irrespective of their ability to pay.

4.7 Conscientious objection

(a) Reasons for Conscientious Objection

While predominantly religious in worldview, this need not necessarily be the case, as an ardent proponent of evolution might reasonably conclude that any termination of a pregnancy deprives the human race of an opportunity to evolve. Religious worldviews include the Christian position summarised as '*imagio Dei*', that all life is made in the image of God and any termination of that life represents an affront to God, most commonly described as murder.

For those who hold such worldviews, it is unthinkable to participate in any way in the termination of an unborn child, representing as it does an offence against God and/or against humanity. If the Northern Territory contemplates a scheme whereby the termination of unborn children can be legally performed, then any person who objects to this as a matter of conscience must be allowed to refuse any involvement in the procedure.

(b) The Difficulty with a Requirement for Referral

The Discussion Paper concedes that persons who hold a conscience-based objection should not be required to terminate or assist in the termination of an unborn child is best practice.[50] However the Discussion Paper immediately relates that the Department of Health proposes to bind the conscience of a conscientious objector with a requirement to make a referral to another health professional to allow that procedure to occur. The referral involves facilitating the very termination of pregnancy which is opposed by the conscientious objector and so contradicts best practice as set out in the Discussion Paper. Two further problems arise within such a restriction:

Article 18 of the *Universal Declaration of Human Rights* provides that:

> *Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*

Article 18 of the *International Covenant on Civil and Political Rights* provides that:

> 1. *Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.*

[50] Ibid, p 8.

2. *No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.*

3. *Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.*

4. *The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.*

Australia has ratified both these treaties, and while the ratification of a treaty does not automatically incorporate its terms into domestic Australian law, these provisions represent the societal expectation on a global level that freedom of conscience should be protected. Yet these Articles not only provide for the right of a freedom of conscience, but also the freedom to manifest those beliefs in public.

It is noted in Article 18(3) of the *International Covenant on Civil and Political Rights* that freedom to manifest one's beliefs is only subject to legal limitation when the limitation is necessary to protect matters such as public health and the fundamental rights and freedoms of others. As to public health, the judgment regarding what advice a health professional should provide in particular circumstances should be dictated by the professional judgment of the health professional which necessarily includes that professional's conscience for if the conscience can be so easily dissected from the individual, then it offered little guidance to the health professional in the first place. As to the question of fundamental rights and freedoms, it is submitted that there is no fundamental human right to obtain a termination of pregnancy in international human rights law.[51]

Thus it is submitted that while the Discussion Paper correctly acknowledges the importance of freedom of conscience to refuse to participate in a termination of a pregnancy, there is a failure to recognise that a requirement placed upon a conscientious objector to make a referral for a termination of pregnancy is just as much an imposition upon freedom of conscience. It is worth noting that section 84 of the *Health Act 1993* (ACT) provides that:

(1) No-one is under a duty (by contract or by statutory or other legal requirement) to carry out or assist in carrying out an abortion.

(2) A person is entitled to refuse to assist in carrying out an abortion.

4.8 Safe Access Zones

(a) Operation in other jurisdictions

Section 9 of the *Reproductive Health (Access to Terminations) Act 2013* (Tas), provides that a person must not engage in prohibited behaviour within 150 metres

[51] Contribution to the General Discussion on the preparation for General Comment No 36 Article 6 of the ICCPR: Right to Life, Part I – included as Annexure 1.

of a site where the terminations of pregnancies are performed. "Prohibited Behaviour" is defined to include:

> *a protest in relation to terminations that is able to be seen or heard by a person accessing, or attempting to access, premises at which terminations are provided…*[52]

Similar provisions have been enacted in Victoria,[53] and the Australian Capital Territory.[54]

(b) Freedom of political expression

The purpose of the legal provisions described in the previous section is to restrict the freedom of those who are opposed to the provision of pregnancy termination services from expressing that view in public within a given distance from a site that provides those services. Proponents of these laws have a legitimate concern in protecting vulnerable women from unlawful interference or offensive conduct, however such things are already offences under Northern Territory law.[55] The difficulty is that proponents of such laws also wish to silence those who seek only to respectfully and gently present their beliefs regarding the life of an unborn child, with the intention of aiding not only the unborn child but also the mother. While the Australian *Commonwealth Constitution* lacks a 'freedom of speech' along the lines of the First Amendment to the Constitution of the United States of America, the High Court of Australia has determined the *Commonwealth Constitution* does contain an implied freedom of political expression,[56] which operates as a restraint on legislative action.[57]

This freedom does not confer an unfettered right, but rather allows for restriction when that restriction is appropriate and adapted to fulfilment of the purpose of the restriction.[58] In this case, the contemplated law is expressly intended to prevent those who hold one particular view of pregnancy termination from expressing that view in public, near a site which provides pregnancy terminations. It is submitted that a restriction on the presentation when of such a political view within 150 metres of such a site would not be considered a reasonable restriction for the following reasons:

(i) A 150 metre radius is 300 metres in diameter and 70,685 square metres in area.

(ii) An area that size will include private property, and thus restrict a business owner from placing material which opposes the termination of pregnancies in his or her own shop window if they were within the given zone. This restricts the freedom of people to adorn their private property as they see fit.

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[52] *Reproductive Health (Access to Terminations) Act 2013* (Tas), s 9(1)(b).
[53] *Public Health and Wellbeing Act 2008* (Vic), ss 185B & 185D.
[54] *Health Act 1993* (ACT) ss 85-87.
[55] Eg *Summary Offences Act* (NT) ss 47 (Offensive Conduct), 53 (Obscenity); *Criminal Code* (NT) ss 187, 188
(Assault).
[56] *Nationwide News Pty Ltd v Wills* (1992) 177 CLR 1; *Australian Capital Television Pty Ltd v the Commonwealth*
(1992) 177 CLR 106.
[57] *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520.
[58] *Nationwide News Pty Ltd v Wills* (1992) 177 CLR 1 at 50, per Brennan J.

(iii) The matters set out above are applicable to residential property, which will likely be included within a zone of the size defined above. This restriction is even more intrusive, as it would restrict what a person can or cannot display on the outside of their own home.

(iv) A radius based zone would include areas which are not even visible to those attending a site which provide pregnancy termination services, which means such a zone could not possibly be tailored to the purpose of the legislation.

(v) In the context of the Northern Territory, if a restriction zone of this size were applied, and amendments which also made termination of pregnancies available in remote communities were enacted, then it should be noted some of those communities may well be smaller than 300 metres in diameter. Accordingly, the effect of this legislation would be to prevent any public opposition to a political issue in an entire community. It is submitted that any provision which prevents the public expression of a political position throughout an entire community would be deemed an unreasonable restriction on the freedom of political expression and thus be unconstitutional.

It should be noted that even if the High Court were to determine that the restriction does not rise to that which requires a legal defence of freedom of speech, it does nevertheless allow for a practical reduction in the freedom of political expression. The consequence is a restriction on the extent to which people are free to express their view on this issue.

Further, it should be noted that even if such laws were constitutional, they would still be undesirable burdens on freedom of political expression. As set out above, no woman or anyone else should be subjected to assault or offensive behaviour, however the restriction of the freedom to gently express genuinely held beliefs to those who hold different views is an absolute necessity in a country governed by a representative government responsible to the people.

Finally, if the precedent is set that the parliament of the Northern Territory can prevent the discussion of a political issue wherever it likes, then there is no barrier to one side of politics preventing the discussion of any particular political issue in a given zone. This is of particular concern in the Northern Territory, as there is a unicameral parliament and the government of the day would always have the numbers to enact such restrictions upon discussion of issues by their opponents.

(c) Summary

In summary, given the difficulties set out in this section, there should be no restriction upon the freedom of political expression within the Northern Territory as it relates to protests around services intended to provide the termination of a pregnancy. If that submission is rejected, then there should at least be no action to enact such measures until current legal challenges to Tasmanian legislation have been exhausted, lest the Northern Territory enact an unconstitutional legal regime.

4.9 Informed consent to treatment

The question of what information should be provided to a woman who contemplates the termination of her pregnancy has been considered in section 4.2(a) above. A further issue

is to whom that information should be provided when there is some question as to the mental capacity of the mother, which must be considered in the carefully in any amendment to the current legal regime.

(a) Children and people incapable of giving consent

Section 11(5)(b) of the *Medical Services Act* (NT) provides that women who fall into two categories, the first of which includes women who are under the age of 16 years. The second category is of women of any age who are unable to given consent, which usually arises due to some limitation to their mental capacity. In these situations, Section 11(5)(b) provides that the responsibility for the decision rests with the "*each person having authority in law*", who would usually be parents, a personal or statutory authority appointed under the *Adult Guardianship Act* (NT) for an adult, or the statutory authority appointed under the *Care and Protection of Children Act* (NT) for a child.

In each of these cases, the common circumstance is that the mother who undergoes the termination of her pregnancy is the person who is subject to any medical risks associated with the termination of a pregnancy, and the issues set out in section 3 above, and the person who makes the decision bears none of those risks. In the case of statutory authorities, even the current regime contemplates that Northern Territory public servants will be empowered to make significant medical decisions on behalf of those who will bear the consequence of those decisions.

In order to best protect those women who do not have control over the medical treatment to which they are subjected, the appropriate person for giving consent to medical treatment must have informed consent. As set out above, the person giving consent must have related to them the information set out in section 4.2(a) above. Further, given the guidelines referred to in section 3 above, the methods of medical termination of pregnancy should not be applied to any woman for whom another person has decision making responsibility at all.

The Discussion Paper raises for the consideration the scenario where a young woman feels pressured to seek unsafe or unsupervised termination of her pregnancy due to the restrictions in the system set out above,[59] however it fails to consider that young women who find themselves pregnant may face significant pressure from the fathers and other family members to have their pregnancies terminated quickly and easily. This is a situation which would be accentuated by the adoption of the *Gillick* principle as it would extend these difficulties to even younger girls.

This is a situation that no young woman should find herself in, however the remedy is not to make termination of pregnancy services more available. Rather it is submitted that the remedy is to encourage the community to present holistic care options such that a young woman has non-judgmental support to fall upon, such that she does not feel any pressure to terminate her pregnancy.

(b) Children over the age of 16 years

Section 11(5)(a)(i) of the *Medical Services Act* (NT) provides that a woman aged 16 years or older may give consent to the termination of her pregnancy, if she is

[59] Discussion Paper, p 9.

otherwise capable of giving consent. It seems strange that women who fall within this category are able to make decisions involving the medical risks of a pregnancy termination and the issues set out in section 3 above and yet are not allowed to enter some contracts or vote. However, if they are the appropriate decision maker than they should be required to give the information necessary to provide informed consent, as set out in 4.2(a) above.

5. Conclusion

For the reasons set out above, it is submitted that the review of the manner in which termination of pregnancy services are provided in the Northern Territory should conclude that there are unacceptable risks of harm to the people involved. Accordingly, there should be no expansion in the provision of those services, but rather a reduction in those services in favour of holistic support for pregnant women to free them from any sense of pressure to undertake a significant medical or surgical procedures.

Alternatively, if the position is to proceed with an expansion of pregnancy termination services as proposed within the discussion paper, then that expansion should be limited by current guides applying to medical termination procedures. Further, any expansion should contain within the capacity to keep detailed records of the impact of the expansion upon the people involved, both mothers and staff, in order to ensure that the best medical information is available for any future healthcare review.

Submission #101

Sir/madam,

I would like to draw your attention to the following suggestion for the new legislation.

‘Ability for doctors and other health staff to conscientiously object to involvement in a women’s termination of pregnancy. However, these provisions will also include a requirement for a doctor who conscientiously objects to refer the woman to a doctor who does not have a conscientious objection to providing these services.’

As a practitioner who has on many occasions had to deal with distraught clients who have not only had their request for TOP care refused but have also been subjected to religious emotional blackmail by the original doctor AND not been given a referral to another doctor, I strongly suggest that there is some mechanism introduced to ensure this suggestion is implemented and policed.

Thank you.

Submission #107

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27 January 2017

Women's Health Strategy Unit
Department of Health
Northern Territory Government
Floor 4, Darwin Plaza, Smith Street,
Darwin 0800

Dear Sir/Madam

ACL Submission regarding Termination of Pregnancy Law Reform

The Australian Christian Lobby's (ACL's) vision is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With more than 80,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

Termination of Pregnancy Law Reform; improving access by Northern Territory women to safe termination of pregnancy services

ACL thanks the Department of Health for this opportunity to contribute to the government's community consultation process with regard to the government's proposed termination of pregnancy law reform bill.

Concerns with the public consultation process

The timing of this discussion paper is unfortunate spanning, as it does, the Christmas period and January – a time when temperatures in the Territory are at their highest and many choose to holiday elsewhere. The ability of the NT community to respond to the government's paper is therefore severely compromised in ways which might have been anticipated and may undermine the value of the public consultation process.

Medical practitioners from the Northern Territory have expressed their concern to the ACL about the lack of awareness of the government's proposed amendments, even within the fraternity of Northern Territory health care workers. If the government's timetable presents a significant barrier to

participation for health care professionals, the ability of those living in remote communities, who may be unfamiliar with Parliamentary processes and often have dubious internet connections to contribute to this public consultation process must be regarded as non-existent.

Exclusion zones

The proposal to create "safe access" exclusion zones of 150 metres around facilities where abortion procedures are undertaken, would have the effect of prohibiting anti-abortion communication within these zones. Again, this may be problematic given the geography of the Territory. Alice Springs, for example, is the NT's third largest city and provides the only formal health care facilities for hundreds of kilometres in any direction. Alice Springs has three medical facilities (where abortions could take place), which serve outlying communities, as well as the population of the city itself. However, Alice Springs is not, in itself, a large city. If radii of 150m are drawn around each of these three facilities, the resulting area covers most of the city. Professor Nicholas Aroney has drawn attention to serious challenges to the enforcement of exclusion zones in other states on the grounds that these contravene Australia's constitution.[1] The effect of these proposals in the context of the NT therefore differs significantly in proportion compared with the situation in other Australian jurisdictions. In the NT, the proposed "safe access" zones could effectively impose a code of silence on the entire town.

ACL is also concerned that such stipulations compromise the ability of health care workers, or family and friends to speak to their patients, their daughter, their partner, in any way that might be considered to dissuade them from proceeding with an abortion. This represents an untenable limitation on their ability to offer the impartial advice required by the practice of their profession and contravenes the Code of conduct for Doctors in Australia, which states:

> *"Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively … Doctors have a responsibility to protect and promote the health of individuals and the community ... Good communication underpins every aspect of good medical practice."*[2]

The proposed exclusion zones introduce the possibility that women might proceed with abortion only because their medical advisors are unable to advise them freely of alternatives. This obviously places doctors, medical staff and counsellors in an untenable ethical position and exposes women and their unborn babies to the risk of proceeding on an irreversible course of action with incomplete advice. It cannot be supported on the basis of serving women's best interests.

Health risks to women in remote communities

The Attorney General's recommendations to liberalise the NT's abortion laws would be concerning in any state but their implications for women living in the Territory's conditions are particularly serious. The Discussion Paper is clearly intended to appeal to the ideology that equates liberal abortion laws with better conditions for women. It therefore claims that greater access to 'medical abortions' using

[1]Professor Nicholas Aroney, Submission 1020, *Health (Abortion Law Reform) Amendment Bill 2016*, Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Queensland Parliament. Available at: http://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/18-HealthAbortion/submissions/1020.pdf

[2]Medical Board of Australia, Good medical practice: a code of conduct for doctors in Australia, March 2014. Retrieved 15/09/16 from http:/medicalboard.gov.au/Codes-Guidelines-Policies.aspx, p. 5.

RU486, for example, will help the NT to keep pace with the changing nature of medicine, best practice in medicine, societal expectations and legislation elsewhere in Australia.[3]

This is to completely ignore the risks that the use of RU486 poses to women. The abortion process triggered by RU486 lasts a minimum of three days if all goes well, but women can bleed for up to six weeks. According to a 2011 'audit' of 7000 abortions performed in South Australia in 2009, 28 women who had surgical terminations were re-admitted for post-operative treatments, compared with over 370 women who had received "medical" abortions, using drugs[4]. Many women who have taken RU486 need a second abortion because the drugs fail to completely terminate their pregnancy and remaining parts of the unborn baby need to be removed to prevent an infection. A woman's life can be placed at risk if she haemorrhages excessively, needs a blood transfusion but is not near an emergency clinic.

The increased health risks of using RU486 are acknowledged in the advice routinely given to women choosing this form of abortion to remain within two hours of emergency facilities. RU486 is not an easy method of abortion, requiring multiple visits to a doctor and the administration of two drugs over several days causing powerful contractions endured without an aesthesia. The prolonged abortion is a lonely, painful experience that takes place away from medical supervision. The remains of the child may be visible to the woman who must then suffer the additional trauma of packaging up the dead foetus for disposal.

Complications from exposure to RU486 can include haemorrhaging, high blood pressure, vomiting, cramping and sepsis. In large cities, women who find themselves in an emergency as a result of taking the RU486 drug can find a hospital relatively quickly. This option is not available to many Territorians. By presenting RU486 as a quick fix to unwanted pregnancies, the government is therefore creating the conditions for a new wave of backyard abortions that may endanger the lives of Territory women. Remoteness significantly compounds the potential serious ramification of complications. Everyone agrees that women facing unsupported pregnancies should be offered real support – not a removal of all support, and the supply of a chemical which is harmful to both them and their unborn child.

Reducing protection for health workers and doctors (by reducing advising doctors from 2-1)

The government proposes to follow Victoria's legislation concerning conscientious objection which obliges health care workers who object, on the grounds of conscience, from assisting with a woman's abortion, to refer the woman to a practitioner who is known not to hold such an objection. Not only is this obligation in itself a violation of the freedom of conscience for the health care workers concerned (a situation which continues to attract criticism in Victoria), but conditions in remote communities mean that it would be impossible for nurses supporting these communities to excuse themselves from practical involvement in the abortion process. RU486 could be prescribed over the phone. In the absence of anyone else to assist the woman, nurses would be forced to participate.

Again, the disconnect between the theory or how the government represents its proposals and the problems likely to be encountered in implementing them in the context of the NT compounds the impression that the government's proposals have been developed by big-city academics from Melbourne and Sydney with little consideration of the geography, the demography and the limited backup health support available to isolated Territorian women.

[3] "Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services", p. 1.

[4] Jamie Walker, "Abortion Pill Less Safe Than Surgery", *The Australian,* 7 May 2011. Available at: http://www.theaustralian.com.au/national-affairs/abortion-pill-less-safe-than-surgery/news-story/459ea5d20e7c06bb83907eac8bc63537

Protections for women and health workers are also jeopardised by the proposal to reduce the number of 'suitably qualified medical practitioners' who need to approve an abortion from two (the usual requirement) to one. This removes important safe guards for women, who may be subject to undue pressure to have an abortion, and for the qualified medical practitioners' who may be open to accusations of applying undue pressure or other forms of mal-practice.

Top End Women's Legal Service Inc.

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27 January 2017

Attn: Department of Health Consultation Team
Department of Health
Northern Territory Government

By email to DOH.consultation@nt.gov.au

Dear Department of Health Consultation Team,

Submission to the Termination of Pregnancy Law Reform in the Northern Territory Discussion Paper

Thank you for inviting comments to the Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe Termination of pregnancy services Discussion Paper ("the Discussion Paper"). The Top End Women's Legal Service Inc. ("TEWLS") welcomes the opportunity to make a submission to the Discussion Paper, including proposed reforms to legislation and policy.

About TEWLS

TEWLS is a community legal centre focused on the advancement of women's rights. We are funded by the Commonwealth Attorney General's Department to provide referrals, legal advice, casework and community legal education to women in the Top End of the NT. TEWLS provides assistance in a number of areas of law including domestic and family violence, sexual assault, family law, compensation for victims of crime, housing, discrimination, workplace health and safety, employment law, motor vehicles and consumer credit debts. We provide outreach services for culturally and linguistically diverse women, Aboriginal women in the town communities surrounding Darwin and women incarcerated in the Darwin Correctional Precinct.

Our Submission

TEWLS welcomes the Northern Territory Government's move to reform termination of pregnancy law and policy in the Northern Territory. As a service focused on the advancement of women's rights, TEWLS supports and promotes women's reproductive rights, including safe and affordable access to abortion services.

TEWLS notes that we have had the opportunity to view the respective submissions of the advocacy group *What RU4 NT?* and the *Human Rights Law Centre*. TEWLS' submission will address key reforms proposed in the Discussion Paper, as noted by both *What RU4 NT?* and the *Human Rights Law Centre*.

A Gestational limits – abortion after 23 weeks gestation

TEWLS is concerned that there is no reference to abortion after 23 weeks gestation in the Discussion Paper. While TEWLS understands that the current law relating to abortion in the Northern Territory provides that abortion after 23 weeks gestation is able to occur in extremely limited circumstances under section 11(4) of the *Medical Services Act* (NT), we submit that this limitation is inconsistent with International Human Rights Law as well as unduly narrow. TEWLS notes the submissions of *What RU4 NT?*[1] and the *Human Rights Law Centre*,[2] where discussions of fatal foetal abnormality and serious health condition in the pregnant woman support access to abortion for pregnancies of more than 23 weeks gestation.

Recommendation 1: *TEWLS recommends that for pregnancies of more than 23 weeks gestation, legislation should permit abortion where it is considered appropriate, taking into account a woman's medical circumstances, the foetus' medical circumstances, as well as the woman's current and future holistic circumstances.*

B Approval by medical practitioner/s

As noted in the Discussion Paper,[3] it is proposed that a termination of pregnancy, surgical or medical, may be performed in the Northern Territory where a number of requirements are met. One of these requirements is the consideration of all relevant clinical and psycho-social matters such that "an opinion about eligibility for termination of pregnancy" can be formed. TEWLS considers this requirement to be unduly restrictive and counter-intuitive to the Discussion Paper's purpose, where the requirement serves to effectively negate the autonomy and competency of women to determine whether an abortion is in their best interests.

TEWLS submits that access to abortion should be a woman's decision, made in consultation with a relevant medical practitioner. TEWLS recommends the removal of the requirement for a medical practitioner to provide approval for the relevant abortion so as to enshrine the autonomy of women in the Northern Territory.

Recommendation 2: *TEWLS recommends the new legislation specifically dealing with termination of pregnancy in the Northern Territory should not include a requirement for a medical practitioner to provide approval for the relevant abortion.*

C Mandatory counselling

Further to the above, the Discussion Paper proposes the requirement of, "Information and counselling are provided about current choices and future contraceptive options" to be met prior to termination of a pregnancy.

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[1] What RU4 NT?, *Submission: Response to Government on Termination of Pregnancy Law Reform* (January 2016), 2.
[2] Human Rights Law Centre, *Submission: Abortion law reform in the Northern Territory* (January 2016), 13.
[3] 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.

TEWLS supports the submission of the *Human Rights Law Centre,*[4] and submits that the requirement for counselling or a referral to counselling be removed from the new legislation specifically dealing with termination of pregnancy in the Northern Territory.

Recommendation 3: *TEWLS recommends that the new legislation specifically dealing with termination of pregnancy in the Northern Territory should not include a requirement for counselling or referral to counselling.*

D Decriminalisation of abortion under the *Criminal Code (NT)*

As noted by the *Human Rights Law Centre*,[5] there is insufficient clarity in the Discussion Paper to assess the extent to which abortion will be decriminalised in the Northern Territory. TEWLS submits that consideration should be given to relevant sections of the *Criminal Code* (NT) so as to elaborate on the proposed "criminal offence under other circumstances".[6] TEWLS supports the adoption of Victorian legislation, where criminal provisions were repealed and/or amended to provide an offence for an unqualified person to perform an abortion, without criminalising the conduct of a woman seeking an abortion.

Recommendation 4: *TEWLS recommends that relevant sections of the Criminal Code (NT) should be repealed and/or amended in line with the Crimes Act 1958 (VIC), where it would be an offence for an unqualified person to perform an abortion.*

E Support for proposed reforms

In addition to the above recommendations, TEWLS supports the following proposals as provided in the Discussion Paper:

- "Termination of pregnancy" definition in the new legislation specifically dealing with termination of pregnancy in the Northern Territory to include both surgical and medical procedures;
- In relation to appropriate location of treatment, Option 3 – location at which termination of pregnancy could be conducted in the Northern Territory to lie with the individual medical practitioner, such that abortion services are not confined to regional centres;
- NT Health Services to retain responsibilities for termination of pregnancy services to ensure safe and accessible abortion services to all women in the Northern Territory;
- Inclusion of legislation in line with the Victorian legislation relating to conscientious objection;
- Inclusion of provisions to establish safe access zones, with amendment to the relevant zones at hospitals such that the safe access zone would commence from the entrance to the hospital grounds;

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[4] Human Rights Law Centre, *Submission: Abortion law reform in the Northern Territory* (January 2016), [48] – [50].
[5] Ibid, 8.
[6] 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.

- Inclusion of provisions to establish an offence for breaching the afore mentioned safe access zones; and
- Inclusion of the *Gillick* principle of competence for women under the age of 16, as well as provisions noting that where Gillick is not satisfied, the consent of one appropriate parent or guardian will satisfy "informed consent". TEWLS notes that the consent of only one parent or guardian should be sought so as to include circumstances where there is a sole parent or a parent who is not involved in the relevant young women's life.

Conclusion

We thank you for your consideration of the above and would be pleased to be contacted should you wish to discuss the above comments further on (08) 8982 3000 or email to admin_tewls@clc.net.au.

Yours faithfully,
TOP END WOMEN'S LEGAL SERVICE INC.

Vanessa Lethlean
Managing Solicitor

Submission #116

To: NT Department of Health
DOH.consultation@nt.gov.au

Re: "Termination of Pregnancy Law Reform" Discussion Paper

I support the view that the timing of the release of this 'discussion paper' is inappropriate. It is during the December-January period that many Territorians are away from the NT. This does not allow sufficient opportunity for a valid discussion that takes into consideration the fullest possible breadth of opinions. As a Territorian, I expect the NT government to actually endeavour to represent the views of all Territorians. This means allowing opportunity for feedback especially from those who are most vulnerable, and those belonging to our Aboriginal and Torres Strait Islander community. This would take time — time that has not been allowed for in the current window.

Please allow for a balanced community discussion over an extended period of time, before further steps are taken to make change to legislation.

I would like to make the following points regarding the 'discussion paper':

1. The notion that current legislation limits access to Termination of Pregnancy (ToP) in the NT.
Within my experience as a GP practising in both urban and remote clinics in the Northern Territory, I have not felt that access to ToP is impaired. The current system (where ToP is mostly done surgically in the hospital) in my experience is highly efficient, accessible, and safe. It is most often a day procedure (where the patient is admitted and discharged the same day), or an overnight stay only. If a medical ToP is performed (at a later gestation for instance), the patient is admitted to hospital until the termination is complete.
In saying that there is need to improve access, there should be concrete statistics to support a claim that current access is insufficient (e.g. number of women who reside in the NT who seek ToP services interstate). The discussion paper only mentions 'anecdotal evidence that women travel interstate to access medical termination services'. Where are the statistics to support this?

2. “The decision about the location at which a termination of pregnancy could be conducted in the Northern Territory, whether this is in a clinic, hospital or home setting, would rest with the individual medical practitioner” (consideration 5 in the ‘discussion paper’)

It is potentially dangerous to put the onus on medical practitioner to make the call about prescribing RU486 in remote communities in the NT where there is often no consistent medical practitioner (ie. locum GP’s, and not necessarily the same locum every time). The first situation is of most concern, as locums generally come from outside the NT and often do not understand the cultural and geographical context they work in, and thus unknowingly, could prescribe RU486 inappropriately, and thus compromise the safety of the patient (who for example, may not remain in a location that is within 2 hours of a hospital in event of an adverse outcome).

The AMA(NT)’s recommendation that the patient remain within two hours of a hospital when taking the medication, does not necessarily prevent inappropriate prescription of RU486. Many remote communities are more than 2 hours from a hospital by road, but less than 2 hours by air. So, does ‘within 2 hours of a hospital’ include the time from when the adverse event (e.g. haemorrhage) occurs, plus the time it takes for the woman to present to the community clinic, plus the time it would take for the staff to arrange air retrieval (which is not always immediately possible due to the nature of the demand on air retrieval services at a particular time)? Clearly, this recommendation is open to interpretation by the medical practitioner, which shows that there needs to be more detail about what a safe distance from hospital means. If a woman in a remote community is having a haemorrhage, or goes into septic shock and she cannot get to a hospital very quickly, her life is in danger.

So, given the vulnerability of our remote population, legislation on medical ToP in the NT should be specific, so as to protect these women from potentially adverse outcomes. It should *not* rest on the doctor alone to decide, particularly in situations with locum GP’s, who cannot necessarily be expected to understand the remote NT context.

I suggest that the reference group you propose would develop NT-specific best practice guidelines, should actually have their guidelines become legislation. This

would protect both the potential patients and medical practitioners.

Submission #120 [Note: for amended submission by respondent, see Submission #120B]

A response to the Department of Health (NT) 2016 Discussion Paper : 'Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services:

I have perused the above named Discussion Paper and find some of the proposals are directed towards allowing medical (MS2-Step) terminations via telemedicine in remote settings where facilities, investigations and transport are inadequate.

If the NT government does not exercise due care in this matter, the NT Government will become guilty of the deaths of young Indigenous women in remote locations, where an expert ultrasound cannot be performed and reported by a radiologist to exclude an ectopic pregnancy which can cause severe internal bleeding after the MS-2Step drugs are given. This bleeding can cause death! (NB. Even evacuating a patient from nearby Belyuen, has taken longer than 2 hours, on occasion.) An ultrasound is mandated by the Royal Australasian College of Obstetricians and Gynaecologists, before using these drugs. An expert ultrasound also allows gestational age to be clarified. The Therapeutic Goods Act and the Pharmaceutical Benefits Scheme stipulate that MS-2 Step is not to be prescribed beyond 63 days. The patient may also have other undiagnosed/ or diagnosed medical problems that should preclude the prescription of MS – 2 Step. A nurse or an inexperienced medical practitioner may fail to diagnose these contraindications, such as renal failure, hepatic failure, rheumatic heart disease, and other conditions.

Moreover, in a Public Summary Document – July 2014, the Australian Pharmaceutical Benefits Advisory Committee (PBAC)Meeting: Section 7: PBAC Outcome states:

Section "7.9: The PBAC advised that mifepristone+ misoprostol is not suitable for prescribing by nurse practitioners."

Also, "Section 8 Recommended listing:

Condition/indication: Termination of an intra-uterine pregnancy

Clinical criteria: The condition must be an intra-uterine pregnancy of up to 63 days of gestation

Treatment criteria: Must be treated by a prescriber who is registered with the MS-2 Step Prescribing Program

Administrative Advice:

NOTE: No increase in the maximum quantity of number of units may be authorised.

NOTE: No increase in the maximum number of repeats may be authorised."

(My comment: This means that additional units of these drugs cannot be authorised to abort babies between 9 and 14 weeks gestation.)

I note with concern, that the Discussion Paper, on the top of Page 14 (attachment 3) –

" Summary table showing differences between current legislation and proposed changes", states:

"Section 11 Medical Services Act repealed and provisions included in a new act

PROVISION - Directed health practitioners

Current Act - Not included

PROPOSED ACT –

Registered pharmacist, nurse or nurse practitioners ("directed practitioner") may prescribe, supply and administer medication in the performance of a medical termination of pregnancy of less than 14 weeks provided:

(a) the suitably qualified medical practitioner has ASSESSED the woman in accordance with the woman in accordance with the relevant provisions and has directed the health practitioner to prescribe, supply or administer the medicines;

(b) the directed practitioner acts in accordance with professional standards and guidelines applicable to the medical practitioner in relation to all aspects of the treatment/procedure, support and location/access to emergency services."

My Comments:

Why does the discussion paper in attachment 3, speak of 14 WEEKS when this would be "off label" prescribing, and not in accordance with 63 days as stipulated by the TGA, and the PBS.

Also, the PBS clearly states that a nurse CANNOT prescribe MS – 2 Step.

It is of great concern that the word "examination" by a medical practitioner is to be substituted with "assessment", to allow for telemedicine in remote communities.

These proposals are substandard and dangerous, and remote Indigenous women are worthy of the care normally provided to 'white' women in Darwin and Alice Springs and should therefore not be legislated.

I am writing to voice my medical concerns about the proposed use of RU486 (medical abortion) in the Northern Territory. I recently retired as Director of General Surgery at the Royal Darwin Hospital after working at RDH for over 12 years.

The primary and most important consideration in assessing the suitability of a treatment, is patient safety. A " one-size fits all" policy is not appropriate in relation to the delivery of health services to "at risk" groups in the formulation of NT Health Policy. The Northern Territory Government has a very particular responsibility in ensuring the health and safety of Indigenous women in relation to the "Closing the Gap" Policy of the Federal Government.

A South Australian Health Department audit of nearly 7,000 abortions performed in 2009 and 2010 compared the safety of RU486 with surgical abortion, (E.A. Mulligan, "Mifepristone in South Australia" published by "Australian Family Physician" Vol. 40, No.5, May 2011).

The South Australian audit showed that, "1 in 18 patients who used RU486 (Mifepristone) had to be re-admitted to hospital i.e., (a total of 5.7% of first trimester medical abortions (women using RU486) vs. only 0.4% of surgical abortions). The same study revealed that as many as 33% of women who had second trimester RU486 abortions required some form of surgical intervention".

The findings of that South Australian audit were published in “The Australian” (May 7, 2011): Abortion pill ‘less safe that surgery’ reported by Jamie Walker. (http://www.theaustralian.com.au/national-affairs/abortion-pill-less-safe-than-surgery/story-fn59niix-1226051434394)

In the USA, the Food and Drug Administration (FDA) “Mifepristone U.S. Postmarketing Adverse Events Reports Summary (since approval in the year 2000 until) 30/4/2011”, revealed that at least 11 women have died as a result of complications related to taking RU486; 612 women were hospitalized after taking RU486; and of these, at least 339 women required blood transfusions as a result of serious blood loss. The report also indicates that 58 women were prescribed RU486 despite having an ectopic (tubal) pregnancy (which is a serious contraindication for using RU486, and entails a risk of death.

In a Statement: “The use of mifepristone for medical termination of pregnancy” (Reviewed February 2016), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists mandates:-

1. “Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care ..... from the administration of mifepristone until the termination of pregnancy is complete.”

This is because there is a small but significant incidence of major haemorrhage which may be life-threatening, requiring hospitalisation; blood transfusion and surgery.

Serious and potentially life threatening complications which may occur are bacterial sepsis (for example, Clostridia sordellii); incomplete abortion (where parts of the baby and placenta remain in the womb), necessitating emergency surgery; and ectopic (tubal) pregnancy which may rupture and cause internal bleeding , which may cause rapid death without speedy interventions.

NB. In remote settings in the Northern Territory, air evacuation may not always be possible during the Wet Season; furthermore, even in good weather, because of the tyranny of distance, and because not every remote community has a plane sitting on the airstrip, there can be very prolonged aviation delays.

Moreover, in the USA, despite the mandatory requirement for the availability of rapid transport to close and adequately equipped facilities, fourteen deaths (up until 2012) have occurred as a result of using RU486 (Mifepristone).

2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) also stipulates that :

“Accurate gestational assessment is essential to selecting optimal treatment options and regimens. Ultrasound examination is mandatory prior to termination of pregnancy to confirm gestation and exclude ectopic pregnancy; a diagnosis of ectopic pregnancy can be very difficult after attempted medical or surgical abortion.”

N.B. Skilled ultrasound assessments are not usually available in rural and remote NT clinics; and so RU486 is an inappropriate drug.

3. The RANZCOG also mandates three visits to the RU486 prescribing doctor. At the initial visit (before giving the patient RU486) arrangements must be made for diagnostic ultrasound to establish gestational dates and to exclude ectopic (tubal) pregnancy ; blood group in case

urgent transfusion is necessary; rhesus negative status must be established in case Rh Immune Globulin needs to be administered to the mother during the medical abortion, because of danger to subsequent pregnancies. These services must be available to the patient. Again, logistics for this may be challenging and patient co-operation is imperative.

NB. Due to language difficulties (English not first language) and cultural reasons Indigenous people often do not comply with attendance at medical appointments and medical instructions, which may result in serious consequences for the patient.

In addition, any woman (Indigenous or non Indigenous) who has issues with drugs, alcohol, homelessness or domestic violence, would be at a greater risk due to an uncertain lifestyle, and would b e unsuitable candidates for a medical abortion (RU486).

4. The RANZCOG also stipulates that as with all proposed medical procedures, a truly informed consent must be obtained. This can be extremely difficult to obtain with certainty due to language barriers (even with interpreters), and the (unfortunately) poor educational level of some Indigenous patients. In like manner, women discharged from a treatment facility need written instructions about “follow up” arrangements, symptoms of concern and lines of communication to access help and advice 24 hours/day. In that many Indigenous people have poor readings skills (through no fault of their own), such written advice is of little help to the patient.

The RANZCOG also recommends that there should be another person with the patient until the abortion process is complete. This other person needs also to understand the written instructions, and again this may not be possible.

5. The RANZCOG recommends that the RU486 (Mifepristone)- (medical abortion) only be used in a treatment facility ie. as an inpatient in a hospital, if gestation is greater than 63 days.

NB. During the medical abortion process, which may take 2 – 7 days or longer, there is a real risk that a patient may abscond from hospital, as often happens at Northern Territory. Such a patient could be at serious risk.

6. Importantly, up to 90% of women undergoing RU486 –(medical) abortion experience very unpleasant side effects, such as severe abdominal cramps, nausea and vomiting, diarrhoea, headache and prolonged bleeding. Sometimes if the pregnancy continues after the administration of RU486, the viable baby will be damaged when born.

NB. It is a well established fact that the incidence of depression and suicide increases post abortion. A woman may see the baby in the toilet and even if it is tiny, this can be very unsettling. Especially this is so in the culture of an Indigenous woman, as the baby is a person, no matter how small. The house where the ‘ baby died’ may have to be vacated for cultural reasons.

Thus, in summary, medical (RU486) abortion is not a procedure that can be safely used. Especially in remote communities in the Northern Territory; or even in Darwin or other NT towns, there will be health risks to patients who are noncompliant or who abscond. Without doubt, there will also be deaths or serious complications among young women.

In the light of the RANZCOG statements, these deaths will be the result of negligence on the part of the authorities who sanction such use and the practitioners who ignore the advice of the foremost clinical authority in obstetrics and gynaecology in Australia.

Submission #120B [Note: for original submission by respondent, see Submission #120]

AMENDED response to the Department of Health (NT) 2016 Discussion Paper : 'Termination of Pregnancy Law Reform; Improving access by Northern Territory women to safe termination of pregnancy services:

27TH January, 2017-01-27

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   N.B. Skilled ultrasound assessments are not usually available in rural and remote NT clinics; and so RU486 is an inappropriate drug.

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In addition, any woman (Indigenous or non Indigenous) who has issues with drugs, alcohol, homelessness or domestic violence, would be at a greater risk due to an uncertain lifestyle, and would b e unsuitable candidates for a medical abortion (RU486).

4. The RANZCOG also stipulates that as with all proposed medical procedures, a truly informed consent must be obtained. This can be extremely difficult to obtain with certainty due to language barriers (even with interpreters), and the (unfortunately) poor educational level of some Indigenous patients. In like manner, women discharged from a treatment facility need written instructions about "follow up" arrangements, symptoms of concern and lines of communication to access help and advice 24 hours/day. In that many Indigenous people have poor readings skills (through no fault of their own), such written advice is of little help to the patient.
   The RANZCOG also recommends that there should be another person with the patient until the abortion process is complete. This other person needs also to understand the written instructions, and again this may not be possible.

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NB. During the medical abortion process, which may take 2 – 7 days or longer, there is a real risk that a patient may abscond from hospital, as often happens at Northern Territory. Such a patient could be at serious risk.

6. Importantly, up to 90% of women undergoing RU486 –(medical) abortion experience very unpleasant side effects, such as severe abdominal cramps, nausea and vomiting, diarrhoea, headache and prolonged bleeding. Sometimes if the pregnancy continues after the administration of RU486, the viable baby will be damaged when born.

NB. It is a well established fact that the incidence of depression and suicide increases post abortion. A woman may see the baby in the toilet and even if it is tiny, this can be very unsettling. Especially this is so in the culture of an Indigenous woman, as the baby is a person, no matter how small. The house where the ' baby died' may have to be vacated for cultural reasons.

Thus, in summary, medical (RU486) abortion is not a procedure that can be safely used. Especially in remote communities in the Northern Territory; or even in Darwin or other NT towns, there will be health risks to patients who are noncompliant or who abscond. Without doubt, there will also be deaths or serious complications among young women.

In the light of the RANZCOG statements, these deaths will be the result of negligence on the part of the authorities who sanction such use and the practitioners who ignore the advice of the foremost clinical authority in obstetrics and gynaecology in Australia.

Finally, I make two further points:-

A doctor who has a conscientious objection to abortion will have the same objection to referring to another doctor who is willing to refer a patient to doctor who performs abortion. This is because a doctor who has a conscientious objection is not willing to become complicit with the performance of an abortion. This proposed law is unjust, and criminalizes the doctor who does not refer to another doctor to facilitate an abortion. Abortion is an operation that is different to all other operations which are generally life preserving and thus bring benefit to the patient. Abortion, however, brings death to the most vulnerable human beings; for this reason, many doctors would refuse to be involved in any way. Their ethical stand should be protected; they should not be prosecuted.

Furthermore, I find it strange that this proposed legislation does not encourage patients to consider other options, such as adoption or foster care within the extended family. Frequently, if a pregnant patient is provided with social, emotional and financial assistance, she will wish to continue the pregnancy. In order for a woman to truly make an informed "choice", she should be fully informed regarding options other than abortion. She should also be allowed a "cooling off" period, such as is available in Consumer Law regarding purchases. Such counselling should not be provided by those with a vested interest, such as the abortionist. Extensive counselling may not be available at a remote clinic.

I respectfully suggest that a parliamentary enquiry should be conducted regarding the safety and ethics of these proposed laws and that all regulations regarding of the use of MS-2Step should be enshrined in legislation for the protection and welfare of all Northern Territory women, and in particular, remote Indigenous women.

Thank you for considering my comments,

Yours faithfully,

[signature block removed]

27th January, 2017

ADDENDUM: (10th March, 2017)

Since writing the above submission, further information has become available regarding the complications of RU486 abortions in relation to the gestation of the pregnancy.

The Department of Health in the State of Iowa, USA, requires abortionists to report serious adverse medical complications for surgical or medical (chemical RU486) abortions. It has been reported that between 2012 and 2015 the serious adverse complication rate for RU486 abortions was 3.18%. However, after March 2016, the serious complication rate for RU486 abortions doubled to 6.74%.

The reason stated for the increase in serious RU486 complications, is that until March 2016, the FDA (USA Food and Drug Administration), stipulated RU486 should only be used prior to and including 7 weeks' gestation. In March 2016, the FDA relaxed the 7 week restriction, and allowed RU486 to be used up to and including 10 weeks gestation.

Most of the serious RU486 complications were related to 'incomplete abortion', (ie. when parts of the placenta and/ or baby parts have not been expelled following the RU486 abortion, usually necessitating a surgical abortion to remove these retained parts).

Severe bleeding or infection may result from retained placental or baby parts. In such occurrences, urgent surgical intervention is necessary. (NB: this serious risk to women's health must be considered by the Northern Territory Government in relation to the current proposed Abortion Bill.)

RU486 may cause serious complications even when used according to the manufacturer's recommendations (and the TGA (Australian Therapeutic Guidelines Administration) advice. When RU486 is used "off-label", (above 7weeks) in Ohio, USA, the serious complications DOUBLED.

NB: IT IS ALARMING THAT ON PAGE 5, PART 2, ITEM 8, THE PROPOSED "TERMINATION OF PREGNANCY LAW REFORM BILL 2017" Bill ALLOWS FOR RU486 ABORTIONS TO BE PRESCRIBED UP TO 14 WEEKS.

Furthermore, on Page 9, Part 4 (Reporting) and Part 5 (Miscellaneous matters) the proposed Bill states under 18 Regulations, "THE ADMINISTRATOR 'MAY' MAKE REGULATIONS UNDER THIS ACT. ....and the regulations 'may' provide for the CHO (Chief Health Officer) to collect statistics."

IT SHOULD BE LEGISLATED THAT IT IS ESSENTIAL THAT STATISTICAL DATA RELATING TO ABORTIONS AND RELATED ADVERSE COMPLICATIONS AND CONSEQUENT DEATHS ARE ACCURATELY COLLECTED AND MADE AVAILABLE TO THE PARLIAMENT AND TO THE PUBLIC. THIS IS PARTICULARLY

IMPORTANT BECAUSE A NEW FORM OF ABORTION, NAMELY RU486 (MS-2step) is being proposed to be used more widely in the Northern Territory.

The Northern Territory Government, due to the potential dangers of RU486 (MS-2Step) should thoroughly consider increased risks to the health of Territory women, particularly Aboriginal women in remote communities.

Submission #123

1. I find generally some of the terminology vague, especially when read from the perspective of a remote health service/remote health practitioner. For example, what exactly is meant by 'suitable emergency care' (as quoted from the RANZCOG guidelines)? The ability to administer IV fluids and emergency medicines while arranging evacuation, or operating theatres and staff? Especially if medical practitioners are to be making their own decisions about location of terminations, I would ask that these require more explicit definition. (Please also consider the tremendous turnover of staff, and our reliance on casual/agency staff in remote health centres). Another example, is the cited 'two hours from a hospital'; is this by road? by hypothetical air evacuation? Would this be part of the criteria?

No doubt these details will be nutted out as the legislation is written; I ask that the remote practitioner is considered. Working in relative isolation, we often rely heavily on such guidelines to guide our professional practice and decision making.

2. I would strongly agree with the Department's proposal that option 3 - ie. that professional standards and guidelines are adopted by the practitioner - in order to as much as possible ensure safety and best practice for clients in their care.

3. Given the potential difficulty of accessing medical services in the remote setting, I would suggest that the wording regarding conscientious objection be carefully considered. Locum doctors/DMOs etc who wish to conscientiously object may not be aware of other colleagues who do not have a conscientious objection.

4. Especially around issues of consent for women under the age of 16, I would strongly request that community consultation and permission is given before any legislation is passed. At the best of times, from my experience, termination of pregnancy is a painful process for that woman and her family (very little is secret in a small community, no matter how much effort is taken to protect privacy and confidentiality). I cannot speak on behalf of senior community members but I would expect that they would have their own views on the best process in the instance that appropriate parents/guardians cannot be found to give consent (there may be occasions when this is not appropriate, however, I am also assuming that of course, parental/guardian consent would be the first preference). I also mention this as I would hope any termination process would also at some stage involve conversation around options for contraception (again, something which should involved legal guardians to consent for those under the age of 16).

5. I assume there is more community consultation to come? Termination is something that affects all in a small community - clinic staff and family members alike. I asked an Aboriginal Health Practitioner colleague just now if she had heard about this proposed law reform and she said she had not. She is very interested to hear more. I would urge the Department to strive for appropriate community consultation and to integrate their concerns and feedback into any legislation that is passed. These laws have very real impacts in the community. Cultural safety is paramount.

Submission #124

Dear Sir/ Madam,

I am writing in response to the prospective changes to the abortion law.

1. Termination of pregnancy (TOP) is a criminal offence according to the current act with some exceptions - There would have been pretty strong reasons why TOP was considered to be a criminal offence by those who preceded us in the medical field. The basis of medicine is to preserve 'life', not take it. TOP except where there is a serious risk to the 'mother' and the 'child' in her that may result in either' death, I understand. Even these TOP are 'painful experiences' to the family and especially the mother. It is a shame that years of brainwashing that TOP is 'okay', sadly there are many who've become emotionless or numb to to it. The policy makers included. If the DoH has a right to its 'already made up mind on TOP reform law' then I doubt it will consider any of the responses similar to mine. The Government must not consider what people want in majority but 'what is right'. That is the basis of law.

2. Why is it that the unborn babies rights are not considered? To undermine the rights of the unborn child is to say they do not exist or that they do not have life. It is purely incorrect as life in the mothers womb begins at conception. If the mother or father to be did not want children why do they engage in irresponsible sex? We only try to put bandage over problems such as sex addictions, alcohol addictions, poor parenting or no parenting, have sex but dump your babies as a result. What kind of a crooked generation do we live in? And we call this 'medical advancement'! Wow, we must applaud ourselves. Really.

3. Freedom of speech - I do not think that setting up a table and chair by qualified unbiased health professionals within 150m distance of TOP premises to provide a safe and probably last opportunity for mothers and fathers to seek support and access to well informed choices given by people who truly care about the community and when it is done in respectful way considering individual choices would be considered as act of harassment. It'd be loss of freedom of speech.

4. As a current NT health professional , I respect my job, my service to the community, I have always been loyal to DoH and I admire the value and dedication NT health department has towards its people. Let's not commit murder by legalising murder of the unborn children.



Criminal Lawyers Association of the Northern Territory (CLANT)

Patron: The Hon Justice Dean Mildren • President: Russell Goldflam (telephone: 040 1119020)•
Secretary: Sarah Gibbs • PO 969, ALICE SPRINGS NT 0871 • www.clant.org.au •ABN:64391168 310

Submission on Termination of Pregnancy Law Reform[1]

The Criminal Lawyers Association of the Northern Territory (CLANT) welcomes the opportunity to respond to the Northern Territory Department of Health Discussion Paper on this issue, and commends the Northern Territory Government for taking a positive, progressive and consultative approach to this important area of law reform.

CLANT's objects include "to promote and advance the development and improvement of criminal law throughout the Northern Territory", and we are members of the legal profession, not doctors. Accordingly, this submission will focus on aspects of termination of pregnancy concerned with criminal law.

In relation to the medical aspects of this topic, CLANT defers to our colleagues in the medical profession, but recommends that NT law be formulated in accordance with current medical best practice. In that regard, CLANT notes that all jurisdictions except the Northern Territory permit medical (as distinct from surgical) termination of pregnancy, and that Mifepristone and Misoprostol are approved and recommended medicines by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Women and girls in the NT lack choice in their abortion treatment and are currently at risk of criminalisation if they seek treatment which is safe, widely approved and globally used. In addition, medical practitioners and other health workers in the NT are at risk of criminalisation in relation to termination of pregnancy if they seek to treat patients in what would otherwise be a safe and medically acceptable way.

Accordingly, CLANT supports the decriminalisation of abortion, as has occurred in the ACT, Victoria and Tasmania. Termination of pregnancy should be a decision made by a pregnant woman or girl in consultation with her medical and health practitioners. As with other medical treatments,

[1] Partly taken from research by CLANT Vice President Felicity Gerry QC, published online as part of a joint CDU/Menzies research project in 2014/15: Gerry, F., Belton S.,Yogaratnam J., (2015). *Reproductive Health and Rights in the Northern Territory: Reforming the Medical Services Act 1974*. Darwin, NT: Charles Darwin University, Menzies School of Health Research, accessed at https://espace.cdu.edu.au/eserv/cdu:52966/Gerry_52966.pdf

practices and procedures, regulation of abortion should be by way of the existing Territory and Commonwealth legislative framework governing the medical, pharmacy, nursing, health worker and allied professions, supported by their well-established array of disciplinary bodies.

Part VI Division 8 ("Abortion") of the *Criminal Code* (NT) should be repealed. Section 170 ("Killing unborn child") of the *Criminal Code* (NT) should be amended to clearly exclude from its scope conduct engaged in by a medical practitioner in the course of treating a patient.

In 2009, YWCA Australia and Women's Legal Services Australia, with the endorsement of 135 organisations, produced the *NGO Report on the Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in Australia*. Its recommendations included:

- THAT all Australian governments reinstate the requirement that State and Territory governments provide for women's reproductive and sexual health services.
- THAT all State and Territory governments decriminalise abortion, and move to adopt harmonious laws related to termination of pregnancy across jurisdictions.
- THAT all Australian governments examine schemes to address the barriers to access of sexual health services and education faced by women in rural, regional and remote areas.
- THAT the Australian Government liaise with State and Territory governments to increase access to RU 486 and take positive steps to support its sale in Australia.

The NT has the highest teenage pregnancy rate in Australia. Among the factors causing this are lack of education, cultural practices, vulnerability, disadvantage – and lack of access to appropriate reproductive health services.

Currently, women and girls seeking termination of pregnancy are required to travel to hospitals in Darwin or Alice Springs and to access specialist services from an obstetrician/gynaecologist. Those who are unable to travel for reasons of poverty, location or pressure of time and circumstances risk poor health outcomes and on-going social and mental consequences through unwanted pregnancy and its consequences.

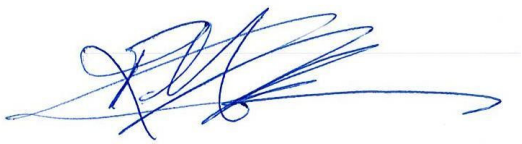
CLANT urges that the most serious consideration be given to submissions from both the health professions and community groups that these harms would be substantially mitigated by the substantial liberalisation of the regulatory framework governing the termination of pregnancy.

CLANT supports the Department of Health's proposal for provisions similar to those in Victoria regarding doctors who have a conscientious objection to performing abortions. Those measures appear to strike a common sense and practical balance between the competing interests in this sensitive area.

CLANT also supports the Department of Health's proposal for the creation of Safe Access Zones, and the associated imposition of sanctions against those who harass or otherwise unreasonably infringe the privacy of patients or health providers.

As with any medical procedure, a decision to terminate a pregnancy should only be taken with the informed consent of the patient. In relation to young pregnant women, CLANT notes that the Gillick competence principle forms part of Australian common law,[2] and submits that no legislative action is required to give effect to the principle that a minor is capable of giving informed consent when having sufficient intelligence to be able to understand fully what is proposed.

CLANT submits that both the Department of Territory Families, in its role as guardian of children in care, and the Office of the Public Guardian, in its role as guardian of adults subject to guardianship orders, should develop appropriate protocols, practices and procedures to ensure that the girls and women under their respective guardianship are given access to reproductive health services, in accordance with the Gillick competence principle.



Russell Goldflam
PRESIDENT

27 January 2017

[2] *Secretary, Department of Health and Community Services v JWB and SMB* (Marion's case) (1992) 175 CLR 218, per Mason CJ., Dawson, Toohey, Gaudron at 237-238; Deane J at 293-294; McHugh J at 311. This leading case, it is noted, originated in the Northern Territory.

Submission #129

SOUTH AUSTRALIAN ABORTION ACTION COALITION

COMMENT ON TERMINATION OF PREGNANCY LAW REFORM DISCUSSION PAPER

South Australian Abortion Action Coalition (SAAAC) is a broad coalition of people whose goal is to improve access to abortion in South Australia. Members have diverse backgrounds including women's, LGBTQI and consumer advocacy; health, legal, & social science practitioners; and students, researchers & educators.

SAAAC believes that enabling abortion services to be regulated as a health service like any other, by the removal of all laws relating to abortion from criminal law, will remove many of the current barriers to service provision. SAAAC also recognises the ongoing impact on access, of abortion stigma and protestor activity on consumers and providers, and the necessity for enabling legislation to remove conscientious objection to refer women for abortion, and implementing safe access zones around abortion clinics.

In 1969 South Australia became the first state in Australia to legislate provisions in the Criminal Code for lawful abortion to occur, and subsequently developed and provided services in metropolitan and country hospitals. This legislation remains unchanged since 1969, and like the NT, presents many barriers to best health care. The location of legislation for a commonly required health procedure in criminal law exposes medical practitioners and women to unnecessary risk, or fear, of prosecution for providing or seeking a health care service, and imposes significant limitations on the provision of modern health services that are patient centred and evidence based.

SAAAC welcomes the NT Government review of legislation with the goal of improving women's access to safe termination of pregnancy services.

SAAAC supports repeal from criminal legislation, regulation by health law and national practitioner regulation as the appropriate legal frameworks, supported by professional standards and evidence based guidelines for best practice for termination of pregnancy.

Therefore, SAAAC supports the following in the discussion paper:

broad definition for termination of pregnancy;

recommendation that the decision about location for termination of pregnancy resting with the medical practitioner working within professional standards and guidelines;

public service provision to ensure affordable services for all women

requirement for a medical practitioner with a conscientious objection to termination of pregnancy to refer the woman to a practitioner who does not have such an objection

legislation for safe access zones

service provision on the basis of contemporary best practice informed consent

adoption of the Gillick principle for obtaining consent from young women under the age of 16.

SAAAC makes the following comment in relation to:

Criteria for providing treatment

1. **Opinion of a suitably qualified medical practitioner.** Informed consent of the woman should be the standard for provision. Clinical guidelines support appropriate assessment and where appropriate the involvement of a multidisciplinary team. Requiring opinion of more than one medical practitioner reduces women's agency even further and creates unnecessary hurdles due to:
    a. Availability of a second practitioner
    b. Willingness of practitioners to provide a second opinion
    c. Compromises confidentiality and privacy

2. **Gestation Limits.** Legislation limiting gestation for termination of pregnancy places unnecessary barriers, and pressures on women and providers.

Abortions in the second or third trimester are rare in all states and territories of Australia and in other countries such as the UK. Data from the SA Pregnancy Outcome Unit consistently shows that the majority of abortions (91%) occur within the first 14 weeks, or first trimester of pregnancy[1].Abortions occurring at 20+ weeks gestation account for 2% of all abortions; 50% of these abortions occur for reasons of fetal anomaly[2]. Women require abortions after 20 weeks gestation for the same reasons as first trimester abortions; because they decide they do want to continue with the pregnancy. Australian & overseas studies[3] [4] [5] [6] have identified a number of factors affecting the timing of the decision for abortion:

Symptoms of pregnancy are not clear: Later presentation may occur because pregnancy can go unrecognised by women or fail to be diagnosed by doctors. Some women continue to menstruate in pregnancy. When effective contraception is being used, pregnancy symptoms, may be discounted. Long-acting methods of contraception, such as implants and IUDs suppress menstruation. These may be younger women or menopausal women, women with irregular bleeding or women with medical conditions, which make pregnancy unlikely.
Difficult personal circumstances: Delay in seeking abortion can be due to anxiety about confiding in parents or partner; failure of anticipated emotional or economic support (from family, partner, or employer), or change in socio-economic circumstances. Women experiencing domestic violence, mental or physical health issues, trauma, or addiction also experience barriers in organising care.
Reproductive Coercion: Is recognised as a tool of domestic violence, and includes a range of male partner pregnancy-controlling behaviours; such as contraceptive sabotage, or forcing a woman to continue with an unwanted pregnancy. Usually occurring in the context of relationships violent in other ways3, women can find it extremely difficult and dangerous to access abortion services causing significant delays in presentation.
Difficulty accessing abortion: Some women make a decision to have an abortion earlier in pregnancy but experience delays in access. Some women are given misinformation – sometimes deliberately, about abortion availability. Women living in

rural, regional or remote locations, experience delays because of waiting time for appointments, specialist referral and travel times.
Diagnosis of fetal anomaly occurs later in pregnancy: the timing of screening tests for fetal anomaly and procedures for diagnosis determine the timing for abortion. There is a range of screening tests in the first trimester. Some indicators then require further diagnostic tests but results may not be available until after 14 weeks gestation. If a decision is made to proceed to abortion it is usually then performed in the second trimester. The next screening test is a morphology scan at 19-20 weeks gestation. About 30% of abortions for fetal anomaly are performed at 20+ weeks following the detection of abnormalities on this scan. Further investigations are often required including second ultrasound, genetic testing, fetal MRI and referral to other specialists. Some complex clinical conditions can take even more time to before a confident picture or the safest time for abortion is determined. The Royal Australian & New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recognise special circumstances of late presentation or diagnosis and support the availability of legal abortion without a gestational cut-off so that women and their specialists are able to decide as late as necessary avoiding regret and suffering caused when decisions are made under the pressure of arbitrary limits[7].

3. **Specialist Assessment:** Abortion providers are specialists but not necessarily obstetrician / gynaecologists. General practitioners and medical practitioners with specialist skills in the provision of abortion, provide the majority of abortions in SA[8]. In Victoria, requires consultation of another medical practitioner at gestations of 24 weeks – but does not prescribe a specialist obstetrician/gynaecologist. Whilst in many circumstances an obstetrician gynaecologist will be involved, assessment is most appropriately provided by the woman's specialist multidisciplinary team, and the decision to proceed based on fully informed consent by the woman herself. This approach is consistent with allowing services to be guided by professional standards and best practice guidelines and contributes to accessible and timely service provision.

4. **Assessment:** Allowing for developments in technology the removal of any requirement for 'examination' is critical in ensuring interpretation does not present an access barrier.

The report of the Victorian Law Reform Commission recognised the complexities of late termination of pregnancy and the importance of a modern law ensuring accessibility to the small numbers of women requiring these procedures[9].

Suitably qualified medical practitioner

Health care services following professional standards and best practice guidelines develop models of practice for safe and appropriate care for their consumers. Limits of the profession of the service provider can inhibit service development. Specialist nurses now provide many services once only provided by medical practitioners and safely provide termination of pregnancy and other fertility control services internationally[10, 11]. The development of the nurses' role in the delivery of termination of pregnancy services has been limited in Australian due to legislation prohibiting it.

All registered health care practitioners must meet the standards of their profession. Legislation which refers to appropriately qualified, or credentialed practitioners will enable development of the role nurses and midwives in abortion service provision in Australia.

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Submission #131



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30 January 2017

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Department of Health
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Dear Minister

Submission on termination of pregnancy law reform

Australian Lawyers for Human Rights ("**ALHR**") thanks you for your invitation to comment on the proposed changes to legislation governing termination of pregnancy in the Northern Territory.

ALHR was established in 1993 and is a national organisation of Australian solicitors, barristers, academics, judicial officers and law students who practise and promote international human rights law in Australia. ALHR has active and engaged National, State and Territory committees and a secretariat at La Trobe University Law School in Melbourne. Through advocacy, media engagement, education, networking, research and training, ALHR promotes, practices and protects universally accepted standards of human rights throughout Australia and overseas.

We make the following observations in response to the Department of Health's discussion paper issued in December 2016.

1. Summary

1.1 ALHR strongly supports the government's proposal to:
- repeal section 11 of the *Medical Services Act*;
- introduce a new Act regarding abortion; and
- amend the *Criminal Code Act*.

1.2 The existing legislative framework governing abortion in the Northern Territory makes an abortion a criminal offence except in very limited circumstances, as specified in the *Medical Services Act*. The effect of these laws is that many women are prevented from seeking early termination of unwanted pregnancies. The requirement for abortions to occur in a hospital in practical terms prevents women from accessing a medical termination, such as the drug RU486, as an additional option to surgical termination.

1.3 ALHR supports reforms that uphold sexual and reproductive health rights, and allow women and girls autonomy over their own bodies and health. In response to the discussion paper, ALHR specifically supports:
- broadening the circumstances in which abortion services can be provided;
- enabling women's access to medical termination, such as through RU486;
- the creation of safe access zones;
- enabling girls under the age 18, who have sufficient capacity, providing their consent to an abortion, without the requirement for consent necessarily defaulting to an adult; and
- thorough consideration of the remoteness of the Northern Territory and accessibility of services for Aboriginal women in the development of any guidelines in support of the new legislation.

1.4 ALHR endorses the Human Rights Law Centre's submissions on the discussion paper dated 18 January 2017.

1.5 UN Human Rights Bodies have provided States with clear guidance on when there is a need to decriminialise abortion and have emphasised that ensuring access to safe and legal abortion services in accordance with human rights standards is part of State obligations to eliminate discrimination against women and girls and ensure their right to health as well as other fundamental human rights.

2. International Human Rights Law

2.1 The United Nations Human Rights Committee has stated that the denial of access to safe and legal abortion is a breach of the fundamental human rights of women and girls, specifically under several articles of the *International Covenant on Civil and Political Rights* ("**ICCPR**")[1] including the right to an effective remedy, prohibition on torture and cruel, inhuman and degrading treatment, right to private life and right of minors to measures of protection.

2.2 The Committee on the Elimination of Discrimination Against Women has specified that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women".[2] The Committee has also more recently requested that States "remove punitive measures for women who undergo abortion" and has stated that the criminalisation of practitioners who provide abortion services also violates women's rights.[3]

2.3 Similarly, the Special Rapporteur on the right to health has argued that laws criminalising abortion "infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health". The Rapporteur has called on States to decriminalise abortion.[4]

2.4 The United Nations Committee on Economic, Social and Cultural Rights has also established that the right to health – which comprises reproductive and sexual health –

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

2 Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health*, A/54/38/Rev 1 (1999) [11].

3 Concluding Observations on Peru, CEDAW/C/PER/CO/7-8 (2014), para. 36; Statement on sexual and reproductive health and rights: Beyond 2014 ICPD Review (2014).

4 UN Secretary-General, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/66/254 (2011), para. 21.

requires health services, including legal abortion services, which are available, accessible, acceptable and of good quality.[5]

2.5 The Committee on the Rights of the Child has recommended that "States ensure access to safe abortion and post abortion care services irrespective of whether abortion itself is legal".[6]

2.6 There is significant and consistent domestic and international jurisprudence that establishes that the right to life is not inconsistent with the provision of abortion services. Indeed, the view of the Australian Government is that the right to life under the ICCPR was "not intended to protect life from the point of conception but only from the point of birth".[7]

3. Criteria for providing treatment

3.1 ALHR notes the proposal in the discussion paper that an abortion may be performed where each of the following criteria is met:

- informed consent is given by the woman (or other appropriate person in law);
- information and counselling are provided about current choices and future contraceptive options;
- consideration has been given to all relevant clinical and psycho-social matters including the woman's current and future physical, psychological and social circumstances regardless of gestation; and
- decision making is based on a holistic assessment of the woman involving formation of an opinion by:
  - one suitably qualified medical practitioner for gestations of not more than 14 weeks; and
  - two suitably qualified medical practitioners for gestations of more than 14 weeks and up to but not more than 23 weeks, where an obstetrician or gynaecologist is recommended as one of the two suitably qualified medical practitioners.

3.2 ALHR has the following concerns about this proposal, outlined below:

- it does not give proper effect to the woman's choice;
- mandated counselling is redundant and, in some cases, inappropriate; and
- specifying criteria for termination according to different gestation periods is arbitrary, and fails to consider the circumstances of each case.

3.3 The requirement for medical practitioners to consider psychosocial matters and complete a holistic assessment is not problematic in itself, but when such an assessment empowers a practitioner to effectively override a woman's wishes, it is not supported by ALHR. The proposed decision making process by a practitioner usurps a woman's decision making capacity. Allowing practitioners to have a right of veto in respect of a woman's choice to terminate undermines a women's right to make a decision about her own body. Interference with these rights should – as is the case with any proposed limitation on a human right – be contextual and proportionate. It is a disproportionate limitation on the human rights of the woman concerned to allow such an interference on the basis of satisfaction of psychosocial criteria as assessed by another person or persons.

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5 General Comment 14 (2000) on the right to the highest attainable standard of health, paras. 8, 12. 27.

6 General Comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 70.

7 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.

3.4 ALHR considers the requirements for the approval of up to two medical practitioners, including a specialist, to be excessive. We note that medical practitioners have a duty of care to their patients and are bound by professional medical obligations. Medical practitioners must refer to specialists in certain circumstances, for example for reasons such as level of expertise and complexity of a case. Mandating assessment by two practitioners presents additional hurdles for women – not only is one health professional able to override the choice of the woman, but two, because if either practitioner does not support a woman's desire to terminate her pregnancy, under the proposed legislation their veto will override her wishes.

3.5 ALHR is very concerned that there is no provision for abortion after 23 weeks pregnancy. Therefore as it stands, the current law will continue to apply, which only permits abortion after 23 weeks in order to save a woman's life. Foetal abnormalities account for a small but important proportion of abortion requests. Indeed, modern prenatal diagnosis is predicated on the availability of legal abortion should an abnormality be detected. 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. ALHR strongly supports the Human Rights Law Centre's recommendation that the new laws must therefore allow abortion after 23 weeks in a broad range of circumstances, similar to the *Abortion Law Reform Act 2008* (Vic).

3.6 ALHR submits that there should not be a prescribed approach for different gestation periods. It should be a matter for medical practitioners to assess each case according to its circumstances, best practice and clinical guidelines.

3.7 ALHR recommends that there be no requirement for one or more medical practitioners to approve a woman's choice to have an abortion. If a medical practitioner must approve a woman's choice, that requirement should not apply to gestations under 24 weeks.

3.8 ALHR objects to the proposal concerning mandatory counselling on choices and contraceptive options. Medical practitioners already have a duty to provide advice on current options and risks because informed consent is a requirement of medical treatment. There are also situations where such counselling may be irrelevant and/or inappropriate, for example where a woman has used contraception but it has failed, or where a pregnancy has occurred as a result of rape. Specifically legislating for counselling is redundant. ALHR recommends that this criterion be removed. This approach will also account for possible evolution of the definition of informed consent, as best practice in the medical profession continues to strengthen.

4. Suitably qualified medical practitioner

4.1 ALHR agrees with the proposed definition of suitably qualified medical practitioner as it requires the practitioner to have appropriate knowledge of abortion services without being overly prescriptive. The government should consider referring to the *Therapeutic Goods Administration Act* and the Pharmaceutical Benefits Scheme in the regulations so that suitability can also be established where existing legislation authorises a practitioner to administer abortion-inducing medication.

5. Prescribing, supplying and administering drugs that induce medical termination

5.1 ALHR supports any changes to legislation that protect practitioners and health professionals from criminal charges for lawfully supplying and administering abortion-inducing drugs. This increases safe access to abortion. We support the wording recommended in the discussion paper for a provision authorising the prescription, supply

and administration of termination drugs.

6. Criteria for the most appropriate location of treatment and care

6.1 ALHR proposes that termination both within and outside hospitals be specifically authorised in the new legislation. However, due to the remoteness of the Northern Territory, we recommend against hospitalisation being required for certain gestation periods. Instead, we recommend that the circumstances of the woman and the pregnancy be taken into account so that if it is deemed safe by a suitably qualified medical practitioner, any termination can occur in a non-hospital setting. If the government does not adopt this approach, ALHR would support a legislative presumption that for gestation periods from 24 weeks a hospital setting is preferred, where the presumption can be rebutted after considering the time and cost of travelling to a hospital, the effect of travel on the woman and any risks for the woman if she receives abortion services in a non-hospital setting.

6.2 We note the Australian Medical Association NT's advice that the woman be within two hours of a hospital when she takes medication to terminate a pregnancy. To manage this requirement in a jurisdiction as vast as the Northern Territory, ALHR supports the proposal in the discussion paper requiring practitioners effecting termination to follow professional standards and guidelines. We support the development of these guidelines, as recommended, because this would increase safe access to abortions by providing valid options for women in remote areas.

6.3 ALHR supports the development of plain English and culturally appropriate resources to inform women of available services.

6.4 ALHR supports an evaluation and monitoring strategy, including the collection of data, as this will assist the government to strengthen the proposed framework over time. There should be guidelines regarding the collection of data and privacy, so that only relevant data is collected and women's identities are protected.

7. Provision of services

7.1 All abortion services must be accessible. As previously outlined, geographic accessibility is one component of this. However, consideration must also be given to affordability. ALHR agrees that the Top End Health Service and Central Australia Health Services should retain responsibility for abortion services. Where a woman is permitted by law to have an abortion, cost should not be a barrier to her having one. For these reasons ALHR believes that all abortion services should be publicly available.

8. Conscientious objection

8.1 ALHR supports the provision for persons involved in decision-making about abortion or treatment itself to conscientiously object and be relieved of any duty to terminate a pregnancy. ALHR supports the proposed wording which requires the objecting practitioner to refer to another practitioner who the practitioner knows does not hold the same objection. However, ALHR recommends that a timeframe be specified and that immediate referral is an appropriate timeframe.

8.2 ALHR also endorses the Human Rights Law Centre's recommendation that the law 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. We share their view that such an 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.

9. Safe access zones

9.1 ALHR supports safe access zones around abortion clinics as a way of protecting and promoting human rights and women's safety, and minimising opportunities for antisocial behaviours. This reference to human rights includes the right to non-discrimination (on the basis of gender, property or other status), not be submitted to cruel, inhuman or degrading treatment, privacy, personal autonomy and the highest attainable standard of physical and mental health. ALHR supports a penalty to give greater effect to safe access zone provisions.

10. Informed consent to treatment

10.1 ALHR agrees with informed consent being a criterion for providing treatment, and for the definition of informed consent to be in line with current practice such as the guidelines for obtaining informed consent used by the Health and Community Services Complaints Commission.

10.2 ALHR strongly supports application of the *Gillick* principle so that whether girls under 18 can give informed consent is determined by establishing a certain level of understanding. If this principle is not applied, girls will have to seek consent from their parents or legal guardians to have an abortion. This undermines their ability to make decisions about their own health, and can also put both their mental and physical health at risk.

11. Other

Decriminalisation

11.1 ALHR supports the Human Rights Law Centre's submissions about changes to the *Criminal Code Act*. ALHR agrees that the complete decriminalisation of termination of pregnancy affecting a health professional is important in order to avoid unsafe abortion. We endorse the Human Rights Law Centre's recommendation to:

- repeal sections 170 and 208A-C of the *Criminal Code Act* and replace them with a provision that makes it an offence for an unqualified person (but not the pregnant woman) to perform an abortion; and
- insert *the destruction of a foetus of a pregnant woman other than in the course of a medical procedure* into the definition of "serious harm".

Aboriginal women

11.2 ALHR notes that Aboriginal women are disproportionately affected in accessing health services given the number of Aboriginal women that live in remote and very remote communities vis-à-vis non-Aboriginal women. When developing guidelines to support the new legislative framework, such as guidelines for practitioners, the government must specifically consider the nature of the barriers that Aboriginal women face in accessing services, and work towards minimising the burden of those barriers to Aboriginal women.

Geographic location

11.3 Similarly, when developing guidelines to support the new legislative framework, the government must specifically consider the impact of the guidelines on all women who live in remote areas, and how to eliminate any barriers to them accessing abortion services.

Funding

11.4 To enable reform of abortion legislation, adequate funding needs to be provided to the health portfolio. We note that the new legislation is intended to commence on 1 July

2017. However, the only existing abortion services in the Northern Territory are in Darwin and Alice Springs. There are no services available in Katherine or remote areas and communities. It is critical to ensure that women are not prevented from seeking abortions due to geographical location, unaffordable transport to a hospital, lack of services or long wait times. Implementation of the new legislation will need to be properly resourced.

12. Conclusion

12.1 ALHR welcomes the Northern Territory's decision to review the law on abortion. This is an opportunity for the government to create a strong framework that upholds human rights, respects a woman's right to make decisions about her own health, is in line with evidence-based policy and considers best practice in other jurisdictions, such as Victoria.

12.2 If you would like to discuss any aspect of this submission, please contact ALHR at nt@alhr.org.au.

Yours sincerely

Jackie Antoun, Clare McKenzie and Rachana Rajan
Northern Territory Convenors
Australian Lawyers for Human Rights

Submission #133

To who it May Concern,

I wish to react to the Royal Darwin Hospital intranet announcement on **Termination of pregnancy law reform. The notice stated, "**The Northern Territory Government is seeking to create contemporary legislation for termination of pregnancy that is in line with other jurisdictions, professional guidelines and best practice. This legislation will reflect the advances in available medical services while also acknowledging the unique challenges to clinical care presented by the geographical and population profile of the Northern Territory".

It is quite unfortunate that the medical fraternity and the academia in general are not interrogating the prevailing political position on a question as important as life, death, abortion. Legalisation of abortion is a political decision in our political dispensation where legality is guaranteed by the parliament passing a law. Abortion is therefore not more legitimate than slavery was or female circumcision is in some countries. We do not need to be reminded that Nazi Germany passed laws to provide for extermination of Jews in gas chambers.

It is however the role of science to challenge public opinion or legislation on important issues, particularly where the trajectory contradicts scientific or medical knowledge.

The following are examples of scientific information that remind us that destruction of a foetus is not qualitatively different from killing a person:

1. The foetus has 23 chromosome pairs like the rest of us

2. In time, the foetus grows to adulthood like any other child does

3. Medical imaging technology demonstrates that the foetus is not just a collection of cells till time of delivery, rather in mid and late trimester, modern imaging facilities can show a being with the features that define us as humans including the eyes, limbs, mouth and developed nervous and other bodily systems

4. It has been demonstrated that the foetus can experience pain and respond to several stimuli

5. There is significant association of increased incidence of depression and affective conditions in women following abortion

It is really shameful that a teaching hospital and a bunch of academics consider that the important question in relation to the subject of abortion is "seeking to create contemporary legislation for termination of pregnancy that is in line with other jurisdictions, professional guidelines and best practice". It is this type of pseudo-science that will bring an end to civilization as we know it today.

I would like to research further on the contributions of the Academy of Science in Germany during the Second World War. Certainly if the trust of submissions from German scientists on the Jewish extermination was anchored on creating contemporary legislation for Gas Chamber methods that is in line with other jurisdictions, professional guidelines and best practice and reflect the advances in available medical services while also acknowledging the unique challenges to clinical care presented by the geographical and population profile as it relates to mass killing of other humans, then the German scientific community failed science, humanity and God.

Submission #134 Women's Abortion Action Campaign

Please find below cryptic feedback from **Women's Abortion Action Campaign re the NT TOP Law Reform process** - my apologies that it is actually into the next working day -I was... and to quote an African American trade union activist from the documentary Union Maids....."just tired" (1). To assist the reader...the below comments and/or recommendations are based on on the Discussion Paper for this law reform process...basically each of the headings in the Discussion Paper are utilised below:

Re: repeal provisions which relate to abortion in the NT Criminal Code Act: WAAC completely opposes the mention of what is a very simple medical procedure in any Crimes Act or Criminal Code. WAAC **recommends** the removal of the abortion operation from the NT Criminal Code Act - needing and having an abortion is a health issue, it is **not** a crime no matter at which stage of the pregnancy a woman is seeking a termination. The removal of abortion provisions from Crimes Acts or Criminal Codes in Australian states has been the broad direction for many years albeit with worrying distortions of that process (such as in WA). To retain mention of abortion in the NT Criminal Code **is to maintain discrimination against women at law in the NT as women are the only ones who require access to an abortion.** Issues which arise [and which subsequently impact access to this simple medical procedure] when there is mention of abortion in a Criminal Code are: * confusion regarding the meaning of the wording; * this confusion is played upon by anti-abortion activists and/or anti-abortion doctors as a deliberate strategy to confuse women and their partners/family/friends; * confusion causes delays and in a territory/state of the size which the NT is...any confusion will result in delays in a woman presenting for a termination; * the mention of abortion in the NT Criminal Code will continue to have a deterrent effect upon both male and female trainee doctors as they proceed through their University degrees such that they will **avoid** wanting to know anything about this simple medical procedure - this will in and of itself affect access for NT women - having an abortion is not a crime; therefore this procedure should be removed from the NT Criminal Code - that will have a substantial impact on the thinking of the community. **WAAC recommends:** bring the NT laws into the 21st century - remove any and all mention of abortion from the NT Criminal Code

Re: the current laws in the NTand the difficulties identified in changing the Medical Services Act: WAAC notes the explanation of the difficulties in the Discussion Paper at pages 1-2; WAAC further notes the solution suggested solution to "enact separate legislation specifically dealing with termination of pregnancy" HOWEVER...for the same reasons that WAAC opposes mention of abortion in the NT Criminal Code so also does WAAC oppose separate legislation which specifically [and only] deals with termination of pregnancy. To have separate legislation for this simple medical procedure [when conducted early in a pregnancy] **will assist the anti-abortion forces in the Northern Territory.** Abortion should not be singled out in this way...it is one of many operations which can be conducted in day surgeries safely - to single out this procedure in legislation it will facilitate the targetting of attacks by anti-abortion groups against women and their family and/or partners as they enter clinics. **Abortion should come under generic legislation which governs a range of medical procedures and the conditions under which those procedures can be provided.** There is no case for singling out this simple medical procedure in any area of legislation. **Addressing below the sub-headings in the Discussion Paper:**

Re: definition of TOP: suggested example of a definition is OK;

Re : Criteria for providing treatment - proposal infantilises women: the key criteria for an

abortion to occur is that the woman wants to to either have an operation to terminate her pregnancy or because she is early in her pregnancy and she wishes to first try the chemical method of abortion [aka: mifepristone 'n misoprostol] - **this is not an operation which a woman needs the consent of a doctor for her to be able to have it - it is a service which should be readily available in all states and territories of Australia; WAAC opposes the inclusion of criteria to be met - the inclusion of criteria equals the creation of barriers and/or restrictions on access** - it is offensive for all women, but most especially for NT women, when it is proposed that 1 doctor needs to 'approve'/'agree with' her decision for women who are "not more than 14 weeks pregnant" and, then, a woman will need not one but two doctors to "form an opinion [aka: 'I-agree-with-your-decision-because-you-are-not-capable- of-making-this-decision-without-two-of-us-also-saying-it-is-OK"] -for gestations between 14 wks and up to but not more than 23 wks of pregnancy - this proposal is anti-woman and divorced from the reality of the NT. WAAC notes that the documents announcing the consultation [dated 8th December 2016] states that: This legislation will reflect the advances in available medical services while also acknowledging the unique challenges to clinical care presented by the geographical and population profile of the Northern Territory. The above proposal in the Discussion Paper and the proposed criteria will result in the **de facto placing of restrictions on NT women being able to access this simple medical procedure** - the "criteria for providing treatment" is completely failing to recognise the size of the state; notably there is no mention in the Discussion Paper of some basic factual information such as how many obstetricians or gynaecologists there actually are in the NT; and, most especially, it fails to recognise that many O and G specialists **do not** want to perform abortions. In raising this issue...for some of them...it is about a moral objection to abortion....for others...it is because they know and recognise that a termination of pregnancy can be done well by an appropriately trained general practitioner or a GP who has done some specialisations in the gynae ward of a local public hospital. But, most especially, some O and G specialists know that if one also performs abortions as well as the other range of procedures which they are qualified to perform....issues can arise in your waiting room...if one woman is waiting to have a termination of pregnancy and if there is a woman sitting beside her who has finally been successful in carrying a pregnancy near to full term after many years of treatment for fertility issues....there can be discord in the emotions being lived through out there in the waiting room...it is all about a spectrum of personal lives and experiences which can occur in an Obstetrican or Gynaecologists waiting room...

Other recommendations by WAAC: * that the NT government providing funding for an all options pregnancy counselling and brokerage service run by women for women to cover the entire NT; * that such a service have a budget to assist low income pay for their travel costs; accommodation costs; childcare costs; incidentals costs; to travel to their nearest TOP clinic/service; * that such a service maintain interstate connections with similar services in other states;

* that the state government establish a fund so that all staff in a TOP service can undertake travel overseas and/or interstate to build their links with like minded professionals; * that the NT government provide funding for abortion providers to encourage them to maintain international links in our region with other abortion providers [e.g. in Malaysia, other parts of Asia] and with the abortion providers organisation in the US and/or in the UK; Canada and any other nations.

_____

Footnotes: (1) I can recommend seeing the doco Union Maids - the trade union activist in the doco who said this was relating an anecdote of the early days of the women unionists getting some actual sick leave; as the union organiser, she was asked by a union member: "what do I put on the form?" [when applying for sick leave]. The union organiser said: "...put down jus' tired....just tired" P.S. I ran out of time to make comments from a former abortion provider

perspective - but a lot of thought needs to go into the layout of your clinic; the ambience of it; the importance of having available as reading material a wide range of women's and men's health articles/journals lying around for people to read; flowers at your front desk; friendly people; smiles on people's faces...running an abortion service is not all doom and gloom....it is a right...not a privilege to be able to be treated like a decent human being and not like you have to 'feel thankful' that the service is there... got to get to work...not sure if you'll actually be able to read this.... regards, Marg Kirkby

CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

TERMINATION OF PREGNANCY LAW REFORM

CHILDREN BY CHOICE SUBMISSION ON THE 'TERMINATION OF PREGNANCY LAW REFORM: IMPROVING ACCESS BY NORTHERN TERRITORY WOMEN TO SAFE TERMINATION OF PREGNANCY SERVICES' DISCUSSION PAPER

DECEMBER 2016

ABOUT CHILDREN BY CHOICE

We are a non-profit community organisation providing counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting.

We provide a Queensland-wide telephone counselling, information and referral service to women experiencing unplanned pregnancy. We deliver sexual and reproductive health education sessions in schools and youth centres, and offer training for health and community professionals on unplanned pregnancy options. We advocate on women's sexual and reproductive health issues at a state and federal level, and support access to all options with an unplanned pregnancy, including abortion.

We are the only independent, not-for-profit women's service dedicated to unplanned pregnancy in Australia. As an organisation, we have over 40 years' experience in unplanned pregnancy and reproductive choice. We have supported over 200,000 women during this time with decision-making counselling, accurate information about their options, referrals to health services and community organisations, post-abortion support, and/or financial assistance to access abortion and contraceptive services.

We are a pro-choice, all options, woman-centred service. We support and trust women to make the best decision they can with an unplanned pregnancy, for themselves and their families. Women are the experts in their own lives. Nobody else can know better than the pregnant woman herself what is best for her in her situation.

CONTACT

Kate Marsh

Communications Coordinator

Children by Choice

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07 3357 9933 (ext 3)

COMMENTS

Children by Choice supports the decriminalisation of abortion across all Australian jurisdictions, and welcomes the Northern Territory Government's commitment to revising abortion law in the Territory.

We support the proposed changes to the Territory's abortion law, and commend the Department of Health for their approach to abortion laws which reflect best practice and community expectation.

We are particularly pleased to see the commitment to ensuring access to services for vulnerable Territorians as outlined in the Department of Health's discussion paper, and the responsibility for this aspect of provision being taken on by the Department.

Medical practice in many areas, but particularly relating to the provision of pregnancy termination, has changed considerably since the 1970s, and it is not only appropriate but critical that legislation keeps pace with these developments and does not hinder access to services for Territorians which Australians in other jurisdictions are legally entitled to, such as medication abortion.

Medical professionals are highly regulated through a number of channels and it is our belief that this is sufficient to govern their provision of termination services, without the need for complex and detailed legislative regulation around specific aspects of provision. We are pleased to see this reflected in the Department of Health's discussion paper.

We also welcome the proposal to remove the need for a second medical professional's approval for a termination to be provided prior to 14 weeks gestation, and that the importance of an holistic approach to counselling is emphasised in the discussion paper.

While we would prefer to see the need for a second doctor's approval after 14 weeks waived also under the proposed reforms, we recognise that this is already standard practice for Territorian abortion service provision so trust that it will not be too onerous a burden for those seeking abortion at later gestations to meet. We would emphasise that although no national abortion data exists, we know from South Australian Department of Health statistics that the vast majority - over 90% - of terminations in that jurisdiction are provided before 14 weeks gestation. Women seeking abortion later in pregnancy generally do so because of complex circumstances and it is vital that a range of supports exist for women in these situations to avail themselves of if they choose.

Submission #136

SWOP NT – The Northern Territory Sex Worker Outreach Program - On behalf of;
Northern Territory sex workers' SWOP NT Sex Worker Reference Group (SWRG)
Response to the Northern Territory Government Termination of Pregnancy Law Reform 2017

27-01-2017
Women's Health Strategy Unit
GPO Box 40596
Casuarina NT 0811

Submitted via email directly to: DOH.consultation@nt.gov.au

Primary contact: Natasha Fyles
Secondary contact: Dr Sarah Watson
Phone (08) 8985 8018

Attention: Minister Natasha Fyles
Attorney General; Minister for Health
Leader of Government Business

Dear Minister Fyles

Please accept this submission to the Women's Health Strategy Unit in response to the governments discussion paper - **Termination of Pregnancy Law Reform; Improving access by Northern Territory (Persons) women to safe termination of pregnancy services**

Who Are We?

The Sex Worker Outreach Program, Northern Territory (SWOP NT). SWOP NT is a peer-based health promotion service that engages sex workers, and works with other sex industry stakeholders within the Northern Territory, to encourage workplace safety in accordance with the industry's legal, health & safety requirements. The SWOP project is a member of Scarlet Alliance and is located within (NTAHC) Northern Territory AIDS & Hepatitis Council, Darwin, as a NTAHC program that delivers peer services across the Territory. SWOP's peer-led health promotion, through outreach, advocacy and broader programming, aims to improve sex workers' lives by holistically addressing issues – including human rights.[1]

Sex Workers Are Experts in our own Sexual and Reproductive Health

"The meaningful involvement of affected communities in sexual health responses improves the relevance, acceptability and effectiveness of sexual health programs, and recognises their right to self-determination and participation in decision-making processes that affect their lives."[2]

SWOP NT emphasises that sex workers are well equipped with knowledge of prevention of pregnancy during the provision of sexual services at work. Methods of contraception are chosen to prevent BBV's and STI's and pregnancy and therefore includes frequent condom use. Sex workers are generally well aware of options for termination in each state and territory in Australia but like other persons who seek terminations of pregnancy are not always able to fully access support and or appropriate options that enables the best choice for each individual's circumstances that reside in the Northern Territory.

[1] http://www.ntahc.org.au/programs/sex-worker-outreach-progam-swopnt/sex-worker-rights
[2] https://www.ntahc.org.au/what-we-do/training-and-education/advocacy-health-policy-and-reproductive-sexual-health#accordion-1-2 A PowerPoint and oral presentations from NTAHC - SWOP NT & Care & Support Coordinators/officers & CDC Senior Policy Officer.

As a peer program, SWOP NT is opposed to any regulation that will inhibit sex workers' ability to work safely, and this includes any reduced access to pregnancy termination services required for sex workers workplace health and safety (WHS) or for our private lives.

Sex workers within the SWOP NT program do not support the existing legislation specific to pregnancy termination in the Northern Territory and we welcome long awaited reforms for people seeking holistic and safe termination of pregnancy options. We are adding our direct experience as sex workers as safer sex experts, who may also be affected by condom breakage in our work and our private lives and therefore like other people who fall pregnant, are at times living with an unexpected pregnancy.

Our submission expresses the direct experiences of sex workers working under a two-tiered licencing system within the Northern Territory, including FIFO workers from other states and territories: The current criminalisation of some sex workers in the territory is relevant to SWOP NTs' response to the governments discussion paper for the termination of pregnancy reforms as the Northern Territory licencing of the sex industry has detrimental impacts on sex workers' privacy and compounds stigma and discrimination against sex workers as some sex workers are able to work legally and others are by default criminalised.

What happens when some aspects of sex workers WHS and Public health are criminalised?

SWOP NT states that a system that deviates from decriminalisation, for example by over-regulating with specialised licencing constraints, creates a two-tiered system where some persons are able to choose freely and others are not.

Criminalization increases vulnerability to blood borne viruses (BBVs) & sexually transmitted infections (STIs) by fuelling stigma and discrimination. This sets up barriers preventing sex workers' free access to sexual & reproductive health services, safer sex prophylactics and educational support networks, as provided by SWOP NT.

SWOP NT, as a primary harm reduction service, argues that removing penalties for example sex work ensure there are less barriers to workplace health and safety. Sex workers WHS must include appropriate options for "safer abortion" as decriminalisation of both sex work and abortion leads to the reduction of stigma and discrimination, and opens doors for access to wider services, achieving better outcomes for not just sex workers but generally for positive public health.

We know from sex workers' direct experience in the Northern Territory and as FIFO workers, that:

- Sex workers are diverse in gender - women and transmen work in the sex industry. Stigma and discrimination against sex workers seeking abortion services is not uncommon as the questions in relation to partners support in pre counselling triggers workers who will not disclose that a condom had broken with a client due to judgement in the assessment process. Multiple stigma is increased for Transmen, Brotherboys, Queer and or Intersex workers who have expressed great difficulty when attending abortion assessments and or clinics to undergo surgical abortion.

  "People who may need access to safe abortion services are not only cis-women. [i]Trans-men, gender queer and gender-non-conforming persons, as well as others of diverse gender identity who do not identify as women, can and do get pregnant.[3] It is therefore not only cis-women and girls who over the course of their lives may need and/or seek an abortion. [4]Individuals of diverse gender identity, however, face extensive challenges in accessing safe abortion information and

[3] Kelleway Mitch (2014), *STUDY: Yes, Trans Men Can Get Pregnant Despite Testosterone, Dysphoria.*
[4] Rankin, Laura (2013), *Not Everyone Who Has an Abortion is a Woman – How to Frame the Abortion Rights Issue*.

services, a result not only of the stigma surrounding abortion itself, but additional barriers they face in realizing their sexual and reproductive health and rights (SRHR)" [5]

- Sex workers who are diligent at work with use of condoms who choose to undergo surgical termination due to breakages and or who have chosen not to use contraception with a sexual partner outside of work are then judged for their occupation. Clinical staff in other states have asked sex workers questions in counselling and assessment process's that have assumed that pregnant sex workers had not used condoms at work.

  One worker from SWRG, Poppy, states: **"I was made to feel ashamed of my work as a sex worker because I disclosed my choice of work and because I chose to have a surgical termination. The reality was that I have a partner and at that time in our lives my pregnancy was not possible due to many factors, but none were related to my work. I paid out a significant amount of money to travel interstate and I did leave the decision to terminate my pregnancy quiet late as I wanted to be sure I made the best decision for myself"**

- Sex work is at times undertaken by young people. Young people who sell sex are particularly at risk with multiple issues that includes barriers to service provision due to fear of mandatory reporting. A recent Policy Brief by Sex Workers from The Asia Pacific region raises and addresses Reproductive Health barriers for young people and youth who seek pregnancy termination services.

  [ii]**The Global Network of Sex Worker Projects (NSWP) states in the 2016 policy brief as part of the; "Recommendations for policy makers:**

  - **Implement comprehensive, accessible, and affordable SRH services and information for young people under 18. This must include HIV prevention and treatment, harm reduction supplies and information, abortion and maternal care"**

  "Age of consent legislation and parental consent requirements for access to sexual health examinations, harm reduction commodities, HIV testing, and abortion services, also create barriers to accessing services, as most young people do not want to disclose their activities to their parents" [6]

- Sex workers who are survivors of sexual assault 'who work illegally are fearful of reporting the assault. SWOP NT has at times not found out that a worker needed assistance until they were ready to disclose that they had survived a sexual assault. Often the period of time is post the recommended time period for safe use allocated for the morning after pill" from Clinic 34 and often the outcome is that the worker needs to travel away for safer options than is currently offered in the Northern Territory for termination if determined by the worker as an unwanted pregnancy.

[5] http://www.september28.org/how-does-abortion-stigma-work/ http://www.september28.org/wp-content/uploads/downloads/2015/09/Infog-7-factsheet-1.pdf ...
[6] http://www.nswp.org/sites/nswp.org/files/Policy%20Brief%20Young%20Sex%20Workers%20-%20NSWP,%202016.pdf

- Northern Territory sex workers have travelled interstate to receive treatment options for unwanted pregnancy for lack of options and in relation to not disclosing sex work or working in criminalised environments. The level of stigma and discrimination that sex workers report to SWOP in relation to health service providers is unacceptable. Inappropriate questions based on stigma and discrimination, judgements of where and how a sex worker works is unfortunately very common.

- Stigma and discrimination affects sex workers lives daily as many sex workers have not disclosed to any other person but another sex worker, agency owner, or sex worker only organisation that they are working in the industry. This level of fear creates a reluctance to access public health professionals especially if the worker is working under a criminalised system, which we have in place in the Northern Territory.

- **These reforms outlined in the discussion paper from the government and the recommendations from public submissions will mean people who require access to abortions outside hospital settings are able to choose to do so in privacy. For sex workers who already are challenged by criminality, geographic locations, cultural and socioeconomic constraints, internalised stigma and external stigma and discrimination the changes that allow for better physical and mental health outcomes such as being able to access RU486 mifepristone for medical abortion is vital. In 2015 RU486 has been approved to access over the phone in other Australian jurisdictions.** [7]

- Sex workers are a cross section of our society they are daughters, sisters, mothers, fathers, brothers, and sons who all may at some point require a termination of pregnancy the LGBTI and sex worker communities must be a part of the voices of people who seek support of Pregnancy termination services.

"According to Medicare, 44 men had abortions or D & Cs in Australia last year. Official statistics on how many had abortions are unclear because Medicare uses the same item code for abortion and D & Cs in the event of a woman having a miscarriage" ……. Statistics for the Northern Territory were documented as **"No men gave birth to babies in the Northern Territory."** [8]

SWOP NT has documented that sex workers travel interstate for termination of pregnancy and therefore questions based on gender diverse sex workers experiences if the statistics from Medicare for the Northern Territory are unable to determine if transmen or Brotherboys or persons who are Intersex travelled interstate seeking termination of pregnancy due to our current legislation.

Decriminalisation is the best practice model of regulation

Sex workers are acutely aware of the damage that any criminalisation has on the health of Australia's population. SWOP NT agrees with the proposed reforms as detailed in the paper, including:

[7] http://www.abc.net.au/news/2015-09-28/medical-abortion-drugs-now-available-over-the-phone/6810124

[8] http://www.dailytelegraph.com.au/news/nsw/pregnant-men-new-statistics-reveal-men-have-given-birth-to-54-babies-in-australia/news-story/ed8a56f4b906d20a4093c82562173c8e ….

1. Decriminalisation of abortion
2. Providing a definition for 'termination of pregnancy' which clearly permits the use of medicine such as RU486 and clearly permits terminations outside of hospital settings
3. Ensuring people who seek support for termination options are provided with supportive care from health professionals about future contraceptive options
4. The provision of a 'suitably qualified medical practitioner', not just a specialist, be able to provide terminations of pregnancy
5. Provision for health professionals such as pharmacists and nurses to dispense and administer medications under the supervision of a doctor
6. Removing the requirement for two doctors to examine a person who is seeking an abortion under 14 weeks' gestation
7. Removing the need for a person to justify the reason they seek an abortion
8. Enabling young people and minors to have access to consensual to treatment
9. Requiring doctors with a conscientious objection to refer a patient to another doctor who can assist
10. Establishing safe access zones around places where terminations are performed.

SWOP NT seeks that the following be additionally implemented:

1. A person who is pregnant be permitted to terminate a pregnancy after 14 weeks if they are assessed by two suitably qualified medical practitioners that it is appropriate in all the circumstances, noting that some foetal abnormalities are detected late in a pregnancy.

2. SWOP NT considers that the Act should make allowances for a person who seeks health services to not have to undergo mandatory counselling about future contraception before or after they have had an abortion. Doctors already owe a duty of care under the relevant clinical guidelines to provide support, advice and guidance about contraceptive options and sex workers are able to contact SWOP NT for appropriate referral to long term referral pathways for sex workers to reputable organisations such as Family Planning and Clinic 34 for reproductive health support under clinical care.

3. SWOP additionally recommends that the drafting of legislation be "inclusive not exclusive in use of language and terminology in relation to preferred gender pronouns" and that the terminology for persons that can become pregnant and should be able to access safer pregnancy termination options be broader than current terminology limited to "Cis-gendered women and girls" within the discussion paper.

<u>Conclusion</u>

On behalf of Northern Territory sex workers SWOP NT wishes to thank the Northern Territory government for the opportunity to submit our voices as sex workers to add to public consultation comments on the government's discussion paper to pursue the government's commitment to putting in place urgent reform of the Northern Territory Medical Services Act.

SWOP NT endorses the Family Planning Welfare Association of NT and the WHAT RU4 NT? Submissions in full.

We in sincerity ask the government to pass legislation that does not discriminate against people who seek abortion including sex workers who work legally or illegally and follow the guidance of people who live in the Northern Territory who are "key affected populations" in being able to access with equity holistic abortion services and medical treatment".

SWOP NT refers sex workers to both Clinic 34 and Family Planning NT, these organisations need to be able to offer broader options for people who need support and referrals for pregnancy termination. SWOP NT and the SWRG have faith in the Northern Territories politicians to endorse the World Health Organisations (WHO) internationally ratified policy guidelines that recommend full decriminalisation of access to termination of pregnancy options that represents an important step for holistic reproductive health rights. [9]

Yours sincerely

Leanne Melling - Thurs-Fri
Skye Ozanne - Tues-Wed
SWOP NT Outreach Officers
Sex Workers Outreach Program (SWOP NT)
Work Mobile: 0447022332
Work Landline: 08 8944 7707
Northern Territory AIDS & Hepatitis Council
46 Woods Street, Darwin, 0801
http://www.ntahc.org.au/programs/sex-worker-outreach-progam-swopnt

[i] A "cis-woman," shorthand for "cis-sexual woman" or "cis-gender woman," is a woman whose assigned gender is female, and whose assigned female gender is more or less consistent with her personal sense of self. Definition borrowed from About.com Civil Liberties

[ii] http://www.nswp.org/sites/nswp.org/files/Policy%20Brief%20Young%20Sex%20Workers%20-%20NSWP,%202016.pdf The overarching term 'young people who sell sex' refers to adolescents under 18 and young adult sex workers up to 29 years of age. This broader definition points to similarities between the experiences of those under and over 18, as indicated by the large number of studies on young people who sell sex that include persons both under and over 18 years of age.

[9] WHO | Safe abortion: technical and policy guidance for health systems
www.who.int/**reproductivehealth**/publications/un**safe_abortion**/9789241548434/en/
Safe abortion: **technical** and **policy guidance** for **health systems**. ... Authors: **World Health Organization**, **Department** of **Reproductive Health** and **Research**. Publication details. Number of pages: 132. Publication date: **2012**

Submission #137

The Termination of pregnancy law reform is a divisive reform that brings passionate response from both sides of the table. I oppose this reform on the grounds of any abortion being wrong and would like you to take serious consideration to ensure this reform is opened up to a full and comprehensive discussion by a Parliametary Committee before any further decisions are made. This request is made with reference to the election promise by the current Labor Government to ensure Proper Reform to Parliament.

I have attached a link that I believe is worth of a read. And if I may quote a couple of sentences which affirm my believe that any abortion is wrong.

"**It make a degradation of human dignity"** and **"Abortion is not a step forward in women's health. It's a step backward for humanity."**

Our Politicians are entrusted to make laws for the good of all citizens. This is a law reform that will bring further threat and disposability of human life in the name of convenience. Territory women deserve more than this. Territory babies deserve better than this.

Please do the right thing by all Territorians and ensure this reform does not get the 'Fast Track' pathway through Parliament that is currently on the agenda.

Submission #138

Dear Natasha

I am a voting resident of the Northern Territory and I completely disagree with the passing of the RU486 abortion pill.

As our elected politicians, you must know the following:

“Let every person be subject to the governing authorities. For there is no authority except from God, and those authorities that exist have been appointed by God.” Romans 13:1

THE TEN COMMANDMENTS:

1. Thou shalt have no other gods before Me
2. Thou shalt not make unto thee any graven image.
3. Thou shalt not take the name of the Lord in vain
4. Remember the Sabbath day to keep it holy
5. Honour thy Father and thy Mother
6. Thou shalt not KILL
7. Thou shalt not commit adultery
8. Thou shalt not steal
9. Thou shalt not bear false witness against thy neighbour
10. Thou shalt not covey. EXODUS 20:1-17

With consideration of the above, I enclose a message from Jesus for your perusal as a law-maker.

It is the sin of abortion which will be the downfall of many nations and for this they will be punished severely.

July 29, 2012fatherofloveandmercy
My dearly beloved daughter the apostasy in the world has God’s children confused about the existence of sin.

Many souls, when they think of Sin, instantly think of the most grevious of sins such as murder.

Sin takes many forms. Sadly because sin has been dismissed as faults or traits it is now deemed to be simply a natural weakness. Many no longer believe in sin.

Abortion, after murder of one's brother, is the greatest form of genocide in the world. Yet it is not only tolerated but laws are brought in by your nations which deem it a necessity.

It is the sin of abortion which will be the downfall of many nations and for this they will be punished severely.

Abortion is a despicable act and it wipes out generations of God's children who cannot defend themselves.

No one will kill a child of God and avoid severe punishment.
The anger of My Father will be witnessed by those nations, who have legalised abortion, during the Chastisement.
They will be wiped out and no compassion shown to them just as they showed no remorse for this mortal sin when they condoned the killing of God's children in the womb.

I call out to those who cunningly try to dismiss abortion as something which is needed to protect the rights of a mother.

Lies are used to camouflage the atrocity of abortion which defies the Law of God.

For this sin, any lawmaker, doctor or any person who contributes in any way to this abominable act, is guilty in the eyes of God and will suffer the punishment which lies ahead.

To those who condone execution I say this.

You, who condemn a man to be killed, are guilty of the same crime he may be guilty of.

You are guilty of murder in this instance and it is a mortal sin. You have not been given the right to take a life. Or to judge. Only I, Jesus Christ, have the right to judge.

Anyone who contributes to the death of a murderer, through the act of execution will suffer in the fire of Hell for eternity, unless they repent.

So many of you believe in the law, an eye for an eye. How misguided you are. Do you not accept My Father's Commandments? Thou shalt not kill.

Thou shalt not kill also applies to those aggressive armies who march into lands which do not belong to them, in order to control.

It applies to armies who shoot and kill innocent souls. All of this is murder. It is against the law of My Father.

Other sins such as greed, lust, speaking ill of others, cheating people out of what is rightfully theirs, revenge and slander all lead to all other sins.

They become acceptable in your world today because your greatest love is for yourselves.
The lie, which you have been forced to swallow by your false teachers, self-gratification, is your path to sin.

You are told that you must spend your time satisfying your hunger for wealth.

You are told that you must look after yourself – that you are the most important person in your life. You must seek out everything to satisfy all your senses. Everyone else comes second.

This leads to greed, selfishness, lust and then you can be enticed to commit mortal sin.

Sin will now be accepted by your nations like never before.

Laws will be introduced which will legalise mortal sin and woe to those of you who object.

Those who will advocate such wickedness will tell you that these laws are to protect the vulnerable when, in fact, all they do is to legalise murder, abortion, same-sex marriage and the idolatry of false gods.

They will condone the persecution of the poor and cast them out onto the streets to make paupers out of them.

They will bring in laws to force you to stop practising your religion. By doing so you will be breaking the law – a sin in their eyes.

As I told you before your world is so full of untruths that good is presented as evil and evil presented as good.

Your world is back to front and, as a result, sin flourishes.
I urge you to go back and study the Ten Commandments. Obey them and live as you are expected to in the eyes of My Father.

Break the Commandments and you sin. Argue that certain sins are okay and you defy My Father.

Obedience to the Laws of God is weak and fragile in the world at this time. Many of God's children have not been told firmly, by My sacred servants, of the consequences of sin.

Tolerance of sin is the greatest sin of all.

Tolerance is a cunning lie planted in the minds of humanity by the king of lies, Satan.

Tolerance is another way of justifying sin to suit man's weakness for succumbing to the temptation of Satan.

Wake up and accept sin for what it is.

Argue amongst each other and defend sin all you like but it will never be acceptable in the eyes of My Father.

To enter Paradise you must be free from sin.

To become free from sin you must repent.

To repent you must first of all accept the Ten Commandments.

Then you must show true remorse.

True remorse can only be felt by those who humble themselves before Me.

Only then can sin be forgiven.

Only then are souls fit to enter My Father's Kingdom.

Your Saviour
Jesus Christ

Submission #140

Hello

For your information

https://www.youtube.com/watch?v=kHNzoZ4oheU
https://www.youtube.com/watch?v=IRDnVSMr5j0

also, the effects of abortion

http://hopeafterabortion.com/?p=109

Submission #143

Dear Politician,

Firstly, I am a mother of two beautiful babies, my son is 21 months old and my daughter is 6 month old and they are an absolute joy to behold.
Secondly, I am an Advocate for human rights for families in the field of Early Childhood. I have a Bachelor in Children's Services and relevant qualifications to work in Early Childhood Programs and I have thoroughly enjoyed working in this field for the past twenty years.

I am a practicing Catholic and God tells us in his Holy Bible "If you love *me*, you will keep my commands" and I would like to name His 6th commandment here, that states "thou shalt not kill" I love Jesus, so I must do what I can to uphold his commandments. God's Holy Word will never return null and void. It's not just because I am a Christian that I completely reject any attempt to have this unsafe abortion pill introduced into the NT but it is because I am a just person who will always stand for the Truth.

I am writing to implore you not to pass legislation in the Northern Territory that would legalize the RU486 abortion pill including any amendments and any changes to increase the timeline limit for surgical abortion.

When, I went for my first scan at six weeks with my daughter, I could see my baby. The sonographer pointed out the baby's arms and legs as they are already budding and how this little miracle already has a heartbeat after 23 days.

From the moment of conception, the unborn baby is already in the world and he or she or they have soul's which are mature from the moment of conception. I was once only six weeks in my own mother's womb and you were too. The only difference between us and any unborn baby is time.

I urge you to please stop and think about the devastating consequences this unsafe RU486 abortion drug will have on each Territorian baby and their future generations to come. There are already too many abortions occurring with surgical abortion and NT Government want to try and greatly increase the number of deaths on these innocents and potentially their mothers too with such a deadly combination of unsafe drugs that are named 'safe' in this one sided

discussion paper. There are so many terrible side effects to using this unsafe RU486 drug, short term and long term.

I and a few colleagues with medical backgrounds had requested a meeting with Michael Gunner but he is on annual leave. The health minister was unable to meet with us due to a busy schedule in the weeks leading up to the submission date, being 27 January, 2017. One would think that the whole process has been 'done and dusted' without any consideration for any other view point. I am starting to wonder if this is a democratic government or a communist one.

As we were brushed off from meeting with key people who have the final word on the unsafe RU486 Abortion Drug, I've now added more vital information to the important discussion points that I implore all of you to read. This is not a run of the mill notice, it's not a notice on business but it is a notice on life or death. Please, think carefully about your decision when you make a stand against or for each life of the unborn whom are voiceless human beings who are helpless and innocent in all of this and that of their mother's who would also suffer the severe side effects of this unsafe drug.

I have now added some information to the bullet points that were to be discussed with either the Chief Minister or the Health Minister.

The layout content to be discussed was:

- The unbiased approach to this discussion paper including the timing- Christmas/School holiday period.
- The strong desire to push this unsafe drug into the NT when it is so demographically different to the rest of Australia; we cannot and must not use a blanket approach. The land mass of the NT occupies about one sixth of Australia's total land mass and is equivalent in size to France, Italy and Spain combined and it is entirely different in socio economic status to the rest of Australia.
- Playing 'Mum & Dad' with the decision to take responsibility and decision away from families of minors.
- The lack of a committee to discuss this ethically with mature discussion and with evidenced based research that would carefully consider the cohort of people in our Territory.
- We should be upholding the gift of life. There are many examples of babies surviving and living a very successful life after being born at 18 weeks in many countries around the world. For Example: UK. Has it been considered to provide the necessary facilities to have this life saving equipment in our own hospitals?

- There has been little if any consultation with Aboriginal and Torres Strait Islander Peoples.

- The Severe Side effects from using RU486;

  There is no information on the severe, life-threatening, or even lethal adverse events, such as infection and sepsis, which can occur in otherwise healthy young women who have used RU486 for medical abortion. 13!17!111!112!114} Clostridium sordellii is an emerging bacterial infection associated with toxic shock and has been associated with the medical abortion deaths in North America and Europe. 11! Since the approval of RU486 in September 2000 *in the US, the FDA has been informed of 8 deaths in North America due to serious infections following medical abortion with RU486. These women died from sepsis (serious infection involving the bloodstream) and seven women were found to involve infection with bacterium, Clostridium sordellii and once case involved infection with Clostridium perfringerns (incomplete abortion, where parts of the baby and placenta remain in the womb). 11!111! In May of 2011, an additional death of a 16 year old Portuguese girl became the first fatality ever reported in the European community due to clostridium sordellii toxic-shock after medical abortion. 12J112JI14J Although patients typically lack a fever, they exhibit rapid pulse, low blood pressure, and very high red and white blood cell counts. 111!114! Clostridium sordellii is present in the vagina in 5% of all women and in up to 29% of women after pregnancy loss. {26} Clostridium sordellii infections as a result of medically induced abortions have a 100% fatality rate. f11JI12!114J*

- There is no mention of infertility from use of this drug. *f11J*

- There are no options mentioned on counseling women or pregnancy support options or adoption (many many parents strongly desire to adopt and there is only a 1% adoption rate in our land of the Northern Territory.

- There is no mention of the special reversal medication against the RU486 Abortion Drug and that it would be available where the RU486 is dispensed. There is actually a website on RU486 reversal with quotes from women who lost their babies and those who saved them. http://abortionpillreversal.com/.http://abortionpillreversal.com/. - see here: https://www.spuc.org.uk/news/videos/new/2015/september/support - pavement - counsellorshttps://www.spuc.org.uk/news/videos/new/2015/september/support-pavement -counsellors

- There is no information provided on the cost to tax payers and society in general with mental health issues following trauma and depression, potential suicide and fatal suicide after using this **pill** as we have researched and read comparative studies that will highlight to you the definite increase of these issues from countries such as Sweden and Denmark (well functioning societies).

- The very important discussion on our freedom of speech has been brushed over.

- The protection and well being of all medical staff has not even been made a very serious item in this discussion paper.

These were the serious issues that I was hoping to have heard and considered carefully by our leaders.

I am the Inclusion Support Program Manager for currently Early Childhood Australia NT Branch (ECANT) (I am currently on maternity leave) where I have worked for the past ten years. ECANT is funded by the federal government to deliver the national Inclusion and Professional Support Program across all of the Northern Territory. This work has taken me out to many communities working with staff and families in Education and Care programs both in urban remote and very remote communities. Locations like Daguragu and Emu Point to name a few.

The demographics of the Northern Territory are so different to anywhere else in Australia. All other States and Territories have already made this dangerous abortion drug legal and we've already had a death of a mother in Australia a few years ago and there are many other severe side effects that have been documented that I know others are documenting in their submissions so I do not need to repeat it here for you. The NT is so different because of the huge numbers of the high population of Indigenous families living in remote and very remote communities. To legalize something that would put a mother's life in danger not only to herself, her family and her community but it is outright murder itself when the Government is aware that there is not adequate health care facilities in these remote areas to deal with the above mentioned side effects and that the with inaccessibility to 24 hour health care assistance as this would need to be face to face support as people with English as a second language would have difficulty describing their hemorrhaging, septic shock and other side effects over the phone. Culturally, there is also the 'shame factor' for indigenous women who may not seek urgent medical attention if required. Also, the disciplines of time and hygiene practices do not yet fully match that of the western culture. Yet, we are actually legally considering an abortion pill that has time line restraints for it to be successful. We are also not culturally inclusive with indigenous culture in relation to hygiene standards. There is an assumed benchmark of hygiene associated with the use of this unsafe RU486 abortion drug that if not followed, can have highly destructive consequences to the mother's immediate health and wellbeing as well as long term psychological implications.

As of 2014, Indigenous people accounted for 3% of the total Australian population with a very high 30% representing the NT population (ABS 2014h). We are also very unique in comparison to other jurisdictions throughout Australia in that 4 out of 5 (80%) Indigenous people in the Northern Territory live in either remote or very remote areas with more than half living in very remote areas. The national birth rate for Indigenous women is higher than for all Australian women. Nationally, in 2013, the total fertility rate for Indigenous women was 2.3 babies per woman, compared with 19 for all women (ABS 2014f).

We should be upholding the gift of life and not offering more methods to take it away. There are great success rates with Mothers and Fathers who can see their baby in the womb, then refusing to terminate the life of their child/ren. A solution to the high incident of abortion rates in the NT would be to introduce a mobile ultrasound unit. *"When the* mother *sees her moving* child, *a bonding takes place."* (Page 11482, Congressional Record- House, Library of Congress US). There is evidence based research that supports this method of supporting parents to rethink the decision of taking the life of their unborn baby and opting to keep the baby or offer the child/ren up for adoption.

A Finland study produced findings that show women are seven times more lightly to commit suicide after abortion. Two studies of the entire population of women in Denmark published in 2012 have shown similar results. The first found that the risk of death following abortion remains higher in each of the first ten years following the

abortion. The second found that the risk of death increases with each abortion, 45% after one abortion, 114% after two abortions, and 192% percent after three or more abortions. (141

These staggering statistics are from two societies that we would deep very functional.

Please click on the following link to hear from a woman who lost her 7 week old baby to RU486.

http://liveaction news.org/ she-took-abortion - pill-then- saw- her-seven-week-old-baby/http://1iveactionnews.org/she-took-abortion-pill-then-saw-her-seven-week-old-baby/

Do we really need even more loss of life that could have been avoided?

I urge you to please strongly consider the above and make the Truthful decision to completely reject this unsafe RU486 Abortion Pill and all the recommendations that accompany this bill from coming into our beautiful part of Australia that is so unique and so different to the rest of Australia.

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Submission #144

ProLife OB|GYNS

AAPLOG American Association of Pro-life Obstetricians & Gynecologists

The American Association of ProLife Obstetricians and Gynecologists, a 2500 member organization, supports offering abortion pill reversal (APR) to women who regret initiating the abortion pill process, after appropriate informed consent. We recently co-sponsored a press conference at the National Press Club supporting APR, and dispute the accusation that this procedure is "junk science." The use of progesterone to counteract mifepristone, a synthetic anti-progesterone steroid, is a logical extension of decades of therapies for pregnancy loss caused by progesterone deficiency. Research studies have shown that use of progesterone reverses the effects of mifepristone blockage, and progesterone has been used safely for decades in pregnant women. Many women are ambivalent about their abortion decision, and there is increasing evidence that many abortions are coerced. These women welcome the opportunity to reverse their initial decision, and should be given accurate information about this process.

Progesterone reversal of mifepristone is an off-label use of an FDA approved drug. Off-label use of FDA approved drugs is legal, and widely prevalent in the USA. *In fact, the most common abortion pill protocols use non-FDA approved doses, and non-FDA approved protocols for pregnancies beyond seven weeks.* It is hypocritical for abortion advocates to criticize off-label use of pharmaceuticals when in fact they are widely engaging in this practice themselves.

It is also inaccurate for abortion advocates to state that 30-50% of babies survive mifepristone. Research studies have demonstrated that the use of mifepristone alone allows for 7% to at the very most 40% initial survival of the mifepristone poisoning, depending on gestational age. Our reversal process has thus far demonstrated better survival that this. Although some babies will survive mifepristone without additional progesterone support, it is scientific common sense to supply the hormone being blocked in order to increase the survival rate of fetuses for women who have changed their mind. We believe there is ample evidence that progesterone markedly improves survival.

A small case series of this new procedure has been reported in the Annals of Pharmacotherapy, a peer-reviewed journal, in December, 2012. As of March 31, 89 babies have been born and dozens more unborn babies are alive following progesterone reversal of mifepristone. Only one minor birth defect, a port-wine stain, has occurred this group thus far; this does not appear related to the mifepristone or progesterone. More than 200 physicians are part of a national network providing this service to women. Outcomes of treatment are reported to the APR project of Culture of Life Family Services, and analyzed by physicians, RNs and a statistician associated with the project. As more women receive this therapy, the results will continue to be reported in the medical literature. And more mothers of newborns will gladly share their gratitude at receiving help in reversing their mistake.

Mary L Davenport, MD, FACOG, Director of Public Policy
Donna J. Harrison M.D. Executive Director
American Association of Pro-Life Obstetricians and Gynecologists

www.aaplog.org Life. It's why we are here.

"When mom changes her mind," Mary L. Davenport, MD, FACOG American Thinker, February 24, 2015
http://www.americanthinker.com/blog/2015/02/when_mom_changes_her_mind_reversing_pill_abortions_in_progress.html

"Wantedness and coercion: key factors in understanding women's mental health after abortion." Marth Shuping, MD, June, 2011, Association for Interdisciplinary Research on Values and Social Change,
http://www.theunchoice.com/articles/howcommoniscoercion.htm

April 1, 2015



Have you ever change your mind about something and wished you could undo what you had done? Did you ever wish you could pull back words out of the air and put them back into your mouth? Did you ever desire to undo the knots and tangles you have placed on your personal relationships?

Many women today find themselves in life and death situations, hoping that they can reverse the effects of the abortion pill, mifepristone, also known as RU-486. These are women who have started the medical abortion process and wish to stop it in order to save the lives of their unborn babies.

The medical abortion process uses two drugs, mifepristone which kills the unborn baby and misoprostol (Cytotec) which is taken 24-48 hours later and causes the uterus to contract to expel the remains of the baby. Reversal is possible if the second drug, misoprostol, is not taken.

Now, there is hope for these women. Abortion Pill Reversal (APR) has helped about 200 women successfully reverse the effects of mifepristone. About 110 healthy babies have been born with the remainder safe and sound, developing in their mothers' wombs.

Progesterone is a hormone that is essential to maintaining a healthy uterine environment for an unborn baby. Mifepristone works as a progesterone receptor blocker, thus negating all the healthy effects of progesterone.

Think of a hormone as a key that turns a lock and allows a door to open. The opening of the door represents the hormone effect in a cell. Mifepristone, being a receptor blocker is like a false key. It fits into the lock but does not turn the lock to open the door; thus, there is no hormone effect while the mifepristone sits in the receptor.

Imagine, now, that instead of just one true key and one false key, you have multiple true keys outnumbering the false keys. That would give the good guys an advantage in the competition to enter the lock. The more times the good keys enter the lock, the better the chances of defeating the false keys.

Progesterone, the hormone of pregnancy is the true key that we administer to outcompete the mifepristone, the false key. Since it is the natural hormone of pregnancy, it is very safe. There are no known birth defects associated with the use of progesterone in pregnancy, according to the US Food and Drug Administration (FDA).

Speaking of birth defects, people often ask if an unborn baby who is exposed to mifepristone might have a risk of birth defects. Fortunately, the medical literature does not suggest that there is an increased birth defects risk with mifepristone. In March 2014, the American College of Obstetrician Gynecologists (ACOG) released a practice bulletin that states that no evidence exists that mifepristone causes birth defects.

A women considering reversing the medical abortion finds us on the web at **www.abortionpillreversal.com**. After reading some introductory material, if she is still interested, she calls our 24/7 hotline and speaks to a specially-trained nurse who can answer all he questions.

If the woman would like to proceed with a reversal, the nurse puts her in contact with a qualified physician in her area. The doctor takes it from there, administering or prescribing the progesterone to counteract the mifepristone.

Dr. Mary Davenport and I have published the first article in the peer-reviewed medical literature in *The Annals of Pharmacotherapy* detailing a case series of reversals. Along with Dr. Matthew Harrison, the associate medical director of APR, we are currently preparing two new articles regarding mifepristone and its reversal.

To see how you can help us in this life-saving mission, visit **www.abortionpillreversal.com**, write to us at **apreversal@gmail.com** or call our administrative line, **(619) 577-0997**.

George Delgado, M.D., F.A.A.F.P. **July 4, 2015**

Progesterone Use to Reverse the Effects of Mifepristone

George Delgado and Mary L Davenport

OBJECTIVE: To present a series of cases demonstrating successful reversal of mifepristone effects in women who chose to reverse the medical abortion process.

CASE REPORTS: Four of 6 women who took mifepristone were able to carry their pregnancies to term after receiving intramuscular progesterone 200 mg.

DISCUSSION: Mifepristone has been available in the US since 2000. By 2008, approximately 25% of abortions prior to 9 weeks were accomplished with mifepristone. Some women who take mifepristone wish to reverse the medical abortion process. Progesterone competes with mifepristone for the progesterone receptor and may reverse the effects of mifepristone. A PubMed literature search from 1996 to May 2012 did not reveal any trials or case studies evaluating the efficacy of progesterone use to reverse the effects of mifepristone.

CONCLUSIONS: Health care professionals should be aware of the possible use of progesterone to reverse mifepristone in women who have begun the medical abortion process by taking mifepristone and then change their minds.

KEY WORDS: medical abortion, mifepristone, progesterone.

Ann Pharmacother 2012;46:xxxx.

Published Online, 27 Nov 2012, *theannals.com*, doi: 10.1345/aph.1R252

Mifepristone has been available in the US as an oral tablet since 2000. It is indicated by the Food and Drug Administration (FDA) for termination of pregnancy up to 49 days after the first day of the last menstrual period. Mifepristone is followed 2 days later by misoprostol to complete the abortion.[1]

The drug's development was hailed as a breakthrough in abortion technology and as an advance for women in facilitating control of their bodies and privacy. By 2008, medical abortion replaced surgical abortion in one-fourth of approximately 800,000 abortions performed annually prior to 9 weeks.[2]

We present a series of patients who took mifepristone to terminate their pregnancies and then sought assistance to block the mifepristone effects. The 2-day gap between the ingestion of mifepristone and misoprostol in the typical abortion regimen potentially affords an opportunity to intervene and reverse the effects of the mifepristone. Six physicians in the US trained in NaProTECHNOLOGY protocols at the Pope Paul VI Institute have given progesterone as an antidote to mifepristone, treating 7 patients. The rationale of the proposed treatment was that higher bioavailable levels of progesterone could competitively inhibit the mifepristone to prevent the induced abortion.

Pharmacology of Mifepristone and Progesterone

Mifepristone was first tested to take advantage of its anti-glucocorticoid properties. It binds with high affinity to glucocorticoid receptors, about 4 times as avidly as dexamethasone.[3] When its antiprogesterone properties were discovered it was considered useful for fertility control because of its potential to counteract the actions of progesterone, which is critical for sustaining pregnancy.[4] Additionally, it has been studied for the treatment of endometriosis, uterine fibroids, and Cushing syndrome.[5-7] Mifepristone's most significant application has been in induced abortion because, by binding to the progesterone receptor, placental failure ensues and the developing embryo loses its nutrition and oxygen supply.

Mifepristone is an orally active compound with a nearly 70% absorption rate, but its bioavailability is reduced to approximately 40% because of the first-pass effect.[8] It binds to the progesterone receptor twice as well as progesterone, in addition to binding to the serum transport protein α_1-acid glycoprotein.[9] Demethylation and hydroxylation are catalyzed by CYP3A4; 3 metabolites retain biologic activity. The half-life of mifepristone is approximately 18-25 hours. Mifepris-

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tone and its metabolites can be measured up to 72 hours after an ingested dose.[10] The half-life of progesterone is longer, approximately 25-55.13 hours.[11-13]

Current Regimens of Medical Abortion

The original FDA-approved regimen of mifepristone and misoprostol paralleled the European protocol that had been used in the 1990s. It consisted of mifepristone 600 mg followed 2 days later by oral misoprostol 400 µg.[14] Later trials evaluated mifepristone 200 mg.[15-18] The FDA and the drug's distributor recommend the 600-mg dose; however, others state that the 200-mg dose has been used in most of 1 million abortions.[19] The success rate of medical abortion decreases with gestational age. In the FDA clinical trials the rate of incomplete abortion was 5% before 49 days and 7-8% at 50-63 days; the rate of an ongoing living embryo ranged from less than 1% before 49 days to 9% at 57-63 days.[14]

Results of Progesterone Therapy

We report on 6 women who were treated with progesterone in an attempt to reverse pregnancy termination after mifepristone ingestion. Four of these women eventually delivered healthy term newborns. A seventh patient was lost to follow-up. Of the 2 abortions, 1 occurred soon after an intramuscular injection of progesterone was administered (patient 6). Data on this patient are incomplete. The other patient (patient 5) received progesterone micronized 200 mg vaginally 7 hours after ingesting mifepristone and receiving progesterone 200 mg intramuscularly 18 hours after mifepristone. However, a live embryo was not documented at the abortion clinic or in the physician's office for this patient.

Case Reports

CASE 1

A 19-year-old woman, gravida (G) 1 para (P) 0, elected to have the mifepristone effects reversed at gestation age 8 weeks. Misoprostol had not been ingested. The initial progesterone dose was 200 mg in oil intramuscularly 30-40 hours following mifepristone ingestion. The progesterone regimen was given 2 consecutive days and then 2 doses every other day, and then twice a week until 9 weeks 5 days.

Progesterone 200 mg in oil intramuscularly was restarted at 11 weeks 2 days and given twice weekly; the dose was then decreased to 100 mg twice a week and stopped at 29 weeks 5 days.

A viable male was delivered at 37 weeks. No untoward effects of progesterone noted and no birth defects were noted. Neonatal complications included neonatal physiologic jaundice and circumcision wound infection.

CASE 2

A 25-year-old woman, G8 P7007, elected to have the mifepristone effects reversed at gestation age 11 weeks. Misoprostol had not been ingested. The initial progesterone dose was 200 mg in oil intramuscularly 72 hours following mifepristone ingestion.

Further progesterone treatment included an intramuscular injection of 200 mg in oil for 2 weeks, then progesterone micronized orally for 5 months. No untoward effects of progesterone were noted.

A viable infant was delivered, with no neonatal complications or birth defects noted.

CASE 3

A 19-year-old woman, G3 P1011, elected to have the mifepristone effects reversed at gestation age 7 weeks. Misoprostol had not been ingested. The initial progesterone dose was 200 mg in oil intramuscularly 36-48 hours following mifepristone ingestion.

Further progesterone treatment included an intramuscular injection of 200 mg in oil 2 more times the first week, then weekly for 5-6 weeks, then 200 mg in oil twice weekly for 2 weeks, then micronized progesterone orally for 5 months. No untoward effects of progesterone were noted.

A viable infant was delivered at 39 weeks 3 days, with no neonatal complications or birth defects noted.

CASE 4

A 20-year-old woman, G1 P0, elected to have the mifepristone effects reversed at gestational age 7 weeks 4 days. Misoprostol had not been ingested. The initial progesterone dose was 200 mg in oil intramuscularly 46 hours following mifepristone ingestion. Further progesterone treatment included an intramuscular injection of 200 mg in oil twice weekly for 19 weeks. No untoward effects of progesterone were noted.

A viable female infant was delivered at 40 weeks 1 day, with no neonatal complications or birth defects noted.

CASE 5

A 21-year-old woman elected to have the mifepristone effects reversed; gestational age was unknown. Misoprostol had not been ingested. The initial progesterone dose was 200 mg in oil (time following mifepristone ingestion unknown). The abortion was completed soon after the progesterone injection.

CASE 6

A 19-year-old woman, G1 P0, elected to have the mifepristone effects reversed at gestational age 7 weeks. Misoprostol had not been ingested. The initial micronized

progesterone oral capsule dose was 200 mg administered intravaginally 7 hours following mifepristone ingestion. Further progesterone treatment included an intramuscular injection of 200 mg 18 hours after ingestion, which was repeated 2 days later. No untoward effects of progesterone were noted.

The abortion was completed 3 days after mifepristone ingestion.

Discussion

The experience of these patients suggests that medical abortion can be arrested by progesterone injection after mifepristone ingestion prior to misoprostol due to the competitive action of progesterone versus mifepristone. Possible confounding factors are the lack of embryocidal and feticidal efficacy of mifepristone with increasing gestational age and the absence of documentation of viable pregnancy before ingestion of mifepristone in some patients. We welcome further clinical trials utilizing this protocol or others, in order to have an evidence basis for the best protocol. We believe that if further trials confirm the success without complications of this or similar protocols, it should become the standard of care for obstetrician-gynecologists, family physicians, and emergency department physicians to attempt mifepristone reversal on patient request.

SUGGESTED PROTOCOL

A rational protocol for treating women who have ingested mifepristone and then wish to continue the pregnancy can be considered. We drew on our experience of successfully treating pregnant women with threatened spontaneous abortion or low serum progesterone levels with intramuscular progesterone using the protocol of Hilgers.[19,20] Progesterone has been studied extensively and appears to be safe during all trimesters of pregnancy.

Table 1. Progesterone Dosing and Ultrasound Time Table[a]

Day	Progesterone 200 mg Intramuscularly	Ultrasound to Confirm Viability
1	X	X
2	X	
3	X	
5	X	
7	X	X
9	X	
11	X	
13	X	X
16[a]	X	

[a]Continue twice per week until the end of the first trimester. At end of the first trimester, the dose should be tapered according to the protocol of Hilgers.[19,20]

Protocol

1. Progesterone 200 mg intramuscularly as soon as possible after ingestion of mifepristone.
2. Transvaginal or transabdominal ultrasound as soon as possible to confirm embryonic or fetal viability (Table 1). If less than 6.5 weeks after last menstrual period, monitor serial human chorionic gonadotropin (HCG) levels. However, HCG levels may not increase at the same rate as those of healthy controls.
3. Repeat progesterone 200 mg intramuscularly daily for 2 more days, then every other day until day 13 after the ingestion of mifepristone.
4. Treat with progesterone 200 mg intramuscularly twice weekly until the end of the first trimester and according to the protocol of Hilgers.[19,20] However, do not decrease the dose until the end of the first trimester.

A primary care physician or emergency medicine physician may not want to continue the protocol once it is initiated. Such physicians may want to be ready to refer the patient to a physician comfortable with progesterone supplementation during pregnancy.

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Conflict of interest: Authors reported none

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Submission #145

27 January 2017

Natasha Fyles
NT Health Minister
NT Parliament
Darwin NT 0800

Ms Fyles

I understand that huge changes to NT abortion laws have been recently proposed and that these changes would remove existing safeguards and allow for serious and detrimental ramifications to women's health.

As a local married Christian mother of four beautiful children, I would like to respond to these proposed changes. This issue is too important to remain silent.

These changes are clearly NOT 'an important step in modernising' medical procedures.

- Removing the safeguard of abortion procedures needing to take place in the safety of a hospital where women can be appropriately cared for.
- Providing the pesticide drug RU486 for use in 'out-of-hospital' settings.
- Removing the right of doctors and nurses and other health professionals to conscientiously object to either provide, or refer, a woman for an abortion.
- Removing the constitutional right to voice concern regarding the ethics of abortion.
- Removing safeguards for women who may be pressured by a partner or family member to have an abortion.

It is the duty of our governments to protect their citizens from potential harm. Offering young women, many of whom live in rural communities a long way from any hospital emergency department, the human pesticide, RU486, puts them in harm's way. RU486 is not as easy method of abortion, requiring multiple visits to a doctor and the administration of two drugs over several days causing powerful contractions endured without an aesthesia.

The prolonged abortion is a lonely, painful experience that takes place away from medical supervision. The remains of the child may be visible to the woman who must then suffer the additional trauma of packaging up the dead foetus for disposal. This must give rise to concern for the woman's ongoing medical health not to mention that bleeding can continue for a further two to three weeks.

This proposed legislation disregards the recent Australian study of over 1000 abortions revealing 1 in every 18 patients who used RU486 had to be re-admitted to hospitals. The study also revealed as many as 33% of women who had second trimester RU486 abortions required surgical intervention. This adds to the cost and the burden of health care in the Territory.

This is an unacceptably high failure rate which puts women's lives in danger, especially NT women in remote communities who use RU486. Remoteness significantly compounds the potential serious ramification of complications.

Pro-choice and pro-life advocates agree that women facing unsupported pregnancies should be offered real support – not a removal of all support, and the supply of a chemical which is harmful to both them and their unborn child.

I would like to see this issue debated much more widely and much more publicly rather than having an issue of this importance in society simply be slipped in during the Christmas/New Year holiday period. If the proponents of these changes are open to debate, then why has it not been advertised more freely and openly? If you believe your position to be correct, why be afraid to hear the other side of the debate?

One thing that should change even if abortion by drug or surgery is still legal in the NT is the availability or non-availability of support offered to women wanting to maintain their pregnancy but needing crisis care to aid them at this sometime difficult and emotional time in their lives. Why would the government provide abortions under the guise of 'family planning' but not assist women who need help – be it financial, housing and counselling support – just to get safely get to the blessed state of delivering a healthy baby – even if they then end up giving up their child for adoption. At least they have chosen the right path and do not have to continue through life as a legal murderer. Money should definitely be set aside by the government to establish and fund safe housing and counselling for pregnant women in crisis.

Our family base our beliefs on the words of Jesus Christ and the Bible. We believe that human life is sacred and that we are created in the image of the Almighty Holy God. I understand this is not everyone's worldview. I do believe however, that elected officials should be listening to the electorate and canvassing views of the other side, maybe the minority opinion. On so many moral issues, our society's standards are sadly declining. You may argue for freedom and liberality but you will never convince me that our society and our families will be better off with these lower standards of morality. You will never convince me that murder in the womb is acceptable. We must call a spade a spade and pretending that abortion at any stage is less criminal and immoral than murder of a child after birth is just pretending. It is delusional to expect that this murderous and government sanctioned undercurrent in our society, even paid for at the hands of an unsuspecting taxpaying public to a certain extent, will not have terrible repercussions. Same sex marriage and abortions and other downward changes do not progress society but re-gress society. Unhealthy sexual relationships and murder serve to add to an increasing mental and physical health burden. Where will it all end?

I urge you to widen this debate and to extend this deadline giving more and more of the public the opportunity to respond and contribute to such an important debate.

I would welcome you to contact me to speak further on this issue.

Thank you for your time in reading and considering this matter.

I look forward to hearing from you.

Yours sincerely