

# INFORMATION PAPER

relating to the

## *Draft Reproductive Health (Access to Terminations) Bill*

Revised pregnancy termination laws  
proposed for Tasmania

March 2013

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## A. Invitation to comment

The Department of Health and Human Services has released for consultation the draft *Reproductive Health (Access to Terminations) Bill* setting out proposed changes to pregnancy termination laws in Tasmania.

Currently, termination laws are contained within the *Criminal Code Act 1924*. Women and doctors who fail to follow specific criteria in that Act face criminal sanctions. This approach is out of step with advances in safe medical practices, community expectations and attitudes towards women and reproductive health. The revised framework for Tasmania removes the threat of criminal sanctions for woman and doctors. The goal is to implement laws that do not impede the delivery of vital reproductive health services and to improve the health and wellbeing outcomes of Tasmanian women.

**The Department invites written comments on the draft Bill.** This paper sets out information on the current law, the need for change and the proposed changes.

The draft Bill, and this paper, can be downloaded from [www.dhhs.tas.gov.au/pophealth/womens\\_health](http://www.dhhs.tas.gov.au/pophealth/womens_health). Hard copies can be obtained by contacting 1800 671 738.

All comments on the draft Bill are welcome – even a short statement indicating your support or otherwise for the revised laws. If you need assistance in making a submission please contact the number above.

Responses from organisations will be published on the Department's website. Responses from individuals will not be published unless the individual requests.

Comments on the draft Bill must be in writing and emailed to [public.health@dhhs.tas.gov.au](mailto:public.health@dhhs.tas.gov.au) or posted to Population Health Equity, GPO Box 125 Hobart, TAS, 7001.

**All responses must be received by 5:00pm Friday 22 March 2013.**

## B. Terminology

### Termination

In this paper, the word 'termination' is used to describe the medical procedures that bring about the end of a woman's pregnancy. Clinical coding uses the words 'abortion' and 'termination' as alternatives, and it is understood the word 'abortion' is often used to refer to the ending of a pregnancy that occurs without medical intervention, while the word 'termination' refers to the procedures performed by medical practitioners. As this paper and the proposed laws are about the latter, the word 'termination' is used in both.

### Reproductive health

The term reproductive health is used in this paper consistent with the meaning given to it by the World Health Organisation:

The World Health Organisation defines *health as a state of complete physical, mental and social wellbeing - and not merely the absence of disease or infirmity.*

*Reproductive health addresses the reproductive processes, functions and system at all stages of life.*

*It therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.*

*Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice.*

*[And, for those continuing a pregnancy] the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant'.<sup>1</sup>*

## C. Current law

### *Current law in Tasmania*

The law regarding pregnancy terminations is currently contained in Tasmania's *Criminal Code Act 1924*.<sup>2</sup>

It is a crime for a woman to have a termination in Tasmania - unless it is 'legally justified'. This means two doctors must decide that continuing the pregnancy would pose a greater risk to the woman's physical or mental health than terminating the pregnancy.

In assessing this risk, each doctor can take into account any matter the doctor considers is relevant. In addition to counselling a woman on the medical risks, the doctor must also refer the woman for counselling on 'other matters relating to terminating a pregnancy and carrying a pregnancy to term'.

A doctor, or any person assisting a doctor in a termination, who fails to follow this framework is guilty of a crime.

At any stage, a woman may be refused treatment, including counselling, if a doctor or counsellor has a 'conscientious objection'.

While ethical codes applying to doctors suggest a referral to another service provider should be made, there is no obligation to do so under the current legislation.

### *The need for change – a summary*

The current law is based on laws of the United Kingdom and Ireland from the 1800's. It fails to recognise: safe medical practices; community standards; and women as competent and conscientious decision makers. There is also uncertainty amongst women and doctors about how the law works in practice.

As a result, women may feel fear and stigma for seeking a termination and doctors may be reluctant to provide the service for fear of criminal sanctions.

As it stands, the law impedes the delivery of termination services which, in turn, negatively affects the health and wellbeing outcomes of Tasmanian women.

<sup>1</sup> [http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)

<sup>2</sup> See sections 134, 135, 164 and 165

## D. The revised framework proposed for Tasmania

Under the revised framework, laws governing access to terminations will be taken out of the *Criminal Code Act 1924* and placed into a new Act, called the *Reproductive Health (Access to Terminations) Act*. This will be a health based Act, not a criminal one. The draft Bill released for consultation contains the proposed wording for the revised laws.

The Bill provides that women and doctors will no longer face the threat of criminal sanctions for terminating a pregnancy.

At or before 24 weeks into the pregnancy,<sup>3</sup> a doctor may perform a termination, like any other medical procedure, on the request and consent of a woman.

After 24 weeks, the current two doctor approval will continue to apply, and a doctor may terminate a pregnancy as long as two doctors (one being a specialist in obstetrics or gynaecology) have certified in writing that the woman's physical or mental health is at greater risk of injury from continuing the pregnancy than from terminating it. This will not apply in emergencies where a termination is necessary to save the life of a pregnant woman or to prevent her serious physical injury.

In determining the risk of injury to a woman's physical or mental health, each doctor can currently take into account any matter he or she considers relevant. Under the new framework the law will provide greater certainty to women and doctors by providing that in assessing this risk doctors must have regard to the current and future physical, psychological, economic and social circumstances of the woman.

Doctors not following the after 24 week framework will risk professional sanctions.

Doctors will still be required to advise the woman of the medical risks of continuing and terminating a pregnancy, however the law will no longer provide that doctors must always refer a woman to counselling on 'other matters'. This is consistent with the legislative approach for all medical procedures and attending counselling will be a private decision for a woman.

Consistent with current laws, no person will be under a duty to perform or assist in a termination if the person objects to terminations on the basis of a conscientious belief – unless it is an emergency and a termination is necessary to save the life of a pregnant woman or to prevent her serious physical injury - in which case there is a duty to treat. The Bill sets out this duty for doctors and nurses.

Doctors and counsellors holding a conscientious objection to terminations will now be required to refer a woman who seeks a termination, or counselling in relation to pregnancy options, to a service provider who does not hold such an objection (unless an emergency as above). Failure to so may result in a fine.

If a person supplies a woman with medicines that can cause a termination, and the person is not lawfully permitted to supply those medicines, the person is guilty of an offence, under laws regulating the possession and supply of medicines (eg, the *Poisons Act 1971*).

Access zones will be introduced within 150 metres of premises at which termination services are provided. Within an access zone a person must not engage in prohibited behaviour – which includes protesting in relation to terminations, harassing or intimidating a person, filming or threatening them or impeding their access to the premises. Failure to comply may result in a fine and/or a period of imprisonment (up to 12 months).

<sup>3</sup> The length of an average pregnancy is 40 weeks.

Consistent with current laws, it will still be a crime:

- for anyone other than a doctor to terminate a pregnancy
- for a person to terminate a pregnancy without the woman's consent (eg, by assaulting a woman)
- for a person to aid and abet the commission of a crime.

Laws governing consent and substituted decision making, confidentiality, minors, and the regulation of health practitioners and facilities are not affected by the revised framework and current laws regulating these matters will continue to apply

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The revised framework for Tasmania is similar to Victoria's *Abortion Law Reform Act 2008*.

Victoria's Act implements one of the models proposed by the Victorian Law Reform Commission in its *Law of Abortion: Final Report 2008*. That report contains a comprehensive analysis of the elements of termination law. In preparing the report, the Commission considered over 500 submissions and held meetings with 36 groups and individuals.

The report can be found at [www.lawreform.vic.gov.au/inquiries/abortion](http://www.lawreform.vic.gov.au/inquiries/abortion)

The views, research and recommendations contained in the report have been considered in the development of the revised framework proposed for Tasmania.

## E. Why changes to the law are needed

### *The law needs to change to recognise unplanned pregnancies will occur*

Even with comprehensive education programs and increased availability and use of contraception, unplanned pregnancies will still occur for a number of reasons – including as a result sexual assault, lack of communication and support within a relationship, or the failure of contraception.

Contraception is not 100 percent effective 100 percent of the time - even when it is used perfectly (that is, consistently and correctly).

Research published by Marie Stopes International<sup>4</sup> estimates that at any given time just over half of all Australian women of reproductive age (15-44 years) have experienced an unplanned pregnancy.

Another study showed that 60 percent of women experiencing an unplanned pregnancy were using at least one form of contraception when they conceived – with 1 in 5 using more than one form of contraception.<sup>5</sup>

Given that unplanned pregnancies will occur, it is important that laws governing women's options during this time support positive sexual and reproductive health outcomes.

Current criminal laws in Tasmania fall short in this regard.

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<sup>4</sup> Marie Stopes International, *What women want when faced with an unplanned pregnancy*, (2006)

<sup>5</sup> Marie Stopes International, *Real Choices: Women, Contraception and Unplanned Pregnancy*, (2008)

## **The law needs to change because it currently regulates access to terminations under criminal laws**

Current laws governing access to terminations are contained solely within the *Criminal Code Act 1924* which criminalises and regulates access in a way not done for other medical procedures.

The crimes of ‘procuring / aiding in an abortion’ (sections 134 and 135) sit within Chapter 14 of the *Criminal Code Act 1924*. That Chapter is titled ‘Crimes against morality’.

Current laws are based on laws of the United Kingdom of Great Britain and Ireland from over 150 years ago. Section 134 of Tasmania’s *Criminal Code Act 1924* still uses almost the exact wording as section 58 of the *Offences Against the Person Act* of 1861.

That Act provided that a termination was a crime (referred to then as a ‘felony’) and the punishment for a woman was to be “*kept in Penal Servitude for Life or for any Term not less than Three Years,—or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour, and with or without Solitary Confinement*”

Still today, in 2013, Tasmanian law provides that women and doctors who terminate a pregnancy outside a specific legal framework are guilty of a crime that is punishable by up to 21 years in prison.

Criminalising women and doctors for accessing and providing reproductive health services is not an acceptable position in 21<sup>st</sup> century Australia.

The Public Health Association of Australia strongly believes the criminal law is an inappropriate vehicle – both in principle and practice – for regulating the provision of terminations.<sup>6</sup>

The Victorian Law Reform Commission recommended against criminalising women for having a termination and noted that doctors who perform unlawful terminations should be liable to professional rather than criminal sanctions.<sup>7</sup>

Both Victoria and the ACT have decriminalised terminations so that women having a termination need not fear criminal sanctions.

### **Changes to the criminal law in 2001**

In December 2001, the Tasmanian Parliament amended the *Criminal Code Act 1924* by introducing section 164 – which is the current framework that must be followed for a termination to be ‘legally justified’.

Section 164 was intended to clarify the law by providing that terminations were ‘legally justified’ and not a crime when certain criteria were met by the woman and by two doctors.

The goal was to provide certainty to the medical profession in the hope of reactivating services that had virtually ceased after a complaint raised uncertainty for practitioners as to the legality of terminations. As a result, Tasmanian women were travelling to Melbourne in order to access services.

Despite the changes in 2001, the anticipated increase in service delivery has not eventuated and women and doctors continue to be regulated under criminal laws.

<sup>6</sup> Public Health Association of Australia, *Abortion in Australia, Public Health Perspectives, 3<sup>rd</sup> edition, (2005)*

<sup>7</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report, (2008)*

## **The law needs to change because it acts as a barrier to healthcare services**

In practice, there is uncertainty as to the circumstances in which a termination may be legally performed.

In 2004, a survey of doctors across Australia showed that 37 percent of respondents felt they did not fully understand the terminations law in their jurisdiction. Even those claiming familiarity with the law provided incorrect responses, suggesting their perceived and actual understanding of the law was at odds.<sup>8</sup>

Outdated and uncertain laws and the threat of criminal prosecution act as a deterrent to doctors and so impede the provision of a full range of safe, accessible and timely reproductive services for women.

While some termination services are available in Tasmania, they are limited, and access is a particular issue for vulnerable groups, such as those who are young, financially disadvantaged, or living in rural or remote areas.

Terminations are not available through the public health system unless necessary to save a woman's life or due to severe fetal illness. Only one provider is known to provide terminations using medicines. Otherwise, surgical termination services in Tasmania are available only through private clinics – of which there are two providers.

Private providers fill part of the gap in service delivery. However, they are heavily reliant on fly-in / fly-out doctors and operate on a model of day care only and, as such, they do not provide terminations after 12 weeks. Women seeking a termination after this time must travel to another state to seek a safe and legal service.

Accessing termination services in Tasmania before 12 weeks can be difficult if there are waiting lists, if a doctor's flight into the State is late or cancelled, or if there are obstacles in accessing two doctors (one a specialist) to provide the necessary certification. As such, despite best (and early) efforts, a woman may not be able to see a provider prior to 12 weeks – which means she can no longer access the service in Tasmania.

The direct cost of having a termination in Tasmania is around \$300 to \$400. Women who use their Medicare card are refunded \$30.

Costs associated with having a termination increase significantly if women must travel interstate for services - incurring travel costs, accommodation, loss of income and a range of other personal and family impacts.

Support organisations assist financially where possible, however this option is not available to everyone and does not always cover all costs involved.

Women who cannot raise the money required for the procedure and other incidental costs cannot access safe and legal termination services and are then faced with continuing an unplanned and unwanted pregnancy.

The Victorian Law Reform Commission notes that though there are few studies on outcomes for women forced to continue unwanted pregnancies, several have found that such women have poorer psychological outcomes and show more signs of mental illness, emotional stress, guilt and anxiety, than women able to have a termination.<sup>9</sup>

<sup>8</sup> Marie Stopes International-Quantum Market Research, *General Practitioners: Attitudes to Termination*, (2004), (2,495 respondents)

<sup>9</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008), page 39, referencing National Health and Medical Research Council, *An Information Paper on Termination of Pregnancy in Australia*, (1996)



Some studies have also found that poor outcomes extend to the child, who is more likely to have psychiatric problems, poorer social adjustment and school performance.<sup>10</sup>

The proposed framework aims to address these issues by providing clear and certain laws and removing the threat of criminal sanctions for women and doctors.

The goal is to ensure the law does not act as a barrier to services, so that Tasmanian women seeking a termination have access to safe, affordable services with a capacity for timely access in Tasmania.

### **The law needs to change to acknowledge women as capable decision makers**

Good health is essential to leading a productive and fulfilling life, and the right of women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.<sup>11</sup> Decisions about whether to parent and the number and spacing of children impacts on all of a woman's life aspirations – whether for education, work or any form of self determination.<sup>12</sup>

Laws that deny women the final decision on whether to have a termination do not fully recognise women as competent and conscientious decision makers. They prevent women from taking charge of their reproductive lives and from making the best decision for them about whether and when to bear children and enter into parenthood.

Making decisions about an unplanned pregnancy is not separate from the complex web of women's experiences, understandings and feelings about mothering children – but part of it. The decision making process women go through when determining whether or not to continue a pregnancy is the same – only the outcome differs.<sup>13</sup>

Research on the experiences of women terminating a pregnancy note that in deciding to have a termination women make considered decisions based on multiple and contingent factors.<sup>14</sup> Most decisions reflect a woman's considered view that she would be unable to be a good mother to a(nother) child while meeting her existing obligations to herself, her partner, existing children, her parents, or her community.<sup>15</sup>

Women's accounts reveal the complex personal and social contexts within which reproductive events must be understood.

As noted by the Victorian Law Reform Commission,<sup>16</sup> termination is a decision of deep moral significance for many people and the woman herself is the best person to make such a decision.

<sup>10</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008), page 40, referencing Reproductive Choice Australia, and the Australian Reproductive Health Alliance, *RU486/Mifepristone: A Factual Guide to the Issues in the Australian Debate*, (2008)

<sup>11</sup> Fourth World Conference on Women, Beijing Declaration Platform for Action, paragraph 92, (1995)

<sup>12</sup> Leslie Cannold, *The Termination Myth: Feminism, Morality and the Hard Choices Women Make*, (Wesleyan University Press, 1998), page 1, referencing Susan Faludi, *Backlash: The Undeclared War against Women* (Vintage, 1992)

<sup>13</sup> As above

<sup>14</sup> Melbourne School of Population Health, *Understanding Women's Experiences of Unplanned Pregnancy and Termination*, (2009), (examining the experiences of women receiving support from the Pregnancy Advice Service of the Royal Women's Hospital in Victoria; 3,827 women; audit of records and interviews with 60 women)

<sup>15</sup> Reproductive Choice Australia and the Australian Reproductive Health Alliance, *RU486/Mifepristone: A Factual Guide to the Issues in the Australian Debate*, (2008), referencing Bankole, Singh et al, (1998); Cannold (2000)

<sup>16</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008), Chapter 8

## **The law needs to change to recognise that a termination is a safe medical procedure**

There is no medical basis for singling out terminations and regulating access in a different way to other medical procedures.

In the 1800's, there were still significant risks associated with terminations – as for all surgery. In the late 1890's, drugs to induce a termination were being (euphemistically) advertised, though in many cases termination was a secondary effect of the woman poisoning her body with large quantities of drugs.<sup>17</sup>

As scientific methods began to dominate medical practice and technologies were developed to prevent infection, medical care on the whole became much safer and more effective.<sup>18</sup>

New surgical techniques, medications approved for use by the Therapeutic Goods Administration, regulation of service providers and facilities ensure terminations today are low risk medical procedures.

While all surgery and medication carry a degree of risk, in a medical setting where sterile facilities are available, providers are qualified, and appropriate medications are used, termination is a safe procedure for which major complications and death are rare at all gestations.<sup>19</sup>

The risk of illness and death associated with a safe termination is lower than for childbirth.<sup>20</sup> Whilst the risks for both are low, a recent study using US data between 1998 and 2005 found the risk of death associated with childbirth is approximately 14 times higher than for a termination.

Similarly, pregnancy related complications were more common with childbirth than with a termination.<sup>21</sup>

This is not to suggest pregnant women should prefer termination simply because it carries fewer risks than childbirth, rather it demonstrates that a termination is a safe medical option.

### **Terminations do not cause breast cancer or reduce future fertility**

Evidence does not support an association between terminations and an increased risk of breast cancer or infertility or subsequent ectopic pregnancy or placenta praevia.<sup>22</sup> There may be a small increase in risk of subsequent pre-term birth, although there is insufficient evidence to imply causality.<sup>23</sup>

### **Terminations do not cause negative mental health outcomes**

There is no scientific evidence that a termination causes negative mental health outcomes.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists notes that studies suggest there is mainly improvement in psychological wellbeing in the short term after a termination and the overwhelming indication is that legal and voluntary terminations rarely cause immediate or lasting negative psychological consequences in healthy women.<sup>24</sup>

<sup>17</sup> Bird J, *Abortion Techniques in Australia: A History*, Family Planning Information Service, (April 1981)

<sup>18</sup> [http://www.prochoice.org/about\\_abortion/history\\_abortion.html](http://www.prochoice.org/about_abortion/history_abortion.html)

<sup>19</sup> Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Termination*, Evidence-Based Clinical Guideline Number 7, (2011)

<sup>20</sup> Public Health Association of Australia, *Abortion in Australia, Public Health Perspectives*, 3<sup>rd</sup> edition, (2005)

<sup>21</sup> Grimes, D; Raymond E; *The comparative safety of legal induced terminations and childbirth in the United States*, *Obstetrics & Gynecology*, 2012 February (using United States data in 1998-2005); Re complications - citing a study by the Centers for Disease Control and Prevention using data from 1998 to 2001

<sup>22</sup> Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Termination*, Evidence-Based Clinical Guideline Number 7, (2011)

<sup>23</sup> As above

<sup>24</sup> Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals*, (2005)

As such, the decision to attend counselling sits best with the individual woman, rather than being required by law.

While there is no evidence having a termination causes negative mental health outcomes, the American Psychological Association Task Force on Mental Health and Abortion<sup>25</sup> notes that negative psychological responses can occur following a termination as a result of:

- perceptions of stigma, need for secrecy and low social support for the termination decision;
- personality factors such as low self-esteem and use of avoidance and denial coping strategies;
- characteristics of the particular pregnancy, including the extent to which the woman wanted and felt committed to it; or
- a pre-existing history of mental health problems - across studies this is shown as the strongest predictor of post-termination mental health outcomes.<sup>26</sup>

The American Psychological Association notes that many of these same factors also predict negative psychological reactions to other types of stressful life events - including childbirth - and therefore are not uniquely predictive of psychological responses following termination.

While counselling need not be mandatory, it is important that unbiased and non-judgmental counselling services are available for those who choose it.

## The law needs to change to recognise community standards

Most Australians support access to safe and legal terminations.

In May 2012, a survey of Tasmanians found 86 percent of respondents across the State and across ages support termination being treated as a health issue between a woman and her doctor rather than as a criminal matter.<sup>27</sup>

A 2010 survey published in the *Medical Journal of Australia*<sup>28</sup> found that 87 percent of respondents believe that termination should be lawful in the first trimester<sup>29</sup> with a majority also supporting laws that enable women to access termination services after 24 weeks.

The 2005 *Australian Survey of Social Attitudes*<sup>30</sup> found 79 percent of respondents agree or strongly agree that a woman should have the right to choose a termination.

The views of Australian GP's were collected in a 2004 survey by Marie Stopes International<sup>31</sup> and showed:

- 84 percent of respondents believe women should have access to termination services;
- almost 30 percent of Tasmanian GP's feel the law places an unreasonable burden of responsibility on them (Tasmanian GP's were more likely to hold this view than their counterparts in other jurisdictions).

<sup>27</sup> Survey of 1,000 Tasmanians, conducted by Enterprise Marketing and Research Services on behalf of Family Planning Tasmania

<sup>28</sup> de Crespigny, L, et al, *Australian Attitudes to Early and Late Terminations*, Medical Journal of Australia, (2010), (1,500 respondents)

<sup>29</sup> 61 percent unconditionally and 26 percent in certain circumstances

<sup>30</sup> The survey is a major national social survey conducted by researchers from the Australian Demographic and Social Research Institute at the Australian National University (3,902 respondents)

<sup>31</sup> Marie Stopes International-Quantum Market Research, *General Practitioners: Attitudes to Termination*, (2004), (2,495 respondents)

<sup>25</sup> American Psychological Association, *Report of the APA Task Force on Mental Health and Termination*, (2008)

<sup>26</sup> Confirmed recently by the Academy of Medical Royal Colleges, *Induced Termination and Mental Health*, (2012)

Another 2004 study<sup>32</sup> found 77 percent of respondents with religious affiliations support a woman's right to choose, compared to 93 percent of those with no religious affiliations.

Public discussions on terminations can sometimes be dominated by the strongly expressed opinions of well organised and resourced interest groups. The above data indicate that opposition to terminations is a minority viewpoint.

Importantly, the proposed changes to termination laws in Tasmania will not deny a doctor or a woman opposed to terminations the ability to live by their beliefs. Rather, the law will extend that right to all Tasmanian women. In that way, each individual woman is able to make the best decision for her, according to her beliefs and having regard to her individual circumstances.

### To conclude

The current law in Tasmania needs to change:

- so that women can have a termination without fear of criminal sanctions;
- so doctors can provide terminations without fear of criminal sanctions;
- to remove barriers to the provision of accessible, equitable, and quality termination services with a capacity for timely access;
- to balance the existing right of doctors to follow their personal beliefs on termination and (except in an emergency) refuse to treat a woman - with the right of all women to quality and non-judgemental healthcare and to unbiased information from which to make informed choices; and
- to respect and acknowledge women as competent and conscientious decision makers.

The proposed laws for Tasmania accept the limitations of contraception and recognise the widespread public acceptance of fertility control and of the need for termination services. They mark respect for and acknowledgement of a woman's right to make decisions about when and whether to become a parent. They indicate a public health awareness of the costs of dangerous or limited termination services – not only to women but to their existing children, partners, families, health services and society.

## F. Some of the changes explained

### *Different frameworks up to and after 24 weeks*

The revised laws propose to adopt a new framework for terminations at or before 24 weeks gestation, and to keep the current two doctor approval requirement for terminations after 24 weeks.

The length of an average pregnancy is 40 weeks. The decision to place a dividing line at 24 weeks is based on clinical practice and approaches in other jurisdictions.

Up to 24 weeks, the same body of law that regulates access to all other medical procedures will govern access to terminations. It will be a private decision for a woman in consultation with her doctor and such other persons as she may choose. A woman will be the final decision maker as her consent will provide the legal authority for the termination.

After 24 weeks, the existing two doctor approval will remain - that is, two doctors (one being a specialist in obstetrics or gynaecology) must be of the view that the woman's physical or mental health is at greater risk of injury from continuing the pregnancy than terminating it.

<sup>32</sup> Betts, K, *Attitudes to Termination in Australia: 1972 to 2003*, (2004) referred to in *Termination in Australia, Public Health Perspectives*, 3<sup>rd</sup> edition, Public Health Association of Australia, (2005)

In assessing this risk, each doctor can currently take into account any matter he or she chooses. Under the new framework the law will provide greater certainty to women and doctors by providing that in assessing the risk doctors must have regard to the current and future physical, psychological, economic and social circumstances of the woman. These parameters reflect a combination of the approaches in Victoria and New South Wales.

The Royal College of Obstetricians and Gynaecologists<sup>33</sup> notes that terminations become more complex in the presence of advancing gestational age, fetal illness and pre-existing maternal disease.

The Victorian Law Reform Commission<sup>34</sup> notes that in decisions involving complex considerations it is often a matter of good clinical practice to seek the opinion of an additional doctor.

Victoria, in its *Abortion Law Reform Act 2008*, introduced a similar framework in which the approval of two doctors is required for terminations after 24 weeks.

In 2007, a committee of the UK Parliament affirmed 24 weeks as the placement of a dividing line, which has formed part of British law for many years. The House of Commons Science and Technology Committee looked at evidence on scientific and medical developments since the law was last amended in 1990, and concluded there was no justification for lowering the limit.

Placing the line at 24 weeks allows a reasonable time to make decisions after routine screening that generally occurs around 20 weeks.

In this way, the framework recognises that placing the final termination decision with two doctors occurs only for women in the third and final trimester of pregnancy.

It is noted that terminations at a later gestation account for a very small percentage of overall terminations.

### *The obligation to refer*

Under the current law, no person is under a duty to participate in treatment (unless in an emergency) if the person objects to terminations on the basis of a conscientious belief.<sup>35</sup>

It is proposed to retain this right in the new legislation and introduce an obligation for doctors and counsellors who do hold a conscientious objection to refer the patient to a service provider who does not so object.

Such referral is standard clinical practice to ensure continuity of care where a patient has a clinical issue which that provider is unable or unwilling to address for any reason.

Referral obligations exist under the Tasmanian Charter of Health Rights and Responsibilities, the Australian Medical Association Code of Ethics, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Code of Ethical Practice.

The obligation to refer balances the rights of providers to operate within their own personal values with the equally important ethical consideration to act in the best interests of patients and to ensure women receive impartial advice on the full range of pregnancy options. It also ensures individual values do not become institutional or geographic barriers to the timely provision of quality services.

<sup>33</sup> Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Termination, Evidence-Based Clinical Guideline Number 7*, (2011)

<sup>34</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008)

<sup>35</sup> See section 164 of the *Criminal Code Act 1924*

A referral obligation was recommended by the Victorian Law Reform Commission<sup>36</sup> and was adopted for health practitioners in Victoria's *Abortion Law Reform Act 2008*.

### Access zones

It is proposed to introduce access zones within 150 metres of premises at which terminations are provided. Within an access zone a person must not protest or engage in sidewalk interference in relation to terminations, or graphically record, harass, beset, intimidate, interfere with, threaten, hinder, obstruct or impede another person.

The purpose of access zones is to ensure women may access and doctors may provide terminations without fear of intimidation, harassment, obstruction or similar.

Such behaviour jeopardises the safety and wellbeing of the woman, her friends, partners, families, and other support persons, as well as health service providers.

The goal of improving accessible, equitable and timely services in Tasmania would be compromised if a person or group of persons were permitted to harass and impede a woman accessing termination services.

This was recognised as an important issue by the Victorian Law Reform Commission. Across Australia, including Tasmania, no other medical procedure attracts the number and persistence of protesters.

A person engaging in prohibited behaviour in an access zone may face a fine and/or a period of imprisonment of up to 12 months.

<sup>36</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008)

## G. Termination rates

### Estimated termination rates

The majority of terminations performed in Tasmania occur in private clinics and, as such, exact numbers are not available.

Standard national data on terminations is not routinely collected, though estimates have been made at various times using data from South Australia (where comprehensive data is collected and published), Medicare and hospitals.

Whilst Medicare and hospital data has its limitations<sup>37</sup> and precise figures are not available, it has been estimated that the termination rate per 1,000 Australian women aged 15-44 was: in 1985 - 17.9; in 1995 - 21.9; and in 2003 - 19.7.<sup>38</sup>

In South Australia, where comprehensive terminations data is collected and published, the termination rate in 2009 was 15.6 per 1,000 women aged 15-44 years.<sup>39</sup>

In terms of numbers, most commentators put the annual number of terminations across Australia at somewhere between 70,000 and 80,000.<sup>40</sup>

Rates in other developed countries are comparable to Australia's estimates, ranging from 15.1 per 1,000 women aged 15-44 in the United States (2009),<sup>41</sup> 17.1 in England

<sup>37</sup> See Australian Parliamentary Library Research Brief by Pratt, A, et al, *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*, (February 2005)

<sup>38</sup> Chan, A; Sage, L.C; *Estimating Australia's abortion rates 1985-2003*, Medical Journal of Australia, (May 2005)

<sup>39</sup> SA Health, *Pregnancy Outcome in South Australia 2009*, (June 2011)

<sup>40</sup> See Australian Parliamentary Library Research Brief by Pratt, A, et al, *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*, (February 2005)

<sup>41</sup> National Centre for Chronic Disease Prevention and Health Promotion, CDC, *Abortion Surveillance – United States 2009*, (November 2012)

and Wales (2011),<sup>42</sup> and 17.3 in New Zealand (2011)<sup>43</sup>. The global rate was 28 in 2008.<sup>44</sup>

In Australia, in 1970, the number of terminations per live births was estimated at 1 in 4.<sup>45</sup> In 2002, the estimated number of pregnancies ending in a termination was 25 percent.<sup>46</sup> In 2009, approximately 21 percent of reported pregnancies in South Australia ended as terminations.<sup>47</sup> This figure is comparable to Canada, England and Wales, Sweden, New Zealand, and the United States.<sup>48</sup>

Other annual International rates range from 7.7 terminations per 1,000 women aged 15-44 in Germany, to 90 in Eastern Europe. These rates tend to reflect the attitude of each country to comprehensive sexuality education and effective contraception rather than the sexual behaviour of the people who live there.<sup>49</sup>

### **Most terminations occur in the first trimester**

Available evidence suggests that the vast majority of terminations occur during or close to the first trimester and only a very small percentage occur after 20 weeks.

The Australian Institute of Health and Welfare estimates that throughout Australia in 2003-2004, 94.6 percent of terminations occurred before 13 weeks gestation, 4.7 percent occurred between 13 and 20 weeks, and 0.7 percent occurred after 20 weeks.<sup>50</sup>

<sup>42</sup> UK Department of Health, *Abortion Statistics, England and Wales: 2011*, (May 2012)

<sup>43</sup> Statistics New Zealand, *Abortion Statistics: Year ended December 2011*, (June 2012)

<sup>44</sup> Sedgh, G, et al, *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, The Lancet, (2012)

<sup>45</sup> Bird J, *Abortion Techniques in Australia: A History*, Family Planning Information Service, (April 1981)

<sup>46</sup> Chan, A; Sage, L.C; *Estimating Australia's abortion rates 1985-2003*, Medical Journal of Australia, (May 2005)

<sup>47</sup> SA Health, *Pregnancy Outcome in South Australia 2009*, (June 2011)

<sup>48</sup> Chan, A; Sage, L.C; *Estimating Australia's abortion rates 1985-2003*, Medical Journal of Australia, (May 2005)

<sup>49</sup> [http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Abortion\\_in\\_Australia](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Abortion_in_Australia)

<sup>50</sup> As referred to in Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008), Chapter 3

In South Australia, 92 percent of terminations in 2009 were performed within the first 14 weeks of pregnancy and 1.8 percent were performed at or after 20 weeks (54 percent of these were for fetal illness).<sup>51</sup>

A 2009 Melbourne School of Population Health study found 90.1 percent of women in the study presenting to the Pregnancy Advisory Service did so between four and 11 weeks; with 9.3 percent presenting between 12-18 weeks; and 0.6 percent presenting between 19-30 weeks.<sup>52</sup>

The small number of women who terminate a pregnancy after 20 weeks gestation often do so in severe circumstances, such as illness, a diagnosis of fetal illness, sexual assault or other exacerbating circumstances.<sup>53</sup>

Whilst terminations at a later gestation are uncommon, where termination laws are restrictive or termination is widely stigmatised, women might delay seeking a termination, which would impact on the prevalence of terminations at a later gestation.<sup>54</sup>

This can also occur where laws limit the availability of affordable services and women must delay accessing services in order to save enough money to cover the costs associated with proceeding with a termination.

<sup>51</sup> SA Health, *Pregnancy Outcome in South Australia 2009*, (June 2011)

<sup>52</sup> *Understanding Women's Experiences of Unplanned Pregnancy and Abortion*, (2009), Melbourne School of Population Health (3,827 women; 12-month audit of patient records; interviews with 60 women)

<sup>53</sup> [www.childrenbychoice.org.au/info-a-resources/facts-and-figures/18-info-a-resources/facts-and-figures](http://www.childrenbychoice.org.au/info-a-resources/facts-and-figures/18-info-a-resources/facts-and-figures)

<sup>54</sup> Sedgh, G, et al, *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, The Lancet, (2012)

## Termination laws affect service delivery not termination rates

Removing restrictive termination laws does not increase termination rates. A 2007 study by the Guttmacher Institute and the World Health Organisation<sup>55</sup> found that:

- unrestrictive termination laws do not predict a high incidence of terminations; and
- restrictive termination laws are not associated with lower termination rates.

A study published in 2012 by the same author found that terminations continue to occur in measurable numbers in all regions of the world, regardless of the status of termination laws.<sup>56</sup>

This is not to say that the restrictiveness or otherwise of termination laws will not impact on the health and wellbeing of women. Indeed the reverse is true – there is a close association between restrictive termination laws and increased rates of sickness and death in women.<sup>57</sup>

This is because restrictive termination laws, rather than reducing incidences of termination, reduce the delivery of safe and legal services. Studies show that even when termination is a crime or affordable services are not available, women continue to have terminations – though in the absence of safe and legal services they are forced to either travel elsewhere at increased expense, delay and impact, or seek illegal, unregulated and unsafe services at an increased risk to their health and lives.<sup>58,59</sup>

<sup>55</sup> Sedgh, G, et al, *Induced Abortion: Estimated Rates and Trends Worldwide*, The Lancet, (2007)

<sup>56</sup> Sedgh, G, et al, *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, The Lancet, (2012)

<sup>57</sup> Public Health Association of Australia, *Abortion in Australia, Public Health Perspectives, 3<sup>rd</sup> edition*, (2005)

<sup>58</sup> As above, referencing Rahman, Katzive and Henshaw (1998)

<sup>59</sup> The Victorian Law Reform Commission notes that a World Health Organisation study released in 1964 showed Australia had the highest death rate due to terminations among 12 countries studies. In Victoria, illegal termination was among the top four causes of death in pregnancy.

This research suggests that the revised framework proposed for Tasmania will not increase the overall incidence of Tasmanian women having a termination. It is hoped that the changes will enable and encourage increased service delivery within the State, so that Tasmanian women will no longer be required to travel interstate to access safe and legal services.

## Termination rates are affected by the availability and use of contraception

What does affect termination rates is the rate of unplanned pregnancy and the availability and use of contraception. Studies have shown a strong correlation between termination rates and contraceptive use. Rates of unplanned pregnancy and termination decline as contraceptive use increases.<sup>60</sup>

Comprehensive sexual health education, and improved access to and use of contraception are included in a broader sexual and reproductive health strategic framework being developed for Tasmania.

<sup>60</sup> Victorian Law Reform Commission, *Law of Abortion: Final Report*, (2008), referencing Sedgh, G, et al, *Induced Abortion: Estimated Rates and Trends Worldwide*, The Lancet, (2007)



## H. Broader sexual and reproductive health strategy

### *A Tasmanian Sexual and Reproductive Health Strategic Framework*

Improving access to terminations for women in Tasmania is part of a broader strategy to improve the sexual and reproductive health of all Tasmanians, especially vulnerable populations.

Government and the community sector are currently working together to develop a Tasmanian Sexual and Reproductive Health Strategic Framework.

The Framework has a number of priority areas including reducing unplanned pregnancies and increasing access to a full, safe and effective range of reproductive and contraceptive options. Access to contraception that is free or low cost, accessible and available in all areas is important in preventing unplanned pregnancies and sexually transmitted infections.

Sexual and reproductive health isn't just about sexually transmitted infections or disease. It is about a positive and respectful approach to sexuality, sexual relationships and reproductive health that includes physical, mental and social wellbeing. It is also about ensuring the sexual rights of all people are respected, protected and fulfilled.

It is therefore important that people have access to a full range of services including gynaecological and obstetric services, contraceptive options and screening and treatment of sexually transmitted infections.

The promotion of positive sexual and reproductive experiences that are free from violence and discrimination and are accessible to all are critical to improving health outcomes.

### *Young people, sexual health and teenage pregnancy*

Improving the sexual and reproductive health of Tasmania's young people means working to ensure they have access to accurate and timely information that can support them to make decisions about their relationships and sexual and reproductive health.

Young people need access to contraception, access to services and the knowledge and skills to negotiate and navigate their way through adolescence, a time when for many young people they begin to experience sexual activity and relationships.

The goal of the *Sexuality and Relationships Education in Tasmanian Government Schools Strategy 2012-2014* is to support and enable school communities to provide relationships and sexuality education that aims to develop responsible behaviours and attitudes and to provide students with the knowledge, skills and behaviours to make informed decisions.

The Making Choices Two Taskforce has already begun work on a number of strategies to reduce unplanned teenage pregnancy. This includes reviewing the range of clinical services available to young people in secondary colleges, development of a resource for parents to help them talk to their children and young people about relationships and sex (*Talk Soon, Talk Often*), and further resources are being developed to support the delivery of relationships and sexuality education in schools.

There is a strong commitment in Tasmania to improving the information, education and services available to young people so they are able to make informed decisions about pregnancy and parenting.



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