

South Australian Law Reform Institute

BY EMAIL: salri.new.ref@adelaide.edu.au

Submission

Reform of South Australia's Abortion Laws May 2019

Australian Women's Health Network (AWHN) welcomes the opportunity to make a submission to the South Australian Law Reform Institute's review of termination of pregnancy laws.

Summary

AWHN's submission recognizes that South Australia's current laws relating to abortion are outdated and no longer fit for purpose. AWHN supports the decriminalisation of abortion law to give women better or greater reproductive control and the right to autonomy over their bodies.

It is AWHN's position that abortion should be a woman's decision, affordable to all, and accessible regardless of location. Abortion should be provided by appropriately trained health professionals utilising the most up to date, evidence-based methods suited to the particular woman's circumstances. Abortion should be regulated like other health care, not by criminal law.

To achieve this, AWHN supports the following:

- Removing all references to abortion from the criminal law by repeal of Divisions 17 and 18 of the *Criminal Law Consolidation Act 1935 (SA)* (**CLCA**); and
- The establishment of safe access zones of 150m to protect women and health care workers at premises where abortion care is provided.

Submission content co-ordinated and submitted by:

Marilyn Beaumont OAM
National Board Chair
Australian Women's Health Network
Phone: 0419 597 516
Email: marilyn1379@gmail.com

The Australian Women's Health Network (AWHN) provides a national voice for women's health issues, with woman centred analysis of health care models and research. AWHN adopts a social view of health within a health promotion framework, drawing on a variety of interventions with an aim to prevent women's illness, disease and injury, and to

promote women's independence, health and wellbeing. Further information about the organisation can be found on the [AWHN website](#).

AWHN has among its key priority action areas, women's sexual and reproductive health. This submission is informed by this. Of particular relevance, the **AWHN Women and Sexual and Reproductive Health Position Paper 2012 and 2nd Edition 2019 (WS&RH)** can be found on the [AWHN website](#). It states:

A rights-based approach to health recognises women as the experts in their own lives. It recognises that they have the right to self-determination, to privacy, to consent to sex, and to receive comprehensive and understandable information to enable them to make the best decisions about their health in the context of their own lives. Women's reproductive and sexual rights are enshrined in international treaties (Appendix 1) and law which must be upheld Australia-wide.

A rights-based approach to sexual health underpins the World Health Organisation's (WHO) definitions of sexual health and reproductive health (Sexual health, human rights and the law (2015). The Beijing Declaration and its Platform for Action (1995) included the recognition of the human rights of women as integral to the achievement of optimal health and well-being.

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (United Nations, Fourth World Conference on Women, Beijing, 1995, p. 36).

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to which Australia is a signatory, includes the rights of women to "freely choose a spouse and only enter into marriage if 'free and full consent' is given" and "to decide the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (Part IV, Article 16).

To support effective rights-based action on women's sexual and reproductive health in Australia, eight major guiding principles have been developed. AWHN WS&RH paper Appendix 2 is a comprehensive guide to these principles.

The actions recommended by AWHN require implementation and delivery in accordance with these principles:

1. Health action requires respect for the reproductive rights and sexual rights of Australian women.
2. Services must be accessible, responsive and accountable to their clients.
3. Diversity must be acknowledged and supported in health policy and service provision.

4. Sexual and reproductive health initiatives must address the social determinants of health, especially gender.
5. Strategies must build and enhance the capacity of communities.
6. All governmental and private health and related community sectors must work together to achieve high quality sexual and reproductive health outcomes.
7. Effective approaches to sexual and reproductive health must consider the whole person, including their social, emotional, physical and spiritual dimensions.
8. Interventions must be safe, effective and evidence based.

The AWHN WS&RH position paper's recommendations on termination of pregnancy include:

- **Action 16** (page 20): It is recommended that abortion be decriminalised through law reform in those States where abortion still forms part of the criminal code.
- **Action 17** (page 20): It is recommended that access to safe and legal abortion be provided to all Australian women through the public health system and through accessible licensed private providers.
- **Action 18** (page 20): It is recommended that federal, state and territory governments address inequities in abortion service delivery to ensure women living in regional, rural and remote areas have timely access to affordable services.

AWHN members include:

- many organisations and individuals that are active in advocacy for safe and legal termination of pregnancy laws in all Australian jurisdictions. This includes the new legislation to remove abortion from the Crimes Acts and secure safe access zones around termination of pregnancy service provider premises in ACT, Victoria, Tasmania and Queensland. It also includes advocacy in NSW to secure safe access zones and current action to remove abortion from the state Crimes Act.
- many who are in referral agencies for women and their options regarding continuing with a pregnancy or not, or are providers of abortion services.

Much of this experience has been brought together in this submission. We also acknowledge South Australian Abortion Action Coalition's submission.

Submission

AWHN asserts that the regulation of abortion by criminal law creates barriers for women and service providers when accessing and providing contemporary best practice health care. Health care and technologies have changed significantly since the current South Australian law was put in place in 1969. These laws are now outdated. They are restricting women's, particularly rural women's, access to this essential health care service.

The following features of the current law create significant barriers for South Australian women:

- That abortions must be performed in a prescribed hospital;
- That two (2) doctors must examine the woman and certify that she meets the legally specified criteria;
- That there is a 28 week upper gestational limit but the child destruction clause makes for an uncertain gestation limit; and
- That there is a 2-month residency requirement.

The current law creates particular barriers for rural and remote women accessing abortion services. The hospital and the two doctor requirements can be hard to meet in rural and remote locations. As a consequence, nearly 9 out of 10 rural women have to travel to metropolitan Adelaide because they cannot access abortion care from their local doctor or by telemedicine. Aboriginal women are disproportionately resident in rural and remote locations and so disproportionately affected.

Early Medication Abortion (**EMA**) with mifepristone (RU486) and misoprostol has been widely available in Australia since 2013 as an alternative to surgical abortion for pregnancies less than 9 weeks' gestation. The provision of EMA by telemedicine and/or local primary health care services, as is the case in every other jurisdiction in Australia, could improve accessibility for country and Aboriginal women. This is currently obstructed by the law in South Australia.

The residency requirement means that women from interstate locations such as Broken Hill, Alice Springs, Mildura or Darwin, who usually access specialist health services in Adelaide, and those from overseas such as international students who have not been in South Australia for 2 months, cannot access abortion services in this state.

Women who present for a termination when they are past 20 weeks of pregnancy are a small minority of all those who seek an abortion. The current law, regarding the upper limit of pregnancy after which a person can no longer have an abortion, puts unnecessary pressure on their decision-making and can obstruct their access to care. Although clause 8 of section 82A of the CLCA specifies that 28 weeks is the upper limit, advice from SA Health to abortion providing services in recent years has meant that an abortion is only available up to 23 weeks and 6 days. This upper limit not only restricts women's access to appropriate health care but also compromises the care that health professionals can give. It can mean decisions about the pregnancy must be made in haste and without all necessary

diagnostic information, conditions that severely compromise decision making based on informed consent and the delivery of best care.

South Australia's current laws relating to abortion are outdated and no longer fit for purpose. The presence of abortion in SA criminal law has reinforced stigma and shame, and obstructs women's access to advances in abortion care.

Because women in all their diversity require abortions, those who already experience stigma can be more seriously affected by abortion stigma. Delays in accessing treatment due to fear of judgment and delays in diagnosis due to ill-informed assumptions or institutional practices characterise the experiences of those with mental health conditions, disabilities, non-normative sexualities and gender identities and more.

AWHN supports the decriminalisation of abortion law to give women better or greater reproductive control and the right to autonomy over their bodies.

AWHN submits that abortion should be a woman's decision, affordable to all, and accessible regardless of location. Abortion should be provided by appropriately trained health professionals utilising the most up to date, evidence-based methods suited to the particular woman's circumstances. Abortion should be regulated like other health care, not by criminal law.

To achieve this, AWHN supports the following:

- Removing all references to abortion from the criminal law by repeal of Divisions 17 and 18 of the *Criminal Law Consolidation Act 1935 (SA) (CLCA)*; and
- The establishment of safe access zones of 150m to protect women and health care workers at premises where abortion care is provided.

These reforms would enable abortions to be provided on the informed consent of the woman and in the most appropriate location by appropriately trained health professionals in accordance with World Health Organisation (**WHO**) recommendations. Further these reforms would enable best practice abortion care to incorporate technological advances and be guided by medical evidence.

AWHN does not support the enactment of any new criminal offences specifically referencing or related to abortion. AWHN does not support the enactment of any specific legislated regulation in relation to abortion at all, with the exception of the introduction of safe access zones.

Law reform for best practice abortion care

AWHN submits that best practice abortion care is delivered when abortion, at any stage of the pregnancy, is treated as a health procedure.

Despite its currently outdated and restrictive laws, South Australia has excellent specialised abortion services in metropolitan Adelaide which have been described by interstate counterparts as the gold standard model for abortion service delivery.

South Australia is in a unique position compared to other Australian jurisdictions which have decriminalised. It has the experience of nearly fifty years of abortion service delivery in a legislatively regulated context from which to learn. SA is behind the national trend to decriminalise abortion but unlike the process of decriminalisation in ACT, Victoria, Tasmania, the NT and Queensland, SA moves to do so from a position of very good publicly provided services. Because of this experience and community expectation, South Australia should undertake law reform which delivers best practice abortion care now and in the future. It is critical that reform of abortion law in South Australia is 'future proofed', so as not to create restrictive or prescriptive laws that would become outdated or stop technological and medical advances from delivering best practice abortion care. Legislative treatment of abortion as a health care procedure like any other will achieve this and provide safe, effective and efficient provision now and for the future.

RESPONSE TO CONSULTATION QUESTIONS

AWHN makes the following submissions in response to the consultation questions published by SALRI on 2 April 2019.

Role of the Criminal Law: Questions 1 – 4

In response to questions 1, 2, 3 and 4, AWHN submits that no aspect of abortion care should be criminalised. AWHN does not support the enactment of any new criminal offences specifically referencing or related to abortion. No woman should ever be criminally responsible for the termination of her own pregnancy.

AWHN asserts women's rights to make decisions about their own health care and their own bodies. Criminalising health procedures that are accessed only by women and those with female sexual organs discriminates against them on the basis of sex or gender, and infringes their human rights.

AWHN submits that abortion should be treated as a medical procedure and regulated according to the normal standards and practices that govern all other health services, which include specific clinical guidelines for each area of care.

AWHN does not support the enactment of any new criminal offences for abortions not performed by an appropriate health practitioner. AWHN submits that sufficient safeguards against medical procedures being performed by unqualified persons exist under the law currently. All health procedures, practices and services are closely controlled and regulated by government, industry and professional bodies, and breaches are dealt with seriously. In this way, existing health law, regulations, codes of practice, clinical protocols and institutional policies and procedures provide a comprehensive regulatory framework that protects patients, promotes good quality and safety in health care and ensures accountability. There are more than 20 health statutes in South Australia, and nearly 70 Commonwealth statutes, covering virtually every aspect of health, aged and disability care and public health.¹

Assault that results in pregnancy loss

It is important that assaults targeting the fetus, or are reckless as to harming the fetus, be appropriately punished. Assault that results in the loss of a pregnancy or damage to a fetus is an offence under the CLCA, section 24 (serious harm) and section 23 (harm). Harm is defined as any "physical or mental harm (whether temporary or permanent)" and assault causing harm carries a potential imprisonment penalty of 5 – 13 years. Victorian legislation addressed concern that these assaults may not be appropriately punished when reforming their abortion law by explicitly changing the Crimes Act 1958 (Vic) to include the destruction of the fetus in the definition of serious injury; as NSW had previously done.²

¹ For example, see: *Health Care Act 2008*; Medical Practitioner Code of Conduct; Perinatal Practice Guidelines; Hospitals' own codes of conduct and procedures; *Consent to Medical Treatment and Palliative Care Act 1995*; *Therapeutic Goods Act 1989* (Cth); *Good Medical Practice: A Code of Conduct for Doctors in Australia*; *Health Practitioner Regulation National Law (South Australia) Act 2010*.

² Rankin M J, 2013 *The Offence of Child Destruction: Issues for Medical Abortion*, *Sydney Law Review* 35(1), pp1–26.

Who should be permitted to assist in performing terminations: Question 5

In response to Question 5, AWHN submits that health practitioners, registered under the Health Practitioner Regulation Law, including but not only medical practitioners, be permitted to authorise or perform, or assist in performing abortions in South Australia. This should be on the basis of their accredited scope of practice as it is for the provision all other health care procedures.

Expanding provision by registered health practitioners other than doctors is a safe and cost-effective solution to the barriers to access caused by lack of providers, a particular access issue in non-metropolitan settings.³ The WHO provides guidelines for practice to support the development of local practice.⁴

The scope of practice for nurse practitioners, midwives and Aboriginal Health Care Practitioners can be safely expanded to include provision of abortions, but as a future health workforce is unknown, AWHN submits that there should not be legislative constraints limiting flexibility in determining the appropriate providers. Government and the community place their confidence in the regulatory processes of the Australian Health Practitioner Regulation Agency to ensure safe health care provision. Abortion provision should be no different.

Gestational limits and grounds for termination of pregnancy: Questions 6 - 11

In response to Questions 6, 7 and 8, AWHN submits that regulatory specification related to stage of pregnancy is unhelpful in the delivery of best care. It produces outcomes that are contrary to women's best interests and is an unnecessary hindrance to the provision of evidence-based best care by health practitioners.

AWHN does not support any mandatorily regulated gestational limits in relation to the provision of abortion. AWHN supports women being able to access abortion on request at any stage of pregnancy.

The great majority of abortions in South Australia are performed in the first trimester (<14 weeks) – 90% in 2016. In that year 2.8% of all abortions were performed at 20 weeks or more. Half of these abortions were performed for reasons of fetal abnormality, and the remaining half for reasons of maternal and mental health, including some for reasons of specific medical conditions but most in this half for reasons of mental health. As explained above, these are performed only up to 23 weeks and 6 days.

The factors that lead women to make the decision to seek to end their pregnancy at 20 weeks or later are often distressing and traumatic. It can be presumed that women who

³ Doran F, Nancarrow S. *Barriers and facilitators of access to first trimester abortion services for women in the developed work: a systematic review*, *Journal of Family Planning and Reproductive Health Care*, Vol 41, 170-180. Accessed at: <https://srh.bmj.com/content/41/3/170.info>

⁴ For example: World Health Organisation Guidelines https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf?sequence=1; Barnard S, Kim C, Park Min H, Ngo Thoai D. *Doctors or mid-level providers for abortion*. *Cochrane Database of Systematic Review* 2015 (7):CD011242. Accessed at: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011242.pub2/full>

seek an abortion for reasons of fetal abnormality, make this decision about a pregnancy that was wanted. Some diagnostic tests cannot be made until after 20 weeks, some need further investigation to produce a conclusive result. In some cases, system failure leads to late diagnosis of problems – for example, poor access to health care for women in rural, regional and remote areas leads to delayed access to tests. Some women, and their doctors, will not recognise their pregnancy until 20 weeks or later, due to youth, or irregular menstrual bleeding or menopausal symptoms. While relatively rare, some women will seek an abortion at 20 weeks or later due to illness or injury, or diagnosis of a serious condition like cancer or unanticipated deterioration in an existing health condition.

Women who seek abortions at 20 weeks or later on the grounds of their mental health will most often be women whose control over their own life circumstances is severely limited. This includes women who experience reproductive coercion, a recognised form of domestic violence, who may have been prevented from seeking an abortion earlier, who have serious drug and alcohol issues, or serious mental health conditions, or who are homeless and/or otherwise isolated from medical and institutional supports in general, or who experience the unanticipated loss of a partner. There are a small group of women seeking an abortion at 20 weeks or later who are given misinformation, sometimes intentionally, about access to abortion. These life circumstances are far from consistent with the idea that women who seek abortions after the first trimester have ‘needlessly’ delayed the timing of their decision or their access to appropriate health care. In these circumstances mandatorily regulated gestational limits in relation to the provision of abortion are contrary to women’s best interests.

In these diverse and nearly always difficult contexts mandated gestational limits put pressure on the decision-making process of the woman, couple or family whose lives are at the centre of the matter. When a pregnancy is diagnosed late, or tests indicate fetal abnormality only at the end of the second trimester, she may have to decide the fate of her pregnancy, and so her own future and that of her family, in a very short space of time. In this context mandated gestational limits also put pressure on health care providers whose obligation to provide best care, in the form of conclusive diagnosis or supportive women-centred counselling, is compromised by a regulatory regime that forecloses options for reasons other than the patient’s informed consent. When mandated gestational limits mean that a woman’s options will shortly cease, or that her health care providers’ actions will become impossible, a woman may choose an abortion when further tests or access to counselling or simply more time would lead her to decide to continue the pregnancy.

The status of the fetus can and will be considered in women’s decision-making and the willingness of health care providers to perform abortions but this is a matter for which there are no clear clinical or ethical parameters. There are diverse views about the status of the fetus in relation to the woman in whose body it is located. Where the status of the fetus depends on a definition of its viability, among other concerns, this can be hard to determine. The degree to which viability can be measured does not necessarily take into account the length of life to be expected outside the woman’s body, or the quality of life, or the meaning of being unwanted by the woman who carries the fetus. For some people the determination of the status and viability of the fetus will be a matter of faith or principle, for others a matter of scientific definition, for some it will be a subjective definition of the woman/couple/family

involved, for some a complex mix of all of these. In this dense space where different views quite rightly exist and can be equally respected, the institution of mandatory gestational limits does not promote ethical or patient-centred care.

AWHN anticipates, as has been the case in other jurisdictions when abortion is decriminalised, that in South Australia existing Department of Health and Wellbeing policies will be revised and standards and guidance for health care practitioners will reflect a new legal environment so that health care professionals will be able to provide care for women who need abortions that is consistent with contemporary clinical evidence and ethical integrity. This will include guidelines for later gestation abortions.

In response to **questions 9 and 10**, AWHN does not support specifying ground(s) for ‘a lawful termination of pregnancy’, or the distinction of lawful from unlawful terminations or any associated criminal offences as set out above.

AWHN submits that the decision to have an abortion should be made by the pregnant woman and provided in consultation with a suitably qualified health practitioner. Requiring certain preconditions to be met in order to have ‘a lawful termination’ is the effect of the current law. For the reasons outlined above, this unreasonably and unnecessarily limits individuals’ access to health care.

In response to **question 11**, AWHN submits that there should be no mandated considerations for abortion at any stage of pregnancy. AWHN restates its submissions in relation to question 9 above.

Consultation by the medical practitioner: Questions 12 – 14

In response to Questions 12, 13 and 14, AWHN submits that the stipulation in SA current laws (made nearly 50 years ago) which require a woman to consult two (2) doctors is completely out of step with the principles of informed consent for adults as legislated for the provision of all other medical procedures in South Australia.⁵ This provision demeans women’s decision-making authority and creates significant barriers and additional loss of privacy for South Australian women living in regional and rural areas.

AWHN submits that there should be no requirement to consult another health practitioner, unless it is deemed necessary as part of the woman’s health assessment, i.e. when or if the woman’s medical or psychosocial condition warrants further investigation or support. A women’s informed consent should be obtained by her primary health practitioner before that practitioner makes any such referral. She should then be referred to the most appropriate expert health practitioner, as occurs with any health condition. When there is no contraindication to proceeding with the abortion, the woman should not be referred to another health practitioner under any circumstances.

Conscientious objection: Questions 15 - 17

In response to Questions 15, 16 and 17, AWHN notes that provisions regarding conscientious objection are already made for health professionals in their codes of conduct. These codes recognise that situations can arise where the values or beliefs of practitioners

⁵ *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*.

are so opposed to the needs of their patient that the health professional has a moral conflict. This situation places both the health professional and the patient at risk. Therefore professional codes of conduct provide clear instruction as to the responsibilities to patients. By way of example, the Australian Medical Association's (AMA) 2019 Conscientious Objection Position Statement provides clear direction to doctors with a conscientious objection for referral to a medical practitioner that will support the woman's decision for an abortion.⁶ The Australian Nursing and Midwifery Federation (ANMF) has guidelines for exercising conscientious objection.

AWHN does not support any new laws with reference to abortion and conscientious objection, but rather extensive efforts to ensure both the community and health professionals are aware of these requirements.

Counselling: Question 18

In response to Question 18, AWHN does not support any proposals for compulsory counselling or mandatory waiting periods for women accessing abortion. No other Australian jurisdiction has imposed counselling as part of decriminalisation of abortion. Counselling was not imposed on women as part of the 1969 law reform in South Australia and it should not be imposed now. AWHN supports contemporary evidence based counselling practices and clinical services

Protection of women and service providers and safe access zones: Questions 19 – 24

In response to Question 19, 21 and 23, AWHN supports the introduction of 150 metre safe access zones that will cover the area around premises where termination of pregnancy is conducted, as legislated in Victoria.⁷ AWHN submits that in the zone around such premises it should be an offence to conduct these behaviours in relation to patients and/or staff who are entering or leaving such premises:

- beset, harass, intimidate, interfere with, threaten, hinder, obstruct or impede;
- communicate in relation to abortion in a manner that is able to be seen or heard by a person accessing, or attempting to access, premises at which reproductive health services are provided, and is likely to cause distress or anxiety (this prohibition does not apply to those who work at the abortion clinic);
- impede access to a footpath, road or vehicle without a reasonable excuse within the zone; and
- make or publish a recording of another person entering or leaving such premises without their consent.⁸

⁶ AMA Position Paper 'Conscientious Objection' 2019 dated 27 March 2019, accessed at: <https://ama.com.au/position-statement/conscientious-objection-2019>. See also the statement of the Australian Nursing and Midwifery Federation http://anmf.org.au/documents/policies/P_Conscientious_Objection.pdf

⁷ *Public Health and Wellbeing Amendment (Safe Access) Bill 2015 (VIC)*

⁸ These prohibitions follow the safe access zones instituted in Victoria by the *Public Health and Wellbeing Amendment (Safe Access) Act 2015 (VIC)*.

In response to **Questions 20 and 22**, AWHN submits that these zones should be automatically established and the prohibition of behaviours should apply at all times, not confined to periods of operation.⁹

The introduction of safe access zone legislation in Tasmania, Victoria, the ACT, the NT and Qld, and in Canada and various states of the USA, demonstrates governments' commitment to ensure citizens' right to provide and access health services without hindrance. South Australia should provide the same protections for our citizens. The High Court of Australia in *Clubb v Edwards & Anor*; *Preston v Avery & Anor*¹⁰ in April this year upheld the Victorian legislation¹¹. As Nettle J noted at paragraph 258, "...women seeking an abortion and those involved in assisting or supporting them are entitled to do so safely, privately and with dignity, without haranguing".¹²

As the validity of the Public Health and Wellbeing Amendment (Safe Access) Act 2015 (VIC) has been tested and upheld in the High Court of Australia, South Australia can adopt this legislation in its current form.

In response to **Question 24**, AWHN refers to its responses to question 19, 21 and 23 as set out above.

Collection of data about termination of pregnancy: Question 25

In response to Question 25, AWHN submits that data about abortions in South Australia should not be reportable as it is currently. In relation to any other medical procedure the collection of data, particularly when the data is to be reported on, requires application to and granting of permission from the hospitals ethics committee. The collection of data that currently occurs in South Australia is a gross invasion of women's privacy and should cease.

AWHN notes that the form COR 19 is currently required by regulation to be completed by the doctor performing an abortion and signed by them and a second doctor who has also examined the woman. The COR 19 documents personal detail not required for any other health service and includes specific details of the abortion care and treatment provided. Data from the COR 19 forms the basis of reports released by the Pregnancy Outcomes Unit annually and tabled in the South Australian Parliament. AWHN supports the removal of this regulation and reporting requirements.

AWHN submits that data collection about abortions should be treated the same as any other health procedure. National health and medical research guidelines should inform the process. Research ethics require that the purpose for data collection should be clear and justifiable, and that the results are used to improve health care. The annual tabling in Parliament of the abortion data has never resulted in a discussion to improve services for women but provided a media opportunity to report on the surveillance of women's reproductive decisions.

⁹ *Public Health and Wellbeing Amendment (Safe Access) Act 2015 (VIC)*.

¹⁰ [2019] HCA 11.

¹¹ Above n 14.

¹² Above n 15, 84, [258].

Rural and regional access: Questions 26 - 28

In response to Question 26, AWHN does not support differing laws based on a woman's location. AWHN supports all women being able to access high quality abortion in South Australia. To improve access for rural women, including Aboriginal women and women from interstate or overseas, AWHN strongly supports the removal of:

- the requirement that only medical practitioners can perform abortions;
- any requirement for residency for women to access abortion services in South Australia;
- the requirement for an abortion to be provided in a prescribed hospital; and
- the requirement for women to see two (2) doctors.

In response to **Question 27**, AWHN supports all women being able to use telehealth or other electronic services to consult with medical and/or health practitioners.

In response to **Question 28**, AWHN supports abortion services being provided by telemedicine and/or locally by appropriately trained health care professionals in primary health care settings. This would mean women could choose to have a medical abortion at home or in their closest regional centre and only need to travel to Adelaide for abortion procedures requiring more specialised care.

Removal of prescribed hospital requirement: Question 30 and 31

In response to Question 30 and 31, AWHN submits that the requirement for abortions to take place in a prescribed hospital be removed. Service delineation models which provide guidance to hospitals and health practitioners already create a framework for the management of abortion services in South Australia. There is no necessity for this to be a legal requirement.

Removal of child destruction clause

As stated above, AWHN supports the full repeal of Division 17 and 18 of the CLCA.

The 2008 Victorian Law Reform Commission Report strongly recommended removal of all references to child destruction from abortion laws.¹³ The Victorian Parliament heeded this advice in 2008 when they repealed the sections of their criminal code relating to abortion.

¹³ Victorian Law Reform Commission, *Law of Abortion – Final Report* dated 1 January 2008, accessed at: http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Abortion_Report.pdf