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# A REPRODUCTIVE RIGHTS FRAMEWORK SUPPORTING LAW REFORM ON TERMINATION OF PREGNANCY IN THE NORTHERN TERRITORY OF AUSTRALIA

SUZANNE BELTON,\* FELICITY GERRY QC\*\* & VIRGINIA STULZ\*\*\*

*This article describes the reproductive rights framework underpinning the campaign to reform the law on termination of pregnancy in the period 2013 to 2017 in the Northern Territory of Australia. We begin by outlining the pre-reformed legislation governing abortion in the NT. We then evaluate the reformed 2017 law using the typology established by Cook and Ngwena,<sup>1</sup> namely: (1) whether the law provides evidence-based access to health care; (2) whether it provides transparent access to health care; and (3) whether it provides fair access to health care. We finish by remarking on the continuing problems with the legislation and conclude that only complete decriminalisation will fulfil Australia's commitments under the Convention on the Elimination of All Forms of Discrimination Against Women ('CEDAW') and other human rights instruments.*

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<sup>1</sup> Rebecca J Cook and Charles G Ngwena, 'Women's Access to Health Care: The Legal Framework' (2006) 94(3) *International Journal of Gynecology & Obstetrics* 216.

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## I INTRODUCTION

In March 2017, the Northern Territory ('NT') government modified the law on termination of pregnancy ('TOP') by amending the *Medical Services Act* ('MSA') with the effect of partial decriminalisation.<sup>2</sup> Previously, the law required attendance at hospital, consent of both parents for minors under 16, and agreement of more than one practitioner to the termination. It also criminalised the use of any abortifacient for early medical abortion ('EMA'). The NT was the last jurisdiction in Australia not to have legal access to EMA.<sup>3</sup> The *Termination of Pregnancy Reform Act 2017* ('the 2017 Act') decriminalises termination of pregnancy in certain circumstances. It also provides protection for women if medical practitioners have a conscientious objection, implements safe access zones around clinics to protect staff and patients, and ensures that bio-data will be provided to the Chief Medical Officer. However, it leaves scope for appropriate future reform and continues to criminalise abortion in some circumstances.

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<sup>2</sup> *Medical Services Act 2017* (NT).

<sup>3</sup> Barbara Baird, 'Medical Abortion in Australia: A Short History' (2015) 23(46) *Reproductive Health Matters* 169, 172.

Our view is that the law in the NT has been improved, but it still does not comply with Australia's international obligations to ensure women in the NT have unfettered access to suitable reproductive healthcare.

Against a background of advocacy and action by academics, health and legal professionals, and members of the public, in 2014 to 2015 we undertook a collaborative project funded by Menzies School of Health Research and Charles Darwin University on women's health and law in the NT. We gained research ethics permission (HREC# 12-1816) to analyse over 5,000 cases of surgical termination of pregnancy, and some of that data is presented here. We undertook a literature review, examined the compliance of the NT legislation with international human rights obligations, and held a forum to discuss local issues viewed through the lens of women's reproductive health rights. This included consideration of the availability of early termination by the medications, mifepristone and misoprostol. Following the project, we continued to engage in local advocacy which came to fruition with legislative reform in July 2017.

Our work followed the 58<sup>th</sup> session of the Commission on the Status of Women which resolved progress towards achieving Millennium Development Goal 5 on improving maternal health, namely to: (1) reduce maternal death and (2) achieve universal access to reproductive health.<sup>4</sup> The Commission noted that progress on women's reproductive rights was slow and uneven, as well as that globally there remained an urgent need to fully achieve Goal 5 and strengthen legal systems to ensure accessible quality, comprehensive, and integrated sexual and reproductive health care services.<sup>5</sup> Our project highlighted the injustice and discrimination against women seeking to terminate a pregnancy in the NT prior to reform, and our 2015 discussion paper provided a legal and human rights-based focus for the campaign.<sup>6</sup> In this paper, we note the continuing problems with the NT legislation and conclude that there remains an ongoing failure to fulfil Australia's commitments.

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<sup>4</sup> *Commission on the Status of Women*, UN ESCOR, 58<sup>th</sup> sess, Supp No 7, UN Doc E/2014/27-E/CN.6/2014/15 (10 March 2014) [23].

<sup>5</sup> United Nations Population Fund, 'UNFPA Welcomes Outcome of the 58th Session of the Commission on the Status of Women', *UNFPA* (Web Page) <<http://www.unfpa.org/press/unfpa-welcomes-outcome-58th-session-commission-status-women>>.

<sup>6</sup> Felicity Gerry, Suzanne Belton and Jeswynn Yogaratnam, 'Reproductive Health and Rights in the Northern Territory: Reforming the Medical Services Act 1974' (Menzies School of Health Research, Charles Darwin University, December 2015).

## II HEALTH AND ABORTION

Preventing and managing unwanted and unviable pregnancies is a public health issue requiring quality health services.<sup>7</sup> A third of Australian women experience elective abortion in their lifetime. Half of all pregnancies are unplanned, and a fifth of all pregnancies are terminated, while up to a third are miscarried spontaneously.<sup>8</sup> The publicly available data for the NT is limited and old.<sup>9</sup> The total population of the NT is 239,500, and the estimated total number of terminations is 1,000 annually. By way of comparison, 4,000 babies are born annually. This number does not include the small number of abortions performed in one private hospital, so numbers for the NT are underestimated. Indigenous people make up one-third of the NT population; they are comparatively younger and have higher fertility rates. Figure 1 shows publicly available data for Indigenous and non-Indigenous women.

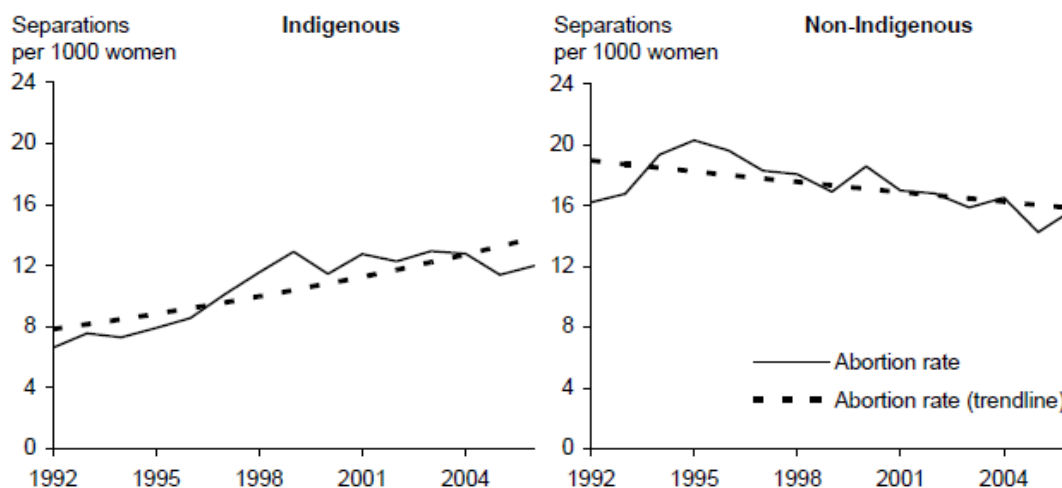


Figure 1: Induced abortions, annual rate by Indigenous status and NT residents admitted to NT public hospitals in 1992–2006.<sup>10</sup>

In 2010, the abortion rate was reported to be 12 out of 1,000 women and rising. This contrasts with the non-Indigenous rate of 15.4 out of 1,000 women and falling as of the

<sup>7</sup> Ibid.

<sup>8</sup> Family Planning NSW, 'Reproductive and Sexual Health in New South Wales and Australia: Differentials, Trends and Assessment of Data Sources' (Report, 2011).

<sup>9</sup> Xiaohua Zhang et al, 'Trends in the Health of Mothers and Babies, Northern Territory, 1986–2005' (Department of Health and Families, 2010).

<sup>10</sup> Gerry, Belton and Yogaratnam (n 6) 38.

end of 2006.<sup>11</sup> As data from private hospital abortions were not included, non-Indigenous rates are likely to be higher. Johnstone's work has shown that for Indigenous women there are patterns of rising abortion in the urban areas, whereas rural-remote rates have declined.<sup>12</sup> She also found that this was associated with Indigenous fertility rates and access to contraception.<sup>13</sup> Public health focuses on disparities in access to health care, and legislation should work towards equity in health care provision.<sup>14</sup>

EMA has been available in Europe since 1988, in the US since 2000, and in other Australian jurisdictions since 2006.<sup>15</sup> The history of EMA's entry into Australia is convoluted and politicised.<sup>16</sup> Mifepristone and misoprostol for EMA are approved and recommended medicines by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.<sup>17</sup> The lack of clarity on medical abortion in NT legislation put the Territory several decades behind evidence-based reproductive health care and was a frustration for health practitioners who wished to offer current health care practice to their patients. EMA includes the provision of doses of mifepristone and misoprostol orally before nine weeks' gestation. It is efficacious and well-accepted by women as a method of terminating an accidental, mistimed, unwanted, or unviable pregnancy. Very few medical abortions require follow-up due to complications such as excessive bleeding or continued pregnancy.<sup>18</sup> In South Australia, 22% of terminations are performed as a medical abortion as the preferred method, and 80% of terminations of pregnancy are performed by general practitioners.<sup>19</sup>

EMA is possibly as revolutionary as the oral contraceptive pill. This medicine produces an experience like a heavy menstrual period or miscarriage which general practitioners

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<sup>11</sup> Ibid.

<sup>12</sup> Kim Johnstone, 'Indigenous Fertility in the Northern Territory of Australia: What Do We Know? (And What Can We Know?)' (2010) 27(3) *Journal of Population Research* 169.

<sup>13</sup> Ibid.

<sup>14</sup> Cook and Ngwena (n 1).

<sup>15</sup> Baird (n 3); Caroline M de Costa et al, 'Introducing Early Medical Abortion in Australia: There Is a Need to Update Abortion Laws' (2007) 4(4) *Sexual Health* 223.

<sup>16</sup> See Baird (n 3) and de Costa (n 15) for excellent accounts.

<sup>17</sup> Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'The Use of Mifepristone for Medical Termination of Pregnancy' (Report, February 2016).

<sup>18</sup> Ea Mulligan and Hayley Messenger, 'Mifepristone in South Australia' (2011) 40(5) *Australian Family Physician* 342, 343.

<sup>19</sup> Pregnancy Outcome Unit, SA Health, Government of South Australia, 'Pregnancy Outcome in South Australia 2013' (Report, October 2015).



prescribe to women for use at home.<sup>20</sup> This generally does not require women and girls to attend hospital, nor the input of expensive senior doctors, nor the use of surgical theatres. The reformed legislation in the NT now enables access to EMA and surgical terminations, largely provided in the public health system.<sup>21</sup>

The mortality rate from any type of abortion is extremely rare; childbirth is riskier.<sup>22</sup> There is only one case in Australia of death after a medical abortion due to sepsis. Mulligan's reporting on medical abortion in South Australia found that complications such as haemorrhage, treatment failure, and sepsis were not common, similar to surgical abortion.<sup>23</sup> The risk from perforation from surgical instruments and anaesthetics was limited to the extremely low proportion who developed complications.<sup>24</sup> These research findings of safety and efficacy of abortion are echoed from multiple studies globally which include hundreds of thousands of cases.<sup>25</sup> Non-availability of abortion services increases maternal morbidity and mortality in population studies,<sup>26</sup> and it is unknown if this plays any part in the higher rates of maternal mortality or morbidity for Indigenous women in the NT or perinatal outcomes.<sup>27</sup> The reformed legislation in the NT assists in promoting maternal health and works towards decreasing morbidity.<sup>28</sup> Nonetheless, it remains a barrier to freedom of choice which can affect overall health.

### III RIGHTS OF WOMEN IN THE CONTEXT OF TERMINATION OF PREGNANCY

Academic opinion on human rights versus legal control over women's reproductive self-determination is already well published.<sup>29</sup> In 2013, writing in the American context, Diya

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<sup>20</sup> Caroline de Costa, 'Use of Mifepristone for Medical Abortion in Australia, 2006–2009' (2011) 194(4) *The Medical Journal of Australia* 206, 207.

<sup>21</sup> Cook and Ngwena (n 1).

<sup>22</sup> S Johnson et al, 'Maternal Deaths in Australia 2006–2010' (Research Discussion Paper No 4, Australian Institute of Health and Welfare, 2014).

<sup>23</sup> Mulligan and Messenger (n 18) 343.

<sup>24</sup> Ibid.

<sup>25</sup> H von Hertzen et al, 'WHO Multinational Study of Three Misoprostol Regimens after Mifepristone for Early Medical Abortion. I: Efficacy' (2003) 110(9) *British Journal of Obstetrics and Gynaecology* 808, 814; See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists (n 17).

<sup>26</sup> World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2012).

<sup>27</sup> Zhang et al (n 9).

<sup>28</sup> Cook and Ngwena (n 1).

<sup>29</sup> Rosalind P Petchesky, 'Rights and Needs: Rethinking the Connections in Debates over Reproductive and Sexual Rights' (2000) 4(2) *Health and Human Rights* 17.

Uberoi and Maria de Bruyn identified impediments to state duties under international human rights law to protect people's health in the context of abortion:<sup>30</sup>

- prohibiting or impeding access to contraception or forcing a contraceptive method on women;
- controlling pregnant women's actions through laws and regulations such as those which deny decision-making capacity or provide for punitive measures regarding pregnant women's actions, including a presumption of neglect;
- criminalising or impeding access to safe, legal abortion; and
- criminalising and violating international human rights law including rights to life, health, information on scientific progress, freedom from inhuman or degrading treatment or punishment, rights to dignity and autonomy in decision making, the right to privacy and presumption of innocence, and rights to non-discrimination and equality.

They noted that the *International Covenant on Economic, Social and Cultural Rights* ('CESCR') guarantees all persons the right to equal protection under the law without discrimination based on sex, and the *Convention on the Elimination of Discrimination Against Women* ('CEDAW') stipulates that governments must take all appropriate measures to eliminate discrimination against women in health care. The UN Committees for CESCR, CEDAW, the *International Covenant on Civil and Political Rights* ('CCPR'),<sup>31</sup> the *Convention on the Rights of the Child*,<sup>32</sup> and the *Convention against Torture*,<sup>33</sup> have all made recommendations to governments to consider revising laws that criminalise and penalise abortion.<sup>34</sup> By ratifying the CCPR, Australia committed itself to recognise the right of everyone to education and the enjoyment of the highest attainable standard of

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<sup>30</sup> Diya Uberoi and Maria de Bruyn, 'Human Rights Versus Legal Control over Women's Reproductive Self-Determination' (2013) 15(1) *Health and Human Rights* 161, 163.

<sup>31</sup> *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

<sup>32</sup> *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entry into force 2 September 1990).

<sup>33</sup> *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) ('*Convention against Torture*').

<sup>34</sup> Ipas, 'Maternal Mortality, Unwanted Pregnancy and Abortion as Addressed by International Human Rights Bodies' (Chapel Hill, NC, 2013).

physical and mental health.<sup>35</sup> Taking steps to achieve the full realisation of this right shall include those necessary for the reduction of the stillbirth rate and infant mortality, as well as for the healthy development of the child.<sup>36</sup>

It follows that Australia has recognised that women and girls have rights to make their own informed sexual choices, bear the consequences of their choices, and survive through the provision of appropriate health services in pregnancy and for their children to have an enhanced survival rate through appropriate spacing. In addition, by ratifying the CEDAW,<sup>37</sup> Australia has also committed itself to *eliminate* discrimination against women. Article 12 of CEDAW prohibits all forms of discrimination against women in the delivery of health care. States are required to ensure equality of access to health care services, including those related to family planning, and ensure women receive appropriate services in connection with pregnancy, confinement, and the post-natal period. A restrictive abortion law exacerbates the inequality that results from the biological fact that women carry the exclusive health burden of contraceptive failure and the consequent moral, social, and legal responsibilities of gestation and parenthood.<sup>38</sup> Failing to provide appropriate and confidential healthcare in the context of reproductive health unambiguously constitutes a form of discrimination against young women and girls. The Convention obliges State parties to submit to the CEDAW reporting mechanism. The goal in this context is for maternal mortality and morbidity to be reduced, the dignity of women to be enhanced, and their reproductive self-determination to include access to health care and the benefits of scientific progress.<sup>39</sup>

Further, by virtue of the UN *Convention on the Rights of the Child*,<sup>40</sup> Australia has *positive* obligations in international law to *ensure* that children are not subjected to cruel, inhuman, or degrading treatment.<sup>41</sup> Failing to provide adequate and confidential medical services, in the context of reproductive health to children who are at risk of harm via the

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<sup>35</sup> *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 13.

<sup>36</sup> *Ibid* 12.

<sup>37</sup> *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981).

<sup>38</sup> Rebecca J Cook, 'International Human Rights and Women's Reproductive Health' (1993) 24(2) *Studies in Family Planning* 73, 74.

<sup>39</sup> *Ibid*.

<sup>40</sup> *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).

<sup>41</sup> *Ibid* 37.

consequences of failing to properly treat unwanted and/or unviable pregnancies, constitutes an irreparable violation of the child's physical and psychological health. Therefore, we suggest (as Uberoi and de Bruyn did in the US) that it is beyond argument that international law requires that Australia create an effective and proactive mechanism that operates to protect women and girls from unnecessary health risks. Australia has a legal duty to ensure that quality, comprehensive, and integrated sexual and reproductive health care services, commodities, information, and education mechanisms are adequately resourced.

Intrinsic to these legal obligations is the requirement that states must not only respond to the need for reproductive health care but respond in an effective way.<sup>42</sup> Australia regularly submits national reports to the CEDAW committee on how it meets treaty obligations. The Federal Government Office for Women coordinates the reports by compiling information from government sources. In addition, a Shadow Report is submitted to the UN by non-government sources to balance governments' claims.

A 2010 UN communique diplomatically stated:

The Committee remains concerned about the lack of harmonization or consistency in the way that the Convention is incorporated and implemented across the country, particularly when the primary competence to address a particular issue lies with the individual states and territories. It notes for example that inconsistent approaches have arisen with regard to the imposition of criminal sanctions, for example with regard to abortion.<sup>43</sup>

In the 2016 CEDAW report, the Australian government wrote, 'Laws relating to pregnancy termination are matters for states and territories. The Australian Government has no constitutional powers in this area.'<sup>44</sup> The Federal Australian government suggests that it has limited power in the harmonisation of the multiple laws that regulate women's access to abortion; this is left to the eight states and territories that comprise the

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<sup>42</sup> Ronli Sifris and Suzanne Belton, 'Australia: Abortion and Human Rights' (2017) 19(1) *Health and Human Rights* 209.

<sup>43</sup> UN Committee on the Elimination of Discrimination against Women, *Concluding Observations of the Committee on the Elimination of Discrimination against Women: Australia*, 46<sup>th</sup> sess, UN doc CEDAW/C/AUL/Q/7/Add.1 (12 July 2010) 3.

<sup>44</sup> Australian Government Office for Women, Department of Prime Minister and Cabinet, 'Australia's Eighth Report on the Implementation of the Convention on the Elimination of All Forms of Discrimination against Women August 2010–July 2014' (Report, 15 December 2016).

federation. Australian women who become weary of the diplomatic exchanges directed at the UN may seek their reproductive health rights under the Optional Protocol to CEDAW, which allows individuals to file complaints to the UN CEDAW Committee after domestic remedies have been exhausted. The value of the CEDAW Committee's investigations of claims of serious violations of CEDAW in Australia in this context cannot be underestimated. Of course, the difficulty for individual women is the pressure and publicity that such litigation may create with regard to such a personal issue. Further examination of individual claims is outside the scope of this article, but it is worth bearing in mind if our views, that regulation remains restrictive, are accepted.

#### IV LAWS IN THE NORTHERN TERRITORY

Prior to the passing of the 2017 Act, the law on termination of pregnancy in the NT was governed by two pieces of legislation: the *Criminal Code* ('NTCC') and the MSA 1974. The MSA 1974 was amended and revised in 2006 and 2011, but the provisions and practical reality in relation to abortion had not changed. It allowed for termination up to 23 weeks but with separate provisions for pregnancies up to 14 weeks' gestation and those up to 23 weeks' gestation. In relation to abortion up to 14 weeks' gestation, subsections 11(1) and (2) of the MSA 1974, before the 2017 reform, made it lawful for a medical practitioner to provide medical treatment with the intention of terminating a woman's pregnancy if, after medically examining her, the practitioner reasonably believed she was pregnant for not more than 14 weeks. These subsections also required the practitioner *and another senior specialist medical practitioner* to be of the opinion, formed in good faith, that 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 that there was 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. It also provided that treatment was to be given in hospital. This meant there had to be two medical professionals making the decision under restrictive criteria and at least one of the medical practitioners had to be a gynaecologist or obstetrician unless it was not reasonably practicable in the circumstances to find a gynaecologist or obstetrician to examine the woman.

In relation to abortion from 14 to 23 weeks' gestation, subsection 11(3) of the MSA 1974 made it lawful for a medical practitioner to give treatment with the intention of terminating a woman's pregnancy if, after medically examining her, the medical practitioner was of the opinion that termination of the pregnancy was immediately necessary to prevent serious harm to her physical or mental health, and, when giving the treatment, the practitioner reasonably believed she was pregnant for not more than 23 weeks. Finally, subsection 11(4) made it lawful to give medical treatment with the intention of terminating a woman's pregnancy only if the treatment was given or carried out in good faith for the sole purpose of preserving her life, and the appropriate person consented to the giving of the treatment. Otherwise, as provided by section 11, TOP was a criminal offence.

In clinical practice, this required two highly qualified health practitioners working in specific urban locations with very particular circumstances. Women had legal permission for surgical treatment only in limited circumstances. The effect of these limitations, in the case where the woman could not access local health care, was that women travelled elsewhere, ordered medicines online, or continued the pregnancy. These issues were exacerbated by further provisions in the MSA 1974, such as subsection 11(5) in relation to consent for minors:

The appropriate person for giving consent to medical treatment ... is the woman if she is at least 16 years of age; *and* is otherwise capable in law of giving the consent; or *each person* having authority in law apart from this subsection to give the consent if the woman is under 16 years of age; or is otherwise incapable in law of giving the consent.

This meant that in clinical practice both parents had to be consulted. For children where the pregnancy was the result of familial abuse, this created a requirement of consent from a parent who may be the abuser.

Prior to the 2017 reforms, the MSA 1974 raised the following issues of concern which drove a successful agenda for reform:

1. There appeared to be no justification for the differentiation between 14 and 23 weeks' gestations.

2. The restrictive definition of medical practitioner excluded those eminently able to provide appropriate health care beyond a hospital, including midwives, nurses, and pharmacists.
3. Access to approved medical treatment was so restricted that, in the NT, doctors, women, and girls were at risk of criminal prosecution in the context of acceptable modern termination by the administration of medication. Further, the words 'includes surgery' implied that only surgical termination of pregnancy was acceptable.
4. The criteria requiring medical practitioners to make findings about harm to the woman or girl, or abnormalities in the foetus, inhibited autonomy.
5. The requirement for treatment in a hospital inevitably restricted abortion to hospitals in only two urban centres, which reduced access to health services and promoted a lack of confidentiality.
6. The lack of conscientious objection provisions fostered a culture where doctors were able to put their personal beliefs before patient welfare and inhibit services, which impacted women seeking a lawful abortion.<sup>45</sup> Ethical service provisions needed to allow for informed choice, prevent patient trauma, avoid the risk of service delays leading to fewer or more invasive options, and enable rural women to seek other practitioners.
7. The requirement for a specialist obstetrician or gynaecologist as part of the decision-making process prevented women's access to primary health care providers, which is the wholly appropriate place of treatment in this context.
8. The requirement for each person having the authority of law to make decisions about a child inevitably meant both parents must consent, which inhibited treatment for minors.

Prior to 2017, the requirement under the MSA 1974 for treatment to be provided in hospitals had the practical effect that women potentially had to travel some hundreds of kilometres to Darwin or Alice Springs to access specialist services from an obstetrician

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<sup>45</sup> Suzanne Belton, Caroline de Costa and Andrea Whittaker, 'Termination of Pregnancy: A Long Way to Go in the Northern Territory' (2015) 202(3) *Medical Journal of Australia* 130.

or gynaecologist. They were also required to have surgical abortions as prescribing EMA was legally restricted. Inevitably, there are no figures for women who travelled to other parts of Australia seeking an abortion. With only one or two willing and able health practitioners, the effect on health care at times was catastrophic in the NT.<sup>46</sup> Delays in health service provision meant that women carried a foetus for longer than they should, increasing potential negative health and legal consequences.

In relation to the abortifacients, mifepristone and misoprostol, Part VI, Division 8 of the NTCC provided criminal sanctions that covered both the woman and the practitioner. Section 208B stated that

a person is guilty of an offence if:

- (a) the person: (i) administers a drug to a woman or causes a drug to be taken by a woman; or (ii) uses an instrument or other thing on a woman; and
- (b) the person intends by that conduct to procure the woman's miscarriage.<sup>47</sup>

Section 208C created a criminal offence where a person

- (a) supplies to, or obtains for, a woman a drug, instrument or other thing; and
- (b) knows the drug, instrument or other thing is intended to be used with the intention of procuring the woman's miscarriage.' In both sections, the maximum penalty was imprisonment for seven years.<sup>48</sup>

Notes for sections 208B and 208C provided that '[u]nder section 11 of the MSA 1974, in certain circumstances it was lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy'.<sup>49</sup> Part 1, Division 1 of the NTCC defined 'medical treatment to include 'dental treatment and all forms of surgery'.<sup>50</sup> By normal interpretative rules, this did not appear to include treatment that prescribed medicines. A medical practitioner was not defined in the NTCC but, on any ordinary interpretation, did not include health workers nor nurses who provide the majority of primary, reproductive, and sexual health care in the NT. It followed that treatment had to be surgical, and many appropriately qualified and experienced health professionals could

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<sup>46</sup> Ibid.

<sup>47</sup> *Criminal Code Act 2017* (NT).

<sup>48</sup> Ibid.

<sup>49</sup> Ibid.

<sup>50</sup> Ibid s 4 (definition of 'medical treatment').



not treat those seeking medical abortion without risking criminal prosecution. Anyone prescribing mifepristone and misoprostol committed a criminal offence, despite those abortifacients being approved and recommended medicines elsewhere.<sup>51</sup>

The effect of the unreformed legislation denied women their health rights to patient autonomy in abortion health care and criminalised women, children, and health practitioners. The indirect effect of lack of access to abortion was that some women and female children were forced to carry to term with the consequent effect on health and well-being that an unwanted and unplanned pregnancy may bring. Barriers to appropriate treatment increased as medicine had progressed in an environment where the law remained static.<sup>52</sup> The consequence was that women's access to termination was prohibited by the very laws which were designed to lawfully create voluntary motherhood; the law simultaneously acted as a barrier to women's access to services and as a tool to ensure that women have effective access to health services.<sup>53</sup> In applying Cook and Ngwena's framework, it was neither evidence-based, transparent, nor fair legislation.

The 2017 legislative reform repealed section 11 of the MSA 1974 in its entirety and made consequential amendments to the NTCC, thus removing many of the restrictive criteria and allowing for drug prescriptions and a wider cohort of treating practitioners in a wider range of locations. However, despite the campaign to remove all regulation of TOP, the position for NT women is now governed by the *Termination of Pregnancy Law Reform Act 2017*.<sup>54</sup> This still provides separate provisions for pregnancies up to 14 weeks and those up to 23 weeks. For those up to 14 weeks, section 8 allows for appropriate advice and the prescription of drugs to be authorised by a single health practitioner. While the definition includes a much wider cohort of treating practitioners, two are required to consult and agree under section 9 for pregnancies up to 23 weeks. In any other circumstances, criminalisation remains unless termination is necessary for the preservation of life. Provision is included for contentious objection and safe access zones for treatment.

Although this represents significant progress, the retaining of any criminal provisions still restricts a woman's freedom in the context of health care and provides an available

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<sup>51</sup> Anne O'Rourke, Suzanne Belton and Ea Mulligan, 'Medical Abortion in Australia: What Are the Clinical and Legal Risks? Is Medical Abortion Over-Regulated?' (2016) 24(1) *Journal of Law and Medicine* 221.

<sup>52</sup> *Ibid* 221.

<sup>53</sup> Cook and Ngwena (n 1).

<sup>54</sup> *Termination of Pregnancy Law Reform Act 2017* (NT).

mechanism for future legislative reform in another direction. This remains risky for NT women as it leaves them at the whim of political manoeuvring.

#### V ACCESS TO EVIDENCE-BASED HEALTH CARE

Cook and Ngwena suggest that courts are interested in scientific evidence and safety and not religious or political biases. Similarly, health care should be based on scientific evidence — most importantly, as science advances, the provision of clinical health care evolves. However, there are several factors which work against evidence-based health abortion care in Australia. One is the lack of bio-data and clinical evidence, and the other is fossilised laws (even where amended) which impede the provision of quality health care via free choice.

Any lack of health data is surprising in a developed nation. The total numbers of TOP are not known, the types or timing of procedures have not been systematically recorded, and the characteristics of women seeking abortion are not monitored for public health purposes. There are two jurisdictions which mandate the reporting of abortion — South Australia and Western Australia — where records are relatively complete but only contain limited information that could be used to design public health interventions. The lack of nationally consistent data suggests that abortion is not a priority in either health research or policy.

There are other contexts where Australian law is used to inhibit evidence-based reproductive health care.<sup>55</sup> For example, health care providers cautiously interpret the law to mean that counselling is required prior to abortion.<sup>56</sup> This is particularly so in unreformed jurisdictions such as Queensland where section 282 of the *Criminal Code Act 1899*,<sup>57</sup> provides that '[a] person is not criminally responsible for ... providing ... medical treatment ... if ... providing the medical treatment is reasonable, having regard to the patient's state at the time and to all circumstances of the case'. The test of lawfulness has been determined by the courts to mean that abortion can be lawfully performed where it is necessary to prevent serious danger to the woman's life or physical or mental health

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<sup>55</sup> Sifris and Belton (n 42).

<sup>56</sup> The Tabbott Foundation, 'Australia's Medical Termination Provider' (Web Page)

<<https://www.tabbot.com.au/>>.

<sup>57</sup> *Criminal Code Act 1899* (Qld).

and further that social and economic considerations cannot be taken into account.<sup>58</sup> In New South Wales, under section 82 of the *Crimes Act 1900*,<sup>59</sup> it is an offence 'for any person ... to administer a drug to unlawfully procure a miscarriage'. The term 'unlawfully' has not been defined but precedent suggests that abortion is generally regarded as lawful if it is performed to avoid serious danger to the woman's mental and physical health.

In the NT, Part two, section 7 of the *Termination of Pregnancy Law Reform Act 2017* states that:

A suitably qualified medical practitioner may perform a termination on a woman who is not more than 14 weeks pregnant, if the medical practitioner considers the termination is appropriate in all the circumstances, having regard to:

- (a) all relevant medical circumstances; and
- (b) the woman's current and future physical, psychological and social circumstances; and
- (c) professional standards and guidelines.

It follows that lawfulness still depends on the assessment of a medical practitioner who must examine the woman's whole life circumstances. These types of unreformed legislation can lead to defensive clinical practice and referrals to psychologists to conform with the perceived intent of the law. Mandatory counselling is discriminatory, humiliating, intrusive, and wasteful of health resources. Research evidence and clinical practice concede that few women require counselling, whereas all women have a right to information to assist in making a pregnancy choice.<sup>60</sup>

The lack of legal availability of EMA in the NT was highly significant in propelling the groundswell for legal reform given the restrictions that criminalisation placed on both women and practitioners. The provisions of the reformed 2017 Act which allows for EMA is a significant improvement.

While the 2017 Act is an improvement, continued regulation has no sound health basis and limits the freedom of practitioners to treat a patient in any circumstance. In addition,

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<sup>58</sup> *R v Bayliss and Cullen* (1986) QDC 011.

<sup>59</sup> *Crimes Act 1990* (NSW).

<sup>60</sup> Kirsten Black, 'Some Women Feel Grief after an Abortion, but There's No Evidence of Serious Mental Health Issues', *The Conversation* (online, 26 April 2018) <<https://theconversation.com/some-women-feel-grief-after-an-abortion-but-theres-no-evidence-of-serious-mental-health-issues-95519>>.

in cases over 23 weeks, criminalisation remains. Termination of pregnancy over 23 weeks is rare but sometimes necessary and therefore does not require legal regulation where performed by an authorised health practitioner. When termination is requested, it is often in catastrophic situations. The pregnancy is often wanted, and women are advised by doctors that their child has a serious foetal abnormality, or there is poor maternal health, or the woman is dealing with social/mental dysfunction such as substance abuse.

The routine tests during antenatal care are not yet advanced enough to detect problems early in pregnancy. Ultrasound scans during pregnancy occur at 16 to 18 weeks' gestation; genetic testing is not complete until 20 weeks which means that health practitioners must deal with these issues at later gestation. These practitioners should not be criminalised for providing a termination in such circumstances. One case study provided by a NT health care professional is compelling:

The limiting of access to abortion to 23 weeks has significant implications when diagnosis of genetic anomalies takes up to 2 weeks (and occasionally longer). We had a case in 2015 where despite early genetic screening and an initially normal diagnosis, a small but significant chromosomal abnormality was not identified until 28 weeks. Despite every effort to obtain a late termination interstate, it was not possible to do this due to the fact that the woman involved was an NT resident.

Publicly funded late termination services in Victoria were not available as she was not a Victorian resident. A private service provider was prepared to perform a procedure for her, but unfortunately medical indemnity was not obtainable as again she was not resident in the state where the procedure would be performed.

This has resulted in the woman and her family having a child with a significant burden of disability and had a devastating effect on the mental health of the parents involved. These cases are rare, but I feel that it is important that, as doctors involved in the care of pregnant women, we have the discretion to offer late termination of pregnancy in such circumstances.<sup>61</sup>

According to the most recent figures from the Australian Institute of Health and Welfare, 0.7% of abortions in Australia were carried out at or after 20 weeks;<sup>62</sup> most (94.6%) were

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<sup>61</sup> Interview with NT health professional (identity concealed).

<sup>62</sup> Narelle Grayson, Jenny Hargreaves and Elizabeth A Sullivan, AIHW National Perinatal Statistics Unit, 'Use of Routinely Collected National Data Sets for Reporting on Induced Abortion in Australia' (Report, December 2005).

performed before 13 weeks of gestation. Data from the NT shows a very similar pattern of a very small number of women requiring this type of health care.

<b>Gestational age</b>	<b>Number</b>	<b>%</b>
0–13 weeks	5233	95.5
14–19 weeks	73	1.3
>20 weeks	11	0.1
Unstated	156	2.9
<b>Total</b>	<b>5473</b>	<b>100.0</b>

Table 1: Surgical termination of pregnancy, numbers and percentages of gestation in weeks 2006–2011, Northern Territory.

Most women who have a termination are treated within 10 weeks of having a positive pregnancy test, although we note that records are not kept of women who requested termination but were turned away or went interstate for care. In addition, the provisions remain out of step with other Australian jurisdictions. For example, Victoria, the Australian Capital Territory, and Tasmania have legislation that enables doctors to assist women confronting serious foetal abnormality or maternal health problems after 23 weeks.

#### VI TRANSPARENT ACCESS TO HEALTH CARE

Abortion laws should articulate clearly how they facilitate access to health care. Cook and Ngwena state that legal uncertainty is ‘where fear of criminal prosecution and liability to prolonged imprisonment cause a reluctance to provide and/or seek services’, and this exists in Australia.<sup>63</sup> The continued criminalisation of abortion in Western Australia, South Australia, New South Wales, and Queensland is contrary to international obligations under CEDAW and maintains social stigma ultimately perpetuating the chilling effect on health services and women’s wellbeing. Notably, Queensland Clinical

<sup>63</sup> Cook and Ngwena (n 1) 219.

Guidelines are a positive development in providing clear clinical instruction for health practitioners but may not be enough if the law remains unreformed.<sup>64</sup> The International Confederation of Midwives has a policy statement supporting safe abortion and articulating midwives' roles in supporting women in their fertility choices.<sup>65</sup> Unfortunately, there are no similar national statements from Australian nurses nor midwives supporting women's reproductive health rights, even in spite of the policy statements of both the Australian Medical Association and the Public Health Association of Australia that support access to health services and health practitioners' obligations in providing terminations.

Conscientious objections to providing abortion information, counselling, assessment, or treatments puts personal morals ahead of professional obligations. Only Victorian and Tasmanian laws explicitly deal with the duties of health providers who find themselves unable or unwilling to perform an abortion. The reformed NT law also has a clause for guiding conscientious objectors: they are legally obliged to expeditiously refer the patient to a colleague who can engage the patient's request. In the other five jurisdictions, this is left to the health provider's discretion. This type of legal fuzziness can mean that women need to 'jump through hoops' as described in research exploring the barriers to access to abortion.<sup>66</sup>

Travel to abortion services in urban areas or other parts of Australia are not well understood.<sup>67</sup> However, it is common for women to seek access interstate when it is not available in their area through either lack of skilled workforce, legal barriers, or health system weaknesses.<sup>68</sup> Not only is this a personal burden, but it discriminates against women as a group. This is notwithstanding the little information sharing or continuity of health care for women who travel to another region or state for abortion and then return

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<sup>64</sup> Queensland Health, 'Queensland Maternity and Neonatal Guidelines, Supplement: Therapeutic Termination of Pregnancy' (Queensland Clinical Guidelines, State of Queensland, 2018).

<sup>65</sup> International Confederation of Midwives, 'Midwives' Provision of Abortion-Related Services' (Position Statement, The Hague, 2015).

<sup>66</sup> Frances Doran and Julie Hornibrook, 'Barriers around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16(1) *Rural and Remote Health* 3,538: 1–12, 4 .

<sup>67</sup> Carolyn Nickson, Anthony Smith and Julia M Shelley, 'Travel Undertaken by Women Accessing Private Victorian Pregnancy Termination Services' (2006) 30(4) *Australian and New Zealand Journal of Public Health* 329, 333.

<sup>68</sup> Frances Doran and Susan Nancarrow, 'Barriers and Facilitators of Access to First-Trimester Abortion Services for Women in the Developed World: A Systematic Review' (2015) 41(3) *Journal of Family Planning and Reproductive Health Care* 170, 176.

home. Nickson, Shelly, and Smith inform us that Tasmanians travel to the mainland, Queenslanders travel to New South Wales, and Northern Territorians travel to Queensland and South Australia.<sup>69</sup> There are international cases where this type of breach in health care resulted in governments being found liable for violations of local laws and international human rights duties.<sup>70</sup>

## VII FAIR ACCESS TO HEALTH CARE

Fair and reasonable access to health care is a well-accepted notion in Australia with the introduction of a universal health welfare system in the 1970s, initially titled *Medibank* and later *Medicare*. The Australian taxation system funds the public health system at the federal level of government. Women pay the same percentage as men through compulsory taxation of wages; however, access to appropriate reproductive health care is not fair nor transparent for Australian women. The state bears legal responsibilities of non-discrimination in the provision of health services. We argue that sex-based discrimination occurs due to the failure of the state which it is obliged to remedy.

Women seeking to terminate their pregnancies experience difficulties accessing public health services and, in most states and territories, use private health services at personal financial cost sometimes in combination with personal private health insurance if they are wealthy enough to have it.<sup>71</sup> Notably, South Australia and the NT have considerable abortion health services in the public health system. The shift of abortion public health work to private providers is real and can cause delays and discontinuities in health care as women try to find suitable providers, in addition to meeting the upfront out-of-pocket costs. As a group, women are castigated if they are perceived to be having terminations 'too late'. It seems axiomatic that women whose terminations are delayed due to health system dysfunction could claim damages from the state. However, a full examination of individual legal rights is outside the scope of this article.

Our research, the project forum and community debate, focused attention on these issues. We found that there was support for the use of approved abortifacients in the NT, but

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<sup>69</sup> Carolyn Nickson, Julia Shelley and Anthony Smith, 'Use of Interstate Services for the Termination of Pregnancy in Australia' (2002) 26(5) *Australian and New Zealand Journal of Public Health* 421, 423.

<sup>70</sup> Cook and Ngwena (n 1).

<sup>71</sup> Nickson, Smith and Shelley (n 67) 45.

public debate often returned to the 1960s and 1970s agenda without recognising women's right to abortion which was already legalised.<sup>72</sup> It was recognised that the need to be in or near a hospital inhibited the use of approved abortifacients for women and girls in remoter communities. It was understood generally that approved abortifacients are low risk, but there was concern around supervision in remote conditions. Other practitioners took the view that as spontaneous miscarriage is dealt with in remote communities, there is no reason why managed miscarriages could not be. The forum thought that well-equipped clinics in remoter areas could and should be able to use approved abortifacients for women. It was unreasonable for women, girls, and health professionals in the NT not to have access to approved abortifacients, and furthermore it would be safer to manage terminations medically than risk women importing unknown abortifacients by post as had happened in Queensland.<sup>73</sup>

Another concern during the 2014 forum was the consent processes for minors seeking abortion in the NT. Public sentiment found this was unreasonable and discriminated against young people. Processes and laws for gaining medical consent from minors exist in Australia, which rely on the principle of *Gillick* competency, where health practitioners assess the maturity of the minor in the provision of health care.<sup>74</sup> The authorisation of medical care — in this case, abortion — by parents or guardians was not necessarily in the best interests of the child nor required. It can breach patients' rights to confidentiality, and, as Cook and Ngwena point out, chronological age is less important than the capacity to understand.<sup>75</sup>

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<sup>72</sup> Barbara Baird and Suzanne Belton, 'Feminism on the Frontier: The History of Abortion Law Reform in 1973 in the Northern Territory, Australia' (2019) 28(1) *Women's History Review* 139, 139.

<sup>73</sup> *R v Brennan & Leach* [2010] QDC 329 (Everson DCJ).

<sup>74</sup> The Australian High Court gave specific and strong approval for the *Gillick* decision in *Department of Health and Community Services v JWB and SMB* [1992] HCA 15; (1992) 175 CLR 218 ('*Marion's case*'). The *Gillick* competence doctrine is part of Australian law (see, eg, *DoCS v Y* [1999] NSWSC 644). There is no express authority in Australia on *Re R* and *Re W*, so whether a parent's right terminates is unclear. This lack of authority reflects that the reported cases have all involved minors who have been found to be incompetent and that Australian courts will make decisions in the *parens patriae* jurisdiction regardless of *Gillick* competence. In South Australia and New South Wales, legislation clarifies the common law, establishing a *Gillick*-esque standard of competence but preserving concurrent consent between parent and child for the ages 14–16.

<sup>75</sup> Cook and Ngwena (n 1).



Politicians split almost equally over the issue of reforming the MSA 1974 and not necessarily along political party sides. One female member of Parliament from the conservative Country Liberal Party stated:

I have confidence in the [medical] profession, the AMA and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to determine the appropriate administration of RU486 and the guidelines associated with it. The medical board and the Australian health practitioner regulation agencies are our professional watchdogs over the medical profession.

It is true that all jurisdictions except the Northern Territory allow the use of RU486 outside a hospital environment for medical terminations of pregnancy up to nine weeks under the supervision and assessment of a medical practitioner. This debate is not about the introduction of the drug RU486 in Australia but introduction into the Northern Territory. We are the exception, and the question is whether or not we want to become the rule.

I am a proud Territorian. The Territory does many things differently and we are proud of it. Unfortunately, there are examples of where Northern Territory differences are not something to be proud of. I am thinking specifically of issues affecting women, such as our higher rates of domestic violence and our inability to access RU486.<sup>76</sup>

This member of Parliament retained her seat in the last election and is only one of two Country Liberal Party members remaining in the Legislative House of Assembly. She voted for reform in 2017. This perhaps gives an indication of the need for political will to achieve women's health rights in the NT and thus mitigate the risks we have suggested that continuing regulation can create for the future.

#### VIII SOLUTIONS AND CONCLUSIONS

Taking a rights-based approach and using Cook and Ngwenya's framework, in the context of reproductive autonomy for women seeking to end a pregnancy, was useful.<sup>77</sup> The NT found some solutions in the 2017 reforms. Namely, the 2017 Act broadened the named health providers to include nurses, midwives, Aboriginal health practitioners, and

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<sup>76</sup> Northern Territory, *Parliamentary Debate*, Legislative Assembly, 20 April 2016 (addressing the *Medical Services Amendment Bill*) 8,173.

<sup>77</sup> Heather Douglas and Katherine Kerr, 'Abortion, Law Reform and the Context of Decision-Making' (2016) 25(1) *Griffith Law Review* 129.

pharmacists. Importantly, the definition of ‘medical treatment’ now includes termination by prescription and removes the requirement for hospitalisation and senior specialists. Furthermore, taking the example from Victorian and Tasmanian legislation, the NT now has protection zones to prevent harassment and intimidation of health staff and women. It also contains a conscientious objection clause, and the requirement to seek out consent from parents of minors has been removed. Anonymous bio-data is collected and could be analysed and interpreted for health policy and system planning. However, this legislation is not perfect — it appears to be a political compromise that fails to leave the issue of women’s health to the woman and her health practitioner. The reformed 2017 Act attempts to increase access and fairness to abortion health services. While it is an improvement on the MSA 1974, it is not a comprehensive instrument on reproductive health rights and thus may not age well as medicine continues to advance.

In reviewing Australia’s international obligations, the legislative frameworks against a background of campaigning brings us to the conclusion that there should be national uniform legislation to completely decriminalise abortion in Australia. Given the considerable effort it took to change the legislation in the NT, such reform may be a while away. In the meantime, women’s health rights are not comprehensively observed,<sup>78</sup> which leaves Australia bound to report these issues to the CEDAW Committee. Of course, women also have the opportunity to make individual complaints, but the process is long. Unfortunately, the lack of access to rights-based lawyering in the NT is outside the scope of this paper.

Despite the remaining limitations of the 2017 Act, the concerns about its implementation, and the lingering human rights issues, it is our view that the 2017 Act enables some improvement in evidence-based access to health care, more transparent access to health care, and fairer access to health care.

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<sup>78</sup> Sifris and Belton (n 42) 14.

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