Human Rights Law Centre

Modernising Queensland's archaic abortion laws

The Termination of Pregnancy Bill 2018

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About the Human Rights Law Centre

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1. Introduction

1. On 22 August 2018, the *Termination of Pregnancy Bill 2018* (the **Bill**) was introduced into Queensland Parliament. The Bill reflects a draft bill prepared by the Queensland Law Reform Commission (the **Commission**) after an extensive consultation and review process. The Bill was referred to the Health, Communities, Disability Services, and Domestic and Family Violence Prevention Committee (the **Committee**). This submission responds to the questions posed by the Committee.

2. The Human Rights Law Centre (**HRLC**) made a submission to the Commission's inquiry and has made submissions to this Committee's previous inquiry into abortion law reform bills.

3. The HRLC is a national human rights organisations whose mandate includes the protection and promotion of women's reproductive rights. We have worked closely with Children by Choice, Women's Legal Service Queensland and Pro Choice Queensland on the reform of Queensland's abortion laws. Across Australia, the HRLC has advocated for the decriminalisation of abortion and safe access to abortion services in New South Wales, Victoria, the Northern Territory, the ACT and Tasmania.

4. The HRLC would like to appear as a witness before the Committee, and authorises the publication of this submission.

2. Executive Summary

5. The Bill will bring Queensland's archaic abortion laws into the 21st Century, and in doing so, promote the right of every single Queenslander to control what happens to their bodies and their lives.

6. The passing of the Bill is critical to improving health outcomes for women. It would see abortion treated has a health matter to be determined between a woman and her doctor, not a criminal justice matter.

7. Queensland's current abortion laws are hopelessly out of step with community standards and modern medical practice. Although it is legal to access and provide abortion in Queensland in some circumstances, it nonetheless remains a criminal offence. Women's basic rights to non-discrimination and to freely chose if and when to have children are undermined by a system that threatens prosecution for personal medical decisions. The threat is not merely theoretical as can be seen in the example of a Cairns couple who were charged with procuring a miscarriage in 2009.

8. Restrictive abortion laws do not stop abortions. Rather, they lead to worse health outcomes:[1] women delayed in obtaining vital healthcare; forced to resort to medically dangerous alternatives; or coerced into carrying an unwanted pregnancy. These risks are heightened for those who have difficulty accessing health services, including young women and girls, transgender and gender diverse people, women living remotely, women with a disability, Aboriginal and Torres Strait Islander women, women of culturally or linguistically diverse backgrounds and women who cannot afford to travel to jurisdictions with more liberal laws.

9. Passing the Bill would demonstrate that Queensland's Parliament respects women as competent decision-makers over their bodies and is committed to promoting women's health, safety and equality. The Bill would do this by:

   (a) removing abortion from the *Criminal Code 1899* (Qld);

   (b) recognising that women are capable of making complex decisions concerning their lives and those of their family, by legalising abortion where a woman consents up to 22 weeks pregnancy;

   (c) recognising that in the rare, complex and typically distressing situations in which an abortion is required after 22 weeks gestation, doctors must be able to act in the best interests of their patients by jointly assessing what is appropriate in all the circumstances and not being obstructed by arbitrary barriers;

   (d) creating safe access zones around services that provide abortion care so that women are not forced to run a gauntlet of abuse and harassment to see their doctor;

   (e) requiring doctors with a conscientious objection to abortion to disclose this and refer their patient to a professional without an objection, thereby ensuring that women can access the health information and care they need with minimal delay; and

   (f) ensuring that in cases of medical emergency, access to immediate and quality treatment is not compromised by a legislative requirement for two doctors to approve an abortion or by a doctor's personal views about abortion.

10. In addition to reforming the law, it is critical that the Queensland Government ensure that affordable, impartial and confidential abortion services are practically available to all Queenslanders, including in the state's vast regional and remote areas.

Recommendations

11. The HRLC recommends that the Bill be passed.

[1] E.g. Royal Australian and New Zealand College of Obstetricians and Gynecologists, 'Queensland Abortion Law Reform' (Media Statement, undated), https://www.ranzcog.edu.au/news/Queensland-abortion-law-reform

12. The HRLC also recommends that:

    (a) The Bill be amended to include an additional provision in Part 4, in which it is prohibited, within a safe access zone, to harass, intimidate, beset, threaten or hinder; or obstruct or impede access to an abortion service by any means; or to obstruct or block a footpath or road leading to an abortion service without reasonable excuse.

    (b) Clause 15 be amended to insert "or is reasonably likely to cause distress or anxiety to a person mentioned in paragraph (b)" after sub-clause (1)(c).

    (c) Replacing references to 'woman' with 'pregnant person' so as to ensure the Bill is inclusive of all Queenslanders.

3. Responses to questions

Questions 1-3: Terminations up to and after 22 weeks pregnancy

13. The HRLC supports clauses 5 and 6 of the Bill in their entirety. These clauses are consistent with community values and modern medical practice and are framed in a way that promotes the health, equality and decision-making capacity of women.[2]

14. Clauses 5 and 6 are written in clear language and are similar to the successful approach to modernising Victoria's abortion laws in 2008. This is critical in light of the uncertainties and fears caused by the criminalisation of abortion in Queensland to date.

Terminations up to 22 weeks

15. As with other health matters, all Queenslanders should have the freedom to choose what happens to their bodies in consultation with their doctor. Clause 5 of the Bill, which legalises a doctor performing an abortion with the consent of the woman up to 22 weeks pregnancy, achieves this.

16. Such an approach is consistent with the values of an overwhelming majority of Queenslanders. Polling in 2017 demonstrated that 82 per cent of people agreed that it should be legal for a woman to decide to have an abortion in consultation with a medical professional, while 70 per cent agreed that Queensland women should have the same rights as Victorian women to have an abortion.[3] Women in Victoria have the right to choose to have an abortion in consultation with a doctor up to 24 weeks pregnancy.

[2] Consistent with Queensland's international human rights obligations: see Committee on Economic, Social and Cultural Rights, *General Comment No 22: Sexual and Reproductive Health* E/C.12/GC/22 (2016) [28]. See also Centre for Reproductive Rights, ***Safe and Legal Abortion is a Woman's Human Right*** (Briefing Paper, 2011).
[3] Essential Research, 'Queensland Abortion Law Reform Poll' (February 2017).

17. The law should not impose a requirement on women to seek permission from two doctors prior to 22 weeks pregnancy (sometimes referred to as a 'gestational limit'). While the HRLC's submission to the Commission earlier this year recommended that if a gestation limit was set in law it should be no less than 24 weeks, we support the 22 weeks outlined in the Bill because:

    (a) Queensland Clinical Guidelines on perinatal care at the threshold of viability recommend that obstetric management be maternally focused until 22 weeks based on the threshold for foetal viability being between 23 weeks and 0 days and 25 weeks and 6 days.[4]

    (b) Abortions after 22 weeks are required to be performed at particular hospitals in Queensland because of the additional complexity.[5]

    (c) A gestational limit of 22 weeks aligns with approval processes at the Royal Brisbane and Women's Hospital.[6]

    (d) Screening for foetal health is generally recommended to take place at 18-20 weeks[7] and if a serious or fatal foetal condition is identified, it is critical that the prospective parents have time to learn about and assess all their options.

18. The HRLC would not support any amendments that seek to reduce the gestational limit below 22 weeks, even to 20 weeks. This would mean passing decision-making power from a patient to two doctors at an earlier stage of pregnancy (see further discussion below). In practical terms, this creates additional barriers to safe abortion services, particularly for vulnerable people who are more likely to be delayed in seeking care, such as young women and girls, Aboriginal and Torres Strait Islander women, survivors of sexual assault and women escaping family violence.

19. In addition, the experience in Western Australia demonstrates the harm that can be caused to women if their right to control their bodies and lives is curtailed from the 22 weeks currently set in the Bill.

20. Abortion is legal up to 20 weeks pregnancy in a broad range of circumstances in WA, as an exception to the criminalisation of abortion.[8] After 20 weeks, two doctors out of a panel of at least six hold the power of deciding whether an abortion is justified on the basis of the mother or foetus having a severe medical condition. A review of the WA laws in 2002 noted that

[4] Department of Health, *Queensland Clinical Guideline: Perinatal Care at the Threshold of Viability* (2014) 7.
[5] Queensland Law Reform Commission, Review of Termination of Pregnancy Laws (Report no 76, 2018) [15].
[6] Ibid.
[7] Genetic Health Queensland, 'Prenatal Screening and Testing' (Queensland Government, 2015) https://www.health.qld.gov.au/__data/assets/pdf_file/0022/423931/prenatal-brochure.pdf
[8] See section 334 of the *Health (Miscellaneous Provisions) Act 1911* (WA) and section 199 of the *Criminal Code Act 1913* (WA). These reforms were introduced by the *Acts Amendment (Abortion) Act 1998* (WA).

women who received a diagnosis of a serious foetal condition in the days leading up to the 20 week limit felt adversely impacted by the uncertainty surrounding whether they would be able to access an abortion, the pressure to make a decision within the 20 week period (while it was still theirs to make) and a diminished sense of personal control.[9]

Terminations after to 22 weeks pregnancy

21. The HRLC supports the broad wording of clause 6 of the Bill. It would require a person's treating doctor to consider whether an abortion is appropriate in all the circumstances after 22 weeks pregnancy and consult another practitioner who also considers an abortion to be appropriate.

22. It should be noted that strict practice guidelines, clinical standards and hospital approval processes already guide Queensland hospitals in providing abortion care after 22 weeks pregnancy.

23. It is estimated that abortions after 22 weeks make up approximately 1 per cent of all abortions in Australia.[10] They are typically required in complex and distressing circumstances for the individuals involved, such as the discovery of a fatal foetal or serious maternal condition in the context of a wanted pregnancy.[11] Women may be delayed in accessing treatment because of family violence, the trauma of sexual assault or a lack of awareness of pregnancy.

24. The law should not aggravate the distress for individuals in such circumstances through unduly narrow wording. It is not the role of the law to predict and circumscribe the types of circumstances in which people will find themselves needing an abortion after 22 weeks.

25. In addition, a legal requirement for two doctors to approve a patient's decision is inconsistent with an adult's usual role as primary decision-maker about medical procedures to their own body. It situates women as incompetent decision-makers in need of protection and doctors as gatekeepers.[12] Accordingly, restrictions on abortions after 22 weeks should be broadly worded so as to facilitate joint decision-making in the best interests of a patient.

26. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (**RANZCOG**) has explained that gestational limits discriminate against women in the most difficult or vulnerable circumstances. RANZCOG has recommended that "no specific clinical circumstances" should be imposed that dictate eligibility for abortion because each woman's

[9] Report to the Minister for Health on the Review of Provisions of *The Health Act 1911* and *The Criminal Code* relating to abortion as introduced by *The Acts Amendment (Abortion) Act 1998* (Department of Health, 17 June 2002), 23.
[10] Women's Health Victoria, *Fact Sheet: Abortion After 24 Weeks* (May 2016), http://whv.org.au/static/files/assets/639c6f2c/Abortion_after_24_weeks_Q_A_.pdf.
[11] Ibid.
[12] Rebecca Cook and Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press, 2010) 86-87.

circumstance will be different.[13] It supports a multidisciplinary approach, without gestational limits, in which late-term abortion is available "for the rare situations where both managing clinicians and patient believe it to be the most suitable options in the circumstances".[14]

27. If Queensland Parliament considers it necessary to legislate for two doctors to agree that an abortion is appropriate after 22 weeks pregnancy, then it should be the treating doctor who seeks the second opinion, not the patient. A person dealing with a distressing diagnosis or serious trauma should not be forced to expose themselves to the judgment of two doctors before being given the healthcare they need. Such a requirement would also disadvantage marginalised women, particularly those living in regional parts of Queensland.

Abortions after 22 weeks to save a life

28. The HRLC supports clause 6(3), which would make it legal for a medical practitioner to perform an abortion after 22 weeks pregnancy to save another foetus or the life of a woman without seeking a second opinion.

29. Clearly, where emergency treatment is required, the law should authorise this as clearly as possible so as to prevent the risk that confusion about the law leads to death or injury or additional trauma. Imposing any barrier to emergency treatment will increase this risk.

Question 4: Conscientious objection

30. Health professionals have a right to freedom of thought, conscience and religion. However this must be balanced against the rights of their patient to life, health, autonomy and non-discrimination.[15] The HRLC supports clause 8 of the Bill, which respects the right of health practitioners to conscientiously object but imposes:

    (a) a duty to refer a woman to another health practitioner who does not have a conscientious objection; and

    (b) a duty to perform, or assist with, the termination of a pregnancy in cases of medical emergency.

[13] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Consultation Paper, 2017) [182].
[14] RANZCOG, 'Termination of Pregnancy' (C-Gyn 17, July 2016) [4.4]; RANZCOG, 'Queensland Abortion Law Reform' (Media Statement, 15 February 2017).
[15] Note that freedom of religion can be limited in certain circumstances, including to protect health and to protect the rights and freedoms of others: *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 (entered into force 23 March 1976) art 18(3). Also, Committee on the Elimination of Discrimination Against Women, *General Recommendation 24 on Women and Health,* 20th session, 1999.

31. Medical practitioners are in a position of power and authority over their patients. A duty to refer ensures that women receive the treatment and information they need without unnecessary, and potentially harmful, delays.[16]

Question 5: Safe access zones

32. Patients and staff can be severely affected by the intimidating and abusive behaviour of some anti-abortionists outside abortion clinics.[17]

33. The HRLC supports the establishment of 150 metre safe access zones around health services that provide abortion care in Queensland. Women should not have to run a gauntlet of intimidation and abuse to see their doctor or access health care and information.

34. This is consistent with legislative developments in Tasmania, Victoria, New South Wales and the Northern Territory.[18]

The nature and impact of anti-abortion activities

35. The Commission's report noted evidence of people engaging in anti-abortion "protesting", "prayer vigils" and "footpath counselling" (without consent) outside reproductive health clinics in Queensland, which may "impact on the safety, privacy and well-being of women" and service providers.[19]

36. Around Australia, the conduct of anti-abortionists has included harassment, intimidation, jostling, striking, blocking footpaths, following women from their cars, handing out graphic and medically misleading information and attempting to provide counselling without consent.[20] Women and their families can be seriously affected by the behaviour of anti-abortionists. Some women delay urgent medical care or follow-up, while others experience distress, anger and fear, which can cause additional discomfort during and after treatment.[21] One study from the United Kingdom has noted that mere presence of anti-abortion activities outside a clinic is a gateway factor in creating distress for patients.[22]

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[16] Consistent with Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* A/54/38/Rev 1 (1999) [11].
[17] See *Clubb v Edwards* (No M46 of 2018, High Court of Australia), 'Submissions of the Castan Centre for Human Rights Law seeking leave to appear as ***amicus curiae***' (25 May 2018): http://www.hcourt.gov.au/assets/cases/06-Melbourne/m46-2018/Clubb-Edwards_CastanCentre.pdf.
[18] *Reproductive Health (Access to Terminations) Act 2013* (Tas); *Public Health and Wellbeing (Safe Access Zone) Amendment Act 2015* (Vic); *Public Health Amendment (Access to Reproductive Health Clinics) Act 2018* (NSW); *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3.
[19] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, 2018) [5.1].
[20] See for example, *Fertility Control Clinic v Melbourne City Council* (2015) 47 VR 68 [15].
[21] See *Clubb v Edwards* (No M46 of 2018, High Court of Australia), 'Annotated submissions of the Fertility Control Clinic (a firm) applicant to intervene, alternatively to be heard as ***amicus curiae***' (25 May 2018): http://www.hcourt.gov.au/assets/cases/06-Melbourne/m46-2018/Clubb-Edwards_FCC.pdf.
[22] Graeme Hayes and Pam Lowe, *A Hard Enough Decision to Make: Anti-Abortion Activism Outside Clinics in the Eyes of Clinic Users* (Aston University, 2015).

37. The threat of violence is also real. In 2001, an anti-abortionist murdered a security guard at the East Melbourne clinic.[23] More recently in New South Wales, an assault occurred in the context of anti-abortion activities outside a clinic in Surry Hills, Sydney.[24]

Sensible and proportionate safe access zones

38. Safe access zones can engage the freedom of expression of anti-abortionists, including the implied freedom of political communication in the Australian Constitution. These rights are not absolute and may be limited.[25]

39. The High Court is currently considering a challenge to Victoria and Tasmania's safe access zone laws. However, the specific provisions being challenged in the Victorian and Tasmanian laws are different to those in the Bill.

40. The HRLC considers that sensible and proportionate safe access zones, enacted for a legitimate purpose, such as protecting women from violence, harassment and surveillance when accessing a health service, do not unreasonably restrict freedom of expression.

41. Patients are a "captive audience" outside abortion clinics. People access such clinics because they need specialist reproductive healthcare and they may not be able to access it elsewhere, particularly in regional and remote parts of Queensland. In practical terms, they cannot escape the conduct directed at them.

42. Courts in the United States and Canada have recognised that patients of abortion clinics should not be forced to endure anti-abortion activities where they cannot escape it.[26] The Supreme Court of the United States has noted that "targeted picketing of a hospital or clinic threatens not only the psychological, but also the physical, well-being of the patient held "captive" by medical circumstance".[27]

43. The UN Committee on the Elimination of Discrimination Against Women has recognised that 'abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment".[28] The protection of women's privacy, safety and dignity when accessing reproductive healthcare is consistent with Queensland's human rights obligations.

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[23] See Jamie Berry & Ian Munro, '"Remorseless" recluse gets life' (*The Age*, 20 November 2002) https://www.theage.com.au/articles/2002/11/19/1037697662403.html.
[24] 'Anti-abortion activist caught on camera punching a man whose wife was in clinic' (news.com.au, 18 May 2018), https://www.news.com.au/lifestyle/parenting/pregnancy/.
[25] *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966 (entered into force 23 March 1976) art 19(3). For the implied constitutional freedom, see *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *Coleman v Power* (2004) 220 CLR 1.
[26] See e.g. *R v Spratt* (2008) BCCA 340, [80]-[89]; *Hill v Colorado* (2000) 530 US 703, 718.
[27] *Madsen v Women's Health Centre Incorporated* (1994) 512 US 753, 768.
[28] CEDAW Committee, *General Recommendation 35 on gender-based violence against women, updating General Recommendation No 19*, UN Doc CEDAW/C/GC/35 (14 July 2017) [18].

Amendment to the definition of prohibited conduct in the Bill

44. Clause 16 of the Bill includes a prohibition on audio or visual recording without consent, which the HRLC supports.

45. Clause 15 prohibits conduct that relates to abortions (or could reasonably be perceived as relating to abortions) that could be seen or heard by people entering or leaving a clinic, and that is "reasonably likely to deter a person from entering or leaving, or from requesting, undergoing or providing, a termination at the premises". Conduct does not have to actually deter a person, or have actually been seen or heard by that person, to be prohibited.

46. Unlike Victoria and New South Wales, the Bill lacks a clear prohibition on plainly unacceptable behaviour, such as intimidation, obstruction or harassment in safe access zones. Instead, the obstructive, harassing or intimidating behaviour must be "reasonable likely to deter" a woman from requesting or undergoing an abortion.

47. The HRLC is also concerned that the current wording of the Bill may not stop conduct likely to cause serious psychological distress or harm where it is unlikely to also deter a person from accessing abortion care. This is clearly an undesirable outcome.

48. The additional deterrence element is likely to act as a barrier to enforcement because it requires the prosecution to establish the type of conduct that is reasonably likely to deter. This will not be easily proven and could change depending on the circumstances and the vulnerabilities of patients and staff.

49. The laws should protect against unwanted interference in women's private decisions. Canadian courts have explained that a broad "white line prophylactic rule" that prohibits behaviours without additionally needing to prove intention or an impact on the victim is necessary because it is too difficult to attempt to characterise each interaction between anti-abortionists and patients as harassing or not harassing.[29] Similarly, safe access zones in Queensland should not be undermined by the difficulties of proving deterrence in every case.

50. The HRLC therefore recommends the following amendments to the Bill, which are consistent with the approach in New South Wales and Victoria:

    (a) An additional clause in which it is prohibited, within a safe access zone, to harass, intimidate, beset, threaten or hinder; or obstruct or impede access to an abortion service by any means; or to obstruct or block a footpath or road leading to an abortion service without reasonable excuse and *without a requirement to prove such conduct is reasonably likely to deter*.

[29] *R v Watson*, citing US Supreme Court in *Hill v Colorado.*

(b) Inserting "or is reasonably likely to cause distress or anxiety to a person mentioned in paragraph (b)" into clause 15 after sub-clause (1)(c).[30]

Question 5: offences for unqualified persons

51. The HRLC supports the regulation of abortion as a health matter rather than one of criminal justice. We support the approach taken to decriminalisation in the Bill, including the creation of offences for unqualified persons performing or assisting with the performance of an abortion.

Question 6: Other matters

Counselling

52. The HRLC is opposed to the inclusion of mandatory counselling in abortion laws. The Bill does not contain a requirement for women to undergo counselling, which is appropriate and consistent with recommendations of both the Queensland and Victorian Law Reform Commissions.[31]

53. While voluntary, confidential and impartial counselling can be important for some people before or after the decision to have an abortion, no person should be forced into counselling.

Sex-selective abortion

54. We are concerned by a claim recently made by an anti-abortion group that decriminalising abortion and improving access to safe and quality abortion services in Queensland would increase sex-selective abortions.

55. We are not aware of evidence to support such a claim.

56. One study of births in Victoria appears to have been the basis for this claim.[32] Critically, the study found that, from over 1 million births *in Victoria*, the overall ratio of boys to girls was appropriate. While it identified higher numbers of boys born to mothers from China, India and South East Asia, it could not draw conclusions on the contribution that overseas assisted reproductive services or abortion had on the findings.

57. The study made no recommendations about abortion laws. Rather, its conclusions emphasise the importance of health policy makers reinforcing "social policies to tackle gender discrimination in all its forms".[33]

[30] The Human Rights Law Centre has intervened in support of a similar provision in Victorian law, which is currently being challenged in the High Court: see *Clubb v Edwards* (No M46 of 2018, High Court of Australia).
[31] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report 76, 2018) [6.16]; Victorian Law Reform Commission, *Law of Abortion* (Final Report, 2008) recommendation 5.
[32] Kristina Edvardsson et al, 'Male-biased Sex Ratios in Australian Migrant Populations: A Population-Based Study of 1191250 Births 1999-2015' (2018) 1(13) *International Journal of Epidemiology* 12.
[33] Ibid,12.

58. We are not aware of evidence that a legislative ban on sex-selective abortions would impact on male-female birth ratios in Australia. If anything, it is likely to lead to greater marginalisation, and even racial profiling, of women from culturally and linguistically diverse backgrounds at the hands of health practitioners unsupportive of abortion.

59. The World Health Organisation and United Nations agencies have found that imposing restrictions or prohibitions on access to health services like abortion for sex-selective reasons is more likely to have harmful impacts on women and "may put their health and lives in jeopardy".[34] In recommending measures that tackle the socio-economic practices and values that place low value on women, they warn that:

> *Restricting access to technologies and services without addressing the social norms and structures that determine their use is therefore likely to result in a greater demand for clandestine procedures which fall outside regulations, protocols and monitoring. Discouraging health-care providers from conducting safe abortions for fear of prosecution thus potentially places women in greater danger than they would otherwise face.*[35]

60. If there is evidence of sex-selective abortions taking place in Queensland, we urge evidence-based socio-economic measures that address the structures and values in society that see females valued less than males, rather than an approach that will make it harder for some women to access quality reproductive healthcare.

Gender neutral language in laws

61. It is important to ensure that abortion law reforms cover all people who could become pregnant. By referring exclusively to women, the language of the Bill excludes people who may need to access reproductive health services, such as transgender men and gender diverse people who do not identify as female.

62. Section 32B of the *Acts Interpretation Act* 1954 (Qld) should ensure that the new laws extend to transgender men and gender diverse people, however the language of the Bill itself should be inclusive.

63. In the interests of ensuring that Queensland's laws are fully inclusive, we recommend replacing references to 'woman' with 'pregnant person'. This would be consistent with the primary object of such a provision, namely to ensure all people can access abortion services.

[34] Office of the High Commissioner for Human Rights, UN Population Fund, UN Children's Fund, UN Entity for Gender Equality and the Empowerment of Women, World Health Organization, 'Preventing Gender-Biased Sex Selection: An Interagency Statement OHCHR, UNFPA, UNICEF, UN Women, WHO' (World Health Organization, 2011) 6.
[35] Ibid.