Human Rights Law Centre

Modernising NSW's archaic abortion laws

Submission on the Reproductive Health Care Reform Bill 2019 to the NSW Parliament Standing Committee on Social Issues

13 August 2019

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About the Human Rights Law Centre

The Human Rights Law Centre uses a strategic combination of legal action, advocacy, research, education and UN engagement to protect and promote human rights in Australia and in Australian activities overseas.

It is an independent and not-for-profit organisation and donations are tax-deductible.

The Human Rights Law Centre has advocated for the decriminalisation of abortion, improved access to abortion care, and safe access zone laws around Australia. Most recently, we collaborated with pro-choice partners to secure abortion decriminalisation in Queensland and safe access zones in NSW, and successfully intervened in a High Court challenge to Victoria's safe access zone laws. We are an active member of the NSW Pro Choice Alliance.

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1. Introduction

1. On 1 August 2019, the *Reproductive Health Care Reform Bill 2019* (**Bill**) was introduced into the NSW Legislative Assembly. The Bill was referred to the Legislative Council's Standing Committee on Social Issues (**Committee**) after passing the Legislative Assembly on 8 August 2019. A number of amendments were made to the bill in the Legislative Assembly.

2. The Human Rights Law Centre (**HRLC**) would like to appear as a witness before the Committee, and authorises the publication of this submission.

2. Executive Summary

3. NSW has a historic opportunity to bring its archaic abortion laws into the 21st century, and promote the right of every person to control what happens to their bodies and their lives.

4. We urge the Legislative Council to pass the Bill in its current form, without further amendment or delay. This Bill is critical to improving reproductive health outcomes across NSW and will see abortion treated has a health matter to be determined between a patient and their doctor.

5. NSW's current abortion laws are hopelessly out of step with community standards, modern medical practice and human rights. Although it is legal to access and provide abortions in NSW in certain circumstances, abortion is still a criminal offence under the *Crimes Act 1900* (NSW), punishable by ten years imprisonment. This is unacceptable.

6. The international human rights framework is clear: NSW has a duty to guarantee safe access to abortion services and post-abortion care, including by decriminalising abortion.[1] Forcing women to carry pregnancies to term against their will causes serious physical and psychological harm, and has been recognised as violating the right to freedom from torture and cruel, inhuman or degrading treatment.[2] Laws that criminalise or restrict medical procedures needed by women discriminate against women[3] and threaten basic rights to life, health and bodily autonomy. Such laws also perpetuate wrongful stereotypes of women as "reproductive instruments"[4] and as incapable of making decisions about their own bodies.

[1] Committee on Economic, Social and Cultural Rights, *General comment No 22: Sexual and Reproductive health*, UN Doc E/C.12/GC/22 (2016) [28]; Committee on the Elimination of Discrimination Against Women. *General Recommendation No 35: Gender-Based Violence against Women, Updating General Recommendation No. 19*, UN Doc CEDAW/C/GC/35 (2017) [29(c)].
[2] Human Rights Committee, *Views: Communication No 2425/2014*, UN Doc CCPR/C/119/D/2425/2014 (17 March 2017) ('*Whelan v Ireland*'). See also Juan Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment*, UN Doc A/HRC/31/57 (5 January 2016) [43].
[3] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health,* A/54/38/Rev 1 (1999) [11]: Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional protocol, concerning communication no.2324/2013,* UN Doc CCPR/C/116/D/2324/2013 (9 June 2016) [7.9]-[7.11].
[4] Human Rights Committee, *Views adopted by the Committee under article 5(4) of the Optional Protocol, concerning communication no 2324/2013*, UN Doc CCPR/C/116/D/2324/2013 (17 November 2016) [7.11]

7. Women's basic rights to non-discrimination and to freely choose if and when to have children are undermined by the current NSW system that threatens prosecution for a personal medical decision. The threat is not merely theoretical – only two years ago, a mother of five was prosecuted for administering misoprostol to herself in an attempt to end her pregnancy.

8. No other health procedure has been regulated in law like abortion. It is time to start treating abortion like all other health procedures. Passing the Bill would demonstrate that NSW's Parliament respects women as competent decision-makers over their bodies and is committed to promoting women's health, safety and equality. We also applaud the use of gender-inclusive language in the Bill, which, in an Australian first, recognises that transgender men and gender diverse people also experience pregnancy.

9. The Bill introduced into the Legislative Assembly to decriminalise abortion in NSW was consistent with current clinical practice, as well as the laws in Victoria and Queensland[5], and the recommendations of the law reform inquiry processes that led to those laws.

10. The Bill was amended in the Legislative Assembly. While we recommend that the Legislative Council pass the Bill in its current form, we have outlined concerns about a number of those amendments, as well as with the "unqualified person" offence, in this submission.

11. We note that a number of the amendments made to the Bill in the Legislative Assembly have been criticised by medical professionals, lawyers and women's advocates for being unnecessary, confusing, or insulting to medical practitioners and women.[6] It is critical that NSW Health monitor the impact of these amendments to ensure that they do not, in their practical application, undermine access to safe and high quality reproductive healthcare, particularly for vulnerable women who find themselves in the difficult circumstance of needing an abortion after 22 weeks gestation.

12. We emphasise that in addition to reforming the law, there is a real need for the NSW Government to ensure that affordable, impartial and confidential abortion services are practically available to all pregnant people across NSW.

3. Recommendations

13. The HRLC makes the following recommendations:

    (a) The Legislative Council should pass the Bill in its current form in order to decriminalise abortion without delay and improve reproductive health outcomes.

[5] *Abortion Law Reform Act 2008* (Vic); *Termination of Pregnancy Act 2018* (Qld)
[6] See e.g., Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Reproductive Health Care Reform Bill 2019: Proposed Amendments' (Media Statement by Dr Vijay Roach, President, 7 August 2019); Australian Medical Association, 'Unfounded Fearmongering on Abortion Puts Women and Doctors at Risk' (Media Statement, 7 August 2019) Michael McGowan, 'NSW abortion law: informed consent requirement confusing, says AMA' (*The Guardian*, 8 August 2019).

(b) NSW Health should work with relevant stakeholders, including medical regulatory and professional bodies and women's health organisations, to:

(i) clarify the application of guidelines referred to in the Bill (in relation to informed consent and the performance of abortions after 22 weeks) and to ensure that the development and application of guidelines facilitate equitable access to abortion care;

(ii) ensure that doctors who provide information about counselling under clause 7, provide information about services that offer unbiased and all-options healthcare and information;

(iii) ensure that the counselling clause and the requirement in clause 6 for two "specialist medical practitioners" do not create barriers to patients accessing timely reproductive healthcare;

(iv) undertake proactive measures to:

(A) ensure that health practitioners with a conscientious objection to abortion understand and comply with their legal, ethical and professional duties; and

(B) identify regions of NSW in which there are gaps in comprehensive reproductive healthcare services and information as a result of conscientious objectors, and ensure services are available to these regions including by providing funding for services.

(c) The Minister for Health should include consideration of the Legislative Assembly amendments as part of the five year review of the Act required under clause 16.

4. Removal of abortion from the *Crimes Act 1900*

14. Currently, sections 82-84 of the *Crimes Act 1900* (NSW) make abortion a criminal offence, with penalties of up to ten years imprisonment for doctors and women who participate in an "unlawful" abortion. Courts have interpreted the criminal law as allowing for "lawful" abortions in circumstances where a medical practitioner honestly believes the continuation of pregnancy places a woman's life or physical or mental health in serious danger.[7]

15. The Bill would repeal sections 82-84 and thereby remove abortion from the *Crimes Act* where it is performed by a medical practitioner with their patient's consent.

16. The legal status of abortion directly affects the planning, safety and quality of reproductive health services.[8] As was noted in a Parliamentary inquiry in Queensland, the decriminalisation

[7] See *R v Wald* [1971] DCR (NSW) 25, 29 (per Levine DCJ). Kirby J considered that a woman's mental health after the pregnancy was relevant: *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47, 60.
[8] Public Health Association of Australia, *Abortion in Australia: Public Health Perspectives* (2005) 12.

of abortion means medical practitioners "focus on practicing in accordance with evidence based clinical standards to address women's health care needs, free of the threat of criminal proceedings".[9]

17. No person should ever have to fear criminal prosecution for seeking healthcare or trying to help their patients. It is long past time to remove abortion from the criminal law.

Unqualified person offence

18. The bill creates an offence for an unqualified person to perform or assist with an intentional termination of pregnancy. Prosecutions under this offence provision are subject to approval by the Director of Public Prosecutions (**DPP**).

19. There are no other medical procedures for which a specific offence provision is attached – existing health and criminal law frameworks are considered sufficient to deter unqualified people performing procedures, from vasectomies to neurosurgery.[10] We agree with the principle of deterring unqualified people from performing or assisting with any medical procedure. However, we are concerned that a specific criminal offence carrying a seven year prison sentence may deter a woman from seeking help, for example if something goes wrong after a friend or family member acts altruistically to obtain abortion medications online.

20. It is the criminalisation of abortion and a lack of accessible abortion services that create a market for unqualified operators. A policy response focusing on ensuring abortion services are affordable, confidential and accessible across NSW will stop women from turning to unqualified people in desperation to access the health treatment they need.

21. The HRLC believes that abortion should be treated like all other health procedures in law, so as to facilitate the best possible reproductive health outcomes for all. The need for this provision should be considered as part of the Minister's five year review.

22. We note that the unqualified person offence is broadly consistent with the laws in Victoria and Queensland, with the addition of a safeguard requiring the DPP to approve prosecutions, thus ensuring that they will only occur in the public interest. We support the inclusion of this safeguard.

[9] Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016 and Inquiry into Law Governing Termination of Pregnancy in Queensland* (Report No 24. August 2016) 63.
[10] For example, the *Health Practitioner Regulation National Law (New South Wales) Act 2009* (NSW); *Therapeutic Goods Act 1989* (Cth); and *Crimes Act 1900* (NSW).

5. New legislative criteria for all terminations

23. Clauses 5 and 6 of the Bill, as amended, allow a doctor to perform an abortion on a person not more than 22 weeks gestation with their "informed consent". After 22 weeks gestation, a "specialist medical practitioner" is only permitted to perform an abortion if a range of criteria are satisfied.

24. Prior to amendment, these clauses were clear, and consistent with the approach in the Queensland *Termination of Pregnancy Act 2018*, which was preceeded by a comprehensive review of abortion laws by the Queensland Law Reform Commission.[11] Clear laws are essential for ensuring that doctors and women can make decisions with a shared understanding of the obligations placed on them.

25. We have a number of concerns with specific amendments to the bill, which are outlined below. More broadly, the bill has become more difficult to interpret as a result of the amendments.

Informed consent

26. Doctors have a duty of care in law to their patients, which requires them to ensure that patients are able to give informed consent to treatment, including abortion care. Ordinarily, consent will be valid if the patient has capacity to give consent; gives consent freely and with no pressure; and understands the effect, material risks and alternatives of the treatment.[12] A doctor who fails to obtain informed consent (outside of emergency situations) would be liable to criminal charges and negligence claims.

27. Despite informed consent being a clear requirement in common law, applying to all medical procedures, an amendment was passed in the Legislative Assembly inserting a statutory requirement for "informed consent" that applies to all abortions, except in an emergency.[13]

28. The Bill now defines "informed consent" in Schedule 1 as consent given "freely and voluntarily" and "in accordance with any guidelines applicable to a medical practitioner in relation to the performance of the termination".

29. This amendment is unnecessary given the existing legal requirements for doctors, which are also reiterated in a NSW Health Policy Directive.[14] The Attorney-General acknowledged this when moving the amendment:

[11] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report, 2018). Similar laws were enacted in Victoria after a review by the Victorian Law Reform Commission, however the gestation period in the *Abortion Law Reform Act 2008* (Vic) is 24 weeks.
[12] See *Rogers v Whitaker* (1992) 175 CLR 479; NSW Ministry of Health, *Policy Directive: Consent to Medical Treatment - Patient Information* (published January 2005, last reviewed June 2017), https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_406.pdf
[13] Reproductive Health Care Reform Bill 2019 (NSW), cl 5(2), 6(1)(c).
[14] NSW Health, *Policy Directive: Consent to Medical Treatment - Patient Information* (published January 2005, last reviewed June 2017), https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_406.pdf, 9-10.

> *"I know that basic medical practice requires such informed consent. I note, for example, the framework for terminations in New South Wales public health organisations currently specifies that written consent of the woman is needed before a termination is performed."*[15]

30. More alarmingly, the amendment creates legal uncertainties about the obligations of doctors towards their patients in relation to abortion. It is not clear how the definition inserted into the Bill should operate alongside the existing common law, and what this means in practice for doctors who are seeking to obtain informed consent.

31. Of particular concern is the inclusion in the definition of "*any* guidelines applicable to the medical practitioner in relation to the performance of the termination" [emphasis added]. There is no limitation as to which guidelines will now define "informed consent", how many different sets of guidelines could apply, and who is responsible for their development. It may have been intended that the definition be linked to the existing NSW Health Policy Directive on consent to medical treatment, however this is not what is set out in the legislation.

32. In the United States, the concept of informed consent has been manipulated by anti-choice politicians in some states in ways that are harmful to women, for example, forcing patients to look at materials with graphic images of foetuses in order to give informed consent.[16] We are concerned that there is potential for guidelines around informed consent to be used in similar ways in NSW in the future – bypassing the Parliament to fundamentally change the intent of this Bill and the foundations of informed consent.

33. We note that the Australian Medical Association has also expressed concern about this amendment and warned that it creates an "extra hurdle" for woman accessing health care, and is confusing where this is the "status quo" required of doctors in all medical procedures.[17] We are concerned that this provision may create a barrier to quality reproductive healthcare.

34. The HRLC does not consider there to be a need for a separate definition of "informed consent" in the Bill and is particularly concerned with the reference to guidelines in the definition. This is a matter that should be included as part of the Minister's five year review.

35. In addition, we recommend that NSW Health work closely with relevant stakeholders, including medical regulatory and professional bodies and women's health organisations, to clarify the application of the guidelines and ensure that the development and application of the guidelines facilitate equitable access to reproductive healthcare.

[15] New South Wales, *Parliamentary Debates*, Legislative Assembly, 8 August 2019, 14 (The Hon Mark Speakman MP).
[16] See e.g. Jessica Mason Pieklo, 'The slippery slope of "informed consent" abortion laws' (*Rewire News*, 30 August 2012)
[17] Reported in Michael McGowan, 'NSW abortion law: informed consent requirement confusing, says AMA', (*The Guardian*, 8 August 2019).

Counselling

36. Another Legislative Assembly amendment to the Bill was the insertion of a clause that requires doctors to assess whether a patient would benefit from a discussion about accessing counselling.[18] If they assess that their patient would benefit, and their patient is interested in counselling, the doctor must provide information about accessing counselling, including publicly-funded counselling. This obligation applies to medical practitioners prior to performing an abortion at any stage of a pregnancy.

37. In its extensive review of abortion laws, the Victorian Law Reform Commission found that the provision of counselling is a "clinical matter best left to professional judgment based on a woman's circumstances".[19] The Queensland Law Reform Commission (**QLRC**) reached the same conclusion, noting that while it is "important that professional, unbiased, confidential and non-judgmental counselling is available and accessible to women who are contemplating a termination, and women who have undergone, or contemplated but decided against, a termination", it is "better addressed as a matter of clinical practice, rather than by legislation."[20]

38. The QLRC noted that a requirement *in law* relating to counselling could act as "an additional barrier" and and "give rise to uncertainty regarding enforceability and lawfulness for health practitioners."

39. From the perspective of women and pregnant people, the inclusion of a counselling provision in the bill reinforces stereotypes of vulnerability and suggests that women aren't capable of making considered decisions for themselves.

40. We note that clause 7 is limited to requiring a doctor to *assess* whether a patient would benefit from discussing access to counselling. While undesirable to include this in law, we understand that this wording is at least broadly reflective of clinical practice. We urge NSW Health to:

    (a) work with relevant stakeholders, including medical regulatory and professional bodies and women's health organisations, to ensure that doctors who provide information about counselling provide information about services that offer unbiased and all-options healthcare and information; and

    (b) monitor implementation of this provision to ensure it is not creating barriers to patients accessing timely reproductive healthcare.

[18] Reproductive Health Care Reform Bill 2019 (NSW), cl 7.
[19] Victorian Law Reform Commission, *Law of Abortion: Final Report* (March 2008) [8.139].
[20] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report, 2018) 194.

6. New requirements that apply only to terminations after 22 weeks gestation

The 22 week gestation period

41. The Bill has a gestation period of 22 weeks, after which a set of criteria must be satisfied before a medical practitioner can deliver healthcare in the form of an abortion. It is critical that this gestation period not be lowered.[21]

42. This reflects the approach recently adopted in the *Termination of Pregnancy Act 2018* (Qld) following extensive examination of abortion laws by the QLRC. Both the Australian Medical Association (NSW) and Royal Australian and New Zealand College of Obstetricians and Gynacologists (**RANZCOG**) have supported this approach.[22]

43. We note an attempt in the Legislative Assembly to amend the gestation period in the bill to 20 weeks.

44. Patients who need abortion care after 22 weeks face extremely distressing and complex circumstances, and are often confronting a fatal or serious diagnosis in the context of a wanted pregnancy. It is critical that the gestation period in the Bill not be reduced and that the existing criteria set out in clause 6 not be amended further. We have **attached** a factsheet that further explains the importance of the gestation period being no earlier than 22 weeks.

Specialist medical practitioners

45. The Bill was amended in the Legislative Assembly to require that medical practitioners involved either in performing, or giving an opinion about the appropriateness of, an abortion after 22 weeks, be "specialist medical practitioners". The term "specialist medical practitioner" is defined to include obstetricians, gynaecologists and "other expertise that is relevant to the performance of the termination, including, for example, a general practitioner who has additional experience or qualifications in obstetrics".[23] This requirement does not apply in cases of emergency.

46. The QLRC considered whether specific criteria should be set down in law in relation to the medical practitioners involved in abortions after 22 weeks. It concluded:

[21] In submissions to recent law reform inquiries in South Australia and Queensland, the HRLC stated that gestation periods in law are unnecessary, and if they are to be included, should operate no earlier than 24 weeks gestation. See for example, Human Rights Law Centre, *Reproductive Freedom in Law* (Submission to the South Australian Law Reform Institute, May 2019). As far as the HRLC is aware, for no other medical procedure or surgery does the law set criteria that must be satisfied before medical practitioners can treat their patient. We also note that RANZCOG has explained that gestational limits discriminate against women in the most difficult or vulnerable circumstances and has recommended, in the context of attempts to reform abortion laws in Queensland, that there "should not be a specified gestational range": Royal Australian and New Zealand College of Obstetricians and Gynaecologists 'Queensland abortion law reform' (Media Statement, 15 February 2017).
[22] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 'Reproductive Health Care Reform Bill 2019' (Media Statement, 2 August 2019); Australian Medical Association, 'AMA (NSW) President Welcomes Bill to Decriminalise Abortion in NSW' (Media Statement, 28 July 2019).
[23] See Reproductive Health Care Reform Bill 2019 (NSW) cl 6 and sch 1 (definition of "specialist medical practitioner").

> *It is unnecessary for the legislation to impose additional requirements about the qualifications, expertise or experience of the second medical practitioner. These are matters properly to be determined on a case by case basis in accordance with good medical practice.*[24]

47. The *Health Practitioner Regulation National Law (NSW)* already deals with credentialing and regulation of health practitioners. In addition, doctors practicing outside of their accreditation and training also risk insurance coverage and civil proceedings against them.

48. The HRLC is concerned that the narrow definition of "specialist medical practitioner" and the requirement for both medical practitioners to satisfy this definition, could add to the anguish, pain of women needing an abortion after 22 weeks. For example, a patient requiring treatment for cancer may already have an oncologist and obstetrician treating them who both recommend a termination of pregnancy, to be performed by the obstetrician. Under the amended Bill, the oncologist cannot be considered a "specialist medical practitioner" and therefore another "specialist medical practitioner" would need to be found. This could result in delays in the provision of care, as well as bringing more people unnecessarily into a very personal and difficult decision. The law should facilitate best medical practice, not create barriers through overly prescriptive laws.

49. The HRLC considers that at the very least, only one of the medical practitioners involved in a termination after 22 weeks should be required to be a "specialist medical practitioner" (as defined by the Bill). We recommend that this be considered as part of the five year review and, that in the meantime, NSW Health monitor the implementation of this part of the Bill to ensure that it does not create barriers to patients accessing timely reproductive healthcare.

Public hospitals and approved health facilities

50. The Bill was amended in the Legislative Assembly to include a requirement that abortions after 22 weeks to occur in public hospitals or "an approved health facility".[25] The Secretary of the Ministry of Health is authorised to approve health facilities, and to issue guidelines about the performance of abortions after 22 weeks at approved health facilities.

51. The HRLC is pleased to see clarification that "ancillary services" are excluded, which means ultrasounds and the prescription of medication are not restricted. Inclusion of ancillary services would have threatened accessibility for people in regional and remote parts of NSW in particular.

52. We understand that all terminations after 22 weeks already occur in appropriately credentialed hospitals in NSW. In addition, NSW Health's *Guide to Role Delineation of Clinical Services*

[24] Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws* (Report, 2018) 102.
[25] Reproductive Health Care Reform Bill 2019 (NSW) cl 6(1)(d).

provides a framework that describes the minimum support services, workforce and other requirements for clinical services to be delivered safely.[26]

53. While it was unnecessary to amend the bill in this way, the provision appears unlikely to impact on existing practice. The implementation of this provision should be monitored to ensure that it doesn't result in delays in access to abortion care.

54. It is critical that abortion law reform in NSW supports affordable access to abortion, particularly for women in regional and remote areas who have, for too long, had to travel considerable distances to access the limited number of hospitals that provide abortion services.

7. Access to healthcare and conscientious objection

55. Encountering a doctor with a conscientious objection to abortion can impede timely access to vital health services, which in turn can imperil a woman's physical and psychological health. A recent study in Victoria identified incidents of doctors subverting, misusing or directly contravening conscientious objection duties, with some reporting that it was "common practice" for doctors in rural areas to refuse to refer women seeking an abortion to someone who could advise them.[27]

56. Health professionals have a right to freedom of conscience and religion. However this must be balanced against the rights of women to life, health, autonomy and non-discrimination.[28] Doctors have a duty of care to all their patients, which requires them to act in their patients' best interests.

57. Health practitioners choose their profession and are in a position of power and authority in relation to their patients and the public. This is especially true for doctors who decide to practice in regional and remote locations. Their right to conscientiously object has been, and continues to be, very well protected. However, the same cannot be said for the rights of women who have experienced emotional, physical, financial and social harm as a result of being delayed or prevented in accessing time-sensitive healthcare as a result of encountering one or more doctors with a conscientious objection.

58. Women must be able to access the services they require without discrimination or delay. RANZCOG supports this approach, stating that "health practitioners owe a duty of care and

[26] NSW Ministry of Health, *NSW Health Guide to the Role Delineation of Clinical Services* (June 2018).
[27] Louise Anne Keogh et al, 'Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspective of abortion service providers', *BMC Medical* (31 January 2019).
[28] Note that freedom of conscience and 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); Committee on the Elimination of Discrimination Against Women, *General Recommendation 24 on Women and Health,* UN Doc A/54/38/Rev.1 (1999) chap 1.

must refer the patient to other health practitioners or health services where a woman is able to receive the health care she needs".[29]

59. Prior to amendment in the Legislative Assembly, the Bill respected the right of health practitioners to conscientiously object (except in emergencies). However, it imposed a duty to ***refer*** (or transfer the care of) a woman to another health practitioner who could provide the relevant service and whom it was believed did not hold a conscientious objection. In our interpretation, that provision did not require a formal referral.

60. The duty to refer was consistent with the laws in Victoria and Queensland. It is also consistent with the recommendation of the UN Committee on the Elimination of Discrimination against Women.[30] Most recently, a Canadian appeal court found that the duty to provide an effective referral struck the right balance between equitable access to healthcare and freedom of religion.[31]

61. The Bill was amended by the Legislative Assembly however, to replace the duty to refer with a duty to "give information" about "how to locate or contact" a medical practitioner who the conscientious objector believes does not hold an objection.[32] It is unclear what will satisfy this amended duty. For example, would instructing a patient to do their own internet search for a clinic that can help them satisfy this duty?

62. Given the disruption caused to a patient's healthcare by a doctor with a conscientious objection, and the challenges with enforcing conscientious objection duties more broadly, it should be a priority of NSW Health and the relevant health regulatory bodies to clarify and enforce the duties of health practitioners with a conscientious objection. NSW Health should also ensure that conscientious objectors are not leaving entire regions without access to comprehensive reproductive healthcare and information.

63. We recommend NSW Health work with relevant stakeholders, including medical regulatory and professional bodies, to undertake proactive measures to:

    (a) ensure that health practitioners with a conscientious objection to abortion understand and comply with their legal, ethical and professional duties; and

    (b) identify regions of NSW in which there are gaps in comprehensive reproductive healthcare services and information as a result of conscientious objectors, and ensure services are available to these regions including by providing funding for services.

[29] Royal Australian and New Zealand Colleage of Obstetricians and Gynaecologists, 'Statement on the Reproductive Health Care Reform Bill 2019' (Media Statement, 30 July 2019).
[30] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and Health* A/54/38/Rev 1 (1999) [11].
[31] *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario* [2019] ONCA 393
[32] Reproductive Health Care Reform Bill 2019 (NSW) cl 9(3)(a).

8. Responding to sex-selective abortion claims

64. We are concerned by unsubstantiated claims that decriminalising abortion and improving access to safe and quality abortion services in NSW would increase sex-selective abortions.

65. We are not aware of evidence to support such a claim and note that such claims, and the corresponding call for laws that ban of sex-selective abortions, are typically made by opponents of abortion.

66. The most recent study considering sex ratios in Australian populations, published in 2018 by La Trobe University, appears to have been the basis for these claims.[33] 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 a handful of countries, it *could not draw conclusions* on the contribution that overseas assisted reproductive services or abortion had on the findings. 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".[34]

67. A rushed amendment to the Bill saw a Ministry of Health review about this issue incorporated into the Bill, to be carried out within 12 months.[35] We note that this amendment was agreed to as an alternative to a more concerning amendment that proposed banning "gender selection". There is no evidence to show that there is a problem. However if there was, abortion bans are certainly not the appropriate way to deal with it.

68. The Bill should enshrine an approach where good clinical practice and a patient's best interests are primary. Bans on sex-selective abortions will have unintended consequences that hurt women and block timely access to healthcare. A ban would require a doctor to interrogate a woman's reasons for seeking an abortion at any stage of pregnancy, thus completely undermining the spirit of the Bill to provide women with control over their own body.

69. There are hundreds of sex-linked conditions that vary in severity and can present devastating diagnoses. In application, a ban on sex-selective abortions would place a burden on providers to scrutinise a patient's pregnancy choices and second-guess patients' reasons for seeking an abortion, thus discouraging honest, confidential conversations and interfering in the provider-patient relationship. The ban could discourage a woman who is a carrier of a sex-linked condition from having honest, confidential conversations about her concerns with her doctor out of fear that she could be forced to proceed with a pregnancy that would lead to the birth of baby who will suffer and then die.

[33] 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.
[34] Ibid 12.
[35] Reproductive Health Care Reform Bill 2019 (NSW) cl 14.

70. We are concerned that a ban would likely lead to marginalisation, and even racial profiling, of women from culturally and linguistically diverse backgrounds at the hands of health practitioners unsupportive of abortion, based on negative and wrongful stereotypes. We note that unsubstantiated conclusions were drawn about particular ethnic communities during the Legislative Assembly parliamentary debate, which highlights our concerns about the interaction between a legislative ban and the stereotyping of women from culturally and linguistically diverse backgrounds. While nominally aimed at combatting gender and racial discrimination, these laws could actually work to make quality reproductive healthcare less accessible by causing some women to fear they will be treated with suspicion. As a result, women may withhold vital information from healthcare providers or not feel they can seek care at all.

71. If the proposed 12-month review finds that sex-selective abortion is a problem in NSW, the appropriate response is to invest in social and educational programs that tackle sexism, not to impose bans that are likely to cause even more harm to women.

72. 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".[36] In recommending measures that tackle the socio-economic practices and values that place low value on women, the WHO and UN agencies 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.*[37]

[36] 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.
[37] Ibid.