

# Reproductive Health and Rights in the Northern Territory: Reforming the Medical Services Act 1974

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Terms explained

Termination of pregnancy and abortion are used interchangeably

Medical termination of pregnancy is abbreviated to MTOP

## Introduction

1. This discussion paper was prepared for the purposes of a panel event on the 24<sup>th</sup> of November 2014. It deals with Australia's international obligations in relation to reproductive health and the current state of the law in relation to abortion in the Northern Territory (NT) of Australia which is largely set out in the Medical Services Act 1974 (MSA) and the NT Criminal Code (NTCC). We have provided some data, where available, although current and accurate data is problematic. We have found that some legislation on reproductive health across Australia has been reformed although the result is by no means uniform.
2. Our preliminary conclusion is that the current state of the law in relation to reproductive health in the NT puts Australia in breach of its international law obligations to provide women and girls with the right to reproductive health and the highest standards of medical care. Medical professionals, women and girls in the NT are criminalised. Women and girls in the NT are prevented from being able to determine freely and responsibly the number and spacing of their children and are unnecessarily exposed to health risks with consequent physical and emotional damage, as well as experiencing a lack of privacy. This constitutes a serious breach of the state's duty of care that, in our preliminary view, will require a report to the next CEDAW Committee.
3. It is also our preliminary view that immediate remedial action must be taken to enable freedom of choice for women and girls and the provision of flexible and suitable medical or surgical abortion services in the Northern Territory and to enable Australia to move towards better compliance with international obligations in the context of reproductive health.

4. To this end, we make recommendations for urgent implementation which were informed through discussion with interested parties to form a picture as to what is or may be achieved by way of both legal reform and practical measures.<sup>1</sup>

## Context

5. It is important to note that the current NT law allows for legal abortion. This discussion is about how to give women and girls in the NT proper health care in that context.
6. The modern international approach to women's health is one of autonomy, dignity and respect.
7. Abortion can be an emotive topic as it relates to unwanted and unviable pregnancies. We have approached this issue as a matter of law and public health.
8. We have taken it as accepted that any termination of pregnancy should be safe and services ought to be accessible.
9. We have taken it as accepted that women and girls have a right to the highest standards of reproductive health as set out in international law.
10. In Australia, emergency contraception, or the 'morning after' pill, is available for over-the-counter, non-prescription purchase, for women and girls over the age of 14, increasing its availability as an emergency contraceptive (although access to emergency contraceptive is still limited throughout regional towns and centres, with some women having to travel to hundreds of kilometres in some cases for access)<sup>2</sup>.
11. Pregnancy tests are available over the counter, and when unwanted pregnancy is diagnosed, women may wish to assess the available options. Women who then seek advice from their GP or the Family Planning Clinic (once the pregnancy is confirmed) are referred to hospitals where services are limited. Only surgical termination is available so women are required to carry the pregnancy for some weeks before treatment is possible,

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<sup>1</sup> Independent Member for Goyder, Ms Kezia Purick introduced the reformed Medical Services Act to parliament on 2<sup>nd</sup> December 2015.

<sup>2</sup> NGO recommendations to CEDAW in July 2009

[http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/YWCA\\_Australia46.pdf](http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/YWCA_Australia46.pdf)

since surgical termination is most effective at around 8 weeks gestation. The legislation requires that the procedure be performed by a specialist, despite it being simple, safe and common. This creates an unnecessary workload on NT specialists, and also means that there are so few authorised clinicians that services are limited. Those who can afford private services are placed under pressure to travel interstate, or covertly order abortifacients online. Such limitations in service provision expose women and girls to health risks and also highlight the inequity for those women and girls without the means to travel.

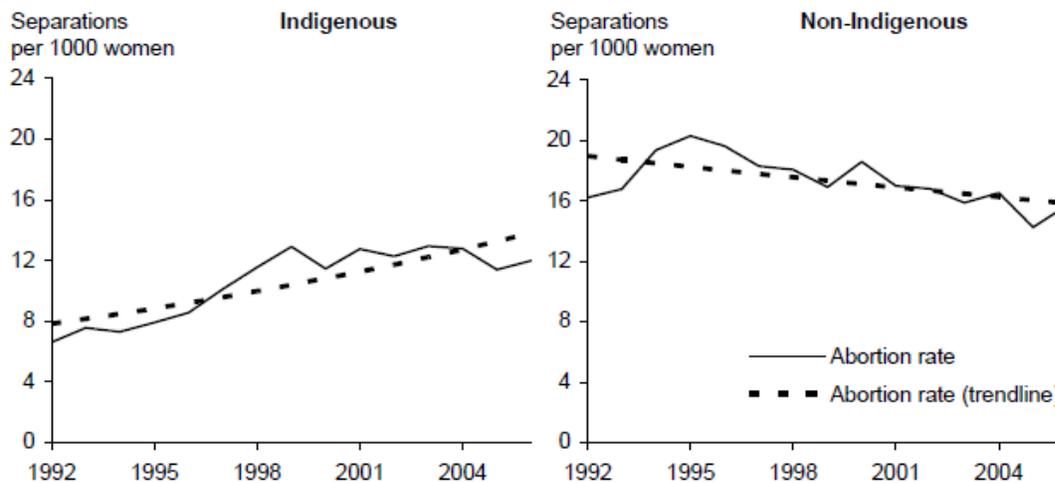
12. Abortifacients such as misoprostol and mifepristone are safe and widely used worldwide, including in Australia. They are regulated and available on the Pharmaceutical Benefits Scheme.
13. The time frame for the availability of an abortion is inconsistent in Australia.
14. We have found that some legislation on abortion across Australia has been reformed although the result is by no means uniform. We have also considered the South African approach<sup>3</sup>
15. We have found that women and girls in the NT lack choice in their abortion treatment and are currently at risk of criminalisation if they seek treatment which is safe, widely approved and globally used. They also suffer the indignity of a lack of privacy due to the lack of appropriate and accessible services.
16. In addition, medical practitioners and other health workers in the NT are at risk of criminalisation in relation to termination of pregnancy if they seek to treat patients in what would otherwise be a safe and medically acceptable way.
17. This paper allows for discussion as to how the law can and should change.

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<sup>3</sup> See Annex

## Data

18. Preventing and managing unwanted and unviable pregnancies is a public health issue requiring quality health services. A third of Australian women experience elective termination of pregnancy in their lifetime. Half of all pregnancies are unplanned and a fifth of all pregnancies terminated, while up to one third miscarry spontaneously.<sup>4</sup> Abortions are provided to women and girls in a variety of complex situations, including those who are survivors of rape, incest, those whose fetus has serious abnormalities or where there are other social, medical or health implications.<sup>5</sup>
19. The publically available data is limited and is eight years old.<sup>6</sup> The total population of the NT is 239,500 and the estimated total number of elective abortions is 1,000 annually. By way of comparison 4,000 babies are born annually. This number does not include the small number of abortions done in one private hospital, so figures for the NT are under estimated. Indigenous people make up one third of the NT population; they are comparatively younger and have higher fertility rates. Figure 1 shows the most recent publically available data for Indigenous and non-Indigenous women.



<sup>4</sup>Reproductive & Sexual Health in NSW & Australia, Differentials, Trends & Assessment of Data Sources, Family Planning NSW, 2011.

<sup>5</sup> Kirkman M, Rosenthal D, Mallett S, Rowe H, et al. Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual and Reproductive Healthcare*. 2010;1(4):149-55.

<sup>6</sup> Zhang X, Dempsey K, Johnstone K, Guthridge S. Trends in the health of mothers and babies, Northern Territory 1986-2005. Darwin: Department of Health and Families, 2010

Figure 1. Elective abortions, annual rate by Indigenous status, NT residents admitted to NT public hospitals, 1992-2006 Source: Northern Territory Government 2010 p.38

20. In 2010, around 40% of women giving birth in the NT were Indigenous and the abortion rate was reported to be 12/ 1,000 women and rising. This is in contrast to the non-Indigenous rate of 15.4/ 1,000 women and falling as of the end of 2006.<sup>7</sup> As abortion data from the private hospital was not included in the report, non-Indigenous rates are likely to be higher. Johnstone's work has shown that for Indigenous women there are patterns of rising abortions in the urban areas, whereas rural-remote rates have declined. She found that this is associated with Indigenous fertility rates and access to contraception.<sup>8</sup>
21. All of these women and girls were required, by law, to travel to hospitals in Darwin or Alice Springs and were required, by law, to access specialist services from an obstetrician/ gynecologist (see NT law below). Inevitably there are no figures for women who travel to other parts of Australia seeking a termination of pregnancy. Nor is there any data on women who purchase abortifacients through the internet and use them in the Northern Territory.

### **Procedure for early termination**

22. Early termination of pregnancy (before 9 weeks gestation) can be safely achieved by use of medicine (MTO) rather than surgical instruments/ suction. MTO has been available in Europe since 1988, in the US since 2000, and in other jurisdictions in Australia since 2006.<sup>9</sup> This puts the Northern Territory at best 8 years behind or at worst 26 years behind

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<sup>7</sup> Zhang X, Dempsey K, Johnstone K, Guthridge S. Trends in the health of mothers and babies, Northern Territory 1986-2005. Darwin: Department of Health and Families, 2010

<sup>8</sup> Johnstone K. Indigenous fertility in the Northern Territory of Australia: what do we know? (and what can we know?). *Journal of Population Research*. 2010;27(3):169-92.

33. Johnstone K. Indigenous Fertility Transitions in Developed Countries. *New Zealand Population Review*. 2011;37:105.

<sup>9</sup> de Costa CM. Medical abortion for Australian women: it's time. *The Medical journal of Australia*. 2005;183(7):378-80

evidence-based reproductive health care. MTOP is the provision of doses of mifepristone and misoprostol orally before 9 weeks gestation. It is efficacious and well-accepted by women as a method of terminating an accidental, mistimed, unwanted or unviable pregnancy.<sup>10</sup> Less than 5% of medical termination of pregnancies require follow-up due to complications such as excessive bleeding or continued pregnancy.<sup>11</sup> In South Australia, 22% of abortions are performed as a MTOP as the preferred method.<sup>12</sup> And 80% of terminations of pregnancy are performed by general practitioners.<sup>13</sup> It is cost-effective as it reduces the surgical resources required by curette termination of pregnancy.

23. Mifepristone and misoprostol are approved and recommended medicines by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.<sup>14</sup> Together these medicines produce an experience similar to a heavy menstrual period or miscarriage and general practitioners prescribe them to women for use at home.<sup>15</sup> This generally does not require women and girls to attend hospital, or the input of expensive senior doctors or the use of surgical theatres.

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<sup>10</sup> Mulligan E, Messenger H. Mifepristone in South Australia -- the first 1343 tablets. *Australian family physician*. 2011;40(5):342-5.

7. Aubény E. Medical abortion in a non-hospital setting. *European Journal of Contraception & Reproductive Health Care*. 2012;17:S161.

<sup>11</sup> Scheil W, Scott J, Catcheside B, Sage L, Kennare R. *Pregnancy Outcome in South Australia 2011*. Adelaide: South Australian Government, Pregnancy Outcome Unit, 2013.

9. Goldstone P, Michelson J, Williamson E. Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study. *Medical Journal of Australia*. 2012;197(5):282-6.

<sup>12</sup> South Australian Government. *South Australian Abortion Reporting Committee Ninth Annual Report - For the Year 2011*. Adelaide 2013.

<sup>13</sup> South Australian Government. *South Australian Abortion Reporting Committee Ninth Annual Report - For the Year 2011*. Adelaide 2013.

<sup>14</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. *The use of mifepristone for medical termination of pregnancy*. College Statement 2012.

<sup>15</sup> de Costa CM. Use of mifepristone for medical abortion in Australia, 2006-2009. *The Medical Journal of Australia*. 2011;194(4):206-7.

24. The mortality rate from any type of termination of pregnancy is extremely rare, childbirth is riskier.<sup>16</sup> There is one case in Australia of death after MTOP due to sepsis. Mulligan's reporting on 947 MTOP in South Australia found that complications such as haemorrhage, treatment failure, and sepsis were not common, and similar to surgical termination of pregnancy. The risk from perforation from surgical instruments and anaesthetics was limited to the extremely low proportion who developed complications.<sup>17</sup> In Sweden MTOP is provided by nurse-midwives with efficacy and safety outcomes better than that of doctors. These research findings of safety and efficacy of MTOP are echoed from multiple studies globally which include hundreds of thousands of cases.<sup>18</sup> The process is essentially a controlled and anticipated miscarriage and we know of no woman dying from a spontaneous unexpected miscarriage in the NT.

## **Practical Matters**

25. The legislation restricts choice and prevents the provision of current evidence-based health care.
26. Women and girls are required to travel to specialist services which may be a vast distance from support and children they are required to care for. Those who do not travel for reasons of poverty, location or pressure of time and circumstances may risk poor health outcomes and on-going social and mental consequences through unwanted pregnancy and its consequence. In the NT women and girls are referred to the Royal Darwin or Alice

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16. Johnson S, Bonello MR, Li Z, Hilder L, EA. S. Maternal deaths in Australia 2006–2010. Canberra: AIHW, 2014.

17 Mulligan E, Messenger H. Mifepristone in South Australia -- the first 1343 tablets. Australian family physician. 2011;40(5):342-5.

18 Herten Hv, Honkanen H, Piaggio G, Bartfai G, Erdnetungalag R, Gemzel-Danielsson K, et al. WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. I: Efficacy. British Journal of Obstetrics and Gynaecology. 2003;110(Sept):808-18. And The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. The use of mifepristone for medical termination of pregnancy. College Statement 2012.

Springs public hospitals or the Darwin Private Hospital for assessment. Having been assessed and provided with advice, all women or girls at any stage of pregnancy are then referred to a pre-admission clinics for a same-day procedure at a later date. No differentiation is made between those who could be treated by MTOP and those at a later stage of gestation. There is no provision for other locations.

27. The pressure on women who can afford to travel interstate for MTOP or to unlawfully order medication online is unknown but is logically obvious . Conversely there is pressure on others to carry to term with significant health and welfare results. There is no data available on women and infants' outcomes who are forced into motherhood in the NT. Research from the US indicates that women who are declined termination of pregnancy, are often poorer and more disadvantaged than other women.<sup>19</sup> The NT has the highest teenage pregnancy rate in Australia which is due to a combination of lack of education, lack of access to appropriate reproductive health services, cultural practices, vulnerability and disadvantage. Some of those girls would avail themselves of MTOP if it were available – enabling them to choose motherhood at maturity.
28. The pressure on services is unnecessary when other safe procedures are available.
29. Examination of women and ultrasound screening is within the expertise of suitably trained nursing/midwifery staff / medical officers and would not normally require a specialist obstetrician/ gynecologist or sonographer. Again, as abortion remains stigmatised, the dangers for significant lack of confidentiality by identification either at the health services or in travelling long distances to health services are obvious and would be lessened if primary health care services could provide MTOPs.
30. All procedures are surgical with the attendant risks of anaesthesia, perforation and infection.

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<sup>19</sup> Greene Foster (2014) The Turn Away Study see <http://www.ansirh.org/research/turnaway.php>

31. Treatment lacks confidentiality, particularly for girls travelling from remote communities.

## **International Law – a summary**

32. By ratifying the International Covenant on Economic, Social and Cultural Rights, Australia committed itself to recognise the right of everyone to education<sup>20</sup> and to the enjoyment of the highest attainable standard of physical and mental health and to take steps to achieve the full realisation of this right shall include those necessary for<sup>21</sup>:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

33. It follows that women and girls have rights to make their own informed sexual choices and to bear the consequences of their choices, to survive through the provision of appropriate health services in pregnancy and for their children to have an enhanced survival rate through appropriate spacing.

34. By ratifying the Convention on the Elimination of All Forms of Discrimination against Women 1979 ([CEDAW](http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx))<sup>22</sup> Australia committed itself to *eliminate* discrimination against women. Failing to provide appropriate and confidential healthcare in the context of

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<sup>20</sup> Article 13 <<http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>>

<sup>21</sup> Article 12 <<http://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>>

<sup>22</sup> UN Human Rights Resource: Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 <<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>>

reproductive health unambiguously constitutes a form of discrimination against young women and girls. The Convention obliges States parties to submit to the CEDAW reporting mechanism. The goal in this context is the reduction of maternal mortality and morbidity and enhancement of the dignity of women and their reproductive self-determination to include access to health care and the benefits of scientific progress.<sup>23</sup>

35. 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 to ensure women 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>24</sup>

36. Further, by virtue of the UN Convention on the Rights of the Child 1989 ([CRC](#))<sup>25</sup> Australia has *positive* obligations in international law to *ensure* that children are not subjected to cruel, inhuman or degrading treatment (art. 37). Failing to provide adequate and confidential medical services in the context of reproductive health to children who are at risk of harm via the consequences of failing to properly treat unwanted and / or unviable pregnancies constitutes an irreparable violation of the child's physical and psychological health.

37. These obligations were reinforced in March 2014 by 58<sup>th</sup> session of the [Commission on the Status of Women \(CSW\)](#)<sup>26</sup> which resolved that progress towards achieving Millennium Development Goal 5, on improving maternal health, and its two targets, to reduce maternal death and achieve universal access to reproductive health, has been slow

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<sup>23</sup> Cook R. International Human Rights and Women's Reproductive Health Studies in Family Planning Vol 24, No 2. (Mar-Apr., 1993)

<sup>24</sup> Cook R. International Human Rights and Women's Reproductive Health Studies in Family Planning Vol 24, No 2. (Mar-Apr., 1993)

<sup>25</sup> <http://www.unicef.org/crc/>

<sup>26</sup> <http://www.un.org/womenwatch/daw/csw/>

and uneven. There is an urgent need to fully achieve this goal, which is still far from being realised, particularly for Indigenous women. There is also a need to ensure that maternal health and universal access to sexual and reproductive health are central to any future development agenda<sup>27</sup>.

38. The CSW conclusions reflect the “sincere determination of United Nations Member States to further promote, protect and fulfil the human rights of women and girls. However, in accelerating the achievement of the Millennium Development Goals and laying the ground for effectively achieving gender equality and the realisation of the human rights of women and girls in the post-2015 development agenda, it is essential to redouble our efforts to ensure the sexual and reproductive health and rights of women and adolescent girls, including through the development and enforcement of policies and legal frameworks and strengthening of legal systems that make universally accessible and available quality, comprehensive and integrated sexual and reproductive health care services, commodities, information, and education, including comprehensive sexuality education for all young people, in and out of school, with particular attention to adolescent girls”<sup>28</sup>.
39. Therefore it is beyond argument that international law requires that Australia creates an effective and proactive mechanism that operates to protecting women and girls from unnecessary health risks.
40. It is our view that it is also beyond argument that Australia has a legal duty to ensure that quality, comprehensive and integrated sexual and reproductive health care services,

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<sup>27</sup> UNFPA Statement 22<sup>nd</sup> March 2014 <  
<http://www.unfpa.org/public/cache/offonce/home/news/pid/16936;jsessionid=5B304AEA5D59437A11301FBDB646E148.jahia01>>

<sup>28</sup> UNFPA Statement 22<sup>nd</sup> March 2014 <  
<http://www.unfpa.org/public/cache/offonce/home/news/pid/16936;jsessionid=5B304AEA5D59437A11301FBDB646E148.jahia01>>

commodities, information, and education mechanisms are adequately resourced and these obligations clearly apply in the Northern Territory.

41. 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. The current legislation criminalises women and girls in the NT and is not effective in practice.
42. We have attached the South African legislation at Annex D which expresses the principle of reproductive rights in the preamble by way of an example.

## **Australia**

43. In July 2009 the NGO Report on the Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in Australia was prepared by YWCA Australia and Women's Legal Services Australia, with the endorsement of 135 organisations.<sup>29</sup> In relation to health it made a number of recommendations including the following:

- THAT the Australian Government be commended for its commitment to a new National Women's Health Strategy.
- THAT all Australian governments ensure that women-specific health indicators such as those that were in the Public Health Outcomes Funding Agreements be maintained under the current funding arrangements.
- THAT the continued funding of stand-alone women's health services be welcomed as a great achievement.

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<sup>29</sup> NGO recommendations to CEDAW in July 2009  
[http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/YWCA\\_Australia46.pdf](http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/YWCA_Australia46.pdf)

- THAT all Australian governments reinstate the requirement that State and Territory governments provide for women’s reproductive and sexual health services.
- THAT all State and Territory governments decriminalise abortion, and move to adopt harmonious laws related to termination of pregnancy across jurisdictions.
- THAT the Australian Government increase funding for termination of pregnancy, to address the growing gap between the Medicare Rebate and the cost of service provision, including through increasing the level of rebate available through the Medicare system.
- THAT all Australian governments examine schemes to address the barriers to access of sexual health services and education faced by women in rural, regional and remote areas.
- THAT the Australian Government liaise with State and Territory governments to increase access to RU 486 and take positive steps to support its sale in Australia.
- THAT the Australian Government introduce a National Sexual and Reproductive Health Strategy, including a national curriculum on sexual health, and better training of general practitioners and health professionals in the provision of youth-based sexual health services.

44. Australia was last reviewed by the CEDAW Committee in 2010. What resulted was a 15 point action plan. Although reproductive rights are not specifically mentioned, recommendation 1 reads: “Make sure the human rights framework protects women’s human rights”. The next report was due in 2014.<sup>30</sup>

45. Pursuant to Article 12 CEDAW, abortion law reform in Australia has strengthened women’s right to access safe and legal abortions, particularly in Western Australia (1998), Tasmania (2001) and in Victoria (2008). In 2002 the ACT removed all references to abortion from its Criminal Code.

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<sup>30</sup> YMCA CEDAW Action plan for women in Australia: <[http://www.womenslegalnsw.asn.au/downloads/law-reform/2011CEDAWNGOS\\_CEDAWActionPlan.pdf](http://www.womenslegalnsw.asn.au/downloads/law-reform/2011CEDAWNGOS_CEDAWActionPlan.pdf)>

46. The website [www.childrenbychoice.org.au](http://www.childrenbychoice.org.au) summarises the situation as follows:

**Queensland & New South Wales:** Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.

**Australian Capital Territory:** Legal, must be provided by medical doctor.

**Victoria:** Legal to 24 weeks. Legal post-24 weeks with two doctors' approval.

**South Australia:** Legal if two doctors agree that a woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Unlawful abortion a crime.

**Western Australia:** Legal up to 20 weeks, some restrictions particularly for under 16s. Very restricted after 20 weeks.

**Tasmania:** Legal to 16 weeks on request, and after that point with the approval of two doctors.

47. Abortion was most recently decriminalised in Tasmania. By the Reproductive Health (Access to Terminations) Act 2013, abortion is lawful on request up to 16 weeks gestation, and beyond that point with the agreement of two doctors. As well as stipulating that abortion is no longer a crime for women in Tasmania, the reforms of 2013 include provisions around conscientious objection and access zones. Section 6 states that medical practitioners with a conscientious objection to abortion are not obliged to participate in termination of pregnancy procedures except in an emergency to save the woman's life or prevent serious physical injury. There are sanctions for those who do not refer pregnant women seeking information about pregnancy options to another doctor or counsellor without a conscientious objection. Section 9 of the Bill prohibits threatening or harassing behaviour, protesting, footpath interference, and the recording of persons entering an

abortion facility, within 150m of a premises providing abortion, known as 'access zone' legislation.

48. It is important to note that jurisdictions, such as ACT, Victoria and Tasmania have reformed legislation regulating abortion which has decriminalised and enabled women and girls to enact their human right to control their reproductive autonomy. The intention of the law should (in our view) similarly focus on the health needs and rights of women and girls in the NT.

## **NT Law – The Criminal Code (NTCC)**

### *49. Use of drugs and treatment by health workers*

Division 8 of the NT Criminal Code (NTCC) provides criminal sanctions in the context of abortion. Decisions to prosecute would be made by the DPP based on evidence and public interest in accordance with the Directors Guidelines.<sup>31</sup> The NTCC provides as follows:

#### *208A Definition*

In this Division:

"drug" includes a poison.

#### *208B Procuring abortion*

(1) A person is guilty of an offence if:

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<sup>31</sup> DPP NT Legislation and guidelines <<http://www.dpp.nt.gov.au/legal-resources/Pages/guidelines-and-legislation.aspx>>

- (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.

**Maximum penalty: Imprisonment for 7 years.**

- (2) It is immaterial that the woman is not pregnant.

*208C Supplying things for procuring abortion*

- (1) A person is guilty of an offence if the 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.

**Maximum penalty: Imprisonment for 7 years.**

- (2) It is immaterial that the woman is not pregnant.

50. Notes for s208B and 208C Note for section 208B provide that “Under [section 11](#) of the [Medical Services Act](#), in certain circumstances it is lawful for a medical practitioner to give medical treatment with the intention of terminating a woman's pregnancy”. Part 1, Division 1 of the Code defines "medical treatment" to include “dental treatment and all forms of surgery”. By normal interpretative rules this does not appear to include treatment that prescribes drugs.

51. A medical practitioner is not defined in the Code but, on any ordinary interpretation, does not include health workers or nurses who provide the majority of primary, reproductive and sexual health care in NT.
52. It follows that treatment must be surgical (not drugs) and that appropriately qualified and experienced health professionals cannot treat those seeking MTOP without risking criminal prosecution. Anyone prescribing mifepristone and misoprostol is committing a criminal offence despite those abortifacients being approved and recommended medicines.

## **Late term abortion**

Section 170 NTCC makes it a criminal offence to unlawfully kill a child. It reads as follows:

### *170 Killing unborn child*

Any person who, when a woman or girl is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a crime and is liable to imprisonment for life.

53. There are no exemptions at all to s170. Accordingly, any medical treatment involving a late term abortion is a criminal offence.

54. Late termination of pregnancy accounts for a very small percentage of all terminations. In 2005 in Australia less than 1% occurred after 20 weeks. Late abortions are very rare, very difficult to obtain and are often sought for reasons that are particularly distressing for the woman. Severe fetal abnormality can make late termination the only option. Diagnosis of many fetal abnormalities is not possible until mid- pregnancy. There is often uncertainty around the diagnosis of fetal abnormality, which becomes clearer by waiting until a later stage of pregnancy.<sup>32</sup>

### **NT Law – The Medical Services Act**

55. The Medical Services Act 1974 has been amended and revised in 2006 and 2011 but the provisions and practical reality in relation to termination of pregnancy have not changed. It allows for medical terminations up to 23 weeks and separates provisions for pregnancies up to 14 weeks and those up to 23 weeks. It provides as follows:

#### *Medical termination of pregnancy*

- (1) It is lawful for a medical practitioner to give [medical treatment](#) with the intention of terminating a [woman's](#) pregnancy if:
  - (a) after medically examining her, the practitioner reasonably believes she has been pregnant for not more than 14 weeks; and
  - (b) after medically examining her, the practitioner and another medical practitioner are of the opinion, formed in good faith:

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<sup>32</sup> Law of Abortion Final Report 2008 Victorian Law Reform Commission  
<http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>

- (i) the continuance of the pregnancy would involve greater risk to her life or greater risk of harm to her physical or mental health than if the pregnancy were terminated; or
  - (ii) there is 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; and
  
- (c) the treatment is given in a hospital; and
  
- (d) when giving the treatment, the practitioner reasonably believes she has been pregnant for not more than 14 weeks; and
- (e) the appropriate person consents to the giving of the treatment.
  
- (2) At least one of the medical practitioners required to form an opinion mentioned in subsection (1)(b)(i) or (ii) must be a gynaecologist or obstetrician unless it is not reasonably practicable in the circumstances to get a gynaecologist or obstetrician to examine the [woman](#).
- (3) It is lawful for a medical practitioner to give [medical treatment](#) with the intention of terminating a [woman's](#) pregnancy if:
  - (a) after medically examining her, the practitioner:
    - (i) reasonably believes she has been pregnant for not more than 23 weeks; and
    - (ii) is of the opinion termination of the pregnancy is immediately necessary to prevent serious harm to her physical or mental health; and

- (b) when giving the treatment, the practitioner reasonably believes she has been pregnant for not more than 23 weeks; and
  - (c) the appropriate person consents to the giving of the treatment.
- (4) It is lawful for a medical practitioner to give [medical treatment](#) with the intention of terminating a [woman's](#) pregnancy if:
  - (a) the treatment is given or carried out in good faith for the sole purpose of preserving her life; and
  - (b) the appropriate person consents to the giving of the treatment.
- (5) The appropriate person for giving consent to [medical treatment](#) under subsection (1), (3) or (4) is:
  - (a) the [woman](#) if she:
    - (i) is at least 16 years of age; and
    - (ii) is otherwise capable in law of giving the consent; or
  - (b) each person having authority in law apart from this subsection to give the consent if the [woman](#):
    - (i) is under 16 years of age; or
    - (ii) is otherwise incapable in law of giving the consent.
- (6) A person is not under any duty to terminate or assist in terminating a [woman's](#) pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so.
- (7) This section does not relieve a medical practitioner, in giving [medical treatment](#) with the intention of terminating a [woman's](#) pregnancy, from liability to give the treatment:
  - (a) with professional care; and
  - (b) otherwise according to law.

(8) In this section:

"medical treatment" includes surgery.

"woman" includes any female.

56. The drafting of this legislation raises the following issues:

- (i) Whilst it is generally accepted that a foetus will not survive if born before 24 weeks, there appears to be no medical justification for a differentiation between 14 and 24 weeks. Logic indicates that women and girls should be free to consult suitably qualified health professionals for the most appropriate treatment up to 23 weeks gestation. **Here we can discuss amending the legislation to allow for medical treatment “with the intention of terminating a woman’s pregnancy if the practitioner reasonably believes she has been pregnant for not more than 23 weeks”.**
- (ii) Section 11(8) reads ““medical treatment" includes surgery”. Medical practitioner is not used or defined. “Health Practitioner” is defined in section 5 as meaning “a person engaged in the provision of a medical service referred to in paragraphs (c), (d), (e), (k) or (m) of the definition of [medical services](#)” but is not referred to in section 11. Section 11 is therefore capable of interpretation on the basis that the treatment is not to be provided by health practitioners but by doctors /surgeons. This is reinforced by subsection 2 which requires at least one medical practitioner to be a gynecologist. The exclusion of midwives, nurses and approved drug suppliers is out of step with current practice. **Here we can discuss amending the legislation to make it “lawful for a medical or health practitioner to give medical treatment” and / or for the need for guidance on the current law.**
- (iii) The application of the legislation to pregnancies up to 14 weeks completely prevents women and girls from accessing approved drug treatment. It follows that in the NT, doctors, women and girls are at risk of criminal prosecution in

the context of acceptable modern termination by drug administration. The words “includes surgery” are insufficient to enable medical practitioners to be confident in what is an acceptable treatment in order to avoid a criminal sanction and will inevitably lead to over caution. **Here we can discuss whether the definition of medical treatment should include “the use of an instrument, an approved drug or combination of approved drugs or any other accepted means of treatment to terminate pregnancy by a health or medical practitioner”.**

- (iv) The criteria requiring medical practitioners to make findings about harm to the woman or girl or abnormalities in the foetus inhibit choice. **Here we can discuss whether such provisions are required at all.**
- (v) The requirement for treatment in “hospital” inevitably restricts termination of pregnancy to a small number of hospitals with the consequent lack of options including primary health care services and lack of confidentiality. **Here we can discuss what provision for reproductive health services ought to be available in the NT.**
- (vi) The conscientious objection provisions, whilst understandable can be severely inhibiting when there are so few services. This may impact significantly on women seeking a lawful termination of pregnancy. Ethical service provision needs to allow for informed choice, to prevent patient trauma, to avoid risk of service delays leading to fewer or more invasive options, and to enable rural women in particular to seek alternative practitioners. **Here we can discuss to what extent delays can occur when treating clinicians have a conscientious objection, the effect that can have on the patients, to include pressure to travel interstate and how the approval of health practitioners to administer treatment in this field could avoid unnecessary conflict arising between patient choice and conscientious objection.**
- (vii) The requirement for “an obstetrician or gynaecologist” as part of the decision making process prevents access to primary health care providers which is wholly appropriate treatment in this context. **Here we can discuss the removal of such a requirement.**

- (viii) The requirement for each person having the authority of law to make decisions about a child inevitably means both parents must consent which inhibits treatment for those who are victims of interfamilial abuse and on a practical level is unworkable. **Here we can discuss alternative options for girls faced with the need for reproductive health care and what ought to be best practice in this field in relation to minors.**

## **Correspondence**

57. By letter dated 7<sup>th</sup> October 2013 these matters were raised by the Family Planning Welfare Association of the NT with Minister Lambley. To date the government has been briefed by the Department of Health that legal reform should occur but no action has been taken.

## **Conclusion**

It is our view that the law in the NT is contrary to international law and policy, inappropriate and out of date. It is also our view that the services in the NT are insufficient and lack confidentiality. We consider that there is inordinate pressure on services and risks to patient safety and health and that both law and services in relation to reproductive health in the NT should be restructured.

## Questions

- (i) How to achieve safe, effective, confidential and dignified reproductive healthcare in the NT?
- (ii) How to prioritise NT Parliamentary debate / legislation on this issue?
- (iii) Whether to make a report to the CEDAW Committee and, if so, in what terms?
- (iv) How to amend section 170 of the NT Criminal Code to add a medical and practitioner exemption so that late term abortions are properly exempted?
- (v) How to amend sections 208B and 208C of the NT Criminal Code or whether to repeal those provisions to remove criminalisation?
- (vi) How to amend section 11 of the MSA 1974 or whether it should be repealed?
- (vii) Whether there should be one piece of legislation that deals with all terminations up to 23 weeks gestation?
- (viii) Until the NT law is changed, to what extent can the public interest test in the Directors Guidelines be invoked to argue there should be no prosecution in relation to any health practitioner, woman or girl who procures or terminates or attempts to terminate an unwanted and /or unviable pregnancy of less than 24 weeks duration by non-surgical terminations by use of those drugs added to the Pharmaceutical Benefits Scheme<sup>33</sup>?
- (ix) To what extent is there a need for training on the international law in this field?
- (x) To what extent should the Department of Health in the NT issue fresh guidance on the interpretation of existing legislation to enable non-surgical terminations by those drugs added to the Pharmaceutical Benefits Scheme?
- (xi) AOB?

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<sup>33</sup> Currently RU486 Misoprostol and Mifepristone (RU486)

## **ANNEX – SOUTH AFRICAN LAW**

PRESIDENT'S OFFICE

No. 1891.  
22 November 1996

NO. 92 OF 1996: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996.

It is hereby notified that the President has assented to the following Act which is hereby published for general information:-

### ACT

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

(Afrikaans text signed by the President.)

(Assented to 12 November 1996.)

### PREAMBLE

Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services;

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of

pregnancy according to her individual beliefs.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

#### Definitions

1. In this Act, unless the context otherwise indicates-

- (i) "Director-General" means the Director-General of Health; (iii)
- (ii) "gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last; (iv)
- (iii) "incest" means sexual intercourse between two persons who are related to each other in a degree which precludes a lawful marriage between them; (ii)
- (iv) "medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974); (v)
- (v) "Minister" means the Minister of Health; (viii)
- (vi) "minor" means any female person under the age of 18 years; (vii)
- (vii) "prescribe" means prescribe by regulation under section 9; (x)
- (viii) "rape" also includes statutory rape as referred to in sections 14 and 15 of the Sexual Offences Act, 1957 (Act No. 23 of 1957); (ix)
- (ix) "registered midwife" means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978); (vi)
- (x) "termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman; (i)
- (xi) "woman" means any female person of any age. (xi)

Circumstances in which and conditions under which pregnancy may be terminated

2. (1) A pregnancy may be terminated-

- (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
- (b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-
  - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
  - (ii) there exists a substantial risk that the fetus would suffer from a

severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-

(i) would endanger the woman's life;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.

Place where surgical termination of pregnancy may take place

3. (1) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the Gazette for that purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act,

(3) The Minister may withdraw any designation under this section after giving 14 days' prior notice of such withdrawal in the Gazette.

Counselling

4. The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

Consent

5. (1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.

(2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

(3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

(4) Subject to the provisions of subsection (5), in the case where a woman

is-

- (a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or
- (b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2, her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2(1)(b)-
  - (i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or
  - (ii) if such persons cannot be found, upon the request and with the consent of her curator personae:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.

(5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that-

- (a) during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b)-
  - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
  - (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
- (b) after the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b), the continued pregnancy-
  - (i) would endanger the woman's life;
  - (ii) would result in a severe malformation of the fetus; or
  - (iii) would pose a risk of injury to the fetus, they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be: Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

Information concerning termination of pregnancy

6. A woman who in terms of section 2(1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this Act by the person concerned.

#### Notification and keeping of records

7. (1) Any medical practitioner, or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2(1)(a) or (b), shall record the prescribed information in the prescribed manner and give notice thereof to the person referred to in subsection (2).

(2) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.

(3) The person in charge of a facility referred to in section 3, shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director-General: Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.

(4) The Director-General shall keep record of the prescribed information which he or she receives in terms of subsection (3).

(5) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information.

#### Delegation

8. (1) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director-General or any other officer in the service of the State, any power conferred upon the Minister by or under this Act, except the power referred to in section 9.

(2) The Director-General may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the Director-General by or under this Act or delegated to him or her under subsection (1).

(3) The Minister or Director-General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

#### Regulations

9. The Minister may make regulations relating to any matter which he or she may consider necessary or expedient to prescribe for achieving the objects of this Act.

#### Offences and penalties

10. (1) Any person who-

(a) is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2(1)(a);

(b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c); or

(c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.

(2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months.

#### Application of Act

11. (1) This Act shall apply to the whole of the national territory of the Republic.

(2) This Act shall repeal-

(a) the Act mentioned in columns one and two of the Schedule to the extent set out in the third column of the Schedule; and

(b) any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993), possessed legislative authority with regard to the termination of a pregnancy.

#### Short title and commencement

12. This Act shall be called the Choice on Termination of Pregnancy Act, 1996, and shall come into operation on a date fixed by the President by proclamation in the Gazette.

#### SCHEDULE

No. and year of law	Short title	Extent of repeal
Act No. 2 of 1975	Abortion and Sterilization Act, 1975	In so far as it relates to abortion