Castan Centre for Human Rights Law
Faculty of Law, Monash University

Submission to the Abortion Legislation Committee

Abortion Legislation Bill

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Abortion Legislation Committee
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Dear Members of the Committee:

Abortion Legislation Bill 2019

We are pleased to provide this Submission to the Abortion Legislation Committee. Our submission addresses:

1. The decriminalisation of abortion together with the requirement that a medical practitioner form the view that an abortion post-20 weeks gestation is 'appropriate';
2. Conscientious objection to abortion; and
3. Safe access zones.

We consent to this submission being made public, and would be pleased to make an oral submission to the Committee.

The Castan Centre for Human Rights Law is an academic centre of the Faculty of Law at Monash University in Melbourne, Australia. We undertake research, education and the dissemination of international and Australian human rights law scholarship. We have provided submissions into enquiries with respect to abortion law reform in five Australian states[1] and appeared as *amicus curiae* before the High Court of Australia in the case of *Clubb v Edwards* which involved a challenge to the constitutional validity of safe access zone legislation.[2] Over the past two years, we have been conducting empirical research into barriers to access to abortion in Australia and, in particular, the impact of anti-abortion picketing and effectiveness of safe access zones. Our submission draws upon this research.

1. Abortion as a health issue, not a criminal justice issue

The Bill takes the important step of removing abortion from the *Crimes Act 1961* and treating abortion as a health issue. We believe that this step is critical to removing the uncertainty and stigma around this medical procedure. It furthermore promises to better align New Zealand's law with modern medical practice and better entrench respect for women's choices concerning their own bodies and lives. Access to reproductive health services is fundamental to women's health and in the 21st century should be regulated as a standard health matter and not as a matter of

[1] Parts of this submission are drawn from the authors' Submission to the Queensland Law Reform Commission's Review of Termination of Pregnancy Laws (February 2018) and Submission to the South Australian Law Reform Institute, *Abortion: A Review of Law and Practice* (May 2019).

[2] *Clubb v Edwards, Preston v Avery* [2019] HCA 11 (10 April 2019).

criminal law. Therefore, **we support the decriminalisation of abortion that is proposed by the Bill. Abortion should be treated by law as a health issue and not a criminal justice issue.**

However, we submit that the Bill should go one step further and remove the distinction between abortion prior to 20 weeks gestation and abortion after 20 weeks gestation such that, for all abortions (regardless of gestation) the legal requirements are informed consent and the professional willingness and ability of the medical practitioner. Such an approach treats abortion in the same way as any other medical procedure, rather than stigmatising the patient through a more onerous procedure. That is, the decision to terminate a pregnancy should rest with the woman only, rather than requiring the medical practitioner to determine the appropriateness of an abortion.

Under the proposed approach, doctors become the gatekeepers to legal abortion for pregnancies post 20 weeks gestation. This approach entrenches the power imbalance between patients and their doctors, removes from patients the ability to decide what is in their own best interests, and renders patients beholden to the medical profession for allowing them to access abortion services. An example of a preferable approach may be found in the law of the Australian Capital Territory, which does not prescribe a temporal limitation on the legal availability of abortion on request; thus abortion is regulated in the same way as other medical procedures, where the requirements are a patient's informed consent and the clinicians' professional willingness.[3]

Decriminalisation and international human rights norms

Treating abortion as a health issue is consistent with norms of international human rights. Access to abortion has increasingly been viewed as a core component of the right to reproductive health which is, in turn, an integral part of the right to health.[4] The UN Committee that supervises the implementation of the International Covenant on Economic, Social and Cultural Rights[5] (ICESCR) has characterised the right to reproductive health as a set of freedoms and entitlements, including unhindered access to health facilities and services and the right to make free and responsible decisions, free of violence, coercion and discrimination.[6]

The right to terminate a pregnancy has been conceptualised as falling within a number of norms of human rights by human rights bodies, including United Nations treaty bodies and special rapporteurs. These bodies have called on states to remove barriers to access to abortion, including barriers constituted by restrictive laws. In a series of decisions, the Human Rights Committee which oversees State parties' implementation of the International Covenant on Civil and Political Rights[7] (ICCPR), has found restrictions on access to abortion to violate the right to privacy and non-discrimination and the right to be free of torture and cruel, inhuman or degrading treatment.[8] In its updated General Comment on the right to life, the Human Rights Committee reiterated its position that restrictions on abortion may violate the right of women and girls to life and breach obligations of non-discrimination, privacy and amount to cruel, inhuman or degrading

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[3] See *Health Act 1993* (ACT) Part 6.

[4] UN Committee on Economic, Social and Cultural Rights, 'General Comment No 22: On the Right to Sexual and Reproductive Health', UN Doc E/C.12/GC/22 (2 May 2016) para 1.

[5] Opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

[6] UN Committee on Economic, Social and Cultural Rights, 'General Comment No 22: On the Right to Sexual and Reproductive Health', UN Doc E/C.12/GC/22 (2 May 2016) [5].

[7] Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).

[8] *LMR v Argentina*, HRC, Communication No 1608/2007, UN Doc CCPR/C/101/D/1608/2007 (28 April 2011); *Mellet v Ireland*, HRC, Communication No 2324/2013, UN Doc CCPR/C/116/D/2324/2013 (9 June 2016); *Whelan v Ireland*, HRC, Communication No 2425/2014, UN Doc CCPR/C/119/D/2425/2014 (11 July 2017).

treatment. The Committee called on states to refrain from imposing criminal sanctions against women obtaining abortions and doctors providing abortion services.[9]

Laws that criminalise abortion have been underpinned by - and have served to perpetuate - gender-based stereotypes which state parties to the Convention on the Elimination of Discrimination against Women[10] (CEDAW) are obliged to eliminate.[11] These include stereotypes conceptualising a woman's reproductive capacity as a duty rather than a right, with women's reproductive function prioritised above their health and welfare.

In 2018, the CEDAW Committee concluded a major inquiry into grave and systematic violations of human rights constituted by barriers to access to abortion, including laws which criminalise abortion. The inquiry concerned the failure of the United Kingdom of Great Britain and Northern Ireland to establish a comprehensive legal framework to protect and guarantee women's right to abortion in Northern Ireland and to address social, practical and financial obstacles to access which exacerbate poverty and disproportionately affect rural women.[12] The Committee called for the urgent repeal of provisions which criminalise abortion.[13] It found that the deliberate maintenance of these laws, which disproportionately affect women and girls, are in breach of a number of obligations enshrined in CEDAW. These include the obligation to eliminate discrimination in the field of health care; the obligation to address discrimination against women in rural areas, the obligation to ensure women's equal right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. These violations were systematic in light of the criminalisation of abortion, and grave owing to the severe harm and physical and mental anguish they generated[14] and were found to amount to cruel, inhuman and degrading treatment and gender-based violence. The Committee found that restrictions on the exercise of reproductive choice which affect only women 'involves mental or physical suffering constituting violence against women and potentially amount to torture or cruel, inhuman and degrading treatment' and affront 'women's freedom of choice and autonomy, and their right to self-determination.'[15]

The CEDAW Committee's report on barriers to access to abortion in Northern Ireland is part of a growing body of work recognising restrictive abortion laws as a form of gender-based violence and cruel, inhuman or degrading treatment. In its most recent General Recommendation on gender-based violence, the Committee explicitly recognises the criminalisation of abortion as an example of gender-based violence which may amount to cruel, inhuman or degrading treatment or torture.[16] The CEDAW Committee's findings are consistent with the conclusions of other human

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[9] UN Human Rights Committee, General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life, UN Doc CCPR/C/GC/36 (30 October 2018) at [8].

[10] Opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981).

[11] *LC v Peru,* CEDAW Committee, Communication No 22/2009, UN Doc CEDAW/C/50/D/22/2009 (17 October 2011) [8.15].

[12] Report of the Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to CEDAW.

[13] Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to CEDAW,UN Doc CEDAW/C/OP.8/GBR/1 (23 February 2018) [85].

[14] Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to CEDAW,UN Doc CEDAW/C/OP.8/GBR/1 (23 February 2018) [65], [81].

[15] Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to CEDAW,UN Doc CEDAW/C/OP.8/GBR/1 (23 February 2018) [65]

[16] General Recommendation 35 on Gender-Based Violence Against Women, Updating General Recommendation No 19 (n 40) para 18 and (including text accompanying footnote 27).

rights bodies. The Special Rapporteur on Torture and UN Committee against Torture have recognised the vulnerability to ill-treatment or torture of women seeking abortion[17] and recognised barriers to access to abortion as a form of torture or ill-treatment'.[18] The UN Special Rapporteur on Violence against Women, its Causes and Consequences has observed that the failure by states to establish the conditions that enable a woman to control her own fertility violate a woman's right to security of person;[19] in essence a right to protection from the intentional infliction of bodily or mental injury.[20]

Calls for decriminalisation of abortion have been made in the CEDAW Committee's most recent concluding observations concerning News Zealand's compliance with its obligations under CEDAW[21] and the Human Rights Council's Universal Periodic Review process. **We submit that the decriminalisation of abortion will bring New Zealand's law into line with international norms.**

2. Conscientious objection[22]

Clauses 19 and 20 of the Bill provide a regime whereby persons requested to provide abortion services or information about such services may refuse to provide such services or information, but must tell the patient how to 'access the list of abortion service providers.'

Likewise, in a number of Australian jurisdictions, doctors with a conscientious objection may refuse to participate in the provision of abortion services, but the law imposes what has become known as an "obligation to refer" to a doctor without such a conscientious objection.[23] The one exception to the provisions allowing a doctor with a conscientious objection to refuse to participate in an abortion involves emergency circumstances.[24] This specific issue was propelled into the global spotlight in October 2012 when a woman who was 17 weeks pregnant sought treatment at a hospital in Ireland. Despite the fact that she was having a miscarriage and the foetus had no chance of survival, the hospital refused to terminate the pregnancy while a foetal heartbeat remained. By the time the abortion was eventually performed, days after she presented to the hospital, she had contracted septicaemia and died as a result.[25] This tragedy demonstrates that in the year 2012 it was possible for a woman to walk into a hospital in Western

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[17] Juan Mendez, 'Report of the Special Rapporteur on Torture', (A/HRC/31/57, 5 January 2016) [44]; see also Committee against Torture, 'General Comment 2: Implementation of Article 2 by States Parties', (UN Doc CAT/C/GC/2, 24 January 2008) [22].

[18] Juan Mendez, 'Report of the Special Rapporteur on Torture', (A/HRC/31/57, 5 January 2016) [42], [44].

[19] Juan Mendez, 'Report of the Special Rapporteur on Torture', (A/HRC/31/57, 5 January 2016) [66].

[20] See generally HRC, 'General Comment No. 35 Article 9 (Liberty and Security of Person)' (UN Doc CCPR/C/GC/35, 15 December 2014) [9].

[21] Committee on the Elimination of discrimination against Women, Concluding observations on the eighth periodic report of New Zealand, UN Doc CEDAW/C/NZL/CO/8 (25 July 2018) at [40].

[22] This section is drawn from: R Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act* 2013: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900.

[23] *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6-7; *Abortion Law Reform Act 2008* (Vic) s 8; *Termination of Pregnancy Law Reform Act 2017* (NT) s 11; *Termination of Pregnancy Act 2018* (Qld) s 8.

[24] See *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6 (where emergency includes threat to life or risk of serious physical injury); *Abortion Law Reform Act 2008* (Vic) s 8 (where emergency refers to threat to life); *Termination of Pregnancy Law Reform Act 2017* (NT) s 10 (where emergency refers to threat to life); *Termination of Pregnancy Act 2018* (Qld) s 8.

[25] D Dalby, 'Hospital Death in Ireland Renews Fight Over Abortion', *The New York Times* (14 November 2012), http://www.nytimes.com/2012/11/15/world/europe/hospital-death-in-ireland-renews-fight-over-abortion.html.

Europe and be denied a potentially lifesaving abortion. It demonstrates the importance of abortion legislation containing a provision which requires doctors to perform an abortion in an emergency situation.[26] **We submit that conscientious objection should not be permissible in an emergency situation; the Bill does not currently make this clear.**

It is clear that many doctors who conscientiously object to abortions possess a sincere, deeply held belief in the immorality of abortion. In Australia, provision for doctors to conscientiously object to participating in an abortion has been relatively uncontroversial. The lion's share of the controversy that has arisen in connection with the issue of conscientious objection has stemmed from laws imposing what has become known as an "obligation to refer". This issue raises the question of how, in a democratic society, a doctor's right to conscientious objection should be balanced against a woman's: right to life; right to health; right to privacy and autonomy; right to equality and freedom from discrimination; and right to be free from torture or cruel, inhuman or degrading treatment or punishment. These rights are examined further in the section above, Here, we focus on a woman's right to health as this right is directly referential to a doctor's ethical obligation to prioritise a patient's health and wellbeing.[27]

At one end of the spectrum is the view that the right of a patient to receive timely and effective health care should at all times be paramount. Those who support this view argue that the potential negative consequences for women of a doctor's conscientious objection to abortion render it impossible to balance the rights of doctor and patient; they argue that respect for a doctor's conscientious objection invariably results in an infringement of women's rights. This position is to some extent reflected in Sweden, for example, where conscientious objection to abortion is not permitted under law.[28] Thus pursuant to this approach, the beliefs of individual doctors should never trump the health and wellbeing of people in need of a medical service.[29] At the other end of the spectrum is the view that doctors should not only be allowed to refuse to provide abortion services or provide any information about abortion services, they should be allowed (or even required) to actively discourage women from terminating their pregnancies. This position is reflected in the laws of a number of jurisdictions in the United States. A key motivation behind these laws is to dissuade women from accessing abortion services.[30]

In addition to the views occupying either end of the spectrum, there are also various positions that fall somewhere on the spectrum. One such position is the position that has been adopted in the Australian jurisdictions of Tasmania, Victoria the Northern Territory and Queensland discussed above. That is, a doctor with a conscientious objection to abortion may refuse to participate in the procedure but must direct the patient to a practitioner without such a

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[26] It should be acknowledged that there is often difficulty in determining with certainty whether in a given situation a woman's life is truly at risk. This means that in practice a doctor who opposes abortion may actually wait until it is too late and then claim that the obligation did not arise because it was not clear that the woman's life was at risk. See C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 14.

[27] For an analysis of restrictions on abortion as a violation of the right to health, see R Sifris, 'Restrictive Regulation of Abortion and the Right to Health' (2010) 18(2) *Medical Law Review,* 185.

[28] See A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 91; A Heino et al, 'Conscientious Objection and Induced Abortion in Europe' (2013) 18 *European Journal of Contraception and Reproductive Health Care* 231.

[29] C Fiala and J H Arthur, 'Dishonourable Disobedience – Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 *Woman – Psychosomatic Gynaecology and Obstetrics* 12 at 18.

[30] See, for example, Center for Reproductive Rights, *2012: A Look Back* (2013), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/USLP_endofyear_Report_1.9.12.pdf.

conscientious objection. While this position appears to go beyond the requirements of the Australian Medical Association's *Code of Ethics*,[31] it closely reflects the position adopted in a number of other countries[32] as well as other ethical codes and guidelines of the medical profession itself. For example, in its *Rights-Based Code of Ethics*, the International Federation of Gynecology and Obstetrics states that a doctor has a right to conscientious objection but that in such circumstances a patient has a right to be referred to a doctor without such a conscientious objection. The Code directs that members should:

> [a]ssure that a physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.[33]

The World Medical Association's *Declaration on Therapeutic Abortion* also affirms the obligation to refer. It states that:

> If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw, while ensuring the continuity of medical care by a qualified colleague.[34]

Similarly, the World Health Organization has stipulated that:

> Individual health-care providers have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health care facility, in accordance with national law.[35]

Thus it seems that, despite the significant controversy which the obligation to refer has provoked in Australia, it is in fact a position that has been adopted by a number of respected organisations representing the health-care and medical community on a global scale; there is a widely adopted view within the health-care community that good medical care requires continuity of care. This sentiment is reflected at the local level in the *Code of Ethical Practice* of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which states that:

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[31] The *Code of Ethics*, as revised in 2016, states that: "If you refuse to provide or participate in some form of diagnosis or treatment based on a conscientious objection, inform the patient so that they may seek care elsewhere. Do not use your conscientious objection to impede patients' access to medical treatments including in an emergency situation" See: https://ama.com.au/system/tdf/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016.pdf?file=1&type=node&id=46014.

[32] See, for example, A O'Rourke et al, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38(3) *Monash University Law Review* 87 at 107.

[33] International Federation of Gynecology and Obstetrics, *Rights-Based Code of Ethics* (October 2003), http://www.figo.org/sites/default/files/uploads/wg-publications/wsrr/Rights-Based_%20Code_of_Ethics_October%202003%20-%20Copy%20-%20Copy.pdf.

[34] World Medical Association, *Declaration on Therapeutic Abortion*, a*dopted by the 24th World Medical Assembly, Oslo, Norway, August 1970* (*amended by the 35th World Medical Assembly, Venice, Italy, October 1983; 57th WMA General Assembly, Pilanesberg, South Africa, October 2006),* http://www.wma.net/en/30publications/10policies/a1/.

[35] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd ed, 2012) at 69.

> [d]octors should offer or arrange a further opinion and/or ongoing care with another suitable practitioner if … the therapy required is in conflict with the doctor's personal belief/value system.[36]

Thus the imposition of an obligation to refer seems like a reasonable way to balance the rights of a doctor against the rights of a patient; it also seems to be an approach which is adopted by a number of key medical organisations both locally and globally. **We support clause 19(2) of the Bill, which requires conscientious objectors to refer patients to another provider.**

The question nevertheless arises, what should be the approach in areas where the doctor with a conscientious objection is the only doctor within a reasonable geographical proximity of the patient, rendering the obligation to refer of little practical utility should a woman not be in a position to travel. **We recommend that serious thought be given to this issue and to the circumstances of women who may have no point of access to services.**

3. Safe access zones

Clauses 15 through 17 of the Bill establish a regime for safe access zones.

Safe access zones around clinics that provide abortion services now operate in the majority of Australian jurisdictions, namely Tasmania, the Australian Capital Territory, Victoria, the Northern Territory, New South Wales and Queensland.[37] The two states which have not yet established safe access zones, namely South Australia and Western Australia, are currently conducting inquiries considering their introduction. In all jurisdictions where safe access zones are in place, certain conduct is prohibited within the radius of the designated zone. In the Australian Capital Territory, the radius of the zone is determined by the Health Minister and must be at least 50 metres from a clinic. In all other jurisdictions, the radius of the zone is 150 metres around clinics in which abortions are provided.

Efficacy of safe access zones

Penovic and Sifris, two of the authors of this submission, have conducted semi-structured, in depth interviews throughout Australia with health professionals and others working in the field of women's reproductive health on the effects of anti-abortion picketing outside clinics and the effectiveness of safe access zones.[38] We understand that some of the activities which have taken place outside clinics in New Zealand have been similar to anti-abortion conduct which has occurred in Australia when and where safe access zones are not in place. Our research underpinned the Castan Centre's amicus curiae submissions in the constitutional challenge to Victoria's safe access zone legislation (*Clubb v Edwards*), which were cited by the High Court of Australia in its judgment. Our submissions elaborated on the extent of the threats, intimidation and harassment experienced by clinic staff and patients seeking access to clinical services prior to the introduction of safe access zones. They demonstrated that the objectives of the legislation

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[36] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Code of Ethical Practice* (2006) at 6.

[37] See *Reproductive Health (Access to Terminations) Act 2013* (Tas), *Health (Patient Privacy) Amendment Act 2015* (ACT), *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic); *Termination of Pregnancy Law Reform Act 2017* (NT) Part 3; *Termination of Pregnancy Act 2018* (Qld); *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018* (NSW).

[38] For an in-depth discussion of the Victorian component of this research see: Ronli Sifris and Tania Penovic, 'Anti-abortion protest and the effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 *Monash University Law Review* 317 (special issue on the law of protest).

were not merely theoretical; that women's safety, privacy, health and wellbeing have been undermined by picketing activity.

Individuals who engage in anti-abortion activities outside clinics frequently describe themselves as 'sidewalk counsellors' seeking to render assistance to women.[39] This characterisation differs markedly from what we heard from interviewees who spoke of their unwelcome intrusions into the personal space of patients and staff. Examples of anti-abortionists' conduct provided to us include:

- Approaching, following or walking alongside people approaching clinic premises;
- Dispensing brochures or plastic foetal dolls;
- Displaying posters with distressing words or images, such as photographs of dismembered foetuses;
- Castigating patients and staff as murderers;
- Chasing, photographing, heckling, threatening and verbally abusing patients and staff; and
- Preventing patients from exiting their cars or obstructing clinic entrances.

Clinic picketing has given rise to serious concerns about personal safety. Health professionals told us of pervasive concerns about unpredictable behaviour and a threat of confrontation. One interviewee told us that she perceived 'the physical threat' as 'imminent'[40] and another spoke of her efforts to 'just blend in' when approaching her workplace, to never speak to the picketers but rather pretend they were not there because 'you don't know who you're dealing with.'[41] Another expressed concern about being hurt and told us that speaking to picketers may 'aggravate them more and … make them become more aggressive'.[42] Picketers would often provoke a hostile response from patients or their companions and physical altercations would sometimes ensue.[43]

The picketing of clinics by anti-abortionists not only invades the privacy of women who are already in a vulnerable situation, it also stigmatises women seeking abortions and undermines their health and well-being. Clinic staff stressed the importance of a supportive environment on patient well-being and the deleterious impact of an unsupportive or discriminatory environment.[44] While some women were relatively unaffected by their interactions with anti-abortionists, others were extremely traumatised, and considered by health professionals to be at heightened risk of adverse

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[39] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic, Melbourne, 22 March 2017; Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) at 107.

[40] Interview with a nurse practitioner and midwife, Victoria (27 March 2017).

[41] Interview with clinic staff, Melbourne (12 April 2017).

[42] Interview with clinic staff (12 April 2017); Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).

[43] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).

[44] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with a social worker, Melbourne (20 March, 2017).

medical outcomes and ongoing psychological problems.[45] Women with a history of sexual or physical violence are particularly vulnerable to shaming, humiliation and stigmatisation.[46]

Clinic picketing in Australia has operated as a barrier to access to reproductive health services, experienced most acutely by vulnerable and disadvantaged women.[47] Some women failed to carry through their reproductive choices[48] or attend follow-up appointments[49] in order to avoid contact with picketers. Some deferred treatment in circumstances where timeliness is critical and delay can change the treatment options available (and the legal requirements for obtaining an abortion) while increasing the risk of complications. We were told of women in regional Victoria who were 'very traumatised by the prospect of having to negotiate their way through protesters … and more inclined to delay the initial contact with the service, knowing what they're going to be up against when they eventually get into the service which … [is] sometimes booked out two or three weeks in advance'.[50] Clinic picketing has also operated as a barrier to access by deterring staff from working in reproductive health services, resulting in reductions in service availability and the suspension of regional services due to an inability to recruit staff.[51]

The general consensus among our interviewees is that anti-abortion activities outside clinics are harmful to both patients and staff who work at clinics; undermining public safety and the enjoyment of fundamental human rights and that safe access zones go a long way towards helping combat this problem. Our interviews have revealed that safe access zones in Australia are achieving their objectives of protecting the right of patients and staff to privacy, facilitating safe access to health services without fear and reducing misinformation and stigma. The activities of anti-abortionists have accordingly been de-individualised; sending 'a wonderful positive message … that society won't condone that sort of behaviour' targeted at women accessing health services.[52]

Safe access zones have been particularly effective in preventing harmful conduct. While some of the conduct of anti-abortionists falls within the ambit of criminal or tort law, the secrecy and stigma around abortion and the emotional intensity of patients' experiences has operated to frustrate the enforcement of these laws. We were told by interviewees that women seeking abortion were not in a position to issue legal proceedings or complain to regulatory bodies or the media. Where safe access zones are not in place, women's inability to seek redress without further incursions into their privacy enables picketing to continue with impunity.

In most Australian jurisdictions where safe access zones are in place, safe access zone legislation has been introduced in conjunction with legislative amendments decriminalising abortion, as proposed in New Zealand's Abortion Legislation Bill. **We submit that safe access zones are an important component of laws which facilitate access to abortion in accordance with international norms. The experience in Australia demonstrates that decriminalisation alone**

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[45] Interview with a social worker, Melbourne (20 March 2017); Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).

[46] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).

[47] Interview with a social worker, Melbourne (20 March, 2017).

[48] Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).

[49] Ibid; Interview with Medical Director of a health service in regional Victoria (1 May 2017).

[50] Interview with health coordinator, regional health service, Victoria (1 May 2017).

[51] Bendigo Weekly, 'GPs Could Help Staff Abortion Clinic' (25 January 2013) <http://www.bendigoweekly.com.au/news/gps-could-help-staff-abortion-clinic> accessed 28 July 2018.

[52] Interview with a social worker, Melbourne, 20 March 2017.

does not stop clinic picketing. When abortion was decriminalised in the state of Victoria, safe access zones were not introduced. The government opted for 'a wait-and-see approach'; to assess whether the decriminalisation of abortion would lead to an abatement of the clinic picketing.[53] Safe access zone legislation was adopted seven years later, by which time it was clear that these activities had not decreased.

Compatibility of safe access zones with anti-abortionists' human rights

Although safe access zones seek to protect the rights of persons requiring access to premises at which abortions are provided, they have been decried by some as an attack upon religious freedom and freedom of speech[54] as well as peaceful assembly and association.[55] These rights are implemented in sections 14 through 17 of the New Zealand Bill of Rights Act 1990 and can be subject, under section 5, to reasonable limitations.

Safe access zones are directed to an are effective at achieving multiple objectives: to protect the safety, privacy and dignity of persons requiring access to clinics. They prevent human rights abuses, including acts of gender-based violence.[56]

In *Clubb v Edwards* (in which, as noted above, we appeared as amicus curiae), the High Court of Australia determined that safe access zone legislation in Victoria and Tasmania does not contravene the freedom of political communication implied in the Australian Constitution, and is therefore constitutionally valid. Although the implied freedom of political communication is a uniquely Australian constitutional doctrine, it bears broad similarities with the freedom of expression protected by section 14 of the New Zealand Bill of Rights Act 1990: it permits communication to be subject to legal restrictions in pursuit of legitimate policy objectives.

Like New Zealand Bill of Rights Act jurisprudence, the High Court of Australia uses proportionality analysis to determine the constitutionality of restrictions on the implied freedom of political communication. In our view, the judgment is instructive with regard to the compatibility of the proposed safe access zones with section 14 of the Bill of Rights Act and, moreover, other rights such as manifestation of religion and belief (section 15), freedom of peaceful assembly (section 16) and association (section 17).

As the High Court held in *Clubb v Edwards*, facilitating access to abortion services in a manner that promotes womens' safety and dignity is without question a compelling objective. Moreover, safe access zones do not prevent anti-abortionists from expressing their views. Rather, they impose limitations within a tailored geographic space, operating to ensure that anti-abortionists do not engage in targeted harassment and abuse. To the extent that safe access zones limit rights such as freedom of expression, they comply with the principle of proportionality with respect to the form of expression, the means of its dissemination and the importance of the interests which the restriction serves to protect. The limitations are tailored to their objective and are not overly broad. Safe access zones do not impair the ability of those who wish to express their opposition

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[53] Victoria, *Parliamentary Debates*, Legislative Assembly, 22 October 2015, 3975 (Jill Hennessy).

[54] Angela Shanahan, 'Free Speech Against Abortion Hasn't Got a Prayer', *The Australian* (Australia, 30 July 2016); Monica Doumit, 'How New Abortion Clinic Laws Prey on Those who Pray', *The Catholic Weekly* (12 May 2016) <https://www.catholicweekly.com.au/how-new-abortion-clinic-laws-prey-on-those-who-pray/> accessed 28 July 2018.

[55] These rights are enshrined in Articles 18, 19 and 21 of the International Covenant on Civil and Political Rights respectively and may be subject to limitations provided by law which are necessary for the protection of public order, morals or health or the rights and freedoms of others.

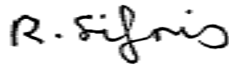
[56] See generally Tania Penovic and Ronli Sifris, 'Expanding the feminisation dimension of international law: targeted anti-abortion protest as violence against women' (2018) 7(2) *Cambridge International Law Journal* 241.

to abortion from associating, assembling and expressing their views. Safe access zones are necessary to avoid the targeting of a captive audience of individuals requiring access to clinics with confrontational expression that undermines their safety, privacy and dignity.

Accordingly, we support sections 15, 16 and 17 of the Bill.

Thank you again for the opportunity to provide this submission.

Yours faithfully,



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