The Secretary
Queensland Law Reform
PO Box 13312
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Dear Madam Secretary,

Thank you for the opportunity to provide comment on the Queensland Law Reform Commission's review of termination of pregnancy laws. This submission was prepared by Abigail Aiken, MD, MPH, PhD, Assistant Professor at the LBJ School of the University of Texas at Austin, and Rebecca Gomperts, MD, MPP, PhD, Founder and Director of Women on Web International Foundation.

The submission draws upon an analysis of data from Women on Web (WoW), a non-profit online telemedicine service that provides medication abortion in settings where safe abortion is not available. Between 2015 and 2017, WoW received requests for medication abortion using online telemedicine from 254 women living in Australia. The number accessing WoW per year increased rapidly over the three-year period.

To use the service, women submit an online consultation form including questions about pertinent medical history and demographics, which is reviewed by a doctor. Upon approval, the doctor prescribes mifepristone and misoprostol in the WHO-approved dose for medication abortion, which is then dispatched by a partner organization. Women then receive instructions for how to correctly use the medication, information on how to recognize the signs of potential complications, and resources and support via a specially trained online helpdesk.

Since 2006, WoW has provided medication abortion to tens of thousands of women across the globe. Evaluation of the service has demonstrated effectiveness on par with medication abortion provided within the clinic setting[1], and has shown that the service is safe and also acceptable to users.[1-3]

We conducted an analysis of key demographic and clinical characteristics of Australian women requesting medication abortion through WoW. Below, we discuss these data and respond point-by-point to the items listed in the consultation paper. As with any law or policy, we hope that any change to the existing law in Queensland will be evidence-based, and we are in glad to be able to provide important evidence.

Please don't hesitate to contact us for further information. We will be happy to assist in any way that would be helpful. We consent to the use of information from this submission in future publications from this review. However, we request that the information on WoW statistics be attributed to us as the authors of this report.

Sincerely,

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Section 1: Who should be permitted to perform or assist in performing terminations

1. Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Most abortions in settings where abortion is legal are carried out by licensed doctors, usually obstetrician-gynecologists. However, evidence shows that when other licensed healthcare professionals, including midwives and nurse practitioners are permitted to perform surgical abortions and prescribe medication abortion (200 mg mifepristone plus 800-1200 mcg misoprostol), the outcomes for women are equally good as when the abortion is performed or prescribed by a doctor, and the care provided is more cost-effective.[4-6] Additionally, family doctors (GPs) could also successfully prescribe and administer mediation abortion. In some settings, the prescription and administration of medication abortion through pharmacies is also permitted, and has been shown to be safe and effective.[7] Allowing a wide range of trained healthcare professionals to provide both surgical and medication abortion is essential for allowing optimal access for women, particularly those who live in remote areas. We therefore recommend that physicians, midwives, and nurse practitioners be permitted to perform or assist in performing abortion care in a wide range of settings, including at pharmacies.

An additional consideration in terms of the integration of accessible, affordable, and acceptable abortion services into the Queensland healthcare system is that they must be covered in full or at least in part by the public healthcare system or by private insurance plan. In addition to a need for privacy, majors reason why Australian women contact WoW is because they cannot afford an abortion through the formal healthcare setting, or because they are undocumented. Simply making abortion available does not automatically make it accessible or acceptable.[8]

2. Should a woman be criminally responsible for the termination of her own pregnancy?

We strongly recommend against holding women criminally responsible for terminating their own pregnancies. First, it is clear from the rapidly rising number of Australian women who use the WoW service, that making abortion a criminal offence does not deter women who are sure they want to end their pregnancies from doing so. Evidence from Ireland and Northern Ireland, which have abortion laws similar to those currently in effect in Queensland, also demonstrates that the presence of criminal penalties for termination of pregnancy does not deter women from sourcing and directing their own abortions.[2] Indeed, Ireland is poised to reform its abortion law for this exact reason.

Second, it is also clear that the main impact of criminalizing abortion is to engender stigma and drive the practice underground. Leaving women who are sure they want to end their pregnancies to do so under a shroud of secrecy and shame leads to isolation and fear, and increases the likelihood that women will resort to unsafe methods such as ingesting noxious substances or physical trauma.[9]

Section 2: Gestational limits and grounds

3. Should there be a gestational limit for a lawful termination of pregnancy?

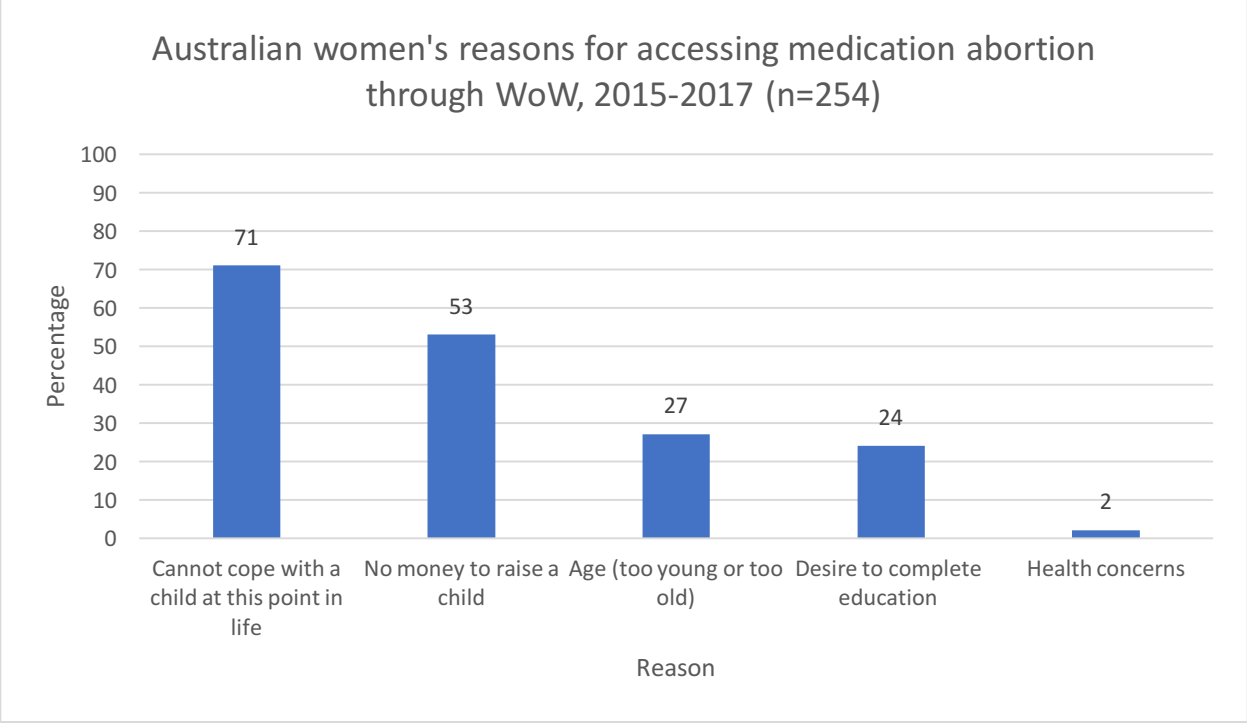
We understand why a gestational limit for lawful termination of pregnancy may be preferred by politicians, as it will make any change to Queensland's current law seem like a less dramatic change. However, we recommend against a gestational limit for two main reasons. First, the limit will always be arbitrary. Wherever the line is drawn, there will always be someone just on the other side of it. Second, evidence shows that women who want to end their pregnancies tend to want to do so as early as possible. Among those requesting help from WoW, 79% were under 7 weeks gestation at the time of their request, while 21% were between 7 and 10 weeks. Evidence from countries with later gestational limits, like the UK, where the limit is 24 weeks, and the US, where there is no gestational limit, shows that the vast majority of abortions (92%) still take place at under 13 weeks gestation.[10,11] Those who do seek later abortions tend to do so because of impending medical risk to their physical or mental health, recently diagnosed fetal anomaly, or exceptional social or economic circumstances that mean their pregnancy has either just come to light, or they have only just been able to come forward about the pregnancy, or they have experienced serious challenges accessing the healthcare system.

A gestational limit is therefore usually a solution looking for a problem, since the vast majority of people want to access abortion care early, and those who do not will usually be experiencing circumstances beyond their control. If it is felt that a gestational limit must be drawn, we strongly recommend that it not be before 13 weeks (when the majority of abortions in most settings occur) and that exceptions be granted after the limit due to changing circumstances (e.g. threats to physical or mental health, newly diagnosed fetal anomaly, barriers to healthcare access etc.).

5. Should there be a specific ground or grounds for lawful termination of pregnancy?

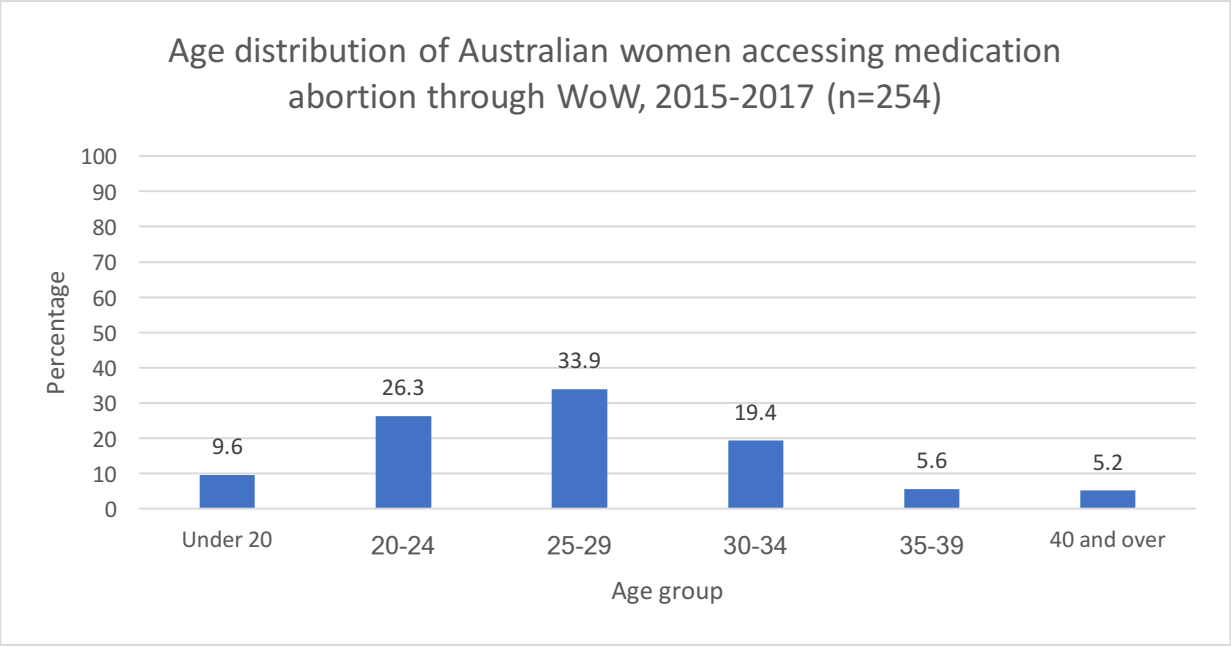
For several reasons, we strongly recommend against specifying any particular ground or grounds for lawful termination of pregnancy. First it is clear from the reasons provided by Australian women who contact WoW that are multiple reasons why women may seek abortion care. Each set of circumstances is as unique as the individual experiencing them. The chart below shows the reasons shared with WoW by Australian women who requested medication abortion through the service between 2015 and 2017 (Figure 1). Most women give more than one reason, so the percentages sum to greater than 100.

Figure 1



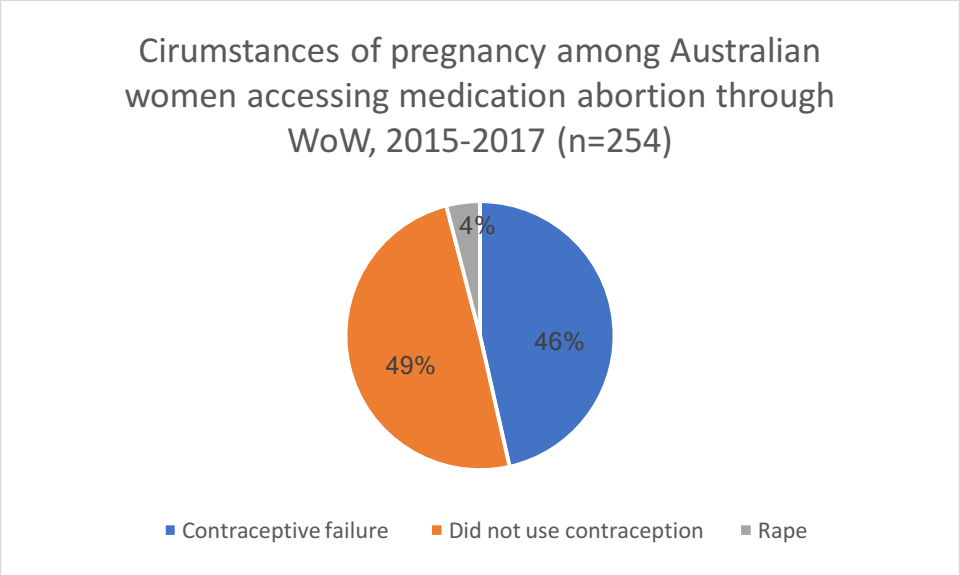
Second, the need for abortion is not limited to any single sector or cross-section of Australian society. All age groups are represented among women who requested medication abortion from WoW between 2015 and 2017 (Figure 2). Among these women, over a third (35%) were already mothers.

Figure 2



Third, while some may argue for allowing abortion in only very specific circumstances, such as rape, we strongly caution against this practice. Rape is a greatly under-reported crime, and placing a reporting or disclosure burden on rape survivors is unjust and potentially dangerous. Moreover, allowing abortion in only very limited circumstances does not address most of the reasons why women need abortions. Thus, legislating for only specific limited grounds will not address the real policy issue and will only drive abortion further underground. Among Australian women contacting WoW, 46% become pregnant because they experienced a contraceptive failure, 49% were not using contraceptives, and only 4% become pregnant as a result of rape (Figure 3).

Figure 3



Section 3: Consultation by the medical practitioner

8. Should a medical practitioner be required to consult with one or more others (such as another medical or health practitioner) or refer to a committee before performing a termination of pregnancy?

We strongly recommend that any medical practitioner licensed to perform a termination of pregnancy not be required to consult with others or with any sort of committee before proceeding with the abortion. The decision about whether or not to have an abortion rests with the person who is pregnant. The role of the healthcare professional in abortion decision-making, as in other types of medical care, is to provide sufficient accurate information to help the patient make an informed choice. Abortion is an extremely safe procedure[12], but it is at its most safe, effective, and acceptable when carried out as early as possible. Requiring consult between practitioners or referral of cases to a committee would not only cause delays in accessing care, it would also be a waste of money and resources.

Section 4: Conscientious objection

11 & 12. Should there be a provision for conscientious objection?

We recommend that all healthcare professionals be allowed to opt out of providing abortion care based on moral or ethical objection if that is their choice.

However, opting out of actively participating in abortion care should not exempt any healthcare professional from directing the person who is seeking abortion to an alternative source of care. All healthcare professionals who elect to not to provide abortion care should be obliged to direct the person seeking the abortion to a practitioner or service that will be able to meet their needs.

To avoid conscientious objection from becoming prohibitive (e.g. if there are only a few providers in a remote region), abortion care should be incorporated into standard medical training for obstetricians and gynecologists, and for midwives. It should also be offered as a standard part of family practitioner and nurse practitioner training. Being trained to provide abortion care is an integral part of caring for patients in these disciplines and thus should be seen as the norm rather than the exception.

Section 5: Counselling

13. Should there be any requirements in relation to offering counselling for the woman?

We recommend that counselling should be readily available as an optional service for women both before and after their abortion. Not all women want or require counselling before or after an abortion, and thus there is no need for counselling to be mandatory. The best practice guidelines of professional bodies in other settings where abortion is available (e.g. the RCOG in the UK, and ACOG in the US), state that abortion counselling should be voluntary and available upon request, but not mandatory. For women who do want counselling but who live in remote areas, a tele-counselling service could be offered.

Section 6: Protection of women and service providers and safe access zones

14. Should it be unlawful to harass, intimidate or obstruct:
    (a) a woman who is considering, or who has undergone, a termination of pregnancy; or
    (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

We recommend that both of these things should be unlawful. While those who do not support abortion rights and/or have an objection to abortion should be allowed to express their opinions, freedom of speech or expression should not include the right to harass, intimidate, or obstruct others from making a personal decision about their own health or medical care, or from providing a healthcare service for others.

15 & 16. Should there be a provision for safe access zones in the area around premises where termination of pregnancy services are provided?

We recommend that safe access zones be designated around abortion clinics or any place where abortion services are provided upon the request of those providing the service. Since those who work at the clinic or service are in the best position to judge the level of harassment, obstruction, or threat to the personal safety of themselves and their patients, safe access zone should be automatically approved upon request.

17. What behaviors should be prohibited in a safe access zone?

We recommend that any behavior that is experienced by a provider or patient as harassment, intimidation, obstruction, or threat to personal safety should be prohibited in a safe access zone.

18. Should the prohibition on behaviors in a safe access zone apply only during a particular time period?

We recommend that prohibitions of the behaviors listed above should apply at all times.

19. Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

We recommend that recording a person entering or leaving an abortion clinic without their consent should be an offence due to the potential for severe threat to personal safety.

Section 7: Collection of data about terminations of pregnancy

20. Should there be mandatory reporting of anonymized data about terminations of pregnancy in Queensland?

We recommend that fully anonymized and de-identified data on abortions provided in Queensland be subject to the same reporting requirements as any other medical practice. It may be the case that numbers of abortions performed will automatically be recorded through medical billing data, in which case, there should be no extra reporting burden on clinics or providers.

We also strongly recommend against legislating the practice of abortion differently from other medical practices, i.e. there should not be a separate practice register that healthcare professionals who provide abortions have to sign on to.

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