

REPORT TO
THE MINISTER FOR HEALTH

ON THE

REVIEW OF PROVISIONS OF *THE
HEALTH ACT 1911* AND *THE CRIMINAL
CODE* RELATING TO ABORTION AS
INTRODUCED BY THE
*ACTS AMENDMENT (ABORTION) ACT
1998*

17 JUNE 2002

REVIEW OF PROVISIONS OF THE *HEALTH ACT 1911* AND THE *CRIMINAL CODE* RELATING TO ABORTION AS INTRODUCED BY THE *ACTS AMENDMENT (ABORTION) ACT 1998*

TABLE OF CONTENTS

Executive Summary and Recommendations	5
Introduction	5
The Review Process	6
Terms of Reference	6
<i>The Acts Amendment (Abortion) Act 1999</i> Review Steering Committee	6
Background	7
Consultation with the public and Key Stakeholders	10
General findings and recommendations	12
1.1 The Effectiveness of the “Informed Consent” Provisions in providing Women with Adequate Information and Counselling	16
The Term ‘Counselling’ Section 334(5)(A)	16
Requirement In Section 334(5)(A) That Medical Risks Of Termination Be Provided By A Medical Practitioner	17
Disclosure Of Information Concerning Medical Risks Of Abortion	18
2.1 The Effectiveness of the Department of Health funded Abortion Counselling Services in Fulfilling their Role of Providing Counselling Service for Woman Requesting Advice Pre/Post Abortion	21
Improving the Provision Of Counselling Services	22
Particular Issues Which Affect Counselling In Relation To Post 20-Week Terminations	22
3.1 The Operation and Effectiveness of the Provisions of the Act relating to Dependant Minors, Especially in regard to the Scope and Use of Magistrate’s Discretion	25
Children’s Court Orders	25

4.1	The Identification of Gaps or Deficiencies in the Delivery and Access of Abortion and Counselling Services Under the Act	28
	Audit	28
	Barriers In Accessing Abortion Services	28
	Disposal Of Products Of Abortion	29
	Registered Nurse Shortages	29
	Videoconferencing Technology	29
	Information For Women	30
	Members Of The Community With Special Needs	30
5.1	The Operation and Effectiveness of the Procedures for Abortion After 20-Weeks of Pregnancy	33
	The Law In Relation To Post 20-Week Abortions	33
	Applications For Terminating A Post 20-Week Pregnancy	33
6.1	The Adequacy and Effectiveness of the Notification Procedures Required Under the Act	35
	Notification Form Pursuant To S335(5) (D) And (E)	35
7.1	The Adequacy of the Powers of Enforcement and the Penalties for Breaches Provided for in the Act:	38
	Audit Of Compliance.	38
8.1	The Availability of Preventative Education and General Evidence-Based Research Information for Medical Practitioners and the Community	40
	Preventative Education	40
	Evidence Based Information for Medical Practitioners And The Community	42
	CONCLUSION	44

APPENDICES

Appendix A Western Australian Abortion Legislation	45
Appendix B Extract from a Publication from the National Cancer Institute of America	52
Appendix C Press Release from the UK Royal College of Obstetricians and Gynaecologists	54
Appendix D Summary of Services Funded by the Department of Health	56
Appendix E Other Support Services for Women with Unplanned Pregnancies	60
Appendix F Practice Direction No.1 of 1998, Children's Court of WA	64
Appendix G Data from the WA Department of Health	67
Appendix H Extract from the Report on Abortions Notified in South Australia, 2000	69
 Bibliography	 71

REVIEW OF PROVISIONS OF THE *HEALTH ACT 1911* AND THE *CRIMINAL CODE* RELATING TO ABORTION AS INTRODUCED BY THE *ACTS AMENDMENT (ABORTION) ACT 1998*

Executive Summary and Recommendations

Introduction

The *Acts Amendment (Abortion) Act 1998* (“the Act”) came into operation on 26 May 1998. The amendments effected changes to the provisions relating to abortion laws in *The Criminal Code* and introduced a new section to the *Health Act 1911* setting out the requirements for the performance of an abortion to be justified. The effect of the legislative changes is that it is unlawful to perform an abortion unless it is justified under section 334 of the *Health Act 1911*.

Abortion is a procedure and practice which has been universally practised in some form since the beginning of recorded history. While deliberate terminations of pregnancy are reported throughout history, all races, cultures and religious groups have sharply divergent and frequently irreconcilable opinions on this highly controversial subject. It is not the purpose of this review to canvas those opinions or to discuss them.

As indicated above, the debate concerning the desirability of legislation to permit such procedures has previously been held in Parliament in Western Australia. This review concerns only the operation and effectiveness of those provisions passed by the Parliament of Western Australia four years ago. It is neither the intention nor the expectation that this review will in any way reconcile the different views about abortion in Western Australia.

The purpose of this review was to examine the *operation* and *effectiveness* of the provisions of the *Health Act 1911* and *The Criminal Code* related to abortion.

It is a requirement of the Act that the Minister administering the *Health Act 1911* is to carry out the review as soon as practicable after the expiration of 3 years from the commencement of the Act. The Minister is to prepare a report based on the review and cause the report to be laid before each House of Parliament within 4 years after the commencement of the Act.

A summary and recommendations from the *Acts Amendment (Abortion) Act 1998* Review Steering Committee, established to advise the Minister, are listed below.

The Review Process

Terms of Reference

The Minister for Health requested that:

A review be undertaken of the operation and effectiveness of the legislative framework provided in the *Acts Amendment (Abortion) Act 1998* (“the Act”) in regulating the performance of abortion in Western Australia and in particular the review was to consider:

1. The effectiveness of the “informed consent” provisions in providing women with adequate information and counselling.
2. The effectiveness of the Department of Health funded abortion counselling services in fulfilling their role of providing counselling services for women requesting advice pre/post abortion.
3. The operation and effectiveness of the provisions of the Act relating to dependant minors, especially in regard to the scope and use of magistrate’s discretion.
4. The identification of gaps or deficiencies in the delivery and access of abortion and counselling services under the Act.
5. The operation and effectiveness of the procedures for abortion after 20-weeks of pregnancy.
6. The adequacy and effectiveness of the notification procedures required under the Act.
7. The adequacy of the powers of enforcement and the penalties for breaches provided for in the Act.
8. The availability of preventive education and general evidence-based research information for medical practitioners and the community.

The *Acts Amendment (Abortion) Act 1998* Review Steering Committee

The review of the Act was undertaken by officers from the Department of Health and Department of Justice. This group formed the Review Steering Committee.

The Review Steering Committee required access to a wide range of expertise to assist in conducting the review. Individuals and organisations were consulted on an ‘as needs’ basis to provide expert opinion, analysis and information for the review and to ensure representation from relevant areas, including expert medical advice.

The Review Steering Committee also obtained information relevant to the review, including statistics on abortion, preventive educational strategies and published national and international literature.

Background

Introduction of the *Acts Amendment (Abortion) Act 1998*

Prior to the legislative changes enacted in May 1998, the legal situation regarding the performance of abortions in Western Australia could best be described as “uncertain”. Abortion was an offence in *The Criminal Code*, except to save the life of the mother. Both the woman who had an abortion and the medical practitioner who performed the abortion, risked prosecution. Although there had never been a test case in Western Australia, the general view was that the same reasoning behind decisions in 1969 and 1971 in cases on abortion in Victoria and New South Wales, (which liberalised the interpretation of when an abortion could be performed to include situations in which a medical practitioner had a reasonable belief that the continuation of the pregnancy would cause danger to the physical or mental health of the woman¹), would apply in Western Australia.

Women in Western Australia did have access to abortion services at two abortion clinics, through private medical practitioners and at King Edward Memorial Hospital. The rate of abortions in Western Australia was considered comparable to other states, such as New South Wales and Victoria, where abortion was being provided within a more certain legal framework. While abortion conducted by skilled medical practitioners was readily available, there was always a risk of prosecution in an untested legal environment. There were also limitations for the Department of Health in the funding of counselling services and the collection of statistics for a service where the legality of the service was uncertain.

There had been attempts to reform the abortion laws since the 1970s. However, these had not been successful, perhaps because abortion is such a contentious and sensitive issue.

The legal uncertainty regarding performance of abortion resulted in disadvantages for both women and medical practitioners. The medical practitioners were not operating with the protection of the law and there was always the risk of prosecution. The whole system was operating in a secretive manner, and so women had to ‘know where to go’ to obtain an abortion. Information about access to abortion was not universally available. Those without access to this information included younger women, rural women and those of non-English speaking background.

Within this context, unexpected charges for carrying out an abortion were laid against Dr Victor Chan and Dr Hoh Peng Lee in February 1998. This was the first test case of the abortion legislation in Western Australia. Test cases in other states against medical practitioners performing abortions had mostly resulted in acquittals and release of a clear statement of the circumstances under which abortion could be legally performed. The arrest of the two medical practitioners in Western Australia triggered a review of the laws dealing with abortion, particularly as the Director of Public Prosecutions identified that there was a case to answer.

On 17 March 1998 debate began in the Parliament of Western Australia and continued for some months. Wider discussion and heated argument amongst politicians and the community took place. Medical practitioners and the health industry were widely

¹ R. v. Davidson [1969] VR667
R. v. Wald [1971] 3NSWDCR25

consulted in order to effectively address health and related issues. On 26 May 1998 the *Acts Amendment (Abortion) Act 1998* (the Abortion Act) that amended the *Health Act 1911* and *The Criminal Code* eventually was passed after two months of active public debate and numerous amendments to the original proposal.

The effect of the Abortion Act was to make it lawful for a medical practitioner to perform an abortion provided that the women concerned had given “informed consent”. A woman can only give informed consent if she has been adequately counselled by the medical practitioner about the medical risks of having a termination and of continuing with the pregnancy. Counselling also includes an explanation of the procedure to be performed appropriate to gestation. In this context information may be provided on vacuum aspiration, mini labour, and choices as to where the termination can be performed. Explanations are provided on the anesthetic which will be used and any possible associated risks, as well as information about short and long term psycho-social risks and the risks posed to future pregnancies. The woman should also be provided with information about the availability of more general counselling services and be provided with information regarding the support services available if she chooses to continue the pregnancy (e.g. Department for Community Development).

It is noted that whether or not an offer for referral for further counselling is actioned is a matter for the woman concerned and she is not required to be counselled elsewhere to meet legal requirements. Providing a referral for further counselling is offered, the medical practitioners may elect to provide the counselling. The medical practitioner providing counselling, however, must not, be the same medical practitioner who performs the abortion or assists in the performance of the abortion.

Current situation in Western Australia - Summary

- Circumstances in which an abortion can be provided are now covered by the *Health Act 1911* rather than *The Criminal Code*.
- Women in Western Australia can now legally obtain an abortion up to 20-weeks of pregnancy, or after 20-weeks in limited circumstances and with agreement of two panel medical practitioners.
- In order to meet the requirements of the legislation, the woman must give informed consent to the procedure. To give informed consent a woman must have been informed of the medical risks of terminating or continuing with a pregnancy and have been *offered* the opportunity for further counselling.
- The medical practitioner who performs the abortion cannot be the person who provided counselling.
- Medical practitioners involved in referral, counselling and carrying out abortion procedures now have the protection of a clear legislative framework.
- A woman who is a dependant minor (under 16 years) is not regarded as having given informed consent unless a custodial parent or guardian has been informed that the performance of an abortion is being considered and given the opportunity to participate in the counselling process and medical consultations. In order to vary this requirement, a dependent minor must seek the permission of the Children’s Court for an order that the custodial

parent or guardian should not be given the information.

- Hospital and medical staff have the right to refuse to take part in abortion procedures.
- Although abortion in Western Australia is now legalised, a medical practitioner can still be prosecuted under *The Criminal Code* section 199 if requirements in the Health Act are not met.

Consultation With the Public and Key Stakeholders

Public submissions were requested by newspaper advertising, which appeared in *The West Australian* on 20 December 2001. Additional information about the review was made available on the Department of Health's website. The closing date for public submissions was 25 January 2002.

The Review Steering Committee considered all submissions when preparing its report and recommendations for the Minister for Health

Key stakeholders were invited to contribute written submissions based on the Terms of Reference. Letters inviting submissions were sent to:

Australian Legal Right to Abortion (ALRA)
Australian Medical Association (AMA)
Australian Nursing Federation
Beaconsfield Multicultural Women's Health Centre
Bridgetown Health Services
Catholic Education Association of Western Australia
Central Law Courts
Centrecare
Chief Justice David Malcolm
Children's Court of Western Australia
Coalition for Defence of Human Life
Commissioner of Police
Consumer Representative Unions of Western Australia
Department for Community Development
Department for Community Development, Women's Policy Office
Department of Education
Department of Health, Sexual Health Program
Department of Justice
Derbarl Yerrigan Health Service
Director Public Prosecutions
Ethnic Disabilities and Advocacy Centre
Family Planning WA (FPWA)
General Practice Divisions of Western Australia
Geraldton Regional Hospital
Goldfields Women's Health Centre
Independent Schools Association
Ishar Multicultural Women's Centre
Kalgoorlie Regional Hospital
King Edward Memorial Hospital
Legal Aid
Marie Stopes International
Nanyara Medical Group
National Council of Women, WA
Peel Health Campus
Port Hedland Regional Hospital
Public Health Association
Relationships Australia
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Rural Doctors Association
Southwest Women's Health Centre

West Point Health Service
Western Australian Aboriginal Community Controlled Health Organisation
(WAACCHO)
Women's Electoral Lobby
Women's Health Care House
Women's Health Resource Centre Inc, Geraldton

129 formal submissions were received from individuals and key stakeholders. Most submissions addressed the Terms of Reference.

The submissions were received from a wide cross-section of the community. Many submissions raised issues reflecting objections to abortion. These could not be considered as they were outside the terms of reference for the review, which were limited by the terms of the Act to the operation and effectiveness of the legislation. Many of the submissions also raised issues that related more to perceived shortfalls in the way in which the legislation was being applied, rather than to problems with the legislation itself. Administrative issues that have been able to be addressed as part of this legislative review are included in this report.

A wide range of issues were covered in the submissions. There were some major themes that emerged out of the submissions. These were:

- ♣ There was a divergence of views expressed in the submissions. Some submissions raised concerns that abortion was too easily available and others that the conditions contained in the current legislation were too restrictive especially for women in small communities. The majority view from key stakeholders and service providers was that the legislation seems to be working well in ensuring that women have access to safe, legal abortions.
- ♣ There was agreement that women need to have adequate information on the physical and psycho-social risks associated with induced abortion. However, there is a divergence of view about what information should be provided. Some submissions raised concerns about the level and accuracy of information that is currently being provided to women.
- ♣ From the submissions it is apparent that there is not a clear understanding in some sections of the community and the medical profession of the obligations and responsibilities of medical practitioners in relation to abortion counselling.
- ♣ There was strong support in the submissions for more to be done to address the number of unplanned and teenage pregnancies, although there were widely divergent views about the appropriate preventive strategies that should be adopted to achieve a reduction in the numbers.

The Review Steering Committee valued the contributions that were made in the submissions received.

General Findings And Recommendations

The Acts Amendment (Abortion) Bill was introduced into the Western Australian Parliament with the intent of providing “abortions in those sad circumstances where they are necessary, in safe, legal conditions for Western Australian women.” It was hoped that ultimately, “through taking abortion out of the shadows”, to regulate and

reduce the number of terminations carried out.²

The review concluded that the abortion legislation is generally working in the manner in which Parliament intended.

The review found that while the legislative provisions in the *Health Act 1911* had achieved the aim of making safe abortions available to Western Australian women, there are a number of improvements that can be made in the way in which the administration of abortion support services and educational services relating to pregnancy may be improved.

It has been recommended that the Department of Health further examine a number of specific issues arising from the review. It is expected that the Department will carry out this work in consultation with relevant stakeholders and provide regular reports to the Minister for Health in relation to the results of their examinations.

There have been no prosecutions for the unlawful performance of an abortion since the *Acts Amendment (Abortion) Act 1998* was introduced. There have been no charges laid under *The Criminal Code* in respect of alleged breaches of the legislation.

The Department of Health, being the public sector agency principally assisting the Minister for Health in the administration of the *Health Act 1911*, will continue to oversee the *Health Act 1911* and be responsible for the oversight of implementation of the following recommendations.

Recommendation 1

The legislative provisions in the *Health Act 1911* and *The Criminal Code* relating to abortion to be retained in the current form.

Recommendation 2

The Department of Health to review the effectiveness of information currently provided to Medical Practitioners and to establish a mechanism to monitor the knowledge of medical practitioners with regard to the legal requirements for informed consent and provide further information and education as required.

Recommendation 3

The Department of Health to consider the role of specially trained Advance Practice Nurses in providing medical risk counselling as set out in Section 334(5)(a) and provide a report to the Minister to coincide with any review of the Nurses Act.

Recommendation 4

The Department of Health to produce evidence-based guidelines concerning medical risks of abortion and an information booklet, and to review these and other relevant publications annually to ensure they are consistent with available clinical evidence and prevailing clinical opinion.

Recommendation 5

The Department of Health to undertake an investigation of the gaps in the availability of

² *Acts Amendment (Abortion) Bill (Second Reading) Warnock Pendal 8 April 1998 – (Hansard 1712/1)*

specialty areas of counselling and support services and to propose to the Minister for Health strategies to address these gaps.

Recommendation 6

The Department of Health to undertake an investigation of the gaps in services for women undergoing a post 20-week abortion, including counselling services for women who have been declined a post 20-week abortion and review the provision of funding for such services, and to propose to the Minister for Health strategies to address these gaps.

Recommendation 7

The Attorney General to be invited to review the appropriateness of the Children's Court to hear applications and to recommend ways in which difficulties faced in rural and remote areas may be addressed.

Recommendation 8

The Department of Health to conduct an audit addressing quality of care for women requesting an abortion.

Recommendation 9

The Department of Health to review options for security arrangements around abortion clinics.

Recommendation 10

The Department of Health to develop guidelines on the disposal of foetal tissue for distribution to service providers.

Recommendation 11

The Department of Health to develop strategies to cope with the shortage of registered nurses available to assist with abortion procedures.

Recommendation 12

The Department of Health to assess options to enhance women's access to medical services in relation to information and counselling on medical risks, including the option of video-conferencing where other alternatives are impractical or unavailable.

Recommendation 13

The Department of Health to develop guidelines for the delivery of abortion services to members of the community who have special needs related to cultural background, location and other relevant factors.

Recommendation 14

The names of the panel members appointed by the Minister for Health to make determinations in regard to post 20-week abortions, to remain confidential.

Recommendation 15

The Department of Health to ensure that the management and staff of health services, including medical practitioners, be made aware of legal obligations and clinical practice procedures concerning post 20-week abortions.

Recommendation 16

The Department of Health to review the statutory provisions relating to the reporting of abortions in Section 335 of the Health Act 1911.

Recommendation 17

A report on notified abortions to be included in the Department of Health's Annual Report. This information to be made available to service providers and the general public.

Recommendation 18

The Department of Health to consider improvements to the collection of additional data including examining the notification forms from overseas and interstate jurisdictions.

Recommendation 19

The Department of Health to develop a monitoring system to oversee compliance standards, to follow up breaches of the Act, and for regular audits on the compliance and accountability of notification forms.

Recommendation 20

The Department of Health to regularly advise the management of facilities which provide abortion services of their requirement to lodge notification forms and support appropriate training for staff through the distribution of appropriate Operational Circulars.

Recommendation 21

The Department of Health to undertake a study of the multi-strategy approach used in the Netherlands to prevent unplanned pregnancies and develop a program to reduce the number of unplanned pregnancies in specific target groups.

Recommendation 22

The Department of Health and the Department of Education to strongly support the provision and review of current culturally and developmentally appropriate sexual health curriculum materials and support professional development for teachers to deliver the curriculum materials.

Recommendation 23

The Department of Health to ensure continuing education in relation to the understanding of legal requirements of the abortion legislation for medical practitioners.

1.1 The Effectiveness Of The “Informed Consent” Provisions In Providing Women With Adequate Information And Counselling.

1.1.1 Abortion up to 20-weeks of pregnancy is justified if the woman has given informed consent to the procedure.³ The requirements to be met before the woman can give informed consent are that a medical practitioner must provide counselling on the medical risks of terminating the pregnancy and of carrying the pregnancy to term and must also provide an opportunity of referral for further counselling about matters relating to the woman’s decision⁴. There are three additional grounds that may justify abortion under the Health Act 1911 but these grounds also require the woman to give informed consent unless it is impracticable for her to do so⁵. The additional grounds are: serious personal, family or social consequences if the abortion is not performed⁶; or serious danger to the pregnant woman’s physical or mental health if the abortion is not performed⁷; the pregnancy of the woman is causing serious danger to her physical or mental health⁸.

1.1.2 The key requirement in relation to the lawful performance of abortions in Western Australia is the requirement that a woman give informed consent to the procedure. The requirements to be satisfied in order for informed consent to be given are defined in the *Health Act 1911* as:

334(5) In this section – “informed consent” means consent freely given by the woman where

- (a) a medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term;*
- (b) a medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and*
- (c) a medical practitioner has informed her that appropriate and adequate counselling will be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.*

1.1.3 Providers of abortion services have advised that since the enactment of the legislation women presenting for abortions were generally well informed and emotionally prepared for having an abortion.

The Term “Counselling” in Section 334(5)(A) of the *Health Act 1911*

1.1.4 While the requirements for informed consent appear to be providing more information and counselling than before, this was an area where medical practitioners expressed confusion about their obligations. The confusion appears to particularly relate to the term counselling as it is used in section 334(5)(a) of the *Health Act 1911*. The term is also used in section 334(5)(b) and (c) although problems do not appear to have arisen in relation to those sections.

³ Section 334(3)(a), *Health Act 1911*

⁴ Section 334(5), *Health Act 1911*

⁵ Section 334(4) *Health Act 1911*

⁶ Section 334(3)(b), *Health Act 1911*

⁷ Section 334(3)(c), *Health Act 1911*

⁸ Section 334(3)(d), *Health Act 1911*

- 1.1.5 The main problem encountered is that the term “counselling” in section 334(5)(a) is being interpreted as “psychological counselling” needing to be offered by a specialist counsellor. Consequently some women are being sent directly to counselling services with a belief that it is mandatory for them to do so in order to access abortion services. In fact, the counselling that women require in section 334(5)(a) is in relation to medical risks and must be provided directly by the medical practitioner.
- 1.1.6 In November 2001, shortly prior to the commencement of the review process, the Department of Health distributed a booklet entitled “*Notes for Medical Practitioners on Abortion Legislation in WA*” that provides clarification of the counselling requirements in section 334(5). There was insufficient time between the distribution of this publication and the review to assess whether the information provided in the publication has addressed the concerns about the medical risk counselling requirements. This issue is addressed in greater detail later in this report

Recommendation 2

The Department of Health to review the effectiveness of information currently provided to Medical Practitioners and to establish a mechanism to monitor the knowledge of medical practitioners with regard to the legal requirements for informed consent and provide further information and education as required.

Requirement in Section 334(5)(a) that Information about the Medical Risks of Termination be Provided by a Medical Practitioner

- 1.1.7 Advance Practice Nurses had provided counselling and medical risk information about health outcomes throughout Western Australia for many years prior to the 1998 changes to the abortion legislation. The requirement in section 334(5)(a) that information about the medical risks of termination be provided by a medical practitioner (as opposed to an Advance Practice Nurse⁹) has caused difficulties. Information received during the review noted instances where this requirement has resulted in limited access to medical risk information for women particularly in rural and remote regions. However, it is noted that these nurses also fulfilled a role in metropolitan areas, especially for women from lower socio-economic status backgrounds.
- 1.1.8 It is recommended that to ensure equity of access for women to medical risk information, consideration be given to allowing specially trained Advance Practice Nurses to provide medical risk counselling.

⁹ Registered Nurses who have completed the Family Planning Association Sexual and Reproductive Health certificate

Recommendation 3

The Department of Health to consider the role of specially trained Advance Practice Nurses in providing medical risk counselling as set out in Section 334(5)(a) and provide a report to the Minister to coincide with any review of the Nurses Act.

Disclosure Of Information Concerning Medical Risks Of Abortion

- 1.1.9 Provision of appropriate medical information to women undergoing an abortion was seen to be an area where there were significant concerns. A number of submissions commented on the adequacy of the advice and printed information on medical risks provided by medical practitioners and other organisations. Some submissions suggested that possible physical and psychological problems, including risks of infertility, following induced abortion were not adequately addressed during the provision of medical risk information. In particular, some submissions raised concerns about the Department of Health publications¹⁰, which address the issue of the risks of breast cancer following an induced abortion.
- 1.1.10 It is the responsibility of the medical practitioner to properly and adequately advise women of all relevant medical risks of termination of pregnancy and of carrying a pregnancy to term.
- 1.1.11 The provision of printed pamphlets or other materials produced by the Department of Health or other organisations does not imply that any obligation to counsel a woman is necessarily satisfied by providing this information alone. The information booklet and pamphlets provided by the Department of Health summarise evidence-based information on major risk factors that have been identified in the literature. Providing a pamphlet is not a ‘stand alone’ means of provision of counselling of medical risks, but rather the material should be used as an aid in communicating with women seeking an induced abortion. The information required to properly, adequately and appropriately counsel a woman will always depend on her individual needs and the circumstances of the case.
- 1.1.12 Information, including written material should be high quality and evidence based for both consumers and medical practitioners.
- 1.1.13 The Department of Health’s Notes for Medical Practitioners on the Abortion Legislation in Western Australia were distributed to medical practitioners in December 2001 and include advice that counselling about medical risks of having a termination and of continuing a pregnancy should include:
- Medical risks of continuing with the pregnancy;
 - Explanation of the procedure to be performed, appropriate to gestation;
 - Choices as to where the termination can be performed;
 - An indication of the time involved;
 - Explanation of the anaesthetic which will be used and possible associated

¹⁰ Notes for Medical Practitioners on the Abortion Legislation in Western Australia; Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term-Information for General Practitioners; A Summary of Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term-Information for Women.

- risks;
- Short-term medical risks involved;
- Long-term medical or psycho-social risks;
- Risks to future fertility;
- Information regarding the support services available for women wishing to continue with the pregnancy; and
- Information about referral for counselling, availability of follow-up counselling and other matters to assist medical practitioners.

1.1.14 A range of international publications summarise the current position in relation to the abortion and breast cancer issue. The National Cancer Institute of America concludes that there appears to be no increased breast cancer risk in women who have had induced abortions (Appendix B) and the UK ¹¹Royal College of Obstetricians and Gynecologists notes that the evidence is inconclusive but that, “when only those studies least susceptible to bias are considered, induced abortion does not seem to increase the risk” (Appendix C)¹².

1.1.15 The review concluded that the discussion of the risks of breast cancer where it occurs in the booklet¹³ entitled: “Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term” and “Notes for Medical Practitioners on Abortion Legislation in WA”, both produced by the Department of Health, are consistent with credible medical opinion¹⁴. It is noted that the breast cancer debate was not referred to in the information pamphlet for women published in 1998. It may be appropriate to consider including reference to the debate in future publications.

1.1.16 The review recommends that the booklets and leaflet produced by the Department of Health should be updated. To this end, it is recommended that the Department of Health develop evidence-based guidelines (which will of necessity include an independent literature review and analysis) and prepare an information booklet based on those guidelines. The Review Steering Committee noted work undertaken in the United Kingdom resulting in the publication of “About Abortion Care”¹⁵ in May 2001.

1.1.17 Future abortion publications should include a date for revision of the publication. In an area where risks to women are being continually reviewed, it is prudent to review the publication on a two-yearly basis¹⁶.

1.1.18 As the production of information booklets and pamphlets will require expert medical and technical information, a wide range of expertise will be required. The importance of independent advice in this regard is noted.

Recommendation 4

The Department of Health to produce evidence-based guidelines concerning medical risks of abortion and an information booklet, and to review these and

¹¹ National Cancer Institute Fact Sheet http://cis.nci.nih.gov/fact/3_53.htm

¹² <http://www.rcog.org.uk>

¹³ At page 11 of the booklet.

¹⁴ By way of illustration, National Health Medical Research Council – National Breast Cancer Centre of Australia, Harvard School of Public Health, American Cancer Society, American College of Obstetricians and Gynaecologists, Royal College of Obstetricians and Gynecologists.

¹⁵ <http://www.rcog.org.uk>. Also funded by the Health Department in UK.

¹⁶ This approach is in line with that taken in the United Kingdom.

other relevant publications annually to ensure they are consistent with available clinical evidence and prevailing clinical opinion.

2.1 The Effectiveness of the Department of Health Funded Abortion Counselling Services in Fulfilling Their Role of Providing Counselling Services for Women Requesting Advice Pre/Post Abortion.

2.1.1 Following the introduction of the abortion legislation, the then Government introduced a strategy¹⁷ to support the provision of access to ongoing counselling and support for women with an unplanned pregnancy¹⁸. The Department of Health currently purchases specific services from the following six counselling and support services for women with an unplanned pregnancy, their families and support people.

- Centre Care (Post Abortion Counselling);
- Family Planning WA;
- Goldfields Women's Health Centre (Kalgoorlie);
- Relationships Australia;
- South West Women's Health and Information Centre (Bunbury);
- Womens Health Resource Centre (Geraldton).

2.1.2 The aim of these counselling agencies is to deliver a service which allows women to make an informed decision with regard to an unplanned or unwanted pregnancy, as well as to provide counselling for post-termination issues or for the continuation of the pregnancy. Counselling services are also provided for husbands, partners or significant members of the women's families who are experiencing psychological, emotional and/or social difficulties in their lives as a result of the women's experience of the unplanned pregnancy and subsequent decision. For specific details regarding wheelchair access, audiovisual materials, translator services and deaf and visually impaired services refer to Appendix D.

2.1.3 The review is aware of 12 other services that provide counselling and support specifically in relation to continuation of pregnancy, as listed in Appendix E. In addition, a number of other agencies offer services for unplanned pregnancy and post-abortion counselling and as a consequence an exhaustive list was not produced.

2.1.4 King Edward Memorial Hospital (KEMH) also offers counselling and support services, particularly in relation to women with diagnosed foetal abnormalities. These services include a multi-disciplinary approach to counselling including obstetricians, paediatricians, geneticists, genetic counsellors, nurses, clinical psychologists and chaplaincy staff. Counselling at KEMH occurs pre-procedure and post-procedure and additional support services are individualised for the woman and her family's needs.

Improving the Provision of Counselling Services

2.1.5 A number of submissions suggested that specialty areas of counselling and support services could be improved. Women outside the Perth metropolitan area

¹⁷ Known as a "Strategy to Implement a Program of Public Information".

¹⁸ "Guidelines for Counselling" were produced in August 1998.

were identified as disadvantaged in terms of access to unplanned pregnancy and abortion counselling services. Counselling services to address specific issues unique to post 20-week abortions were identified in some submissions as being inadequate. The need for counselling services for women who undergo repeat terminations was another area of concern identified in some submissions. Some submissions reported a lack of resources, including financial.

- 2.1.6 Some submissions raised concern that there were limited counselling opportunities available for women who elected to proceed with a pregnancy. The availability of counselling services for women continuing with an unplanned pregnancy has been identified as inadequate in many rural and remote regions, including the Kimberley.
- 2.1.7 Counselling through pregnancy would depend on individual women's needs (eg. genetic, relationship counselling) and is made available from a variety of services. Unplanned pregnancy counselling services funded by the Department of Health provide some services for women who wish to continue with a pregnancy. These agencies provide free consultations and when these have been expired a fee usually applies. In cases of financial hardship, this cost may be waived. In some instances, women receive counselling and support throughout their entire pregnancy. Women may also be referred to other health and welfare services, as appropriate, eg Department for Community Development or the Adolescent Clinic at KEMH for additional services and support. It is recognised that some of these services may be unavailable in rural and remote locations.

Recommendation 5

The Department of Health to undertake an investigation of the gaps in the availability of specialty areas of counselling and support services and to propose to the Minister for Health strategies to address these gaps.

Particular Issues Which Affect Counselling in Relation to Post 20-Week Terminations

- 2.1.8 The Genetic Services of Western Australia at King Edward Memorial Hospital provides counselling for women/couples making decisions regarding termination of pregnancy following the diagnosis of a foetal abnormality. Counselling is provided pre and post decision-making and includes counselling for couples who also choose to continue a pregnancy. The introduction of the abortion legislation has improved the access women have to information and counselling regarding abortion, which has led to increased referral to Genetic Services for specialised counselling. Concerns were raised in relation to a lack of specialised counselling services for women who have been declined a post 20-week abortion.
- 2.1.9 The reasons for a late diagnosis of foetal abnormality are many and varied. Some of the more common reasons presented during the course of this review included the following:
- booking for testing late in pregnancy; and
 - an abnormality being being diagnosed late in pregnancy.
- 2.1.10 On occasions, a foetal abnormality may be suspected of which the nature or severity is uncertain. In this situation to have the facility for observation or

further evaluation of the foetus over a period of weeks is central to the accurate diagnosis of either the nature of the abnormality or its severity.

2.1.11 When a diagnosis of foetal abnormality has been made a few days prior to 20-weeks, women have reported the following experiences:

- a feeling that their decision to terminate the pregnancy is pressured by a time factor, as once the pregnancy is deemed over 20-weeks the decision is no longer theirs alone;
- the situation of these women and their ability to make a decision was seen to be aggravated by their perceived sense of uncertainty as to whether they will have access to termination once the 20-weeks has passed;
- a diminished sense of personal control in making important life decisions;
- concerns that decisions may be made in haste or be fear based, with potential psychological implications; and
- concerns about the subjectivity of the panel decision or possibility of judgment.

There were also reports of emotional distress following diagnosis of foetal abnormality inhibiting the ability to reach an informed decision.

2.1.12 When the Ministerially appointed panel declines a request for an abortion post 20-weeks the following sequels were reported to the review:

- limited psychological support/counselling available;
- inadequate funding for counselling allocated for women whose abortions are declined;
- unique issues of guilt and grief associated with continuing a pregnancy following a declined request for abortion; and
- conflicting feelings in utilising counselling through KEMH when the request has been declined by the panel at KEMH.

2.1.13 The Review noted advice from KEMH in regard to situations where a request for a post 20-week abortion was refused given the potential for increased risk of self-harm and potential bonding issues when the baby is born. There is also the possibility of additional parenting difficulties if the baby has a disability or special needs. While it appears that counselling services in this area have improved following the introduction of the Act, there are still gaps in service that require further consideration.

Recommendation 6

The Department of Health to undertake an investigation of the gaps in services for women undergoing a post 20-week abortion, including counselling services for women who have been declined a post 20-week abortion and review the provision of funding for such services, and to propose to the Minister for Health strategies to address these gaps.

3.1 The Operation and Effectiveness of the Provisions of the Act Relating to Dependant Minors, Especially in Regard to the Scope and Use of Magistrate’s Discretion.

- 3.1.1 A dependant minor (under the age of 16 years and being supported by a custodial parent or legal guardian) seeking a termination of pregnancy must meet additional requirements before she can give informed consent to a termination. Either a custodial parent of the minor must have been informed that an abortion is being considered and given the opportunity to participate in counselling¹⁹, or an order from the Children’s Court of Western Australia must be obtained dispensing with the requirement to inform and include the custodial parent in the process²⁰.
- 3.1.2 The medical practitioner providing medical risk counselling must be satisfied that the parent or guardian has been informed (unless applying for an order from the Children’s Court) and has been given the opportunity to participate in a counselling process and consultations between the medical practitioner and the minor. If the custodial parent/guardian is provided with the necessary information, and has been given the opportunity to participate in counselling/consultation, a dependant minor may give the necessary informed consent, even if this is not consistent with the parent/guardian’s views.

Children’s Court Orders

- 3.1.3 Applications made to the Children’s Court pursuant to section 334(9) of the *Health Act* are applications for an order to withhold information and to exclude certain persons from being involved in the dealings between a medical practitioner and their patient. The Court does not grant permission for an abortion or order an abortion.
- 3.1.4 There has been a total of 26 applications for an order to the Children’s Court of Western Australia since May 1998, as follows:

Year	Number of Applications
1998	3
1999	5
2000	8
2001	8
2002	2 (to March)

Table 4: Number of Applications to Children’s Court for an order under the *Health Act 1911* from 1998.

Source: Children’s Court of Western Australia

¹⁹ Section 334(8)(a), Health Act 1911

²⁰ Section 334(9), Health Act 1911

- 3.1.5 The Children’s Court has developed policies and guidelines for processing applications. A copy of these policies can be found at Appendix F.
- 3.1.6 Minors requesting Children’s Court approval are represented by solicitors from the Legal Aid Commission of Western Australia. The solicitor prepares an affidavit on the applicant’s instructions outlining the background and circumstances of the matter. This is provided to the Children’s Court together with a medical practitioner’s certificate confirming the pregnancy, the options and consequences discussed with the minor in relation to an abortion, and the ‘domestic situation’ of the minor.
- 3.1.7 All applications made to the Children’s Court to date have been approved. Reasons given for granting an order to exclude custodial parents from being informed of the intended abortion were varied and included fears of violence, retribution, cultural and religious reasons.
- 3.1.8 Issues were raised during this review by the Children’s Court, in relation to the appropriateness of utilising the Children’s Court in hearing these types of applications. The suggestion was made that it may be more appropriate to hear these applications in the Family Court where there are counselling facilities and more judicial staff available.
- 3.1.9 Concerns were raised that although the Children’s Court procedures were working well for urban dwelling dependant minors, this may not be the case for all rural and regional areas. One example cited is that it is particularly difficult for dependant minors in far north Western Australia, where the magistrates visit only once every four weeks, to make timely applications. Other examples were provided in relation to difficulties that minors, without the benefit of a female custodial parent, may experience if they are from a culture where men are not traditionally involved in issues which are seen as “women’s business”. Additionally, minors in some areas do not have knowledge of legal aid services to assist them in the legal processes.

Recommendation 7

The Attorney General to be invited to review the appropriateness of the Children’s Court to hear applications and to recommend ways in which difficulties faced in rural and remote areas may be addressed.

- 3.1.10 A number of submissions expressed concern that legislative processes for dependant minors were impinging on the rights of parents to participate in decision making processes and provide support, whilst others indicated that the legislative support for minors was adequate.
- 3.1.11 The decision as to whether to inform the custodial parent or guardian, or to seek to vary this requirement by applying to the Children’s Court under section 334 (9) of the *Health Act 1911*, is one for the dependant minor herself to make. It is also an issue to which the normal requirements of medical practitioner/patient confidentiality apply (i.e. that confidentiality be maintained by the medical practitioner except where the patient has consented to the release of information).
- 3.1.12 The legislation encourages the involvement of a custodial parent of the dependant minor by requiring that a custodial parent be informed that the

performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed. The legislation provides for an alternative approach in those circumstances where a Court is satisfied that it is not appropriate to advise a custodial parent of the intended abortion.

3.1.13 Allegations of criminal activity were raised in some submissions in relation to dependant minors. The submissions raised concerns that sexual intercourse with a woman under 16 years of age is a criminal offence and approval of an application for an order to preclude parental involvement could be seen as covering up a criminal act, such as incest or sexual assault.

3.1.14 The review noted that legislation covering dependant minors does not preclude criminal charges being laid. Dependant minors seeking a Court Order to exclude parental involvement have access to a solicitor who can provide legal advice in relation to any possible criminal offences.

4.1 The Identification of Gaps or Deficiencies in the Delivery and Access of Abortion and Counselling Services Under the Act.

A number of submissions identified issues under this Term of Reference. These can be conveniently grouped under the following categories.

Audit

- 4.1.1 Concerns were raised in submissions to the review that there was no systematic, critical analysis of delivery of care including the procedures used for diagnosis and treatment of health problems, the provision of resources and the resulting outcome and quality of life for the woman following an abortion. The recent “*National Audit of Induced Abortions*”, undertaken in the United Kingdom²¹ provides an illustration of such a review in the UK context. It is recommended that consideration be given to a similar process being undertaken at the state level in Western Australia. This would have particular relevance and benefits in ascertaining the status of women’s access to abortion services in rural and remote regions of Western Australia.

Recommendation 8

The Department of Health to conduct an audit addressing quality of care for women requesting an abortion.

BARRIERS IN ACCESSING ABORTION SERVICES

- 4.1.2 Concerns were raised in submissions to the review regarding the safety of both service providers and women attending a facility for an abortion. Some submissions reported women being confronted with groups of people opposed to abortion. Some women have reported being too intimidated to enter the premises and having to change their appointment time. A number of submissions suggested that a suitable solution would be the imposition of a “Bubble” or “Buffer Zone” (area around the perimeter of a clinic which excludes demonstrators) and /or the development of risk management plans.
- 4.1.3 The use of “Bubble” or “Buffer Zones” to impose reasonable limits on the proximity of anti-abortion demonstrators to women entering abortion clinics has been utilised overseas, particularly, in the United States and Canada²². Such actions bring concepts such as free speech and assembly for demonstrators into conflict with the privacy interests of women seeking to be alone in accessing the medical services they have chosen. This is not an issue that can be properly addressed in the course of this review.
- 4.1.4 Other matters were refusal by some medical practitioners to provide information regarding the option of termination of pregnancy for personal, moral or religious reasons, and a refusal to offer referral to another service provider. There were complaints that some women had been billed for the consultation and that the

²¹ National Audit of Induced Abortion 2000. <http://www.rcog.org.uk>

²² By way of illustration in British Columbia the bubble zone legislation titled “*Access to Abortion Services Act*” was passed in September 1995. The bubble zone legislation can keep protesters up to 50 metres away from facilities that provide abortions. In Colorado the law establishes a 100 foot buffer zone.

medical practitioner had refused them a referral to another service provider. While these are serious issues they are not matters for a review of the legislation and as a consequence were not investigated further.

Recommendation 9

The Department of Health to review options for security arrangements around abortion clinics.

Disposal of Products of Abortion

- 4.1.5 Concerns were raised by service providers (both public and private) that there were no guidelines available for the disposal of tissue obtained from abortion. It is recognised that this is an area where specific guidelines are required.

Recommendation 10

The Department of Health to develop guidelines on the disposal of foetal tissue for distribution to service providers.

Registered Nurse Shortages

- 4.1.6 A shortage of registered nursing staff available and prepared to assist with second trimester medical terminations of pregnancy was raised as a significant issue. In rural and remote areas, inadequate staffing could lead to additional difficulties in cases where nursing staff conscientiously opposed to abortions need to assist medical practitioners with induced abortions. Section 334 (2) of the *Health Act 1911* provides that: “No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion.”

Recommendation 11

The Department of Health to develop strategies to cope with the shortage of registered nurses available to assist with abortion procedures.

Videoconferencing Technology

- 4.1.7 The requirement set out in section 334(6)(a) and (b) of the *Health Act 1911*, which would preclude the medical practitioner providing counselling from assisting with anaesthetic procedures, places a significant burden on medical practitioners in isolated and rural areas. This is because section 334(6)(b) does not allow the medical practitioner who has provided the medical risk counselling and referral information to perform or assist at an abortion.
- 4.1.8 The use of communications technology (principally videoconferencing²³) to provide medical services is an option for increasing access to medical practitioners in the rural regions. This technology has been used effectively in the mental health area for many years. However, it is desirable that this new provision be region specific to deal with situations only where there is a shortage of local medical practitioners such that it presents difficulties in providing appropriate services to women.

²³ It can also include audioconferencing, audiographics, interactive satellite television and computer conferencing. Many of these separate technologies are now being converged.

Recommendation 12

The Department of Health to assess options to enhance women's access to medical services in relation to information and counselling on medical risks, including the option of video-conferencing where other alternatives are impractical or unavailable.

Information for Women

4.1.8 Both women seeking abortion and health professionals involved in the provision of this service need easy access to information on the provision of induced abortion services. It is good practice that all information shared with a woman in the initial interview be supported with good quality, accurate, impartial, written information that is easy to understand and well presented. Research findings over the past decade have shown that patients tend to be more satisfied with communication after they are provided with printed information.²⁴ Consideration should also be given to having this information translated or recorded on audio-tapes for women who have a limited understanding of English, limited literacy or who are vision impaired.

Members of The Community With Special Needs - Aboriginal And Torres Strait Islander Women

4.1.9 During the course of this review a number of significant issues for "women with special needs" in relation to the delivery and administration of abortion services were noted. Those members of the community who may have special needs include (but are not limited to), women with diverse cultural backgrounds, women with mental disorders, women with language difficulties, and the hearing/visually impaired. It is not possible to address all the significant range of issues which impact on these women within the context of this report.

4.1.10 It is recommended that the Department of Health consult with groups with special needs, and service delivery professionals in order to develop detailed guidelines for the delivery of abortion services to those members of the community who have particular needs because of cultural background, location or other special needs.

4.1.11 The review also noted that considerable barriers and issues existed for women from rural and remote areas who wish to consider, and/or access, termination facilities. Cases were cited where scheduled visits from medical practitioners were intermittent and where women were forced to travel to other regions or the metropolitan area.

4.1.12 In both metropolitan and rural regions it was noted that there have been difficulties generally with some medical practitioners refusing to provide requested information for women wanting to access terminations. This is of particular concern in small towns and communities where the refusal by a general practitioner to either provide the requested information or to refer the patient to another medical practitioner, may have significant adverse consequences for the woman. This may mean that the woman may have to travel a considerable distance to access appropriate services. For women on

²⁴ Dixon M, "Assertions about patient information are not supported", British Medical Journal, 1995, 311: 946 (7 October).

very low incomes this can be a problem. It also increases the gestational age at which a termination is likely to be obtained.

- 4.1.13 Input received from different areas of the state indicated a relatively low uptake of abortion counselling and services from women with diverse cultural backgrounds, especially in rural and remote areas. There is an impression of considerable barriers and issues for women with different cultural backgrounds who wish to raise sensitive reproductive health issues and consider, and/or access an abortion. Some women were reported to have concerns in regard to the confidentiality of this information in remote areas where they may be related to, or known socially by staff. There were reports of women from rural and remote areas being isolated and unsupported when they made a decision to terminate a pregnancy, especially if they lived in communities with a high rate of teenage pregnancies. There were also reports of medical practitioners feeling constrained by the law and unable to provide contraception to minors (under 16 years), and reports of girls as young as 12 years having babies.
- 4.1.14 The availability of culturally appropriate information pamphlets for women, that take into account varying levels of literacy, is also identified as a gap. A further issue was the financial difficulties faced by women living in remote and rural areas in accessing funds to enable them to travel to Perth for terminations.
- 4.1.15 The Patient Assisted Transport Scheme (PATS) is an important mechanism for access to all specialist services. PATS will collect and provide transport for the women to the nearest centre where the specialist procedure is offered.
- 4.1.16 Confidentiality and disclosure were identified as problems with seeking PATS assistance in relation to abortion services, especially in small towns or communities where there may be only one medical practitioner. There were reports of women travelling to Perth (at their own expense) rather than attending their local medical practitioner for a referral due to issues of possible identification. The provision of comprehensive services is hampered by:
- restrictions on PATS assistance for an accompanying spouse or support person;
 - the long distances remote and rural women must travel to access clinics or educational services;
 - negative attitudes towards sexuality education restricting educational services and training programs;
 - the cost of services, consultations and contraceptives which are barriers to young people, students and those on low incomes; and
 - lack of culturally specific programs for cultural/ethnic groups.
- 4.1.17 Indigenous women's accessibility to abortion counselling is not known although input from different areas of the state indicated a relatively low uptake of services. Concerns were raised regarding the availability and accessibility of culturally safe women's health services, including confidential reproductive health and abortion counselling services, especially in remote areas where women may be related to or socially known by staff, and where they feel isolated and unsupported when making the decision to terminate a pregnancy. The need to provide more culturally appropriate written information was also identified.

- 4.1.18 The Review Steering Committee concluded that there was not a statewide viewpoint representing all Aboriginal and Torres Strait Islander people.
- 4.1.19 The need for a holistic approach to Aboriginal women's reproductive health issues was also identified as well as recognizing the need to professionally develop key female Aboriginal Health Workers. The work of unplanned pregnancy counselling in country regions mostly falls on GPs and there is no specialized counselling services available in the Kimberly.
- 4.1.20 The Review Steering Committee noted that this area requires more investigation. The WA Aboriginal Community Controlled Health Organisation (WAACCHO) may be appropriate to coordinate a response addressing the operation and effectiveness of the abortion legislation for Aboriginal people and forward recommendations to the Department for Health.
- 4.1.21 Information was provided to the review on the important role of Aboriginal Health Worker and the crucial role they play in assisting Aboriginal women in remote and rural areas. They offer an important entry point for many women who may otherwise have limited access to information about unplanned pregnancies, advice and help. The Department of Health is currently developing enhancement to the curriculum for Aboriginal Health Workers. These enhancements include specific development in the provision of counselling to Aboriginal people in rural and remote areas.
- 4.1.22 In the Kimberley region it was noted that there are no specialised services available in relation to counselling prior to and post termination. This role falls mostly on general practitioners of which there are limited numbers in some non-metropolitan areas. Concerns were raised during the review that the Department of Health funded counselling services have not reached the Kimberley region. The telephone counselling type services were thought to be of very limited use for all but the most educated and literate clients.

Recommendation 13

The Department of Health to develop guidelines for the delivery of abortion services to members of the community who have special needs related to cultural background, location and other relevant factors.

5.1 The Operation and Effectiveness Of The Procedures For Abortion After 20-Weeks Of Pregnancy.

The Law In Relation To Post 20-Week Abortions

5.1.1 After 20-weeks pregnancy an abortion is only lawful in Western Australia if two doctors agree that the pregnant woman or the foetus has a severe medical condition justifying abortion, and the abortion is performed in an approved facility. The two doctors must be members of a Ministerially appointed panel²⁵. The only facility that has been approved by the Minister to perform these post 20-week abortions is King Edward Memorial Hospital. Once a decision has been reached by the Ministerially appointed doctors then that decision is final. The Act does not allow for appeal rights in relation to post 20-week terminations.

5.1.2 Since the change of legislation in May 1998, there have been 107 induced abortions where the gestational period is greater than, or equal to 20-weeks. This represents 0.37% of the total number of induced abortions performed.

Number of Induced Abortions of Gestational Age Greater than, or Equal to, 20-weeks in WA

Jul –Dec 1998	15
Jan-June 1999	17
July – Dec 1999	11
Jan-June 2000	15
July-Dec 2000	22
Jan-June 2001	15
July – Dec 2001	12

Source: Health Information Centre, Department of Health, 2002

Applications For Terminating A Post 20-Week Pregnancy

5.1.3 The Ministerially appointed panel agrees to terminations of pregnancy only on the grounds of severe medical condition²⁶ of the mother or child. Where a condition is operable²⁷ it is highly unlikely that this would fulfil the criteria for a termination of pregnancy²⁸. No induced abortions have been approved (after 20-weeks) for social and/or psychiatric reasons²⁹. However, it is recognised that severe psychiatric disorders may fulfil the criteria.

5.1.4 Concerns were raised in relation to the panel appointed by the Minister for Health and the non-disclosure of the names of the panel members who approve applications for post 20-week terminations.

²⁵ Section 334 (7)(a), *Health Act 1911* the panel must consist of 6 medical practitioners appointed by the Minister.

²⁶ Section 334(7), *Health Act 1911*.

²⁷ By way of illustration a cleft palate, being an operable condition, would not fulfil the criteria.

²⁸ The Royal Women's Hospital in Victoria performs post 20-week abortions for the following reasons: serious foetal abnormality (almost all late terminations are for this reason) and life threatening maternal illness (this is a rare occurrence and assessment of such cases would involve an appropriate medical specialist).

²⁹ Five (5) applications for a post 20-week termination on psychiatric/social grounds have been denied.

- 5.1.5 The Review Steering Committee recognized that there are competing tensions and a need for trade-offs between openness and transparency and issues of security. The importance of provision of an environment where panel members are able to come to a decision regarding a request for a post 20-week abortion, without external pressures or fears of harassment, was identified. After consideration, it was determined by the Review that the public interest would best be served in not disclosing the names of the panel members.

Recommendation 14

The names of the panel members appointed by the Minister for Health to make determinations in regard to post 20-week abortions, to remain confidential.

- 5.1.6 Barriers exist for some women living in non-metropolitan and remote areas who wish to consider or access services for a post 20-week termination of pregnancy due to the Ministerially appointed facility being located in Perth. Anecdotal information included in one submission claimed that post 20-week abortions have occurred outside of King Edward Memorial Hospital. This claim has not been substantiated.
- 5.1.7 There were concerns expressed in relation to the possibility of a foetus surviving briefly following a termination, particularly in relation to post-20-week abortions. While this is seen as very unlikely, it is essentially a clinical issue and not one for consideration in terms of this review. Nonetheless, it is prudent that these concerns are noted by the Department of Health in relation to clinical practice for terminations of pregnancy.

Recommendation 15

The Department of Health to ensure that the management and staff of health services, including medical practitioners, be made aware of legal obligations and clinical practice procedures concerning post 20-week abortions.

- 5.1.8 Some concerns were also raised in relation to post 20-week abortions being performed at King Edward Memorial Hospital during June and July 1998 between when the Act came into force and prior to the panel being formally established. During this time some urgent cases were processed. Advice received from King Edward Memorial Hospital indicates that the procedures followed prior to the terminations were the same as had been followed before the introduction of the Act and also consistent with the procedures adopted by the panel when it was appointed. No further action is recommended in respect of this limited period.

6.1 The Adequacy and Effectiveness Of The Notification Procedures Required Under The Act.

- 6.1.1 There are a number of statutory reporting requirements that impact upon the notification requirements for abortions. Section 335 of the *Health Act 1911* deals with the mandatory notification of “abortions” amongst other matters.
- 6.1.2 A number of the provisions of Section 335 appear to be inconsistent and impose multiple reporting requirements. Section 335(1) and (2) require, in part, a midwife to furnish a report to the Executive Director Public Health (EDPH) on every abortion attended by the midwife and in doing so to state the name and address of the mother. However, Section 335(5)(d) and (e) require a medical practitioner who performs an abortion to notify the EDPH in the prescribed form, although however, according to paragraph (e) of this provision this must not include any particulars from which it is possible to identify the patient. In practice, midwives do not perform abortions and therefore do not furnish reports under Section 335 (1).
- 6.1.3 The statutory reporting requirements in Section 335 of the *Health Act 1911* are confusing and it is recommended that they be reviewed.

Recommendation 16

The Department of Health to review the statutory provisions relating to the reporting of abortions in Section 335 of the *Health Act 1911*.

Notification Form Pursuant To Section 335(5)(D) And (E)

- 6.1.4 The notification form which is prescribed for use in relation to the notification of terminations in Western Australia pursuant to Section 335 (5)(d) and (e) of the *Health Act 1911* is set out in Schedule 1 of the *Health (Section 335(5)(d) Abortion Notice) Regulations 1998*. This Section places a requirement on medical practitioners who perform abortions in Western Australia to notify the Department of Health within 14 days of the procedure. They are required to complete a notification form that does not identify the client. Notification forms have been developed in order to collect relevant and valuable epidemiological information. This data is then utilised to assist with the planning of programs such as the prevention of unwanted pregnancies.
- 6.1.5 The Abortion Notification system pursuant to Section 335(d) and (e) of the *Health Act 1911* was implemented in May 1998 and since that time 29,000 ‘*Notifications by Medical Practitioners of Induced Abortion*’ have been received, representing on average approximately 8,300 per annum. See Appendix G for more information on abortion statistics in Western Australia.

In accordance with the Legislation, the Department of Health has recently revised the Form 1 Abortion Notification to improve reporting procedures. The Form now requires a tick box answer and requests the following information:

1.	Gestational age at date of abortion (best estimate).....weeks	
2.	Method of termination: (tick one or more)	
	Vacuum aspiration (suction curettage)	<input type="checkbox"/>
	Dilatation and curettage (sharp)	<input type="checkbox"/>
	Dilatation and evacuation	<input type="checkbox"/>
	Vaginal prostaglandin or analogue instillation	<input type="checkbox"/>
	Other (specify).....	<input type="checkbox"/>
3.	Reason for termination of pregnancy: (tick one)	
	Reason other than foetal abnormality	<input type="checkbox"/>
	Suspected foetal abnormality	<input type="checkbox"/>
	Actual foetal abnormality	<input type="checkbox"/>
	specify if known.....	
	Selective reduction of multiple pregnancy	<input type="checkbox"/>
4.	Patient's age (last birthday):.....years	
5.	Origin of patient	
	Aboriginal but not Torres Strait Islander origin	<input type="checkbox"/>
	Torres Strait Islander but not Aboriginal origin	<input type="checkbox"/>
	Aboriginal and Torres Strait Islander origin	<input type="checkbox"/>
	Neither Aboriginal nor Torres Strait Islander origin	<input type="checkbox"/>
	Not stated	<input type="checkbox"/>
6.	Postcode of residence of patient:.....	

6.1.6 The statistical data obtained through the notification process is aggregated and is not presented in a way that could identify an individual person. Other Department of Health and Australian Bureau of Statistics information is presented in a similar manner.

6.1.7 Currently, data relating to abortions is not widely available, even to service providers, who are currently relying on anecdotal information to develop

preventive strategies. In response to this concern, the review examined a number of other jurisdictions, in particular, South Australia, New Zealand and the United Kingdom.

- 6.1.8 There are some important opportunities for the collection of valuable data, which is beneficial to the overall community. The Department of Health notes the collection of short-term complication rates on the notification forms in South Australia, New Zealand and the United Kingdom, and the United Kingdom requirement for chlamydia screening. See Appendix H for an extract from the report on abortions notified in South Australia for the year 2000.

Recommendation 17

A report on notified abortions to be included in the Department of Health's Annual Report. This information to be made available to service providers and the general public.

Recommendation 18

The Department of Health to consider improvements to the collection of additional data including examining the notification forms from overseas and interstate jurisdictions.

7.1 The Adequacy Of The Powers Of Enforcement And The Penalties For Breaches Provided For In The Act.

- 7.1.1 The amendments to *The Criminal Code* repealed provisions that made it a crime for a woman to attempt to procure her own miscarriage. *The Criminal Code* now provides that a medical practitioner who performs an abortion that is not justified under section 334 of the *Health Act 1911* is guilty of an offence and may be liable for a fine of up to \$50,000³⁰. A person who is not a medical practitioner, and who performs an abortion and is found guilty of a crime, is liable to imprisonment for 5 years³¹.
- 7.1.2 The WA Police Service has reported that their records show that three complaints have been received in relation to alleged breaches of *The Criminal Code* relating to abortion since the abortion legislation was introduced. There have been no charges laid in respect of alleged breaches of the legislation. There are no specific cases that would enable comment upon powers of enforcement.

The review considers that the penalties for breaches provided for in the Act are adequate.

Audit of Compliance

- 7.1.3 There were a number of concerns raised during the course of this review from service providers and others in relation to a perceived lack of audit and follow-up of potential breaches of the Act.
- 7.1.4 There were concerns about non-compliance with notification forms both in terms of content, time lines and the failure to lodge forms with the Department of Health. There have been no regular audits of hospital or medical practitioner records (cross-checked with the notification form). Therefore, it was difficult to ascertain whether or not medical practitioners were complying with this requirement.
- 7.1.5 Other concerns included women being coerced into abortions by employers, financial concerns, partners and families and overly pessimistic prognoses for foetal disabilities.
- 7.1.6 There is a perceived lack of process for handling complaints in this area, however mechanisms that already exist for dealing with complaints include the Office of Health Review, Medical Board of WA and the Health Consumers' Council WA.
- 7.1.7 There is a general penalty of \$10,000 (maximum) for non-compliance of Section 335 (5)(d) in the *Health Act 1911*.

³⁰ Section 199(2), *Criminal Code*

³¹ Section 199(3), *Criminal Code*

Recommendation 19

The Department of Health to develop a monitoring system to oversee compliance standards, to follow up breaches of the Act, and for regular audits on the compliance and accountability of notification forms.

Recommendation 20

The Department of Health to regularly advise the management of facilities which provide abortion services of their requirement to lodge notification forms and support appropriate training for staff through the distribution of appropriate Operational Circulars.

8.1 The Availability of Preventive Education And General Evidence-Based Research Information For Medical Practitioners And The Community.

- 8.1.1 A recent report on the global incidence of induced abortions show that in the period 1995-1996, 91,900 abortions were performed in Australia, giving an annual abortion rate of 22.2 per 1000 women aged 15-44 years³². This is the second highest reported rate for any developed country, only just behind the United States. In addition, Australia has a teenage live birth rate of around 20 per 1000 women aged 15-19 years. The public health implications, including cost to the community, both long and short term, are considerable. The need to develop preventive programs in contraceptive education, counselling and public information, was supported by the previous Government in the Strategy to Implement a Program of Public Information.
- 8.1.2 Government policy supported the 1998 abortion legislation as follows:
- support by the Department of Health for the Department of Education and schools to develop new approaches to sexuality and teenage pregnancy;
 - information for the post school-aged population on contraceptive methods available; and
 - support and information for general practitioners to actively discuss reproductive health issues with their patients.

Preventive Education

- 8.1.3 There was general consensus across the submissions that there was a need to reduce the number of unplanned pregnancies and abortions occurring within Western Australia. The need for programs aimed at preventing unplanned pregnancies was supported, although the content and proposed strategies for preventive interventions varied.
- 8.1.4 Although there has been focus by the Department of Health on developing preventive programs, there is still need for considerable improvement in this area. The new structure of the Department, which has unified the policy and administration functions with health service providers should facilitate greater collaboration between functions of the Department of Health and between the Department of Health and other government and non-government organisations in this regard.
- 8.1.5 It is noted that the Netherlands has an abortion rate of only 6.5 per 1,000, making it the lowest abortion rate in the Western World. With the lowest teenage pregnancy rate in the world³³ and liberal abortion laws, any initiative in the Netherlands deserves attention. The Netherlands uses a multi-strategy approach to prevent unplanned pregnancies. Although the country has no mandatory national curriculum, nearly all secondary schools provide sex education³⁴. However, sex education is not enough to explain the Dutch record. The Dutch media have been at the forefront of an open dialogue on the

³² Short R, "A Wish List for improving Australian women's reproductive health in the new millenium" Aust NZ Journal Obstetrics & Gynaecology, 2000: 40: at page 1.

³³ Doppenberg H, "Contraception and sexually transmitted diseases: what can be done?" Experiences and thoughts from the Netherlands, *British Journal of Family Planning*, 1993, 18: 123- 125.

prevention of unplanned pregnancy and women's/teenage magazines reinforce this knowledge³⁵. The Netherlands also promotes³⁶ the use of both the pill and condoms in recognition of the fallibility of contraception. The use of condoms is also promoted to prevent the transmission of sexually transmitted diseases. There are also a range of other strategies used to reduce the number of unwanted pregnancies and abortions in the Netherlands. These strategies are culturally embedded and target community attitudes across all age groups.

- 8.1.6 Contraceptive practices incorporate social, cultural, economic and religious factors, all of which are embedded within wider community attitudes towards sexuality and human relationships. A multi-strategy approach to prevent unplanned pregnancies, such as the Netherlands model, is therefore recommended as no one single approach can provide a solution.

Recommendation 21

The Department of Health to undertake a study of the multi-strategy approach used in the Netherlands to prevent unplanned pregnancies and develop a program to reduce the number of unplanned pregnancies in specific target groups.

- 8.1.7 Some submissions identified a lack of education about contraception, limited access to reproductive health, and contraceptive failure (e.g. condom breakage, missed oral contraceptive pills, diaphragm problems) and high failure rates associated with Billings/rhythm methods of fertility control as major contributing factors to unplanned pregnancies.
- 8.1.8 Although there was consensus across submissions for the need to develop and maintain pregnancy prevention programs, there was also debate as to which strategies to adopt. Some submissions expressed concern that current school sexual health programs promoted sexual promiscuity by promoting condom and other contraceptive usage and that abortion was being promoted as a 'backup' to failed contraception. Several submissions claimed that education promoting abstinence had been effective in the United States but did not feature in WA school sexual health courses. At the same time, concern was expressed that some children were not being taught broader views of sex education – in the context of life experiences and the importance of committed relationships.
- 8.1.9 In 2002, schools in WA will have access to a new education support package, "Growing and Developing Healthy Relationships", that addresses both relationships and sexual health education for early and middle childhood and adolescent groups. In 1999, the Department of Health's Sexual Health Program, with the involvement and support of the Department of Education, initiated and funded the update and rewrite of the school health and HIV curriculum materials. A reference group with wide representation was involved in this process. The release of this support package will assist teachers in promoting reproductive health programs. The publication is based on the notion that any effective sexual health program for teenagers should promote a range of strategies, including abstinence. However, the publication also recognises that

³⁵ Ibid p 124

³⁶ Ibid p 125

research indicates that there are some teenagers who will take risks, thus a harm reduction model is adopted.

8.1.10 Other preventive strategies suggested during the review include:

- promotion of programs for adolescents in self-esteem, assertiveness, personal safety in social situations, legal rights, rights for others, and self respect;
- provision of a major targeted media program to promote the need for contraception;
- ensuring that women have access to affordable, acceptable and diverse contraceptive choices, including the availability of emergency contraception (particularly the “morning after” pill);
- development of preventive programs to target women in their mid 20s to late 30s where the abortion rate is highest. This recognises that school populations are not the only populations which would benefit from exposure to information about contraceptive education and relationships;
- promotion of all aspects of pregnancy and birth, e.g. relationships, commitment, self control, good health and moderation, physical and psychological aspects of pregnancy and abortion, and carrying a child to birth; and
- examination of international experience in preventive education for unplanned pregnancy, including an analysis of social determinants and community attitudes relating to abortion.

Recommendation 22

The Department of Health and the Department of Education to strongly support the provision and review of current culturally and developmentally appropriate sexual health curriculum materials and support professional development for teachers to deliver the curriculum materials.

Evidence-Based Information For Medical Practitioners And The Community

8.1.11 The importance of providing education and information to medical practitioners on abortion, prevention and legislative obligations under the Act was highlighted during the review. As mentioned previously in this report, the education of health providers in addressing abortion provision and legislative obligations is vital to ensure that women are provided with adequate and unbiased information.

8.1.12 In response to the changes in legislation in 1998, the Department of Health produced three pamphlets to assist medical practitioners to fulfil the requirements of informed consent as set out in Section 334(5)(a) of the *Health Act 1911*.

These pamphlets were:

- *Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term—Information for General Practitioners;*
- *Guidelines for Counselling;* and
- *A Summary of Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term—Information for Women*

The documents summarised evidence-based information on major risk factors that have been considered in the literature. The publications are intended to assist medical practitioners when counselling women, who are considering a possible termination of pregnancy, on the medical risks involved in proceeding with a termination or carrying a pregnancy to term.

8.1.13 In November 2001, the Department of Health released the document *Notes for Medical Practitioners on the Abortion Legislation in WA*. These notes are intended to help medical practitioners understand the requirements of section 334 of the *Health Act*, in relation to the following issues:

- the medical practitioner's obligations in relation to the concept of informed consent;
- the implications of the 20-week limit and best practice in timing of any abortion procedure; and
- the particular legal requirements in relation to dependant minors.

Recommendation 23

The Department of Health to ensure continuing education in relation to the understanding of legal requirements of the abortion legislation for medical practitioners.

CONCLUSION

The *Acts Amendment (Abortion) Bill* sought to “provide abortions in those sad circumstances where they are necessary, in safe, legal conditions for Western Australian women.” By “taking abortion out of the shadows” – it was also hoped that the legislation would regulate and reduce the number of terminations carried out.³⁷

The review concluded that the abortion legislation is generally working in the manner in which Parliament intended. The review found that the legislation has provided the framework and procedures to achieve the intended objectives.

There have been no prosecutions for the unlawful performance of an abortion since the *Acts Amendment (Abortion) Act 1998* was introduced. There have been no charges laid under *The Criminal Code* in respect of alleged breaches of the legislation.

The review found that while the legislative provisions in the *Health Act 1911* had achieved the aim of making safe abortions available to Western Australian women, there are a number of improvements that can be made in the way in which the administration of abortion support services and educational services relating to pregnancy may be improved.

The suggested improvements are contained within the 23 recommendations presented by the Review Steering Committee in this report.

³⁷ Acts Amendment (Abortion) Bill (Second Reading) Warnock Pandal 8 April 1998 – (Hansard 1712/1)

APPENDICES

APPENDIX A WESTERN AUSTRALIAN ABORTION LEGISLATION

WESTERN AUSTRALIA

ACTS AMENDMENT (ABORTION) ACT 1998

No. 15 of 1998

AN ACT to amend *The Criminal Code* to remove offences related to procuring abortion, to amend the *Health Act 1911* to regulate the performance of abortion, as a consequence, to amend the *Evidence Act 1906* and the *Children's Court of Western Australia Act 1988* and for related purposes.

[Assented to 26 May 1998]

The Parliament of Western Australia enacts as follows:

PART 1 - PRELIMINARY

Short title

1. This Act may be cited as the *Acts Amendment (Abortion) Act 1998*.

Commencement

2. This Act comes into operation on the day on which it receives the Royal Assent.

PART 2 - *THE CRIMINAL CODE & EVIDENCE ACT 1906*

The Code

3. In this Act "**the Code**" means *The Criminal Code*.

[Reprinted as at 21 April 1997 as the Schedule to the *Criminal Code Act 1913* appearing in Appendix B to the *Criminal Code Compilation Act 1913*.
For subsequent amendments see Act No. 19 of 1997.]

Sections 199, 200 and 201 repealed and section 199 substituted

4. Sections 199, 200 and 201 of the Code are repealed and the following section is substituted -

..

Abortion

- 199.** (1) It is unlawful to perform an abortion unless –
- (a) the abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and
 - (b) the performance of the abortion is justified under section 334 of the *Health Act 1911*.

(2) A person who unlawfully performs an abortion is guilty of an offence.

Penalty: \$50 000.

(3) Subject to section 259, if a person who is not a medical practitioner performs an abortion that person is guilty of a crime and is liable to imprisonment for 5 years.

(4) In this section –

“**medical practitioner**” has the same meaning as it has in the *Health Act 1911*.

(5) A reference in this section to performing an abortion includes a reference to –

- (a) attempting to perform an abortion; and
- (b) doing any act with intent to procure an abortion,

whether or not the woman concerned is pregnant.

”.

Section 259 repealed and a section substituted

5. Section 259 of the Code is repealed and the following section is substituted –

..

Surgical and medical treatment

259. A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment –

- (a) to another person for that other person's benefit; or
- (b) to an unborn child for the preservation of the mother's life,

if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

”.

Evidence Act 1906 amended and saving

6. (1) The Second Schedule to the *Evidence Act 1906** is amended in Part 1 –
- (a) in the item commencing “s. 199”, by deleting “Attempt to procure the miscarriage of a woman” and substituting the following –
“ Abortion ”; and
 - (b) by deleting the items commencing “s. 200” and “s. 201”.
- (2) In relation to an offence committed before the commencement of this Act, the *Evidence Act 1906** applies as if subsection (1) had not been enacted.

[* Reprinted as at 10 September 1996.

For subsequent amendments see 1996 Index to Legislation of Western Australia, Table 1. pp. 76-77, and Act No. 57 of 1997.]

PART 3 – HEALTH ACT 1911 & CHILDREN'S COURT OF WESTERN AUSTRALIA ACT 1988

Health Act 1911 amended

7. (1) After section 333 of the *Health Act 1911* the following section is inserted –

“

Performance of abortions

334. (1) A reference in this section to performing an abortion includes a reference to –

- (a) attempting to perform an abortion; and
- (b) doing any act with intent to procure an abortion,

whether or not the woman concerned is pregnant.

(2) No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion.

(3) Subject to subsections (4) and (7), the performance of an abortion is justified for the purposes of section 199 (1) of *The Criminal Code* if, and only if –

- (a) the woman concerned has given informed consent; or
- (b) the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or
- (c) serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or

- (d) the pregnancy of the woman concerned is causing serious danger to her physical or mental health.

(4) Paragraphs (b), (c) or (d) of subsection (3) do not apply unless the woman has given informed consent or in the case of paragraphs (c) or (d) it is impracticable for her to do so.

- (5) In this section –

“**informed consent**” means consent freely given by the woman where –

- (a) a medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term;
- (b) a medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and
- (c) a medical practitioner has informed her that appropriate and adequate counselling will be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.

(6) A reference in subsection (5) to a medical practitioner does not include a reference to –

- (a) the medical practitioner who performs the abortion; nor
- (b) any medical practitioner who assists in the performance of the abortion.

(7) If at least 20-weeks of the woman's pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless –

- (a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and
- (b) the abortion is performed in a facility approved by the Minister for the purposes of this section.

(8) For the purposes of this section -

- (a) subject to subsection (11), a woman who is a dependant minor shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed that the performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed;
- (b) a woman is a dependant minor if she has not reached the age of 16 years and is being supported by a custodial parent or parents; and
- (c) a reference to a parent includes a reference to a legal guardian.

(9) A woman who is a dependant minor may apply to the Children's Court for an order that a person specified in the application, being a custodial parent of the woman, should not be given the information and opportunity referred to in subsection (8) (a) and the court may, on being satisfied that the application should be granted, make an order in those terms.

(10) An order made under subsection (9) has effect according to its terms and is not liable to be challenged, appealed against, reviewed, quashed or called in question in or by any court.

(11) If the effect of an order under subsection (9) is that no custodial parent of the woman can be given the information and opportunity referred to in subsection (8) (a), subsection (8) does not apply in relation to the woman.

(2) Section 335 (5) of the *Health Act 1911* is amended -

(a) in paragraph (a) by inserting after ``abortion'' the following -

``
 (other than an abortion to which paragraph (d) applies)
 '';

and

(b) by inserting after paragraph (c) the following paragraphs -

``

(d) When a medical practitioner performs an abortion, the medical practitioner shall notify the Executive Director, Public Health of the fact in the prescribed form within 14 days of the abortion being performed.

(e) A notification under paragraph (d) must not contain any particulars from which it may be possible to ascertain the identity of the patient.

”.

Review of provisions relating to abortion

8. (1) The Minister administering the *Health Act 1911* is to carry out a review of the operation and effectiveness of the provisions of the *Health Act 1911* and *The Criminal Code* related to abortion as soon as is practicable after the expiration of 3 years from the commencement of this Act.

(2) The Minister is to prepare a report based on the review made under subsection (1) and cause the report to be laid before each House of Parliament within 4 years after the commencement of this Act.

***Children's Court of Western Australia Act 1988* amended**

9. Section 20 of the *Children's Court of Western Australia Act 1988* is amended -

(a) by deleting “and” after paragraph (b); and

(d) after paragraph (c) by inserting the following –

“

; and

(e) under section 334 of the *Health Act 1911*.

”.

APPENDIX B

Extract from a publication from the National Cancer Institute of America

6 March 2002

Abortion and Breast Cancer

The relationship between abortion and breast cancer has been the subject of extensive research. The current body of scientific evidence suggests that women who have had either induced or spontaneous abortions have the same risk as other women for developing breast cancer. Until the mid-1990s, results from studies of breast cancer, and induced or spontaneous abortion, were inconsistent. Some investigators reported an increase in risk, typically from interview studies of several hundred breast cancer patients compared to other women. Other studies found no evidence of increased risk.

Recent large studies, particularly cohort studies, generally show no association between breast cancer risk and previously recorded spontaneous or induced abortions. In a large-scale epidemiological study reported in *The New England Journal of Medicine* in 1997, researchers compared data from Danish health registries that included 1.5 million women and more than 10,000 cases of breast cancer. The registry data on abortions was collected before the diagnosis of breast cancer was made. After adjusting the data for several established breast cancer risk factors, the authors found that “induced abortions have no overall effect on the risk of breast cancer.” The strengths of this study include its large size, the ability to account for breast cancer risk factors that may differ between women who have had abortions and those who have not, and the availability of information on abortion from registries rather than having to rely on a woman’s self-reported history of abortion.

In 2000 and 2001, additional findings were reported from studies that collected data on abortion history before the breast cancers occurred. These studies showed no increased breast cancer risk in women who had induced abortions. In three of the studies, information on abortion was based on medical records rather than on the woman’s self-report. In another study, interview data was collected before any breast cancer diagnosis. The studies were conducted in different populations of women, and varied in size and the extent of details on established breast cancer risk factors.

Most of the early studies necessarily relied on self-reports of induced abortion, which have been shown to differ between breast cancer patients and other women. Other problems with these studies included small numbers of women, questions of comparability between women with breast cancer and those without, inability to separate induced from spontaneous abortions, and incomplete knowledge of other breast cancer risk factors that may have been related to a woman’s history of abortion.

Even though it appears that there is no overall association between spontaneous or induced abortion and breast cancer risk, it is possible that an increased or decreased risk could exist in small subgroups of women. For example, the large Danish study found a slightly lower breast cancer risk in women with abortions occurring before 7 weeks gestation, and a slightly higher risk in women who had abortions at 7 or more weeks. The

National Cancer Institute is currently funding at least six other studies examining complete pregnancy history, including induced and spontaneous abortion, in relation to the risk of breast cancer.

Well-established breast cancer risk factors include age, a family history of breast cancer, an early age at menarche, a late age at menopause, a late age at the time of the first birth of a full-term baby, alcohol consumption, and certain breast conditions. Obesity is a risk factor for breast cancer in postmenopausal women.

APPENDIX C

Press Release from the United Kingdom Royal College of Obstetricians and Gynaecologists

11 August 2000

Abortion and Breast Cancer

In March 2000 the RCOG published an Evidence-Based Guideline on "The Care of Women requesting Induced Abortion". Induced abortion is one of the most commonly performed gynaecological procedures in Great Britain. Around 180,000 terminations are performed annually in England and Wales and around 12,000 in Scotland. At least a third of British women will have had an abortion by the time they reach the age of 45. The Guideline Development Group views induced abortion as a healthcare need. The aim of the guideline was to ensure that all women considering induced abortion have access to a service of uniformly high quality. The guideline summary is available on the RCOG website (www.rcog.org.uk).

The guideline includes many aspects of abortion care, including the provision of information for women about potential complications. One of these recommendations reviews the evidence of the association between breast cancer risk and abortion. (shown below)

The RCOG wishes to reassure women who have had an abortion, or who have breast cancer, that the research evidence on this question to date is **INCONCLUSIVE**. The association found in some studies has not been found in others of equal quality. Indeed studies based on the linkage of national registers on induced abortion and breast cancer, which are less open to bias than case-control studies that rely on recall of subjects, have not shown any significant association.

Breast Cancer Risk: available evidence on an association between induced abortion and breast cancer is inconclusive (Grade B)

Two carefully conducted meta-analyses examining the relationship between induced abortion and subsequent breast cancer have been published. The two reviews have reached different conclusions about the nature of any association. The validity of case-control studies of abortion and breast cancer have been seriously questioned because of the evidence that there is a significant difference between cases and controls in their willingness to reveal whether or not they have had an abortion. Studies based on the linkage of national registers on induced abortion and breast cancer are less open to bias than case-control studies relying on recall of subjects. Two such studies have not shown any significant association.

A recent review from Grimes' group has highlighted the differences in validity of the various available studies. When only those studies least susceptible to bias are included, the evidence suggests that induced abortion does not increase a woman's risk of breast cancer in later life.

APPENDIX D

SUMMARY OF SERVICES FUNDED BY THE DEPARTMENT OF HEALTH

1. FAMILY PLANNING WA (FPWA)

FPWA is a non-government, community-based agency providing counselling, clinics, education, information and resources in the areas of sexual and reproductive health.

FPWA has been providing counselling since the 1980's and developed a separate counselling unit in 1992. In November 1998, *FPWA* launched its new specialist counselling service (the Roe Street Centre for Human Relationships). This new service gives priority to clients facing an unplanned pregnancy.

FPWA counselling services provided include:

- unplanned pregnancy and post termination counselling for women facing an unplanned pregnancy, their partner and immediate family;
- qualified and trained counsellors.
- a supportive and non-judgmental environment.
- telephone counselling for rural and remote regions;
- information on options available for women who choose to continue with their pregnancy (e.g. advice on adoption/linkage to Department for Community Development);
- translator services and special requirements such as wheelchair access, translator, e.g., deaf/visually impaired services are available;
- audio-taped information is available from the library;
- extensive range of library material and resources on many aspects of reproductive health; and
- free counselling service (sliding scale of costs when free services are completed).

2. RELATIONSHIPS AUSTRALIA - SPECIALIST COUNSELLING SERVICES

Relationships Australia's Specialist Counselling Service offers assistance for women and their families with issues surrounding an unplanned pregnancy, an abortion or carrying an unplanned pregnancy to term.

Relationships Australia's Specialist Counselling Service provides the following services:

- confidential and non-judgmental support by qualified counsellors;
- support and counselling for women and members of their families who are experiencing psychological, social and emotional difficulties as a result of their experience with an abortion or after carrying an unplanned pregnancy to term;
- information on options available for women who choose to continue with their pregnancy (e.g. advice on adoption/linkage to Department for Community Development);
- qualified, experienced counsellors;

- sessions for women needing counselling for an unplanned pregnancy;
- counselling assistance for family members;
- day and evening sessions;
- telephone counselling;
- counselling appointments without a referral;
- post pregnancy counselling (free for the first two sessions then based on a sliding scale to ensure the service is affordable to people on all income levels);
- counsellors from a variety of backgrounds and interpreters can be arranged;
- translator services and services for those with visual/hearing impairments can be arranged;
- wheelchair access;
- some audio-taped resources are available; and
- free counselling service (then sliding scale once free sessions are completed).

3. GOLDFIELDS WOMEN'S HEALTH CENTRE

The *Goldfields Women's Health Centre* provides a range of health services for rural women, including an unplanned pregnancy counselling service.

Goldfields Women's Health Centre offers the following services:

- confidential and non-judgmental support;
- support and counselling for women and members of their families who are experiencing psychological, social and emotional difficulties as a result of their experience with an abortion or after carrying an unplanned pregnancy to term;
- information on options available for women who choose to continue with their pregnancy (e.g. advice on adoption/linkage to Department for Community Development);
- qualified, experienced counsellors;
- sessions for women needing counselling for an unplanned pregnancy;
- counselling assistance for partners/ family members;
- telephone counselling;
- counselling appointments without a referral;
- post pregnancy counselling;
- counsellors from a variety of backgrounds and interpreters can be arranged;
- translator services and services for those with visual/hearing impairments can be arranged;
- wheelchair access; and
- some audio-taped resources are available.

4. CENTRECARE POST ABORTION/UNPLANNED PREGNANCY COUNSELLING SERVICE

Centrecare Post Abortion/Unplanned Pregnancy Counselling Service offers counselling services for women who have undergone a pregnancy termination or have carried an unplanned pregnancy to term and are experiencing a range of feelings that may be overwhelming.

Centrecare's Post Abortion Counselling Service offers the following services:

- a confidential and non-judgmental Loss and Grief Counselling Service for women and their partners, family and friends;
- specialised support for women who have experienced a miscarriage or stillborn birth;
- support and advice;
- a range of therapeutic counselling options; and
- advice for women continuing with an unplanned pregnancy is available.

5. WOMEN'S HEALTH RESOURCE CENTRE, GERALDTON

The *Women's Health Resource Centre* provides a non-judgmental service to women of the Midwest.

The *Women's Health Resource Centre* provides the following services:

- counselling for women and members of their families who are experiencing psychological, social and emotional difficulties as a result of their experience with an abortion or after carrying an unplanned pregnancy to term;
- information on options available for women who choose to continue with their pregnancy (e.g. advice on adoption/linkage to Department for Community Development);
- sessions on demand, rather than set sessions;
- telephone counselling;
- community education, on request;
- confidential sessions with qualified counsellors;
- assistance with linkages to assist travel/accommodation issues women may face;
- translator/interpreter services can be arranged as well as assistance for those with special needs, e.g. audio-visual problems;
- wheelchair access; and
- some audio-taped material is available.

6. SOUTH-WEST WOMEN'S HEALTH AND INFORMATION CENTRE INC

South-West Women's Health and Information Centre takes a holistic approach to empowering women to care for their health and well being.

South West Women's Health and Information Centre offers the following services:

- a free and confidential counselling service for women, their partners and family who are facing an unplanned pregnancy;
- support and counselling for women and members of their families who are experiencing psychological, social and emotional difficulties as a result of their experience with an abortion or after carrying an unplanned pregnancy to term;
- information on options available for women who choose to continue with their pregnancy (e.g. advice on adoption/linkage to Department for Community Development);
- one-to one community education on all aspects of women's health;

- education sessions with GP's and early childhood classes
- talks at local schools on avoiding teenage pregnancies;
- telephone counselling;
- referral to other agencies for more specific information;
- a comfortable library where women may browse on a range of up to date information, books, videotapes and leaflets;
- pregnancy testing; and
- wheelchair access.

APPENDIX E

SUPPORT SERVICES FOR WOMEN WITH UNPLANNED PREGNANCIES

Continuation of Pregnancy - Agency Referral List -April 2002

1. Adolescent Clinic – King Edward Memorial Hospital: Telephone 9340-2222

Multidisciplinary support (doctors, dieticians, social workers, psychologists, nurses, midwives, etc) for adolescent girls under 18 years during their pregnancy. Antenatal advice and care. The Adolescent Support Service offers a home visiting link with a qualified midwife. Most girls in the program choose to keep their babies. A 4-week follow-up service is provided as well as post partum contraceptive advice. Parenting education is provided and the girls are linked with existing community services to ensure they have an ongoing support service.

A qualified on-site interpreter/translator is available. Assistance is provided for visually/hearing impaired clients. Wheelchair access.

An extensive range of pamphlets and other written information is available. The Health and Information Referral Centre is based on site.

2. Department for Community Development – Family & Children’s Services: Telephone 9222-2555

Social worker support and assistance. Information and advice, including telephone information/counselling line.

Extensive library /resources, including audiovisual material. A range of written information can be accessed on a wide range of topics, e.g. adoption information, parenting.

Wheelchair access. Translator/Interpreter services can be arranged as well as assistance for visually/hearing impaired clients.

3. Pregnancy Assistance – 195 Lord St, East Perth: Telephone 9328-2929

Assistance for women continuing with an unplanned pregnancy and post abortion counselling.

Advice and practical resource assistance e.g. attaining baby products, prams, clothing etc.

Information packs and pamphlets provided.

Limited wheelchair access.

Translator/interpreter and specialist services for visually/hearing impaired clients not available.

4. Pregnancy Help – Bunbury: Telephone 1300 139313

Pregnancy support and counselling for women continuing with their pregnancy. Post abortion counselling is available. Some baby goods such as clothes, cots and prams. Practical assistance offered.

Wheelchair access. No translator/interpreter service or services for visually/hearing impaired but this could be arranged, given notice.

Literature/pamphlets available.

5. Pregnancy Help – Geraldton: Telephone (08) 9921-6544

Pregnancy support and counselling for women continuing with their pregnancy. Post abortion counselling is available. Some baby goods such as clothes, cots and prams. Practical assistance offered.

Wheelchair access. No translator/interpreter service or services for visually/hearing impaired but this could be arranged, given notice.

Literature/pamphlets available.

6. Department for Community Development - Adoption Service: Telephone 9222-2870

The Department for Community Development-Adoption Service provides information, advice and counselling for people considering adoption or who are already part of an adoption.

Social worker support and assistance. Information and advice, including telephone information/counselling line.

Extensive library /resources, including audiovisual material. A range of high quality written information can be accessed on a wide range of topics, e.g. adoption information, parenting.

Wheelchair access. Translator/Interpreter services can be arranged as well as assistance for visually/hearing impaired clients.

7. Adoption Research & Counselling Service (ARCS): Telephone 9370-4914

A free counselling service for women and their families considering relinquishing a baby. Other counselling services are available (means tested and ranging from \$15 to \$45) for anyone affected by adoption.

Translator/interpreter services could be arranged.

A comprehensive specialist adoption resources library is available.

8. Ngala Family Resource Centre: Telephone 9367-7855

Offers a wide range of services to assist parents of young children up until school age. The focus of the program is on early parenting. E.g. sleep, feeding, behavioural problems/issues. Offers a telephone helpline, parent education group meetings, centre consultations, home visiting service, day and overnight stays, an early childhood centre, regional services and a program for fathers.

Wheelchair access. Interpreter/translator services can be arranged as well as assistance for people who are visually/hearing impaired.

A wide range of resource material provided, e.g. pamphlets, audio-visual tapes.

9. Child Support Agency: Telephone 131272

Assists couples to ensure custodial parents are financially supported to care for children. Helps manage child support responsibilities and entitlements. Focuses on financial arrangements.

Interpreter/translator services can be arranged.

10. Trinity Uniting Church Learning Centre – educational support for teenage mothers:
Telephone 9481-1077

A coordinator and teacher(s) are available to assist teenage girls to complete their high school education. A crèche is available on the premises and the girls complete individualised programs developed by SIDE (School of Isolated and Distance Education - Education Department WA).

11. Parent Help Centre and Parenting Line: Telephone 9272-1466 or 1800 654 432 (free for STD callers)

Offers Triple PPP (Levels 1-4 of Positive Parenting Program). Advice and information pamphlets on management of child behaviour, especially toddlers and primary aged children. A resource line can also provide links with other appropriate statewide agencies to assist with specific problems.

Translator/Interpreter services can be arranged.

Use of TTY machine for hearing impaired clients.

12. Centerlink - Social Security entitlements: Telephone 9261-3261

Provides information on a wide range of government Social Security entitlements.

Interpreter/Translator services can be arranged.

Wheelchair access.

APPENDIX F

PRACTICE DIRECTION NO. 1 of 1998, CHILDREN'S COURT

CHILDREN'S COURT OF WESTERN AUSTRALIA

Practice Direction No. 1 of 1998

Procedure and forms to be adopted when dealing with applications under section 334 (9) of the *Health Act 1911*.

Commencement

1. This Practice Direction will take effect immediately.

Procedure

2. Applications under section 334(9) of the Health Act 1911 are to be known as "Health Act applications".
3. Health Act applications are to be treated as urgent and listed before the next sitting of the Children's Court.
4. At the direction of the President, Health Act applications are to be heard and determined in chambers and not in court.

Records

5. Health Act applications are to be numbered and prefixed with the jurisdiction and Court Location codes and entered into a separate manual index. For example, an application lodged in the Fremantle Court would be numbered as follows: C FR 3/98. The index is to be kept in a safe place.
6. A separate range of numbers from those used for normal Children's Court matters must be used for Health Act applications.
7. Health Act applications are not to be entered into the CHIPS computer system. This is important to ensure that court officers do not disclose details or any particulars of an application to persons other than the applicant.
8. The magistrate's order recorded on the application is to be considered as the original order. Where the application is approved, two copies of the extracted order are to be signed by the judicial officer making the order. One copy is to be given to the applicant and the other is to be filed. The second copy may be given to the applicant on demand.
9. Health Act applications are to be filed separately from the Children's Court

complaints and applications. The application and associated papers must be placed in an envelope, the application number written on it, the envelope sealed and then filed. Files must be kept in a safe place.

Records in Country Registries

10. After three months has elapsed from the date of determination, all documentation relating to a Health Act application must be forwarded to the Perth Children's Court.
11. No information or copies of documents regarding the application may be given to any person other than the applicant within the three-month period when the records are retained at the place of application. Applicants requiring information or copies of documents after three months from determination of the Health Act application should be referred to the Perth Children's Court.

Disclosure of Information

12. No confirmation that a Health Act application has been made to the Children's Court should be made to any person.
13. Information and copies of documents relating to a Health Act application may only be provided to the applicant.

Forms

14. The application form and extract of order forms are appended to this Practice Direction.

Dated this 27th day of November 1998

Judge A.D. Fenbury
PRESIDENT
CHILDREN'S COURT OF
WESTERN AUSTRALIA

APPENDIX G

DATA FROM THE WA DEPARTMENT OF HEALTH



Figure 1: Induced abortions in Western Australia, 1998-2001. Number by age group.
Source: Department of Health, Health Information Centre.

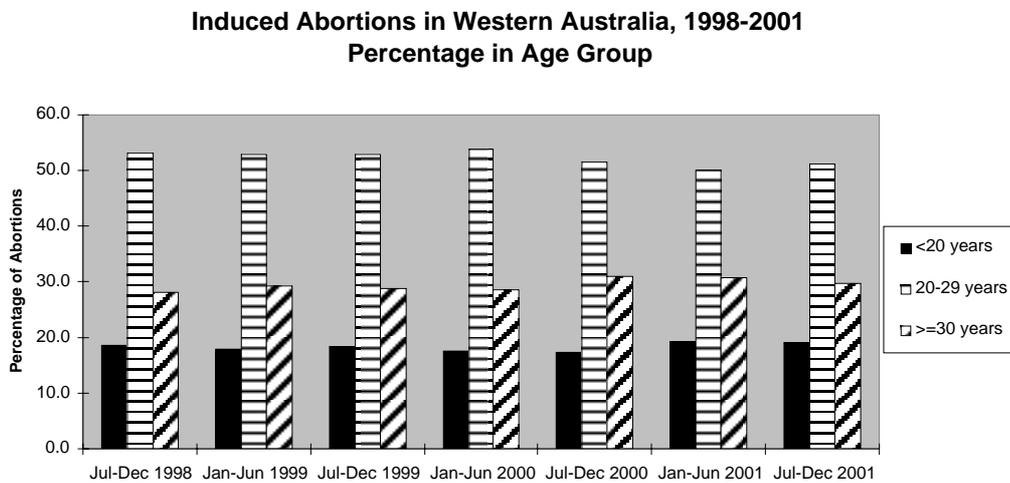


Figure 2: Induced abortions in Western Australia, 1998-2001. Percentage in Age Group.
Source: Department of Health, Health Information Centre.

Date	AGE GROUP (Years)						TOTAL
	<16	16-19	20-29	30-39	>40	Not Recorded	
Jul-Dec 1998	44	721	2179	984	173	15	4116
Jan-Jun 1999	47	696	2186	1036	177	5	4147
Jul-Dec 1999	48	700	2143	987	185	8	4071
Jan-Jun 2000	45	678	2205	1015	154	4	4101
Jul-Dec 2000	64	673	2176	1117	193	0	4223
Jan-Jun 2001	63	736	2074	1102	174	3	4152
Jul-Dec 2001	51	752	2143	1081	169	18	4214

Table 1: Induced abortions in Western Australia, 1998-2001, Numbers in Age Group.

Source: Department of Health, Health Information Centre.

Date	AGE GROUP			Total
	Less than 20 years	20-29 years	Greater than or equal to 30 years	
Jul-Dec 1998	18.7	53.1	28.2	4116
Jan-Jun 1999	17.9	52.8	29.3	4147
Jul-Dec 1999	18.4	52.7	28.8	4071
Jan-Jun 2000	17.6	53.8	28.5	4101
Jul-Dec 2000	17.5	51.5	31.0	4223
Jan-Jun 2001	19.3	50.0	30.8	4152
Jul-Dec 2001	19.1	51.1	29.8	4214

Table 2: Induced abortions in Western Australia, 1998-2001. Percentage in Age Group.

Source: Department of Health, Health Information Centre.

The Abortion Notification system data collection was implemented in May 1998 in accord with legislative requirements. 29,000 'Notifications by Medical Practitioners of Induced Abortion' have been received, representing on average approximately 8,300 per annum. Trend data for the seven, 6-month periods show minimal variation in both actual numbers and maternal age group proportions.

APPENDIX H

EXTRACT FROM THE REPORT ON ABORTIONS NOTIFIED IN SOUTH AUSTRALIA - THIRTY-FIRST ANNUAL REPORT – FOR THE YEAR 2000

In 2000 there was a slight reduction from the previous year in both the number of abortions notified, and in the rate per 1,000 women in the reproductive age group. The total number of abortions was 5,546, and there were 3 late notifications for 1999, making an amended total for that year of 5,663.

The rate for all women in the reproductive age group reduced slightly to 17.5 per 1000 women, from 17.8 in 1999. The abortion rate for teenage women reduced further, after the slight fall in 1999, to 22.4 per 1,000 women. The highest rate among the 5-year age groups was 32.1 per 1000 women, in the 20-24 year age group, but this was also lower than the 1999 rate of 33.7 per 1000. There appears to be some stabilising of the abortion rate, and of the rates among young women under 25-years. These rates are still very much higher than those of many western European countries.

There are still also two main areas of concern in the statistics. The first concerns women seeking repeat abortions – of 1,635 women who had previous abortions under the Act in SA, more than half (853 or 52/2%) had an earlier termination either in the same year or in the previous 2-years. The other area of continuing concern is the number (39) of late terminations, at a gestation of 20-weeks or more, performed for maternal mental health reasons, although this number is lower than in 1999.

There was a slight increase in the number of married women, or women who were separated or divorced seeking termination, and slight reductions in the number of never married women or those in a de facto relationship. The principal reason given for the majority of terminations was risk to the mental health of the woman (97.6% of women,) with abnormalities of the foetus in 2.1% and specified medical conditions of the mother in 0.3% of terminations, much the same as in previous years. An increasing proportion of abortions, now 55.3%, is being performed at the Pregnancy Advisory Centre, which is administratively under The Queen Elizabeth Hospital. While 17.5% of all women who had terminations were country residents, only 6.8% of terminations were performed in country hospitals.

Of the 117 terminations performed for an identified or possible abnormality in the fetus 41 were for chromosomal abnormalities. Although there were no terminations for rubella or maternal infection there were five for possible damage from drugs taken by the mother including two for exposure to isotretinoin (Roaccutane®). There was a fall in the proportion of late terminations for foetal abnormalities (25% in 2000, compared with 31% in the previous 3-years). Complications following termination were reported and 10 women were readmitted to hospital following the procedure for treatment of a complication.

This Annual Report of the Committee Appointed to examine and Report on Abortions Notified in South Australia is distributed to local health and community service professionals, and to interstate and overseas organisations on request. There were a further 32 requests for data in 2000, including additions to the information provided in

the Report. These data provide information for educational and health planning and evaluation purposes, and are also of particular value in monitoring prevalence rates and diagnostic and preventive measures for birth defects.

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- Dopperberg H, Contraception and sexually transmitted diseases: What can be done? Experiences and thoughts from the Netherlands *British Journal of Family Planning* 1993, 18: 123-125.
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- Short, R A wish list for improving Australian women's reproductive health in the new millennium. *Australian /New Zealand Obstetrics Gynaecology* 2000: 40, p1.
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WEBSITES

- <http://www.rcog.org.uk> (press release 11 August 2000)
- <http://www.rcog.org.uk> National Audit of Induced Abortions
- http://cis.nci.nih.gov/fact/3_53.htm National Cancer Institute of America Fact Sheet