ABORTION LEGISLATION REFORM BILL 2023

Second Reading

Resumed from an earlier stage of the sitting.

MR M.J. FOLKARD (Burns Beach) [3.54 pm]: I continue yet again! Justice dictates that individuals have authority over their own health and wellbeing. Women's autonomy empowers them to seek medical care, access essential healthcare services and engage in preventive measures in accordance with their own values and preferences. The anti-abortion lobby contends that individuals have a moral responsibility to accept the consequences of their actions, including unintended pregnancies, and that they should not rely on family planning methods to avoid those consequences. How does that argument work when many religious ministers have been locked up for child sexual abuse and religious organisations have covered up that behaviour? Really?

Some anti-abortion arguments claim that family planning methods disrupt the natural order of life and reproduction and go against religious and ethical beliefs. Critics of family planning argue that promoting contraception encourages casual sexual behaviour and undermines traditional values of abstinence or making responsible sexual choices. The same critics claim that family planning methods fail, leading to unintended pregnancies despite efforts to prevent them, making the whole concept of family planning unreliable. Really? I remember having a conversation with a male religious zealot during the last federal election. He stated that a father has the right to ensure that the woman must carry the child if he wants them to and should be able to interfere with the process and be present during any conversations with the doctor. Really? That is absolutely wrong.

Many anti-abortion arguments stem from religious beliefs that view human reproduction as a divine process. They argue that family planning interferes with God's plan in life and should be avoided. Certain anti-abortion groups emphasise teachings that abstinence is a more effective and morally aligned way to prevent unintended pregnancies than relying on contraceptive methods. Well, members, I dealt with that suicide that I mentioned before and I do not recall God being in that room; I just remember the pain that I witnessed.

This is a fine piece of legislation. If it saves one child, it will be a brilliant piece of legislation. If it saves two, it will be the finest piece of legislation this house will ever have had the privilege to debate.

I commend the bill to the house.

MRS R.M.J. CLARKE (Murray–Wellington) [3.57 pm]: I rise to speak on the Abortion Legislation Reform Bill 2023. We are on the verge of a significant change that has been a long time coming. The Cook government has proposed reforms to our outdated abortion laws. The Abortion Legislation Reform Bill 2023 aims to establish a new model for abortion care in Western Australia under the Public Health Act 2016, amend powers in the Health (Miscellaneous Provisions) Act 1911 regarding abortion processes, amend the Criminal Code and make amendments to other acts to remove barriers to accessing abortions and protect the privacy of individuals who access abortions.

After extensive public consultation, it became clear that our community and health professionals overwhelmingly supported reform in this critical area of health care. Western Australia's abortion laws have been unchanged for far too long—25 years—and it is time to bring them in line with contemporary values and the realities of women's healthcare needs. Under the proposed reforms, abortion will be fully decriminalised, with the Criminal Code offence set to be repealed. By including abortion in the Public Health Act 2016, the Labor Cook government will take a significant step forward in addressing inequity of access and removing barriers that have hindered women from accessing safe and timely abortion care. The Cook Labor government listened to the voices of health professionals and others in our communities whose support has been overwhelming. The suggested changes will allow health practitioners to object on moral grounds, but they will also ensure that patients' needs are prioritised by requiring practitioners to transfer care or provide information about where to access that care. Moreover, the number of health practitioners required to be involved in that care will be reduced from two to one, the ministerial panel requirement for later term abortions will be abolished, and mandatory counselling provisions will be removed. These reforms align with our commitment to improve health care for women and foster a compassionate and empathetic approach to reproductive health care.

It became evident during public consultation that increasing the gestational age limit was widely supported. After careful consideration, it has been determined that increasing the limit to 23 weeks will best reflect current clinical practice and bring us in line with other jurisdictions. More than 17 500 survey responses were received during the consultation period. The resounding support from our fellow citizens, especially women, has been heartening. It is testament to the shared belief that women deserve access to comprehensive reproductive health care free from unnecessary barriers and stigma.

Although the proposed reforms will fully decriminalise abortion, it is essential to note that it will remain an offence for an unqualified person to perform or assist with an abortion. This is vital to ensure the safety and wellbeing of women

who seek abortion care. The proposed reforms mark a significant step towards ensuring that women have control over their reproductive choices and can access safe and compassionate healthcare services when they need them most.

Western Australia remains the only state that has not decriminalised abortions performed by licensed medical professionals. Although abortions are generally legal, the use of criminal law to regulate health care has resulted in stigmatising patients and caregivers. Currently, patients in Western Australia are required to consult two physicians before gaining access to abortion care, and counselling is mandated in all cases. Additionally, a small number of women who face distressing and complicated situations and require an abortion after 20 weeks' gestation are forced to travel out of state to receive the care they need—care that should be available in WA. These legal requirements are medically unjustified and create barriers for patients to receive timely and compassionate care, especially for those in rural and remote areas or with limited incomes. We will follow the lead of other Australian states and territories and bring in much-needed change.

Abortion is permissible in the Australian Capital Territory up to 16 weeks' gestation and it may be performed by either a doctor or a nurse. Beyond 16 weeks, patients need to travel to another state. In New South Wales, abortions can be performed up to 22 weeks' gestation, but after that, the procedure requires approval from two doctors. In the Northern Territory, one doctor can approve and perform an abortion up to 24 weeks' gestation, but after 24 weeks, the approval of two doctors is necessary. Queensland permits abortions when the gestation is 22 weeks and six days, after which time two doctors need to agree on the necessity. In Tasmania, abortions are allowed up to 16 weeks' gestation. After that, two doctors must approve the procedure. Victoria permits abortions up to 24 weeks' gestation; beyond that, two doctors must agree on the necessity.

We firmly believe in upholding women's rights to make decisions about their bodies. These new laws represent a significant step forward in empowering women to make choices with the dignity they deserve. Abortion is a crucial part of women's health care. It is our responsibility to ensure that every woman can access safe and compassionate care. No woman should be forced to travel long distances or compromise her health due to limited abortion services. These progressive laws will remove obstacles and give women the autonomy they rightfully deserve. We understand the importance of reproductive health care and we are dedicated to creating an environment in which women can freely exercise their choice. These reforms stand as testament to our commitment to women's wellbeing by offering them the support they need to make decisions that align with their lives and circumstances.

Our determination is to build an inclusive, fair and responsive healthcare system that caters to the needs of all our citizens. This government continues to make significant investments to strengthen and improve our health and mental health systems to meet the needs of all Western Australians. The Cook Labor government is delivering a record $2.7 billion additional investment into WA's health system, with the 2023–24 state budget featuring a significant investment in regional health and mental health, including more than $2.2 billion per annum on regional health and mental health services and $28.5 million on initiatives to attract and retain key health and mental health professionals to primarily work in regional WA, with priority given to hard-to-staff sites. Moreover, $160 million was allocated for the redevelopment and expansion of Peel Health Campus and to bring it back into public hands. Only Labor committed to bring the hospital back into public hands and transform it into a true regional hospital. The redevelopment and expansion of Peel Health Campus is testament to the tireless efforts and hard work of the Cook Labor government to improve healthcare services for our communities. One of our significant commitments is to prioritise the wellbeing and health of every individual in Western Australia, including those in the Murray–Mandurah region, which is why we have dedicated ourselves to addressing the longstanding needs of our healthcare system, with a focus on bringing essential services back into public hands. The decision to transfer the operations of Peel Health Campus from the private sector to the South Metropolitan Health Service is the result of meticulous planning and thoughtful consideration. The government has actively engaged with the community and healthcare professionals through extensive public consultation, which provided valuable insights and overwhelming support for change. The commitment of $6.5 million in addition to the $152 million already allocated reflects our unwavering determination to transform Peel Health Campus into a state-of-the-art facility that provides comprehensive and inclusive care for our community. The expansion will provide an array of new services, including additional inpatient beds, enhanced mental health care, improved palliative care and the introduction of a much-needed mental health emergency centre.

Our efforts in this healthcare transformation align perfectly with our broader vision for a healthier and more equitable Western Australia. The sustainable health review has been a guiding light, ensuring that our healthcare services remain person-centred, equitable and readily accessible to all. This renovation is a celebration of what we can accomplish when we work together, driven by a shared desire to improve the lives of those we serve. Another of our commitments to support women who have experienced family and domestic violence is coming to fruition. As was recently announced by the Minister for Health, Amber-Jade Sanderson, the pilot to integrate legal services with women's health services will soon be rolled out in Kalgoorlie and Northbridge. The aim is to create a safe and secure space where women can access the support they need. This innovative initiative is supported by a $360 000 grant and involves a partnership between Women's Legal Service WA and health services that aims to provide women

with wraparound health and legal support in one place. By combining these essential services, we aim to make specialist legal assistance more accessible to those who may otherwise face barriers to seeking help. The two selected sites for this trial are the Womens Health and Family Services in Northbridge and the Goldfields Women's Health Care Centre in Kalgoorlie. These centres will facilitate a seamless integration of legal, physical, psychosocial and other health-related services to ensure that women receive comprehensive care tailored to their individual needs. This collaborative effort between the Cook Labor government, WA Health and WLSWA will not only empower clinicians to identify and respond to the unique challenges faced by women experiencing domestic and family violence, but also provide lawyers with a better understanding of their clients' health concerns as they relate to legal matters. I am proud to emphasise that this initiative aligns perfectly with our vision for a sustainable, person-centred and equitable healthcare system. It also harmonises with the *National plan to end violence against women and children 2022–2032*, the youth justice strategy and the *Path to safety: Western Australia's strategy to reduce family and domestic violence 2020–2030*.

As we embark on this pilot, we remain steadfast in our commitment to providing services to a diverse range of groups including women and families, those in remote and rural communities and culturally and linguistically diverse individuals. Together, we are taking a significant step forward in creating a supportive environment in which women can seek help and find a pathway to healing and recovery. This integrated approach underscores our dedication to ensuring that health care remains a fundamental right for all, regardless of the challenges they may face. As we move forward, we will closely monitor and assess the impact of this pilot to guide our efforts in further enhancing services and support for those in need. Our commitment remains unwavering and we will spare no effort to ensure the safety, wellbeing and empowerment of every woman in our community. Together, let us celebrate this momentous milestone in women's rights and health care as we progress towards a more compassionate and empowered future for all. Our state is becoming a place where every woman can make choices with dignity, knowing her wellbeing and autonomy are cherished and protected. I commend this bill to the house.

MR P.C. TINLEY (Willagee) [4.11 pm]: It is a pleasure to make a contribution to the debate on the Abortion Legislation Reform Bill 2023. I want to take a different tangent to that of previous speakers, and the many who will come after me, who I am sure will have had some personal connection with or know somebody who has had a connection to the concept of abortion and its impact on their life, at least in terms of unplanned pregnancy. I want to step back and take a more tangential view, if you like, and talk about how we ended up needing laws that tell women what they can and cannot do with their body. It stems from this concept of the role of government or society in the health system and in making these life choices. We see it happen often. We saw it with voluntary assisted dying legislation. When these life issues get thrown up from time to time, there is the societal norm, there are progressives, there are those who want to defend the status quo and those who want to take a retrograde approach and continually demean over half the population of the world, quite frankly. We are privileged to live in a democracy in Australia and Western Australia where we can have a debate, reach a consensus and bring to book the concept that the right to choose is enshrined as a human right and not a societal right.

It is worth stepping back and talking about the role of the state in health care. It is a long history, as members might imagine, but just indulge me because it is worth noting for the record how we have landed where we have. I will cite a journal article called *The medicalization of health and shared responsibility* by Gianmarco Contino. It was one of the articles that I read that was quite striking in the way it approached this issue around the role of the state in the health of society. The idea of a state that takes care of its own citizens is relatively new, obviously not in our lifetime, but as we look across human development. Germany was the first welfare state and it was created Otto von Bismarck in 1880. Von Bismarck established the first known or recorded welfare state in which health care was available to a limited degree. That was followed by welfare reforms in England around the 1900s. Traditionally, welfare had been delegated to families, communities and religious organisations such as the missions, as members might recall. Health care itself emerged relatively late but its consequences were considerably more disruptive than providing financial benefits for citizens. State responsibility for the health of citizens was reversed from the dependency model to the state in the service of healthy individuals. The original idea that if a person was crook, they would get looked after was slowly reversed with the healthy status of everybody in the community being of importance to the system. In England in 1942, the Beveridge plan implemented the first public healthcare system in the world.

We know that medicine has made important strides in understanding diseases and expanded beyond what might be called codified diseases into the day-to-day maintenance of health. It has taken on almost a psychosocial model of the totality of somebody's health, which has its good points. The trade union movement across the developing world at the time, particularly at the turn of the century, was taking into consideration the environmental health of workers and that became enshrined in legislation over a long period of time after a lot of battles. The health system was no different. The blurred line between disease, predisposed conditions and health has allowed a pervasive medicalisation of the whole process. I will come back to the term "medicalisation", which describes a process by which nonmedical problems become defined and treated as medical problems. This is where we sometimes lose

our way in debates like this. The question is: does abortion constitute a medical problem? Anybody who has a view on this, particularly from a social view or individual rights view, will say that it is not a medical opinion. I am in a sling because I have a medical problem. A woman who has an unwanted pregnancy does not have a medical problem. She has a choice, and that is what this legislation so eloquently puts before us. In response, medicine itself has undergone socialisation—that is, the dilution of the tight medical control in health and disease choices in favour of peer relationships between different actors. Those different actors come to play right through the development of public policy in the health sphere over so many years. When we come to Australia and the history of the matter before us, which is abortion, it is complex and evolving. Again, it is worth recording this here for the benefit of debate.

Before the nineteenth century, as I have said, abortion was not explicitly addressed in Australian law—it was not there. It was actually considered a private matter and not subject to criminal prosecution. During the latter part of the nineteenth century, colonial governments began to enact legislation that restricted abortion. These laws were often modelled on British law that criminalised abortion. In 1901, with the formation of the Commonwealth of Australia, the criminalisation of abortion became the responsibility of individual states and territories. Each state had its own laws regarding abortion and, in most cases, it was heavily restricted or entirely prohibited. Members can see from the matrix on this grey-coloured chart that was produced by the minister's department how each state approaches the idea of abortion. This non-uniform approach, if you like, is actually a legacy of Federation.

The 1960s saw the emergence of the feminist movement in Australia, which included a push for women's reproductive rights and advocacy for safe and legal abortion. There were many heroes and pioneers of that movement in New South Wales and Victoria in particular that undertook a long and sustained campaign to get advancement and progression in this area. Victoria in 1969 became the first state to partially decriminalise abortion. Abortion was allowed to be performed under certain circumstances with the approval of a medical panel—no doubt made up of all men!

Significant movement occurred in the 1970s when other states started to make changes to their abortion laws; for example, South Australia and New South Wales made provisions for legal abortions under certain circumstances. However, in 1973—this resonates with 2022, of course—the landmark US Supreme Court decision Roe v Wade legalised abortion in the United States. This decision had an impact on the debate in Australia and further fuelled discussion around abortion rights and created a whole lot of momentum. Reform however was glacial. It took until about the 2000s when most states and territories reformed their abortion laws to varying degrees to make it more accessible with certain restrictions in different states, particularly in cases of medical necessity or serious fetal abnormalities.

The Australian Capital Territory in 2008 probably had the most progressive abortion laws in that it legalised abortion without restriction, making it the first jurisdiction in Australia to provide abortion services without gestational limits. Ongoing efforts were made in the 2010s to further liberalise abortion laws in some states. However, it continued to be a contentious and divisive issue, as seen in our community even today. Debates often centred around access to abortion, gestational limits, conscientious objection and help for medical practitioners. New South Wales in 2019 decriminalised abortion with the passage of the Reproductive Health Care Reform Act, which was a major step forward for all women.

Abortion legislation here in Western Australia followed a similar trend through history. Going back to the 1800s, abortion was not explicitly addressed in early Australian law, and was considered a private matter. In the 1800s, as Western Australia was being settled by Europeans, abortion was not specifically criminalised. The Criminal Code Act 1899 was introduced and criminalised abortion in Western Australia. Abortion was considered a criminal offence both for the person performing the procedure and the woman seeking it and significant penalties accrued.

The feminist movement gained momentum in the 1960s, and advocacy for reproductive rights started here in Western Australia. The 1970s saw a major shift in attitudes towards abortion. The state began to reform its abortion laws following changes in other states.

A ruling in Victoria in 1969 by Judge Menhennitt established that abortion was lawful if a doctor believed it was necessary to preserve the woman's physical or mental health. This influenced the debate on abortion laws in Western Australia. The 1974 Bolton ruling in the United States in which the Roe v Wade case was decided had consequential impacts here.

The Health Act 1911 was amended in 1998, decriminalising abortion in Western Australia. This amendment allowed abortion to be performed lawfully if two medical practitioners agreed that continuing the pregnancy posed a risk to the woman's physical or mental health. On it goes! The government in 1998 saw the introduction of significant laws. I pause to acknowledge the women of the time, all parliamentarians and the government of the day who participated in achieving this landmark shift in the way abortion was approached. Former Labor member of Parliament Diana Warnock steered the historic 1998 bill through WA's lower house—this place—as did Hon Cheryl Davenport in the other place. They were the architects and drivers of the changes of 1998.

The laws were further liberalised in 2008 with the passage of amendments to the Acts Amendment (Abortion) Act, under the former Carpenter government. The act removed the requirement for approval by two medical practitioners, and allowed abortion to be performed by a qualified medical practitioner and up to 20 weeks' gestation.

By 2021, this government introduced legislation to provide safe access zones around abortion clinics, which was fundamentally important to provide women safety and security as they sought the advice and services of abortion clinics. I have not heard more about it, but I hope that that legislation is working and is effective.

When it comes to objections to abortion, it is worthwhile dwelling on the idea of the socialisation and medicalisation of abortions. Often, objectors to abortion are people who want to either maintain the status quo or move a retrograde step back to something quite abhorrent to most people on this side of the house. In my view, objectors break down into seven or eight categories. One obvious category is the right to life. One of the most prevalent objections to abortion is this idea that human life begins at conception, and it is sacrosanct and morally wrong to abort; therefore, it is a moral argument. A lot of these objectors find themselves in that philosophical theory of a moral fitness test. Moral fitness tests in public policy are sometimes things that give us perverse outcomes. Of course, religious beliefs are not too far behind the right to life objection. Obviously, I will not go into those. They are fairly self-explanatory in talking about the sanctity of life.

This idea of personhood and human dignity is interesting. Some objectors to abortion centre on the concept of a person having an inherent dignity even at conception. That is quite a challenging concept: at conception, we should see a whole human, not just a fetus. I and medical science obviously reject that concept. Debate around the 20-week to 24-week period and such things vend into that argument.

Another objection is the potentiality argument—namely, if we terminate a human, the potential of the human will never be realised and should therefore be protected. If that were the case, I would see more benefit in banning all wars. Any graveyard in Flanders Fields or Gallipoli has row upon row of headstones of 18-year-old, 19-year-old, 20-year-old or 21-year-old—mostly men. What could they have been? When at Villers-Bretonneux recently, I looked across a sea of granite headstones and wondered how many Einsteins were in there? How many great achievements are in the ground and were never realised? Therefore, the concept of "potentiality" cannot be applied just to a woman's right to choose; it should be applied evenly across an entire society that decides that it is all right to send young men and women off to have their lives cut short or irrevocably changed, thereby truncating their potential to be a fantastic contributor to our society.

The other objection is the idea that an abortion has a catastrophic impact on a woman's physical and mental health. I do not deny that any woman who has had to go through this procedure and make a choice like this has not done it lightly. There are so many intersecting issues here, and that in itself is reason for not having an enshrined idea of what a woman can and cannot do with her body. Society needs to genuinely wrap itself around the idea of the choices that women must make and support them through it, particularly in the physical aspect, obviously, and the mental aspect significantly sometimes. The list goes on.

One objection is conscientious objection and the idea that healthcare providers such as doctors and nurses might object to participating in an abortion procedure. This bill will allow for that objection and identifies its requirement.

I will not go on. People who might not support this type of legislation can use many other arguments, and they are valid to those people. One of the great things about this chamber is that people can hold alternative views, and it is important that we all respect those views. However, the majority in a democracy should have the final sway.

The medicalisation of abortion has a long history, and it needs a strong and progressive system that supports and defends the rights of individuals—obviously not just confined to women and their choices, but right across society.

You have to be vigilant. We saw the safe zones that were brought into the Parliament last year, to protect women's right to have access to these services. That came about as a result of events happening to women as they tried to access services. This idea—since I have plotted out the history of abortion since the 1880s and the health care that coincides with it—is that we must continually focus on the progressive attitudes of the contemporary Western Australian, and in this case identify where their needs are and be there with them if not before them.

Vigilance is essential in this place as well because as we all thought, for so many years, the Roe v Wade decision was locked in concrete by the Supreme Court of the United States. It was as important when it came down in 1974 as it was when ostensibly reversed in 2022, when the decision of the Supreme Court sent the right to legislate back to the states.

[Member's time extended.]

Mr P.C. TINLEY: This idea that something that is enshrined in legislation is there forever is a misnomer. We must always be vigilant in these areas, making sure that the ideals of individuality are not trampled on by the idea of a collective fringe. I note the architects of our 1998 legislation were very vocal—just as they were when the legislation

came through this place and the other—about Roe v Wade. In 1998, the Court government made Western Australia the first Australian jurisdiction to decriminalise abortion. Former Labor MP Diana Warnock, who steered the historic 1998 bill through WA's lower house, was "absolutely horrified" by the US Supreme Court's decision on Roe v Wade. She said —

> It was an outrage to me as it will be to millions of women throughout the world, that a panel made up of people openly opposed to abortion because of their religion, should be able to make a decision about millions of other people, namely women, and take them back not only to the 20th century but to the 19th century.

Hon Cheryl Davenport, who introduced the bill into the upper house, sought to remove sections of the Criminal Code that allowed doctors to be jailed for 14 years, and patients up to seven years. She said the overturning of Roe v Wade was a terrible development and that she "just felt we'd gone back 50 years."

This requires our constant and significant vigilance, ensuring that we identify the needs of the community, making sure that our laws in this place are contemporary, keeping pace with the expectations of the community. One of the other great documents that I got from the minister's office is the community consultation report, which, itself, identifies significant support for the legislation. In closing, it is worth mentioning the consultation process and respondents' summary, in particular, the sheer size of the undertaking for that survey. They had 17 514 respondents: 14 100 female, 2 700 men, and 241 other. There were 16 000 residents who responded: 13 000 from metro areas and 2 200 from remote areas. These numbers are approximate. It would not surprise members that the most represented demographic is the 25 to 35-year-old age group. There were 6 300 respondents. Every category that this bill attends to had over 60 per cent of support for that particular option. I think it is instructive for us to understand the numbers involved and the intention that the community expressed. One of the things that this bill identifies, if nothing else, is that we have seen today that the Cook Labor government has the capacity to listen, consult, and adjust. This bill is a very good example in the history of the worldwide abortion debate that will see us progress one step further towards making sure that we are protecting and enshrining the rights of individuals to choose.

MR D.J. KELLY (Bassendean) [4.34 pm]: I am pleased to support these important reforms to make abortion not only legal, but more readily accessible to all women in Western Australia. I will start by saying I understand the positions put by people who oppose abortion. I grew up a Catholic. I had 12 years of Catholic schooling, and when I left school I was one of those people who did not support abortion. Mind you, at that point I had never met anyone who had a different view, because when you go to a Catholic school you only get one view of life presented to you. It was soon after leaving school that I met people who had a different view. I remember a distinct moment when I had a discussion with a woman at university who had had an abortion. She said, "So, basically, you believe I should be in jail, do you?" It was at that point that I really started to understand the absurdity of the proposition that is put by people who oppose abortion, namely, that we should use the Criminal Code to sanction women who access abortion and as a way of preventing abortion. Quite frankly, it was absurd then; it is even more absurd now.

The proposition that in the twenty-first century we should be saying we can force a woman to have a baby against her will is absurd. How anyone could sensibly put that proposition today is beyond me. I want to acknowledge, as others have, the work of mainly women in this place who put through the 1998 legislation. Western Australia, at that time, was leading the pack here in Australia with that legislation. Cheryl Davenport, who was an MLC at the time, and Diana Warnock, who was here in this chamber, both steered that legislation through at a time when they were not in government. They did a remarkable job—an absolutely remarkable job. They did it at a time when they were attacked vitriolically by those who opposed abortion. I acknowledge women like Cheryl Davenport and Diana Warnock, and many others, who got the 1998 legislation through.

As we know, the 1998 legislation was not perfect. Concessions were made in order to get it through both chambers. Although it was groundbreaking at the time, other states have now moved past Western Australia and it is certainly time that we update our legislation. I would like to congratulate the cabinet and, in particular, the Minister for Health, the member for Morley, for bringing forward this legislation and for doing the work that has brought us to this point. The key provisions of this legislation will essentially remove the requirement that two health practitioners sign off on the procedure up to 23 weeks, and only one health practitioner will be required to do that once this legislation is passed. Requiring two health professionals was a barrier that was onerous for many women in Western Australia, particularly those women in regional WA and in remote Aboriginal communities. It is not needed for medical reasons and it is appropriate that that restriction be removed. The requirement for a ministerial panel to agree to abortions after 23 weeks will be removed. The idea that a woman has to go before a ministerial panel for a medical procedure is archaic. It should be a matter for a woman and her doctor. To see the ministerial panel go is well due.

The conscientious objection changes in this bill are significant. Medical practitioners who wish to conscientiously object to performing abortions will still be able to do so, but under this legislation, a medical or health practitioner who has a conscientious objection will have to declare that objection up-front when dealing with a woman seeking an abortion. We have heard stories of practitioners with patients seeking an abortion who did not declare their conscientious objection until quite late in the piece. That obviously puts the woman at a disadvantage. It is only right that if a medical practitioner or health practitioner has a conscientious objection, they inform the patient immediately and are then obliged to refer that woman to other health practitioners who they would reasonably believe are willing to perform the abortion so that the woman is not disadvantaged by the health practitioner exercising their conscientious objection.

The requirement for mandatory counselling will be removed. The current legislation requires counselling. That was put there in 1998 largely by those who believed that if women were given proper counselling, many would choose not to have an abortion. That has no basis in medical need, so the requirement for mandatory counselling will be removed by this legislation. That is a very good thing.

This legislation will also make it easier for women under the age of 18 to access abortion. Some people get very agitated around this. The fact is that there are young women who need to access an abortion and requiring parental consent or parental involvement is simply not practical. A young woman's parents may not be contactable—they may not, in fact, be part of that young person's life—so to require the involvement of an adult who has long since ceased to be a part of that young person's life is simply not reasonable. There will be a requirement on the medical practitioner or health practitioner to determine that the young person is able to make an informed decision, and that is an assessment that health practitioners make in other matters. That reform for young people is very, very important.

That is just a summary of what I understand are the main reforms that will be put in place as part of this legislation. I think the vast majority of Western Australians believe that these are modern and necessary reforms.

Although this is very good reform, we must never be complacent that once this legislation is put in place we can sit back and say that these rights for women are then set in stone and we can be confident that they will apply in Western Australia forever into the future. Around the world, access to abortion is not a medical issue, but a contentious political issue. We have only to look at what has happened in the United States with Roe v Wade. The overturning of that decision after some 50 years did not happen by accident. There are groups within Western Australia with very strong religious views that may be in a minority at the moment, but they will not go away when we pass this legislation. A former member of this chamber, Peter Abetz—or Eric Abetz?

Ms A. Sanderson: Peter Abetz.

Mr D.J. KELLY: Eric Abetz is a somewhat similar character from Tasmania. Peter Abetz, a former member of this chamber who is very active in this religious space, is quoted as saying that he views the decision to overturn Roe v Wade as a sign of great hope. If we pass this legislation, it will be a great improvement, but those who want to wind back these rights will not sit back and say, "That's it". They will continue to agitate around these issues and will wait for a time in the future when they may get an opportunity to wind these things back. People may say, "It just won't happen", but we have only to look at what happened in the United States since the removal of Roe v Wade to see how far those groups in the United States have been successful in banning abortion. I am relying on a report from *The New York Times*, but I understand that in approximately 20 states in the United States, abortion has either been banned or severely restricted since the overturning of Roe v Wade. In Alabama, abortion is banned with no exceptions, even for rape or incest. Can members imagine that? A woman has been raped and a court case may happen in a year's time or the police might be pursuing a suspect in a rape case, and at the same time, the criminal code is acting against that woman who does not want a baby, the father being the person who raped her. Can members believe that that is the law in not only Alabama, which most of us would probably think is a pretty weird place, but also places like Arkansas, South Dakota, Tennessee, Oklahoma, Missouri, Mississippi, Louisiana and West Virginia? In a whole bunch of states in the United States, if a woman is pregnant because she is the victim of incest, the state will use its criminal code to try to stop her aborting that fetus. It is quite hard to believe, but that is the state of the law in a lot of states now in the United States.

The same groups in the United States who support those laws, and who worked for 50 years to get themselves in a position whereby they could impose those laws on the rest of the community, are active here in Western Australia. They did not get to a point at which they can simultaneously implement such extreme laws without a considerable amount of work over a very long period. Getting Donald Trump elected in his own right was not enough to get them in a position in which they could do this. They had to elect state lawmakers in a whole range of states in order to simultaneously do it the moment that Roe v Wade was overturned.

Let us be frank. It was not the only organisation that did this work, but one of the big instigators of this work in the United States was the Catholic Church. The Catholic Church is supportive of what has happened in the United States because it has a view, as I was taught as a student for 12 years of Catholic schooling, that abortion

is never permissible, it is always a sin and it can never be sanctioned. I know that is uncomfortable. Believe it or not, it is uncomfortable for people to acknowledge that the Catholic Church, to which many people still offer their allegiance, would, if it had the opportunity, impose similar laws here in Western Australia. We kid ourselves if we think that is not the case. It is not just the Catholic Church. I refer to the Liberal Party. A whole bunch of quite extreme religious groups have now basically taken over the Liberal Party, certainly in Western Australia, but also around the country. The next time—heaven forbid—that the Liberal Party is in government here in the state of Western Australia, it will not be the Liberal Party of even Colin Barnett; it will be a much more extreme version of that party and may well reflect many of the views that exist in those religious groups in the United States.

[Member's time extended.]

Mr D.J. KELLY: Apart from the extreme views on abortion that those religious groups hold, the contradictions and hypocrisy of what they preach is hard to comprehend. One would think that an organisation that is opposed to abortion would support contraception, but those religious groups do not. They stop women—young women in particular, but women in general—from having access to contraception, and at the same time they oppose abortion.

Ms C.M. Tonkin: They probably support the death penalty, as well!

Mr D.J. KELLY: That is right! The contradiction in what they preach just makes their position completely illogical. Another issue I have been involved in recently is the sexual abuse of children in the care of a lot of religious institutions. Members of the Catholic Church have abused and still abuse children in the tens of thousands across the globe. It is hard to reconcile the Catholic Church's opposition to abortion based on the protection of children with what its members have done to children in the church's care over decades. In 2021, a commission put together by the Catholic Church itself reported that clergy of the Catholic Church in France had abused over 216 000 young people in their care from 1950 to 2015. The Catholic Church's own commission came to that view. If we add in the number of young people who have been abused by lay people, the figure goes to over 300 000. Just this week, a commission in New Zealand found widespread sexual abuse in religious institutions in New Zealand. A similar commission in Portugal recently came to the same conclusion. I would like those people who say that they care for children and, as a result, hold very extreme views on abortion to look at what has happened to those living children. I would like them to be as vocal on that issue as they are on the abortion issue. If they were, the churches that they are a part of may well be in a much better place than they are now.

We are currently running an inquiry into the issue of forced adoption. In that circumstance, churches—again, the Catholic Church, my tribe—were instrumental in ripping children away from mothers who wanted those babies, not because the women were bad mothers, but simply because there was a religious view that illegitimate children should not be in the care of undeserving mothers. That is absolutely shocking. I wish that those people who are so vocal on the abortion issue would be as vocal on things like child sexual abuse and forced adoption and direct their energies in that direction.

Finally, I will touch on the situation at Midland Public Hospital, which is run by St John of God Health Care. It was given a contract in 2015 by the Barnett Liberal government. At that time, the Barnett Liberal government was attempting to privatise as many of the state's public hospitals as it could. When that government came to power, there had been a commitment by the former Labor government and the federal government, I think it was, to build a new hospital in Midland to replace the ageing Swan District Hospital. When Barnett became Premier, he saw an opportunity to cease the funding that was there for a new hospital. Instead of building a hospital that would be run by the health department, he chose to put the contract out to tender and awarded the contract to St John of God Health Care, which is a Catholic healthcare provider. That is the first time that a public hospital in Western Australia was put in the hands of a religious healthcare provider. It is disappointing in itself to have a public hospital privatised, but a key outcome was that as part of the contract, the hospital was not required to perform what were called restricted services. The restricted services were basically all forms of women's reproductive health; the hospital was required to not perform anything to do with terminations or contraception. Interestingly, a lot of people do not know this, but that was also the case for vasectomies. One cannot get a vasectomy done at Midland Public Hospital. How do I know? I am going to tell members a little story.

The ACTING SPEAKER (Ms A.E. Kent): That is too much information, member for Bassendean!

Mr D.J. KELLY: That is right! In about 2015—I was playing vigorous sport at that age—I got a hernia. I went to my GP and he said, "You've got a hernia. Here's a doctor at Swan District Hospital; you'll get it done, no problem." I said to my GP at the time that I was thinking about getting a vasectomy. I asked him, "Would it make sense, while they're down there, to do both procedures at the same time?" The GP said to me that it absolutely makes sense from a patient's point of view, because it is one procedure. It also makes sense from the health system's point of view, because the patient is not booking in twice, so it is cheaper. He said to go off and do it. I took the referral and contacted the doctor, and they told me straight out. They said that the doctor is at Swan District Hospital, but by the time they could fit me in, he will have transferred to Midland Public Hospital, and because it is run by St John of God Health Care, they will not do it. They said, "If you want a vasectomy, you'll have to go elsewhere." I kid

you not! I had it done at Joondalup. As the patient, I had to go and find somewhere else that would perform that procedure. As humorous or uncomfortable as that story may be, it just shows members how ridiculous it is that we have a public hospital in Midland that not only will not perform terminations or provide advice on contraception, but also will not do vasectomies. How ridiculous is that?

I remember putting questions to the government at the time. What if a young woman who was bleeding arrived at the emergency department at St John of God Midland Public Hospital not knowing what was wrong with her, and it was discovered that she was having a miscarriage but did not know she was pregnant? What if, when she found out she then asked, "What do I need to do so that this does not happen again"? At St John of God Midland Public Hospital, she would not be given contraceptive advice, because that is not permitted under the restrictions on practitioners who work at that hospital. At best, she would be told to talk to a GP. My story was a bit funny and humorous, and I was in a position in which I could work my way around it, but if a young person is confronted with that situation and does not want to see a GP, and becomes pregnant again a year later, who is responsible for that? At the moment, it is the state of Western Australia. When these issues were raised with Colin Barnett when he was Premier, he said, "Look, when we let the contract, as Premier, I didn't know." That is like saying do you know the Pope is Catholic? It is ridiculous. Even when pressed, the former Premier washed his hands of that contract. I look forward to the day that St John of God Midland Public Hospital comes back into the control of the state, and is run by the health department, so that the woman and men serviced by that catchment can get the benefit of the full range of medical services that they deserve.

I commend the bill to the house. I congratulate the cabinet, and the Minister for Health, for the doing the work to get this legislation to where it is. It is widely and overwhelmingly supported by the people of Western Australia. It is long overdue. Once we get it in, we cannot and never should assume that the people who oppose this legislation will allow it to remain forever. They will continue to seek a Roe v Wade opportunity to roll back this legislation if they can. We have to do everything we can to make sure that never happens.

MS E.L. HAMILTON (Joondalup) [5.02 pm]: I rise today to make a contribution to the second reading of the Abortion Legislation Reform Bill 2023. The purpose of this bill is to amend the Criminal Code to remove offences related to abortion, amend the Public Health Act 2016 to regulate the performance of abortion by registered health practitioners, prohibit the performance of abortion by certain persons, and to make consequential and related amendments to other acts, and for related purposes.

Access to a safe, legal abortion is a women's healthcare right. However, there are still barriers to timely reproductive health care in Western Australia. Abortion was legalised in 1998 due to the trailblazing efforts of Hon Cheryl Davenport and Diana Warnock, whose unwavering dedication to a woman's right to choose has brought us to this pivotal moment in the fight for reproductive rights. However, laws passed at that time need to be updated to reflect the needs of the WA community in 2023 and moving forward. We need to continue our efforts towards ensuring that abortion is treated as health care and removing it completely from criminal laws. We must keep in mind the struggles that women in Western Australia have faced in the past and continue to face today. It is our responsibility to ensure that all women have access to safe, affordable and compassionate abortion care that better reflects contemporary clinical practice without fear or discrimination. We must continue to lead on these issues to protect and promote women's rights to health care and making decisions about their own bodies.

This is an area of health care that the government has been working on since taking office. In 2021, the government brought Western Australia into line with the rest of Australia with the passing of the Public Health Amendment (Safe Access Zones) Bill 2021, which has unified the country's protective zones around abortion services. These zones ensure that women seeking an abortion can have safe and private access to health services without fear of harassment or intimidation. This is a crucial step towards protecting the rights and wellbeing of women in WA and ensuring that they can have access to reproductive health care in a safe and dignified manner. We know that continued reform in WA is necessary to ensure a women's right to make choices about reproductive, sexual and maternal health, and I commend the Minister for Health for bringing this legislation into the house.

Significant reform to a woman's right to choice in their reproductive health in WA took place back in 1998. As we reflect on the progress made in Western Australia with the introduction of the Acts Amendment (Abortion) Act, is it is important to recognise the significance of the legislation in addressing the restrictive and complex legal framework surrounding abortion. The act achieved several important milestones that have had a positive impact on women's reproductive rights. One of the key achievements of the 1998 act was the decriminalisation of abortion, which ensured that women and healthcare providers who perform abortions are no longer at the risk of being prosecuted or jailed for seeking or providing an abortion. This removed the threat of criminal charges and the associated fear of legal repercussions, allowing women to make choices about their reproductive health without that fear of criminalisation. The act established a legal framework for the regulation of abortion services, providing clarity and guidance to healthcare providers. It defined the conditions under which abortion is considered lawful, such as being performed by a medical practitioner before 20 weeks' gestation—with exceptions—and obtaining

informed consent from the patient. This regulation ensured that abortion services were carried out in a safe and appropriate manner, protecting the health and wellbeing of women.

In addition, the act improved access to safe and legal abortion services by allowing for abortions to be performed in approved medical facilities, including public hospitals, private clinics and approved day surgeries. This increased the availability and accessibility of abortion care for women in WA, reducing the need for unsafe and illegal procedures. It has now been 25 years since the Acts Amendment (Abortion) Bill 1998 was introduced to the Legislative Council as a private member's bill by the then member for South Metropolitan region, Hon Cheryl Davenport. The bill sought to repeal sections of the Criminal Code that made it a criminal offence to procure an abortion. This groundbreaking legislation challenged the status quo at the time and set in motion the path towards decriminalising abortion in WA and brought us into line with other states.

Cheryl Davenport was a vocal advocate for women's reproductive rights and passionately argued, at the time, that criminalisation of abortion was an unjust infringement on women's autonomy and health. She stated that it was a woman's right to control her own body and nobody else's business. Her words echoed the fundamental principle that women have the right to make decisions about their own bodies, free from interference or judgement. Alongside Cheryl Davenport, other remarkable female politicians, including Diana Warnock, recognised the urgency of removing the barriers and stigma that had plagued abortion in Western Australia for far too long. They tirelessly worked to change the outdated laws that created these unnecessary obstacles for women seeking reproductive health care, which resulted in the passing of the Acts Amendment (Abortion) Bill 1998. At the time of the debate, Cheryl Davenport concluded by signalling that this legislation was not perfect, and down the track it would take another good woman politician who cares to make the necessary changes. Here we are, 25 years later, with a bill before the house to ensure that abortion is treated as the health care that it is, and that women are at the centre of the decision-making process of their healthcare needs. We have legislation that will remove the last of the obstacles for women to have timely access to safe and legal health care regardless of where they reside in the state. WA could have been considered to be ahead of its time with its legislation 25 years ago, but since then, other Australian jurisdictions have caught up, and in many cases, are providing more compassionate access to abortion that better reflects contemporary clinical practice.

We know that there are still significant barriers to accessibility and affordability. As part of the development of this bill, the Department of Health conducted a four-week consultation whereby more than 17 500 people made contributions. I note that over 81 per cent of those respondents were women. The consultation identified support for reducing the number of health practitioners required to be involved in care from two to one, abolishing the ministerial panel requirement for later-term abortions, allowing health practitioners to conscientiously object but be required to refer patients to a clinician who is willing and able to provide care, removing mandatory counselling provisions, and removing the requirement for ministerial approval for a health service to perform a late-term abortion. Feedback also supported the proposal to increase the gestational age at which additional requirements apply, to better align with other jurisdictions.

This bill has been shaped by the community, largely women, and by medical practitioners who will have to operate under this framework—doctors who want to do the best for the women who come to see them. The major reforms being proposed will strengthen protections for Western Australians seeking lawful health care; increase accessibility by removing clinically unnecessary barriers; provide a more compassionate approach to late-term abortion by increasing the time for women to make what is often a very difficult decision; and provide a clear framework outlining the rights and obligations of those healthcare practitioners who are unable to assist in abortion care—otherwise known as conscientious objectors. The bill will repeal the current offence in the Criminal Code, leaving only an offence in the Public Health Act 2016 when an unqualified person performs an abortion. This will complete the decriminalisation of abortion in WA.

Women will be able to self-refer up to 23 weeks. This will remove the requirement for consideration by two practitioners, removing a significant barrier for women in rural and remote areas who face particular challenges in accessing safe and timely abortion services, particularly when there may be only one doctor at the location or when there are travelling services.

The reforms we are discussing are also happening at a time when changes are being made nationally to allow access to the abortion pill for women seeking a termination up to nine weeks. Just last month, it was reported that the Therapeutic Goods Administration had approved changes, effective from 1 August, to enable every general practitioner in Australia to prescribe the abortion pill in a move that will help women across the country. Further, the rules for pharmacies will also be relaxed, which means that every chemist will now be able to dispense. Interestingly, nationally, historically only about 10 per cent of GPs could prescribe the abortion pill and one-third of chemists could dispense it. These changes will improve access for women. Presently, a woman in WA who wishes to access a medical abortion after 20 weeks is required to travel interstate. It is just not a possibility here. It means that they would potentially be away from their support network or family and, for Indigenous women, off country.

After 23 weeks, two medical practitioners will need to be satisfied. It is important to note that late-term abortions are extremely rare and account for less than one per cent of all procedures. It usually occurs in very much wanted pregnancies when there is serious anomaly or risk to life. There is currently inequity in access to late-term abortions, which means that we are not currently keeping in line with standard practice.

As part of a pregnancy, a woman receives an ultrasound at 20 weeks. For those living in the regions, this time frame can vary, as doctors fly into and out of locations. It can occur a few weeks before or after this time. For women who receive the devastating news that there are complications with their pregnancy or the pregnancy will not result in a live birth, 23 weeks will give time for consideration of the next steps the women may like to take. This will remove the current legislative requirement at this difficult time for a woman to seek approval from both their original medical practitioner and joint authorisation from another two medical practitioners who are members of a statutory panel appointed by the Minister for Health.

Other key provisions in this legislation include an increase in the gestational age, providing the opportunity for those who live in the regions to travel often 200 kilometres or more to one of the two hospitals in WA that perform a medical abortion—that is, Broome Health Campus and King Edward Memorial Hospital for Women. The requirement for mandatory counselling will be removed, the ministerial panel process will be abolished and all these processes will be brought in line with best medical practice and informed consent provisions.

The current requirement for patients to see a counselling doctor in addition to their treating doctor really is a violation of women's autonomy and dignity. It is out of step with the rest of Australia and is particularly burdensome and will be removed by this reform. WA is the only state where minors, regardless of their maturity, are required to seek parental consent for an abortion. This creates safety issues for those seeking an abortion if, for example, they do not have a relationship with their parents, the parents are not supportive or it goes against the beliefs of the family. Currently, the only way for a mature minor to seek an abortion is through the approval of the Children's Court of WA. This requirement is no longer in touch with those in other states, and, given that doctors already determine whether a young person is a mature minor, this bill will allow mature minors to access abortions in the same way that they access other medical care.

Another concerning issue with the current legislation is the lack of clear duties for doctors who object to abortion, leaving women in the difficult situation of not knowing where to seek safe and legal health care. This legislation will require doctors who refuse to participate in abortion care due to conscientious objection to make this known straightaway at the beginning of the consultation and to refer to a registered health practitioner or health service that can assist and/or provide information that has been approved by the Chief Health Officer and will include information that is updated annually on where women can access abortion.

We have high-quality health care being provided by high-quality clinicians in WA, and the reforms proposed in this legislation will ensure that women receive the high-quality health care that they deserve. The recent events in the United States with the overturning of the Roe v Wade case serves as a stark reminder of the ongoing need to continue to advocate for gender equality and reproductive rights that generations of women have fought for.

I want to share with the house a personal experience that is particularly relevant to the debate today. I was 19 years of age when I fell pregnant. It was a time in my life when I had not yet planned a family and the pregnancy came as a surprise to both me and the family. I found out at about eight weeks that I was pregnant and began the process of understanding what this would mean for me moving forward. I needed to make a very difficult decision about the pregnancy, one that I wanted to make in an informed way. I remember vividly having a conversation with my mother at the time about the options available to me. The point I want to make is that options were available.

Upon reflecting on my contribution to the debate on this bill, it brought back the memories and the decision that I made to proceed with my pregnancy. I reflected upon the circumstances that I was presented with and I could only imagine: what if? What if I had decided not to proceed? What if I had not found out that I was pregnant until further along in the pregnancy? What if I had found out that there was a problem with the pregnancy? There are many what-ifs, and that was from a metropolitan perspective. The reforms in this bill will mean that all these what-ifs could have been answered and that there would have been steps that I could have taken and decisions that I could have made about my health care. I am proud to make a contribution in support of the bill before us today that will ensure that should my daughter require it, she can access the abortion health care she needs without barriers.

As we reflect on the history of abortion laws in WA, I acknowledge again the tireless efforts of advocates and remarkable women like Cheryl Davenport, Diana Warnock and many others who have been champions for women's reproductive rights. The Western Australian Acts Amendment (Abortion) Act 1998 was a significant milestone in the fight for reproductive rights in WA. It decriminalised abortion, regulated the services and improved access to safe and legal care. But we owe it to the women of Western Australia to take further action, and we need to pass these reforms to remove the existing barriers to ensure that women have the autonomy and freedom to make choices

about their own bodies and reproductive health without fear or barriers and for abortion to be treated as the health care issue it is.

I commend the bill to the house.

MS K.E. GIDDENS (Bateman) [5.17 pm]: I am very pleased to make a contribution to this important reform to access to abortion services for women in Western Australia. We have heard that in 1998, Western Australia was in fact a leader in the nation in this regard. It led the way in decriminalising access to abortion for women in Western Australia, but in the 25 years since those reforms, other states have enacted legislation that more accurately reflects where the community sits today and our clinical and medical understanding of the rights of women to access a medical procedure.

I will go through some of the reforms in the Abortion Legislation Reform Bill 2023. As I said, the bill seeks to address clinical barriers to abortion through a number of key provisions. One of these provisions is raising the gestational limit for abortion from the current 20 weeks to 23 weeks. This will improve access to medical abortion for women across Western Australia in a number of ways, but in particular it will be of benefit to women in regional Western Australia. As somebody who found out only a week after I moved to Wyndham in the Kimberley that I was pregnant with my second child, and having been pregnant in a regional area, I absolutely understand what the impact is for women who do not have access to the services available to women in the city. Although I welcomed that pregnancy—I admit that my darling second child was a surprise—nonetheless had the clinician in Wyndham, a very small town, refused to provide me with services, I would have been very stuck indeed. The nearest medical services were 100 kilometres away in Kununurra. If services had not been available there, the nearest services would have been in Broome or Perth. Access to those services would then have been contingent on my ability to travel there, as it was a very long way and I might not have been able to afford flights. This is an equity issue for women across the whole of Western Australia. One of the other provisions in the bill will remove the requirement to consult two medical practitioners. Again, noting the example I just gave, this is really important for women, particularly in regional areas.

Late-term abortions past 23 weeks will no longer require the approval of the original practitioner and two medical doctors from a ministerial panel. Late-term abortion is the area in which commentary around abortions can get a little bit contentious, but it is really important to note that less than one per cent of abortions occur late term. Very often they are performed because of the health or viability of the baby or the health of the mother. This is a particularly traumatic and stressful time for the family and the mother. I would like to recount an experience of a couple that I know. After losing their first child, they tried again and fell pregnant, but then discovered at about 18 and a half or 19 weeks that the baby had some really significant health issues. Because of the current time frame of 20 weeks, they were under extraordinary pressure to make a decision on that pregnancy to meet that requirement. Although they had advice that the child, if born, would not be compatible with life—the fetus had significant deformities—it did not mean that they wanted to make that decision within that time frame. I can only imagine that this time was made even more stressful for them because of the pressure to make a decision. Access to late-term abortion is necessary and important for the health of women, and also for the child.

I think the removal of the mandatory counselling provision is very important. To suggest that doctors, in their role of providing care to patients, do not already provide a range of options and discuss the needs of their patients is somewhat fanciful. Care for their patients is at their core. Because of that, I am very confident that a range of conversations take place and that medical practitioners provide advice in the context of a woman's needs and health. Further mandatory counselling has potentially been harmful to many women and, in the modern context, could be perceived as being emotionally manipulative.

The bill will update provisions for health providers who conscientiously object. Again, healthcare professionals are required to provide care to patients. This provision will not force anyone to provide access to abortion care, but it will provide very clear professional guidelines to medical practitioners who object. The steps will include referring patients to a health practitioner who will perform the service or provide care, and providing access to valid, medically endorsed information that is regularly reviewed by the Department of Health. It is very important that we make medically accurate information accessible to women.

Other provisions in this bill deal with adults without decision-making capacity. I did not realise that under the current legislation, adults without decision-making capacity are not allowed to access abortion. There is no mechanism for them to access abortion. I can think of many circumstances in which not being able to access safe medical abortion care would be very limiting for adults without decision-making capacity. I particularly welcome this provision as it will meet the needs of people through the decision-making oversight of the State Administrative Tribunal.

The other provision that has been mentioned concerns mature minors. We know that some young people are sexually active at a young age and that a potential consequence of that is pregnancy. There is a suggestion that those young people should not have the ability to be informed about their own wellbeing. Although it is hoped that young people will have family support, the reality for some is that that is not the case and there might be a whole

bunch of reasons that it might not be appropriate or possible for them to share that news with their families or seek the support of their loved ones. The bill will remove the arduous and probably traumatic, or at least intimidating, process of having to go to the Family Court.

We know that abortion is a clinical medical procedure, so it is absolutely appropriate that this new framework will sit within the Public Health Act 2016. The bill will repeal both the Criminal Code offence and the corresponding provision in the Health (Miscellaneous Provisions) Act to finally fully decriminalise abortion in Western Australia.

This proposed legislation is in line with current community standards and views on abortion. In preparing to speak on this bill, I had a quick review of correspondence into my office to see whether this was an area on which anybody in my electorate had shared their views with me. Not one person had. That is not to say that people in my electorate do not have a view on this, but this is not the contentious legislation that some may wish to present it as. In fact, the community consultation that was done only recently—in April 2023—supports this view. There was overwhelming support from respondents for the provisions in this bill. For example, the removal of the legislative provision on informed consent and mandatory counselling was supported by 63 per cent of people who participated in the consultation process. Likewise, the option to amend the requirement to consult two medical practitioners to just one health practitioner was supported by 68.8 per cent of respondents. More than 72 per cent of respondents supported the removal of the current provision that enables health practitioners who conscientiously object to not provide a professional referral to another medical practitioner.

In my view, this is not contentious legislation, but I do not want to make the mistake of not acknowledging that there are ethical considerations. In this context, I want to distinguish ethics from morals. In my view, ethics are informed by evidence, knowledge and shared understanding—there is sometimes overlap—as opposed to morals, which are an individual's personally informed view. When it comes to women's rights in particular, we have a long history of morals not serving women well.

I want to consider some of the ethical considerations. I apologise if these are actual terms. I think I made them up this morning, but I am looking at people with social science experience and if they are actual terms and I am misusing them, I am deeply sorry. I will split this, in my own mind at least, into two types of ethical considerations. The first I have called medical ethics—I do not know whether that is a thing. For me, this is about our scientific understanding of fetal development; the safety, efficacy and risk of procedures and their complications; and harm, whether it be physical, emotional or psychological. This is not a special category relating to abortions; indeed, ethics apply in a range of medical procedures and practices. For example, who is and who is not on the organ donor list and what criteria do we use? How do we intervene for people who are at the end of their life? What is the appropriate medical response to an elderly vulnerable person for whom surgery might put them at significant risk? Medical ethics—I am glad that it is a real term—is already used successfully by the medical profession. We know that medical professionals are highly trusted in the community. For those considerations, we continue to trust medical practitioners. Our understanding, as it emerges, continues to be informed by that.

The other type of ethics, which is more complicated, is societal ethics. I am looking at the member for Nedlands; I do not know whether that is a thing! Have I made that up? In this regard, I am talking about the values that we bring to these decisions. For example, I refer to prenatal screening. There have been significant advances in prenatal screening. It is able to provide all sorts of valuable and medically relevant information to women and families who are expecting a child. I support and welcome that. We know that choices do not operate in a vacuum. One of the ethical points I would like to consider is the pressure that society might place on women. We are not talking about individual choice, but society's view about the types of pregnancies that may or may not be worth proceeding with and the types of conditions that would involve proceeding with a termination. Again, this is a complex area. I am not passing moral judgement. We have to look at the way that society supports women and their choices. During my pregnancies, I chose not to have the prenatal screening because it would not have affected my choice in proceeding with the pregnancies. My sister chose to have the prenatal screening because she wanted access to the full range of information to prepare herself. That is very much a choice of women, which I support. As a society, I hope that we value, for example, people with disabilities. We have to look at the strength of our society in relation to these issues to ensure that we are not passing value judgements that prevent women from making a fully free choice knowing that if the child they bring into the world has a disability, they will be supported and cared for by society as a whole.

These issues sit outside the core fact that women are not baby-making vessels; we are individuals in our own right with our own hopes for physical and emotional wellbeing. If we put that at the heart of it, those other ethical considerations I just mentioned feed into the decisions that women make, but they are not central to those decisions. We must absolutely uphold the right of a woman to make a choice. Pregnancy is a gendered issue; fathers are involved but women carry the child. This is reflected by the fact that 81 per cent of respondents in the community survey were women.

[Member's time extended.]

Ms K.E. GIDDENS: The member for Joondalup shared a very personal experience with us in the chamber and asked herself a number of what-ifs. I do not have a personal experience to share in that regard, but I can still ask myself about the what-ifs. What if I fell pregnant because of sexual assault? What if I fell pregnant when I was financially or emotionally not ready to care for a child? What if I fell pregnant when I was in an unstable relationship or experiencing domestic violence? What if my baby was diagnosed with a serious medical condition that would put my health and wellbeing or the health and wellbeing of the child at risk? I do not know what I would do, but I do know that I would want the choice and that women in Western Australia deserve that choice. For that reason, I support the bill and commend it to the house.

MS A.E. KENT (Kalgoorlie) [5.35 pm]: I rise today to add my contribution to the Abortion Legislation Reform Bill 2023. Since colonisation, abortion in Australia has always been regulated by the state, which was previously colonial law. Before the end of the nineteenth century, each colony adopted the imperial Offences against the Person Act 1861, which made abortion illegal in any circumstance. Since then, abortion law has continued to evolve in each state by case law and changes in legislation. In 1998, Western Australia became the first state in Australia to decriminalise abortion. Abortion is lawful in WA as long as it is performed by a medical practitioner in good faith and with reasonable care and skill, and the performance of the abortion is justified under the Health (Miscellaneous Provisions) Act 1911. However, medical care around abortion services has advanced since 1998. The legislation is now outdated and in some circumstances it poses unnecessary barriers to the access and provision of this healthcare service.

This state government undertook reform to contemporise the legislative framework with the aim to remove unnecessary barriers to accessing abortion care and align with laws in other Australian jurisdictions when it is suitable for the WA context. To understand why this legislation is so crucial, it is important to understand how abortion laws have been implemented.

Around the world, the words Roe v Wade have become synonymous with the right to reproductive freedom. The Roe in question was Norma McCorvey, a Texan woman who took her fight to terminate her pregnancy to the courts in 1970. In a landmark ruling in 1973, a majority 7–2 of Supreme Court judges found that although the Constitution of the United States does not explicitly refer to abortion, it implies the right to privacy, which extends to reproductive decisions. For almost 50 years, that reasoning granted American women the constitutional right to an abortion in the first three months of pregnancy and it prevented the states from prohibiting abortion during the second trimester—that is, until the same court voted to overturn the ruling in June 2022, allowing individual states to make their own abortion laws. In Australia, Prime Minister Anthony Albanese described the move as —

> "a setback for women and their right to control their own bodies …

He reiterated that in Australia, access to an abortion is not a matter for partisan political debate. However, it was not always that way. In the years preceding Roe v Wade, another lesser-known case on abortion access was heard before the Victorian Supreme Court and it paved the way for reproductive rights in Australia. In 1950s and 1960s Australia, a burgeoning campaign for greater reproductive freedom was already underway, but unlike the feminist movements that came later, medical professionals were often on the frontline. Dr Erica Millar, an expert on abortion provision in Australia at La Trobe University, said —

> "This was basically on the grounds that unsafe abortion could be very dangerous," … "And they were sick of dealing with patients with complications of abortion and also thinking about the real toll it takes on a person."

By the late 1960s, abortions were already commonplace. They were undertaken by doctors and non-medical professionals, despite it being a criminal offence in all states and territories. In Victoria, at the time, very few people were charged with breaking the abortion laws. It was one of those crimes that was on the books, but not really enforced. Among those offering abortions was Melbourne gynaecologist Ken Davidson. In 1967, homicide squad detectives raided Davidson's East Melbourne surgery after receiving a tipoff that he was set to perform an abortion that morning. Two years later, Davidson found himself before the Victorian Supreme Court. In what would become a nationwide precedent, Victorian Supreme Court Justice Clifford Menhennitt ruled that abortion was not illegal if a doctor honestly believed that a person's physical or mental health would be seriously endangered if the pregnancy were to continue. The judgement relied on the necessity principle, often called the "lesser evils" approach. This was basically the idea that one can break the literal law if the harm in doing so would be less than the alternative. Menhennitt said that if one can show that abortion was the lesser evil in the circumstances, it becomes a lawful abortion. The ruling did not, however, establish that a doctor could perform an abortion for any reason other than health grounds, but it marked a huge shift and, in practice, meant that doctors were free to perform abortions on the basis that being forced to continue with a pregnancy against a person's will was almost always seen to be more harmful than the termination. The Menhennitt ruling allowed doctors the flexibility to perform an abortion essentially

on a pregnant person's choice. During its lifetime, the ruling's influence on Australia, both symbolic and practical, was comparable to Roe v Wade.

There were some major limitations to the Menhennitt ruling. The most significant limitation went to the heart of how abortion was treated in Australia for decades. Roe v Wade granted Americans the positive right to abortion under the Constitution. Australia's equivalent, on the other hand, simply provided a defence to a crime. One refers to rights and, therefore, creates limits to the exercise of legislative power by the United States; the other really just develops a defence to a crime, but does not refer to anything about the crime itself.

With the overturning of Roe v Wade, the power to legislate access to abortion has now been handed back to the states, bringing it more in line with the Australian system, albeit in a very different partisan reality. More than one year after the Supreme Court overturned Roe v Wade, the battle over abortion access is continuing in courthouses and on ballots in states across America. Since the court's decision last year, 14 states have banned most abortions, while other states have had abortion bans blocked in courts. Over the same period, 20 other states have passed legislation to further protect access to abortions. Abortion will be a major issue when Americans go to the polls to cast their votes in the 2024 presidential election. Many expect President Joe Biden to make abortion rights a key focus of his re-election campaign.

In the wake of the US Supreme Court overturning that country's landmark abortion case in Roe v Wade, the WA government committed to look at updating its legislation. In preparation for the introduction of legislative amendments to contemporise the provision of abortion in Western Australia, a four-week consultation was undertaken. During that period, more than 17 500 survey responses were received with over 81 per cent of respondents women. A series of statements were posed, the first being —

> Under current legislation, abortion care can only be accessed if the pregnant person has been provided counselling about the medical risk of termination of pregnancy and of carrying the pregnancy to term, by a medical practitioner other than the one performing the procedure.

Over 67 per cent of respondents supported removing existing legislated provisions requiring mandatory counselling in order to obtain informed consent.

The second statement reads —

> Current legislation requires that informed consent be obtained from the patient by 2 medical practitioners prior to the abortion being performed.

Almost 70 per cent of respondents supported amending provisions to allow only one health medical practitioner to be involved.

The third states —

> Current legislation provides that no person, hospital, health institution, other institution or service is under a duty to participate in the performance of any abortion. There is no requirement on the person or service to disclose such objections.

Almost 72 per cent of respondents supported updated provisions to allow health practitioners to conscientiously object, with clear and unambiguous directions to refer the patient to another health practitioner who is willing and able to perform an abortion.

The fourth states —

> Under current WA legislation, abortions after 20 weeks gestation require approval from 2 doctors who are members of a Ministerial Panel prior to the pregnant person accessing abortion care. Raising the gestational age … will more closely align WA with other Australian jurisdictions and reduce the need for residents to travel interstate to access abortion care.

There was both community and health professional support for increasing the gestational age, with community support to move from 20 weeks to 24 weeks. It should be noted that all practitioners will continue to be guided by professional standards, guidelines and their clinical decision-making in addition to legislation and regulation.

The fifth states —

> Under the current legislation, abortions after 20 weeks gestational age are only authorised when 2 medical practitioners, who are members of a statutory panel of at least 6 medical practitioners appointed by the Minister for Health, agree that either the pregnant person or the unborn baby has a severe medical condition that, in their clinical opinion, warrants the procedure.

Almost 70 per cent of respondents supported removing the requirement for members of a ministerial panel to approve abortions beyond the gestational age limit—in other words, late abortions—but require an additional medical practitioner to be consulted.

The sixth states —

> In WA, late abortions can only be performed at health services approved by the Minister for Health for that purpose. Currently, there are only 2 facilities approved for this purpose in WA.

There was strong support by all stakeholders to remove the requirement for ministerial approval for a health service to perform late abortions.

In the mid-1990s, the conservative Howard government was in power in Australia, with conservative independent Tasmanian Senator Brian Harradine holding the balance of power in the Senate. Howard brokered a deal with Harradine to ensure his support for proposed bills, including the privatisation of national telecommunications provider Telecom. In return, Harradine received support for introducing restrictions on abortion. As an ardent anti-choice campaigner, Harradine did everything he could in his 30 years in the Senate to undermine women's right to safe abortion. Tony Abbott's ministerial ban on medical abortion pill RU-486 had its genesis in a deal between the Howard government and Harradine for his support on the sale of Telstra. I continue to be amazed at how men think that they need to be responsible for things that happen to a woman's body!

Abortion laws in Western Australia have remained unchanged for 25 years, and today marks a significant day for women in this state. Western Australia is now the only Australian state or territory where abortion remains in the Criminal Code. The Cook government will include abortion in the Public Health Act 2016 and remove it from the Criminal Code to better reflect the fact that abortion care is part of everyday health care for women. The Criminal Code has no role to play in regulating access to legitimate abortion services, and, importantly, this offence will be repealed. It is clear that just like the government, the public and medical practitioners recognise that the time has come for a change, and we look forward to delivering this for Western Australian women.

Western Australian women should not face barriers to access safe, private and dignified abortion. Thank you, Minister for Health, for developing this bill. I am proud to commend this bill to the house.

MRS L.A. MUNDAY (Dawesville) [5.49 pm]: I rise today to make a contribution in the debate on the Abortion Legislation Reform Bill 2023. I thank Minister Sanderson and her team for working hard to modernise Western Australia's outdated abortion laws. I am proud to be a part of the Cook government, which understands it is unacceptable that WA women face greater barriers in accessing a critical healthcare service. Introducing these historic reforms to Parliament is a significant moment for women in this state, who deserve fair, equal and timely access to legal medical services.

The purpose of the reform is to contemporise the legislative framework by removing unnecessary barriers to accessing abortion care and aligning WA laws with those in other Australian jurisdictions. Personally and professionally I consider abortion care to be part of the healthcare system that women have the right to access with dignity, safety, respect, and compassion. I genuinely believe that women in this state have a right to make decisions over their bodies, and these laws will enable women to make those decisions, knowing they are supported and heard across and between all areas by policymakers, medical professionals, lawyers, judges and any other supportive community group.

As a woman first, but also as a retired ambo and psychologist, I understand that abortion is a critical component of women's health care. No woman should be forced to travel interstate or risk her own health because she cannot access abortion safely and in a dignified way. All women should be entitled to access health care in this arena, not just people who can afford a plane ticket. I am also really pleased that this bill will decriminalise abortions in WA and also align us with other states in Australia.

Today, I will be particularly focusing on the mental health and wellness of girls and women who are impacted by the power and authority held over them by others, whether that be parents, boyfriends, girlfriends, husbands, their religious views or those of others in their family circle, when it comes to making a decision on aborting their pregnancy. It is a very, very rare woman who uses abortion as a means for contraception, and so the 99.9 per cent of the rest of the female population who may find themselves in the situation in which they have to consider an abortion could be potentially experiencing any of the emotions from guilt, grief, anxiety, shame, loss, heartache or depression, along with emotions expressed by many other words that describe a desperately sad state of mind. Having to front up to a person of authority, whether that be parents, a doctor or any other allied health professional, irrespective of them being a male or female, with the fear of being pre-judged as careless in their actions is a very tough place to be.

In both my other jobs as an ambo and psychologist I have been involved in both the acute fear and the long-term grief of women who have found themselves in this exact spot. I remember one young girl, who was 17 years old,

who lived with her grandfather and could not bring herself to tell him that she was pregnant, so she tried to abort the pregnancy herself at home by drinking a concoction of poisons that her well-meaning friends had told her would work. Luckily for this young girl, she had the courage to call an ambulance after she started vomiting and having diarrhoea and severe stomach cramps. Her story turned out okay, but when she opened up to me about why she had drunk the poison, she explained that she had not tried to overdose and it was not about suicide but more a form of self-harm with the goal being to miscarry. I sat with her, and she talked and I listened. This kid had been through hell and back in her life, and although she had a loving and understanding grandad, she felt too much shame in trying to tell him. I told her I absolutely understood how tough that would have been, and so we made a plan. I told her if she came with me to the hospital, I would chat with the doctors and nurses at the emergency department who were very experienced about these kinds of things, and they would help and support her through the whole process, even sitting and telling her grandad with her. This story turned out well because her choice of medication to try and abort her pregnancy was not life threatening, but I could see the corner she felt backed into and that she thought she had no other choices.

Luckily for this young kid she did not live in a small country town because if that had been the case, it would have added another level of complexity again. I can imagine this because I was a kid from a small country town and my mum put the fear of God into me about getting pregnant, and told me if I did, to come and talk to her because she would not be angry—much!—but we would need to take care of it carefully. I knew what she meant. Mum was always concerned about my reputation and the family's reputation around town. Everyone knew everyone's business back then and nothing was private—all the dirty linen was hung out to dry for everyone's judgement. Skeletons would on occasion fall out of closets and the whispers would go around the school or town. Small-town judgement was very rife and hardy in the 1980s, and although I never had to worry about an abortion, my mum would already know if I had been in trouble that day in school before I even got off the school bus. It was like she was psychic. "How was your day?", she would say. I would say, "It was okay", and then she would give me that look that only a mother could give and say, "Do you have anything you would like to tell me?", and I knew I better come clean. I would be like, "Mum, I swear I didn't start this one. It wasn't my fault." But there was always some well-meaning mum who had rung ahead just to let her know about what Lisa had been up to that day. A small town is a hard place to live sometimes, especially when you come under the glaring judgement of opinionated and narrow-minded people who are really just secretly grateful something never happened to them. What is the saying? "There but for the grace of God go I."

Talking more specifically on this subject, my speech is centred around the term "reproductive coercion and abuse". It commonly takes three main forms: pregnancy coercion, when a woman is pressured or forced to become pregnant against her will; contraceptive sabotage, which is deliberately damaging, hiding, or otherwise interfering with birth control; and controlling the outcome of a pregnancy, forcing a woman to terminate or continue a pregnancy against her will. Research suggests that there is an association between reproductive coercion and family and domestic violence, with regard to unwanted pregnancies, poor mental health, decreased contraceptive self-efficacy and increased risk of sexually transmitted infections.

Some pregnancy-promoting behaviours include physical violence and threats of physical violence towards the woman, or the children, if they try to have an abortion, use contraception, attend medical appointments to access contraception or refuse to have sex. I have had clients and patients whose partners have demanded sex from them on a daily basis as their right as a partner, and they discussed the fear that they would accidentally fall pregnant when they did not want to just by the sheer fact that they were having sex every night. Interestingly, I have had the same partners in the same situation angry that their wife or partner did not fall pregnant—because it was her fault—or that they did fall pregnant while using contraception, thus blaming the female. As we know, there is no guarantee that a contraception will ever be 100 per cent effective, but the blame has ended up 100 per cent on her shoulders.

Another point is sabotaging contraception, called stealthing, which is one way by which the person wanting the pregnancy—which I point out could be either the female or male—secretly breaks the condom, puts pinholes through the condom wrapper, refuses to wear a condom or secretly removes the condom during sex. A woman might say they are on the pill or have a contraceptive in place when they do not with the goal to become pregnant in a manipulative context. I remember sitting with a friend who wanted another baby and we laughed about how she told me that she tricked her husband into thinking they were using contraception when she was really popping her contraceptive pills and flushing them down the toilet. I remember that day we were having a coffee and having a really good laugh. I never really thought about it much until I wrote this speech, but now looking back, this was a type of pregnancy-promoting coercion.

Another point is emotional abuse towards a woman because the partner wants them to become pregnant or continue a pregnancy. I had a client when I was a psychologist who was 28 years old. She had two children who had both just started school full-time. She was very excited about getting her life back, in terms of getting back into the

work force. She worked as a vet and had organised to return to the vet clinic two days a week. Her husband did not want her to return to the workforce. He wanted her to get pregnant again and she did not want to. This situation went around and around in circles for quite a few months until it became untenable because she was not going to give in and he was not going to give in. In the end, the marriage broke down and the wife ended up leaving the marriage because the husband just could not cope with the fact that his wife wanted to work again and have an independent life. It is interesting that this kind of control turns up in different ways.

Other points are withdrawal of physical, financial and emotional support until the woman agrees to become pregnant or continue a pregnancy and preventing access to abortion services. From the research I was reading, this usually affects people of low socio-economic background who feel they do not have a choice through family and domestic violence. A person could have a disability or one partner is intellectually superior to the other and is using them as a means to have babies. There is also preventing access to abortion services. Then there are pregnancy-preventing behaviours, which is physical violence to force contraception use or induce miscarriage. This violence is usually when a man, another partner, a father or parent physically punches a woman with a view to abort the baby. In most cases that I have dealt with, it happens in alcohol and drug-fuelled areas. Unfortunately, it is more common than we would like to think, which is quite sad. There is also emotional and physical abuse; threats of physical violence to the victim–survivor or their children if they do not terminate a pregnancy; or the withdrawal of material, financial and emotional support until the woman agrees to terminate a pregnancy. This pressure can often be from parents or guardians who wield the power to terminate.

Although I understand the importance of counselling as a psychologist and a paramedic, I think that the reform to remove mandatory counselling is a good one; however, I know that every general practitioner or allied health professional who works with women who choose to have an abortion freely offer information and support to make decisions based on their individual situation. No two women's situations are the same.

When I was planning this speech I read through Minister Sanderson's second reading speech. In her role as Minister for Health, she commented that —

> The bill will remove provisions in the Health (Miscellaneous Provisions) Act requiring patients to receive counselling in order to provide informed consent to an abortion. Currently, an assessing medical practitioner must provide the patient with counselling about the medical risks of a termination, continuing a pregnancy to term and the availability of ongoing counselling. This requirement does not reflect contemporary practice, and removing it will align Western Australia with other Australian jurisdictions and reduce barriers to accessing abortion in WA. Instead, medical practitioners will be able to obtain informed consent in line with existing standards of care and professional obligations.

Removing the need to force-feed information to a woman who has generally already decided for or against abortion is unhelpful and may likely, in my opinion, cause more psychological harm than good. As health professionals, the first oath we took was to first, do no harm. In my health role over the last two decades I have sat with many women and offered a safe place for them to share their reasons for choosing to have an abortion. Some felt that they had no choice. Sometimes life circumstances have put them in that situation and an understanding person is needed to help them through it. One of the biggest takeaway lessons for me as a health professional was to always separate the woman from the parties she is with, because often the person or party they are with either knowingly, or unknowingly in some cases, has an impact on the decision-making process of the woman. I refer back to the 17-year-old and her grandad who loved this 17-year-old; they loved each other very dearly. The grandad was thinking that his granddaughter had attempted suicide, and had absolutely no idea what she was going through. If I did not have the experience to separate them and see what was really going on, she would never have opened up to me in front of her grandad. Sometimes it is just a gut feeling. Sometimes it is lack of eye contact or a poor history you are getting from a patient that makes you suspicious that something is not quite right, but a lot of our allied professionals, doctors, GPs—everyone in this arena—is very well aware of what it means to do that. I do not think mandatory counselling will make a difference to this, because we all know that given the right set of circumstances, if a woman is given the opportunity to speak for herself and on her own, she will make the decision that she wants to make.

I thank Minister Sanderson and her team again for her work on the bill. I commend the bill to the house.

MR S.A. MILLMAN (Mount Lawley — Parliamentary Secretary) [6.03 pm]: I rise to make a contribution on the Abortion Legislation Reform Bill 2023 debate. At the outset I express my strong support for the bill that has been brought before the house by the minister. I acknowledge the minister for bringing this legislation before the house. I know that she is a passionate advocate for this issue. She is an incredibly hard worker and is fulfilling an important philosophical and values-based objective. I acknowledge staff in the minister's office, particularly Marije van Hemert and Cassandra Maney, who have been slogging their guts out for the last few weeks and months to assist in bringing this legislation before the house and help backbenchers make their contributions to the debate. I acknowledge a couple of former members of Parliament who have already been mentioned. Diana Warnock was

the state member for Perth between 1993 and 2001. At that time, the electorate of Perth contained some of the areas that are now in the electorate of Mount Lawley. Diana Warnock has always been a great mentor to me and has always helped me when I have had questions, issues or concerns. I think Diana has also been acknowledged by other speakers before me. I also acknowledge Janine Freeman, the former member for Mirrabooka. Janine is an incredible feminist, and I said to her, "Janine, I feel self-conscious about standing up. We've got this incredible caucus of women in the Parliamentary Labor Party who are all such fantastic advocates." As I listened to the members for Dawesville, Bateman, Kalgoorlie and all of the other female members of Parliament who made contributions, I thought, "What more could I contribute to the debate?" Janine used to say to me, "No, you should contribute as well, because feminism is not just about women speaking up for women's rights; it is about men demonstrating their solidarity and participating in that discussion as well." If anyone wants to know why I am standing up and speaking, it is because of Janine. I also acknowledge the Labor Party's EMILY's List Australia. Many people here are members of EMILY's List. It is an incredibly effective organisation that raises awareness of women's issues, including family and domestic violence, the gender pay gap and women's representation or underrepresentation in Parliament.

I pause to reflect. I am grateful that the member for North West Central is here, because with the election of member for North West Central, the Legislative Assembly went beyond 50 per cent women, but I am particularly proud that with last weekend's election of Magenta Marshall as the new member for Rockingham, more than 50 per cent of the state Parliamentary Labor Party's representatives in this chamber are women.

I acknowledge the Department of Health and the Office of the Chief Health Officer. Other members have already spoken about the incredible work put into the *Abortion legislation reform: Community consultation summary report*. I think the member for Kalgoorlie went through it in some detail. When we think about the historical nature of the reforms that we are about to undertake, it is hard not to think that we are in an incredibly privileged position as custodians of public sentiment. We are here to reflect community values, and we can do that comfortable and confident in the knowledge that those community values have been captured by this incredible consultation report. When I look at the statistics in the report about the number and demographic distribution of people who were consulted, and the views that they have on the reform legislation, I see that this legislation is entirely consistent with community expectations. Although in 1998 Diana Warnock and Cheryl Davenport put the Parliament in a position that reflected community attitudes and community values, we now need the strong female political leadership that those members of Parliament identified as needed to advance this issue further. That leadership has been provided and reflects the community attitudes that have been so well captured by the community consultation summary report.

I have listened to some of the contributors who have gone before me, and everyone has talked about the salient aspects of what this law reform will do. I was thinking about what material contribution I could usefully make. I want to start by putting something clearly, squarely and unambiguously on the record, so that further speakers—I am talking about the upper house as well—can make their contributions in the context of this fairly fundamental fact: access to abortion is a woman's right, and women's rights are human rights. I am going to spell out in some detail by reference to the medical view, the views of non-government organisations, the United Nations and international law jurisprudence exactly why safe, lawful access to abortion is a basic human right. I will start with an editorial from *The Lancet*.

Everyone here knows, but for those who do not, *The Lancet* is a weekly peer-reviewed general medical journal. It is one of the oldest of its kind. It is the world's highest impact academic journal and was founded over 200 years ago in the United Kingdom. If someone wants an authoritative statement of the medical position, I do not think they could go to a better editorial than the editorial in *The Lancet*. I refer to its editorial from April 2022. In quite an uncomplicated fashion, the headline for the editorial is "Access to safe abortion is a fundamental human right". It states —

> Abortion is a common medical or surgical intervention used to terminate pregnancy. Although a controversial and widely debated topic, approximately 73 million induced abortions occur worldwide each year, with 29% of all pregnancies and over 60% of unintended pregnancies ending in abortion. Abortions are considered safe if they are carried out using a method recommended by WHO, appropriate to the gestational age, and by someone with the necessary skills. Medical and surgical abortions can be safely managed by a trained health worker at a health-care facility. Medical abortions can also be safely self-managed outside of a health-care facility during the first 12 weeks of pregnancy. Global estimates suggest that approximately 45% of abortions are unsafe, defined as a procedure for termination delivered by persons without the necessary skills or in an environment not in conformity with minimal medical standards, or both. Wide disparities in the prevalence of unsafe abortions exist between high-income (12•5%) and low-income and middle-income (49•5%) countries or by the level of restriction of abortion laws. Unsafe abortions account for 4•7–13•2% of maternal deaths each year, with many more individuals experiencing other physical health complications, such as infection, haemorrhage, or uterine perforation, or psychological consequences, such as depression, anxiety, and eating disorders.

The editorial in *The Lancet* quite clearly and unambiguously states that access to safe abortion is a fundamental human right. It explains the consequences of denied or prevented access to safe abortion. I want to get some more facts on the record.

I now turn to a document entitled "Key Facts on Abortion" produced by Amnesty International. A lot of members have already spoken about this, but a lot of these materials were produced in the context of the United States Supreme Court overturning the decision of Roe v Wade, which generated a great deal of international discussion and debate about the issue. The document states —

> **People have abortions all the time, regardless of what the law says**
>
> Ending a pregnancy is a common decision that millions of people make…
>
> And regardless of whether abortion is legal or not, people still require and regularly access abortion services. According to the Guttmacher Institute, a US-based reproductive health non-profit, the abortion rate is 37 per 1,000 people in countries that prohibit abortion altogether or allow it only in instances to save a woman's life, and 34 per 1,000 people in countries that broadly allow for abortion…

That difference of 37 in countries that do not allow for it and 34 in countries that do is not statistically significant. It continues —

> **Criminalising abortion does not stop abortions, it just makes abortion less safe**
>
> Preventing women and girls from accessing an abortion does not mean they stop needing one. That's why attempts to ban or restrict abortions do nothing to reduce the number of abortions, it only forces people to seek out unsafe abortions.
>
> Unsafe abortions are defined by the World Health Organisation (WHO) as "a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."

The really tragic part is that it estimates that 25 million unsafe abortions take place each year, the vast majority of them in developing countries. It continues to state that "Almost every death and injury from unsafe abortion is preventable". That was from Amnesty International.

Next, I want to move to information from Human Rights Watch, which asked the first rhetorical question that I am trying to address in my contribution: is abortion a human rights issue? It states —

> Access to safe, legal abortion is a matter of human rights. Authoritative interpretations of international human rights law establish that denying women, girls, and other pregnant people access to abortion is a form of discrimination and jeopardizes a range of human rights. United Nations human rights treaty bodies regularly call for governments to decriminalize abortion in all cases and to ensure access to safe, legal abortion in certain circumstances at a minimum.

There are a number of human rights consequences to restricting access to abortion. It continues —

> Countries have obligations to respect, protect, and fulfill human rights, including those concerning sexual and reproductive health and autonomy. Where safe and legal abortion services are unreasonably restricted or not fully available, many other internationally protected human rights may be at risk, including rights to nondiscrimination and equality; to life, health, and information; to freedom from torture and cruel, inhuman and degrading treatment; to privacy and bodily autonomy and integrity; to decide the number and spacing of children; to liberty; to enjoy the benefits of scientific progress; and to freedom of conscience and religion.
>
> These rights are set out the Universal Declaration of Human Rights, and protected in many international treaties…

I will come back to some of those specific treaties a little later. The article continues —

> **Is the right to life at risk when access to abortion is restricted or banned?**
>
> Yes. Legal restrictions on abortion often result in more illegal abortions, which may also be unsafe and may drive higher maternal mortality and morbidity. As a result, lack of access to safe and legal abortion puts the lives of pregnant people at risk.
>
> According to the World Health Organization (WHO), complications from pregnancy and childbirth are the leading cause of death for girls and young women ages 15 to 19, and children ages 10 to 14 have a higher risk of health complications and death from pregnancy than adults. WHO has also found that the removal of restrictions on abortion results in the reduction of maternal mortality.

I now move on to what the United Nations has said. I have talked about the medical position of *The Lancet* and those of a couple of non-governmental organisations, Human Rights Watch and Amnesty International. I will briefly talk about what the United Nations says on abortion, referring to its information series on sexual and reproductive health and rights. This is its position paper from 2020 and it is published by the United Nations Human Rights Office of the High Commissioner. It states —

> **Human rights bodies have provided clear guidance on the need to decriminalize abortion. Ensuring access to these services in accordance with human rights standards is part of State obligations to eliminate discrimination against women and to ensure women's right to health as well as other fundamental human rights.**
>
> The majority of countries in the world provide for certain instances when abortion is legal. A handful of countries have enacted complete bans on abortion. In other States, abortion is highly restricted, but there generally exists an exception for the procedure in order to save a woman's life
>
> …
>
> **Treaty body jurisprudence has indicated that denying women access to abortion can amount to violations of the rights to health, privacy and, in certain cases, the right to be free from cruel, inhumane and degrading treatment. The Human Rights Committee has confirmed that "although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant."**

I pause to re-emphasise the point that "although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant."

Before I turn to some of the jurisprudence, I will talk about the Committee on the Elimination of Discrimination against Women and its observations. It states —

> "Criminal regulation of abortion serves no known deterrent value. When faced with restricted access women often engage in clandestine abortions including self-administering abortifacients, at risk to their life and health. Additionally, criminalisation has a stigmatising impact on women, and deprives women of their privacy, self-determination and autonomy of decision, offending women's equal status, constituting discrimination."

I want to unpack each of those elements and the particular rights of health, privacy and freedom from cruel, inhumane and degrading treatment. I will refer to some of the case law that has been decided through international humanitarian tribunals.

[Member's time extended.]

Mr S.A. MILLMAN: Some of the material in these cases is quite confronting and concerns tragic circumstances. I will refer to three cases—two from Peru and one from Ireland, which were brought before a couple of United Nations bodies. The first case that I will refer to was brought before the Committee on the Elimination of Discrimination against Women or CEDAW. This decision was made in its fiftieth session, from 3 to 21 October 2011. I will give the authority to Hansard so it has the full authority; it is "Communication no. 22/2009" submitted by "TPF." represented by the Centre for Reproductive Rights and the Centre for the Promotion and Protection of Sexual and Reproductive Rights. The alleged victim was "LC" and the state party was Peru.

By way of background, with international humanitarian law cases, the plaintiff, or the applicant, known as the author, brings a matter before the tribunal that is established under the treaty; therefore, the treaty establishes the Committee for the Elimination of Discrimination against Women. That body has the authority to hear the dispute between the complainant, the person who is called the author, and the state's party. The allegation is that the state is a party to the treaty and therefore has international law obligations to ensure that the articles of the treaty are not being breached. Customarily, if a domestic remedy is sought, people go through local courts and, if that is unsuccessful in delivering a result, access is available to the international court system or the treaty-based tribunal decision-making process.

I give members the facts of "LC" v Peru —

> L.C. lives in the Ventanilla District, Callao Province. In 2006, when she was 13 years old, she began to be sexually abused by J.C.R., a man about 34 years old. As a result, she became pregnant and, in a state of depression, attempted suicide on 31 March 2007 by jumping from a building. She was taken to Daniel Alcides Carrion public hospital, where she was diagnosed with "vertebromedullar cervical trauma, cervical luxation

> and complete medullar section", with "a risk of permanent disability" and "risk of deterioration of cutaneous integrity resulting from physical immobility".
>
> The damage to the spinal column, in addition to other medical problems, caused paraplegia of the lower and upper limbs requiring emergency surgery. The head of the Neurosurgery Department recommended surgery in order to prevent the injuries she suffered from worsening and leaving her disabled. As a result, the intervention was scheduled for 12 April 2007.
>
> On 4 April the hospital performed a psychological evaluation of L.C., in the course of which she revealed that the sexual abuse she had suffered and her fear of being pregnant were the causes of her suicide attempt. The following day a gynaecological examination was performed, confirming the pregnancy. The daily status reports on the health of L.C. from 2 to 12 April 2007 recorded the risk both of developing infections and of failing to avoid deterioration of her skin owing to the condition of total paralysis and deterioration of her physical mobility.
>
> On the scheduled day of the surgery, the author —

That is the complainant, the woman's mum —

> was informed that it had been postponed and that the doctor wished to meet with her the following day … At that meeting, the author was informed that the surgery had been postponed because of L.C.'s pregnancy. The author also notes that L.C. was diagnosed with moderate anxiety-depression syndrome, for which she was given no treatment as it was contraindicated during pregnancy.
>
> On 18 April 2007, the author, after consulting with her daughter, requested the hospital officials to carry out a legal termination of the pregnancy in accordance with article 119 of the [Peruvian] Penal Code. In her request the author referred to the conversation she had on 13 April 2007 with the Head of the Neurosurgical Department in which he informed her that he could not operate L.C. due to her pregnancy. [The mother] alleged that the pregnancy seriously and permanently endangered the life, physical and psychological health and personal integrity of L.C. and the spinal surgery could not be performed if the pregnancy continued.

Under these incredibly traumatic circumstances, this 13-year-old girl, who is pregnant as a result of sexual abuse by a 34-year-old man, is in hospital with significant spinal injuries and is in desperate need of surgery, and the medical officials responsible for her care in Peru said that they are not prepared to undertake the surgery because of the risk it would pose to the unborn fetus. This constellation of circumstances in the complainant's submission constituted violation of articles 1, 2, 3, 5, 12 and 16 of the Convention on the Elimination of All Forms of Discrimination against Women.

I will not go through the state's response. At one point, it said that she had an inflammation on her spine, which was the cause of their decision to postpone the surgery, but that observation was made only after they had already postponed the surgery. It was not pertinent to what was going on.

The committee turned to the consideration of the merits; it reads —

> The Committee recalls that L.C. became pregnant at the age of 13 years as a result of repeated sexual abuse and thereafter attempted suicide … the Committee also notes the author's assertion that the operation was initially scheduled for 12 April 2007.

The committee found, at paragraph 8,15, as follows —

> In view of the foregoing, the Committee considers that owing to her condition as a pregnant woman, L.C. did not have access to an effective and accessible procedure allowing her to establish her entitlement to the medical services that her physical and mental condition required … The Committee therefore considers that the facts as described constitute a violation of the rights of L.C. under … the Convention.

It was clearly established that denying access to a medically indicated termination was a breach of this woman's fundamental human rights, particularly her rights to not be discriminated against on the basis of being a woman.

The next example is also from Peru and was submitted by a number of organisations representing Karen Noelia Llantoy Huaman. The UN report reads —

> The author became pregnant in March 2001, when she was aged 17. On 27 June 2001, she was given a scan at the Archbishop Loayza National Hospital in Lima, part of the Ministry of Health. The scan showed that she was carrying an anencephalic foetus.

The author was referred to Dr Ygor Perez Solf, a gynaecologist and obstetrician in the Archbishop Loayza National Hospital in Lima. The report further reads —

> [He] informed the author of the foetal abnormality and the risks to her life if the pregnancy continued. Dr. Perez said that she had two options: to continue the pregnancy or to terminate it. He advised termination

> by means of uterine curettage. The author decided to terminate the pregnancy, and the necessary clinical studies were carried out.

Unhelpfully, Dr Maximiliano Cardenas Diaz, the hospital director, replied that the termination could not be carried out, because to do so would be unlawful as the patient, the author, was not at risk of serious mental or physical defects. The trouble was that the patient had already been assessed as follows —

> A social worker and member of the Peruvian association of social workers, carried out an assessment of the case and concluded that medical intervention to terminate the pregnancy was advisable "since its continuation would only prolong the distress and emotional instability of Karen and her family".

The observation was made —

> The so-called principle of the welfare of the unborn child has caused serious harm to the mother since she has unnecessarily been made to carry to term a pregnancy whose fatal outcome was known in advance, and this has substantially contributed to triggering the symptoms of depression, with its severe impact on the development of an adolescent and the patient's future mental health.
>
> On 13 January 2002, three weeks late with respect to the anticipated date of birth, the author gave birth to an anencephalic baby girl, who survived for four days, during which the mother had to breastfeed her. Following her daughter's death, the author fell into a state of deep depression.

They were tragic circumstances, but there were various allegations of numerous breaches of human rights—namely, articles 2, 3 and 6 of a different covenant. The first reference was to the Convention on the Elimination of All Forms of Discrimination against Women. This case related to an alleged breach of the International Covenant on Civil and Political Rights. The source of these authorities is not based in one document, but is across a few.

To sum up, the refusal to act in accordance with the author's decision to terminate her pregnancy was not justified and amounted to a violation of the covenant. The first case from Peru was a breach of the treaty for the Convention on the Elimination of All Forms of Discrimination against Women. The second case, also from Peru, was a breach of the International Covenant on Civil and Political Rights.

The third and final case I will refer to is also a breach of the International Covenant on Civil and Political Rights concerning an Irish woman. I started my contribution by talking about the importance of reflecting community values, and, unfortunately, the circumstances of this case predate the referendum in Ireland designed to determine whether abortion should be accessible and legal. It was overwhelmingly supported by the people of Ireland, reflecting contemporary community attitudes. Unfortunately, that political remedy was not available to the complainant in this case—a woman by the name of Amanda Jane Mellet. I will finish with this case, because I think its circumstances more closely align with our experience in Australia. The author lives in Dublin with her husband. Again, I will use the term "author" interchangeably with "plaintiff" or "complainant" to mean the person who brought the case before the tribunal. According to "The facts as submitted by the author" —

> She became pregnant in 2011. On 11 and 14 November 2011, in the twenty-first week of her pregnancy, she received scans at the Rotunda public hospital in Dublin. She was informed that her fetus had congenital heart defects, but that even if the impairment proved fatal she could not have a termination of her pregnancy in Ireland. The doctor at the hospital stated: "terminations are not available in this jurisdiction. Some people in your situation may choose to travel". The doctor did not explain what "travel" involved, but only that it had to be overseas. She did not recommend a suitable abortion provider in the United Kingdom of Great Britain and Northern Ireland.
>
> 2.2 On 17 November 2011, after further examination at the same hospital … the fetus had trisomy 18 and would die in utero or shortly after birth.

Again, these are phenomenally tragic circumstances. The facts continue —

> The midwife indicated to her that she could carry to term knowing that the fetus would most likely die inside her, or she could "travel''. The midwife did not explain what "travelling'' would entail and did not give her any further information … since health providers in Ireland are not permitted to make appointments for pregnancy terminations overseas for their patients … The author indicates that her main reason for seeking an abortion was to spare her child suffering.

This claim was brought under articles 7, 17 and 19. Article 17 relates to the state interfering arbitrarily with the complainant's ability to make decisions, so personal autonomy, and article 19 refers to her right to freedom of information, including access to information about her health choices, but article 7 was the interesting one. In the section titled "Claims under article 7", the case states —

> The application of the abortion law of Ireland subjected the author to cruel, inhuman and degrading treatment and encroached on her dignity and physical and mental integrity by: (a) denying her the reproductive health

> care and bereavement support she needed; (b) forcing her to continue carrying a dying fetus; (c) compelling her to terminate her pregnancy abroad; and (d) subjecting her to intense stigma.

Other speakers have already touched on stigma, so I do not need to traverse that. Paragraph 3.15 of the complaint states —

> Laws criminalizing abortion violate the rights to non-discrimination and equal enjoyment of other rights on the grounds of sex and gender.

To cut a long story short, I quote from paragraph 7.8 —

> The Committee considers that the balance that the State party has chosen to strike between protection of the fetus and the rights of the woman in the present case cannot be justified … The Committee notes that the author's much-wanted pregnancy was not viable, that the options open to her were inevitably a source of intense suffering and that her travel abroad to terminate her pregnancy had significant negative consequences for her … that could have been avoided if she had been allowed to terminate her pregnancy in Ireland, resulting in harm contrary to article 7. On that basis, the Committee considers that the interference in the author's decision as to how best cope with her non-viable pregnancy was unreasonable and arbitrary in violation of article 17 of the Covenant.

Once again, we have a decision from an international tribunal asserting in quite clear and unambiguous terms that women's rights are human rights, and access to medically indicated safe, accessible abortions should be enshrined and protected to reduce discrimination and stigma.

I have run out of time. I just wanted to put this debate fairly and squarely in that context so that there is no ambiguity or misunderstanding, and everybody can appreciate that the discharge of our international law obligations will be facilitated by this progressive legislation that speaks clearly to the community considerations and sentiment today. I commend the minister for the bill and I commend the bill to the house.

MR T.J. HEALY (Southern River — Parliamentary Secretary) [6.33 pm]: I am very proud to contribute to the debate on the Abortion Legislation Reform Bill 2023. I speak as a father, a citizen, a Christian and a community representative, and I support and will vote in favour of this bill. I will not speak for very long—enough men have spoken in this chamber about women's bodies and women's rights—but I want to commend the government and the minister for bringing this bill to the house. I will speak about some of our predecessors in this house and their work over many years to decriminalise this health service.

I am very proud that this bill will modernise abortion laws in Western Australia. It will streamline the process for women and remove unnecessary clinical barriers for women in my electorate and around the state. It will provide a more compassionate approach to late-term abortion, providing more time for women to make what is often a very difficult decision for them and their families. Again, I commend the minister and the group that brought the consultation together, but this bill has been shaped by the community, largely women, and by the medical practitioners who will have to operate under this framework.

The bill will place health care access and patient experience at the centre of health reforms and health policy. It will contemporise Western Australia's framework, as I said, remove unnecessary clinical barriers to care, streamline the care pathways and align Western Australia with other jurisdictions. I note that at one point Western Australia was the leader in this space. This bill will bring us into line with the way forward that was forged in this Parliament.

Western Australia's laws pertaining to abortion were passed 25 years ago, and they remain unchanged. Many members will be aware that in 1998, two doctors were charged under the Criminal Code for conducting a termination. In response, Cheryl Davenport, then Labor member, introduced a private member's bill and brought about the process that has led to us being here today. The bill sought to repeal sections of the Criminal Code in regard to procuring an abortion service. As I have said, in the 25 years since, other jurisdictions in Australia have caught up to Western Australia and developed more compassionate access.

Members of my community, members of the public and health practitioners have provided their clear feedback that our abortion laws are restrictive in a national context and prohibitive to the provision of the best healthcare services in the Western Australian community. I stand here as the member for Southern River, and I represent many members of my community. I acknowledge Judyth Watson, Yvonne Henderson, and many who have represented the area that I now represent who have paved the way. I make the comment that it is very disappointing to see what is happening in the United States with the laws pertaining to abortion. I am very proud to stand in this chamber as a Parliamentarian to vote in favour of this bill.

I know that access to abortion is not only about legal barriers. I think that the community consultation process has led to a very valid and rich document that shows that families on lower incomes are disproportionately affected due to restricted access to a number of providers and the ability to travel. I concur with the sections of the bill that

directly address the barriers to abortion, including time frames for patients to access abortion. I concur with the amendments to be made to the Freedom of Information Act to protect the privacy of individuals and health practitioners who access and provide abortion services, which will ensure that the care and wellbeing of the patient is placed first and foremost.

I concur with the clauses of the bill that address the 20-week limitation as manifestly restrictive. Key stakeholders gave us feedback, and I support the move to 23 weeks. I concur with the clauses of the bill that will allow nurses and midwives to potentially prescribe the applicable medication. Unfortunately, there are always a number of scare campaigns and different information provided. I support that protections will remain for those medical practitioners who choose not to participate. I also think it is important that once a doctor has disclosed that they are unable to assist, they will have a responsibility to ensure that the patient is transferred to the care of a person who can provide that health service. I will read some quotes from Cheryl Davenport and Judyth Watson later. I loved being in the chamber for the minister's second reading speech, and I concur with her statement that these reforms "complete the decriminalisation of abortion in Western Australia".

In a previous Parliament, though not passed until this term, safe access zones were established. For those who are not aware, safe access zones were introduced because some people chose to make the poor decision of harassing women and families outside abortion clinics. Laws implementing safe access zones have passed. I voted in favour of them at the time and continue to support them, but I think it is important to outline the context. I am a Christian. I am not saying that every Christian supports this health service but some people said they wanted to be kerbside counsellors, a term I do not like. They interpreted their faith to mean they needed to harass and intimidate, handing out blessing bags, rosary beads and pamphlets. I guess it is part of our corporate memory that those things took place and they are no longer legal.

Some people pretend to have love and compassion, but do not. They spread fear and hate and try to pretend that they are doing so as Christians. The member for Bassendean spoke about a former member of this chamber who plays a leading role in the anti-abortion debate. Unfortunately, people will continue to pose in a certain way. They put anti-abortion flyers and very inappropriate material in letterboxes. Such a flyer was put in my letterbox a few years ago, even though, while standing near the letterbox, I said I did not want it. Some people are aggressive and they do not need to be.

I acknowledge that some members of my community do not like abortion services, and that is fine. No-one will be forced to pursue that health service if they do not want to pursue it. To those who choose to be active on this, I think their time can be better spent. They can be compassionate about life, they can read to children and they can play a role by volunteering and supporting those living in poverty or those people in the community who have literacy issues. They do not need to play active roles and cause pain.

This Parliament and this chamber has a history of a number of men presenting petitions and making hateful speeches that have not added or contributed to the discussion on abortion. I have a copy of a petition presented by one of my predecessors, Barry MacKinnon, a former member for Jandakot. He presented petitions about stopping abortion on demand. I acknowledge that many people are watching these proceedings at home in our community. So many people have made poor choices. Labor is not immune from this; I acknowledge that not everyone has the best record on this subject. Overwhelmingly, members of the Liberal Party have sought to weaponise this issue, and that has not been in the interests of all members of our community.

There is a test of leadership coming. Hon Nick Goiran can make contributions on debates. He can play a role in these sorts of things. I have no problem with that. I will be voting in favour of the legislation in this chamber, and hopefully it will progress to the upper house. We have had similar debates in the upper house. When we were trying to legislate to allow two men to become dads, I remember the filibustering and the pain caused when that and a number of issues were raised. When those inappropriate things happen, I wonder what the Leader of the Opposition, the Liberal Party and the Nationals WA will be doing. I hope that they will make good decisions that we will all be proud of.

I often quote what I think is a Hillary Clinton quote. Forgive me, Hansard, if it is not the correct one. Some time ago it was said that abortion is safe, legal and rare. I would prefer it if no-one had to make a decision about abortion, but I will always fight to ensure that it is legal and safe. Everyone's life and situation is different. It is important that that process is legal so people can make that choice. A woman is the best person to make that decision about her body.

Before we returned from the recess, Judyth Watson, a former member for my area, passed away. She was a great advocate of this and many other issues. In my closing comments, I would like to read from her book *We Hold Up Half The Sky: The Voices of Western Australian ALP Women in Parliament*. I would like to quote a section of

this book—part of the first speech of the former upper house member Cheryl Davenport to this chamber in 1989. She said —

> … I want to speak about a matter which is of great concern to the women and men of Western Australia … the question of abortion law reform. It is a subject about which I personally and many other Western Australian men and women feel very strongly ... I realise that some of my parliamentary colleagues on both sides of the House may have a different view on abortion from mine. I respect their right to have their personal views on the subject …
>
> I remind members of the position taken on this issue by one of my Labor Party predecessors in this House —

The upper house —

> 35 years ago … Hon Ruby Hutchison, who was the first woman ever elected to the Legislative Council, advocated "the decriminalisation of indictable childbirth cases". I imagine that if Ruby … were alive today she would be devastated to learn that reform of these laws has still to be achieved.

Ruby, I hope that, in the passing of this bill, we make you proud. Cheryl continued —

> History and experience have shown that worldwide women with unwanted pregnancies will seek abortion in one way or another. If abortion is not provided safely and routinely by recognised health services, it will be sought illegally and clandestinely, with drastic consequences for women's health and women's lives. Wealthy women have always been able to obtain relatively safe abortions, regardless of the state of the law. It is those less well off who have suffered at the hands of the incompetent …

At the beginning of this book, Judyth Watson said that at that time, the 1990s, out of the 499 people who had been members of the Assembly, only 16 of them were women. I acknowledge that for the very first time in its history, this chamber will be made up of more than 50 per cent women.

I would like to close by quoting more of Cheryl Davenport's remarks from her first speech. She said —

> I believe that we have no alternative but to decriminalise abortion, placing this medical procedure in the health sector where it quite obviously and legitimately belongs.
>
> … I draw to the Council's attention the words of former Federal Labor MP, Dr Moss Cass. During his summing up of the abortion debate … 1977 … he said:
>
>> To change the law does not force one single woman to have an abortion. The present law stops any woman from freely exerting her rights. Gentlemen, if we had babies there would be no laws against abortion.

Debate adjourned, on motion by **Ms C.M. Rowe**.

House adjourned at 6.49 pm