IN THE HIGH COURT OF AUSTRALIA
MELBOURNE REGISTRY

No M46 of 2018

BETWEEN:

KATHLEEN CLUBB
Appellant

and

ALYCE EDWARDS
First Respondent

ATTORNEY-GENERAL FOR VICTORIA
Second Respondent

REPLY OF THE ATTORNEY-GENERAL FOR VICTORIA

Filed on behalf of the Second Respondent

Dated: 22 June 2018

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PART I: CERTIFICATION

1. These submissions are in a form suitable for publication on the internet.

PART II: ARGUMENT

2. The Appellant's Submissions (**AS**) ignore or downplay the demonstrable harms caused to people seeking to access premises at which abortions are provided by the conduct regulated by the communication prohibition. The Parliamentary record and the evidence before this Court make those harms abundantly clear and provide a compelling justification for the law.

3. The appellant says that the burden imposed on political communication is "intense, direct and discriminatory" (AS [64]). That characterisation should be rejected. But even if it were to be accepted, the justification for the law is sufficiently compelling and the law sufficiently tailored to its end to require the conclusion that it is valid.

4. These submissions deal first with two fundamental flaws in the appellant's submissions:

   (1) the appellant's assertion that the communication prohibition is directed to political speech; and

   (2) the appellant's characterisation of the purpose of the law as being to deter communications that are apt to cause "mere discomfort".

   The submissions then deal with suitability, necessity and alleged uncertainty.

5. The Attorney-General also adopts the reply submissions of the first respondent.

A. THE QUESTION OF BURDEN

6. The appellant asserts that a communication about the ethics of abortion is "inevitably political in its practical effect" (AS [34]), with the result that a communication directed to dissuading a woman from having an abortion is necessarily political speech.

7. Contrary to the appellant's submissions, the Attorney does not posit a rigid distinction between ethical and political communications about abortion. In some circumstances, a communication about the ethics of abortion may constitute political speech that falls within the implied freedom. But there is no necessary connection between a communication directed to dissuading a woman seeking an abortion from terminating her pregnancy and political communication in the relevant sense, bearing in mind the purpose of the implied freedom. It is far removed from the exercise of a free and informed choice as an elector, to which the freedom is directed.[1] A communication that is **only** concerned with a personal choice a woman should make does not touch upon "government or political matters".[2]

8. A further aspect of the appellant's submissions is that anti-abortion communication is "most effective" if it occurs near an abortion clinic. The appellant asserts that "it is reasonable to believe that a not insignificant proportion" of protesters near abortion clinics believe this to

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1 *Lange v Australian Broadcasting Corporation (1997) 189 CLR 520 at 560 (the Court).*

2 *See Lange (1997) 189 CLR 520 at 571 (the Court).*

be the "best way to influence public opinion" (AS [40]); that communications that are proximate to abortion clinics will receive publicity from television and other media (AS [36]); and that "major stakeholders" are present at the site who can "influence public debate" (AS [37]). There is no evidence to support these assertions.[3] In any event, the legislation does not prevent anti-abortion protesters from protesting near abortion clinics. What the legislation does is create a safe access zone for persons seeking to access the clinic. The conveying of an effective political message does not require the protestors to be **within** the safe access zone. Finally, even if the appellant's submission is accepted, a burden on the "most effective" communication will be justified where, as here, the purpose is a compelling one directed to public safety and wellbeing.[4]

9. Nor are safe access zones as extensive as the appellant submits. While the premises that define a safe access zone will include premises where medical abortions are provided, they will not include a private residence solely on the basis that a woman has taken (or will take) abortifacient drugs there. For example if a woman takes abortifacient drugs at home,[5] her home is not "premises where abortions are provided", both because there is no "provider" and because the use of the plural connotes the regular provision of abortions.

10. The appellant also submits that the burden is discriminatory (AS [42]-[43], [64]). This ignores the fact the communication prohibition applies to communications in relation to abortions regardless of viewpoint, and is concerned with the likely impact of the communications, rather than the viewpoint expressed. The appellant asserts that "persons who communicate in relation to abortions outside abortion clinics are characteristically persons who oppose abortions" (AS [41]-[42]). That assertion is contradicted by the evidence of protests by pro-choice groups occurring outside the East Melbourne clinic.[6] In any event, even if it were correct to characterise the burden as discriminatory by reason of its practical impact, the burden has a compelling justification, for the reasons advanced in the Attorney's principal submissions (VS [48]-[63]).

B. IDENTIFICATION OF THE LAW'S PURPOSE

11. The appellant incorrectly identifies the law's purpose as "deterring communications which are apt to cause mere discomfort" (AS [72]). She seeks to avoid the clear statement of purpose in s 185A by asserting the objects therein are "stated at a high level of generality"

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3 Cf *Brown v Tasmania* (2017) 91 ALJR 1089, where the special case expressly stated that on-site protests (and media coverage associated with them) had been a catalyst for the granting of environmental protection: see at 1102-1103 (Kiefel CJ, Bell and Keane JJ), 1133 [240] (Nettle J).

4 See *Levy v Victoria* (1997) 189 CLR 579 at 608-609 (Dawson J), 614-615 (Toohey and Gummow JJ), 647-648 (Kirby J). See also Victorian Attorney-General's submissions (**VS**) at [50].

5 As to medical abortions, see: https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-medication; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "The use of mifepristone for the termination of pregnancy" (2016) (accessed at https://www.ranzcog.edu.au/Statements-Guidelines); https://www.betterhealth.vic.gov.au/health/HealthyLiving/abortion-services-in-victoria *(Annexures A, B & C to this Reply, each accessed on 21 June 2018).*

6 *Allanson Affidavit, Exhibits SA6 [**AB 77**] at AB 78, SA7 [**AB 85**] at AB 86, SA8 [**AB 94**] at AB 118, AB 120.*

and "diverge ... from the narrower scope of s 185D in its present operation" (AS [67]). This confuses the statutory purpose with the means adopted by Parliament to give effect to that purpose. Further, as the plurality observed in *Monis*, "[i]n the context of offence provisions, the question of purpose is rarely answered by reference only to the words of the provision, which commonly provide the elements of the offence and no more". The context and historical background may be relevant. And, for many crimes, the social objective may be "self-evident" and thus "readily inferred" from its terms.[7] So it is here. The purpose is set out in s 185A, and the communication prohibition is a way of giving effect to that purpose. The context and historical background are consistent with the expressed purpose. There is nothing to suggest that the law was enacted for some ulterior purpose.

C. APPELLANT'S FOCUS ON "MERE DISCOMFORT"

12. The appellant's focus on a purpose of deterring communications that are apt to cause "mere discomfort" is also inconsistent with the express words of the communication prohibition. The appellant ignores the words used in paragraph (b) of the definition of "prohibited behaviour": what is prohibited are communications that are reasonably likely to cause "**distress or anxiety**". The statute does not refer to "discomfort". The appellant has fixed upon the notion of "discomfort" because of the Magistrate's approach to the meaning of the word "distress" and its application to the appellant's conduct in this particular case. Contrary to the appellant's submissions (AS [17]), the Magistrate said she was satisfied the "engagement between the Accused and the couple entering the Clinic was reasonably likely to cause the couple, **at the least**, discomfort".[8] Further, it was the appellant's counsel who provided the Magistrate with the synonyms for distress identified in the reasons.[9] The appellant's submission was that the impact must be "something more than fleeting".[10]

13. While the meaning of "distress" and "anxiety" is not relevant to the identification of the law's purpose (because the purpose is found in s 185A), it is relevant to assessing whether the communication prohibition is broader than necessary to achieve its purpose. The Attorney accepts that a prohibition on communications that are "reasonably likely to cause distress or anxiety" captures a potentially broad range of communications (VS [56]-[58]). "Anxiety" and "distress" cover harms of varying severity. Discomfort is, in some contexts, an appropriate synonym for distress (at the lower end of the harm sought to be prevented).

14. The breadth of the communication prohibition is necessary to achieve the law's purpose because that purpose is not confined to the physical safety of persons accessing abortion clinics. It is concerned, more broadly, with their "wellbeing", "privacy" and "dignity".

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7 *Monis v The Queen* (2013) 249 CLR 92 at 205 [317] (Crennan, Kiefel and Bell JJ).

8 **AB 295** (emphasis added).

9 T 205-209, in particular T 207.19-209.19 (Annexure D to this Reply). Notwithstanding the Magistrate's reference to the *Australian Concise Oxford Dictionary* [**AB 295**], the dictionary definition does not refer to discomfort. It appears from the transcript that the synonyms were taken from the Appellant's written submissions that were handed up to the Magistrate (Annexure E to this Reply).

10 T 209.10-11, 214.28-31.

That is particularly so where those accessing clinics are, as the appellant correctly accepts, "especially vulnerable" (AS [38]). Moreover, even if one focuses solely on "safety", a restriction on communications reasonably likely to cause distress or anxiety is necessary to achieve that purpose in light of the adverse medical effects from women being deterred from or delayed in accessing abortion services because of such communications (VS [41]).

15. In substituting "mere discomfort" for the statutory language, the appellant seeks to downplay the character of the conduct of anti-abortion protesters and the often serious consequences of that conduct for women and staff attending abortion clinics (VS [14]-[25]). Parliament was concerned to prevent people from suffering harm created by an environment of conflict, fear and intimidation outside abortion clinics; intrusion into a private medical decision; and (in part) the shame and stigma associated with abortion (VS [17]-[25]). That type of harm extends far beyond mere discomfort. The appellant entirely fails to grapple with these matters, which are central to understanding the law's purpose and its justification.

D. PROPORTIONALITY — SUITABILITY

16. The appellant claims there is a lack of connection between the purpose of the prohibition and its effect (AS [79]). This ignores the evidence, which establishes a clear link between communications causing anxiety and distress and a risk to safety, wellbeing, dignity and privacy. Further, the purpose of the prohibition is to **prevent** harm; not to punish a person once harm has been suffered. It is thus appropriate to target conduct that has the potential to cause harm, even if it does not do so in a particular instance (cf AS [80]).

17. Nor is s 185D properly described either "overinclusive" or "underinclusive" (AS [81], [94]). As to the former, the evidence demonstrates that communications that cause anxiety and distress to persons accessing clinics **do** interfere with their safety, wellbeing, privacy and dignity. As to the latter, s 185D proscribes conduct that is demonstrated to have caused significant problems at abortion clinics for many years (VS [14]-[25]). It is not to the point that there could be other conduct capable of causing anxiety and distress that is not regulated by s 185D where, as here, there is no evidence that such other conduct caused problems.

E. PROPORTIONALITY — NECESSITY

18. Contrary to the appellant's contention (AS [83]), it is not possible to remove the communication prohibition or reduce its scope and still retain the effectiveness of the law. Proscribing only the conduct in paragraph (a) would have been inadequate (cf AS [85], [87]). To achieve the law's purpose it is necessary to protect women and staff from conduct that is harmful, although falling short of intimidation or harassment. The evidence shows that passive, "non-violent", polite or silent protest can cause anxiety and distress.[11] Moreover, the Minister's statement that proscribing only the conduct in paragraph (a) would

[11] *Allanson Affidavit at [47]-[48] and Exhibit SA16 (report by Hayes and Lowe, "A Hard Enough Decision to Make: Anti-Abortion Activism Outside Clinics in the Eyes of Clinic Users" (2015) at 27-28* [**AB 199-200**]).

not be sufficient should be given significant weight (cf AS [86]). The Minister explained the reasons for her view, which were cogent and supported by evidence.[12]

19. Finally, the appellant's proffered "less burdensome" alternatives (AS [88]) would each reduce the effectiveness of the law, by reducing its scope so as to exclude communications that may cause serious harm and/or by making the prohibition more difficult to enforce.

F. THE LAW IS NOT UNCLEAR OR VAGUE

20. There is no "void for vagueness" doctrine in Australia.[13] To the extent there is uncertainty or ambiguity in statutory language, "courts must wrestle ... with difficult language. They are required to find its meaning, not permitted to abandon the task".[14] Any ambiguity arising prior to judicial elucidation does not, in this case, bear upon the question of validity.

21. In any event, the communication prohibition is not unclear (cf AS [44]). The issues raised by the appellant (eg, that it is difficult to predict whether conduct is apt to cause distress or anxiety, or that the concept of "premises at which abortions are provided" is unclear) can and will be resolved through the ordinary process of statutory construction and application of the legislation (so construed) to the conduct at issue in any given case.

22. Finally, the "chilling effect" said to flow from the vagueness of the law is overstated (AS [45], [91]). The offence is not one of strict or absolute liability. Thus the prosecution will be required to prove that the alleged offender knew that his or her communication would be able to be heard by persons accessing premises where abortions are provided. Further, it will be necessary for the prosecution to prove that the alleged offender knew she or he was in a safe access zone. It is thus not possible to inadvertently commit the offence.

Dated: 22 June 2018

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12 In relation to evidence, see generally the Allanson Affidavit. There is no breach of parliamentary privilege in relying on the Parliamentary record for this purpose (cf AS [86]).

13 *Brown* (2017) 91 ALJR 1089 at 1117-1118 [148] (Kiefel CJ, Bell and Keane JJ), 1173-1174 [447]-[453] (Gordon J), 1180 [486] (Edelman J); see also at 1121 [168] (Gageler J).

14 *R v Holmes; Ex parte Altona Petrochemical Co Ltd* (1972) 126 CLR 529 at 562.

Annexures
to the
First Respondent's
Reply

Annexure A

BetterHealth Channel

Abortion procedures - medication

Summary

- Medication abortion offers a safe, reliable and non-surgical means of abortion.
- Medication abortion involves the medications mifepristone and misoprostol.
- Mifepristone (previously known as RU486) is taken by mouth. It ends a pregnancy by blocking the action of the hormone (progesterone) that supports the pregnancy.
- Misoprostol is also taken by mouth. It causes the cervix to soften and the uterus to contract to expel the pregnancy.
- Medication abortion is an alternative to surgical abortion for women for whom it is medically suitable, and who have made an informed decision about the best option for them.

Medication abortion offers an alternative to **surgical abortion** for women in the early weeks of pregnancy. Medication abortion uses a combination of two medications, mifepristone and misoprostol, to end a pregnancy up to nine weeks. Mifepristone was previously known as RU486 and is sometimes called the 'abortion pill'.

Medication abortion is a low-risk, non-invasive way to terminate (end) a pregnancy. It is around 99 per cent effective at ending a pregnancy. Around two to five per cent of women who have a medication abortion will need some follow up treatment to complete the abortion.

An increasing number of GPs in Victoria provide medication abortions. The **telehealth option** involves a consultation with a doctor by phone, and tests that are organised locally.

Visit our page **Abortion services in Victoria** for more information about where to find an abortion provider.

Medication abortion procedure

Medication abortion involves using the medications mifepristone and misoprostol instead of surgery to end a pregnancy. It can be done as soon as a pregnancy can be seen in an ultrasound. In Australia, a medication abortion is performed up to nine weeks of pregnancy.

A pregnancy needs high levels of the hormone progesterone to continue. Mifepristone works by blocking the action of progesterone to cause the pregnancy to stop progressing. Misoprostol causes the cervix to soften and the uterus to contract to allow the pregnancy to be expelled from the uterus.

The process and number of appointments for having a medication abortion varies depending on the type of clinic setting you attend, and whether certain tests you need (such as ultrasound and blood tests) are available on site or require separate appointments. A number of clinics are able to offer necessary tests and medication abortion in a single initial appointment.

The process of having a medication abortion generally involves the following steps:

- You will have a medical consultation with a doctor and often a nurse as well, which involves a clinical assessment of medical and other relevant information, and arrangements for you to have an ultrasound and blood tests.
- You will be given information about the **methods of abortion** to help you to make an informed decision about the best method for you.
- If you decide to have a medication abortion, you will be asked to sign a consent form and will be given all the relevant information about what to expect, the steps you will need to take, and about pre- and post-abortion care.
- You will discuss what sort of pain relief, and any other appropriate medication you may require, and how to

obtain it, in preparation for the abortion.

- If you have an intrauterine device, it will need to be removed before you take the first medication (mifepristone).
- You will take a tablet of mifepristone either at the clinic or at home and obtain the other appropriate medications.
- You will take a tablet of misoprostol 24 to 48 hours later. This softens the cervix and helps the uterus push out the pregnancy. This stage nearly always occurs at home. (If you need to travel after taking misopristol and before the abortion is complete, it is recommended that you have a responsible adult who can drive you.)
- The abortion is usually completed some hours later, although it may take longer. You will usually need a day or two of rest or reduced activity.
- You will be encouraged to have telephone contact with the clinic you attended or another source of expert support in case you have any questions or concerns at any time during and after the procedure.

What to expect during and after a medication abortion

After taking the second medication abortion tablet at home, you may experience the following:

- nausea, vomiting, diarrhoea, dizziness, headache and fever
- pain – usually within half an hour and generally much stronger than period pain
- bleeding one to four hours later – heavier than a period and there may be large clots
- after two to six hours the bleeding usually settles to the level of your normal period
- bleeding is usually similar to a normal period for another three to seven days
- unpredictable, irregular or prolonged bleeding can last for up to four weeks after a medication abortion.

Note: The timing of the pain and bleeding is unpredictable. It occasionally starts before taking the second medication, but may take up to 24 hours to start.

Follow-up after a medication abortion

It is important to have a follow-up appointment to make sure the procedure is complete and the pregnancy has ended. Many doctors order a blood test to check that the pregnancy hormone level has dropped. You will be given an appointment for review in two weeks' time.

Medication abortion does not work in around one percent of cases. Around two to five per cent of women will have some pregnancy tissue remaining in the uterus (womb) and will need further treatment such as additional tablets or a small surgical procedure to complete the abortion. Your doctor will discuss this with you.

Self-care at home after a medication abortion

The doctor or nurse will advise you on taking care of yourself in the days following the abortion. This can include using over-the-counter anti-inflammatory medication to help manage the cramps (your doctor can prescribe stronger medication if needed). Hot packs and massaging the painful area can be helpful.

To reduce the risk of infection during the week after having the procedure, it is recommended that you do not:

- insert anything into your vagina, including tampons (do not use tampons until your next period)
- have vaginal sex
- perform any strenuous activity, including sport or heavy physical work, until the bleeding stops
- go swimming or have a bath (you can shower).

Your doctor will have informed you about the risks and symptoms of possible complications and what to do if they occur, such as where to obtain assistance at any time.

Advantages and disadvantages of medication abortion

Advantages of medication abortion include:

- For around 95 to 98 per cent of pregnancies up to nine weeks, no further treatment is needed after taking the two doses of abortion medication.

- Unlike surgical abortion, medication abortion does not need to take place in a hospital or day surgery unit as it does not require a surgeon, anaesthetist or other medical staff to be present during the later stage of the procedure. This makes it a suitable alternative for those living in remote areas provided they have access to emergency care.
- It is a less clinical and non-surgical procedure, which some women may prefer.
- Some women feel it is a more natural process.
- It happens in a home environment.

Disadvantages of medication abortion include:

- Medication abortions are generally more time consuming than surgical abortions, and there may be more doctor visits and tests.
- In a small percentage of cases the medication needs to be repeated, and sometimes a surgical procedure is needed.
- Pain and bleeding generally last longer than following a surgical abortion.
- It is difficult to predict the time it will take for a medication abortion to complete – it may take longer than the expected four to eight hours, after taking the second medication.
- A separate appointment is needed if you would like an IUD inserted.
- Mifepristone is not suitable for some women.

Mifepristone may not be recommended for you if you:

- have certain medical conditions such as bleeding problems, adrenal failure or high blood pressure
- are taking long-term steroid or blood-thinning medication
- have had allergic reactions to medication containing mifepristone.

Side effects and complications of medication abortion

Your doctor will inform you about the risks and symptoms of possible complications and what to do if they occur.

Typical side effects of medication abortion

Typical and frequently occurring side effects of medication abortion include:

- pain from uterine cramping
- unpredictable, irregular or prolonged bleeding.

Contact your doctor if any of these side effects are worrying you or you need medical advice.

Complications of medication abortion

Serious complications of medication abortion are uncommon. They may include:

- haemorrhage (very heavy bleeding) – haemorrhage requiring a blood transfusion occurs in fewer than one in 1,000 women. If you are filling more than two large pads an hour for more than two hours, passing clots the size of a small lemon or feel you are bleeding heavily and feel weak or faint, seek immediate medical attention
- retained products – pieces of tissue may remain in the womb and cause ongoing bleeding. You might need repeat tablets or a small surgical procedure to remove them
- continued pregnancy – in around one per cent of women medication abortion does not work and the woman remains pregnant. The tablets can be repeated if the pregnancy is no more than nine weeks, otherwise a surgical abortion may be required
- infection (needing antibiotic treatment) – this happens to one per cent of women who have a medication abortion. Infection may cause symptoms such as pain, abnormal vaginal discharge or fever. Sometimes the symptoms aren't obvious and can include more general symptoms including tiredness, diarrhoea and vomiting.

If you had an ectopic pregnancy (pregnancy outside the uterus, usually in the fallopian tubes) that was not diagnosed before you took the abortion medication, you will require emergency treatment. This happens to one in 7,000 women who have a medication abortion.

If you are concerned about symptoms, seek medical assistance by contacting the clinic where the medication abortion took place, a GP, your nearest hospital emergency department or by calling 000 for an ambulance.

Other possible complications of medication abortion

If you have signs you are still pregnant after a week or you are not bleeding at all 24 hours after taking misoprostal, seek medical assistance straight away.

If the abortion does not occur and you remain pregnant, it is recommended that you do not continue the pregnancy as in some cases the medications you have taken may cause malformation of the developing fetus.

How will I feel emotionally after a medication abortion?

After having an abortion, most women feel relief, and that they made the decision that was right for them at the time – particularly if they had support, and were able to make a free and informed decision.

If the decision was difficult for you, you may feel sadness or have other negative feelings, especially in the short term.

If you feel you need emotional support, speak to your abortion provider or GP.

Where to get help

- In an emergency, call 000 for an ambulance or go to your nearest hospital emergency department
- 1800myoptions – information on a range of private and public clinics and services which can offer medication abortion Tel. 1800 696 784
- Your GP or gynaecologist
- Your medication abortion service provider
- Women's health clinic
- Family Planning Victoria – comprehensive sexual and reproductive health services for people of all ages Tel. 1800 013 952 or (03) 9257 0100
- Family Planning Victoria Action Centre – comprehensive sexual and reproductive health services for people of all ages, with an afternoon drop-in clinic for people under 25 years of age Tel. (03) 9660 4700 or 1800 013 952

This page has been produced in consultation with and approved by:

Family Planning Victoria

Annexure B

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

The use of mifepristone for medical termination of pregnancy

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

First endorsed by RANZCOG: November 2007
Current: July 2013, Amended February 2016
Review due: March 2019

Objectives: To provide advice on the use of mifepristone for medical termination of pregnancy.

Target audience: All health professionals providing gynaecological care, and patients.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women's Health Committee in November 2007 and reviewed in July 2013 and February 2016.

Funding: The development and review of this statement was funded by RANZCOG.

Table of contents

1. Summary of recommendations

Recommendation 1	Grade
Mifepristone, (a synthetic anti progesterone) in combination with misoprostol (a prostaglandin analogue) is the best available regimen for medical termination of pregnancy. Alternative regimens are reported but are generally less effective and take longer to work.	Consensus-based recommendation
Recommendation 2	**Grade**
Termination of pregnancy by any method should be conducted in accordance with the legal and regulatory requirements of the jurisdiction within which it occurs. Clinicians should be familiar with local requirements, which in some jurisdictions determine where the relevant drugs may be administered and by whom, and may preclude home administration of misoprostol.	Consensus-based recommendations
Recommendation 3	**Grade**
Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care (in a service accepting this responsibility) from administration of mifepristone until termination of pregnancy is complete.	Consensus-based recommendations
Recommendation 4	**Grade**
For gestations above 63 days (9+0 weeks) both mifepristone and prostaglandin should be administered within the treating facility, where it is expected that the conceptus will be passed.	Consensus-based recommendations

2. Introduction

Medical, rather than surgical, termination of pregnancy is an alternative method which may be offered to women when it is available and suitable for them. Mifepristone (a synthetic anti progesterone) in combination with misoprostol (a prostaglandin analogue) is the best available regimen for medical termination of pregnancy. Alternative regimens are reported but are generally less effective and take longer to work.

For around 95% of women up to 9 weeks gestation, mifepristone with a suitable misoprostol regimen results in complete expulsion of the products of conception within a few hours of the administration of the misoprostol, but up to around 5% of women will need surgical evacuation of the uterus for heavy or prolonged bleeding or for continuing pregnancy. Complication rates are comparable to surgical termination of pregnancy. There is also good evidence for effective regimens for medical termination of pregnancy beyond 9 weeks and in the second trimester of pregnancy. Mifepristone dose is well established, but optimal misoprostol regimens continue to be researched and the evidence is likely to continue to evolve regarding dosage, frequency and route of administration at different gestations.

3. Discussion

3.1 Access to mifepristone

Until quite recently surgical abortion was the only method available in Australia. Greater access to medical abortion was possible when mifepristone was registered in Australia in 2012. Initially this medication was approved for use in sequential combination with the prostaglandin analogue, misoprostol, for pregnancies up to 49 days gestation. From February 2015, a composite pack has been available containing both mifepristone and misoprostol with a new indication of termination of pregnancy up to 63 days gestation.

This regimen comprises mifepristone 200mg followed by misoprostol 800micograms taken buccally within 36-48 hours. The oral route is no longer an approved route of administration because it has been shown to be less effective at gestations above 49 days. Mifepristone single pack will continue to be available for the termination of pregnancy for medical reasons beyond the first trimester, which is primarily a hospital based specialist use.

The Therapeutic Goods Administration (TGA) requires that both practitioners and pharmacies are registered with the sponsoring company, before mifepristone is supplied. Holders of FRANZCOG or Advanced DRANZCOG will need to provide evidence of this qualification or complete the online training, offered by the sponsoring company in order to register.

In New Zealand, Mifepristone was approved by the New Zealand Medicine and Medical Device Safety Authority (MEDSAFE) on 30 August 2001. Current approved indications are:

1. As a medical alternative to surgical termination of intra-uterine pregnancy.
2. Softening and dilatation of the cervix uteri prior to surgical pregnancy termination.
3. Preparation for the action of prostaglandin analogues in the termination of pregnancy for medical reasons.
4. Labour induction for the expulsion of a dead fetus (fetal death in utero).

In New Zealand the drug is not available through pharmacies but on a restricted basis to institutions licensed to carry out termination of pregnancy. It is not available for use as a post-coital contraceptive. Within these limitations and subject to legal and regulatory constraints specific to pregnancy termination mifepristone may be prescribed by any medical practitioner.

Any use outside the indications listed above for each country is "off label".

Mifepristone was first registered in France and China in 1988, the United Kingdom in 1991 and has been registered in much of Western Europe and the United States of America for one to two decades. There is an extensive body of literature to support its use.

3.2 Mifepristone use in Medical Termination of Pregnancy

Termination of pregnancy by any method should be conducted in accordance with the legal and regulatory requirements of the jurisdiction within which it occurs. Clinicians should be familiar with local requirements, which in some jurisdictions determine where the relevant drugs may be administered and by whom, and may preclude home administration of misoprostol.

Clinicians should be familiar with the TGA approved product information (Australia) or MedSafe data sheet (New Zealand).

3.3 Staff and facilities for early medication abortion (up to 63 days or 9+0 weeks)

- The prescribing practitioner must supervise and take responsibility for arrangements for the entire process of termination of pregnancy from administration of mifepristone through to confirmation of termination of pregnancy and completion of follow-up including implementation of a contraceptive plan.

- These arrangements must include 24 hour access to specific telephone advice and support and to provision of surgical uterine evacuation or other interventions required for the management of complications, for example through on call arrangements or in an emergency department resourced to respond to women's health needs (such as required for miscarriage care).

- Elements of clinical care may be delivered by another suitably qualified and experienced clinician or service; where more than one service or facility is involved there must be clearly understood pathways and mechanisms for sharing of relevant clinical information and for the provision of care which may be necessary, possibly with shared protocols.

- There is abundant evidence to support the option of misoprostol being self-administered at home by women at less than 63 days gestation who prefer this; the woman must be advised to have an accompanying support person present at least until the conceptus is passed, who should be able to assist in contacting and accessing support and/or emergency care if needed.

- Prescribing practitioners should have appropriate training plus adequate experience in caring for women undergoing termination of pregnancy and/or experiencing spontaneous miscarriage.

- Credentialing arrangements should be established by each service for practitioners who prescribe mifepristone for medication abortion.

- Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care (in a service accepting this responsibility) from administration of mifepristone until termination of pregnancy is complete.

3.4 Staff and facilities for medication abortion (after 63 days or 9+0 weeks)

For gestations above 63 days (9+0 weeks) both mifepristone and prostaglandin should be administered within the treating facility, where it is expected that the conceptus will be passed.

Credentialing arrangements and access to follow-up and emergency care should apply as for earlier medication abortion; in general more specific staff experience and expertise will be needed.

Late termination of pregnancy must take place in a hospital with access to all necessary clinical and psychological support.

3.5 General considerations prior to pregnancy termination

- All women should be given accurate information and appropriate counselling should be available.

- Clinical assessment should be undertaken including medical history and examination.

- Clinicians should consider any contraindications to mifepristone or misoprostol, any co morbidities, surgical risk factors and the woman's preference in choosing a method of abortion.

- Accurate gestational assessment is essential to selecting optimal treatment options and regimens. Ultrasound examination is mandatory prior to termination of pregnancy to confirm gestation and exclude ectopic pregnancy; a diagnosis of ectopic pregnancy can be very difficult after attempted medical or surgical abortion.

- Consideration should be given to screening for STIs and/or antibiotic prophylaxis in accordance with published guidelines and considering local prevalences.
- Blood group and Rhesus status should be assessed if not known and anti-D given to non-sensitised Rh negative women within 72 hours of the termination in accordance with current local guidelines.
- Products of conception should be treated in accordance with local and legislative protocols.
- A plan for future contraception should be made prior to undertaking termination of pregnancy and arrangements made to implement this.

3.6 Clinical protocols

- Protocols should be consistent with established clinical evidence, such as those published in the RCOG Evidence-based Clinical Guidelines and in accordance with institutional guidelines.
- There should be written clinical protocols including dosage, administration, timing and follow up care, including diagnosis and management of failed attempted abortion; the latter should include the option of a repeat course of treatment. Protocols should have distinct provisions for early termination of pregnancy (intra-uterine pregnancy of less than 63 days gestation), late first trimester termination of pregnancy and second trimester termination of pregnancy.
- There should be written information for women about treatment and follow up.
- Written consent should be obtained prior to the commencement of treatment.
- In New Zealand mifepristone must be administered by a health professional in a licensed premise.
- When a woman is discharged from the treatment facility, whether before or after completion of the termination of pregnancy, she should be given clear written instructions as to how to access advice on a 24 hour basis and help in an emergency, as well as information about what to expect and follow-up arrangements. She should be accompanied by a support person who has been adequately informed about what to expect, until the termination process is complete.
- Follow-up should be undertaken to ensure the termination is complete. Local protocols should be developed which include clinical assessment and if indicated HCG estimations and/or ultrasound examination. Follow-up should also confirm ongoing access to and use of effective contraception.

4. Other suggested reading

Therapeutic Goods Administration 2012: Media Release: Registration of Mifepristone Linepharma (RU 486) and GyMiso (misoprostol), 30 August.
Available at: https://www.tga.gov.au/behind-news/registration-mifepristone-linepharma-ru-486-and-gymiso-misoprostol

Therapeutic Goods Administration (TGA) Product Information – MS-2 Step. Version 24 December 2014. Available at https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2014-PI-01965-1

Therapeutic Goods Administration (TGA) Product Information. Mifepristone Linepharma 200 mg Tablet. Version 12-05-2015. Available at
https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2012-PI-02513-1

Australian Public Assessment Report for mifepristone/misoprostol.
Available at https://www.tga.gov.au/auspar/auspar-mifepristone-misoprostol

Swannel C. Medical abortion access extended. MJA. 27th Jan 2015
Available at: https://www.mja.com.au/insight/2015/2/medical-abortion-access-extended

New Zealand Medicines and Medical Devices Safety Authority (MEDSAFE) Data Sheet – MIFEGYNE Mifepristone micronised 200 mg tablets. June 2012.
Available at: http://www.medsafe.govt.nz/profs/datasheet/m/Mifegynetab.pdf

MS Health website
http://www.mshealth.com.au/

Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. RCOG Press November 2011. Available at:
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/

Shand C, Irvine H, Iyengar V. Guidelines for the use of mifepristone medical abortion in New Zealand: Abortion Supervisory Committee; 2004.

For more detail relevant to clinical treatment regimens, clinicians are referred to the RCOG guideline, the references it reviews, relevant Cochrane reviews and other peer-reviewed publications in this evolving literature.

Reports of Australian and New Zealand experience

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

de Costa CM, Russell DB, de Costa NR, Carrette M, McNamee HM. Early medical abortion in Cairns, Queensland: July 2006 - April 2007. The Medical Journal Of Australia 2007; 187 (3): 171-3.

de Costa CM, Russell DB, de Costa NR, Carrette M, McNamee HM. Introducing early medical abortion in Australia: there is a need to update abortion laws. Sexual Health 2007; 4 (4): 223-6.

Dickinson JE, Brownell P, McGinnis K, Nathan EA. Mifepristone and second trimester pregnancy termination for fetal abnormality in Western Australia: Worth the effort. The Australian & New Zealand Journal Of Obstetrics & Gynaecology 2010; 50 (1): 60-4.

Goodyear-Smith F, Knowles A. Choosing medical or surgical terminations of pregnancy in the first trimester: what is the difference? The Australian & New Zealand Journal Of Obstetrics & Gynaecology 2009; 49 (2): 211-5.

Goodyear-Smith F, Knowles A, Masters J. First trimester medical termination of pregnancy: an alternative for New Zealand women. The Australian & New Zealand Journal Of Obstetrics & Gynaecology 2006; 46 (3), pp. 193-8.

Mamers PM, Lavelle AL, Evans AJ, Bell SM, Rusden JR, Healy DL. Women's satisfaction with medical abortion with RU486. The Medical Journal Of Australia 1997; 167 (6): 316-7.

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

Petersen K. Abortion laws and medical developments: a medico-legal anomaly in Queensland. Journal Of Law And Medicine 2011; 18 (3): 594-600.

Petersen KA. Early medical abortion: legal and medical developments in Australia. The Medical Journal Of Australia 2010; 193 (1): 26-9.

Rose SB, Shand C, Simmons A. Mifepristone- and misoprostol-induced mid-trimester termination of pregnancy: a review of 272 cases. The Australian & New Zealand Journal Of Obstetrics & Gynaecology 2006; 46 (6): 479-85.

Shand C, Rose SB, Simmons A, Sparrow MJ. Introduction of early medical abortion in New Zealand: an audit of the first 67 cases. The Australian & New Zealand Journal Of Obstetrics & Gynaecology 2005; 45 (4): 316-20.

Sparrow M. Introducing Mifepristone into New Zealand. O&G 2004; 6 (2): 141-144.

5. Links to other College statements

Emergency contraception (C-Gyn 11)
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Emergency-contraception-(C-Gyn-11)-Review-July-2016.pdf?ext=.pdf

Termination of Pregnancy (C-Gyn 17)
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Termination-of-pregnancy-(C-Gyn-17)-Review-July-2016.pdf?ext=.pdf

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)
https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf

6. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:
https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Associate Professor Stephen Robson	Chair and Board Member
Dr James Harvey	Deputy Chair and Councillor
Associate Professor Anusch Yazdani	Member and Councillor
Associate Professor Ian Pettigrew	Member and Councillor
Dr Ian Page	Member and Councillor
Professor Yee Leung	Member of EAC Committee
Professor Sue Walker	General Member
Dr Lisa Hui	General Member
Dr Joseph Sgroi	General Member
Dr Marilyn Clarke	General Member
Dr Donald Clark	General Member
Associate Professor Janet Vaughan	General Member
Dr Benjamin Bopp	General Member
Associate Professor Kirsten Black	General Member
Dr Jacqueline Boyle	Chair of the ATSIWHC
Dr Martin Byrne	GPOAC representative
Ms Catherine Whitby	Community representative
Ms Sherryn Elworthy	Midwifery representative
Dr Nicola Quirk	Trainee representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in November 2007 and was most recently reviewed in July 2013. In September 2015 the statement was amended.
The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the July 2013 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members

were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

Annexure C

BetterHealth Channel

Abortion services in Victoria

Summary

- Abortion is a safe and legal medical procedure in Victoria.
- Abortion can legally be accessed up to the 24th week of pregnancy (and in certain circumstances beyond this). However, contacting services earlier will minimise procedure costs and maximise your options.
- Most abortion service providers in Victoria are located in Melbourne. Some provide 'same day' services for women from country areas.
- Abortion services are available in some regional areas. Your GP or **1800 My Options** (Tel. 1800 696 784) can provide you with details of these services.
- When there are fees, costs vary among clinics. Discounts are sometimes available for concession card holders. Fees may be reimbursed by private health insurance providers.
- While some doctors may object to abortion, they are required by law to refer you to a pro-choice doctor if you wish to discuss abortion. If you feel your doctor has not done this you can make a complaint via the **Health Complaints Commissioner** or **Australian Health Practitioner Regulation Agency (AHPRA)**
- Please note this information is intended as a guide only. Always contact providers directly for specific information relating to your own circumstances.

Abortion is a safe and legal medical procedure in Victoria. Abortion services are located in both Melbourne and regional Victoria, although the majority of Victorian service providers are in Melbourne. The costs, procedures and time required can vary from service to service.

Depending on how long you have been pregnant, and service availability, you may have the option of either a medication or surgical abortion. For more information about each procedure, and to work out which one is right for you, please visit the following Better Health Channel factsheets:

- **Abortion procedures – medication**
- **Abortion procedures – surgical.**

The gestation of your pregnancy, or 'how many weeks pregnant you are', is counted from the first day of your last period. Medication abortion can be provided between five and nine weeks of pregnancy. Most providers will perform a surgical abortion up to 12 weeks after the last normal period. Some providers will perform abortions later in pregnancy.

Abortion can legally be accessed up to the 24th week of pregnancy (and in certain circumstances beyond this). However, contacting services earlier can minimise procedure costs and maximise options.

1800 My Options is Victoria's Sexual and Reproductive Health information phone line. It is a woman-centred service, established to provide information on contraception, pregnancy options and sexual health. This includes providing:

- a non-clinical and non-judgemental service
- information on relevant clinical services
- information on support and counselling services, based on each woman's needs.

If you need information about how to confirm a pregnancy, or assistance with decision-making or support you can:

- visit your GP
- call **1800 My Options** (Tel. 1800 696 784)
- visit a pharmacy
- contact **Family Planning Victoria** (Tel. 1800 013 952).

- contact **Pregnancy Birth and Baby Helpline** (Tel. 1800 882 436)

Please note this information is intended as a guide only. Always contact providers directly for specific information relating to your own circumstances.

Choosing an abortion service in Victoria

There are a number of issues to consider when you choose an abortion service, including:

- cost
- privacy and safe access zones
- process
- what contraceptive services they offer
- what support services they offer after the abortion.

Costs of abortion services in Victoria

Costs vary among clinics and depend on:

- whether the service charges fees or not
- the gestation of your pregnancy (how many weeks pregnant you are)
- what sort of abortion procedure you will be having
- whether you have a Medicare card
- whether you have a Health Care Card
- whether you have private health insurance, and what your insurance covers
- whether you attend a public hospital, a community health service, a private clinic or a GP.

The process of having an abortion

The process of having an abortion depends on how many weeks pregnant you are, whether you have a **surgical** or **medication** procedure and the service provider. Your abortion provider will give you more detailed information on what you can expect.

Depending on which type of procedure you choose, some services may require two visits, others will require one.

Abortion and contraceptive services

Speaking with a health professional about abortion can also be a good opportunity to discuss contraceptive options. Some services may be able to provide **long-acting reversible contraception** such as an **IUD (intrauterine device)**, or a **contraceptive implant or injection**, at the time of the abortion or at your follow-up appointment.

Support services after an abortion

How you feel after an abortion will depend on your reasons for having one and how comfortable you were about your decision. The majority of women feel relieved and that they made the right decision for them at the time.

If you find that you need additional support, please let your abortion provider know, as providers will either offer follow-up support or refer you to an appropriate support service. You can also access this information via **1800myoptions.org.au** or by phoning 1800 My Options (1800 696 784).

Privacy and safe access zones

In May 2016, the *Victorian Public Health and Wellbeing Act 2008* was amended to provide for the establishment of legally protected safe access zones within a radius of 150 metres around abortion providers. This is to ensure that women and staff who are entering or leaving premises providing abortions can do so safely and privately, without harassment or obstruction.

Abortion services in Victoria

Surgical abortion services tend to be concentrated in metropolitan Melbourne. There are some surgical services available in regional areas. Medication abortion is also available through some health clinics and regional GPs.

Some Melbourne service providers cater for women coming from regional Victoria and offer a 'same-day service'.

To find abortion services, discuss your options with 1800 My Options phone line, your GP, or your local community health or women's health organisation. There are some rural and regional abortion providers that are not listed below.

Telemedicine abortion services

Telemedicine uses telecommunication technologies to exchange health information and provide healthcare services. Healthcare providers that offer medication abortion services via telemedicine include:

Name	Phone	Telemedicine Services	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service
Marie Stopes Australia	1300 323 197	Marie Stopes Australia offers telehealth services in some circumstances. Call for eligibility information Phone for information regarding fees	Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	5–9 weeks	Medication abortion	Contact for information and appointments
Tabbot Foundation	1800 180 880	Services provided via telephone Australia-wide except NT and SA Rural and remote areas included	$250 with Medicare Card, $600 with no Medicare card	5–9 weeks	Medical abortion	Phone at any time

Inner Melbourne metropolitan abortion services

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service
Royal Women's Hospital, Abortion and Contraception Clinic	(03) 8345 2000	Cnr Grattan St and Flemington Rd, Parkville	Public patient: no cost	6 to 18 weeks	Surgical abortion Medication abortion	Monday to Friday	Yes
Fertility Control Clinic	(03) 9419 2922	116–118 Wellington Pde, East Melbourne, VIC, 3002	Please phone for information regarding fees Prices vary for concession and Medicare card holders, and private health card holders	Up to 16 weeks	Usually surgical abortion Medication abortions are also available.	Monday to Saturday	Yes, some same day services are available Please contact service to discuss

Marie Stopes Australia, East Melbourne	1300 405 568	Suite 4, Level 1, 182 Victoria Pde, East Melbourne, VIC, 3002	Phone for information regarding fees Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Medical abortion for early pregnancies between 5 and 9 weeks	Medication abortion	Usually Mondays – one initial appointment with a follow up two to three weeks later	Yes, in most circumstances Please contact service Dr Marie East Melbourne
Marie Stopes Australia, St. Kilda	1300 405 568	338 Dandenong Rd, East St Kilda, VIC, 3183	Phone for information regarding fees Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Surgical abortion up to 14 weeks Medical abortion for early pregnancies between 5 and 9 weeks	Medication abortion	Days of operation vary from week to week Phone for information and appointments	Yes for surgical if an appointment is available Consultation and procedure usually on the same day for surgical

Western Melbourne metropolitan abortion services

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service
Marie Stopes Australia, Wyndham Vale	1300 405 568	510 Ballan Road, Wyndham Vale, VIC, 3024	Phone for information regarding fees Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Up to 16 weeks	Medical abortion	Days of operation vary from week to week Phone for information and appointments	N/A
The Women's Clinic St Albans	(03) 9769 4134	145 Furlong Road (at Western Day Surgery) St Albans, VIC, 3021	Up to 11 weeks – Medicare card without private health insurance: $320 Phone for further information regarding fees Prices vary depending on whether you have a Medicare card, private health insurance and for pregnancies greater than 11 weeks	Up to 15 weeks	Surgical abortion Medical abortion	Days of operation vary from week to week Phone for information and appointments	Yes for surgical procedures

The Women's Clinic Werribee	(03) 9769 4134	242A Hoppers Ln, (at Wyndham Clinic & Day Surgery) Werribee, VIC, 3030	Up to 11 weeks – Medicare card without private health insurance: $320 Phone for further information regarding fees Prices vary depending on whether you have a Medicare card, private health insurance and for pregnancies greater than 11 weeks	Up to 15 weeks	Surgical abortion Medical abortion	Days of operation vary from week to week Phone for information and appointments	Yes for surgical procedures
Cohealth, Footscray	(03) 9448 5502	78 Paisley Street Footscray, VIC, 3011	Please phone for information regarding consultation fees. Bulk billing available for concession and Medicare card holders. fees may apply relating to ultrasound services	Up to 9 weeks	Medication abortion	Will vary depending on GP availability. Please phone for information and appointments	N/A
Cohealth West Footscray	(03) 9448 5501	575a Barkly Street, West Footscray, VIC, 3012	Please phone for information regarding consultation fees. Bulk billing available for concession and Medicare card holders. fees may apply relating to ultrasound services	Up to 9 weeks	Medication abortion	Will vary depending on GP availability. Please phone for information and appointments	N/A
Cohealth Laverton	(03) 9448 5534	95-105 Railway Avenue Laverton,VIC, 3028	Please phone for information regarding consultation fees. Bulk billing available for concession and Medicare card holders. fees may apply relating to ultrasound services	up to 9 weeks	Medication abortion	Will vary depending on GP availability. Please phone for information and appointments	N/A

North Melbourne metropolitan abortion services

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service

Austin Hospital, Family Planning Clinic	03 9496 2533	145 Studley Road, Heidelburg, VIC, 3084	Medicare card: no cost Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Medical: 4-8 weeks. Surgical: limited appointments available up to 18 weeks	Medical abortion (early) Surgical abortion	Please call between 9 am and 4 pm, Monday–Friday to arrange an appointment	Yes
Marie Stopes Australia, Mill Park	1300 405 568	20 Civic Drive, Mill Park, VIC, 3082	Phone for information regarding fees Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Medical abortion for early pregnancies between 5 and 9 weeks	Medical abortion	Days of operation vary from week to week Phone for information and appointments	N/A

Eastern Melbourne metropolitan abortion services

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service
Marie Stopes Australia, Maroondah	1300 405 568	411 Dorset Rd, Croydon, VIC, 3136	Phone for information regarding fees Prices vary for concession and Medicare card holders, and for people who are not covered by Medicare	Surgical abortion up to 24 weeks Medical abortion for early pregnancies between 5 and 9 weeks	Surgical abortion Medical abortion	Days of operation vary from week to week Phone for information and appointments	Depends on type of procedure Early surgical procedures require one appointment only Surgical procedures in later pregnancy require two appointments on up to three consecutive days
Contraceptive and Counselling Clinic – Monash Health	(03) 9594 2457 Fax referrals to (03) 9594 6438	246 Clayton Rd, Clayton, VIC, 3168	Medicare card: no cost Limited places available Phone for further information	Less than 12 weeks on the date of the termination	Surgical abortion	Please call between 2 pm and 3 pm on Fridays for a first appointment where a clinician will be available to discuss any queries	No
Monash Surgical Private Hospital	(03) 9544 9902	252 Clayton Rd, Clayton, VIC, 3168	Medicare card: $350 Not covered by Medicare: $850	Between 6.5–12 weeks	Surgical abortion	Phone for further information and appointments on Monday and Thursday between 10am and 3pm	No

Family Planning Victoria	(03) 9257 0100	901 Whitehorse Road, Box Hill, VIC, 3128	Prices vary for concession and Medicare card holders	Up to 9 weeks	Medical abortion	Phone for information and appointments	N/A

South Eastern Melbourne metropolitan abortion services

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service
Hampton Park Women's Health Care	(03) 9799 2817	4 Warana Dr, Hampton Park, VIC, 3976	Prices change for concession, Medicare and private health card holders Please call for further information	Up to 13 weeks	Surgical abortion Medical abortion	Monday to Saturday	Yes Medical procedures require two appointments around two weeks apart For country women, this service can organise the follow up with your GP or over the phone

Regional abortion services in Victoria

Name	Phone	Address	Fees	Duration of Pregnancy	Type of Procedure Available	Days of Service	Country Women Same Day Service
Gateway Health: Clinic 35	(03) 5723 2000	45-47 Mackay Street, Wangaratta, VIC, 3677	Appointments and investigations are bulk-billed The total cost for medical abortion is the cost of a PBS Script: $38.30 with Medicare Card $6.20 with a concession card	Up to 9 weeks	Medical abortion	Monday to Friday	Women require a minimum of two appointments
Gateway Health: Clinic 35	(02) 6022 8888	155 High Street Wodonga, VIC, 3690	Appointments and investigations are bulk-billed The total cost for medical abortion is the cost of a PBS Script: $38.30 with Medicare Card $6.20 with a concession card	Up to 9 weeks	Medical abortion	Monday to Friday	Women require a minimum of two appointments

Disclaimer: At the time of writing this information was correct. Please confirm details with specific service providers when you first contact them.

Where to get help

- Your GP – in most cases you can start by contacting your doctor. However, as not all doctors will be supportive, you may want to ring your clinic in advance to find a supportive, pro-choice GP. If you need an interpreter, your GP should also be able to provide an interpreter service by phone
- Your local community health centre
- 1800myoptions.org.au, Tel. 1800 696 784
- Family Planning Victoria Tel. (03) 9257 0100 or freecall 1800 013 952
- Pregnancy, Birth and Baby Helpline 1800 882 436
- Women's health service for your region (bottom of page)

This page has been produced in consultation with and approved by:

Women's Health Victoria

Annexure D

MR BROHIER: I adopt those submissions which I put.

HER HONOUR: Of course.

MR BROHIER: Your Honour said you didn't want submissions on the facts. So the only other issue is the reasonably likely to cause distress or anxiety.

HER HONOUR: That's right.

MR BROHIER: I have prepared some brief written submissions on that, and I have a copy for Your Honour.

HER HONOUR: I'm actually going to mark these submissions as an exhibit so that I keep them all neatly. Because as you can see, I am beginning to lose track.

#EXHIBIT 8 - Submissions on the law for the prosecution

#EXHIBIT D2 - Defendant's submissions re case to answer
In this state we don't refer to Ms Clubb as the defendant, we use the term accused.

MR BROHIER: I'm sorry, Your Honour.

HER HONOUR: And I know you have used defendant, it doesn't matter. I have adopted that in my decision, actually, for your benefit.

#EXHIBIT D3 - Defendant's final submissions in relation to the issue of distress or anxiety

MR BROHIER: I've handed a copy to my friend. And there are a couple of dictionary definitions, Your Honour.

HER HONOUR: I'm glad somebody else uses a dictionary.

MR BROHIER: Your Honour, this submission merely addresses the law about reasonably likely to cause distress or anxiety.

HER HONOUR: All right, let me have a look at it. Your definition of communication and mine are different. You say, "There must be a flow or public act which inevitably

results in a flow of information from one to another." That is not the definition that I've got.

MR BROHIER: I'm not fussed.

HER HONOUR: No, I'm fussed. Because you're using the Australian Concise Oxford Dictionary, I'm very particular about my dictionaries. And I am using Oxford Dictionaries as well. So why do I have a different definition? Are you quoting from the dictionary, or are you imparting knowledge from the dictionary?

MR BROHIER: The words, "The act of imparting information," is the quote. And the other is my exposition of the quote.

HER HONOUR: Well, you tell me which is which again. Let's be really clear, and look at paragraph A.

MR BROHIER: "The act of imparting information," is the quote.

HER HONOUR: So where you say, "Inevitably results in a flow of information," that's not from the dictionary.

MR BROHIER: No, that's my submission.

HER HONOUR: Well, why do you refer to the dictionary in that context?

MR BROHIER: Because the dictionary is, "The act of imparting information."

HER HONOUR: It doesn't say that. Come on, it doesn't say that. "There must be a communication. The act of impacting information. Australian Concise Oxford Dictionary. There must be a flow or a public act which inevitably results in a flow of information from one to another."

MR BROHIER: I apologise if I haven't been clear enough.

HER HONOUR: Apology accepted.

MR BROHIER: That was - - -

HER HONOUR: Not a very good form of communication on your

part, because I think that it's ambiguous. But in any event, now that we're clear, that the act of inevitably resulting in a flow of information does not form part of the definition. We're clear about that, aren't we? "All right, let's continue. "The need for the ability of the communication to be seen and heard. And the need for the causing of anxiety or distress, indicates there must be such a flow of information." Where does it say that there is a need for causing anxiety? Let's look at the legislation. Doesn't it use the word "may?" Do you not have a copy of these?

MR BROHIER: The section says, "Reasonably likely to cause distress or anxiety," not "may."

HER HONOUR: "And is reasonably likely to cause distress or anxiety." You refer it as, "The need for causing of anxiety or distress." So you say "need," but the law says, "Reasonably likely to." Is it reasonably likely to cause distress or anxiety?

MR BROHIER: Your Honour will note that the prosecution doesn't give any content to that term, "reasonably likely to cause distress or anxiety." Those terms must mean something, they must mean more than mere window dressing. And so I've given you some synonyms.

HER HONOUR: All right, let's go to those.

MR BROHIER: The synonyms are from a Google search, and the Australian Concise oxford speaks of (indistinct) pain, worry and anguish."

HER HONOUR: All right, so let's look at those. "The submission of the attorney-general adopted by the prosecution make it clear that this element is an important one, and not mere window dressing."

MR BROHIER: That's paragraph 38.

HER HONOUR: "The meaning of the terms are important. Distress, some synonyms, anguish, suffering, pain, agony, ache, affliction, torment, torture, discomfort, heartache, heartbreak, Middle English, from old French, destresce." You could probably say that better that me, couldn't you? How do you say that word? You didn't speak French?

MR BROHIER: Destresce, very poorly.

HER HONOUR: Yes, you do. "Based on Latin, distringere, which is to stretch apart. Severe pain, worry, anguish." Australian Concise, "Concern about being in imminent danger, difficulty." Let's not use the word et cetera when we're talking about definitions, shall we? Let me just look at this.

MR BROHIER: I've given you those definitions, Your Honour.

HER HONOUR: I know you've given them to me, I'm just going to have a look at them. "A feeling of worry, nervousness, or unease about something with an uncertain outcome. Worry, concern, apprehension, consternation, uneasiness, unease, fear, disquiet, disquietude, perturbation, fretfulness, agitation, angst, nervousness." There are degrees, aren't there, of anxiety and distress? And you've described, "Anguish, suffering, pain, agony, torment, torture, heartbreak." But the dictionary is telling me, "Worry, concern, apprehension."

MR BROHIER: That's anxiety.

HER HONOUR: That's anxiety.

MR BROHIER: Distress is a separate word.

HER HONOUR: Yes. You've said anxiety is, "Concern about being in imminent danger."

MR BROHIER: That's one of the definitions which I've handed to you.

HER HONOUR: Yes, but I don't find that here. I find anxiety is a feeling of, "Worry, apprehension." That's a lot lower down on the scale than imminent danger or difficulty.

MR BROHIER: I was giving you what the Australian Concise Oxford said, I've handed you copies of that.

HER HONOUR: Yes, thank you.

MR BROHIER: The short point is paragraph 4, "It must be something more than fleeting."

HER HONOUR: I agree.

MR BROHIER: Because this is one of the parameters has put on. So it must be something that is real, and that is, I might use the word substantial - it's a real parameter on the legislation. And that's a matter Your Honour will have to consider in making your finding. Because of Your Honour's ruling earlier, I won't go into the fact of this issue, unless you want me to.

HER HONOUR: Well, I did say that I was prepared to hear facts relevant to the law. But I didn't want to hear submissions about findings of fact on my part. If there are facts that you wish to refer to in support of your legal premise, then please do.

MR BROHIER: The central fact we ask Your Honour to consider is this. All of the evidence of Dr Allanson was based on an organised protest activity taking place between eight and 10 every day, with a group of people. Are they approaching people or approaching her? And Your Honour will recall, if you look at the cross-examination, I asked her specifically about that, about herself. None

Annexure E

D3 FCB

DEFENDANT'S SUBMISSIONS IN RELATION TO SECTION 185D

INTRODUCTION

1. Clubb repeats and relies on her submissions in relation to the No Case submission in as to the issue of communicating in relation to abortion.

REASONABLY LIKELY TO CAUSE DISTRESS AND ANXIETY

2. The submissions of the Attorney-General adopted by the prosecution[1] make it clear this element is an important one and not mere window dressing.
3. The meaning of the terms are important:
    a. Distress-some synonyms are anguish, suffering, pain, agony, ache, affliction, torment, torture, discomfort, heartache, heartbreak-Middle English: from Old French destreche (noun) destricier (verb) based on Latin distringe 'stretch apart'; Australian Concise Oxford Dictionary -severe pain worry anguish;
    b. Anxiety Australian Concise Oxford Dictionary -concern about being in imminent danger, difficulty etc.
4. These two results must be more than fleeting or they will not be real elements and will be mere window dressing; something which is not open to the prosecution to argue, and which it does not argue.

GENERAL

5. This being a penal statue which takes away (in part) the common law right of freedom of speech, which is also recognised in section 15 of the *Charter of Human Rights and Responsibilities 2006*, both the principle of legality and section 32 of the Charter require the terms of section 185D to be construed strictly (*Hogan v Hinch*[2], the Street Preachers Case[3]).

Dated 9 October 2017

F.C. Brohier

Counsel for the Defendant

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[1] A-G's submissions [38].
[2] (2011) 243 CLR 506 at 535-536;
[3] *Attorney General of South Australia v Corporation of the City of Adelaide* (2013) 249 CLR 1 at 65. French CJ said at [43]:
" Freedom of speech is a long-established common law freedom. It has been linked to the proper functioning of representative democracies and on that basis has informed the application of public interest considerations to claimed restraints upon publication of information. ...The "paramount importance" accorded to freedom of expression and of criticism of public institutions has also played a part in the development of the principles of the law of contempt." The relevant freedom in the ICCPR is the Freedom of Expression (Article 19). Australia ratified the ICCPR on 13 November 1980 http://www.info.dfat.gov.au/Info/Treaties/treaties.nsf/AllDocIDs/8B8C6AF11AFB4971CA256B6E0075FE1E accessed 16 November 2015. In *DPP v Kaba* [2014] VSC 52 at [138] and [181]-[187] Bell J held that the fundamental rights and freedoms of the ICCPR should now be treated as fundamental rights and freedom under the common law for the purposes of the principle of legality.

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