Ms Jenny Ejlak
Convenor
Pro Choice Tasmania
c/- PO Box xxx
NORTH HOBART TAS 7002

26 August 2011

Professor Kate Warner
Tasmanian Law Reform Institute
Faculty of Law, University of Tasmania
Private Bag 89
HOBART TAS 7001

Dear Professor Warner

I write to ask that the Tasmanian Law Reform Institute (TLRI) review Tasmanian law regulating the medical termination of pregnancy, hereafter referred to as 'abortion'.

Whether an abortion can legally take place is currently regulated under the *Criminal Code Act (Tas) 1924* (the Act). Sections 134, 135 and 164 of the Act concern the deliberate termination of a pregnancy (abortion), either criminally (s134, s135) or by 'legally justified' means (s164).

This Act is based on nineteenth century British law at a time when both pregnancy and abortion were far more dangerous to a woman's health than they are today thanks to advances in medical technology and expanded health care systems. It is also worth noting that this nineteenth century law was written at a time when women did not have the right to vote.

These sections of the Act create a range of practical problems for medical practitioners, patients and the whole health sector and are outlined in the attached summary.

The fact that a woman is not legally able to make a decision to terminate her pregnancy (the law requires two medical practitioners to decide what they think is in the patient's best interests), is completely out of step with expectations of medical privacy, best practice medical care, community standards, egalitarian ideas of women as rational competent citizens and as patients entitled to make decisions based on their own circumstances and values. Only women are subject to such medical gatekeeping.

In Australia, laws governing abortion are state and territory based, and most jurisdictions have reformed their original criminal law in some way in the last few decades. The two states which have most recently undergone comprehensive review and reform of their abortion laws have been the Australian Capital Territory in 2002 and Victoria in 2008. Tasmania last amended its Act in 2001 with the addition of s164 after allegations were made to police about illegal abortions in a public hospital.

In 2009/10 a criminal trial took place in Queensland where a young woman was charged with procuring her own abortion and her partner was charged with supplying the means to do so.

If a Tasmanian couple were to take the same action as this couple did in Queensland, similar criminal charges could be brought under the Act as it currently stands. Tasmania risks similar embarrassing exposure on the national and world stage if a scenario like this were to occur.

It is unacceptable that in Tasmania in the 21st century it a woman could be tried as a criminal and sent to jail for terminating her pregnancy.

I note the TLRI objectives include "…the review of laws with a view to –
- the modernisation of the law;
- the elimination of defects in the law;
- the simplification of the law;
- the consolidation of any laws;
- the repeal of laws that are obsolete or unnecessary; and
- uniformity between laws of other States and the Commonwealth."

It is my belief that Tasmanian law in this area is out of date and unnecessary, given the range of legislation, regulations, health professional standards, clinical guidelines and current clinical practice that govern all medical and surgical procedures.

Thus reforming Tasmanian law relating to abortion fits within the TLRI's objectives of; modernising the law, and the repeal of laws that are obsolete or unnecessary.

Prior to law reform in Victoria the Victorian Parliament referred the issue to the Victorian Law Reform Commission (VLRC). The VLRC undertook a comprehensive assessment of the impact of the (then) criminal laws, clinical practice and community standards. It received over 500 submissions, met with over 35 community groups, convened a specialist medical panel and gathered published evidence on all aspects of abortion from national and international sources. Their final publication, *Law of Abortion Final Report* (2008) is an excellent, thoroughly referenced summary of all the issues that could possibly arise in any Australian jurisdiction during a law reform process, and I commend it to you as an invaluable resource. Electronic versions can be downloaded from the VLRC website:
http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/law+reform/home/completed+projects/abortion/lawreform+-+law+of+abortion_+final+report

I look forward to a positive response, and please do not hesitate to contact me if I can provide any further information.

Yours sincerely,

Jenny Ejlak
Convenor, *ProChoiceTasmania*
Secretary, *Reproductive Choice Australia*

Attachment: *Background Paper: Abortion and the Law, Tasmania 2011*

Background Paper
Abortion and the Law, Tasmania 2011.

(*attachment to a submission to the Tasmanian Law Reform Institute seeking review of the Criminal Code Act 1924 as it relates to abortion. Prepared by Jenny Ejlak*)

Rationale - or, why now?

Most Australian jurisdictions have either amended their legislation or rely on judicial precedent for the regulation of abortion. Most law reform in this area has been rapid, reactionary changes as a result of a complaint to police by an anti-abortion activist. This was the case in 2001 in Tasmania where for the first time ever, Parliament was recalled the week before Christmas to debate an amendment to the *Criminal Code Act 1924* (the Act) to prevent state-employed doctors in a public hospital from being charged with criminal offences. This year is the tenth anniversary of that reactionary amendment to the Act in 2001. It is timely that this issue is reviewed.

A proactive approach to law reform is preferable, as Victoria demonstrated in 2007/08. This allows a full consideration of all the issues and a calm, rational debate with sufficient time for all community concerns to be addressed.

The criminal charges and trial of a young couple in Queensland over 2009/10 demonstrated that nineteenth century based criminal laws regulating abortion, despite being significantly outdated, can be and are being used against women, their partners and potentially their doctors in Australia today. This could happen in Tasmania under the current law.

In the Queensland case the young woman openly acknowledged on police video interview that she had taken medication specifically for the purpose of terminating a pregnancy. She did this because she assumed that in 21st century Australia, women have equal rights to healthcare and that one of the world's safest and most common procedures (World Health Organisation, 2003, p14) would surely be legal.

This assumption is indicative of the views of the majority of the Australian community, 80% of whom support a woman's right to access safe, legal abortion services (AuSSA and AES surveys, in Victorian Law Reform Commission 2008 p66).

Background

Tasmania has a colourful and patchy history of access to abortion and I have attached a brief history at the end of this submission, rather than go into detail here. In summary, confusion about the legal status of abortion has had a negative impact on service delivery, stigma, access and equity. The history also describes the impact of a crisis situation when a complaint is made to police about an unlawful abortion.

The sections of the Act in Tasmania are based on sections of the United Kingdom's *Offences Against the Person Act 1861*. The 2001 amendment merely clarified in law what has been a common judicial ruling in both the UK and other jurisdictions of Australia such as Menhennitt in Victoria and Levine in NSW. As described below, this question of risk is outdated due to advances in healthcare between the 19th and 21st centuries.

Current Situation

Currently for an abortion to be legally justified, two medical practitioners, one of whom must specialise in obstetrics or gynaecology, must certify in writing that in their opinion the risks of continuing the pregnancy outweigh the risks of terminating the pregnancy. They are also required to refer the women for counselling.

This 'relative risk' argument stems from original judicial rulings in Britain in the 19th century when both childbirth and abortion carried high risk of injury or death to the woman, particularly so called 'backyard' abortions by unqualified persons. In 21st century Australia this is no longer the case.

The Royal College of Obstetricians and Gynaecologists (UK) stated in 2004 that "Abortion is safer than continuing a pregnancy to term...". In 2008 they also stated that "…the need for two [doctors] signatures is anachronistic."

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) state in their 2005 guidelines that "there is mainly improvement in psychological wellbeing in the short term after termination of pregnancy [and] there are rarely immediate or lasting negative consequences."

In addition to the physical risks and complications associated with pregnancy and childbirth – in Australia, around 15% of women who give birth experience post-natal depression (National Health and Medical Research Council, 2000).

Thus if medical practitioners abiding by the requirements of s164 of the Act were to make recommendations to women based solely on clinical and epidemiological evidence of physical and psychological risk, then they would advise abortion as the least risky option in all cases, thus making the requirement in law redundant.

The law also does not discern between abortion for personal or medical reasons. There are many stereotypes about women who seek abortion but what is often forgotten is that planned, wanted pregnancies can develop into severe foetal abnormality (such that the foetus will not survive outside the uterus) or foetal death in utero. Therapeutic abortion is the medically recommended course of action in these cases yet the law treats a 22wk foetal death in utero in a woman distraught at the loss of her wanted pregnancy in the same way as an abortion of a 6wk embryo in a woman who does not wish to have a child.

Specific abortifacient pharmaceutical drugs were developed in the 1980s and have been used widely across Europe, Asia and other parts of the world since this time. In Australia, due to political deal making, abortifacient drugs such as mifepristone (RU486) were, for many years, not allowed in Australia except with the approval of the federal health minister. This requirement was overturned in 2006 but mifepristone remains limited to those medical specialists who have gained authorised prescriber status under the Therapeutic Goods Administration (TGA). At the time of writing, no pharmaceutical company has received TGA approval to provide the medication to the general medical community, however it is only a matter of time before this happens.

There are clinics in Victoria and elsewhere which offer medical (pharmaceutical) as well as surgical abortion, and there are also medical practitioners in Tasmania who have been prescribing other drugs which have an abortifacient effect, and have done so for many years. It is unclear whether medical abortion is legal under the current provisions of the Act as the Act states that the abortion must

be 'carried out' by a medical practitioner. If a woman were to obtain mifepristone from an interstate clinic and be allowed to bring the drug back to Tasmania to undergo the abortion in her own home with her partner, she would be engaging in a criminal act under s134 of the Act.

General Practitioners

A national survey of General Practitioners in 2004 (Marie Stopes International 2004) found that 29% of Tasmanian GPs (compared with 16% nationally) feel that the law places an unreasonable burden of responsibility on them. A concerning 37% of GPs said they did not fully understand the abortion laws in their state and territory, and furthermore when they were asked specific questions about legality, even those who claimed familiarity with the law provided incorrect responses, suggesting their perceived and actual understanding of the laws are at odds. This suggests that the law is not only misunderstood and burdensome on women but also on medical practitioners. Further research into the medical professions views on the law would be useful.

Even more disturbingly, the same survey found that Tasmania had the highest number of anti-abortion GPs at 30% (compared with 20% national average). This is of no surprise to the interstate abortion providers who fly down each week to provide first trimester abortion services. Anecdotally, they report that many women find it very difficult to find not only two but even one medical practitioner in Tasmania who is prepared to sign a form to comply with the provisions of s164 of the Act. Abortion providers often have to provide both signatures from medical practitioners working in the clinic. This is far from best practice medical care where a patient should be able to have an open and frank discussion with her regular health care provider about her situation and seek unbiased advice prior to attending a procedural clinic. If it were clear in law that there was no criminality attached to abortion then many more doctors would be able to have open discussions with their patients.

In addition to practicing medical practitioners, the law also creates problems for training new health professionals. Due to the perceived grey area of the legality of abortion, modern surgical procedures commonly used for first trimester abortion are not taught in medical training in Tasmania.

Abortion is the only medical or surgical procedure to be singled out in law where patients are not able to make decisions for themselves. Women do not wish to be treated like idiots and doctors do not want to be gatekeepers.

Calls for Law Reform

The Public Health Association of Australia (2005) has consistently stated that "criminal law is an inappropriate vehicle – both in principle and practice – for regulating the provision of abortion."

Rankin (2003) in his Monash University Law Review Paper in talking about Tasmania went so far as to say that "…before the ink is try on the 2001 amendments there should be a campaign for further reform of the law. A campaign focused not upon who may lawfully perform abortions, but rather upon addressing the human rights violations that occur as a result of denying women the right to make their own reproductive choices."

Doctors Lachlan de Crespigny and Julian Savulescu called for clarification of Australia's 'confusing' abortion laws in the Medical Journal of Australia in 2004.

De Crespigny (2005) also suggested that the confusing state and territory laws pose a health hazard for women and a headache for doctors.

Long term abortion law reform campaigner Dr Jo Wainer (2007) published a call for law reform in the journal *Sexual Health* the year before Victoria's law reform and Dr Caroline de Costa (2010) wrote a book on the topic after the criminal trial of two young people in Cairns in 2010. This book is a particularly useful resource which demonstrates in detail the negative impact on doctors, patients and public and private health services of leaving references to abortion in criminal law.

A wide range of commentators and advocates have also called for abortion law reform over many years.

Other Models

The law in each Australian jurisdiction is different. A summary is provided in the 2008 VLRC report pp21-28 and in Caroline de Costa's 2010 book, pp141-149.

It may be instructive to review other jurisdictions' laws and to review the problems or otherwise caused by each different model. I ask that the TLRI take particular note of the ACT and Victorian models with a view to assessing their applicability to Tasmania.

Summary

In summary, sections 134, 135 and 164 of the *Criminal Code Act 1924* are out of date, unnecessary and should be repealed. The current requirements for 'lawful' abortion create a range of problems for health care providers and patients and there is real risk that Tasmanian women could be charged under s134 for procuring an abortion, as was the case in Queensland in 2010. Both the ACT and Victoria have removed all reference to abortion from their criminal law and there have been no negative repercussions as a result. These states provide good models for regulating this health procedure like every other health procedure and should be investigated for their applicability for Tasmania.

References

de Costa, C., 2010, *Never ever again: Why Australian Abortion Law Needs Reform*, 2nd edition Booloarong Press, Australia.
http://www.carolinedecosta.com/nonfiction.html

de Crespigny, L., and Savulescu, J., 2004, *Abortion: time to clarify Australia's confusing laws*, Medical Journal of Australia, 181 (4) pp201-203.
http://www.mja.com.au/public/issues/181_04_160804/dec10242_fm.pdf

de Crespigny, L., 2005, *Australian abortion laws: do they post a 'health hazard'?* RANZCOG Journal *O&G* Vol 7 no 1, Autumn 2005.
http://www.ranzcog.edu.au/index.php/publications/oandg-magazine/cat_view/38-publications/409-oag-magazine/410-oag-magazine-editions/433-past-publications/461--vol-07-no-1-autumn-2005

Marie Stopes International and Quantam Market Research, 2004, *General Practitioners: Attitudes to Abortion*.
http://www.mariestopes.org.au/images/stories/libraryfiles/MSI-GPs-Attitudes-to-Abortion-Research-Nov04.pdf

National Health and Medical Research Council, 2000, *Post Natal Depression: not just the baby blues,* Commonwealth of Australia.
http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/wh30.pdf

Public Health Association of Australia, 2005, *Abortion in Australia: Public Health Perspectives, 3rd edition*.
http://www.phaa.net.au/documents/phaa_abortion_kit.pdf

Rankin, M., 2003, *Monash University Law, Review,* Vol29, No 2.
http://www.austlii.edu.au/au/journals/MonashULawRw/2003/15.pdf

Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2005, *Termination of Pregnancy: a resource for health professionals*.
http://www.ranzcog.edu.au/index.php/publications/womens-health-publications/termination-of-pregnancy-booklet

Royal College of Obstetricians and Gynaecologists, 2004, *The care of women requesting induced abortion*. London; Report No. 7
http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

Royal College of Obstetricians and Gynaecologists, 2008, *Briefing note - Scientific Information on Abortion.*
http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/briefings-and-gas-/human-fertilisation-and-embryology-bill/brie-4

Victorian Law Reform Commission, 2008, *Law of Abortion Final Report*.
http://www.lawreform.vic.gov.au/wps/wcm/connect/justlib/law+reform/home/completed+projects/abortion/lawreform+-+law+of+abortion_+final+report

Wainer, J., 2007 *Abortion and the full humanity of women: nearly there***,** Sexual Health 4(4) 219–221.
http://www.publish.csiro.au/?act=view_file&file_id=SH07063.pdf

World Health Organisation, 2003, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 'Chapter 1 - Safe abortion services: the public health challenge'.
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241590343/en/

ADDENDUM – Submitted to the TLRI 31 October 2011

From an email addressed to Prof Kate Warner of the TLRI

I recently became aware of a United Nations document which was published in August this year which adds weight to the submission I made to the TLRI the same month. I realise it is too late to amend or add to the submission however I wanted to send you this document for your information as it specificially relates to laws governing abortion.

The link is here http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254 I have attached a PDF copy, and copied selected relevant quotes below (emphases are mine).

Kind regards
Jenny Ejlak

United Nations General Assembly, 3 Aug 2011, "Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254

Direct Quotes:

The right to sexual and reproductive health is an integral component of the right to health.

The International Covenant on Economic, Social and Cultural Rights emphasizes aspects of the right to sexual and reproductive health in article 12.2 (a).

The Convention on the Elimination of All Forms of Discrimination against Women … article 16.1 (e) mandates that women be provided the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise those rights.

Criminal laws and other legal restrictions on sexual and reproductive health may have a negative impact on the right to health in many ways, including by interfering with human dignity. Respect for dignity is fundamental to the realization of all human rights. Dignity requires that individuals are free to make personal decisions without interference from the State, especially in an area as important and intimate as sexual and reproductive health.

Criminal laws and other legal restrictions affecting sexual and reproductive health may amount to violations of the right to health.

The criminal laws and other legal restrictions examined in the present report facilitate and justify State control over women's life, such as forcing women to continue unwanted or unplanned pregnancies.

…morality cannot serve as a justification for enactment or enforcement of laws that may result in human rights violations, including those intended to regulate sexual and reproductive conduct and decision making.

The use by States of **criminal and other legal restrictions** to regulate sexual and reproductive health may represent serious **violations of the right to health** of affected persons and are ineffective as public health interventions. **These laws must be immediately reconsidered**.

Criminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's right to health and must be eliminated.

Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers. Examples of other restrictions include: laws prohibiting public funding of abortion care; requirements of counselling and mandatory waiting periods for women seeking to terminate a pregnancy; requirements that abortions be approved by more than one health-care provider; parental and spousal consent requirements;

Criminal prohibition of abortion is a very clear expression of State interference with a woman's sexual and reproductive health because it restricts a woman's control over her body, possibly subjecting her to unnecessary health risks.

States must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality. Safe abortions, however, will not immediately be available upon decriminalization unless States create conditions under which they may be provided. These conditions include establishing available and accessible clinics; the provision of additional training for physicians and healthcare workers; enacting licensing requirements; and ensuring the availability of the latest and safest medicines and equipment.

Although many social and cultural factors generate and exacerbate the stigma attached to abortion, criminalization of abortion perpetuates discrimination and generates new forms of stigmatization.

Recommendations include:

(g) Take steps to standardize national curricula to ensure that sexual and reproductive education is comprehensive, evidence-based, and includes information regarding human rights, gender and sexuality;

(h) **Decriminalize abortion, including related laws**, such as those concerning abetment of abortion; Ensure safe, good quality health services, including abortion, using services, in line with WHO protocols;

(j) Ensure that accurate, evidence-based information concerning abortion and its legal availability is publicly available and that health-care providers are fully aware of the law related to abortion and its exceptions;

(m) Ensure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider;

Abortion in Tasmania

A Brief History of Access Problems for Tasmanian Women

Before and during the 1970s there was no access to termination of pregnancy (TOP) services in Tasmania. Women travelled to Melbourne to access this service at great cost.

In the late 1970s money was bequeathed to a women's shelter which was used to assist women with travel costs for Melbourne trips for this service. Then in 1990 the remaining money was given to a group to set up a private clinic in Hobart which opened in Moonah in 1991. For the duration of its existence, no local doctors who were qualified to perform surgical TOP would work there and so the clinic flew a doctor in from interstate each week to perform the procedures under local anaesthetic. Two local GPs assisted there at different times.

During the time the clinic was operational, the procedure became gradually more available in the public hospital system, and the same in some private hospitals. There were, however, many reports of women being badly treated by hospital staff, and so many continued to use the private clinic or travel to Melbourne for a more respectful and confidential service.

In the late 1990s TOP became more accessible in the public hospitals due to staff (and attitude) changes.

Around early 2000 medical (pharmaceutical) abortions began to be used up to 7 weeks gestation but only three doctors in the south were providing this. One of these doctors moved back to the north west coast of Tasmania not long afterwards, and another stopped offering this service which left only one in Hobart who continued to offer this in private practice until he left the state in 2005.

Due to this increased supply of surgical and chemical TOP in the public and private sectors the demand for the private clinic dropped. The private clinic was at a disadvantage as it had to charge high fees in order to keep running and only a local anaesthetic was available (as opposed to a general anaesthetic in the hospitals). Eventually the private clinic could not sustain itself on the decreased demand and it closed in April 2001.

Unfortunately around the same time there were again staff changes in the public hospital system but this time the effect was a drastic reduction in the availability of TOP. The combined effect of this along with the lack of a private clinic meant in effect that access had regressed 10 years. The health minister and representatives of the Hobart Women's Health Centre and Family Planning Tasmania met several times to discuss options to deal with the access shortage.

The Most Recent Legislative Change

In late 2001 a medical student made a complaint to the police about the 'unlawfulness' of abortion procedures occurring in the public hospital system. A gynaecologist, anaesthetist, nurse and patient were under criminal investigation. Immediately all doctors in the public system, and some in the private system, stopped performing TOP.

This led to a crisis situation where women were again having to fly to Melbourne for the procedure, at great cost financially and in time and difficulty. Some private services were available for those with private health insurance.

The legality argument arose with the lack of definition of what was an "unlawful abortion" in the *Criminal Code Act 1924* as this was not defined.

The police chose to investigate this complaint and sought medical records from the hospital which the hospital administration, backed by the (then) health minister, refused to provide. The premier then recalled both houses of parliament from the Christmas break (the first time in history this had been done) to debate a private members bill to amend the criminal code.

A group of female politicians had banded together and after some debate negotiated a bill that would go far enough to resolve the current crisis but also be conservative enough to be supported by the majority of sitting politicians.

The three weeks that followed was an intense period of heated debate both inside and outside parliament.

The right to life movement flew Margaret Tighe to Hobart and a small group of pro-life lobbyists, including the legal adviser to the Catholic Church in NSW furiously lobbied all members of parliament. Each member received anti-choice literature, some of which was offensive. Parliamentarians expressed dismay at the "brainwashing" of some of the young children who wrote and spoke to them urging them not to allow doctors to "throw babies into buckets to die".

Several restrictive amendments were put forward but luckily most did not pass. Some only by sheer luck at politicians falling asleep and missing the votes!! Parliamentary debate continued into the early hours of the morning. Finally the bill was passed retrospectively and there is now greater clarity to the law.

The result was an amendment to the criminal code, which specified that an abortion was "lawful" if two medical practitioners certified in writing that continuing the pregnancy posed greater risk to the woman's mental/physical health than terminating it. There is no gestational limit in the criminal code, however in practice the majority are done in the first trimester (12 weeks).

Since the legal change

For the first few months of 2002 private providers and anaesthetists from mainland states were flown to Hobart to perform TOP at the Royal Hobart Hospital once a week to clear the backlog and because some key RHH staff were still refusing to perform the procedure (under conscientious objection clauses). There were 5 separate visits for a woman to go through before the day of the procedure.

Gynaecology Centres Australia then set up a private clinic in Hobart CBD which has been operating since about April/May 2002. In 2003 a second clinic was opened in Launceston, and a rival Fertility Control Clinic opened in Derwent Park. They each generally offer TOP one day a week, depending on demand, and gynaecologists and anaesthetists still fly in from Victoria and New South Wales to perform the procedures. The out-of-pocket cost starts from $250.

The official position of the public hospitals in performing TOP is unclear. Many women still choose to fly to Melbourne or other cities for privacy reasons.

Ongoing Issues

The key issue remains that it is legally a doctor's decision whether a woman can have an abortion. The decision is still not the woman's.

There are concerns about the procedure being taken out of the public health system and being handed to private providers, which means that medical students training in the public hospital system will not be trained in the most up to date TOP techniques (private clinics use vacuum aspiration, whereas hospitals usually insist on dilation and curettage, as this is used for other gynaecological surgery.

Jenny Ejlak

Acknowledgements: this information contains material presented verbally and by email by many others, notably Emma Bridge (formerly of Hobart Women's Health Centre) and Paul Duncombe (formerly of Family Planning Tasmania).

Written 2002, updated 2006, 2011.