6. Women’s Reproductive Rights: Confronting power

No book about the modern women’s health movement and its impact on public policy in Australia would be complete without including the work of the maternity-care reform movement and the abortion rights or pro-choice movement. These two groupings have laboured long and hard to establish women’s reproductive health rights and to ensure women’s access to a full range of options. Both have campaigned for women’s rights to control their own bodies and for rights to the information necessary to participate in decisions about their own care. Both have worked to undermine patronising attitudes, to change public opinion and to counter unnecessary medicalisation. And both struggle in the face of staunch resistance from some of the most powerful forces to be found in politics. In the first case, the movement is confronted by sections of the medical establishment, whose power and position it challenges. In the second case, anti-choice forces, including but not restricted to powerful religious organisations, mobilise to resist any proposal to liberalise existing laws. Considering the strength of the interests mobilised against them, women have made important gains in both areas but there are still major reforms to be achieved.

I use the term groupings to describe the two movements because in both cases organisational linkages, internal and external, are loose and fluid. The early maternity reform groups were not closely associated with either the women’s movement or the women’s health movement. Many members did not support feminist goals, while conversely mothers’ rights were not a pressing issue for most feminists. As more women came to identify as feminists in the maternity-care reform movement from the 1970s onwards, differences in priorities and strategies became divisive. Internal dissension and the absence of strong working links with the women’s health movement have undermined effectiveness. Abortion law reform, on the other hand, has been a galvanising force in the women’s and women’s health movements. Because pro-choice activists are to be found in numbers in all feminist organisations, there is less need for dedicated abortion law reform groups than there was in the 1960s and early 1970s. If a threat to existing rights or a window of policy opportunity for goal advancement is perceived, women’s groups quickly and easily form activist coalitions. The strong consensus among feminists about the importance of a woman’s right to control her own body helps to explain why gains have been possible notwithstanding powerful, well-resourced opposition.
The Maternity-Care Reform Movement

Members of the maternity-care reform movement, like those of the broader women’s health movement, saw themselves as agents of social change. They demanded that women’s agency and women’s bodies be respected and they worked for an extension of women’s rights. They challenged the unquestioning acceptance of medical dominance and scientific knowledge that had become entrenched in the post–World War II period. Information about pregnancy, childbirth and breastfeeding, they argued, was abysmally hard to come by when it should be freely available. Moreover, maternity care should be more holistic, should show greater respect for birthing women and their right to make informed decisions and should be delivered in continuous, trusting, collaborative partnerships.

Childbirth, most members of the movement argue, is a normal life event, the province of women for millennia. From the late nineteenth century onwards, it was gradually taken over by a predominantly male medical profession and progressively and unduly medicalised. By the 1960s, dissatisfaction began to be voiced in Australia and most Western countries about aspects of the birthing process, including women’s lack of control and authority. Like the women’s health groups that mobilised a little later, mothers’ groups had dual objectives: they wanted to improve information and services for women and influence public opinion to promote structural changes in the organisation of care. They called for fundamental reform of the rushed, impersonal, hierarchical and medicalised environments that characterised the labour wards of the day (Gosden and Noble 2000:71–2; Reiger 2001:1–84). In most jurisdictions, with the possible exception of some Aboriginal women, there was little choice but to have one’s baby in a hospital, with its attendant ‘preparations’, the most unpopular of which were enemas and pubic shaves. Support persons, including husbands, were generally banished, women were given drugs they did not want and often left alone during labour. Mothers and babies were separated, supplementary bottle feeding, which has a depressing effect on lactation, was common, and family members, including fathers, viewed newborns through nursery windows.

Prenatal services in the 1960s mostly took the form of medical checks; care of the medical kind was provided by general practitioners and private obstetricians. Information about lactation was scarce and rates of breastfeeding were falling dramatically (Reiger 2001:15–36). In line with international thinking, calls were made for a change of direction towards more natural childbirth. Women should be at the centre of the birthing process, there should be less reliance on analgesics, more freedom of movement permitted during labour and persons able to provide emotional support should be allowed to be involved. Employing a
rights approach, maternity-care reform groups argued that women were entitled to have their voices heard, their needs recognised, their bodies respected and their childbearing capacities valued (Reiger 2001:37).

Partly in response to these claims and partly due to broader changes, a series of accommodations was won. Gradually, hospital practices were modified and labour wards made more woman and family friendly. Traditional labour wards were refurbished and efforts made to make them look less like hospitals. Breastfeeding gained acceptance, even in public (at least until the ‘baby’ becomes a toddler). By the early 1980s, birth centres, with more women-friendly practices and more homely atmospheres, were being established in major metropolitan hospitals, despite initial opposition from some obstetricians and midwives (Andrews 2000:23; Reiger 2001:187–262). The medical dominance of childbirth, however, remained almost entirely intact despite the recognition of midwives as autonomous professionals in several countries and by bodies such as the World Health Organisation (WHO) (Reiger 2000:56).

**Maternity-Care Reform Groups**

In Australia, the movement was led by the Childbirth Education Association (CEA), which had been formed in 1961 as the Association for the Advancement of Painless Childbirth, and by Parents Centres Australia. The Nursing Mothers Association (NMA), now the Australian Breastfeeding Association, began in 1964 as a support group but also lobbied to change rigid hospital practices that militated against successful breastfeeding. A plethora of new groups supporting homebirth and maternity reform was established from the 1970s onwards, including Homebirth Access Sydney, Homebirth Australia, Maternity Coalition, the Homebirth Network of SA, Mothers and Midwives’ Action Victoria, Natural Parenting Melbourne, Blue Mountains Homebirth Group, Hunter Home and Natural Birth Support, Birth Choices South West WA Inc., Nimbin Birth and Beyond and Joyous Birth, to name just a few. Homebirth Australia is the peak body for homebirth awareness and promotion.

Other birthing-related groups include the Caesarean Awareness Network of Australia, Caesarean Awareness Recovery Education Support SA and friends of birth centres in different States.

The Maternity Coalition (MC) was formed as an advocacy and information-sharing organisation in Victoria and New South Wales in the late 1980s to influence the State government inquiries into maternity care that had been set

---

1 Reiger (2001) provides a detailed account of the activities of the NMA, later the Nursing Mothers Association of Australia, and the CEA.
up. In the mid-1990s, it clarified its goals and philosophy, working to support both consumers and midwives as participants in all aspects of policy and health decision making and in service delivery. It is committed to the promotion of normal physiological birth and breastfeeding. In 1997, it established its own journal, *Birth Matters*, and began to expand beyond the original two States. In 2011, it is a national, non-profit, umbrella organisation, with some 500 individual and organisational members. It argues for women’s rights to access to the maternity care of their choice, including community-based midwifery care, and it strongly promotes continuity of care throughout pregnancy, birth and for six weeks postnatally (MC 2008; Newman et al. 2011).

At the same time and in line with international developments, Australian midwives began to organise in what has been called the ‘rebirth’ of midwifery. Midwives sought to regain their traditional role as autonomous professionals, caring for women in childbirth, independent of both medicine and nursing. They developed their own competency standards, codes of ethics and their own models of care. As Reiger (2000:53) describes it:

[T]his involves a shift away from a medical/scientific framework and hospital-centric practice towards one emphasising holistic care, the value of intuitive as well as technical knowledge, a collaborative partnership with women and new forms of work organisation. The re-emergence of midwifery away from medical dominance reflects the influence of the feminist critique of medicalised reproduction.

The National Midwives Association was formed in the late 1970s and became the Australian College of Midwives Incorporated (ACMI) in 1987. It has branches in all States and Territories. Other professional groups include the Midwives Action Group, the Australian Society of Independent Midwives, Midwives Australia, the Australian Private Midwives Association, Midwives in Private Practice and the Home Midwifery Association of Queensland. Part of the project to reclaim midwifery was to gain independence from nursing through a separation of education programs. Since the incorporation of midwifery into nursing in earlier decades, a general nursing qualification had been the prerequisite for postgraduate midwifery training. Associations of midwives in the States and Territories, supported by groups such as the MC, set about the task of changing policy to permit the introduction of direct-entry Bachelor of Midwifery degrees. Prospective midwife practitioners would then have a choice of education pathways. Rather than a fragmented medical model, a holistic, continuous model of care is generally promoted. Maternity reform activists want to change present arrangements under which a woman might encounter upwards of 20 midwives and doctors, with none of whom she has a close relationship, during the course of pregnancy and birth (Vernon 2011:3).
A Divided Movement

The maternity-care reform movement in Australia has experienced significant divisions and persistent cleavages alongside commitment to and enthusiasm for change. Breastfeeding and childbirth reform groups faced internal divisions from their inception. They split regularly on personal and philosophical grounds, which sapped energy and limited the materialisation of a national voice. The homebirth movement has been particularly prone to serious divisions on a range of philosophical issues, including disagreements arising from the coexistence within the movement of several strands of feminism (Gosden 1998; Reiger 2001:84–108). Moreover, for the most part, the Australian maternity-care reform movement and the feminist women’s movement have largely worked separately (Reiger 2001:264). Unlike the US situation, for example, in Australia, the maternity reform advocates of the 1960s and 1970s did not see themselves primarily as feminists. Although they worked hard to promote women’s rights, many were socially conservative (Reiger 2001:176). And while not anti-feminist, some members were primarily committed to childrearing as professional mothers and were not particularly interested in feminist goals, which they saw as stressing achievement in the public sphere. Some, especially in the NMA, feared that promoting women’s workforce rights could downgrade their work as mothers in the home.

On the feminist side, childbirth, lactation and mothering have not been major issues, partly due to concerns that such a focus would lead back to essentialism (Reiger 1999b). Economic independence has always been a high priority, however, as well as disruption of the public–private split so that women can participate in both spheres. Work-related issues were therefore emphasised, including accessible child care, education and training opportunities and equal pay. Despite differences, however, there were, and still are, many issues of shared concern, including women’s rights to control their own bodies, unnecessary medicalisation, the male medical takeover of reproductive and other health services, patronising attitudes, the inappropriateness of many treatments and the paucity of information.

Given so much commonality, it is perhaps surprising that collaboration has not been closer. In the United Kingdom, the United States and New Zealand, in contrast, links have been close and productive (Garcia et al1998; Kitzinger 2005). One stumbling block in the Australian context is divergent views about what constitutes access and equity. The issue of private, fee-for-service midwifery practice remains contentious both inside and outside the maternity reform movement. Services provided on a fee-for-service basis are generally not accessible to those on low incomes even when they are publicly subsidised. The introduction of private, fee-for-service maternity care would create the
same access and equity problems that currently plague the medical-care system, unless midwifery fees were set by government. Access to services is a critical issue in the general women’s health movement and important to those in the homebirth movement who are committed to the availability of public-sector birth care for all Australian women ‘across barriers of class and culture’ (Gosden 1998:47).

In the fullness of time, however, some of the differences between the early maternity-care reform groups and feminist groups narrowed. According to Reiger, many maternity-care activists became radicalised through their campaign work, including encounters with hospital systems and medical professionals. Many others were influenced by the increasingly feminist stance taken by the homebirth groups that were being formed, sometimes from among their own ranks (Reiger 2001:159–83). On the other side, as they became established, women’s health groups began to take a keener interest in maternity care and related issues, such as postnatal care. At the level of service provision, women’s health centres responded to the maternity-care needs of their clients. For example, the Leichhardt Women’s Community Health Centre (LWCHC) provides a range of reproductive health services, which includes postnatal services and information and care in relation to postnatal depression (LWCHC web site), and Women’s Health West in Victoria works with diverse groups of African women and girls through the Family and Reproductive Rights Education Program (Women’s Health West web site). The outcome of this convergence was that by the 1980s, maternity-care and birthing issues were on the agendas of both the women’s health and the maternity-care reform movements and had found their way into the first NWHP (Andrews 2000:16). For the most part, however, the two movements continued to move forward along parallel pathways—a direction at least partly shaped by limited resources. Unfunded advocacy organisations run by volunteers, whether they be young mothers or women in paid work, find it difficult to manage the workload within their own groups. Time constraints often mean that the establishment of collaborative links is beyond their capacity.

Maternity-Care Reform Becomes a National Issue

As discussed, the political context of the 1980s was favourable for the advancement of women’s issues. Concerns found their way onto party political platforms—a process assisted by increasing numbers of female politicians and bureaucrats. The development of the NWHP and the National Agenda for Women in the second half of the decade involved extensive consultation with women, stimulating debate and raising expectations that governments would
take effective action to raise the status of women. In this context, the combined impact of advocacy by so many maternity reform and women’s health groups created a set of pressures that governments were unable to ignore. In the two decades following the mid-1980s, upwards of 30 major inquiries into Australian maternity care, some specifically focusing on services for Aboriginal women, were undertaken in the States and Territories. Maternity reform groups were able to influence the inquiries, gaining representation on steering committees and working parties in some cases and providing consumer representatives in others.

Maternity care also attracted the attention of two high-level national health agencies in the 1980s: the Medicare Benefits Review Committee and Australia’s premier medical research institution, the National Health and Medical Research Council (NHMRC). The latter body took the unprecedented step of establishing the Working Party on Homebirths and Alternative Birth Centres in 1986. A report released the following year endorsed the right of women to choose where to give birth and urged hospitals to modernise their premises and practices. A subsequent publication, the *Statement on Homebirths* (1989), again supported birthing choices. As an advocate of birth centres and home births while simultaneously endorsing the importance of the role played by specialist obstetricians, the NHMRC placed itself in a contradictory position. In 2000, on the advice of its Health Advisory Committee, both the 1987 and the 1989 documents were rescinded (Andrews 2000:28–9).

The Medicare Benefits Review Committee was established in 1984 to assess aspects of the operation of the newly reintroduced national health insurance scheme, Medicare, and to consider whether benefits should be extended to cover the services of selected allied health professionals. In general, the committee did not support the extension of fee-for-service private practice. It suggested instead that the Commonwealth should fund States and Territories to allow allied health services—such as dietetics, occupational therapy, physiotherapy, podiatry and speech pathology—to be provided as part of their community health programs. Allied health professionals would be remunerated by salaries or on a sessional basis (Commonwealth of Australia 1986a:343–90). In this context, the committee recommended against an extension of Medicare benefits to the services of private practice midwives; however, it supported the expansion of birth centres in hospitals, the provision of public funding for midwifery services outside hospitals and it recommended a pilot homebirth program to assess feasibility, safety and costs (Andrews 2000:28).

The State and Territory inquiries of the late 1980s and early 1990s placed a broader range of birthing issues on the various policy agendas (Reiger 2001:281, 2006); however, no State or Territory embarked upon major structural reform. The implacable opposition of the Australian Medical Association (AMA), the
Royal Australian College of Obstetricians and Gynaecologists (RACOG) and the College of General Practitioners presented an almost insurmountable obstacle. In 1989, the two colleges issued a joint statement disregarding NHMRC evidence and emphasising their concerns about the safety of homebirth (Reiger 2001:278). At stake, of course, are the economic interests of the profession, which has recognised the profitability of the maternity ‘industry’ since the 1920s (Norling and Woodhouse 1998:19).

Another obstacle to action is concern about cost, which is always at the forefront of State and Territory health policymaking because health is the major expenditure item, consuming approximately one-third of sub-national budgets. And while savings are possible from moving service provision out of acute-care hospitals into community settings, federal financial arrangements are a strong disincentive to such experimentation. In the case of maternity care, the Commonwealth funds most of the cost of services provided by obstetricians and general practitioners through Medicare. In the absence of additional Commonwealth money, the States and Territories are reluctant to introduce new midwifery services for which they would not otherwise have to pay, although the additional expense would be partly offset because there would be fewer hospital midwives. The general approach for Australian governments is to try to shift costs onto the other level wherever possible. It is not customary to freely assume expenses that are the responsibility of another government. Moreover, the prevailing managerialist thinking of the day resulted in the frequent restructuring of government departments, which often dislodged key policymakers, including femocrats. Under the circumstances, action was taken on only a few of the recommendations of the various reviews.

Movement at the Local Level

Some scattered innovations, however, began to be undertaken at the local level. By the mid-2000s, team-based midwifery was being trialled in several major hospitals in capital cities in an attempt to increase continuity of care. There are small publicly funded midwifery programs in Perth, in the northern suburbs of Adelaide and in rural Victoria. The Perth program mainly provides homebirth services, the Adelaide program targets low-income mothers, including Aboriginal mothers, and the rural Victoria program is designed to care for young mothers who do not access antenatal services, including young women with mental health issues, drug and alcohol dependence and the like. A successful midwifery-led birthing facility operates from the Mareeba Hospital in far north Queensland. According to Boxall and Flitcroft (2007), system-wide reform is more likely to be introduced when policymakers are able to refer to sufficient examples of successful and popular, midwife-led, locally based
programs. At this stage, however, most of the hospital-based initiatives, which are hybrid models, do not achieve high levels of continuity of care because deeply ingrained practices such as working in shifts are retained.

**One Step Forward**

Forward movement, albeit on a small scale, came from the Commonwealth in the form of the Alternative Birthing Services Program (ABSP), initially called the Birthing Options Program, which was introduced in 1989. The ABSP was heavily influenced by the views that Australian women expressed when they were consulted for the NWHP and several State-level inquiries. Insufficient information, especially for immigrant, Aboriginal and rural women, lack of control of the birthing process, lack of control over place of birth and difficulties with continuity of care were all major concerns. Stress, depression and family disruption were reported by Aboriginal women who are often required to leave their communities up to six weeks before the birth of their babies. Rising levels of birth interventions, including caesarean sections, inductions and forceps deliveries were raised as concerns and women reported that interventions often proceeded without consultation or discussion. ‘Most birthing women are healthy and wish to experience normal deliveries in an environment of their choice’, the NWHP argued (Commonwealth of Australia 1989:22). The NHMRC’s 1987 finding that homebirths were not less safe than hospital births was noted (Commonwealth of Australia 1989:20–7).

In developing the ABSP, the Commonwealth was not thinking only about women’s health needs; the program also had a number of perceived advantages. Structural changes in maternity care would reduce the cost to Medicare because midwifery-led services would be cheaper than specialist-dominated, hospital-based services and would provide genuine competition for obstetricians, which should keep downward pressure on their fees. It might also encourage specialists to concentrate on high-risk births, where their skills are needed. Shorter hospital stays would not only save money but would free up beds that could be used to reduce waiting lists. At the same time, midwifery-led programs would offer women more choices (Commonwealth Department of Community Services and Health quoted in Andrews 2000:26–7).

The ABSP was an eight-year program announced concurrently with the first NWHP. The stated objectives were to encourage the sub-national jurisdictions to promote greater choice and to promote cost effectiveness in birthing services through expanded birthing centres and the provision of homebirth services. The policy supported midwifery-led models of care and included an option through which the States and Territories might address Aboriginal women’s birthing
issues. In providing a public subsidy for homebirth, the Commonwealth was attempting to make services available to low-income women who had not previously been able to afford private fees. Midwives were to be independent but were not to be private fee-for-service practitioners. Rather, they would be employed by sub-national health services on a salaried or contract basis, as had been recommended by the Medicare Benefits Review Committee (Andrews 2000:31–6).

The ABSP met with vehement opposition from the medical profession. The AMA President of the day, Bruce Shepherd, claimed that the guidelines discriminated against doctors and RACOG announced that it did not support homebirth as a safe option. Moreover, it opposed midwives operating independently of doctors and hospitals. In the event and in order to accommodate the position of organised medicine, the program was modified in its second four-year phase. The emphasis remained on midwifery-led services but homebirth was removed altogether from the objectives, even though trials had begun in South Australia and Tasmania as part of the first phase. The second phase placed more emphasis on community-based midwifery and left the States and Territories to choose whether to pursue homebirth options. Sub-national jurisdictions were specifically encouraged to develop appropriate services for Aboriginal and Torres Strait Islander women, especially in relation to ante and postnatal care (Andrews 2000:37–42).

Despite the many perceived policy advantages, the ABSP was never a major program. Indeed, it has been described as ‘largely symbolic’ given that only $15.3 million was allocated to cover reforms in all States and Territories over eight years (Andrews 2000:27). Nevertheless, a national program, however small, can be seen as a positive outcome following two decades of women’s advocacy. Non-medical approaches to childbirth were put on the national policy agenda for the first time and birth centres that had been considered radical 15 years earlier gained legitimacy and were expanded. The status of midwives and midwifery-led practice was enhanced, especially in birth centres, where midwives gained responsibility and greater autonomy. The ABSP played an important role in supporting innovative services, including those at Alukura for Aboriginal women and a publicly funded midwifery service, the Community Midwifery Program in Western Australia, which includes homebirth. It was the first Australian public policy to seriously challenge the entrenched medical domination of maternity care. As Andrews (2000:38) argues, the program

Explicitly challenged the hegemonic medical model of childbirth that constructed pregnancy as pathological and always a risky business…

---

2 This ‘encouragement’ was something of an abnegation of responsibility because the Commonwealth has full constitutional power to make laws in relation to Aboriginal people. Space limitations preclude a discussion of the initiatives taken under the ABSP, which are reviewed in Andrews (2000).
The medical hegemonic discourse advocated medical surveillance for all women so that the few who might really need intervention were not overlooked. The ABSP approach argued that all women could choose to have a natural, normal birth free of intervention and that measures should be in place for those few women who may need medical intervention or assistance in the case of an emergency.

The ABSP experience also shows that policy change in fields where strong vested interests hold sway is most likely to take place in very small, incremental steps.

**Two Steps Back**

The dozen years following the conclusion of the ABSP were not conducive to the promotion of midwifery-led maternity care at the national level. On the contrary, the Howard Government strengthened medical dominance in the health system generally in a number of ways. First, the proportion of Australians holding private insurance who were therefore able to afford private hospital services was increased at considerable expense to the public purse, beginning with a $2 million publicity campaign to promote private insurance in 1996. Then, in 1998, after lesser measures had failed to increase coverage, a 30 per cent public subsidy for private premiums was introduced. When this measure also failed, the Commonwealth changed longstanding policy, permitting private insurers to charge higher premiums to new subscribers as they grow older. Lifetime Health Cover, as this scheme is called, was accompanied by what amounted to scare tactics in the 12 months leading up to its introduction. An $8.7 million, taxpayer-funded publicity campaign urged people to ‘Run for Cover’, with the result that the numbers of Australians covered by private insurance increased by 50 per cent (Gray 2004:34–8). Higher private insurance coverage, among other things, means more financially rewarding fee-for-service private hospital work for specialists, including obstetricians.

The second windfall for certain groups of specialists, particularly obstetricians and those providing in-vitro fertilisation (IVF) services, came in the form of the Extended Medicare Safety Net (EMSN). Introduced in 2004, the EMSN was supposed to reduce out-of-pocket expenses for citizens; however, an independent review in 2009 found that, overall, the additional Commonwealth expenditure had not lowered costs for patients but had rather increased provider incomes. Moreover, funding was of most benefit to high-income citizens. The 20 per cent of Australians living in the most affluent areas had received 55 per cent of benefits whereas the 20 per cent living in the least affluent areas had received only 3.5 per cent (Commonwealth of Australia 2009f:vi). In 2007, 31 per cent of total benefits under the scheme were paid for obstetrical services and 22
per cent for IVF procedures. The EMSN was found to have had an inflationary impact, forming the basis for steep rises in medical fees, with the most profound effect in the areas of obstetrics and IVF. Between 2003 and 2008, obstetricians reduced their in-hospital fees by 6 per cent while they increased their out-of-hospital fees by 267 per cent. During the same period, in-hospital fees for IVF services were reduced by 9 per cent but out-of-hospital fees were increased by 62 per cent. The review team came to the conclusion that doctors were able to calculate that their patients would qualify for the EMSN and therefore felt ‘fewer competitive market pressures to contain their fees’ (Commonwealth of Australia 2009f:63, 73).

Thus, the introduction of structural changes that increased private insurance coverage and underpinned fee increases far in excess of inflation served to further embed private obstetrical practice. Under such circumstances, it was unlikely that collaborative or shared care arrangements with midwives would flourish. Other actions by the Howard Government that demonstrate its lack of interest in promoting alternative models of maternity care were its return of the ABSP, along with the NWH Program, to the States and Territories in 1998 and its failure to invite midwives to the National Forum on Medical Indemnity Insurance, chaired by the Minister for Health and Ageing, Senator Kay Patterson, in 2002.

Despite the unpromising national political climate, maternity-care reform groups continued to work for change. MC consciously looked to expand and invited members Barbara Vernon and Justine Cairns to join its executive—a move that heralded a period of major advance for the organisation (Newman et al. 2011:85–6). Realising the need for unity, efforts were made in 2002 to form a cohesive front. The National Maternity Action Plan (NMAP), a detailed document supported by research evidence, was written by the leaders of MC and endorsed by a broad coalition of consumer and provider groups. It was launched in all jurisdictions and it called on governments at both levels to support publicly funded, community-based midwifery care in urban, regional and rural areas. The plan pointed out that the right to choose a midwife as a leading carer is available to women in a number of OECD countries and that scientific evidence shows good outcomes for both mothers and babies. Midwives are in the best position to provide continuity of care from early pregnancy until babies are four to six weeks of age, the NMAP argued, and continuity of care

---

3 This number is not a typographical error.
4 Publicly funded, midwife-led care is readily available in New Zealand, the Netherlands, Britain and Canada.
5 In the Netherlands, childbirth has never been as medicalised as in other OECD countries. In 2007, 41.5 per cent of women remained in primary care throughout pregnancy, labour, birth and during the postpartum period, receiving care from a midwife or a general practitioner; 31.3 per cent gave birth at home. Women are very positive about the quality of the care they receive and intervention and pain relief use is very low compared with that in similar countries (Weigers 2009). A recent study of more than half a million Dutch
has been shown to result in fewer obstetrical interventions, such as caesarean sections. Therefore, as well as providing choice and appropriate care for women, midwifery-led services would save health dollars (MC web site). The launch of the NMAP marked the beginning of a period of strong unity within MC. When in 2003 obstetricians threatened to close their practices in response to high indemnity insurance premiums, the then President of MC, Dr Barbara Vernon, welcomed the announcement, issuing a media release claiming that pregnant women would be better off with fewer obstetricians in private practice.

The National Maternity Services Review

Maternity activists attracted the attention of the ALP in opposition, which announced that it would develop a national maternity services plan should it win office in 2007. Another development that put maternity care on the national agenda was the inquiry of the Productivity Commission into the health workforce which reported in 2005. It recommended ‘a shake-up’ of the health industry to break down inefficient professional boundaries and promote flexibility (Lane In press). Momentum also came from the Maternity Services Inter-Jurisdictional Committee, set up by the Australian Health Ministers Advisory Council (AHMAC), which increased dialogue across jurisdictions. Picking up consumer lobbying around the NMAP, it put forward a framework to advance primary maternity service provision (AHMAC 2008).

In government, Health Minister, Nicola Roxon, established a National Maternity Services Review led by the Commonwealth’s newly appointed Chief Nurse and Midwifery Officer, Rosemary Bryant. The review, which began in 2008, was asked to examine the full range of possible maternity services and to seek information on a number of key issues, such as successful models of care for rural and remote communities and the aspects of the Australian system that fuelled high intervention rates. Submission writing was facilitated by the intensive work of MC and other groups and the review received a record number of more than 900 submissions6—more than twice as many as the National Health and Hospitals Reform Commission, which sat at much the same time. Submissions pointed to familiar problems, such as the extremely limited birthing options for women living in rural and remote areas, exacerbated by the closure of more and more rural birthing units because of lack of medical staff. The NSW Midwives Association, the Menzies School of Public Health and the Australian Indigenous women by British researchers found that there is no difference in the perinatal mortality rate during the first week of life between homebirths and hospital births. The number of babies who die or need neonatal intensive care is the same in both groups at seven per 1000 births (de Jonge et al. 2009).

6 Submissions to the review can be found at <http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-submissions>
Doctors Association stressed the problems facing Aboriginal and Torres Strait Islander women whose babies have poorer perinatal outcomes. These submissions argued what experienced practitioners had known for years: that giving birth far from home disrupts the link between birthplace and land, separates families, causes additional and unnecessary stress and is culturally inappropriate and unsafe.\(^7\) Also frequently mentioned were difficulties experienced in obtaining continuity of care and the inappropriate utilisation of acute-care hospitals for healthy birthing women, resulting in the overuse of technologies that should be reserved for women with complications.

The Australian College of Midwives’ submission presented 13 reasons for Australia’s high intervention rate, including the absence of consistent, professionally endorsed, evidence-based guidelines for appropriate practice. David Ellwood, Professor of Obstetrics and Gynaecology at the School of Clinical Medicine, the Canberra Hospital, made a personal submission, focusing on intervention rates, the adverse impact of the private health insurance subsidy on public hospital services and the need for a national approach to maternal and perinatal morbidity and mortality reporting. ‘The inexorable rise in the caesarean section rate is something which needs to be addressed as a matter of some urgency’, Elwood argued. He noted that the rate is significantly higher in the private sector and commented that it is ‘an odd situation’ when women can choose elective caesarean sections and be financially supported for doing so but Aboriginal women are unable to choose to birth naturally on their own country. He argued that an appropriate response would be to increase the availability of midwifery-led care. Ellwood also drew attention to the adverse impact of the EMSN on the capacity of public hospitals to attract medical staff. Incomes are so good in the private sector, he argued, that it is possible to work part-time and still ensure a reasonable income. Policies need to be changed ‘so that full-time employment in the public sector is more competitive with the kinds of incomes which are now possible in the private sector’ (Ellwood 2008).

On the positive side, submissions drew attention to a number of successful local innovations. These include the midwifery-led Belmont Birthing Service in New South Wales, which provides education and preparation for birth, parenting sessions, breastfeeding information and continuity of care. The service is for all women in the Hunter region and is linked closely with John Hunter Hospital’s obstetric services where medical support is available when needed. The Malabar Community Midwifery Link Service, run by the Sydney Royal Hospital for Women, is located in an area with a large Aboriginal population. It is considered to be culturally appropriate, is available to people living in surrounding suburbs and to Aboriginal women from outside the area. Its high standard of service has

---

\(^7\) See, for example, Australian Indigenous Doctors Association (2008); Baldwin-Jones (1989); Cox (2009); Fitzpatrick (1995); Menzies School of Health Research (2008).
been recognised (Homebirth Access Sydney submission). Another successful model of care has been developed by the Orange Aboriginal Medical Service, which has links with local professionals, including allied health professionals, and the Orange Base Hospital.

Submissions to the review by medical unions supported the status quo. It was argued that Australia had a high standard of safety for mothers and babies that would be jeopardised if medical control were undermined. Intervention rates had increased but this was a phenomenon in all OECD countries largely because mothers are older and there is a higher incidence of obesity and related illnesses. The AMA supported expanded funding arrangements for midwives but only if midwives were medically supervised. The idea of independent midwives as autonomous professionals is anathema:

> Highly interventionist government agendas to advance an ideological cause are likely to create problems in the delivery of maternity services and exacerbate tensions in interprofessional relationships...The government should not introduce any publicly funded arrangement which is based on independent midwife care for mothers and babies in Australia or use public funds to establish separate streams of midwife led maternal care on the one hand and medical led maternal care on the other. (AMA 2008)

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)\(^8\) argued for a collaborative model in which obstetricians, general practitioners, midwives, anaesthetists, paediatricians, pathologists and allied health professionals would work together. It opposed independent midwifery practice ‘where one particular professional group or individual works in isolation’. Instead, it proposed a ‘Private Collaborative Model’, under which private midwives and private obstetricians or private general practitioners would work together within a framework of agreed protocols and guidelines.

The review released its report, *Improving maternity services in Australia*, in February 2009 (Commonwealth of Australia 2009g). It made 18 recommendations that it suggested the Commonwealth, States and Territories might consider during the development of the proposed National Maternity Services Plan. A key recommendation was that the importance of the midwifery role should be recognised and choice should be enhanced by expanding the range of maternity-care models on offer. Consideration should be given to changing Commonwealth funding arrangements, and professional indemnity insurance for midwives should be supported. Other recommendations included the development of national multidisciplinary guidelines for collaborative models

---

\(^8\) RACOG amalgamated with the Royal New Zealand College of Obstetricians and Gynaecologists in 1998.
of care, the expansion of birth centres and the provision of more comprehensive information for pregnant and breastfeeding women. Four recommendations related to improving services for Aboriginal women and increasing cultural awareness (Commonwealth of Australia 2009g:57–9). Homebirth, however, was dismissed on the grounds that it is the preferred choice of relatively few women (Commonwealth of Australia 2009g:15–21). In welcoming the report, Minister Roxon said that it brought better services for mothers and babies ‘one step closer’. She noted the widespread concern expressed about high rates of medical intervention, high rates of postnatal depression and the relatively low rates of breastfeeding (Gordon 2009).

Responses to the report followed predictable lines, with midwifery and nursing groups welcoming the endorsement of an expanded role for midwives but expressing reservations about the failure to consider the homebirth option in more depth. The Commonwealth responded with a very modest $120.5 million maternity reform package as part of the 2009–10 Budget. Under the package, the patients of eligible midwives and nurse practitioners9 would have access to specified Medicare and pharmaceutical benefits. The Commonwealth would underwrite a new professional indemnity insurance scheme for midwives and nurse practitioners, deliver more services to rural and remote locations through the Medical Specialist Outreach Assistance Program, increase scholarships for general practitioners and midwives and introduce a 24-hour, seven-day-a-week telephone help and information service (Jolly et al. 2009:8–10).

Legislation to facilitate the new arrangements was introduced into Parliament in June 2009 and had a turbulent passage. The Senate referred it to the Community Affairs Legislation Committee for inquiry—an outcome that had been partly shaped by MC, which had lobbied parliamentarians extensively in order to gain more scrutiny of the proposals. MC had organised the ‘Mother of All Rallies’ in September at which approximately 3000 homebirth supporters had converged on Parliament House. It was also at least partly responsible for the unexpected support for expanded options shown by a number of speakers in the Senate. Another round of public hearings was held and more submissions received. After considering the most controversial issues, particularly homebirth, the committee satisfied itself that the legislation was sound, that it did not remove existing rights and would not make homebirth unlawful. It recommended that the Bills be passed; however, Commonwealth amendments attempting to clarify the meaning of ‘collaborative arrangements’ resulted in referral to the Community Affairs Legislation Committee yet again, provoking more controversy and generating more submissions. The committee concluded that the proposed collaborative arrangements would allow a flexible approach to

---

9 The Australian Nursing Federation has argued for access to Medicare benefits and prescribing rights for nurse practitioners since the 1990s but the proposition has been vigourously opposed by medical unions.
practice across the country and recommended that the Bills be passed. Senator Rachel Siewert, of the Australian Greens, produced a dissenting report arguing that it is unnecessary to legislate for collaborative arrangements since they are already encoded within regulatory frameworks (Senate Community Affairs Legislation Committee 2010). In the event, the Commonwealth did not proceed with its amendments and instead negotiations were held with stakeholders to work out details. The Senate finally passed the legislation in March 2010.

As promised, the National Maternity Services Plan has been developed and endorsed by the Australian Health Ministers Conference to cover the five-year period from November 2010. The plan’s vision is stated as follows:

Maternity care will be woman-centred, reflecting the needs of each woman in a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be able to provide continuous maternity care to all women. (Commonwealth of Australia 2011c:3)

The plan confirms that Australia is a safe place to give birth, except for Aboriginal and Torres Strait Islander women. It also confirms the comparatively high rate of interventions in Australia, which in 2007 was 5.2 per cent above the OECD average. It notes that interventions in the private sector are ‘substantially higher’ than the average (Commonwealth of Australia 2011c:9). Actions agreed for the first year include the facilitation of increased access to midwifery-managed models of care, investigation by the States and Territories of options for the provision of publicly funded homebirths and identification of the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women (Commonwealth of Australia 2011c:61–9). It is too early to assess the effectiveness of the plan but its success will at least partly depend on the provision of sufficient Commonwealth funds to induce the States and Territories to themselves shoulder the costs of services that would otherwise be paid for mostly by the Commonwealth through Medicare.

The new maternity-care arrangements became fully operational on 1 November 2010. Medicare rebatable services can now be provided by eligible midwives for care during pregnancy, labour and birth in a hospital—as long as the midwife has admitting rights—and for home-based postnatal care for six weeks after birth. Routine tests can be ordered and specified drugs prescribed. The Commonwealth is underwriting professional indemnity insurance for all eligible midwives, which has not been available since 2001 when a crisis in the insurance industry
resulted in the withdrawal of existing policies for midwives. A small window is therefore open for the development of new care models. Private obstetricians may enter into arrangements with midwives that allow them to provide continuity and team-based care, before, during and after birth, although the price might be prohibitive for many women. Choices for Aboriginal and Torres Strait Islander women might be expanded, allowing them to birth ‘on country’ or closer to country but only if midwives and doctors willing to collaborate are available. Midwifery Group Practices (MGPs), where hospitals employ midwives to look after women through all the stages of pregnancy and birth, might be expanded. Currently, MGPs, located largely in metropolitan areas, are in their infancy and are unable to meet demand. The new legislation will allow the establishment of private MGPs, provided collaborative arrangements can be negotiated, but accessibility will be an issue (Vernon 2011:36).

There are, however, a number of hurdles to be overcome before significant change emerges. In the first place, few midwives currently have the qualifications and experience to become Medicare eligible. Second, the States and Territories have the capacity to place barriers in the way of successful implementation because they, rather than the Commonwealth, have the power to grant the legal right to prescribe under the Pharmaceutical Benefits Scheme. They also have the power to grant or withhold hospital visiting rights for midwives. In the past, some jurisdictions have granted visiting rights; others have not (Vernon 2011:36). Moreover, State and Territory governments do not have full power in this area because decisions are made at the level of the individual hospital board where doctors have considerable influence. Further, it is not known what stance private hospitals will take in relation to visiting rights. Without visiting rights, a midwife cannot care for a woman in hospital during labour and birth, thereby severely disrupting continuity of care.

The Commonwealth initiatives have met with a mixed response from the maternity-care reform movement. The Australian College of Midwives and the Australian Nursing Federation (ANF), for example, endorse those aspects of the reforms that support private midwifery practice (ANF 2009; Australian College of Midwives 2009). Most groups, however, are disappointed that the Commonwealth is not underwriting indemnity insurance for homebirth midwives, thus virtually excluding homebirth from the reforms.

The new measures do not make homebirth unlawful but indemnity insurance is a condition of registration for midwives, as for other professionals. Transitional arrangements providing exemption from this requirement are due to expire towards the end of 2011, when homebirth will become illegal. One concern is that homebirth will then be driven underground (Commonwealth Department of Health and Ageing n.d.; Jolly et al. 2009:10–13).
The groups within the movement that have worked to achieve an independent midwifery profession are extremely disappointed with the requirement that to become ‘eligible’, midwives must enter into collaborative arrangements with one or more doctors. Under the new arrangements, doctors must approve of a woman’s care and may revoke that approval at any time. This gives medical practitioners control over the way midwives work and control over women’s choices, at least indirectly. It certainly negates midwifery’s claim to independent professional status. As Lane (In press) argues, ‘genuine collaboration fails to flourish under vertical structures’. In her view, we now have a ‘militarised form of collaboration where midwives are now more firmly relegated to subsidiary status than ever before by legislative decree’. Critics question the need for contracts and agreements between private medical practitioners and midwives, arguing that the existing regulatory framework ensures collaboration between team members. A study of existing team-care projects in three States shows that midwives collaborated routinely but that many visiting doctors ‘resisted authentic collaborative practices’ (Lane In press). It has been pointed out that independent midwives who might wish to practice in rural and remote areas will be unable to do so if there is no doctor close by (Barclay 2010:1).

In summary, the path towards maternity-care reform is littered with conflict. Consumers mobilised to assert the rights of birthing women, midwives struggled to become independent professionals, while groups within the medical profession worked to preserve their sphere of practice. Despite intense opposition, however, public policy has been modified and opportunities for incremental expansion of midwifery practice have been created. The movement has achieved a modification of practices associated with childbirth and breastfeeding and has contributed to attitudinal change over many years. Maternity care is, however, as medicalised as ever. The structure of health financing, along with entrenched cultural norms, provides inducements for women to seek medicalised childbirth. Further, the reforms do not provide women with choice of carer, choice of birth location or the right to make their own decisions about care—rights that New Zealand women gained in the 1990s. As a recent analysis argues:

[O]bstetrics, despite increased [numbers of] women entering the profession, continues to act as an institutional bastion of male domination of women, overriding women’s agency in childbirth and maintaining masculine ‘medicine’…while alternative ‘birth models that work’, emphasising interaction, holistic care and the integrity of organisms, struggle for legitimacy and support. (Newman et al. 2011:91)
A Woman’s Right to Choose

Some of the strongest collaborations between Australian feminist groups have taken place around reproductive rights, particularly the right to safe, affordable abortion. Building on the work and achievements of existing abortion law reform associations, the advent of the second-wave women’s movement saw the formation of multiple groups ready to campaign for a woman’s right to access abortion and a full range of contraceptives and abortifacients. Some groups formed to campaign specifically for sexual and reproductive rights. Others were established with a broader agenda but welcomed the chance to work with like-minded groups. Pro-choice groups have worked with each other, with women’s health centres and services, with most groups in the women’s movement, with family planning associations and with groups with a wider focus, such as the YWCA. Along with campaigns against violence, the struggle for reproductive choice has been a unifying force in the women’s movement (Goldrick-Jones 2002:123), although as mentioned, many Aboriginal women do not share the majority view.

Throughout history, women have looked to termination as a response to unwanted pregnancies despite restrictive legislation and unconscionable practices; however, prior to the 1960s, abortion was not politicised in Australia. In contrast with the English situation where the Abortion Law Reform Association was founded in 1936, in Australia, groups had not yet mobilised to call for the liberalisation of old laws (Siedlecky and Wyndham 1990:66). In the United Kingdom, after years of intense debate, the Abortion Act was passed in 1967 legalising abortion up to 28 weeks’ gestation. At the same time, pro-choice groups had mobilised in the United States and some jurisdictions had begun to liberalise their laws. These debates spread to Australia where interest in reform began to be articulated. At the time, governments presided over criminal codes that retained abortion and regimes that taxed contraceptives and excluded sex education from schools.

After the passage of the UK legislation, the Australian Humanist Society promoted the establishment of abortion law reform associations, which by 1971 were set up in all States and the Australian Capital Territory. In the meantime, changes had taken place in two jurisdictions as a result of cases where doctors were charged with procuring abortions. In 1969 in Victoria, the Menhennit ruling set out the conditions under which abortion could be lawfully performed, which included the necessity ‘to protect a woman from serious danger to her life or her physical or mental health’. Three years later in New South Wales, a similar judgment was made by Mr Justice Levine. The definition of mental health was extended to include the effects of economic and social stress. Neither the Menhennit nor the Levine rulings changed the law, as such. The first State to reform its abortion
law was South Australia, where legislation was passed in 1969 making abortion lawful when a medical practitioner considers that continuing the pregnancy involves a risk to the life, physical or mental health of the mother or when there is a substantial risk that the child will be seriously handicapped. The Northern Territory passed similar legislation in 1974, while there were two unsuccessful attempts to introduce legislative reform in Western Australia in the late 1960s and early 1970s (Siedlecky and Wyndham 1990:78–86).10

**Feminists Step up to the Plate**

From the early 1970s onwards, feminists formed groups dedicated to the twin tasks of abortion law reform and the provision of support for women who needed it. Early groups included the Women’s Abortion Action Coalition, set up in 1972 in Melbourne, and the Abortion Information Service, opened in Perth in 1974, which was subject to a police raid early in its existence. A raft of groups was formed in Adelaide in the early 1970s, including The Body Politic, concerned with contraception, abortion and health, and the Adelaide Abortion Referral Service, which later became the Counsellors’ Collective. A Women’s Right to Choose, which held public meetings every few weeks, was another Adelaide group.

In Sydney, Control set up an abortion information, referral and counselling service at Women’s House, in 1973. Pregnancy testing and contraceptive advice were added later. It lobbied doctors to reduce their fees for abortion and encouraged them to introduce their own counselling services and to provide contraceptive advice. All workers were voluntary and rostered themselves to provide services in the evenings and on Saturday afternoons (Stevens 1995:27). An associated group was the Women’s Abortion Action Campaign (WAAC), formed in Sydney in 1972, and in Adelaide and Brisbane in 1973. WAAC’s purpose was to campaign for the repeal of abortion laws and it organised a National Conference on Contraception and Abortion attended by more than 400 women in 1975 (Siedlecky and Wyndham 1990:86). Control, Queensland, also known as the Women’s Pregnancy Advisory and Abortion Referral Service, was set up in 1977 and operated with the support of Women’s House.

No account of the early campaigns for reproductive rights would be complete without mention of the work of Jo and Bertram Wainer in Melbourne. Jo Wainer was the inaugural Secretary of the local Abortion Law Reform Association. As she remembers it, the group had no language with which to discuss reproductive rights and had to invent it. The Wainers gathered information about backyard

---

10 Siedlecky and Wyndham (1990) provide a detailed historical account of Australian struggles for women’s reproductive rights until the 1980s.
abortion networks, police corruption and professional abortionists, which they publicised through every available avenue. In 1969, Bertram Wainer, a general practitioner, devised a scheme through which police corruption could be exposed, and afterwards, agitated for a public inquiry. Test cases were organised to explore the extent of the Menhennit ruling. Because lucrative business dealings were being exposed, threats were made against the Wainers’ lives. Bertram Wainer was evicted from his surgery and censored by the AMA. In 1972, he established Australia’s first open abortion clinic, in St Kilda, and in subsequent years both Wainers continued to campaign (Wainer 2006:1–18).

Coalitions and Collaborations

One of the first major collaborative projects between women’s groups took place in 1982 when the Right to Choose Coalition was formed by WEL, the Union of Australian Women, the Women’s Abortion Action Committee, the Australian Union of Students Women’s Department, the Working Women’s Centre, Melbourne, the Melbourne Unitarian Church, the ALP Status of Women Committee and the Women’s Right to Abortion Committee. The coalition produced a monthly newsletter called Freedom to Choose. The Women’s Abortion Action Coalition also formed in Melbourne and collaborated with interstate groups.

Since the 1970s, activism far too extensive to document here has continued in all Australian jurisdictions, generally involving coalitions of women’s groups. An account of women’s experiences seeking abortion in Queensland, Tasmania and South Australia between 1985 and 1992 has been written by Lyndall Ryan, Margie Ripper and Barbara Buttfield (1994). The work of one of the major actors, Children by Choice, Queensland, was described briefly in Chapter 2. The remainder of this chapter provides an overview of recent collaborative action, including unsuccessful attempts to secure access to medical abortion, and brief accounts of the three successful campaigns to remove abortion from sub-national criminal codes.

The Mifepristone Debacle

Access to medical abortion is available in most OECD countries including the United States but in Australia its use remains illegal in several jurisdictions. Medical abortion can improve access for the hundreds of thousands of women who live far from a surgical facility and it is considerably cheaper than surgical abortion. Availability would increase choice for women, some of whom might be attracted by greater privacy. The retention of abortion in criminal codes
restricts availability and can have disastrous consequences for individuals: in 2010, a young Queensland couple was tried for procuring an abortion, using medicines imported from the Ukraine.\(^{11}\)

Some of the problems that the women’s movement has faced when trying to achieve reform can be attributed to the structure of the Australian political system, where a single senator can achieve a strong bargaining position if her/his vote is critical for the government of the day. Brian Harradine, Independent Senator for Tasmania from 1975 until 2005, was one such and he used the opportunities that presented to the full. Over the years, he made several attempts to have access to contraception and abortifacients reduced, to have Australia’s overseas aid regulated so that abortion and contraceptive provision would be restricted\(^{12}\) and to abolish the Medicare rebate for abortion. In this last crusade, he was unsuccessful.

In the early 1990s, RU-486, also known as mifepristone, was available in Australia, as part of international trials; however, the anti-choice movement staged an intense campaign against it and in 1996 Senator Harradine proposed legislation that required the Commonwealth Health Minister to approve the importation, evaluation, registration and listing of certain abortifacient drugs and, furthermore, to table approval in both Houses of Parliament within five sitting days. Despite women’s movement protests and the work of many parliamentary women, the legislation was passed. Labor Party Senator Rosemary Crowley wrote to AWHN expressing disappointment that she had been ‘unable to persuade a majority’ of her colleagues to oppose the amendment. With the new requirements in place, pharmaceutical companies did not seek approval to market the drug from the Therapeutic Goods Administration (TGA)—a process that is expensive, would provoke political controversy and might result in approval being overturned in Parliament.

This was still the situation in 2006 when, following initial moves by Australian Democrats Senator Lyn Allison and some fancy footwork and face-saving manoeuvres by the Howard Government, a Private Member’s Bill to override the Harradine amendment was introduced from the Government’s own ranks by Nationals Senator Fiona Nash. The Bill was opposed by Health Minister, Tony Abbott, and the Prime Minister. Senator Nash enlisted the support of Senators Judith Troeth (Liberal), Claire Moore (Labor) and Senator Allison in drafting and sponsoring the legislation (Dowse 2009). A massive support campaign was organised by pro-choice groups. Twenty NGOs, including AWHN, Sexual Health and Family Planning Australia, the Australian Reproductive Health Alliance,

---

11 After waiting for almost two years for a trial in an overstretched court system, the couple was acquitted.
12 The restrictions on overseas aid remained in place until March 2009, when, in response to heavy lobbying by the women’s movement, the women’s health movement, the Greens and others, the restrictions were overturned.
Women’s Health NSW, the Public Health Association of Australia and WEL, formed a new coalition: Reproductive Choice Australia (RCA). RCA worked to inform the debate in the media, on the Web and in public forums. It produced fact sheets, wrote letters and held health information sessions. It monitored the media, responding to all significant arguments. There were more than 1000 media articles in the 12 months preceding the passage of the legislation. Pro-choice members of the Senate supported an inquiry into the proposals, which extended the period of controversy. After the Prime Minister announced that a conscience vote would be permitted, RCA systematically lobbied Members of the national Parliament. The Bill passed through both Houses in February 2006. Ninety per cent of women senators, regardless of party, voted for the Bill, but only 46 per cent of men. It was passed in the House on a show of hands because the Government anticipated the outcome and did not want a division to be called (Dowse 2009).

The 2006 amendment removed the power of the Commonwealth Health Minister over the importation of abortifacients, returning authority to the TGA; however, medical abortion is still not freely available because pharmaceutical companies have not applied to import and distribute the relevant drugs. Individual doctors or groups of doctors may apply to the TGA for approval to import and distribute but this type of strategy is hampered because abortion remains in the criminal codes of four States and one Territory.

**Working to Liberalise Laws**

After more than 40 years of activism, the liberalisation of abortion law has been achieved in fewer than half the Australian jurisdictions. When criminal charges were laid against the Queensland couple in 2009, women’s groups moved swiftly into action. Intense controversy erupted, especially in Queensland, where Labor was in government and a woman, Anna Bligh, was Premier. A new coalition, Pro Choice Qld, was established. Large rallies were held, support flowed in from groups around the country and the Government was urged to remove abortion from the State’s criminal code, once and for all. Those Queensland doctors who were facilitating medical abortions suspended operations as fears about illegality re-emerged. State cabinet approved legislative changes in November but only to make mifepristone lawful under the same circumstances as surgical abortion—that is, where there is a serious health risk to the mother. Agitation for decriminalisation continued but at the end of 2009 Premier Bligh made it clear that her government had no plans to act. Any reform legislation would have to be introduced as a Private Member’s Bill and she would not bind her colleagues to any particular position (Elks 2009). That situation prevails in 2011.
In three jurisdictions—Western Australia, the Australian Capital Territory and Victoria—however, women have succeeded in having abortion removed from the criminal code. In each case, women’s groups mobilised and worked closely together. In the Western Australian case, controversy broke out in 1998 when two medical practitioners were arrested for performing an abortion, after a child had repeated family discussion in a classroom ‘news’ slot. The view of the authorities involved was that the correct interpretation of Western Australian law was that abortion was legal only in life-threatening situations. Upon the arrests, hospitals and clinics cancelled abortion lists and the ANF advised members not to participate in procedures. Amid rallies and speeches, two Bills were introduced into Parliament. A member of the Opposition Labor Party, Cheryl Davenport, introduced an abortion repeal bill into the Upper House, while Attorney-General, Peter Foss, introduced a less radical Bill into the Lower House. Unrestrained debate took place over a period of weeks, during which one member made a three-hour speech! Both Bills eventually passed both Houses; however, the Upper House responded by ruling the Foss Bill out of order, leaving only the Davenport Bill before the Parliament. There followed a period in which a host of amendments, some seriously restrictive, was proposed. On 6 May 1998, however, the Lower House passed the Davenport Bill, which made abortion legal in cases where a woman has given informed consent. On 21 May, the legislation was passed in the Upper House. The relevant sections of the Western Australian Criminal Code were repealed and replaced with a new section that makes it unlawful for anyone other than a medical practitioner to perform an abortion. While the campaign for complete repeal failed, termination is now lawful where a woman has given informed consent.\(^{13}\)

The first jurisdiction to achieve complete decriminalisation was the Australian Capital Territory, after feminist campaigns spread over more than 30 years. The legislation in force when self-government was handed down required that all abortions be carried out in a public hospital. Women went on a waiting list, and afterwards, appeared before a committee, which included a psychiatrist, to establish eligibility or otherwise. Most women who could afford it chose to travel interstate rather than be part of the waiting list/committee process. A coalition of local feminist groups, Options for Women, was active on an as-needed basis in the Territory from the 1980s onwards, agitating for reform. Members included Sexual Health and Family Planning ACT (SHFPACT), the ACT Women’s Health Network (ACTWHN), WEL, the YWCA and representatives from a range of services, such as the Rape Crisis Centre, the Domestic Violence Crisis Service and various refuges. After the election of a Labor government led by Rosemary Follett, in 1991, the Minister for Health, Wayne Berry, introduced legislation that allowed a freestanding clinic to be established. The legislation had a

---

13 For a discussion of legal complications that could emerge from the legislation see Stephen (n.d.).
difficult and protracted passage because not all members of the Government supported it but it was eventually passed. Subsequently, SHFPACT borrowed a large sum of money to set up Reproductive Health Services Proprietary Limited (RHS), adding a fraught responsibility to its list of duties. Establishment was supported by the Health Minister, who made secure premises available at peppercorn rent, giving ACT women access to a feminist-run service that met with the ethical code of the Abortion Providers’ Federation of Australia.

In 1994, Minister Berry had a Crimes Amendment Bill prepared, which sought to repeal the three relevant sections of the Criminal Code. Intense campaigns by pro and anti-choice forces followed. The proposal was set aside in preparation for the 1995 election, which the Labor Party lost. In 1998, under a Liberal minority government, which provided another institutional window of opportunity, a counterattack was launched by Independent Member of the Legislative Assembly, Paul Osborne. He introduced a Bill with the stated intention of reducing the number of abortions. Termination was to be permitted only in cases of ‘grave medical risk’ or ‘grave psychiatric risk’, with teams of doctors to be on hand to make assessments. Again, groups of ACT women took to the streets, holding rallies, speaking to the media and lobbying. At the same time, pro-choice members of the Government worked to have the more restrictive provisions of the legislation amended. The modified Health Regulations (Maternal Health Information) Act was passed into law in 1994, causing enormous problems for the board of RHS. The legislation required that women undergo a 72-hour ‘cooling off’ period between their first contact with a doctor and a termination. This requirement was both demeaning and particularly difficult for women living in surrounding rural areas. Another requirement was that information, including pictures of unborn foetuses, be provided to all women seeking an abortion. In the event, legal opinion was obtained that advised that ‘provision’ did not mean requiring women to open and read mandated material provided in large brown, sealed envelopes. Had staff been required to show foetal pictures to clients, the RHS Board would almost certainly have decided to cease operations. The legislation remained in place while the Liberal Party held government.

Prior to the 2001 election, Wayne Berry, in opposition, released draft legislation for the repeal of both the abortion provisions of the Crimes Act and the Osborne legislation. Candidates were questioned by WEL and other women’s groups about their attitudes to the proposed legislation at pre-election gatherings. Labor was returned to government at the October election and, in early December, the two Bills were introduced into the Assembly. Options for Women was brought

---

14 RHS caused continual difficulties for its parent association throughout its 12 years of existence. Apart from ACT Government legislation, which at one time threatened to close the service, there were successive legal cases to be handled, as challenges came thick and fast, requiring that a lawyer be appointed on retainer. That the legal situation played havoc with the organisation’s capacity to obtain affordable insurance was only one of many problems.
out of abeyance to conduct a support campaign. All the customary strategies were used, with perhaps one addition: for several weeks, information stalls were set up in major shopping centres on Saturday mornings. A roster was developed and women from a variety of organisations went together in pairs, hauling fold-up tables and boxes of papers, posters and pamphlets. The most common response from members of the public was ‘You’re joshing me! Are you for real? Abortion is illegal?’

As in the Western Australian Parliament, the ACT Assembly was the site of various manoeuvres, including the introduction of alternative legislation by an anti-choice member. When the time came to vote, no-one could predict what the result would be but indications were that it would be extremely close. And so it transpired: the Assembly was deadlocked at eight votes to eight, until Helen Cross of the LPA, who had not divulged her position, voted with the six Labor members, one Green and one Democrat to pass the two Bills on 21 August 2002. Cross took the view that retention of abortion in the Criminal Code was archaic. Although members were free to exercise a conscience vote, Cross was ostracised and later expelled from her party. The Osborne legislation was repealed and all mention of abortion was removed from the *Crimes Act 1900*. The Australian Capital Territory became the first Australian jurisdiction where abortion is regulated under health legislation like any other medical procedure. The dogged determination of Berry and his assistant, Sue Robinson, made a huge contribution to the outcome, as did Helen Cross, of course, the only member of the LPA who supported the reform.

The most recent success took place in Victoria, where abortion was also removed completely from the Criminal Code, in 2008. The Victorian campaign was a long, carefully planned collaboration between many pro-choice groups, demonstrating the relative ease with which momentum can be mobilised on this issue. The process began in response to the increasingly hostile pronouncements about women’s reproductive rights made by members of the Howard Government, including the Prime Minister and the Health Minister, Tony Abbott. In 2005, representatives from women’s health and reproductive and sexual health groups met and agreed to work proactively to protect women’s rights, forming the Association for the Legal Right to Abortion (ALRA), which was later incorporated. The association had a broad-based membership and its major objective was to have abortion removed from the Criminal Code through a campaign that would last as long as necessary. The approach chosen was to educate politicians, members of the media and the community about the problems that arose from the criminal status of a medical service that many women use. Health professionals and their organisations were encouraged to make their views public.
ALRA strategies included meeting all Victorian Members of Parliament, questioning them about their attitudes to reform legislation and inviting them to join the ALRA. In the first year, seven ALRA briefing papers were written and made available on the web site, which had links to the extensive resources on the WHV web site. A comprehensive range of information papers, including ‘What MPs need to know about termination of pregnancy’, was produced and disseminated. Resources were developed to facilitate community participation in the lead-up to the 2006 election. A table of Victorian parliamentarians was drawn up that included their concerns and voting intentions. All parliamentarians were provided with information and key women in all parties were approached for support. Health movement members met regularly with their local Members of Parliament.

Through the four-year campaign, all briefing papers were reviewed annually and new papers were written in response to issues that emerged from MP interviews. In 2006, ALRA and WHV staged a forum, capitalising on an SBS documentary on the life of Dr Bertram Wainer. Media and communication expertise was obtained and spokespeople were given media training. Activists were careful not to make decriminalisation an issue for the 2006 election as part of a deal with the Premier but they strongly supported pro-choice candidates. Immediately after the November election, campaigning recommenced. The Royal Women’s Hospital, the Centre for Women’s Health, Gender and Society, Melbourne University and WHV cooperated to stage a conference at the end of November that produced an advocacy tool, *Abortion in Victoria, Melbourne Declaration*. ALRA calculated that there were sufficient supporters in Parliament to pass decriminalisation legislation. The following month, WHAV formed a new group, the Abortion Law Reform Women’s Health Services Campaign Organising Group. Its activities included letter writing, media releases, creating copy for newsletters, meeting with parliamentarians, keeping a list of supporters and facilitating local electorate activity. Its work was coordinated by WHV and it made an important contribution to the campaign.

In July 2007, Labor parliamentarian Candy Broad announced her intention to introduce a Private Member’s Bill seeking decriminalisation, amid a storm of protest. By this time, however, a number of key professional bodies, including RANZCOG and the AMA supported decriminalisation. The private Bill was withdrawn in August after Premier, John Brumby, made a commitment to pursue reform and asked the Victorian Law Reform Commission (VLRC) to provide advice on legislative options by March 2008. The Premier argued that it was essential that the law reflect contemporary community standards. The commission held multiple meetings with different groups and received more than 500 submissions. Its report was released in March but remained cabinet-in-confidence until June.
As in other places, campaigning was intense. WHV continued to produce evidence-based resources for general campaign use. Yet another broad coalition, ProChoice Victoria, was formed, which included the Multicultural Centre for Women’s Health, RCA, the Doctors Reform Society of Australia and Marie Stopes International. It helped to organise rallies and forums, it lobbied, wrote letters to *The Age* newspaper and participated in radio and television interviews. An active web-based advocacy tool was established. Anti-choice campaigners targeted pro-choice MPs with messages and letters in an effort to change minds and picketed the entrances to termination facilities. At one point, a 2000-person anti-choice rally was held and the city was draped with posters depicting foetuses at different stages of development. At another point, the Roman Catholic Archbishop threatened to shut down the maternity and emergency departments of Catholic hospitals if the Bill were passed. In the meantime, ALRA and WHV continued a strategy of quiet approaches to parliamentarians and encouragement of active community participation. Community watching networks were formed in different electorates which fed information back to WHV about anti-choice activity.

When the VLRC report was tabled in Parliament, activism intensified. The report recommended three options, two that would leave the situation unclear and conditional and a third, model C, which would provide for lawful abortion on the basis of a woman’s informed consent. Parliamentarians who supported option C were encouraged to make their position known and WHV kept a list.

In August, the Minister for Women’s Affairs, Maxine Morand, introduced the Abortion Law Reform Bill 2008 into the Parliament. Based on model C, the legislation proposed to fully decriminalise abortion during the first 24 weeks of pregnancy, after which women would need the permission of two doctors, who may approve the procedure if they considered it medically appropriate, taking into account a woman’s current and future physical, psychological and social circumstances.

Within Parliament, more than 40 amendments were moved in the Lower House, most of which sought to impose a variety of restrictions, such as making counselling compulsory. Similarly, in the Upper House, more than 70 amendments were put forward. In the event, a conscience vote took place on 11 September and the Victorian Abortion Law Reform Bill passed, unamended, in the Lower House by a vote of 49 to thirty-two. The Bill passed unamended into law in the Upper House late on the night of 10 October 2008 by a vote of 23 in support and 17 opposed (Bullimore 2008; Oliver and Hawkins 2008).

Marilyn Beaumont, Executive Director of WHV, described the ensuing scene at Parliament House as follows:
Those present to witness this history in the making were dignified and respectful of the Parliamentary protocols but only until we had made our way from the Council Chambers. Tears, hugs, clapping and speeches were some of the range of responses and emotions visible in response to the stunning outcome for women’s health in Victoria. Our joining together with so many organisations and individuals in advocacy for abortion to be removed from the *Victorian Crimes Act* and for abortion to be regulated as a health service has been a monumental achievement. (Personal communication, 13 October 2008)

**Conclusion**

Activists in the maternity-care and abortion law reform movements have worked tirelessly for more than 40 years to advance women’s reproductive health rights. The task has been made gargantuan in both cases because powerful opposing interests have countered feminist campaigns at every turn. With only their own skills and the support of female colleagues and sister groups, women have had to try to match the arguments and campaigns of the resource-rich groups pitched against them. The maternity-care reform movement turned the personal into the political when members challenged the medical model of pregnancy and childbirth care that became entrenched after organised medicine achieved the subordination of midwives in the first half of the twentieth century. Like the early abortion law reformers, the issues of respect for women’s bodies and women’s rights to information and self-determination had to be articulated and drawn to public attention. Language had to be invented to express concepts and concerns not previously discussed in public. In both cases, like activists in the rest of the women’s health movement, women thought of themselves as social change agents, part of a movement that would raise the status of women and improve the conditions of their lives.

In both domains, there are major achievements to celebrate but the reforms are incomplete. Health financing arrangements and cultural norms provide incentives for women to seek medically dominated care and the prospects of independent midwifery practice and access to homebirth in the short term look bleak. Abortion remains in the criminal code in five jurisdictions and medical abortion, which has been available in comparable countries for more than a decade, is available to only a tiny number of women in a few special cases. In a policy area where powerful groups have a lot to lose from change, incremental reform rather than radical restructuring is, however, the order of the day. The women of both movements can therefore be justly proud of the reforms they have achieved. In the next chapter, the main policy responses to the women’s health movement at the State and Territory level are examined.
6. Women’s Reproductive Rights: Confronting power

Members of the AWHN Aboriginal Women’s Talking Circle at the Sixth AWHN National Women’s Health Conference, Hobart, 2010.

Photo: Tracey Wing

The Sixth AWHN National Women’s Health Conference Choir, on stage, Hobart, 2010.

Photo: Tracey Wing
National Aboriginal and Torres Strait Islander Women’s Health Strategy

“This image is of my woman’s site on Country where I live. It is where I travel to for maintaining my mental, emotional, spiritual and physical well-being. Within this place I can speak with my inner self and to my ancestors. It is where I seek clarity, guidance and reassurance, and affirm my Aboriginal identity.” Pamela Croft Warcon

The National Aboriginal and Torres Strait Islander Women’s Health Strategy launched at the Sixth AWHN National Women’s Health Conference, Hobart, 2010.
Sandy Angus, co-author, speaking at the launch of the National Aboriginal and Torres Strait Islander Women’s Health Strategy, Hobart, 2010.

Photo: Tracey Wing

Photo: Tracey Wing
At the Sixth AWHN National Women’s Health Conference, Hobart, 2010. From left: Denele Crozier and Jilpia Nappaljari Jones, AWHN committee members, with Jo Willmot and Fran Baum, keynote speakers.

Photo: Tracey Wing