ADVANCING REPRODUCTIVE RIGHTS THROUGH LEGAL REFORM: THE EXAMPLE OF ABORTION CLINIC SAFE ACCESS ZONES

RONLI SIFRIS,* TANIA PENOVIC** AND CAROLINE HENCKELS***

The past two decades have seen significant reforms in abortion law throughout Australia. From the perspective of advancing women's reproductive rights, the most significant abortion law reforms have been the decriminalisation of abortion, removal of impediments to accessing medical abortion, the imposition of an 'obligation to refer' on medical practitioners with a conscientious objection to abortion, and the introduction of safe access zones around abortion clinics. This article focuses on the introduction of safe access zones as a key legal reform that has been implemented in a number of Australian jurisdictions to support and promote women's reproductive rights, drawing on empirical research conducted by the first and second authors and discussing this research in the context of the recent High Court decision confirming the constitutionality of safe access zones.

I INTRODUCTION

The 21st century has seen significant reforms in abortion law throughout Australia. From the perspective of advancing women's reproductive rights,[1] the

* Senior Lecturer, Monash University Faculty of Law; Deputy Director, Castan Centre for Human Rights Law.

** Senior Lecturer, Monash University Faculty of Law; Deputy Director, Castan Centre for Human Rights Law.

*** Senior Lecturer, Monash University Faculty of Law; Associate, Castan Centre for Human Rights Law.

1 According to the Programme of Action adopted at the International Conference on Population and Development in Cairo, reproductive rights include the 'right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents' and 'rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health': *Report of the International Conference on Population and Development*, UN Doc A/CONF.171/13/Rev.1 (5–13 September 1994) ch I res 1 annex ('*Programme of Action of the International Conference on Population and Development*') [7.3]. This recognition was reaffirmed and expanded upon by the 1995 Beijing Declaration and Platform for Action which called on governments to 'take action to ensure the conditions necessary for women to exercise their reproductive rights': *Report of the Fourth World Conference on Women*, UN Doc A/CONF.177/20/Rev.1 (4–5 September 1995) annex II ('*Platform for Action*') ch IV(D) para 107(d). Reproductive rights have furthermore been recognised as falling within a number of fundamental human rights and ensuring universal access to reproductive rights is included within the targets for achieving

most significant abortion law reforms have been the decriminalisation of abortion, removal of impediments to accessing medical abortion, the imposition of an 'obligation to refer' on medical practitioners with a conscientious objection to abortion, and the introduction of safe access zones around abortion clinics. This article focuses on the introduction of safe access zones as a key legal reform that has been implemented across Australia to support and promote women's reproductive rights. It focuses on this specific legal reform for a number of reasons. First, it is likely that in the near future every Australian jurisdiction will have enacted safe access zone legislation and that this measure will therefore soon be a truly nationwide reform aimed at protecting women's reproductive rights. Secondly, two of the authors of this article have conducted empirical research throughout Australia into the need for, and effectiveness of, safe access zones.[2] Therefore, we are in a position to make a unique and valuable contribution to a discussion of this particular legal reform. Finally, the Victorian and Tasmanian safe access zone provisions were the subject of a recent High Court challenge in which the High Court of Australia upheld the constitutional validity of the provisions.[3] We therefore take the opportunity to discuss this decision in the context of the empirical research conducted by the first and second authors, which also formed the basis of submissions of the Castan Centre for Human Rights Law appearing as amicus curiae.

Part II of the article provides an overview of the key reforms to abortion law that have been implemented in Australia over the past two decades to advance women's reproductive rights. Part III then turns to focus on the introduction of safe access zones as a major legal reform that has had a significant impact on the ability of Australian women to access abortion services. In this context, the article discusses empirical research conducted by the first and second authors into the need for, and effectiveness of, safe access zones. In Part IV, we discuss the recent High Court decisions of *Clubb v Edwards; Preston v Avery* ('*Clubb & Preston*')[4] which upheld the constitutional validity of Victorian and Tasmanian safe access zone provisions, in light of our empirical research, focusing on the approach of the judges to determining the proportionality of the Victorian and Tasmanian laws. We conclude that the High Court's findings as to the constitutionality of the laws are reflective of our empirical findings, especially the proportionality of the laws

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gender equality set out under the 2030 Agenda for Sustainable Development: *Work of the Statistical Commission Pertaining to the 2030 Agenda for Sustainable Development*, GA Res 71/313, UN Doc A/RES/71/313 (adopted 6 July 2017) annex ('*Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 Agenda for Sustainable Development*') [5.6].

2 The first and second authors conducted semi-structured interviews with 40 people nationwide working in the area of women's reproductive health to determine the nature and effect of anti-abortion activity around clinics and the impact of the safe access zone legislation. For details regarding the methodology of this research, see Part III of this article. This research subsequently underpinned written submissions by the Castan Centre for Human Rights Law, which appeared as amicus curiae in *Clubb v Edwards; Preston v Avery* (2019) 366 ALR 1 ('*Clubb & Preston*').

3 Ibid.

4 Ibid.

to the legitimate objective of protecting the health, safety, wellbeing, privacy and dignity of Australian women.

II ABORTION LAW REFORM IN AUSTRALIA

The liberalisation of abortion law in Australia has coincided with a global trend towards liberalisation, which has in turn been underpinned by the recognition that ensuring safe access to abortion is a concomitant of compliance with international human rights norms.[5] Before 2002, abortion was a crime in every Australian jurisdiction; although the offence was subject to exceptions, such as where the pregnancy posed a risk to the woman's health. In 2002, the Australian Capital Territory ('ACT') led the way in decriminalising abortion;[6] the past decade has seen Victoria, Tasmania, the Northern Territory ('NT'), Queensland and most recently New South Wales ('NSW') follow suit.[7] In those jurisdictions that have decriminalised abortion (except the NT), as well as Western Australia ('WA'), abortion is legally available on request up to a certain stage of gestation.[8] For example, in Victoria a woman can obtain an abortion on request up to 24 weeks' gestation, in Tasmania the threshold is 16 weeks, in WA a woman cannot be more than 20 weeks pregnant and in both Queensland and NSW the gestational limit is 22 weeks.[9]

In all Australian jurisdictions, abortion is available, at least to a certain stage of gestation, where the pregnancy poses a risk to the physical or mental health of the woman (broadly defined). For example, in Victoria, a woman who is more than 24 weeks pregnant may nevertheless terminate her pregnancy if a doctor believes

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5 Johanna B Fine, Katherine Mayall and Lilian Sepúlveda, 'The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally' (2017) 19(1) *Health and Human Rights Journal* 69.

6 *Crimes (Abolition of Offence of Abortion) Act 2002* (ACT).

7 *Abortion Law Reform Act 2019* (NSW); *Termination of Pregnancy Law Reform Act 2017* (NT); *Termination of Pregnancy Act 2018* (Qld); *Reproductive Health (Access to Terminations) Act 2013* (Tas); *Abortion Law Reform Act 2008* (Vic).

8 It should be noted that the legal availability of abortion does not necessarily correspond with its practical availability. For a discussion of the broader availability of abortion in Australia, see LA Keogh et al, 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2017) 43(1) *Journal of Family Planning and Reproductive Health Care* 18; Barbara Baird, 'Decriminalization and Women's Access to Abortion in Australia' (2017) 19(1) *Health and Human Rights Journal* 197; Amelia Paxman, 'Legalisation Is Just One Hurdle: Access and Cost Is the Real Barrier for Women Seeking Abortion', *The Sydney Morning Herald* (online, 11 May 2017) <https://www.smh.com.au/lifestyle/legalisation-is-just-one-hurdle--access-and-cost-is-the-real-barrier-for-women-seeking-abortion-20170511-gw2b3u.html>; Caroline de Moel-Mandel and Julia M Shelley, 'The Legal and Non-legal Barriers to Abortion Access in Australia: A Review of the Evidence' (2017) 22(2) *The European Journal of Contraception and Reproductive Health Care* 114; Mridula Shankar et al, 'Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-Sectional Study' (2017) 41(3) *Australian and New Zealand Journal of Public Health* 309; FM Doran and J Hornibrook, 'Barriers around Access to Abortion Experienced by Rural Women in New South Wales, Australia' (2016) 16(1) *Rural and Remote Health* 3538: 1–12.

9 *Abortion Law Reform Act 2019* (NSW) s 5; *Termination of Pregnancy Act 2018* (Qld) s 5; *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4; *Abortion Law Reform Act 2008* (Vic) s 4; *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7).

that 'abortion is appropriate in all of the circumstances', including medical, physical, psychological and social circumstances.[10] The health exception, as it is commonly known, is helpful to women in that it provides an avenue for women to access safe abortion services where abortion on request is not available. Nevertheless, as the first two authors have noted previously:

> it does so at the expense of women's agency and autonomy; it positions women at the mercy of their doctors rather than empowering them to make their own decisions regarding their own bodies.[11] The degradation inherent in requiring a woman to request permission from a doctor to terminate a pregnancy is exacerbated in jurisdictions where the authorisation of two medical practitioners is required.[12]

It is also at odds with medical treatment provided in other areas of health care and contradicts the trend towards greater patient autonomy that has become the dominant decision-making paradigm in the medical context.[13]

In addition to decriminalisation, the increased accessibility of medical (as opposed to surgical) abortion is another significant reform that has taken place in the past decade.[14] Despite mifepristone (the drug used to facilitate medical abortion) being included on the World Health Organization's list of essential medicines in 2005,[15] its availability in Australia has a difficult and controversial history.[16] In 1996, the federal Parliament passed the 'Harradine Amendment', which ensured that the written permission of the federal Minister for Health was required for the medication to be imported into Australia.[17] This imposed a significant barrier to the availability of medical abortion in Australia.[18] Even after

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10 *Abortion Law Reform Act 2008* (Vic) s 5. For similar provisions in other jurisdictions, see *Abortion Law Reform Act 2019* (NSW) s 6; *Termination of Pregnancy Law Reform Act 2017* (NT) ss 7, 9; *Termination of Pregnancy Act 2018* (Qld) s 6; *Criminal Law Consolidation Act 1935* (SA) s 82A(1); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5; *Health (Miscellaneous Provisions) Act 1911* (WA) s 334. Such a provision is not needed in the ACT as there is no gestational limit to abortion on request.

11 See, eg, Baird (n 8) 201–2.

12 Tania Penovic and Ronli Sifris, Submission to Tasmanian Legislative Council Committee Government Administration A, *Report on Reproductive Health (Access to Terminations) Bill 2013* (July 2013) 7. See *Abortion Law Reform Act 2019* (NSW) s 6(1)(b); *Termination of Pregnancy Law Reform Act 2017* (NT) s 9(a); *Termination of Pregnancy Act 2018* (Qld) s 6(1)(b); *Criminal Law Consolidation Act 1935* (SA) s 82A(1)(a); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 5(1)(b); *Abortion Law Reform Act 2008* (Vic) s 5(1)(b); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(7)(a).

13 See, eg, Barbara Secker, 'The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics' (1999) 24(1) *The Journal of Medicine and Philosophy* 43; R Gillon, 'Ethics Needs Principles – Four Can Encompass the Rest – And Respect for Autonomy Should Be "First among Equals"' (2003) 29(5) *Journal of Medical Ethics* 307, 310–11.

14 A 'medical abortion' (also sometimes referred to as 'medication abortion') is the term used where the woman ingests medication to bring about an abortion, as opposed to 'surgical abortion' in which the foetus is surgically removed from a woman's uterus.

15 See World Health Organization, 'Essential Medicines List Application Mifepristone–Misoprostol for Medical Abortion' (Application, 2018) 1 <https://www.who.int/selection_medicines/committees/expert/22/applications/s22.1_mifepristone-misoprostol.pdf?ua=1>.

16 Ronli Sifris, 'The Legal and Factual Status of Abortion in Australia' (2013) 38(2) *Alternative Law Journal* 108 ('Legal and Factual Status').

17 See *Therapeutic Goods Amendment Act 1996* (Cth) ss 3, 5.

18 Sifris, 'Legal and Factual Status' (n 16) 108–9.

the repeal of this provision in 2006,[19] it was not until August 2012 that the Therapeutic Goods Administration approved an application by MS Health[20] to include mifepristone on the Australian Register of Therapeutic Goods and the availability of medical abortion therefore became less restricted.[21] This decision meant that registered medical practitioners in general could prescribe the medication required for a medical abortion, rather than only those doctors who had been authorised to prescribe the drug through the Authorised Prescriber process.[22] Finally, in June 2013, mifepristone was included on the Pharmaceutical Benefits Scheme for $38.30, to be used up to nine weeks' gestation, thereby (at least theoretically) securing its affordability as well as its availability.[23] Unfortunately, the reality of the cost of a medical abortion has not lived up to this promise. Despite the significant progress in increasing the accessibility of medical abortion nationwide, a number of obstacles (both legal and non-legal) remain. For example, from a legal perspective, the law in South Australia ('SA') seems to contemplate surgical abortion only, thereby having the unforeseen consequence of excluding medical abortion.[24] Nevertheless, the advent of telemedicine and the fact that mifepristone can be prescribed at the General Practitioner level means that many women living in rural or remote areas who would not be in a position to reach a facility providing surgical abortion services may now access medical abortion services.[25]

Women's reproductive rights have also been further supported by reforms to the law relating to conscientious objection.[26] Most Australian jurisdictions excuse a medical practitioner from participating in terminating a pregnancy where he or she has a conscientious objection to the procedure.[27] This is commonly viewed as an appropriate recognition of the right to freedom of conscience.[28] However, in

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19 See *Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Act 2006* (Cth).

20 MS Health is the pharmaceutical arm of Marie Stopes International. See *MS Health* (Web Page, 2019) <https://www.mshealth.com.au/>.

21 Sifris, 'Legal and Factual Status' (n 16) 109.

22 Though it should be noted that mifepristone still has a 'special status' when compared with other drugs in that doctors are required to undergo special training in order to prescribe it: Caroline de Costa, 'It's Time to Lift the Restrictions on Medical Abortion in Australia', *The Conversation* (online, 1 April 2019) <https://theconversation.com/its-time-to-lift-the-restrictions-on-medical-abortion-in-australia-114364>.

23 Shankar et al (n 8) 309.

24 See *Criminal Law Consolidation Act 1935* (SA) s 82A.

25 Paul Hyland, Elizabeth G Raymond and Erica Chong, 'A Direct-to-Patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 Months' (2018) 58(3) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 335.

26 For a detailed discussion of the issue of conscientious objection in Australia, see Ronli Sifris, 'Tasmania's *Reproductive Health (Access to Terminations) Act 2013*: An Analysis of Conscientious Objection to Abortion and the "Obligation to Refer"' (2015) 22(4) *Journal of Law and Medicine* 900.

27 *Health Act 1993* (ACT) s 84A; *Abortion Law Reform Act 2019* (NSW) s 9; *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11, 12; *Criminal Law Consolidation Act 1935* (SA) s 82A(5); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6; *Abortion Law Reform Act 2008* (Vic) s 8(1); *Health (Miscellaneous Provisions) Act 1911* (WA) s 334(2).

28 International human rights law enshrines the right to freedom of conscience. For example, article 18 of the *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, UN Doc A/810 (10 December 1948) states that '[e]veryone has the right to freedom of thought, conscience and religion; this right includes freedom … to manifest [their] religion or belief in teaching, practice, worship and

Victoria, Tasmania, SA, the NT, Queensland and NSW a medical practitioner cannot rely on conscientious objection where a patient's life is at stake.[29] Another limitation to conscientious objection is contained in the law of those jurisdictions that have decriminalised abortion (except for the ACT). These jurisdictions stipulate that a doctor with a conscientious objection must provide a woman who might be considering a termination with information about where she can go to receive unbiased information about her options.[30] These provisions, known as the 'obligation to refer', aim to ensure a woman's continuity of health care and are commonly viewed as an important step in achieving women's right to access reproductive health care. The 'obligation to refer' provisions have not been without controversy. For example, at the time of the Victorian law reform, the then archbishop of Melbourne Denis Hart threatened to close the maternity departments in Catholic hospitals if these provisions remained in the legislation; this threat was not implemented.[31] Nevertheless, they are supported, both at the local and global level, by the position adopted in a number of the medical profession's ethical codes and guidelines.[32] Finally, the rapid adoption across Australia of safe access zone legislation is a significant example of legal reforms advancing women's reproductive rights.

III SAFE ACCESS ZONES

Legislation providing for safe access zones ('SAZs') around clinics that provide abortion services has been introduced in six Australian jurisdictions, namely: Tasmania, the ACT, Victoria, the NT, Queensland and NSW.[33] Of the two

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observance'. Similarly, at the domestic level both the *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 14 and the *Human Rights Act 2004* (ACT) s 14 also include a right to freedom of conscience.

29 *Abortion Law Reform Act 2019* (NSW) s 9(5); *Termination of Pregnancy Law Reform Act 2017* (NT) s 13; *Termination of Pregnancy Act 2018* (Qld) s 8(4); *Criminal Law Consolidation Act 1935* (SA) s 82A(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas) ss 6(2)–(4); *Abortion Law Reform Act 2008* (Vic) ss 8(3)–(4).

30 *Abortion Law Reform Act 2019* (NSW) s 9(3); *Termination of Pregnancy Law Reform Act 2017* (NT) s 12(2); *Termination of Pregnancy Act 2018* (Qld) s 8(3); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2); *Abortion Law Reform Act 2008* (Vic) s 8(1).

31 Barney Zwartz, 'Archbishop in Abortion Law Threat', *Sydney Morning Herald* (online, 24 September 2008) <https://www.smh.com.au/national/archbishop-in-abortion-law-threat-20080923-4m04.html>.

32 See International Federation of Gynecology and Obstetrics, 'Rights-Based Code of Ethics: FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights' (Code, October 2003); World Medical Association, 'Statement on Medically-Indicated Termination of Pregnancy at the 69th World Medical General Assembly' (Statement, 69th World Medical General Assembly, adopted October 2018) [8]; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Bioethics Working Group, 'Code of Ethical Practice' (May 2006) 6 [2.6]; Australian Medical Association, 'Position Statement on Conscientious Objection' (Publication, 27 March 2019).

33 See *Health (Patient Privacy) Amendment Act 2015* (ACT) s 5, inserting *Health Act 1993* (ACT) div 6.2; *Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018* (NSW) sch 1, inserting *Public Health Act 2010* (NSW) pt 6A; *Termination of Pregnancy Law Reform Act 2017* (NT) pt 3; *Termination of Pregnancy Act 2018* (Qld) pt 4; *Reproductive Health (Access to Terminations) Act 2013*

remaining jurisdictions, SA currently has a Bill before Parliament which (if passed) will facilitate the introduction of SAZs in that jurisdiction and the WA government has committed to introducing SAZ legislation in 2020.[34] So it is likely that, by the end of 2020, all Australian jurisdictions will have enacted SAZ legislation. SAZs are also sometimes referred to as 'buffer zones', 'bubble zones' or 'exclusion zones' because they create a bubble around abortion clinics within which certain conduct is proscribed.[35] Aside from the ACT, all Australian jurisdictions that have introduced SAZs prescribe a zone of 150 metres around a clinic at which terminations are provided, within which certain behaviour is prohibited. The ACT law does not provide for a specific geographical zone but rather provides a minimum zone of 50 metres and leaves the maximum to the discretion of the Minister.[36] While Part IV of this article focuses on the Tasmanian and Victorian SAZ provisions, which were the subject of the High Court challenge in *Clubb & Preston*, the High Court's decision has a bearing on the SAZ regimes in other jurisdictions given the similarities between the provisions and their objectives.

As noted in the Introduction, between March 2017 and December 2019 the first and second authors of this article conducted nationwide qualitative empirical research into the need for, and effectiveness of, SAZs; our research examines the experience and impact of anti-abortion conduct outside Australian clinics and the effectiveness of the legal frameworks established to address it. We conducted semi-structured, in-depth interviews with 40 professionals engaged in health policy, and staff working in clinics providing reproductive health services, including abortion. Most of our interviews were conducted in Victoria and Tasmania, the first two Australian States to introduce SAZ legislation. These are also the jurisdictions that were the subject of the High Court challenge. The jurisdictional breakdown of the interviews was as follows: fourteen people were interviewed in Victoria, seven in Tasmania, three in the NT, six in Queensland, three in WA, three in NSW, one in the ACT and three in SA. Most of the interviews were conducted face-to-face with the remainder conducted via telephone or other forms of technology. The research received prior approval by the Human Research Ethics Committee at Monash University on the basis that it meets the requirements of Australia's National Statement on Ethical Conduct in Human Research.[37]

Interview participants were selected on the basis of their ability to comment on the impact of anti-abortion picketing outside clinics and the effectiveness of the

(Tas) s 9; *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s 5, inserting *Public Health and Wellbeing Act 2008* (Vic) pt 9A. For an in-depth discussion of anti-abortion picketing in Victoria and the effectiveness of safe access zones: see Ronli Sifris and Tania Penovic, 'Anti-abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317.

34 See Health Care (Health Access Zones) Amendment Bill 2019 (SA); Roger Cook and Simone McGurk, 'Government Moves to Introduce Bill for Safe Access Zones in Western Australia' (Media Release, Government of Western Australia, 10 February 2020).

35 *Clubb & Preston* (2019) 366 ALR 1, 41 [168] (Gageler J).

36 *Health Act 1993* (ACT) s 86.

37 See National Health and Medical Research Council, Australian Research Council and Universities Australia, 'National Statement on Ethical Conduct in Human Research' (Statement, 2018).

legal frameworks established to address such conduct. Due to the importance of establishing a relationship of trust with these individuals, some of whom have been personally targeted by picketers, we decided not to undertake interviews with persons who have engaged in clinic picketing. Further, patients were not interviewed due to the reality that few would be equipped to comment on the experience of accessing clinics before and after the introduction of SAZs as well as the risk of exacerbating any trauma caused by their experiences. Interviewees were asked a series of questions about the activities of anti-abortion 'protesters', the impact of these activities and how the experience of accessing premises has changed since legislative reforms commenced.[38] They were also asked about other barriers that women face when confronting a problem pregnancy.

When asked about the conduct of anti-abortionists outside of clinics, our interviewees described a range of activities, ranging from more passive forms of conduct such as silent vigils,[39] which nevertheless convey a clear message of judgement and stigmatisation, to more active forms of conduct such as physically preventing women from entering a clinic.[40] Pieter Mourik, a retired obstetrician and gynaecologist, provided a number of examples from the Englehardt Street Clinic in Albury. He said that the picketers 'used to have up to 40 people there with placards and they used to surround the cars before they got out, they used to call women murderers and you'll burn in hell and it was the most horrendous thing'.[41] Providing another example, he described 'a women [sic] coming from a small town … She didn't want anyone to notice her car, got a taxi into the town, stopped at the clinic and four of them have surrounded the taxi, in the public place, "Don't let her out, she's going to murder her baby"'. Leigh Keane, a Nurse Unit Manager at the Marie Stopes clinic in Midland (WA) noted that 'some days they get really harassing with the patients and they'll be in their face and we get quite a few upset patients coming through at times when they block the driveways'.[42] She also pointed out that clinic staff, as well as patients, were the targets of abuse. For example, 'we have had an incident, it was actually this year, where one of the older men followed one of our staff to her car because she was on the street and he kept trying to talk to her, talk at her and blocked her from closing her car door and she was a bit shaken by that'.[43]

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38 The term 'protest' or 'protestors', when used in this article, is used within quotation marks to denote our view that while the conduct of anti-abortionists outside of clinics is widely referred to by the seemingly benign term of 'protest', it in fact encompasses a range of harmful activities targeted at individuals seeking access to premises at which abortions are provided.

39 Interview with Lesley French, Former Senior Advisor, Minister for Health (Ronli Sifris/Tania Penovic, 2 November 2017); Interview with Paul Hyland, Director, Tabbot Foundation (Ronli Sifris/Tania Penovic, 31 October 2017); Interview with Philip Goldstone, Medical Director, Marie Stopes Australia (Ronli Sifris/Tania Penovic, 13 August 2019).

40 Interview with Leigh Keane, Nurse Unit Manager, Marie Stopes Clinic Midland (Ronli Sifris/Tania Penovic, 26 September 2018).

41 Interview with Pieter Mourik, Retired Obstetrician and Gynaecologist (Ronli Sifris/Tania Penovic, 15 October 2018).

42 Interview with Leigh Keane (n 40).

43 Ibid.

When asked about the impact of anti-abortion conduct outside of clinics, those interviewees who worked at clinics that were subjected to consistent picketing for an extended period of time had no hesitation in expressing their views of the negative effects of anti-abortion 'protest'. For example, Sarah Goldsteen, Nurse Unit Manager at the Greenslopes Day Surgery in Brisbane, commented that 'we had patients coming in in tears, distraught, upset, just because of the way they were treated and were made to feel by the protesters'.[44] Similarly, Philip Goldstone, Medical Director of Marie Stopes Australia remarked that 'patients used to come in, and they were very upset, and very disturbed by having to go through that, because they were already, you know, it's already a difficult day for them'.[45] Another example comes from Debbie Petrovski, Medical Secretary at the Nanyara Clinic in Perth, who opined that '[t]he girls shouldn't have to see them … they don't need to feel bad when they feel bad enough already. A lot of them generally get upset. By the time they get to the desk, they're crying, they're quite really really upset'.[46]

Just as our interviewees revealed the negative impact on staff and patients of anti-abortion conduct outside of clinics, they also consistently observed that SAZs are effective in shielding women from such conduct. That is, SAZs are achieving their objective of protecting women's dignity, privacy, safety and wellbeing. For example, in the words of one interviewee, the enactment of SAZ legislation 'was a huge fantastic achievement that made a huge big difference for women's experience for dealing with an unplanned pregnancy and abortion and for staff',[47] and in the words of another 'I think the exclusion zone … makes a huge difference. It just stops anybody standing out the front of your clinic'.[48]

In light of the negative impact of anti-abortion picketing outside of clinics and the positive effect of SAZ legislation in protecting women from such conduct, the decision of two anti-abortionists to mount a constitutional challenge against parts of the Victorian and Tasmanian SAZ legislation was met with concern by advocates of women's reproductive rights as well as those working on the ground, in the clinics. It is to this High Court challenge that this article now turns.

IV THE CASES OF *CLUBB & PRESTON* (2019) 366 ALR 1

A Background and Context

As mentioned above, aspects of the Tasmanian and Victorian SAZ provisions were the subject of a High Court challenge in the case of *Clubb & Preston* ('the *Clubb* appeal' and 'the *Preston* appeal' respectively). In this case the High Court

44 Interview with Sarah Goldsteen, Nurse Unit Manager, Greenslopes Day Surgery, Brisbane (Ronli Sifris/Tania Penovic, 1 August 2019).

45 Interview with Philip Goldstone (n 39).

46 Interview with Debbie Petrovski, Medical Secretary, Nanyara Clinic, Perth (Ronli Sifris/Tania Penovic, 16 September 2019).

47 Interview with a social worker, Melbourne (Ronli Sifris/Tania Penovic, 20 March 2017).

48 Interview with Medical Director of Gateway Health Wodonga (Ronli Sifris/Tania Penovic, 15 May 2017).

affirmed the constitutional validity of both the Tasmanian and Victorian provisions thereby ensuring that women in Tasmania, Victoria, and, by implication, those other jurisdictions with SAZ legislation, can continue to access the full range of reproductive health care services free of intimidation and harassment.

Tasmania was the first Australian jurisdiction to introduce SAZs in 2013 as part of a broader legislative program that decriminalised abortion. As already mentioned, section 9 of the *Reproductive Health (Access to Terminations) Act 2013* (Tas) prevents protesters from engaging in 'prohibited behaviour' within 150 m of a clinic at which terminations are provided, with a penalty of a fine of up to and including 75 penalty units and/or imprisonment for a term not exceeding 12 months. Such behaviour includes harassment, intimidation or obstruction of a person; visible anti-abortion protesting; footpath interference and recording a person entering premises at which terminations are provided. In April 2015, the appellant, Preston, was found guilty of engaging in prohibited behaviour, and was fined $3,000. The Magistrate rejected his defence that the provision was constitutionally invalid on the basis that it infringed the implied freedom of political communication and decided that the law was valid. Mr Preston sought review of the decision in the Supreme Court of Tasmania. The determination of a number of grounds of review was subsequently removed to the High Court pursuant to section 40 of the *Judiciary Act 1903* (Cth). Following an amended notice of appeal in the High Court the question was whether the SAZ provision violated the constitutionally implied freedom of political communication.

In 2015, when it had become clear that decriminalisation alone would not lead to a reduction in clinic picketing, Victoria enacted the *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015*, which amends the *Public Health and Wellbeing Act 2008* so as to provide for SAZs around a clinic at which abortion services are provided.[49] The Victorian legislation prohibits behaviour such as harassing or intimidating persons accessing a clinic; communicating in relation to abortions in a manner likely to cause distress or anxiety; interfering with access and recording a person accessing a clinic. The prescribed penalty is 120 penalty units or imprisonment for a term not exceeding 12 months.[50] In August 2016 the appellant, Clubb, was charged with engaging in prohibited behaviour. The Magistrate held that the law did not violate the implied freedom of political communication; she decided that Clubb was guilty of the offence, recorded a conviction and imposed a $5,000 fine. Clubb appealed against her conviction to the Supreme Court of Victoria on grounds including that the Magistrate had erred

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49 *Public Health and Wellbeing Amendment (Safe Access Zones) Act 2015* (Vic) s 5, inserting *Public Health and Wellbeing Act 2008* (Vic) pt 9A. In her second reading speech Jill Hennessy noted that:

> At the time, the government preferred to adopt a wait-and-see approach; to assess whether the decriminalisation of abortion would lead to an abatement of the 'protests', obstruction and harassment of women and staff accessing abortion services. Unfortunately, it has not, so I bring this important bill before the house.

Victoria, *Parliamentary Debates*, Legislative Assembly, 22 October 2015, 3975 (Jill Hennessy, Minister for Health).

50 *Public Health and Wellbeing Act 2008* (Vic) ss 185B, 185D.

in holding the provision to be constitutionally valid. The determination of that ground of appeal was subsequently removed to the High Court pursuant to section 40 of the *Judiciary Act 1903* (Cth).

The High Court heard the two appeals together and upheld the relevant provisions of both the Victorian legislation and Tasmanian legislation. It should be noted that there are a number of notable differences between the Victorian and Tasmanian provisions, but these differences did not affect the outcome of the cases. For example, unlike the Victorian law, the Tasmanian law explicitly prohibits 'protest' in relation to abortion.[51] Further, unlike the Victorian provision, the Tasmanian provision does not limit itself to prohibiting communication that is 'reasonably likely to cause distress or anxiety'.[52]

With respect to the *Clubb* appeal, three of the seven judges decided the case on the basis of the threshold question of whether it was necessary to decide the constitutional issue. Writing separate judgments, Justices Gageler, Gordon and Edelman all dismissed the appeal on the basis that as Clubb did not argue that she was engaging in political communication, it was not necessary to decide whether the provision in question impermissibly burdened the implied freedom of political communication.[53] The remaining four judges delved into the substantive constitutional law issue, applying the established test from *Lange v Australian Broadcasting Corporation* ('*Lange*'),[54] as subsequently developed in *McCloy v New South Wales*[55] ('*McCloy*') and *Brown v Tasmania* ('*Brown*')[56] and concluded that the Victorian law did not impermissibly burden the implied freedom of political communication. Chief Justice Kiefel and Justices Bell and Keane wrote a joint judgment, with Justice Nettle writing a separate judgment that substantively agreed with the plurality. With respect to the *Preston* appeal, there was no threshold question to be determined as Mr Preston argued that he was engaged in political communication. All seven judges dismissed Preston's appeal on the basis that the Tasmanian law does not impermissibly burden the implied freedom of political communication.

B Before the High Court: The Substantive Constitutional Question

As noted above, in determining the substantive constitutional question of whether the provisions violate the implied freedom of political communication, the judgments applied the *Lange-McCloy-Brown* test, which requires the Court to ask: (1) whether the law effectively burdens the implied freedom in its terms, operation or effect; (2) if so, whether the purpose of the law is legitimate, in the sense of being compatible with the maintenance of the constitutionally prescribed system of representative and responsible government; (3) if so, whether the law is

51 *Clubb & Preston* (2019) 366 ALR 1, 30 [116]–[119] (Kiefel CJ, Bell and Keane JJ).

52 See *Public Health and Wellbeing Act 2008* (Vic) s 185B (definition of 'prohibited behaviour' para (b)). For a discussion of this point, see, eg, *Clubb & Preston* (2019) 366 ALR 1, 81 [303] (Nettle J).

53 See, eg, *Clubb & Preston* (2019) 366 ALR 1, 32 [131] (Gageler J), 87 [328] (Gordon J), 107 [413] (Edelman J).

54 (1997) 189 CLR 520.

55 (2015) 257 CLR 178.

56 (2017) 261 CLR 328.

reasonably appropriate and adapted to advance that legitimate object in a manner that is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government.[57]

The joint judgment, that of Nettle J and that of Edelman J adopted the structured proportionality approach established in *McCloy* to assist in answering the third question, that being whether the law is reasonably appropriate and adapted to advancing that legitimate objective. This proportionality analysis requires consideration of whether

> the impugned law is 'suitable', in the sense that it has a rational connection to the purpose of the law, and 'necessary', in the sense that there is no obvious and compelling alternative, reasonably practical, means of achieving the same purpose which has a less burdensome effect on the implied freedom. If both these questions are answered in the affirmative, the question is then whether the challenged law is 'adequate in its balance'. This last criterion requires a judgment, consistently with the limits of the judicial function, as to the balance between the importance of the purpose served by the law and the extent of the restriction it imposes on the implied freedom.[58]

In line with his previous judgments, Gageler J declined to adopt a structured proportionality approach, as did Gordon J.

1 Does the Law Effectively Burden the Implied Freedom in its Terms, Operation or Effect?

In the *Clubb* appeal, the joint judgment engaged in a brief discussion of whether there was a burden on political communication, concluding in the affirmative. Nettle J acknowledged that a decision to terminate a pregnancy is a personal (rather than a political) matter and that communications aimed at deterring women from terminating their pregnancies are not political communications.[59] His Honour further rejected Mrs Clubb's 'time, manner and place' argument, loosely based on United States constitutional law, that political communication about abortion is particularly effective when it takes place within close proximity of a clinic.[60] Nevertheless, his Honour concluded that there is a burden on political communication as 'the practical effect of the provision is all but to prohibit political protest about abortions within the 150 m radius'.[61]

Similarly, in the *Preston* appeal all seven judges agreed that there is a burden on political communication, though they disagreed about the extent of the burden[62] and whether the prohibition was viewpoint neutral.[63] Gageler J was particularly forthright in holding that the Tasmanian provision constitutes a burden on political

57 *Clubb & Preston* (2019) 366 ALR 1, 10 [5] (Kiefel CJ, Bell and Keane JJ).

58 Ibid 10 [6] (Kiefel CJ, Bell and Keane JJ) (citations omitted).

59 Ibid 65 [252].

60 Ibid 65 [251]. This argument was also rejected by Gordon J: ibid 98 [376].

61 Ibid 66 [255].

62 For example, Nettle and Gordon JJ (writing separately) viewed the burden as slight whereas Gageler and Edelman JJ (writing separately) viewed it as significant: ibid 81–2 [305] (Nettle J), 93 [355], 97 [371] (Gordon J), 40–2 [163]–[170] (Gageler J), 131 [499] (Edelman J).

63 For example, according to Gordon J the prohibition is viewpoint neutral whereas according to Gageler J it has a discriminatory impact on anti-choice activists: ibid 97 [372] (Gordon J), 42 [170] (Gageler J).

communication, emphasising that in his view: the prohibition is specifically directed against protest, including peaceful protest; the prohibition is content-specific and the content to which it applies is inherently political (ie, protest about abortion); the prohibition is site/location-specific; in its practical operation the prohibition is time-specific and it impacts disproportionately on anti-choice activists.[64]

2 Is the Purpose of the Law Legitimate?

Having decided that the law does impose a burden on political communication, the judges then proceeded to consider the second step of the test, that being whether the objective of the law is compatible with the maintenance of the constitutionally prescribed system of representative and responsible government. In the *Clubb* appeal, the joint judgment decided in the affirmative; reiterating the objectives of the legislation as being 'the protection of the safety and wellbeing of, and the preservation of the privacy and dignity of, persons accessing lawful medical services', and considering the second reading speech.[65] Nettle J also readily concluded the purpose of the law is legitimate, and like the joint judgment, focused on protection of dignity as a legitimate purpose. His Honour asserted that

> the purpose of the proscription … is to protect the safety and wellbeing of women, support persons, and others such as staff, as they access premises at which abortions are provided. That is a legitimate purpose … women seeking an abortion and those involved in assisting or supporting them are entitled to do so safely, privately and with dignity, without haranguing or molestation. The protection of the safety, wellbeing, privacy and dignity of the people of Victoria … is thus consistent with the system of representative and responsible government mandated by the *Constitution*.[66]

In the *Preston* appeal, all seven judges agreed that the purpose of the law is legitimate. Although the object of the Tasmanian provision is not as explicit as that in the Victorian law, according to the joint judgment it is nevertheless clear that '[t]he object of the prohibition is to protect the safety and wellbeing, physical and emotional, of persons accessing and leaving abortion clinics and to ensure that women may have unimpeded access to, and doctors may provide, terminations'.[67] Justices Nettle, Gordon and Edelman adopted a similar approach, referencing the second reading speech and parliamentary debates to discern the legislative purpose of enabling women's access to abortion 'privately, with dignity and without harassment, stigma or shame'.[68] Gageler J took a slightly different approach, opining that in light of his conclusion that the protest prohibition places a 'direct, substantial and discriminatory' burden on political communication, the purpose of the prohibition must be 'compelling' (and not merely 'constitutionally permissible').[69] Nevertheless, in finding that the legislative purpose of ensuring 'that women have access to premises at which abortion services are lawfully

64 Ibid 40–2 [163]–[170].
65 Ibid 17 [47]–[48].
66 Ibid 67 [258] (citations omitted).
67 Ibid 31 [122].
68 Ibid 82 [306]–[307] (Nettle J). See also ibid 98 [378]–[381] (Gordon J), 119–20 [457]–[460] (Edelman J).
69 Ibid 45–6 [183]–[184].

provided in an atmosphere of privacy and dignity' is a compelling purpose, his Honour reached the same conclusion.[70]

3 Is the Law Reasonably Appropriate and Adapted to Advance that Legitimate Object?

Having determined that both the Victorian legislation and Tasmanian legislation impose a burden on political communication and that the purpose of both laws is legitimate, the judges then proceeded to consider whether the laws are reasonably appropriate and adapted to achieving their objective. Both Gageler J and Gordon J (writing separately) reached the same conclusion as the other judges in respect of the Tasmanian provision, that being that the legislation is appropriate and adopted to advancing a legitimate objective.[71]

The plurality as well as Nettle J and Edelman J employed a structured proportionality test to determine whether 'the public interest in the benefit sought to be achieved by the legislation is manifestly outweighed by an adverse effect on the implied freedom'.[72] As mentioned above, this analysis requires a consideration of whether the law is suitable, necessary and adequate in the balance. Where relevant, we refer to empirical research conducted by the first and second named authors which supports the points being made by the judges in establishing the proportionality of the laws.

On the question of *suitability*, in the *Clubb* appeal the joint judgment held that the provision has a rational connection to the legitimate statutory purpose of protecting the health, privacy and dignity of patients in a particularly vulnerable predicament.[73] Specifically, their Honours noted that

> Unimpeded access to clinics by those seeking to use their services and those engaged in the business of providing those services is apt to promote public health. A measure that seeks to ensure that women seeking a safe termination are not driven to less safe procedures by being subjected to shaming behaviour or by the fear of the loss of privacy is a rational response to a serious public health issue. The issue has particular significance in the case of those who, by reason of the condition that gives rise to their need for healthcare, are vulnerable to attempts to hinder their free exercise of choice in that respect.[74]

This emphasis on vulnerability has been a recurring theme in our interviews, with a number of interviewees emphasising the power imbalance between anti-abortionists and women who are in a vulnerable position, and whose vulnerability may be exacerbated by factors such as age, lack of English language skills or experiences of domestic violence.[75] Clinical psychologist Susie Allanson, for

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70 Ibid 48 [197].

71 See, eg, ibid 49 [199], 52 [213] (Gageler J), 100–1 [382]–[389] (Gordon J). As mentioned above, they decline to decide the constitutionality of the Victorian provision.

72 Ibid 21 [70] (Kiefel CJ, Bell and Keane JJ). See also ibid 70–3 [266]–[275] (Nettle J), 105–6 [406]–[409] (Edelman J).

73 Ibid 22–4 [75]–[85].

74 Ibid 24 [84].

75 See, eg, Interview with a nurse practitioner and midwife working in reproductive health (Ronli Sifris/Tania Penovic, 27 March 2017).

example, observed that the patients entering the clinic are a 'captive audience,' rendering them particularly vulnerable to unwanted intrusions.[76] Their Honours adopted a similar approach to the Tasmanian provision in the *Preston* appeal.

Like the plurality, in the *Clubb* appeal, Nettle J quickly concluded that the imposition of a 150 m SAZ is a suitable means of achieving the law's purpose. His Honour noted that

> preventing the kind of molestation and haranguing which Parliament considered to constitute a real risk to … persons accessing or attempting to access or leaving premises at which abortions are provided … is rationally connected to the achievement of the purpose of securing the health and wellbeing of women accessing premises … and is thus suitable in the relevant sense.[77]

His Honour adopted a similar approach in the *Preston* appeal notwithstanding that the Tasmanian provision is not expressly limited to conduct 'reasonably likely to cause distress or anxiety' on the basis that in practice this is essentially a distinction without difference as most protests about abortion outside of a clinic would be reasonably likely to cause distress or anxiety.[78] Former CEO of Women's Legal Service Tasmania, Susan Fahey, for example, observed that 'the judgment and the stigma, it violates, it's highly violent ... there are studies that show it has a lasting trauma and for some women that's the thing that's traumatic about the whole termination process, is crossing those people'.[79] Edelman J also disposed of this step quickly, noting that because it is assumed that Parliament acts rationally this step will almost always be satisfied; given that the purpose of the law is legitimate 'the effect of the protest prohibition can easily be seen as rationally connected with those purposes'.[80]

This assessment of the suitability of the Victorian and Tasmanian provisions accords with our empirical research. As discussed in Part III above, our interviews demonstrate that the SAZs are in fact achieving the objective of protecting patients and staff from harassment and intimidation. For example, one of our interviewees, a nurse practitioner and midwife working in reproductive health, commented: 'I do think the changes to the laws has meant that protest, it's just not visible. It's not threatening … I think if these laws weren't in place, those protesters would still – they'd be doing the same footwork … To the best of my knowledge they've disappeared. I haven't seen them'.[81] Similarly, Susie Allanson remarked that 'we used to have days when everyone coming in was crying … and if they weren't crying, they were just so angry. It's good now'.[82]

On the question of *necessity*, the plurality rejected Clubb's argument that there were less burdensome alternatives available that would achieve the objective of

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76 Interview with Susie Allanson, Clinical Psychologist, Fertility Control Clinic (Ronli Sifris/Tania Penovic, 22 March 2017).

77 *Clubb & Preston* (2019) 366 ALR 1, 74 [276].

78 Ibid 84 [313]–[315].

79 Interview with Susan Fahey, CEO Women's Legal Service Tasmania (Ronli Sifris/Tania Penovic, 3 November 2017).

80 *Clubb & Preston* (2019) 366 ALR 1, 124–5 [472]–[475].

81 Interview with nurse practitioner and midwife working in reproductive health (n 75).

82 Interview with Susie Allanson (n 76).

the legislation.[83] Similarly, in the *Preston* appeal, their Honours emphasised the fact that the prohibition is limited in its location to the area where anti-abortion sentiment is most likely to prevent women from accessing health care and that alone is enough to render it necessary, irrespective of the absence of a requirement in the Tasmanian law that the sentiment be likely to cause distress or anxiety.[84] In the *Clubb* appeal, Nettle J took a different approach, opining that it is for Parliament to decide what is necessary to achieve the objective of the law, and only if the means used are beyond what could reasonably be deemed necessary will the law be adjudged as unnecessary.[85]

Nettle J emphasised the nature of the conduct engaged in by anti-abortionists prior to the introduction of the legislation to highlight that such conduct may be extremely distressing and it is therefore inaccurate to refer to it by euphemisms such as 'sidewalk counselling'.[86] His Honour relied on the empirical research of the first and second authors of this article which was referred to in submissions of the Castan Centre for Human Rights Law appearing as amicus curiae,[87] noting that

> [i]n this matter, some instances of conduct that might fall within para (b) were more graphically elucidated in experiential evidence …
>
> (a) Protesters approaching, following or walking alongside people approaching clinic premises, distributing pamphlets, and distributing plastic models of foetuses.
>
> (b) Protesters equating foetuses with babies by imploring patients not to 'kill' their 'baby', and castigating patients as murderers. …
>
> (e) Protesters displaying large and graphic posters depicting what purported to be foetuses post-abortion, foetuses in buckets, or skulls of foetuses.
>
> (f) Protesters distributing visually graphic literature containing medically inaccurate and misleading information warning that abortion results in infertility, failed relationships, mental illness and cancer.[88]

Indeed, as discussed in Part III above, our research has revealed the nature of the conduct engaged in by anti-abortion picketers as well as the extent of the negative impact generated by the conduct of anti-abortionists outside of clinics. Our interview with a general practitioner working in sexual health in regional Victoria was particularly illuminating on this matter; when questioned about the impact of the anti-abortionists' activities on patients, she made the following observations:

> It's devastating. Absolutely devastating. And it doesn't matter if it's a 16-year-old girl or a 50-year-old woman; it affects all of them … it has been really traumatic for the patients. [The effect is] definitely a long-term effect. I have patients who I'm seeing for the first time. They might be say 45 with an accidental, unexpected pregnancy. And they will say to me I had a termination when I was young, when I was 18, and I'd gone to that clinic, which is one of the clinics in Melbourne, and

83 *Clubb & Preston* (2019) 366 ALR 1, 26 [91].
84 Ibid 32 [125]–[126].
85 Ibid 70 [266].
86 Ibid 75–6 [280]–[281].
87 It should be noted that the authors of this article are the Castan Centre academics who appeared as amicus curiae.
88 *Clubb & Preston* (2019) 366 ALR 1, 75–6 [281] (footnotes omitted).

> I'll never go back there because those people out the front – I still think about it, I still feel stressed about what happened, and just the memory is really upsetting for them … I've had patients who have gone ahead with pregnancies in order to avoid that situation again. Because they've found that traumatic. And it's certainly swayed people's decisions for future pregnancies.[89]

As well as acknowledging the extent of the negative impact of the conduct of anti-abortionists on patients seeking to enter or leave clinic premises, Nettle J also rejected a number of alternative measures presented by Clubb which were argued to impose a lesser burden.[90] In his Honour's view, none of Clubb's suggestions represented an obvious and compelling alternative to the existing provision. Therefore, the requirement of necessity was made out. His Honour adopted a similar approach in the *Preston* appeal, also rejecting the proposed alternatives presented by Preston as neither obvious nor compelling.[91]

Like the plurality and Nettle J, Edelman J concluded that in the case of the Tasmanian provision the necessity requirement is met, but not before opining that the burden that the provision imposes on political communication is both 'deep' and 'wide'. It is 'deep' in the sense that it 'targets protest that has a powerful association with political communication', imposes criminal consequences and is discriminatory in its effect in that the prohibition will be most deeply felt by those 'protesting' against abortion.[92] It is 'wide' in the sense that it covers a fairly extensive area.[93] Nevertheless, his Honour went on to conclude that

> despite the depth and width of the burden, it is unlikely that the purposes of the *Reproductive Health Act* could have been served to the same or a similar extent without imposing a burden that was similarly deep and wide. At the least, the possibility that the purposes could be so served by alternative means is neither obvious nor compelling.[94]

The conclusion of those judges who considered this issue through the lens of structured proportionality, finding that there is no obvious or compelling alternative to the 150 m SAZ, is supported by our empirical research. For example, Sarah van der Wal, a staff specialist working in reproductive health care, emphasised the relevance of context when considering what is an adequate exclusion zone:

> [in a large hospital setting] they're so far from the front door that … there just isn't anywhere they could possibly be, that would be visible to anyone entering or exiting the hospital, the way the buildings work. Whereas I think if you were in a row house in the middle of East Melbourne, that 150 metres might not be adequate, because you could still actually be quite close to the premises and be very visible and very targeted. I think it probably – for us, 150 metres is more than adequate. Whereas for other people, it might not be.[95]

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89 Interview with general practitioner working in sexual and reproductive health in regional Victoria (Ronli Sifris/Tania Penovic, 16 May 2017).

90 *Clubb & Preston* (2019) 366 ALR 1, 76–8 [285]–[291].

91 Ibid 85–6 [316]–[323].

92 Ibid 126 [481].

93 Ibid 126–7 [482].

94 Ibid 128 [486].

95 Interview with Sarah van der Wal, staff specialist working in reproductive health (Ronli Sifris/Tania Penovic, 1 May 2017).

It is our view that the context-dependent nature of the adequacy of the exclusion zone supports the conclusion in both the *Clubb* appeal and the *Preston* appeal that there is no obvious or compelling alternative to the existing exclusion zones.

Finally, in the *Clubb* appeal the joint judgment considers whether the law is *adequate in its balance*. In discussing this final aspect of the test for determining whether a law violates the implied freedom, the joint judgment once again returned to its focus on dignity, noting that a 'law calculated to maintain the dignity of members of the sovereign people by ensuring that they are not held captive by an uninvited political message accords with the political sovereignty which underpins the implied freedom'.[96] This resonates with comments made by a number of our interviewees. For example, Sarah van der Wal noted that it is 'everyone's right, to walk in and walk out of a hospital unmolested for whatever reason they're having to access whatever health care they need'.[97] A nurse practitioner and midwife working in reproductive health remarked that 'women are equal and entitled to reproductive services without fear of judgment, vilification, non-acceptance or gender-based vilification'.[98] Further, as mentioned above, Susie Allanson's description of patients entering a clinic as a 'captive audience' encapsulates this idea that people should be protected from unwanted, unavoidable communications which are foisted upon them.[99]

In addition, their Honours noted that whilst there is a burden on political communication, that burden is slight; it relates only to communications about abortion (and in this respect is viewpoint neutral) and only within a geographic area that prevents certain people from being targeted.[100] Nettle J noted that a law which is suitable and necessary will only be inadequate in the balance if it is 'grossly disproportionate to' or goes 'far beyond what can reasonably be conceived of as justified in the pursuit of that legitimate purpose'.[101] This was not such a case. Therefore, his Honour held that the provision does not violate the implied freedom of political communication. Similarly, in the *Preston* appeal, Nettle J once again found that the law is adequate in its balance. Edelman J reached the same conclusion; although his Honour opined that the burden on political communication is significant, he also took the view that the legislative purpose of protecting women's safety and privacy when accessing health care was of 'great importance to Parliament'.[102] On this basis, his Honour concluded that the 'burden upon freedom of political communication cannot be said to be in gross and manifest disproportion to the importance of the purpose'.[103]

96 *Clubb & Preston* (2019) 366 ALR 1, 24–7 [99].
97 Interview Sarah van der Wal (n 95).
98 Interview with nurse practitioner and midwife working in reproductive health (n 75).
99 Interview with Susie Allanson (n 76).
100 *Clubb & Preston* (2019) 366 ALR 1, 27 [100], 32 [127].
101 Ibid 78 [292].
102 Ibid 131 [499].
103 Ibid 132 [501].

Accordingly, the High Court has upheld both the Victorian and Tasmanian SAZ provisions as being constitutionally valid. Victorian and Tasmanian women can continue to access the health care that they require free of intimidation and harassment. Further, following this decision, the SAZs in other Australian jurisdictions appear to be safe.[104]

V CONCLUSION

The law in most Australian jurisdictions has progressed to a position where abortion is viewed within the paradigm of health and medical treatment rather than falling within the criminal law framework. In fact, not only has the regulatory paradigm shifted from criminal law to health law, but laws have been enacted to protect women from those who wish to continue the age-old practice of naming, shaming and blaming; and the High Court has given its imprimatur to the constitutionality of these laws.

This article has sought to contribute to the discussion around advancing women's access to abortion in Australia by drawing on empirical research conducted by the first and second authors. It began by briefly tracing the reform of abortion law in Australia, highlighting that there has been significant progress in the past two decades with respect to the legal advancement of women's access to the full range of reproductive health care. It then focused on the specific issue of SAZs, which have been particularly contentious in recent years. The position adopted by the High Court of Australia in the recent case of *Clubb & Preston* reflects the data obtained through the empirical research conducted by the first and second authors; that the SAZ provisions in Victoria and Tasmania are a proportionate means of attaining a legitimate constitutional objective. This same data may be invoked to support the SAZs in other Australian jurisdictions. Accordingly, this article has illustrated the practical significance of dismantling legal barriers to abortion access and of using the law to protect women seeking to access a lawful medical service.

Focusing on the law, however, presents only a partial picture. The empirical research of the first and second authors demonstrates that in the struggle to secure women's access to abortion, it is not enough to dismantle the legal barriers to access and to enact legislation to prevent anti-abortion conduct outside of clinics, other non-legal obstacles must also be addressed.[105] While space precludes a comprehensive discussion of the non-legal barriers faced by women seeking abortion in Australia, our qualitative empirical research supports the argument that

104 In February 2020, Clubb pursued her remaining ground of appeal, that the Magistrate had erred in law in convicting her: *Clubb v Edwards* [2020] VSC 49. Justice Kennedy dismissed the appeal. In reaching this decision, her Honour referred to the empirical research of the first and second authors, as submitted by the Castan Centre for Human Rights Law in the High Court proceeding: 'It is however significant that in *Clubb* Nettle J referred to conduct that might fall within para (b) [of the Victorian provision] (as presented by the Castan Centre for Human Rights Law) as including 'protestors' approaching, following or walking alongside people approaching clinic premises, and distributing pamphlets': at [106] (footnotes omitted).

105 See, eg, Keogh et al (n 8).

significant non-legal barriers to abortion access pose a real challenge for many Australian women. These include, for example, financial barriers, geographic barriers, negative practitioner attitudes and deficiencies in practitioner training. Accordingly, while the achievement of reproductive rights through legal reform is an important step in the journey, it is not the end point. In order to fully realise the reproductive rights of Australian women, the enactment of formal legal rights is not enough; government, and we as a society, must act to facilitate the practical realisation of those rights.