Submission
No 12

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Real Choices Australia

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Submission to the Committee on Social issues on the Reproductive Health Care Reform Bill 2019

Thank you for the opportunity to address this very important Reproductive Health Care Reform Bill, which I do in my capacity as an educator and counsellor in this field for more than two decades. I also bring to the discussion my PhD research on the nature of abortion discourse in Australia and the ways in which such discourse has negatively influenced legislation through disinformation and brought about negative consequences for women.

My work over these decades has involved educating health professionals, counsellors, and the public across a broad range of issues which includes the adverse effects of abortion on the wellbeing and mental health of women. For the last 15 years this work has focussed more directly on women's experiences of coercion, both direct from people in their lives, or health practitioners, and based on their circumstances.

My just completed PhD revealed that practitioners on whom women may rely or information, assessment of risk factors, support, or alternative option discussions are largely silenced due to perceived or real professional risks. Such silencing, and therefore isolation of women is only increased when it is enshrined in legislation that says certain segments of the population cannot speak about abortion to their own patients (conscientious objection), or within certain areas (safe access zones).

This paper argues against the decriminalisation of abortion in New South Wales based on both the experiences of women who have relied on restrictions as a means to avoid coerced abortion, and on the fact that such steps are based on disinformation and therefore do not meet any criteria for just law.

This submission seeks to assist the committee to understand the ways in which this legislative change has been based on disinformation and alarmist abstraction which does not reflect reality, and which is ultimately harmful to women. The provisions of the proposed Bill will be addressed based primarily on this foundation, which argues against decriminalisation as a general principle as it removes protections on which some women currently rely.

The proponents of this Bill, seek to convince the government and the public that women face major hurdles to access abortion, and experience the threat of criminal prosecution. This is not true. There have been no criminal prosecutions of any woman or doctor acting within the current law and in fact the majority of the general public are unaware that abortion is within the criminal code.

Most women have no trouble accessing abortion, and have no awareness that it is not completely legal. Even a short perusal of commentary in social media demonstrates how easy it is to access abortion and how little impact the current legal status has,

> *'There are Marie Stopes clinics that advertise them on their website. Not illegal at all!'*
>
> *'It's technically illegal, but they are straight forward to get, no referral needed for private clinics.'*
>
> *'No they aren't. They are perfectly legal not sure where you got your information from.'*
>
> *'They are not illegal.'*
>
> *'You can walk into ANY clinic that performs this procedure with an appointment and have the procedure done.'*
>
> *'Yes, its "technically illegal" however, you do not need a referral, you will not be arrested, you will not be charged with a crime.'*

While some still advocate that abortion decriminalisation helps women 'feel' better about abortion, or gives them greater access, neither of these assertions hold up to any scrutiny. In fact, abortion advocates have lamented that perhaps they got it wrong in Victoria, with Leslie Cannold, former President of Reproductive Choice Australia, stating,

> '*little has changed on the (abortion) service provision front'* she goes on to state that, '*Indeed, it may be that criminal sanctions on abortion don't cause abortion shaming and stigma.'*[1]

Some researchers have even admitted that abortion access may have reduced since decriminalisation in Victoria, *'Since abortion law reform, access to public services has shrunk. It's not getting better.'*[2]

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[1] Cannold, L. (2012). http://rightnow.org.au/opinion-3/abortion-shaming-what-the-law-does-and-doesn't-do/#disqus_thread

[2] Keogh, L., Newton, D., Bayly, C., McNamee, K., Hardiman, A., Webster, A. & Bismark, M. (2017). Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia. *Journal of Family Planning and Reproductive Health Care*; 43;18, 18-24

Part 2 Performance of terminations by registered health practitioners

5: Termination by medical practitioners at not more than 22 weeks
6: Termination by medical practitioner after 22 weeks

The gestation of 22 weeks has been chosen based on likelihood of viability of the foetus, suggesting that there is an awareness that the life of the foetus holds some intrinsic value. Deciding on such a limit however becomes arbitrary when babies of younger gestational ages have been saved when born prematurely and when medical advances mean that it is very likely that this will only improve over time, with even younger babies able to survive with less negative outcomes.

There seems to be no real difference in the proposed ability to procure abortion prior to or after 22 weeks, except for the criteria that the medical practitioner 'consult' with a second practitioner. In practise this has little value when such a consultation can mean the exchange of paperwork for signing, a chat over coffee or a phone call, with no second consultation with the woman.

Including reference to 'future physical, psychological and social circumstances' is euphemism for any reason at all that could be anticipated, even if unlikely and/or unpredictable. Neither the woman, nor medical practitioners have the power to predict such future circumstances so this is at best guess work. In such circumstance it is incumbent on practitioners to also provide predications of more positive circumstances within which the woman may thrive in pregnancy and parenting if appropriately supported.

We know from the Victorian experience that this leads to a situation where half of all later term pregnancies are terminated for psychosocial, not medical concerns[3]. We also know that such moves to allow abortion throughout the entirety of pregnancy for potential and unknown future social circumstances is not in line with community attitudes or expectations.

Both the media and abortion advocacy organisations perpetuate the myth that the majority of people support abortion on demand for women yet surveys which provide contextual information about gestational limits or reasons for abortion paint a very different picture.

The Victorian Law Reform Commission[4] identified five studies as having the greatest reliability, yet not one of these studies demonstrated majority community support for abortion past the first trimester. In fact, the most interesting aspect of at least one of these studies is the level of ambivalence and dissonance displayed when people were asked about 'abortion rights' and also provided context for abortion. In response to one question, 60% of respondents claimed to support a woman's right to abortion on demand, but 51% opposed abortion for financial or social reasons, increasing to 82% opposition to abortion after 20 weeks for non-medical reasons.

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[3] http://realchoices.org.au/wp-content/uploads/2019/08/Late-Term-Abortion-by-Year-CA-vs-PS.pdf
[4] VLRC. (2008). Victorian Law Reform Commission: Surveys of Attitudes. Available at: https://www.lawreform.vic.gov.au/content/4-surveys-attitudes

When asked about professional sanctions as opposed to criminal sanctions for medical practitioners the same dissonance can also be seen. In an article published in 2010[5], abortion providers investigated the attitudes of Australians about abortion itself and about whether doctors should experience professional sanctions for doing abortions. This research demonstrates that the general public is far more conservative about pregnancy termination when questioned about professional sanctions in specific circumstances than we are generally led to believe.

Whilst 61% believe that abortion should be legal in the first trimester, this figure reduces significantly to 12% for the second trimester and only 6% for the third trimester. This is hardly a call from the public for abortion on demand. In terms of professional sanctions for doctors for performing abortions, the same study reveals even less support for abortion in most social circumstances. The percentage of people supporting a lack of sanctions against doctors is significantly higher when asked about abortion for serious health and life threatening situations. But when asked about social circumstances, the numbers change dramatically.

42% of people believe a doctor should face professional sanctions for performing an abortion on a woman when she states that she cannot afford to raise the child, with 28% being uncertain. 45% of people believe a doctor should face professional sanctions for performing an abortion on a woman when she states that she does not wish to have a child at that time, with a further 23% being uncertain. Given that these circumstances encompass the majority of reasons why women have abortions, even in later trimesters, it would appear that the majority of the general public actually do not support abortion on demand for any reason, at any gestation, despite the misleading claims of abortion proponents.

7: Requirement for information about counselling

This clause contains no useful or enforceable processes, particularly when taken in context with the Conscientious Objection clause which is discussed below. It is not possible, on the basis of a short, single consultation for a doctor to know whether a particular woman would benefit from counselling, particularly when the standard practise is to always presume a woman will terminate. One woman's recent call to a Marie Stopes line seeking counselling resulted in her being given an appointment and advised to 'wear 2-piece clothing, not a dress and to bring enough money to cover the procedure'. The presumption was that she would proceed to termination and the process of scheduling clients for such a procedure when they request only counselling seems unethical and coercive.

Implicit in this clause is that an abortion provider can be trusted to decide a woman may need more information or have greater risk factors, or be refused an abortion, but *no other doctor can.* This is discriminatory at the very least and instils both confusion and lack of confidence in women about who can be trusted to fully inform them and seek their best interests.

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[5] De Crespigny, Wilkinson, Douglas, Textor and Savulescu. (2008) Australian attitudes to early and late abortion, Medical Journal of Australia 2010 193: pp9-12 (Appendix F)

9: Registered health practitioner with conscientious objection.

To legally enforce a requirement for any person to act against their moral beliefs and conscience has a number of unintended consequences in the setting of abortion when many people are sensitised already to the pressures of abortion advocating discourse. There are a number of reasons why a doctor may deem abortion to be unsuitable for a particular patient and where he or she may advise a different course of action or justifiably refuse to facilitate abortion. These include, but are not limited to:

- Knowledge that a woman has specific risk factors increasing her risk of physical or psychological harm over that of continuing the pregnancy.
- Knowledge that a woman's cultural background may be a source of coercion toward abortion.
- Knowledge or suspicion that a woman is experience reproductive coercion from a partner.
- Being advised that abortion is sought for what would be deemed unacceptable reasons, such as sex-selection.
- Assessed ambivalence about having an abortion that may be remedied by assisting her to seek out supportive alternatives.

In Victoria, where Conscientious Objection laws exist, Dr Mark Hobart's practise was brought into question when he refused an abortion referral for a woman who met three of these criteria. His patient was from a cultural background that may be coercive, the abortion was sought for sex-selection purposes and he was unclear about whether she may be also experiencing pressure from her partner. He therefore appropriately declined to provide an abortion referral based on his professional judgement and the patient's best interests.

The patient made no complaint about this and continued to see him as her GP. At a follow up appointment he found that his patient had undertaken the abortion and he reported the provider of the abortion to his professional body. On reporting this incident, Dr Hobart found himself the subject of scrutiny for not making the referral, under conscientious objection laws.

In such circumstances, whether Dr Hobart holds a conscientious objection to abortion should be irrelevant as he acted in accord with ethical medical practise. Yet it was Conscientious Objection laws that threatened his work as a medical practitioner and which overstepped the bounds of the privacy of discussion between doctor and patient. If in fact abortion decisions are best made between women and their doctors, the best doctor for such decision making is the one who cares for her general healthcare, not an abortion provider who has never consulted with the woman. However, when medical practitioners witness what occurred to Dr Hobart, all are left wondering whether they can say or do anything that may be construed in negative terms with regard to abortion, even when they have information that an abortion would be more harmful than good for a patient.

Victorian researchers are already calling for further guidelines to '*clarify the limits of the clause (*of CO*), and potentially reduce disingenuous claims of conscientious objection'*[6].

My recent research findings suggest that all doctors, even those who support a woman's right to abortion, may withhold information or not provide adequate assessment based on what they perceive as a professional risk in doing so. This law then interferes with a doctor's professional responsibility to their patient, to fully assess their needs and wellbeing, taking into consideration her risk factors and situation and making the best decision for her.

This law also reinforces to women that if a doctor questions whether abortion is in her best interests, that he/she cannot be trusted. Such a law essentially puts her on a conveyor belt straight to an abortion clinic, where doctors who know nothing about her circumstances, her health history or her real needs, will perform their business, providing abortions.

10: Professional conduct or performance

While admirable in intent, this clause too becomes meaningless when we already have evidence that such reporting of unprofessional conduct can result in one's own professional practise being questioned. It is also somewhat meaningless to the many women I have consulted with as a professional, who have described circumstances where they advised a provider that they were being coerced by a partner, yet this was ignored, or they felt directly coerced by an abortion provider. In one such case one woman describes sitting in front of an abortion provider while he waited for her to take a mifepristone tablet to initiate a medical abortion.

"I was shaking my head and crying saying I wasn't sure I could do it. He said to me 'you can hardly bring such an unwanted baby into the world can you'. 'At that point of horror, I just swallowed the pill.'

Another describes her own tears and ambivalence and being told: *"just take the pill or get out, I have other people to see"*

It is clear from only these 2 of many cases in my own files, that there are abortion providers that do not identify when women need counselling and coerce women themselves. Such cases are drawn from a number of States, including New South Wales so it would seem a systemic problem of abortion provision, not isolated to only 1 or 2 providers. Of course Queensland parliament ignored the direct admission from one of their providers that she performs abortions on knowingly coerced women[7]. While theoretically there should be recourse for such women to make complaints to professional bodies, they are often too vulnerable, and under-resourced to

[6] https://about.unimelb.edu.au/newsroom/news/2019/january/doctors-conscientious-objection-to-abortion-can-affect-womens-health-study

[7] Abortion Coercion

do so. They simply want to put it behind them and try to find some way to live with their unremitting grief.

14: Review in relation to gender selection

While the NSW government has expressed its opposition to abortion for sex selection purposes, this clause does nothing to prevent its occurrence under the proposed legislation. There already exists evidence in Victoria that in certain cultural groups, sex-selection abortion is being undertaken creating an alarming imbalance in the sexes in a very short space of time[8].

When no reason is required to be collected or reported for abortion, it is not possible for a review of sex-selection abortion to be undertaken. As this is a phenomena which can only be noted over time, at what cost is this 'wait and see' approach be acceptable, when it is estimated that at least 300 girls were selectively aborted in the communities under study in Victoria.

16: Review of the Act

This clause raises more questions than solutions when the legislation it is contained within provides no data to be reviewed. With no requirement for providers to report numbers of abortions or for women to provide reasons for abortion, there is literally nothing to be reviewed. It cannot be determined whether there are factors predisposing women to feel pressured toward abortion where it may be more appropriate for government to be ensuring alternatives or whether practitioners are effectively carrying out their professional responsibilities.

Supplementary information on the adverse impact of abortion on women.

Today we have tens of thousands of women living mostly in silence with adverse effects from abortion, some to such a degree that their lives are irrevocably negatively changed. There is substantial evidence in the literature that up to 20% of women experience serious and long term psychological harm from abortion, much of which I addressed in my PhD research and excerpt below.

[9]Much of the research related to negative outcomes for women following abortion has focussed on the measurable mental health effects, including anxiety, depression, suicide, PTSD, and increased use of alcohol and illicit drugs (Coleman, 2011; Curley & Johnston, 2013; Dingle, Alati, Clavarino, Namman & Williams, 2008; Ferguson, Horwood & Boden, 2009).

Less measurable emotions including sadness, grief, anger, shame, embarrassment and abandonment can all feel debilitating and have all been described by post-abortive women in social media and accounts from post-abortion counselling (Burke & Reardon, 2002; Prommanart

[8] https://academic.oup.com/ije/article/47/6/2025/5057663
[9] Garratt, D. (2019). Manipulative Dominant Discoursing: Alarmist Recruitment and Perspective Gatekeeping. Unpublished PhD thesis

& Phatharayuttawat, 2004; Kersting, Reutemann, Ohrmann, Baez, Klockenbusch, Lanczik,& Arolt, 2004). The researcher's experience in hearing the stories of post-abortive women is that they often feel very isolated in their experiences, as the Dominant Discourse does not reflect or acknowledge negative experiences. Negative emotional experiences are often censored and dismissed as being irrelevant, fabricated, purely the result of social stigma or ignored. This censorship magnifies their sense that there may be something intrinsically 'wrong' with how they feel.

With an estimated 80,000 abortions undertaken in Australia each year, 20% equates to 16,000 women living with measurable adverse mental health outcomes in our communities. The cumulative effect of this over time in terms of numbers and community impact is huge.

It is ethically wrong to ignore this harm and add to the abandonment and betrayal of such women, whose real needs should have been assessed and addressed. Abortion is the 'simple' solution for those living outside the sphere of the woman's body, but it is only simple in the short term. This simple common procedure takes minutes, but the effects can last a lifetime and the cost to our economy in lost productivity, and harm, not only to women, but to those with whom they share their lives is immeasurable.

It is not necessary for New South Wales to rush toward an act that other states of implemented just because it is the only state not to have done so. In fact, NSW government have a unique opportunity to fully examine the evidence, assess why it is that many countries are restricting abortion in light of evidence, and truly make the more progressive decision.

Such legislation would include the following:

- Parental notification and consent for minors seeking abortion
- Implementation of waiting periods and immediate prohibition of 'walk in-walk out' style abortion clinics
- Comprehensive and independent assessment of coercion
- Informed consent processed to include an understanding of general and specific risk factors that are evidence based
- Education for professionals to assess, identify and provide supportive care to those suffering adverse effects of abortion
- Support of programs and organisations that meet the actual needs of pregnant and parenting women who may be under-resourced or lacking support.
- Establishment of confidential, supportive mechanisms for women to make complaints specifically about abortion provision.

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Attachment: Briefing Paper on Coercion

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Briefing Paper: Reproductive Coercion: Coercion to Terminate a Pregnancy July 2018

Marie Stopes, one of Australia's biggest abortion providers recently released a draft White Paper entitled Hidden Forces: Shining a Light on Reproductive Coercion. As expected from an organisation heavily invested in marketing and delivering abortion services the paper has a very strong emphasis on coercion related to continuation of pregnancies with coercion to terminate barely warranting a mention.

In a culture where abortion advocacy is the dominant force the majority of published literature on reproductive coercion is biased toward coercion related to contraceptive sabotage and pregnancy continuation. It is no surprise therefore that the literature drawn on in the references to the White Paper rarely addresses coercion to terminate. For the most part coercion to terminate is no longer differentiated from coercion to continue a pregnancy, both being lumped together under the tidy label of 'pregnancy outcome control'.

The White Paper spends a lot of time within its 50+ pages lamenting a lack of clear definition of coercion. I suspect this will remain a long-term problem as abortion advocacy organisations seek definitions that meet their ideological objectives of keeping abortion positively framed. Acknowledging abortion coercion becomes hugely problematic for such groups, especially when coercion in these circumstances must also include many of the reasons that the majority of women seek abortion.

Most abortions occur in the setting of women lacking necessary resources to continue a pregnancy, whether these are practical, economic, relational or supportive. When this is combined with subtle or overt coercion by other people, and by a dominant discourse that offers abortion as a solution for these social inequities, it seems very obvious that coercion toward abortion must be significant.

With leading abortion advocates and providers denying the existence of the dozens of women who change their minds every year after commencing medical abortions, we have a baseline for how such ideologues view the existence or prevalence of coercion to terminate. *'These women simply don't exist'*.

While ignoring the prevalence of coercion toward termination, the White Paper makes a giant leap when it labels the Federal Government's 2006 pregnancy support counselling scheme a form of reproductive coercion because it doesn't allow abortion provider counsellors to access the Medicare rebate for counselling. They suggest that abortion providers, who only receive payment if a woman

proceeds to abortion, demonstrate no bias in decision making counselling and should therefore have access to the payment. Such counsel should form part of any medical or surgical informed consent process without the requirement for added funding to do so.

It is also interesting to see the way in which abortion advocates perceive threat from the very few, mostly unfunded and volunteer driven pregnancy support services which offer support for women who would choose to continue a pregnancy. In spite of the fact that not all of these services have a religious basis, and many of them are volunteer staffed by qualified professionals, they are deemed to be incapable of providing accurate information without bias. In fact they further suggest, in the absence of any evidence, that such services can inflict psychological harm on women.

There is a very interesting statement made in the midst of this section, in relation to pregnancy support counselling services: 'In no other sector can such unregulated practises occur without legal ramifications." I would argue that in no other sector of health care can women demand a medical or surgical procedure for no reason other than that they want one, and doctors be forced to provide access to it either directly or indirectly. Of course the preference within this White Paper is that no doctor ever be allowed a conscientious objection to abortion because this is also a form of reproductive coercion. Apparently women are autonomous, intelligent decision makers who don't need help or support in deciding whether abortion is right for them, but if they happen to come across a doctor who doesn't provide them with an immediate referral, they may be forced to *'continue a pregnancy against her wishes or seek abortion at a higher gestation'.*

While Marie Stopes is being encouraged to take this process of investigation into reproductive coercion forward, it is prudent to note their own record of ignoring any pressures toward abortion from their 2008 survey entitled Real Choices. In their questions on why women resolved their unintended pregnancies in particular ways, parenting, adoption, abortion, their response options reveal exactly what they are looking for. With multiple options to choose 'feeling pressured into' for questions on resolving an unintended pregnancy by parenting or adoption, not one option was provided for a woman to say she was pressured to abort. This alone typifies abortion advocates' interest in abortion coercion and the reasons why it is vital that we now highlight the very real and very prevalent experiences of women pressured to terminate. For this reason, this paper deals only with reproductive coercion related to pressure to terminate.

Coercion is more than just overt pressure

The majority (>95%) of terminations in Australia occur for psychosocial reasons including not having enough resources, whether financial or material, not feeling able to cope with a baby due to age or lack of support, fears about the impact of pregnancy and parenting on other life choices, as well as consideration for the needs of other people a woman cares for.

Abortion advocates cite such reasons, among others, as supporting the need for abortion, yet in reality abortion offers surgical or medical solutions to social and relational problems, meaning women are forced to decide between their social/economic wellbeing and the continuation of a pregnancy. The power of this subtle form of coercion becomes even more insidious for post-abortive women who experience regret, suffering or mental health problems following abortion as the discourse convinces them they made a real choice to terminate and therefore carry full responsibility. Post-termination counselling offered by abortion advocacy organisations are generally geared toward ensuring the right to abortion is upheld and therefore reframing the

woman's experience toward understanding that she made an autonomous and free choice, regardless of her internal experience.

The dominant discourse is strongly abortion advocating, upholding abstracted rights as an ideal. Aspects of the discourse that contribute to its manipulative and coercive nature include alarmist statements, disinformation and the censorship of dissenting voices, regardless of the veracity of facts the latter present. The pervasive effects of the dominant discourse contribute to an environment where continuing a pregnancy is framed as a burden and parenting is experienced as an unsupported journey.

Alarmist, incorrect statements that abortion is anywhere from 14 – 100 times safer than childbirth feed into fears many women may have about birth, and are more like soundbites for abortion marketing. The same is true of alarmism inherent in statements that women will die without abortion access and that abortion access is the only way in which women can achieve 'true' equality.

Coercion exists in the absence of information

Pregnancy termination is a surgical or medical procedure, and therefore governed by guidelines for all other surgical or medical procedures. If abortion provision was practised according to guidelines for other health care it would not be necessary to address whether women are screened for coercive factors, as this should be considered a standard aspect of informed consent practise. Such practise includes that women have a full understanding of the risks and benefits of each option, that they understand and can access the full range of options, and that they are freely consenting. The fact that women are citing coercion as a factor in terminations they have undertaken is a sign that effective and expected screening and informed consent for pregnancy termination is falling short of that expected. Given the highly contentious nature of abortion, it would not seem unreasonable to hold such processes to a higher standard than those for other procedures, yet the opposite appears to be true in practise.

Post-abortive women who have sought counsel or advice through our service often describe very limited and inadequate processes of consent including:

- Group sessions, whereby they were given information and the opportunity to ask any questions only in a group context,
- Only seeing the doctor when they had already been prepped and ready for surgical termination,
- Being asked 'is this what you want?' as the only checking in with their wishes,
- Being 'counselled' in the presence of a pressuring partner, and
- Being given misinformation about the effects of mifepristone and their ability to withdraw consent and discontinue a medical abortion procedure.

Coercion exists in the walk-in – walk-out nature of abortion provision.

Most private abortion clinics operate on a walk in walk out model, whereby a woman phones to make an appointment and is scheduled for termination during the same appointment where she may also receive information and/or counselling. Abortion advocates argue vehemently against alternatives such as ensuring at least two appointments with an opportunity between them to fully consider options, citing the added burden on women of two visits. This is in spite of the fact that there are no other invasive surgical procedures such as termination that can be accessed on the day of request using such a model.

Coercion exists in labelling doctors who object to abortion as untrustworthy

When laws exist that state that a doctor who does not agree with abortion, whether for religious, ethical or medical reasons, cannot be trusted to provide accurate information about abortion, abortion discourse becomes the sole domain of those more concerned with 'rights' than with women themselves. When AMA guidelines advise doctors with a conscientious objection to end consultations with women considering pregnancy options, but then suggest that abortion providers may still decline abortion based on a woman's individual circumstances, the only conclusion is that one group of doctors is untrustworthy.[1]

Censorship within abortion discourse not only affects those who disagree with abortion, but also those who support abortion access, but still feel pressured to withhold information, use certain words, or in some way encourage abortion due to fears of impeding rights.[2] Such internalised censorship means that women have few sources of information about the potential of adverse impacts on their physical or mental health or their relationships. It also means they may view with suspicion any information, no matter how accurate, regarding adverse impacts of abortion.

Coercion exists in the absence of alternatives information

Abortion advocates frequently disparage supportive services established to provide women with material aid, emotional support and decision-making counsel, purely on the grounds of ideology. Where centres exist that offer to meet the identified needs of women, such as material aid, financial resourcing, emotional support, such information should be provided to women in order to provide them with alternative options. Yet, not only do these referrals not happen, but abortion advocates work to discredit and undermine the essential work undertaken by them to support women.

Key Recommendations

1. It is essential that coercion to terminate be seen as a phenomena in its own right, not packaged and hidden in euphemisms such as 'pregnancy outcome control'. The consequences of coercion to terminate are hugely significant on the lives of women and add considerably to the burden of mental health and other emotional issues that they experience.
2. Research on, and education about, coercion to terminate should be a priority at a time when the discourse is rapidly working to further reduce access to necessary supports for women, through legislation and ongoing censorship.
3. Access to independent (not provided by abortion providers) information about, and access to supportive services for women to continue a pregnancy needs to be strengthened and such services need to be more effectively resourced.

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1 Australian Medical Association: Conscientious Objection Policy document: June/July 2013

2 Martin, LA., Hassinger JA., Debbink M. and Harris, LH. (2017). Dangertalk: Voices of abortion providers. Social Science Medicine, July (184). Pp. 75-83