Submission No 46

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Women's Forum Australia

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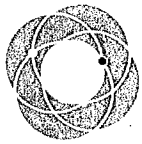

WOMEN'S FORUM AUSTRALIA

THINK•ACT•MAKE A DIFFERENCE

SUBMISSION TO THE STANDING COMMITTEE ON SOCIAL ISSUES INQUIRY INTO THE *REPRODUCTIVE HEALTH CARE REFORM BILL 2019* (NSW)

Executive summary

The Bill is counter-productive to women's health and welfare, removes protections for women, unborn children and health practitioners, and is a radical departure from the current law. The Bill:

1. fails to address the support women facing abortions really need.

Recommendation 1: That the NSW Government, following research into the reasons women choose abortion, support real choice for women by addressing any societal barriers that might make women feel as if abortion is their only choice. These include addressing domestic violence, access and affordability of child care, incentives for flexible workplace and study arrangements and access to pregnancy counselling and psychological support/treatment.

2. ignores the negative health risks of abortion for women.

Recommendation 2: That the NSW Government commission research into the actual harms of abortion, prior to any reform, and that this information should be made available to women, generally and when faced with an unplanned pregnancy.

3. is fundamentally flawed and has not been given due consideration.

Recommendation 3: That the Bill be rejected.

4. does not adequately ensure safeguards for informed consent.

Recommendation 4: Amend the Bill to include a robust informed consent provision, which specifically outlines the framework of safeguards for ensuring and protecting a woman's right to informed consent in the context of abortion.

5. removes and does not include protections for women who are coerced into abortions.

Recommendation 5: Amend the Bill to provide for anti-coercion legislation within the *Crimes Act*, including criminal penalties for any person who coerces or attempts to coerce a woman into having an abortion, as well as any doctor who performs an abortion on a knowingly coerced woman.

6. fails to include protections for minors seeking an abortion.

Recommendation 6: Amend the Bill to include protections for women under 16 seeking an abortion, including screening for abuse and coercion, reporting obligations, and notification to a parent or legal guardian where this will not endanger the woman.

7. makes lawful abortion for any reason, including discriminatory reasons such as terminating children with disabilities or children who are not of the desired sex.

Recommendation 7: Amend the Bill to prohibit abortion on the basis of sex.

Recommendation 8: Amend the Bill to prohibit abortion on the basis of disability.

8. makes no provision for data collection.

Recommendation 9: Amend the Bill to include a provision that requires the mandatory collection, analysis and publication of data about abortions carried out in NSW.

9. removes protections for women and children against late-term abortions, allowing abortion at any stage, for any reason, including abortions of viable babies up until full term.

Recommendation 10: Amend the Bill to exclude abortion for social reasons and restrict it to "as necessary" as under the current law.

Recommendation 11: Amend the Bill to remove section 6 which would permit abortion of viable babies until full term.

10. provides no protections for babies born alive after an abortion.

Recommendation 12: Amend the Bill to include a provision that mandates the same life-saving treatment for a child born alive after an abortion as another child at the same gestation and in the same medical condition.

11. removes protections for women against unlawful abortions.

Recommendation 13: Amend the *Crimes Act* to protect women from criminal sanction in relation to abortion and maintain penalties for other persons performing unlawful abortions.

12. erodes freedom of conscience.

Recommendation 14: Amend section 9 of the Bill to provide a robust protection for freedom of conscience, which must include the right of a health practitioner not to refer for abortion.

13. erases women, denying that they are the ones uniquely impacted by pregnancy and abortion.

Recommendation 15: Substitute the term "person" for "woman" throughout the Bill.

Women's Forum Australia: Who we are and our position

1. Women's Forum Australia is an independent think tank established in 2005 that undertakes research, education and public policy advocacy about economic, social and health issues affecting women, with a particular focus on addressing behaviour that is harmful and abusive to women. Such issues include the sexualisation and objectification of women and girls particularly in media and advertising, violence against women, pornography, prostitution and trafficking, child marriage, abortion, adoption, surrogacy, euthanasia and workplace equality.

2. For our society to be genuinely pro-woman on the sensitive issue of unplanned pregnancy, it is critical for us to consider legislation, policy and practices in a holistic and considered way. Simply focusing on providing women with the apparent "choice" of abortion whenever they want it does not address or resolve the crux of the problem – that is, it does not resolve the underlying issues which make a woman feel, when faced with an unplanned pregnancy, that terminating it is their only choice.

3. Women who abort often cite reasons such as fear of intimate partner violence,[1] coercion from their partner or others, study or career pressures, and a lack of financial and emotional support.[2] Abortion under these circumstances is not choice, it is desperation.

4. Instead of simply providing women with the so-called "choice" of abortion on demand, we need to do far more as a society to address the underlying causes and provide them with positive alternatives that are not going to expose them to further harm. This includes progressing real alternatives for women facing unplanned pregnancies, and addressing issues of domestic violence, access and affordability of child care, flexible workplace and study arrangements and access to pregnancy and counselling support.

5. Instead of more abortion, we would like to see the government address these issues through a formal, comprehensive program of financial support, study and employment assistance and any necessary protections from coercion, especially in domestic violence situations. We need to ensure that women facing an unplanned pregnancy feel empowered to have, and to raise their child, and don't feel as if abortion is their only choice.

6. Women's Forum Australia is, in principle, against the criminalisation of women who have had an abortion and this will be discussed further below. However, we are firmly of the view that the legalisation of abortion on demand is not the answer.

Recommendation 1: That the NSW Government, following research into the reasons women choose abortion, support real choice for women by addressing any societal barriers that might make women feel as if abortion is their only choice. These include addressing domestic violence, access and affordability of child care, incentives for flexible workplace and study arrangements and access to pregnancy counselling and psychological support/treatment.

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[1] Taft A.J. and Watson L.F. (2007), Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women, *Australian and New Zealand Journal of Public Health* Vol 31, No 2, pp 135-142.

[2] Above n18, Finer.

Abortion harms women

7. Women's Forum, since its 2005 research report entitled "*Women and Abortion*"[3], has continued to monitor research around the world relating to the harmful impact of abortion on women.

8. Abortion carries with it risks of physical harm. While carrying a pregnancy to term also carries physical risks, this does not underscore the importance of recognising and disclosing to women the physical risks of abortion. Risks of physical harm from abortions include infection, haemorrhaging, cervical and uterine damage, and subsequent miscarriage.[4] Physical complications increase significantly for each week of the pregnancy.[5] This increased risk to women depending on the relevant gestational period is another reason why any amendment to the laws surrounding abortion should consider whether abortion should be permitted at all after a certain time.

9. Medical abortion (involving only the use of drugs) is often perceived to be safer and less traumatic. However, a UK study found that women found it more painful and stressful – in particular, seeing and feeling the aborted foetus was distressing.[6] Another UK study stated that women were often not told that they would see the foetus, and then "*some people look and they are so upset because it's a perfectly formed little baby and they didn't expect it to be like that*".[7]

10. Women who have abortions are also at a more increased risk of maternal death or suicide. The Queensland Government has recognised this risk, stating:[8]

> "*Suicide is the leading cause of death in women within 42 days after their pregnancy and between 43 days and 365 days after their pregnancy. There appears to be a significant worldwide risk of maternal suicide following termination of pregnancy and, in fact, a higher risk than that following term delivery.*"

11. In terms of psychological harm, most researchers agree that at least 10-20% of women suffer from severe negative psychological complications,[9] which impacts a high number of Australian women, given it is estimated a third of Australian women will terminate at least one of their pregnancies.

12. Risks of psychological harm from abortion include depression, anxiety, suicidal behaviours and substance use disorders.[10] In depth interviews with women have

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[3] Ewing S (2005), "Women and Abortion: An Evidence Based Review" (published by Women's Forum Australia).
[4] Betterhealth.vic.gov.au. (2019). *Abortion procedures - surgical.* <https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-surgical> [Accessed 12 Aug. 2019].
[5] Diedrich J. and Steinauer J. (2009), Complications of surgical abortion, *Clinical Obstetrics and Gynecology*, June Vol 52, No 2, pp 205-212.
[6] Slade P., Heke S., Fletcher J. and Stewart P., Termination of pregnancy: patients' perceptions of care, *The Journal of Family Planning and Reproductive Health Care*, 2001: 27 (2): 72-77.
[7] Lipp A. (2008), A woman-centred service in termination of pregnancy: a grounded theory study, *Contemporary Nurse*, December, Vol 31, No 1, pp 9-11.
[8] Queensland Maternal and Perinatal Quality Council Report 2013, State of Queensland (Department of Health), September 2013, p.16
[9] Coleman PK and Nelson ES, The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes, *J Social and Clinical Psychology*, 1998:17(4): 425-442.
[10] Studies show that women who have abortions are 30% more likely to suffer from mental health problems than other women.
DM Fergusson, LJ Horwood and JM Boden "Abortion and mental health disorders: evidence from a 30-year longitudinal study" (2008) 193 BJ Psych 444 at 449.

shown that these psychological harms are often long-term, emerging months or years after the abortion. While these reactions are often cited as "normal" by health professionals, we need to ask ourselves whether decisions which have such significant psychological effects on women are truly empowering.

13. There is a clear lack of awareness among the general public about the harms of abortion to women. The notion that abortion is a procedure without consequences is simply false.

14. From our research, it is evident that abortion harms women. More evidence and research must be conducted into the risks and harms to women so that there is a solid evidence base to inform any policy change. It is also critical that research into these risks is made available to women to empower them to make an informed decision. Women need objective and unbiased information to make a decision, not just assurances from their abortion provider or doctor that the abortion is fairly "safe".

Recommendation 2: That the NSW Government commission research into the actual harms of abortion, prior to any reform, and that this information should be made available to women, generally and when faced with an unplanned pregnancy.

Comments on the process surrounding the Bill

15. The entire process around the Bill has been shambolic, non-consultative and clearly designed to suppress, rather than promote, discussion, debate and input from the community and key stakeholder groups, including women. It was introduced into the Legislative Assembly, without warning and without broader consultation, with the initial intention to rush it through the Legislative Assembly by the end of the week. While there was one week's delay to the debate – in response to concerns that there had been no consultation – it was then pushed through the Legislative Assembly within a matter of days.

16. The nature of amendments made and the debate around them demonstrate that not even the co-sponsors of the Bill had thought through basic issues, not to mention the broader impact – on women – of what the Bill proposed. The fact that women have not been placed at the centre of this Bill was made abundantly clear when MPs voted down fundamental protections proposed in amendments: protecting women from being coerced into abortions, protecting unborn girls from sex selective abortion practices, protections for minors seeking abortions (and who may have been victims of sexual abuse or domestic violence).

17. The Legislative Council's inquiry into the Bill has similarly been rushed, with less than three working days allowed from when the second reading of the Bill with amendments was released (Friday, 8 August) to when submissions were due (Tuesday, 13 August) and hearings held (Wednesday, 14 August). This is unfortunately reflected in the quality and coherency of our submission, which we have scrambled to pull together in the short time allotted, and for which we required much more time to properly address and consider the myriad of critically important issues posed by the Bill. The insufficient time given to seeking input from stakeholders further demonstrates Parliament and the government's lack of interest in truly consulting on a piece of legislation that significantly impacts all women in NSW.

18. This Bill does far more than simply decriminalise abortion in NSW. The lack of research, evidence and consultation in developing the policy underpinning the Bill has failed all women – especially vulnerable women, who will remain and indeed be put more at risk.

Comments on the substance of the Bill

19. In NSW today, it is already legal for a woman to have an abortion to prevent serious danger to her life, physical or mental health. As one of the most common medical procedures in Australia, with 1 in 3 women experiencing an abortion, and 20,000-30,000 performed in NSW each year, it is also readily accessible.

20. The Bill seeks to remove abortion from the *Crimes Act 1900* (the '*Crimes Act*') and regulate abortion 'like any other health issue'. However, while the Bill purports to make abortion a 'health issue' it effectively treats it as a non-health issue by significantly changing the current law to make abortion available on request without the need for any health grounds at all.

21. Making abortions lawful for non-medical reasons fails to recognise that abortion itself carries with it risks of physical and psychological harm,[11] and unnecessarily puts women at risk. It also gives the green light for women to undergo an abortion based on their current circumstances – such as study or career pressures, lack of emotional or financial support, domestic violence and so on – without actually addressing these underlying issues.

22. The Bill is counter-productive to women's health, removes protections for women, unborn children and health practitioners, and is a radical departure from the current law. The Bill raises the following (non-exhaustive) issues:

    I. The Bill does not adequately ensure safeguards for informed consent.

    II. The Bill removes and does not include protections for women who are coerced into abortions.

    III. The Bill fails to include protections for underage women seeking an abortion.

    IV. The Bill makes lawful abortion for any reason, including discriminatory reasons such as terminating children with disabilities or children who are not of the desired sex.

    V. The Bill makes no provision for data collection.

    VI. The Bill allows abortion at any stage, for any reason, including abortions of viable babies up until full term.

    VII. The Bill fails to protect babies who are born alive after an abortion.

    VIII. The Bill removes protections for women against unlawful abortions.

[11] Fergusson D.M., Horwood L.J. and Boden J.M. (2008), Abortion and mental health disorders: evidence from a 30-year longitudinal study, *The British Journal of Psychiatry* Vol 193, No 6, p 449.

IX. The Bill erodes freedom of conscience.

X. The Bill erases women, denying it is they who are uniquely impacted by pregnancy and abortion.

23. The Legislative Assembly had the opportunity to address many of these issues and to strengthen protections for women, children and health practitioners under the Bill. The fact that the majority of Members voted down protections for women against coercion and sex-selective abortion among others exposes the fact that this Bill is not really about what's best for women, but about the commitment to the "right to abortion" at all costs and enshrining in law the extreme ideology of "abortion on demand, without apology".

24. The Bill ultimately fails to address the support women facing abortions really need. It seeks to 'modernise the law', yet does not make any attempt to understand and address the present-day societal issues, which might make women view abortion as their only choice.

25. In light of the research and evidence on this issue, Women's Forum strongly believes that any legislative or policy changes that truly seek to promote women's welfare in relation to abortion must take into account evidence of the harmful impact of abortion on women's health, the current lack of informed consent and the current lack of support for women seeking abortions in Australia. We need to provide women with more information and more support, not more abortion.

26. If changes are to be made, they should be directed at addressing these pressing issues, rather than exacerbating an already flawed system by legislating for abortion on demand. The Bill in its current form not only fails to implement important protections for women as well as children and health practitioners, it takes away the limited ones that do exist. The Bill is plagued by shortcomings and has not been properly thought through. As already noted, this is in large part due to the way in which sponsors of the Bill sort to ram it through parliament without consultation or proper time for consideration.

27. The Bill is fundamentally flawed and has not been given due consideration. On such a sensitive and complex women's issue, it is critical that any changes be evidence-based, carefully considered and shown to benefit women.

Recommendation 3: That the Bill be rejected.

Essential amendments

28. While our primary position is that the Bill should be rejected, if it is to pass, the following critical issues must be addressed.

I. Safeguards for informed consent

29. The Bill in its current form does not provide adequate safeguards for informed consent in the context of abortion.

30. Informed consent is a legal and ethical right for anyone who undergoes a medical procedure. Given the pressures and lack of support that often drive women to seek an

abortion, as well as the physical and psychological risks inherent in abortion, robust safeguards to ensure women are giving fully informed consent, freely and voluntarily, are required. Women seeking to end their pregnancy often experience a sense of desperation and a lack of a real choice. This is a situation that is unique to abortion, as compared with other procedures. As women in these circumstances are often at their most vulnerable, it is of utmost importance that they are provided with as much information as possible about the termination before choosing to consider it.

31. Obtaining informed consent from patients should be a standard part of all good medical practice, however there are countless stories of women who underwent an abortion without giving fully informed consent (whether because they had a lack of information or were not fully free in their decision).[12] This is an issue of such grave importance to women that it should be addressed by Parliament and enforced.

32. To ensure that a woman seeking an abortion gives fully informed consent, our view is that the legislation should include a clear provision centred around empowering a woman to give informed consent, which should include:

- the specific information the woman should be given;
- an offer for independent counselling (which is not based on the subjective judgment of a doctor as to whether it is "beneficial" for her and is provided by someone independent of the abortion provider); and
- a waiting period to allow the woman sufficient time to process the information she has received, to take advantage of whatever counselling and support she requires, to understand and weigh up her options and, ultimately, make a fully informed decision.

33. This appropriately acknowledges and seeks to address the complexity of circumstances faced by many women seeking an abortion (which include the possibility of coercion by a partner), the significance of the decision to undergo an abortion and the lasting impacts of abortion on women's lives.

Informed consent provisions in other jurisdictions

Australia

34. In Western Australia the law specifically requires that a woman has given "informed consent" to an abortion.[13] This is defined to mean consent freely given by the woman where:

- a medical practitioner has provided counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term and
- has offered the opportunity of a referral to appropriate and adequate counselling about such matters.[14]

[12] *Giving Sorrow Words* by Melinda Tankard Reist gives an account of just a small proportion of many such stories.
[13] http://classic.austlii.edu.au/au/legis/wa/consol_act/hpa1911350/s334.html
[14] *Ibid.*

35. There is no suggestion or evidence that the informed consent requirement has restricted access to abortions in Western Australia. For example, in 2015 (the most recent year for which statistics have been published) Western Australia had a higher rate of pregnancies that end in abortion than South Australia (the only other Australian state which publishes abortion statistics) where the law does not mandate informed consent.[15]

Europe

36. Specific requirements for informed consent prior to abortion are also common in European countries, including:

- Belgium: Laws require that before performing an abortion the doctor must inform the patient of the medical risks and also inform her of options that would be available to her if she chose not to have an abortion, such as adoption.[16]

- Denmark: Laws require that the woman must be provided with medical information and a counselling session before and after the procedure.[17]

- France: Laws require a woman to be informed during the first consultation about the medical and surgical methods of abortion, the risks and potential side effects.[18] It also provides that the patient be offered consultation with a marriage counsellor, family planning counsellor or social services, both before and after the abortion. The woman is free to decline or accept these offers of consultation, but pre-abortion consultation is mandatory for minors.[19]

- Germany: Laws require that an abortion may be performed by a physician at the request of a pregnant woman if she presents to the physician a certificate indicating that she obtained counselling at least three days before the operation.[20]

- Iceland: Laws require that a woman seeking an abortion must be provided with information on medical assistance, pregnancy tests, counselling and support, social assistance, and assistance with the abortion request.[21] In addition, she must be provided with information on the medical risks involved in an abortion and available societal support should she choose to forego an abortion.[22]

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[15] https://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia; https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics.

[16] Code pénal. art. 350(2°) at Boring, N. 2015 Abortion Legislation in Europe, Library of Congress, viewed 19 June 2016, https://www.loc.gov/law/help/abortion-legislation/europe.php.

[17] Sundhedsloven, LBK nr. 1202 af 14/11/2014, art. 100, para. 3. https://www.retsinformation.dk/forms/r0710.aspx?id=152710#Kap25

[18] Code de la santé publique [Public Health Code], art. L2212-3 http://www.legifrance.gouv.fr/affichCode.do;jsessionid=ED741182F75ACC70E37A5FC12AA0CF98.tpdjo02v_1?cidTexte=LEGITEXT000006072665&dateTexte=20150115.

[19] *Id.* art. L2212-4.

[20] Strafgesetzbuch [StGB] [Penal Code], Nov. 13, 1998, Bundesgesetzblatt [BGBl.] I at 3322, *last amended by* Gesetz [Law], Oct. 2, 2009, BGBl. I at 3214, § 218a(1), http://www.gesetze-im-internet.de/englisch_stgb/ index.html.

[21] Act on Counselling and Education Regarding Sex and Childbirth and on Abortion and Sterilisation Procedures, No. 25/1975, *as amended by* Act No. 82/1998, No. 162/2010 and No. 126/2011, art. 6, http://eng.velferdarraduneyti.is/media/acrobat-enskar_sidur/Act_on_counselling_and_instruction_etc_No_25_1975_as_amended.pdf (unofficial English translation)

[22] *Id.* art 12

- Netherlands: Laws require an operating doctor, following a consultation with the woman in person, to "*advise her on the different options available*" and "*inform her of the medical risks*".[23]

- Norway: Laws require that a woman seeking an abortion must be informed both of the medical risks inherent in an abortion and the social support available to her.[24]

- Spain: Laws require that the woman be informed about public benefits and assistance for maternal support and has waited for a three-day period between provision of this information and the abortion procedure.[25]

United States

37. In the United States, a large number of states have passed informed consent laws for abortion, independently of the general medical principles regarding informed consent that exist in every state. 26 of these states include the requirement to undergo an ultrasound or at least be provided with the opportunity to view an ultrasound.[26] Further, 34 states mandate that women receive counselling prior to an abortion, and 29 of these detail the information women must be given.[27]

38. Nearly all the U.S. states require that information be provided to women about the abortion procedure, foetal development and the gestational age of the foetus.[28] 28 states require that information about the risks of abortion be disclosed, including the potential physical and psychological risks for the woman.[29]

39. The fact that so many jurisdictions have informed consent regimes, including mandatory offers of counselling and waiting periods demonstrates their recognition of the significance of abortion and its impacts on women. It also shows that opposition to safeguards to informed consent may be ideologically driven rather than centred on the best interests of women.

Amendments to the Bill made in the Legislative Assembly

40. During debate on the Bill in the Legislative Assembly, two amendments were moved and passed regarding informed consent and counselling. Informed consent and counselling were dealt with as separate issues and separate amendments. Our view is that these amendments are not comprehensive or robust enough to protect the right of women to give fully informed consent when it comes to abortion and that they should be strengthened to ensure protection of this important right.

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[23] Termination of Pregnancy in the Netherlands, Anglo Info, http://southholland.angloinfo.com/information/healthcare/pregnancy-birth/termination-abortion/ at Acosta, L. and Zeldin, W. 2015, Abortion Legislation in Europe, Library of Congress, viewed 19 June 2016, https://www.loc.gov/law/help/abortion-legislation/europe.php.
[24] Lov om svangerskapsavbrudd [abortloven] Lov No. 50 of June 13, 1975, *as amended*, arts 1, 2, 5. https://lovdata.no/dokument/ NL/lov/1975-06-13-50?q=abortlov.
[25] Ley 2/2010 Orgánica de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo [Organic Law 2/2010 on Sexual and Reproductive Health and the Voluntary Interruption of Pregnancy] art. 14, Boletín Oficial del Estado [B.O.E.] Mar. 4, 2010, http://www.boe.es/buscar/act.php?id=BOE-A-2010-3514.
[26] Requirements for ultrasound, The Guttmacher Institute, U.S.A, https://www.guttmacher.org/state-policy/explore/requirements-ultrasound
[27] Counseling and Waiting Period for Abortion, The Guttmacher Institute, U.S.A, https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion
[28] Ibid
[29] Ibid

Informed consent

41. When it was introduced, the Bill made no specific provision for informed consent. The Attorney-General, Mr Mark Speakman MP, moved amendments to include an express requirement for informed consent, defined as consent that has been given "*freely and voluntarily*" and "*in accordance with any guidelines applicable to the medical practitioner in relation to the performance of the termination*"[30].

42. The Bill in its current form provides two provisions with respect to *informed consent* at ss 2(2) and 6(1)(c). Where the foetus is at no more than 22 weeks, a medical practitioner can only perform an abortion where there is informed consent, except in the case of an emergency. After 22 weeks, informed consent is required for an abortion to be performed.

43. Most of the arguments against the amendment made in the Legislative Assembly centred around the fact that informed consent is a legal requirement for all medical procedures. This fails to recognise the complexity of the drivers behind why a woman seeks an abortion, the physical and psychological risks inherently linked to abortion and the significance of the act of abortion (i.e. that it ends the life of a child). While the intent of the amendment appears to be to recognise that informed consent must be safeguarded, it fails to support that intent with clear and specific requirements about what will practically ensure that women are given the information to make an informed decision. For example, inaccurate information about the development of the child does not facilitate informed consent. There have been reports of counsellors assuring women (inaccurately) that their foetus or unborn child is just a "*bunch of cells*" or "*a blob of tissue*" and of women generally not being given information about the development of their baby, including not being offered to see an ultrasound. Without being provided with this information, which is fundamentally about the termination procedure the woman is seeking to undertake, how can her consent be "informed"?

Offer of counselling

44. The new section 7 of the Bill requires that before performing an abortion, a medical practitioner is only required to consider whether it would be beneficial to discuss with the person seeking the abortion to access counselling and if it is considered beneficial, to provide the person with information about counselling. The clause also allows that requirement to be dispensed with in the case of an emergency.

45. In our view, this provision hardly provides a safeguard for the informed consent of women seeking a termination. It is subjective and entirely based on the medical practitioner's judgment. In the case of an abortion provider, there is nothing in the provision that would address any conflict of interest that provider may have in making a decision whether to it is "beneficial to provide counselling", where it is in their interests to encourage the abortion. The power resides completely with the medical practitioner and not with the woman.

46. During debate, it was clear that the weakness of the counselling provision is primarily ideologically motivated. A number of MPs feared that even an offer of counselling would present a barrier to women trying to access an abortion. A number of MPs raised

[30] Schedule 1, *Reproductive Health Care Reform Bill 2019*.

the issue that "*...[s]uggesting counselling to some people can make them feel as if they are making a decision that is not in their best interest or is wrong.*"

47. While people have different views on whether abortion is morally right or wrong, the objective fact remains that abortion is a significant decision with significant potential impacts (both physical and psychological). A woman facing that decision must make a choice based on as much information as possible and should be offered counselling. This is already a requirement under clause 3.1 of the NSW Health Policy Directive, "*Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*". The proposed clause 7 is much more subjective and requires a doctor to make a decision about whether a woman should be offered counselling. This is illogical and denies women the offer of counselling if a doctor does not deem it "beneficial".

A robust informed consent provision

48. We would like to see a stronger informed consent provision, which specifically outlines the framework of safeguards for ensuring and protecting a woman's informed consent. This aligns with the practice in other jurisdictions, which appropriately recognise the significance of the decision to abort a child. Key aspects must include:

<u>Providing the woman with specified key information</u>

49. Key information should, at a minimum, include:

- information about the relative physical and psychological risks of abortion;
- information about the support available to women who want to continue their pregnancies (including financial support, study/career assistance, housing services, health services, domestic violence support services and mental health support);
- information about the alternatives to abortion (including referrals, where appropriate);
- information about foetal development and the opportunity to view ultrasounds.

<u>A mandatory offer for independent counselling</u>

50. In accordance with current practice, any woman seeking a termination should be offered counselling.

51. It is critical that the counselling offered is independent of the abortion provider from which the woman is seeking an abortion to manage any conflict of interest on the part of the provider, who has a financial interest in terminating the pregnancy.

A mandatory timeframe to allow the woman to process information, seek assistance and consider all options available to her

52. In line with the practice of other jurisdictions, we recommend a mandatory waiting period between when a woman first seeks an abortion to when the medical practitioner is able to perform it.

53. Some European jurisdictions, such as Spain and Germany, have a mandatory waiting period of three days. We would recommend that the waiting period be between 3-5 days – however, we are of the view that more consideration of the exact timeframe is required.

54. Ultimately, a robust informed consent provision requires further consideration and consultation with key stakeholders to ensure that there are no unintended consequences and that the safeguards are effective and appropriate. The Bill in its original form made no attempt to deal with these complexities. The amendments made in the Legislative Assembly were clearly made quickly and without the opportunity for the deeper consideration necessary for an issue so significant for women.

Recommendation 4: Amend the Bill to include a robust informed consent provision, which specifically outlines the framework of safeguards for ensuring and protecting a woman's right to informed consent in the context of abortion.

II. Protection for women against coercion

55. Members supporting the Bill in the Legislative Assembly talked about how greater access to abortion will help women experiencing domestic violence. However, the Bill in its present form provides no safeguards for the welfare and autonomy of women who may be at risk of coercion. Moreover, abortion does not in any way undo or address domestic violence and in the case of women suffering domestic violence, abortion heaps further violence and trauma upon these women.[31]

56. In fact, by making abortion lawful for any reason, the Bill arguably removes protections for women against abortion coercion. Whereas now abortions can only lawfully be performed on health grounds, under the Bill where abortion is permitted for any reason, women are even more vulnerable to coercion from their partners, family or others. Recent polls in NSW and Queensland show that one in four people knows at least one woman who has been pressured into having an abortion. In 2017, NSW saw two shocking cases of NRL players who had coerced their girlfriends into having abortions.[32] Last year, during parliamentary hearings on the Queensland abortion bill, an abortion provider admitted to performing abortions on women she knew were being coerced.[33] In light of all this, we should be seeking to implement more protections for women, not to take away the limited ones that exist.

[31] https://www.theaustralian.com.au/commentary/abortion-wont-stop-violence/news-story/acf48960b83b865d9578ddf49a15753c

[32] Wong, R., "Abortion coercion: the NRL still has a long way to go in its treatment of women", Online Opinion, (20 March 2017): www.onlineopinion.com.au/view.asp?article=18914.

[33] https://www.facebook.com/WomensForumAustralia/videos/2415358878711240/UzpfSTYzMjAxODI3NzoxMDE1NzYzOTUwNjMwODI3OA/

Provisions for informed consent and counselling are not enough

57. The current provisions with respect to informed consent and counselling cannot act as a wholesale safeguard for all women, particularly women experiencing intimate partner violence or women at risk of coercion. It is wrong to suggest that the risk of coercion may be negated or answered by the provision of informed consent alone.[34] Particularly as coercion may appear in the absence of any other form of physical or sexual violence.[35] This increases the difficulty of detection in the absence of appropriate screening and in the absence of training.

58. It is widely accepted that there is an association between intimate partner violence and reproductive coercion.[36] Further, the *Pregnancy Care Guidelines* ("the guidelines") produced by the Department of Health recognised that "[v]iolence in pregnancy poses significant risk for women".[37] In 2013, the Australia Bureau of Statistics reported that 22% of women who were pregnant at some time during a relationship experienced violence with their current partner, with 13% reporting that violence occurred for the first time during pregnancy.[38] The guidelines also reported that intimate partner violence is associated with adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations and delayed pregnancy care.[39]

59. Some recent international studies have recommended that reproductive coercion be identified and treated as separate or a "specific behaviour associated with the coercive control that underpins" domestic violence or intimate partner violence.[40] In some cases reproductive coercion has been identified as an indication of abusive behaviour, while others suggest it could be "a secondary form of control in addition to physical abuse".[41] In other studies, reproductive coercion is defined as form or tactic of intimate partner violence (as opposed to a distinct phenomena).[42] The correlation between pregnancy, intimate partner violence, coercive behaviours and abortion must be understood and acted upon.

60. Further, a medical practitioner is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. They also identify health-care providers as the professional they would most trust with disclosure of abuse.[43] The World Health Organisation recommended that all health professionals be trained in "first-line response" to family and intimate partner violence. The steps are to: listen, believe, inquire about needs, validate the person's experience, enhance safety and offer ongoing support.[44]

61. In light of that research, an absence of any protection for women at risk of intimate partner violence and/or coerced abortion is unacceptable. The State should uphold its

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[34] Legislative Assembly, Second Reading Debate, NSW State Parliament (Mr Mark Speakman).
[35] Clark et al (2014); Northridge et al (2017).
[36] Grace and Anderson (2018).
[37] Commonwealth Government Department of Health, "Pregnancy Guidelines, Chapter 29: Family Violence" (21 November 2018).
[38] ABS (2013).
[39] World Health Organisation (2013).
[40] Douglas and Kerr (2018).
[41] Ibid.
[42] Ibid.
[43] World Health Organisation (2013).
[44] Ibid.

commitment to the protection of all women, including the vulnerable, by reforming the criminal law relating to abortion to include anti-coercion legislation.

62. The speed at which the Bill has been introduced has impeded upon the ability of Parliament to properly research, develop and assess appropriate provisions for the identification, intervention and protection of vulnerable women. The protection of women's reproductive health care is not the purpose of the Bill. The development of effective protections will take time and likely form part of future regulations and guidelines – but in the intervening period, if the Bill is passed in its present form, vulnerable women will remain and indeed be put at further at risk. The absence of due process and transparency, in this respect, is a slight against all men and women in this State.

Research on reproductive coercion

63. During the consultation period for the *Abortion Law Reform Act 2008* (Vic), the Victorian Law Reform Commission ("the Commission") considered recommendations[45] for anti-coercion legislation. The Commission stated: "*in the absence of evidence* indicating that coercion is a problem, the commission does not think specific anti-coercion legislation is necessary. The current law governing all medical procedures deals appropriately with issues of consent. No further legislative requirement is necessary" (emphasis added). That recommendation was predicated on research available to the Commission in 2008.

64. During the second reading speech, Mr Greenwich confirmed that the provisions in the Bill "are *based on those enacted in Queensland and Victoria, which came out of extensive Law Reform Commission processes*, adopting the principles of ready access to early stage terminations and use of current common law provisions with additional oversight than currently exists from a second doctor for later stage terminations" (emphasis added).[46] The fact that other commissions conducted extensive processes of consultation earlier does not negate the need to review current and relevant data with respect to women's welfare, abortions and reproductive health care.

65. Circumstances have since changed with "reproductive coercion" being a growing area of study since 2010 (internationally) and 2018 (nationally). Prior to proposing an amendment for inclusion within the Bill, the relevant research that provides a foundation for its consideration is set out below.

<u>Reproductive Coercion is a growing area of research in Australia</u>

66. There is a significant unresolved and unregulated issue concerning reproductive coercion in Australia that has received little attention from the national polities and other investigative bodies, other than preliminary commentary or observation from organisations such as Women's Forum Australia, Marie Stopes Australia, Children by Choice and White Ribbon Australia.

67. There does not appear to be an agreed definition of reproductive coercion. It first appeared in US literature in or around 2010 and was described as "any behaviour that

[45] Victorian Law Reform Commission, *Law of Abortion: Final Report* (1 January 2008).
[46] Second Reading Speech of the *Reproductive Health Care Reform Bill 2019*, 1 August 2019 (Alex Greenwich) ("Second Reading Speech").

interferes with a woman's reproductive autonomy and decision-making".[47] However, for the purposes of this submission, it is sufficient to note that "coerced abortion" is a form of reproductive coercion. It is inaccurate to describe unfettered abortion access as a solution for "the victims of reproductive coercion".[48] It is true the Bill cannot deal with all aspects of reproductive coercion, however, as a Bill that concerns "choices about termination"[49] – the risk of coercion upon a woman's autonomy is directly relevant.

68. Reproductive coercion appears to have only recently become the subject of focused study in Australia, with studies published in academic literature in 2018 and 2019. One study concluded "pregnant and postpartum women need to be screened for partner violence that compromises women's decision-making power regarding their reproductive rights".[50] The result of a recent study in Queensland, which explored "the prevalence and associations with reproductive coercion", suggested that whilst a number of women experienced reproductive coercion independently of other forms of domestic violence, the majority of women that experienced reproductive coercion in circumstances of domestic violence.[51] It was suggested that such results support the need for screening (and re-screening) of reproductive coercion within a health care setting and "as a distinct part of screening for violence during a health care relationship".[52] Another study suggested the lack of robust evidence as well as the poor understanding and awareness within the community as contributing towards the issue of reproductive coercion being neglected in policy, research and practice.[53]

69. At the time of preparing this submission, there did not appear to be any NSW-based or National studies published on this topic of either reproductive coercion or coerced abortion.

<u>International Research on Reproductive Coercion</u>

70. In the US, prevalence estimates for reproductive coercion have generally ranged from 8%[54] to 24%[55] amongst populations being studied, depending on the setting. However, higher rates have been found in women attending sexual and reproductive health services, reaching 40% in one study.[56] As to the occurrence of reproductive coercion in the absence of any other form of physical or sexual violence, drawing upon US studies conducted in health care settings, results have ranged between 45% and 53.4%.[57]

71. Studies indicate there is correlation between reproductive coercion and domestic violence; however more research is required to understand it as a potential warning sign of further violence.[58] Studies have found reproductive coercion by an intimate partner to contribute to both unplanned pregnancies and the forced termination of

[47] Miller et al (2010).
[48] Legislative Assembly, Second Reading Debate, NSW State Parliament (Ms Anna Watson).
[49] Legislative Assembly, Second Reading Debate, NSW State Parliament (Mr Mark Speakman).
[50] Bauleni et al (2018).
[51] Price et al (2019).
[52] Ibid.
[53] Tarzia (2018).
[54] Grace and Anderson (2018).
[55] Tarzia (2018).
[56] Price et al (2019).
[57] Clark et al (2014); Northridge et al (2017).
[58] Price et al (2019).

pregnancies (i.e. coerced abortion).[59] Research has revealed a higher prevalence of unplanned pregnancy and abortions for women that experience reproductive coercion and/or IPV.[60] There is limited research with respect to the impact of reproductive coercion upon mental health.

72. Risk factors generally include age, ethnicity and relationship status.[61] In particular, younger women between the ages of 18-20 years have been found to be at greater risk.[62]

Further research needed

73. It is strongly recommended, even in the absence of amendment, that further research and consultation is conducted with respect to the following:

- developing a clear understanding around how reproductive coercion is defined and situated, together with coerced abortion, within a broader framework of violence against women;

- understanding the association of reproductive coercion (and coerced abortion) with other forms of violence; and

- developing Australian-based studies into the issue of reproductive coercion (and coerced abortion) as a basis to develop evidence-based guidelines for all health practitioners and to determine what a "best practice" or "first line" response should look like and how to implement it.

74. Whilst our submission is focused upon the need to consider coerced abortion, we recognise that reproductive health care issues are broad and complex and must be understood within their relevant broader frameworks to ensure women are truly protected. It is entirely unsatisfactory to reduce reproductive health care issues and reproductive coercion to a consideration of unfettered access to abortion. The vulnerable women of the State deserve better.

Schedule 2 of the Bill should include anti-coercion legislation

75. In light of the relevant research, anti-coercion legislation should be included within the *Crimes Act.* Criminal penalties should apply to any person who intentionally coerces or attempts to coerce a woman into undergoing an abortion against her will, as well as any doctor who performs an abortion on a knowingly coerced woman.

76. It is submitted that any insertion of anti-coercive legislation into the *Crimes Act* should specify intent as an element of the offence and provide for a term of imprisonment as the maximum penalty. This is to ensure that the criminality of the provision is clear: the perpetrator of coercion is the offender, not the woman. Equally, a stipulation of a penalty of imprisonment would demonstrate the State's commitment to safeguarding the autonomy of women and its recognition of the seriousness of a violation of that

[59] Campo (2012).
[60] Price et al (2019).
[61] Grace and Anderson (2018)
[62] Miller et al (2014); Northridge et al (2017).

autonomy. No woman should be coerced into terminating a pregnancy she wants to keep. Such coercion is abhorrent and the criminal law should recognise this.

77. It is also recommended that consideration be given to the inclusion of an aggravated offence. This step would further demonstrate the State's commitment to protecting all women, in particular the vulnerable, every woman deserves protection under the law.

Recommendation 5: Amend the Bill to provide for anti-coercion legislation within the *Crimes Act*, including criminal penalties for any person who coerces or attempts to coerce a woman into having an abortion, as well as any doctor who performs an abortion on a knowingly coerced woman.

III. Protections for women under 16 seeking an abortion

78. There is no consideration in this Bill for the support and protection of underage women who request an abortion. We note with concern that the Legislative Assembly voted down even the most basic requirement to report such requests to the Secretary of the Department of Communities and Justice.

79. In NSW, age of consent laws are designed to protect children and young people from sexual exploitation and abuse.[63] It is illegal for a person to have sexual intercourse with a person under the age of 16 years.[64] Further, the legal age for marriage is 18 years.[65] These laws are not arbitrary; their intent is to ensure that that the law protects those in our society (that is, children) who are particularly vulnerable to sexual abuse or coercion.

80. This Bill should not turn a blind eye to the fact that, in most circumstances where a woman who is under the age of 16 years (a minor) is pregnant, a crime has been committed. The pregnant woman is not the perpetrator of that crime, yet she bears the consequences. Further, in no circumstances should a medical practitioner assume that such a crime is of minor significance in a modern world; quite the contrary. In a world where almost 1 in 5 women has suffered sexual violence since around the age of 15,[66] a medical practitioner has a greater obligation to take all steps possible to ensure that a pregnant minor who arrives at a clinic requesting an abortion is safe from any potential abuse or coercion.

81. Although there are others, for this reason alone the Bill should be amended to include a requirement that a parent of a child under the age of 16 who has requested a termination should be notified. Failure to include such a requirement could function as a shield for perpetrators of abuse such as rape, or incest. If in the circumstances it is not in the best interests of the minor for their parent to be notified, notification should instead be provided to a grandparent, legal guardian, or state authority.

82. The law in this State should also be concerned to ensure that pregnant minors have the best, and most accessible, support available to them. It is evident that for an adolescent, the realisation of an unplanned pregnancy, whether later terminated or

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[63] Child Family Community Australia. (2019). *Age of consent laws*. <https://aifs.gov.au/cfca/publications/age-consent-laws>[Accessed 12 Aug. 2019].
[64] *Crimes Act 1900* (NSW), s 66C(3)
[65] *Marriage Act 1961*(Cth), s 11
[66] Abs.gov.au. (2019). *4906.0 - Personal Safety, Australia, 2016*. <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0> [Accessed 12 Aug. 2019].

not, is in most cases an alarming event which has the potential to significantly impact their lives. The situation calls for both material and emotional support from the people closest to them.

83. Except in exceptional circumstances, the direct source of adult support for most adolescents is a parent, grandparent or legal guardian (hereinafter referred to collectively as 'parents'). Whether the decision made by the adolescent is abortion, parenting or adoption, parents are far more likely to have the material resources to ensure that their child receives the best care possible. They are more likely to be in a position to offer information and knowledge that may assist the medical practitioner in providing that care and ensuring informed consent. Given the usual concern a parent has for their child, parents are also the most likely candidates for the provision of emotional, psychological or any other support necessary to facilitate the best outcome for the child.[67]

84. Parents are also best placed to monitor complications arising from any medical procedures that may be performed. As noted above, risks of physical harm from abortions include infection, haemorrhaging, cervical and uterine damage, and subsequent miscarriage.[68] Risks of psychological harm include depression, anxiety, suicidal behaviours and substance use disorders.[69] Where these risks manifest, meaningful support is more likely to be available where parents are fully aware of them; there is also evidence to show that parental involvement laws are associated with a reduction in suicide rates among females.[70] The law in NSW should make every effort to avoid situations where adolescents are left to face these risks alone.

85. A further purpose of laws which require parental involvement in decisions impacting children or adolescents, is to recognise the particular vulnerability of adolescents' cognitive immaturity in the face of important decisions. Paediatric studies commonly indicate that adolescents do not attain adult levels of competence to make decisions until at least 18, with some even indicating that full maturity in executive brain functioning isn't reached until much later, in the early to mid-20s.[7172] The law recognises this by affirming that there are some important decisions with potentially significant consequences that children or adolescents should not be permitted to take for themselves.

86. Nonetheless in NSW, a person who is aged 14 years and over is deemed to have capacity to provide consent to medical treatment.[73] This is a relatively low age of consent by comparison with other jurisdictions. For example in South Australia, only a

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[67] American College of Pediatricians. (2019). *Parental Involvement and Consent for a Minor's Abortion.* <https://www.acpeds.org/the-college-speaks/position-statements/parental-involvement-and-consent-for-a-minors-abortion> [Accessed 12 Aug. 2019].

[68] Betterhealth.vic.gov.au. (2019). *Abortion procedures - surgical.* <https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-surgical> [Accessed 12 Aug. 2019].

[69] Studies show that women who have abortions are 30% more likely to suffer from mental health problems than other women.
DM Fergusson, LJ Horwood and JM Boden "Abortion and mental health disorders: evidence from a 30-year longitudinal study" (2008) 193 BJ Psych 444 at 449.

[70] In one study published in the Economic Inquiry journal, the enactment of parental involvement laws was proven to be associated with an 11-21% reduction in the number of 15 to 17 year old females committing suicide.
Sabia JS, Rees DI. "The Effect of Parental Involvement Laws on Youth Suicide. *Economic Inquiry.* 2013; 51 (1): 620-636.

[71] Giedd JN. Structural magnetic resonance imaging of the adolescent brain. *Ann NY Acad Sci.* 2004; 1021:77-81.

[72] Giedd, JN. The teen brain: Primed to learn, primed to take risks. The Dana Foundation. <https://www.dana.org/news/cerebrum/detail.aspx?id=19620> [Accessed 12 Aug. 2019].

[73] *Minors (Property and Contracts) Act 1970* (NSW) s 49

person over the age of 16 may consent to medical treatment as though they were an adult.[74] At present, this Bill does not even reinforce the need for parental consent to medical treatment for children under the age of 14 years.

87. Consider the gravity of a situation where a 14 year old becomes pregnant and requests an abortion, and the emotional and psychological impacts such a situation is sure have on that adolescent's still developing cognitive functioning. This Bill should not simply assume that other laws allowing consent to medical treatment from the age of 14 are sufficient, or even that such an adolescent has full decision making capacity in the circumstances; instead, it should be doing everything it can to ensure that the adolescent receives appropriate protection and support.

88. The majority of states in the U.S. require some parental involvement in a minor's decision to have an abortion, whether by requiring parental consent or parental notification.[75] In Western Australia, a child under the age of 16 will not be deemed to have given informed consent to an abortion after 20 weeks unless a custodial parent has been informed that the abortion is being considered, and has been given the opportunity to participate in a counselling process and consultations between the woman and her medical practitioner.[76]

89. In view of the considerations outlined above, we recommend an amendment to the Bill which includes the following requirements be met in the case of a woman under 16 seeking an abortion:

- Before a medical practitioner performs an abortion on a woman under the age of 16, the practitioner must consider whether the woman may have been the victim of a crime involving sexual abuse, the subject of coercion, or is otherwise in need of protection.

- If the medical practitioner observes any of these indications, the medical practitioner must comply with the mandatory reporting obligations in respect of minors in need of protection.

- The medical practitioner must give at least 24 hours' notice to one of the parents or legal guardian of the person seeking the abortion and that person must have been provided the opportunity to participate in a counselling process or a consultation between the person seeking the abortion and their medical practitioner.

- If there are indications that the person to be notified has been the perpetrator of abuse, assault, coercion or other violence against the person seeking the abortion, the medical practitioner must instead comply with mandatory reporting obligations in respect of minors in need of protection, before performing the abortion.

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[74] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 6. In other Australian jurisdictions, requirements consistent with the *Gillick* competence test apply (i.e. a 'mature' minor may consent to medical treatment provided they fully understand the nature of the procedure and its gravity and effects).
[75] Guttmacher Institute. (2019). *Parental Involvement in Minors' Abortions*. <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions> [Accessed 12 Aug. 2019].
[76] *Acts Amendments (Abortion) Act 1998* (WA) s 334(5)

- A woman may also apply to the relevant court for a waiver of the notice requirement.

90. The proposed amendment does not raise the age of consent to medical treatment, but simply ensures that a pregnant adolescent under the age of 16 has the necessary support and protection available to them.

Recommendation 6: Amend the Bill to include protections for women under 16 seeking an abortion, including screening for abuse and coercion, reporting obligations, and notification to a parent or legal guardian where this will not endanger the woman.

IV. Protection against discriminatory abortions

91. While abortion is only available on health grounds under the current law, by allowing abortion on request up until 22 weeks, the Bill makes abortion lawful for any reason. This includes discriminatory reasons such as terminating children with disabilities or terminating children who are not of the desired sex. Given that the Bill imposes no meaningful restrictions on abortion post-22 weeks, abortions may effectively be obtained for any reason throughout the course of a woman's pregnancy.

A. Sex-selective abortions

92. Under the Bill, where abortion is available on request for any reason, there is no protection against prenatal sex discrimination and amongst son-preference cultures residing in Australia, it is by and large females who stand to bear the brunt of discrimination, in keeping with international trends. The Attorney General himself has confirmed that the Bill in its current form would make sex-selective abortion legal in NSW.[77]

93. Sex selective abortion is a well-known problem in China and India, where son-preference cultures have resulted in extremely skewed sex ratios. Sex discrimination carried out via abortion is well documented and has resulted in millions of "missing" girls in some societies.[78] As many as 200 million women and girls are missing worldwide as a result of gendercide.[79] A study released this year has found that sex-selective abortion accounts for over 23 million of these missing females.[80] The practice of sex selection has been widely condemned.[81] Moreover, it widely known that women from son-preference cultures face pressure and coercion to abort their daughters.

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[77] https://www.theaustralian.com.au/video/id-5348771529001-6069380792001/-Immoral-to-abort-a-baby-on-the-basis-of-gender-selection-

[78] Hvistendahl, M., 2011, Unnatural Selection: Choosing Boys Over Girls and the Consequences of a World Full of Men, Public Affairs Publishing. See also: "It's a girl": http://www.itsagirlmovie.com; The Economist, "The War on Baby Girls", 4 March 2010: http://www.economist.com/node/15606229; United Nations Population Fund, "Gender-Biased Sex Selection": http://www.unfpa.org/gender-biased-sex-selection;

[79] https://www.unicef.org/emerg/files/women_insecure_world.pdf

[80] https://www.pnas.org/content/116/19/9303

[81] See for example: Agreed Conclusions on the Elimination of All Forms of Discrimination and Violence Against the Girl Child, Commission on the Status of Women, 51st Session (26 February – 9 March 2007), resolving that we should, "Eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection, which may have significant repercussions for society as a whole.": http://www.unwomen.org/~/media/headquarters/attachments/sections/csw/51/csw51_e_final.pdf.

94. There is evidence that sex selective abortion is already occurring in some parts of Australia. Take for example, the high-profile case of Dr Mark Hobart who refused to perform a sex-selective abortion in Victoria,[82] or the investigation by SBS that found a higher number of boys than girls being born in some ethnic communities in Australia.[83] There is also the more recent study from La Trobe University which indicates that in Victoria – a state which reformed its abortion laws to allow abortion on request for any reason in 2008 – sex selective practices are taking place, with an alarmingly higher number of boys being born than girls in some ethnic communities.[84]

95. Given this background, we are dismayed that an amendment moved to prohibit sex-selective abortion was voted down in the Legislative Assembly.

Concerns about the amendment raised in the Legislative Assembly

96. During debate on the Bill, Leslie Williams MP argued against this amendment, stating that sex-selective abortion could be requested where a woman or her partner has a sex-linked condition, and that a prohibition could discourage such women from having honest, confidential conversations with their doctor. She also stated that there is "no evidence that there is a problem of sex-selective abortions in Australia", which we know is not true.

97. If concerns regarding sex-linked conditions were legitimate, Members could have moved an amendment in line with the National Health and Medical Research Council's position on sex selection in the context of assisted reproductive technology, which prohibits the practice "unless it is to reduce the risk of transmission of a genetic condition, disease or abnormality that would severely limit the quality of life of the person who would be born".[85] However, as per our discussion regarding disability-selective abortion below, consideration should also be given to whether selecting against genetic conditions would unjustly discriminate against persons with disabilities.

98. Mrs Williams also raised the concern that linking the motivation of sex-selection to certain communities could lead to discrimination and racial profiling of women of colour and immigrant women. However, the reality is that sex-selective abortion *is* practiced in particular ethnic and migrant communities. What Mrs Williams refers to as profiling, we call screening, which is a safeguard for these women as well as their unborn daughters. Of course, any screening process must be undertaken sensitively and respectfully, but we cannot fail to do it and as a result risk failing women and girls who fall victim to sex-selective abortion. We also note that if abortion were only available to preserve a woman's life or health as it is under the current law, and was not being made available for any reason until 22 weeks and effectively for any reason thereafter, this concern about profiling women would not even exist. If abortion were only available

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[82] Devine, M., "Doctor risks his career after refusing abortion referral", Herald Sun, (5 October 2013): http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion- referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5.

[83] SBS, "Could gender-selective abortions be happening in Australia?", SBS, (28 August 2015): https://www.sbs.com.au/news/could-gender-selective-abortions-be-happening-in-australia.

[84] Edvardsson K., Axmon A., Powell R. and Davey M. (2018), Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015, *International Journal of Epidemiology*: https://doi.org/10.1093/ije/dyy148; Dow, A., "The 'missing girls' never born in Victoria", 12 August 2018: https://www.theage.com.au/national/victoria/the-missing-girls-never-born-in-victoria-20180811-p4zwxe.html?_ga=2.153057081.1038406648.1539284571-2039037577.1506596324.

[85] https://www.nhmrc.gov.au/sites/default/files/documents/reports/use-assisted-reproductive-technology.pdf, p72.

on the current grounds, doctors would not be left with the same degree of uncertainty as to why a woman is seeking an abortion.

99. Instead of outlawing abortions purely on the grounds of sex, Mrs Williams moved that there would be a review in 12 months to see if such abortions were taking place. Attorney General Mark Speakman also made comments about how it was unclear from the draft amendment what duty would be imposed on a doctor in relation to sex-selection, what happens in the case of genetic disorders, and that this is not "something we can determine on the run". However, he and other Members were quite happy to legalise sex-selective abortion and just see what happens.

100. A "wait and see" attitude is an appalling failure of young girls. The proposed 12 month review means for that whole time - and potentially much longer - sex-selective abortion would be free to occur in NSW, and the Victorian experience shows us that it will. If the practice is already occurring in NSW, then this is the time to stop it. Parliament's job is to send a clear message that sex-selective abortion is not acceptable in NSW, and the law should reflect that.

101. Health Minister Brad Hazzard commented that according to the chief obstetrician, there is no evidence of sex-selective abortion in NSW. He could not know that with the dearth of data on abortion in this state. And even if it is the case that there are no abortions currently being carried out for sex-selective purposes in NSW, the most significant discrepancy in Victoria occurred in the years *after* its laws were changed to legalise abortion for any reason, including sex-selection.

102. Mr Hazzard along with other Members emphasised the need to gather data on this issue. However, the Members' decision not to pass an amendment requiring data collection for abortion contradicts and makes impossible the proposed review for sex-selective abortion. Not needing to give a reason for an abortion before 22 weeks also presents challenges for data collection in this area.

103. Jenny Leong's comments that prohibiting sex-selective abortion would "hurt women and block timely access to health care" and would cause doctors to "second-guess a patient's reasons for choosing what they choose", only serves to expose her ideological commitment to abortion on demand, at any cost – even the cost of little girls' lives.

104. As well as protecting young girls from violence and discrimination before they are even born, a prohibition on sex-selective abortion would also afford some protection to women from son-preference cultures who are coerced into aborting their daughters.

105. The shambolic nature of the effort to rush the bill through parliament was reflected in the fact that a number of MPs voted against the sex-selective amendment on technical grounds, but still want sex-selective abortions outlawed. It's clear the vast majority of MPs and citizens want this, and if MPs had been given a proper opportunity for consultation, our Parliament wouldn't be about to legalise something as vile as sex-selective abortion. This is the kind of deeply disappointing outcome you get when you rush legislation and don't honour people's democratic right to know what laws their parliament is passing.

Recommendation 7: Amend the Bill to prohibit abortion on the basis of sex.

B. Disability-selective abortions

106. There is no provision in the Bill protecting children with disabilities from discrimination, nor were any amendments moved to this effect in the Legislative Assembly. However, we believe such a provision to be of vital importance.

107. A law that allows abortion on request to 22 weeks with minimal safeguards thereafter, permits abortion for any kind of disability, including Down syndrome or a cleft lip. There are countries like Iceland which have been celebrating nearly "eradicating Down syndrome". In other words, they are nearing a 100% elimination rate for aborting every child who is diagnosed with the disability. In Australia, 93% of pregnancies end in abortion when a baby is given a Down syndrome diagnosis. The correct term for this is 'eugenics'. This kind of discrimination against children with disabilities is unacceptable in a society that is meant to be fighting against discrimination and working towards greater inclusiveness for persons with disabilities.

108. Stories of mothers being pressured to abort their children with Down syndrome are tragically becoming more and more common in Australia and internationally. In Perth, a mother was told to abort her daughter and simply "try again for a normal one".[86] A NSW mother was told that her husband would leave her, that she would lose her job, and that the baby would have a poor quality of life as well as ruining the quality of life of her existing children.[87] A Tasmanian mother was repeatedly pressured to have an abortion throughout her pregnancy, despite refusing one at the very outset.[88] All the mothers complained that the information they received was either inaccurate, skewed or out of date and heavily prejudiced towards encouraging termination.

109. Mothers of children with Down syndrome and other disabilities already feel pressure from health practitioners and wider society to abort.[89] What kind of "choice" does a woman have, when abortion is the only option presented, and when it is presented in such a coercive, frightening manner? If abortions are lawful for any reason with no protections against disability-selective abortion, such pressure will only increase and unborn children with disabilities will be further targeted.

110. Even if abortions are already being performed on grounds of disability in NSW, we need to ask whether our society, which is meant to be becoming more progressive on promoting the rights and welfare of people with disabilities, is comfortable with allowing them to be targeted when it comes to abortion. We are not.

Recommendation 8: Amend the Bill to prohibit abortion on the basis of disability.

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[86] Gray, L., "Life with Lily: My doctor assumed we'd abort our baby with Down syndrome", The Australian Women's Weekly (21 March 2019): https://www.nowtolove.com.au/parenting/family/world-down-syndrome-day-lily-mccain-45896.
[87] Bushnell, T., "Support for mothers of children with Down syndrome needed", The Macleay Argus, (5 March 2018): https://www.macleayargus.com.au/story/5078610/macleay-mother-calls-for-greater-down-syndrome-support-photos/#slide=29.
[88] Aubusson, L., "Parents pressured to terminate pregnancy of their babies with Down syndrome", Kidspot, (23 November 2016): https://www.kidspot.com.au/parenting/real-life/in-the-news/parents-pressured-to-terminate-pregnancy-of-their-babies-with-down-syndrome/news-story/0b8335a1a9b67c77e80542591b68a736.
[89] Miller, B., "Down syndrome: Parents say they feel pressured to terminate pregnancy after diagnosis", ABC News, (22 November 2016): http://www.abc.net.au/news/2016-11-22/down-syndrome-parents-pressured-to-terminate-pregnancy/8033216.

V. Data collection

111. Good policy should be based on evidence, which is supported by effective data collection practices. Accordingly, data collection around critical aspects of abortion are necessary for government to:

- better understand the physical and psychological impacts of abortions on women and provide them with any support they need;
- hold abortion providers to account and ensure transparency around the care they give is made public;
- understand the trends in relation to abortions, particularly if they are impacting specific groups of women in society (for example, those experiencing intimate partner violence, women of particular ethnicities or indigenous women); and
- ultimately, create policies that give real support and choice to women facing unplanned or crisis pregnancies.

112. In NSW, there is currently no regime which collects, analyses and publishes data in respect of abortions. For the reasons stated above, the Bill must address this.

Data collection practices around Australia

113. Currently, there is no standardised national data collection about abortion in Australia. During the recent debate in the Legislative Assembly, a number of proponents of the Bill (including the current Minister for Health, Mr Brad Hazzard MP) claimed that data about abortion is already being collected at a federal level because "*terminations are generally eligible for the Medicare rebate*".[90] It is concerning that our own Minister for Health does not have a clear understanding of the data available on abortion. While a Medicare rebate is available for surgical abortion, the item numbers used for abortion procedures are also used for procedures for miscarriage and other gynaecological procedures.[91] In addition, abortive medication is not covered by Medicare.[92]

114. In 2008, the Victorian Law Reform Commission (VLRC) were of the view that a legislative mandatory reporting requirement was not necessary because such reporting is already a requirement of public abortion providers under their funding agreements, in accordance with existing regulations.[93] It should be noted that the VLRC in its report stated that:

> *8.199 ... The data currently collected by DHS is not published. Many submissions and consultations discussed the importance of such data being available for*

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[90] NSW. Parliamentary Debates. 8 August 2019. Mr Brad Hazzard (Wakehurst—Minister for Health and Medical Research) (21:08).
[91] A Chan, L Sage 'Estimating Australia's abortion rates 1985-2003' *Medical Journal of Australia 2005*; 182 (9): 447-452.
[92] It is noted that such medication is part of the Pharmaceutical Benefits Scheme, which means there may be data about the number of doses dispensed. However, there may be limitations in ensuring accuracy when considering state-based distribution. The organisation Children By Choice note that, in Queensland, "*the data is artificially inflated because one large pharmacy group supplies prescription medicines used for medical abortion to service providers in other states, whilst processing the PBS prescriptions in Queensland*" (https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics).
[93] Victorian Law Reform Commission, *Law of Abortion*, Report No 15 (2008) pp 132-133.

future policy development, some seeing it as particularly important for the development of strategies to reduce the number of abortions.

8.200 Failure to disseminate abortion data does not encourage informed discussion of issues, or targeted, well-informed policy making for abortion, reproductive health, and education. Clinical policy and health policy in this area would be assisted by the routine publication of this information.

115. Despite the above observation, the Victorian Government continues not to collate or release any statistics on abortion on a regular basis to assist the development of health policy or social policy to genuinely assist women facing crisis pregnancy. This only supports the argument that for active data collection practices in this area need a legislative requirement to be in place.

South Australia and Western Australia

116. The only two Australian jurisdictions which properly collect, analyse and disseminate information and statistics about abortion are South Australia (since 1970) and Western Australia (since 1999).

117. South Australia's mandatory reporting provisions are outlined in the *Criminal Law Consolidation (Medical Termination of Pregnancy) Regulations 2011.* The Regulations require the notification of medical terminations of pregnancy to the Chief Executive of the Department for Health and Wellbeing. This data is collated and the results provided in an annual report on general "Pregnancy Outcomes in South Australia". The information required to be notified by doctors include the following:

- Details (name, address and qualification) of both doctors who will perform the abortion;
- Details of the woman seeking the abortion (including name, address, age);
- Reason for undertaking the termination and diagnosis. This includes detail on whether it is on medical grounds relating to mother or child or another reason (which must be specified);
- Estimate of gestation age of the foetus;
- Total number of previous pregnancies (including live births, still births, miscarriages and terminations);
- Method of termination (including whether it is surgical, medication only, etc)
- Whether sterilisation of the woman occurred;
- Whether there were any post-operation complications (such as haemorrhaging, sepsis, perforation or trauma to the uterus or maternal death).

118. In addition, the chief executive of each hospital is required to provide a monthly notification of the total number of abortions which occurred at that hospital to the Chief Executive of the Department for Health and Wellbeing.

119. Western Australia's mandatory reporting provisions are outlined in the *Health (Miscellaneous Provisions) Act 2011*, which require both midwives and medical practitioners who assist in or perform abortions to notify the Chief Health Officer. The Abortion Notification System forms the basis of reports released collating 3 years of data at a time. The statistics collated include information about:

- the total number of abortions and overall rate of abortion;
- the age of the woman;
- gestational age of the foetus;
- method of abortion; and
- reason for the abortion, noting that this is classified only as "suspected fetal anomaly", "actual fetal anomaly" or "other".

Amendment introduced and debate

120. In the recent Legislative Assembly debate, Mrs Tanya Davies MP moved an amendment to include "terminations", within the meaning of the Bill, as a "Category 1 condition" which requires notification to the Secretary of the Department of Health of certain information which may be prescribed by regulation. The intention of this amendment would be, in effect, to include abortion as part of the already existing notification system in NSW (rather than setting up a specific abortion notification regime as South Australia and Western Australia have). It would allow the specific fields of data to be prescribed in subordinate legislation.

121. During the debate on the amendment, the Minister for Health argued that it would be inappropriate to include abortion as a "Category 1 medical condition" on the basis that such scheduled medical conditions are "*more like a list of diseases that impact on public health or are generally just statistics on health that are kept for epidemiological purposes.*"

122. It should be noted that other scheduled medical conditions included in Schedule 1 are birth, perinatal death, pregnancy with a child having a congenital malformation and Sudden Infant Death Syndrome. If there is anywhere in legislation that a notification regime for abortion statistics could fit, this appears to be the most suitable. However, if a separate regime is required to ensure data is collected, Women's Forum Australia would support it. Given that members arguing against a prohibition on sex selective abortion cited the need for clearer data that it is occurring, mandatory data collection and reporting must be included in this Bill. This argument underscores the need for more data on abortions and the reasons women seek it. It is further noted that without data, it will be difficult to carry out a meaningful review of the Bill as required under section 16.

Mandatory data collection, reporting and dissemination of information about abortions carried out in NSW

123. The South Australian mandatory reporting provisions better enhance the richness of the data collected. This enables the collation and analysis of richer data which:

- help to better inform women about the health impacts of abortion to ensure informed consent is genuine when they make their choice; and
- assists the government to make policies that help to provide assistance to women and address any issues that may make women feel that abortion is their only option.

124. We would recommend that additional particulars required to be notified include:

- the ethnicity or Indigeneity of the woman, to understand whether abortion particularly impacts certain groups of women and to allow government to ascertain whether they need additional socioeconomic or other support;
- whether the woman has been referred to counselling independent of the abortion provider and has attended counselling; and
- whether the woman has been the subject of intimate partner violence and whether she has been provided any relevant support services to assist her.

125. We note that some members of the Legislative Assembly were concerned that mandatory data collection would "*drastically change the way abortion is treated in the health system and... place barriers in the way of people accessing abortion.*"[94] It is unclear how mandatory notification places "barriers" to accessing abortion and the relevant member did not substantiate that claim. To protect the privacy of a woman seeking an abortion, Women's Forum Australia also recommends that any information notified under a mandatory reporting regime is de-identified and the privacy of the woman seeking the abortion is protected as "health information" under NSW privacy laws.

Recommendation 9: Amend the Bill to include a provision that requires the mandatory collection, analysis and publication of data about abortions carried out in NSW.

VI. Protections for women and children against late-term abortions

126. The Bill removes protections for late-term abortions, including abortions on viable babies up until full term.

The Bill allows abortion at any stage, for any reason

127. Under the current law, abortion is legal where a doctor believes it is "necessary" to preserve a woman from "serious danger to her life, or physical or mental health", at any time during the pregnancy, where the risks of the procedure are not out of

[94] See n 1, Ms Jenny Leong (Member for Newtown) (20:44).

proportion to the danger intended to be averted.[95] This has been expanded to include concerns about threats to the woman's health after the child's birth.[96] Importantly, abortions are only allowed for health reasons under the current law.

128. The current law does not impose a specific gestational limit on abortion. However, the legal test arguably precludes late-term abortions post viability (22-24 weeks), as not only do such procedures themselves pose serious dangers to women, but they would not be "necessary" if the baby was at a gestation where it could be delivered and born alive.

129. Under section 5 of the Bill, abortion is legal until 5 months on request, with no health reason required, or in fact any reason at all (5 months is already considered late-term). This alone makes the Bill far less restrictive than the current law, under which abortion on request does not exist. Allowing abortion on request until five months is out of step with other jurisdictions, where the average time limit for abortion on request is 12 weeks, with strict conditions thereafter. At five months, a woman is well advanced in her pregnancy, and it is possible for the baby to survive outside the womb.

130. Under section 6 of the Bill, abortion is legal after 22 weeks with no upper gestational limit (i.e. up until full term) when after broadly considering a woman's circumstances, two doctors agree that the abortion should be performed. Unlike the current law, no health reason is required. The clause is stated so broadly that it effectively allows abortion at any stage, for any reason.

131. Furthermore, the two doctors do not need to be independent or from a separate clinic or hospital – they could be the abortionist and the anaesthetist operating in the same clinic. There is also no criminal penalty for a doctor who fails to comply with this requirement. The consultation requirement gives the impression of "oversight" (most likely to make the Bill more palatable), but does not provide any meaningful safeguard.

132. Under this Bill, there is no legal reason not to perform an abortion right up until full term. Since the introduction of Victoria's similarly extreme abortion law in 2008, there has been at least one abortion carried out for "psychosocial"[97] reasons after 37 weeks.[98]

133. Regardless of how many women will actually seek late-term abortions and for what reasons – though there is evidence[99] to suggest that late term abortions did increase after the law change in Victoria – the critical point is, that the Bill contains no concrete restrictions, contrary to what its advocates may claim.

134. Removing protections against late term abortions is dangerous for women and for a Bill that seeks to 'modernise' the current law, it is out of step with common practice in

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[95] *R v Wald* [1971] 3 DCR (NSW), derived from *R v Davidson* [1969] VR 667 (Vic), and followed by *R v Sood* [No 3] [2006] NSWSC 762.
[96] *CES v Superclinics* (1995) 38 NSWLR 47.
[97] 'Psychosocial' encompasses any cause other than foetal or maternal physical health.
[98] The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Victoria's Mothers and Babies: Victoria's Maternal, Perinatal, Child and Adolescent Mortality 2010/2011* (Department of Health, Melbourne) p 145: https://www2.health.vic.gov.au/Api/downloadmedia/%7B67598618-4D6D-40B5-8264-61EE036D0F1A%7D
[99] Medew J., "'Abortion tourism' brings scores of women to Victoria for late terminations", The Age (26 October 2015): https://www.theage.com.au/national/victoria/abortion-tourism-brings-scores-of-women-to-victoria-for-late-terminations-20151026-gkiw6u.html.

other jurisdictions,[100] with medical knowledge of foetal viability and pain,[101] and with medical advances including progress in neonatal care.[102] Recently there was a viral video circulating on social media of a baby born at 22 weeks being discharged from a hospital in Alabama. The current Bill would allow babies of the exact same gestation to be aborted 'on request' and for even older babies to be aborted with minimal safeguards.

Reasons women seek late-term abortions

135. Advocates of abortion argue that late-term abortions are rare and undertaken only when a woman's life or health is at risk or where the unborn child suffers from a fatal condition. Yet, a 2013 study undertaken as part of one of the largest studies on abortion in the US, suggests that only a very small proportion are for foetal anomaly or life endangerment.[103]

136. A 2004 study from the pro-abortion Guttmacher Institute found that the most frequent reasons cited for having an abortion *at all gestational ages* included: "that having a child would interfere with a woman's education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%)."[104]

137. According to the 2013 study, other reasons women commonly sought an abortion later on in pregnancy included not knowing they were pregnant, not knowing where to go for an abortion, expense, insurance issues, travel considerations, indecision and disagreements with the father.

138. Such reasons are hard to square with the reality of late-term abortion.

139. Additionally, it should be noted that women who seek late-term abortions are often in vulnerable situations with a limited support system. The 2013 study described five profiles of such women: "They were raising children alone, were depressed or using illicit substances, were in conflict with a male partner or experiencing domestic violence, had trouble deciding and then had access problems, or were young and [experiencing their first pregnancy]."

140. Laws allowing late term abortions with minimal restrictions, put vulnerable women like this at even greater risk and do nothing to address the underlying issues that they are facing.

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[100] In many European countries, abortion is only allowed up until 10-12 weeks, after which there are strict conditions that need to be met for an abortion to be performed (http://www.euronews.com/2016/04/14/europes- abortion-rules---no-single-policy/). In the UK, abortion is only allowed up until 24 weeks to prevent physical or mental health risks to the woman or her other children. It is only allowed after 24 weeks under strict conditions (Abortion Act 1967 (UK), s 1(1)).

[101] Doctors on Fetal Pain, www.doctorsonfetalpain.com.

[102] Salter J., "Premature babies: How 24 week-old babies are now able to survive", The Telegraph (17 November 2014): http://www.telegraph.co.uk/women/womens-health/11121592/Premature-babies-How-24-week-old-babies-are-now-able-to- survive.html; "Premature babies", Better Health Channel, https://www.betterhealth.vic.gov.au/health/healthyliving/premature-babies#.

[103] Foster D.G., and Kimport K. (2013), Who seeks abortions at or after 20 weeks?, Perspectives on Sexual and Reproductive Health, Vol 45, No 4, pp 210-218: https://onlinelibrary.wiley.com/doi/epdf/10.1363/4521013.

[104] Finer L.B et al (2005), Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives, Perspectives on Sexual and Reproductive Health, Vol 37, No 3, pp 110–118: https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf.

141. There are some who insist that allowing late-term abortions is important for women who are particularly vulnerable, such as those who are suicidal, those who are pregnant as a result of sexual violence, or those who have been unable to access support earlier due to family violence or other complex personal circumstances. However, these complex circumstances are not resolved by late-term abortion. If anything, they are exacerbated. Abortion in these circumstances potentially conceals or even legitimises acts of violence. Instead of offering women a traumatic procedure that puts their health and well-being at further risk, health practitioners and others involved in providing support should be attempting to address the root causes that lead women to seek an abortion in these situations.

Recommendation 10: Amend the Bill to exclude abortion for social reasons and restrict it to "as necessary" as under the current law.

Recommendation 11: Amend the Bill to remove section 6 which would permit abortion of viable babies until full term.

VII. Protection for babies born alive after an abortion

142. During debate in the Legislative Assembly, Members voted down an amendment including a provision that would have afforded a child born alive after an abortion "the same neonatal care as would be given to any other child born at the same stage of pregnancy and in the same medical condition."

143. Denying life-saving treatment to a baby born alive after an abortion is inhumane. There is no reason not to provide such a child with the same level of care as would be given to another child at the same gestation and in the same medical condition.

144. Since Victoria reformed its abortion laws in 2008, more than 300 babies were born alive after abortions and were likely left to die.[105]

Recommendation 12: Amend the Bill to include a provision that mandates the same life-saving treatment for a child born alive after an abortion as another child at the same gestation and in the same medical condition.

VIII. Criminal penalties for unlawful abortions

145. Abortion is a very serious issue. Those on both sides of the abortion debate agree that it is not something women take lightly and that it is often one of the most difficult decisions they will make. Whether one respects the moral significance or human rights of the unborn child, the biological reality is that abortion deliberately ends the life of a human being in its mother's womb. It is appropriate that the law includes deterrents for something as serious as this.

146. Women's Forum Australia is, in principle, against the criminalisation of women who have had an abortion. We consider that there are systemic issues which mean that women are not provided with all the support or information available so that they can make a real choice, and due to various pressures, often feel like abortion is their only choice. In our view, it will generally be counter-productive and unjust to charge women

[105] The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, *Victoria's Mothers and Babies: Victoria's Maternal, Perinatal, Child and Adolescent Mortality,* 2009-2017 reports (Department of Health, Melbourne).

under such desperate circumstances, particularly in light of the suffering that many women also experience after abortion. In this regard, an amendment could simply be made to the *Crimes Act* protecting women from criminal responsibility and this is something we would wholeheartedly support.

147. However, we are of the firm belief that criminal penalties must remain for any other person who performs an unlawful abortion in order to maintain some level of protection for both women and unborn children.

148. While Schedule 2 of the Bill makes it a crime for an unqualified person to perform an abortion, the Bill does not protect women against doctors who perform abortions unlawfully. Cases such as *R v Smart* (1981) and *R v Sood* [2006] NSWSC 1141, which involved unlawful late term abortions and the dangerous mistreatment of patients, affirm the need to retain the offences for unlawful abortions in the *Crimes Act* as a matter of justice, deterrence and protection for women. Without such protections, doctors like Dr Smart and Dr Sood may not face adequate penalties, will likely face less scrutiny, and will be less deterred from performing unsafe abortions that benefit them financially. Women would also have to bring their own proceedings, rather than have the protection of the criminal law.

Recommendation 13: Amend the *Crimes Act* to protect women from criminal sanction in relation to abortion and maintain penalties for other persons performing unlawful abortions.

IX. Freedom of conscience protections for health practitioners

149. It is not unreasonable that, due to various risks of harm to mother and child, some doctors may be opposed to terminating pregnancies on the basis that abortion falls outside their conception of medicine as a healing profession. It is also widely acknowledged that doctors have a range of ethical views depending on the developmental stage of the foetus or gestational period of the pregnancy.

150. Section 9 of the Bill requires a health practitioner with a conscientious objection to abortion to refer the patient or transfer their care to a health practitioner who will perform the abortion or to a health service provider with such a practitioner. However, not only would referral "contradict one's very objection to the request in the first place" or cause a doctor to be "complicit in harm", but it would rightly "cast doubt on the objector's sincerity".[106]

151. The referral requirement is deeply concerning for health practitioners who will be forced to violate their conscience or lose their job, for women who will eventually only be able to see doctors for pregnancy care who don't object to abortion (regardless of whether they have differing views on this issue), and for our society for which a fundamental right will be eroded.

Recommendation 14: Amend section 9 of the Bill to provide a robust protection for freedom of conscience, which must include the right of a health practitioner not to refer for abortion.

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[106] Gerrard J.W. (2009), Is It Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?, *Journal of Medical Ethics* Vol 35, No 10, pp 599–602.

X. Recognise "women"

152. It is deeply concerning that throughout the Bill, the term 'woman' has been erased and replaced with the term 'person', denying that it is women who are uniquely impacted by pregnancy and abortion and absurdly suggesting that men could be pregnant. Trans men can of course access abortion but they remain biologically female. The fact that there is not one mention of the term "woman" in a bill that claims to be about women's "health" and "rights" is symbolic of the fact that women haven't been put at the centre of this reform.

Recommendation 15: Substitute the term "person" for "woman" throughout the Bill.

Conclusion

153. Advocates of the Bill claim that it clarifies the current law and aligns it with current clinical practice and other jurisdictions, promotes women's health, and brings the law into the 21st century. In reality however, the Bill is a radical departure from the current law, is counter-productive to women's health, and falls far short of legislation that is suitable for our society today. It removes important protections afforded to women, children and health practitioners under the current law and fails to address the very real issues women are struggling with.

154. In light of the points we have raised, we do not support this Bill. In 2019, we must do better than this for women, children and our community.