Submission No 49

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Women's Bioethics Alliance

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Reproductive Health Care Reform Bill 2019

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Women's Bioethics Alliance

The Secretariat,
Standing Committee on Social Issues
NSW Parliament
Macquarie Street, Sydney
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To the Committee,

Thank you for this opportunity to contribute to this important public debate. While appreciating the opportunity (and noting a 24-hr extension was granted) we do wish to place on record the limitations your very tight deadline has placed on us and, we assume, other contributors from the non-profit sector, to respond as fully as we might have preferred. We question why such restricted time was permitted for contributions and believe this to be averse to the need for proper attention and debate, given the serious nature of the issue.

We are a collaboration of women with backgrounds in women's health, feminist academia, feminist publishing and advocacy against violence against women, who are concerned about the exploitation, commodification and abuse of women's bodies through medical practice, especially regarding reproductive technologies.

Termination of Pregnancy (TOP) is of special interest to us because, as a procedure that ordinarily women would not desire, its widespread practise reflects the oppressive circumstances under which women live. We favour decriminalisation but we also insist that safeguards are necessary to protect women – especially those most vulnerable to coercion of various kinds.

INTRODUCTION

We believe women should not be criminalised for seeking TOP.

We do, however, recommend that women seeking or obtaining TOP be regarded as vulnerable and needing support in diverse ways. We have, elsewhere, critiqued the rhetoric of 'choice' when, in many cases, women have so few real choices. The default is so often TOP, while women's real needs remain unmet. While there is support for the 'right' to TOP, there is less support for women who are at risk of an unwanted TOP and who would have liked to have had their child but were not supported to do so. It is our view that in too many cases, the 'right to choose' only means the right to terminate. A support system should be available offering assistance to deal with finances, relationships, mental health, violence and abuse, and so on according to each woman's individual needs. Returning home after a termination, that woman's situation remains the same unless she is given support and assistance. Our evidence is that while TOP providers should be in a unique position to identify special vulnerabilities (including coercion), they often do not perform such a role in practice.

Most terminations are sought for socioeconomic reasons. Women become pregnant and then seek TOP because of intimate partner violence, relationship dysfunction, financial difficulties, mental illness, sexual exploitation, and other reasons. Many women feel they do not have the resources or support to give birth to a child, they feel they cannot cope, they fear the impact a baby will have on their lives, and they are concerned about the needs of other people in their lives.

In many aspects of women's lives, discriminatory structural and cultural pressures limit their choices and reduce their autonomy. TOP fails to address these problems, and in fact often reinforces them.

We note with concern that decriminalisation of TOP in Victoria has not changed practice but simply worked in favour of providers to clarify the law.[1] This is unsurprising, since the Victorian decriminalisation legislation did not address issues central to women's termination decisions, such as employment, housing affordability, welfare, childcare, violence, and mental health.

However, by considering the decriminalisation of TOP, the NSW Government now has a unique opportunity *to improve women's wellbeing by addressing some of these pressures*.

Safeguards and mandated protocols are important to protect women from coercion and to address each woman's unique needs.

[1] Keogh LA, Newton D, Bayly C, McNamee K, Hardiman A, Webster A and Bismark M (2017). Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia. *J Fam Plann Reprod Health Care* 43:18-24.

There is also opportunity to ensure that termination services can *identify and assist vulnerable women and girls.*

VIOLENCE AND ABUSE

TOP services represent a clinical opportunity to provide interventions for gender-based violence. It is important to acknowledge the presence of violence in the lives of women and girls seeking abortion, and to not miss this opportunity to help them.

Intimate partner violence is a common experience for women who attend TOP clinics; in Australia it is one of the main reasons women seek TOP.[2] This is especially the case for Aboriginal women and girls, and there has been concern in the past about child sex offenders bringing underage girls to clinics for abortions without any investigation as to circumstances.

Given the strong links between gender-based violence of all kinds with TOP, there should be serious consideration given to universal screening for violence in TOP settings where abused women and girls frequently end up.[3] This includes screening for sexual abuse both present and in early life, dating violence especially among teenagers, physical and emotional violence, incest, and trafficking.

TOP services and doctors receiving requests from girls aged 16 and younger should be required to report such cases, as sexual activity in these cases is potentially a crime against the girls. Older men may bring teenage girlfriends in for a termination, and sometimes young girls are victims of incest or trafficking. TOP providers and related services should be required to do all they can to detect and report abuse.

A US study found that healthcare providers of all kinds, including providers of terminations, "are seeing trafficked victims but failing to identify them, thereby unwittingly contributing to continuing criminal activity and exacerbating both public and private physical and mental health problems for this segment of the population."[4] Sex trafficking is a crime that occurs in Australia[5] and so making sure the Australian healthcare system is part of the solution, rather than a facility that props it up, is important especially considering many victims of trafficking are in the country from abroad.

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[2] Cooke D. (2007) Abortion linked to domestic violence, study finds. *The Age* April 7. Accessed at https://www.theage.com.au/news/national/abortion-linked-to-domestic-violence-study-finds/2007/04/06/1175366479425.html Children by Choice said last year that about one third of their clients are abused women. Uibu K (2017). Abortion laws making it harder for women to escape domestic violence, expert warns. *ABC News* 21st June. Accessed at http://www.abc.net.au/news/2017-06-21/abortion-laws-force-abused-women-to-stay-with-perpetrators/8451772

[3] McClosky, Laura (2016). The effects of gender-based violence on women's unwanted pregnancy and abortion. *Yale Journal of Biological Medicine* 89(2):153-159. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918882/

4 Lederer LJ and Wetzel CA (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. *Annals of Health Law*. 23(1): 61-91.

[5] https://www.canberratimes.com.au/story/6037731/sex-worker-testifies-at-nsw-slavery-trial/?cs=14231

We were dismayed to see White Ribbon tweet the following in relation to this Bill: "Women are at increased risk of experiencing violence from an intimate partner during pregnancy. Access to reproductive health services can be life-saving especially for those in abusive relationships." We ask, why must a woman lose her baby to protect herself from violence?

Rather than White Ribbon's harm-doubling proposal, we propose that TOP decriminalisation be approached as an opportunity to enhance women's safety and wellbeing through victim screening and support services.

SEX SELECTIVE TERMINATION

Sex-selective TOP is one of the many deeply ingrained cultural practices that exist around the world, including in Western countries, to devalue female human beings from their very inception. We already know that sex-selective practices in Australia are used to eliminate or avoid female foetuses among Indian and Chinese migrant families, according to a study of all births in Australia over a recent time period, and backed up by Australian Bureau of Statistics data, as well as international research.[6]

We note that there are those who believe sex selective terminations will not be an issue in New South Wales. We disagree. In 2013 there was a first-hand report of just one of many cases of sex-selective termination in Melbourne:[7]

> WHEN Melbourne sonographer Jane (not her real name) told the young Afghani Muslim bride that she was expecting a girl, she felt she had just handed out a death sentence.
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> "It was the worse scan in my 15 years in the profession," she told me.
>
> "My patient came in recently for a routine 20-week obstetric foetal wellbeing scan. She asked the gender of the baby. In the room were family members.
>
> "I said the baby looked healthy and most likely a girl. The grandmother spoke aggressively in another language and left the room slamming the door, followed by the uncle and a little boy.
>
> "The mother was crying hysterically. You would have thought I had just told her that her baby had died…
>
> "I have no doubt about the intentions of the father. The mother may have wanted to keep that child but there was little doubt in my mind she would be aborted."
>
> "Things have changed," she says. "This used to be a joyful job, showing pretty pictures to couples happy with the baby. Now there is more insistence on revealing the sex early and you fear what they will do with the information."

Indian researchers have located female feticide and infanticide as "a symptom of increasing crime against women". Rather than being a product of a backward, poverty-stricken culture,

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[6] Edvardsson K, Axmon A, Powell R, and Davey MA (2018). Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999-2015. International Journal of Epidemiology 47(6):2025-2037. https://academic.oup.com/ije/article/47/6/2025/5057663

[7] Tankard Reist, Melinda (2013). Gender bias cannot start in the womb. *Herald Sun* May 4. https://www.heraldsun.com.au/news/opinion/gender-bias-cannot-start-in-the-womb/news-story/9d0572d2c43e1f1491225bad729d0e09

it is enabled by increasing wealth and access to TOP and prenatal testing technologies.[8] If allowed, it will flourish in Australia.

We hope that the NSW Parliament shares our horror at this form of sex discrimination, and act to prevent it by supporting a provision in the legislation making sex-selective TOP unlawful.

COUNSELLING AND COERCION

TOP is a difficult decision for many women, sometimes with lifelong consequences, and a decision made in complex circumstances. In a recent Australian study, the major challenge identified by women obtaining termination of pregnancy was deciding whether to undergo the procedure.[9]

We suggest that TOP research in Australia has failed to capture the difficulties in coping with it, having extremely low participation rates. For example, of 59 women who initially agreed to be contacted after their 'medical' termination, only 18 participated, in an Australian study.[10] And in another Australian study, only 23.5% of women responded to the survey.[11] Low response and retention rates in TOP research indicate distress and avoidance.

We are therefore disappointed to see the weak provisions for counselling. Part 7 of the draft Bill appears to make counselling completely optional, to the point where the practitioner does not even need to provide it if asked.

Counselling is necessary to identify women who are being coerced to obtain a TOP. Practitioners are aware that this happens (for example, evidence given by a TOP practitioner to the Queensland Parliament) yet have consistently avoided taking action to identify and assist coerced women.[12] We believe it is feasible and essential for medical practitioners to provide *comprehensive and independent assessment of coercion* for women and girls requesting TOP. Informed consent protocols can use evidence-based practice to identify women who are at high risk for being coerced and for experiencing regret, grief, or psychological harm after TOP.

There is a body of evidence in Australia that coercion is not uncommon for significant numbers of women. *Giving Sorrow Words: Women's Stories of Grief After Abortion* documents the experience of women who felt pressured to undergo terminations –

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[8] Bose, Ashish (2007). Female Foeticide: A Civilisational Collapse. Chapter 3 in Patel, Tulsi (ed.), Sex-Selective Abortion in India: Gender, Society, and New Reproductive Technologies. SAGE. p87.

[9] Shankar M, Black KI, Goldstone P, Hussainy S, Mazza D, Petersen K, Lucke J and Taft A (2017). Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Aust NZJ Public Health* 41(3):309-371.

[10] Hulme-Chambers A, Temple-Smith M, Davidson A, Coelli L, Orr C and Tomney JE (2018). Australian women's experiences of a rural medical termination of pregnancy service: a qualitative study. *Sexual and Reproductive Healthcare* 15:23-27.

[11] Shankar M, Black KI, Goldstone P, Hussainy S, Mazza D, Petersen K, Lucke J and Taft A (2017). Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Aust NZJ Public Health* 41(3):309-371.

[12] https://www.youtube.com/watch?v=dEknsikSwGo

including pressure applied within the clinic setting.[13] Many women described in addition, a lack of informed consent, poor or no counselling, a system weighted in favour of termination and not birth. Many described feeling bullied into terminating for the benefit of others (in more severe cases, some suffered physical and mental injury).

Debbie Garratt, in her doctoral research, has focused on women's experiences of coercion, both directly and indirectly, and from health practitioners or women's personal circumstances. She has gathered evidence from women about TOP coercion and we commend this work to you.[14]

In addition, and most concerning, Garratt has found that all doctors, including those identifying as 'pro-choice', may withhold information about TOP and avoid providing adequate assessment for a vulnerable woman. This occurs because doctors perceive that the professional risk is too high, thus isolating women and removing an essential avenue of support and information for them. Instead, they are referred directly to TOP providers who have a business to run.

We believe that counselling should always be offered to a woman and provided to her if she requests it, at no cost to herself, without her partner or accompanying person. Furthermore, it must be *independent of the TOP provider* to prevent conflict of interest. This was acknowledged in the Queensland Law Reform Commission's review of pregnancy termination laws in 2018.

INFANTS BORN ALIVE DURING ABORTION PROCEDURES

Babies that survive TOP must be provided with medical care. This is the only option for a humane society. Australia must take no part in infanticide. This is of special interest to us as traditionally and to this day the practice of infanticide has favoured the death of baby girls.

ABLEISM

We also strongly oppose the use of TOP to eliminate individuals with disability or severe illness. Rather we urge more support for women who are raising children with special needs, and the addressing of ableist attitudes within the medical and broader communities.

We commend to you Fiona Place's memoir, *Portrait of the Artist's Mother*.[15] Place describes the pressure from medical institutions to undergo screening during pregnancy and the traumatic nature and assumptions that a child with Trisomy 21 should not live, even though people with Down syndrome do live rich and productive lives. Fiona's son, Fraser, has become an artist and his prize-winning paintings have been exhibited in galleries in Sydney and Canberra. She has become an advocate for people with disabilities, and describes

[13] Tankard Reist, Melinda (2000). *Giving Sorrow Words: Women's Stories of Grief After Abortion,* Duffy & Snellgrove, NSW.
[14] Garratt, Debbie. (2019). Manipulative Dominant Discoursing: Alarmist Recruitment and Perspective Gatekeeping. Unpublished PhD thesis.
[15] Place, Fiona (2019). *Portrait of the Artist's Mother: Dignity, Creativity and Disability*. Spinifex Press, North Melbourne.

perfectly how, as a pro-choice writer and mother, prenatal testing and abortion have made her family's life so much more difficult.

We also commend the 2006 anthology *Defiant Birth: Women who resist medical eugenics,* in which Melinda Tankard Reist gathered accounts of women who continued their pregnancies despite intense pressure from doctors, family members and social expectations.[16] Due to perceived imperfections in the baby, or because of their own disabilities, they have faced silent disapproval or open hostility. But these women stared down the routinisation of testing, confronted this stigma and had their babies anyway. The narratives contained in this book demonstrate the real and ongoing stigma against disability in a perfectionist society.

PROVISION OF MEDICAL ABORTION

We are concerned about those whom the Bill suggests can offer medical terminations (using generic RU486 and a prostaglandin).

Regulated by the TGA, global TOP provider Marie Stopes with its subsidiary MS Health that sells the required drugs, is the only group in Australia to facilitate medical termination. In order to become a medical TOP provider, a GP needs to register with Marie Stopes and complete the MS Health training model. Only a small number of GPs have done this, possibly because of the serious complications that can happen after the administration of both drugs: severe haemorrhaging needing urgent blood transfusion, continued bleeding for up to 6 weeks, higher rates of sepsis, as products of conception remain in the woman's womb (who might need to undergo a second termination or D&C).

We are deeply dismayed that promoters of medical TOP proclaim this method to be most useful for Aboriginal women in remote communities, where it is rare to have hospitals in reasonable distance to perform life-saving blood transfusions and monitor sepsis.[17]

We note that in one large retrospective observational study in Cairns (n=1712), for 29.3% of women the outcome was unknown after their MTOP.[18] In a retrospective analysis of 15 008 women receiving early medical abortion, around 13% were lost to follow up.[19] Women of low socio-economic status appear to be more likely to be lost to follow up.[20] This is concerning and it calls into question whether the standard of care is as high as for other medical procedures. Please refer to Dr Renate Klein's research in *RU 486: Myths, Morals and Misconceptions* (Klein, Raymond, Dumble, Spinifex Press, 2013 re-released with updated preface 2018).

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[16] Tankard Reist, Melinda (2006, re-released 2019 with new preface). *Defiant Birth: Women who resist medical eugenics*. Spinifex Press, North Melbourne.
[17] Klein, Renate (2013). *RU486: Misconceptions, Myths and Morals*, Spinifex Press, North Melbourne.
[18] Downing SG, Cashman C and Russell DP (2017). Ten years on: a review of medical termination of pregnancy performed in a sexual health clinic. *Sexual Health* 14:208-212.
[19] Goldstone P, Walker C and Hawtin K. (2017). Efficacy and safety of mifepristone-buccalmisoprostol for early medical abortion in an Australian clinical setting. *Aust NZJ Obstet Gynaecol* 57:366-371.
[20] Gatter M, Cleland K and Nucatola DL (2015). Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days. *Contraception* 91:269-273.

GENDER NEUTRAL LANGUAGE

We object to the use of the term 'person' rather than 'woman' throughout the Bill. While transmen may also access abortion, they remain biologically female. This Bill is meant to be about women's health, so it must refer to women otherwise it contributes to women erasure.

CRIMES ACT 1900

We note that the only penalties relating to TOP that this Bill would leave in the *Crimes Act 1900* are for "unqualified persons" (a person who is not a medical practitioner) who performs an abortion or a person who is not a registered health practitioner who assists in a TOP.

However it concerns us that if a doctor performs a termination outside the new law, for example by failing to consult a second doctor before performing a termination after 22 weeks, then no criminal penalty applies.

We ask that a penalty for doctors performing TOP outside the provisions of the law remains in the *Crimes Act 1900* so as to provide protection to women and children. We support the removal of any penalty against a woman in relation to her own termination from the *Crimes Act 1900*. This could be done by a simple amendment to the *Crimes Act 1900* while avoiding the many defects we have identified in the current Bill.

CONCLUSION

Thank you again for the opportunity to contribute to discussion of this Bill. We sincerely hope that NSW Parliament will reform termination of pregnancy legislation to meet the real needs of women.

Yours sincerely

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Dr Renate Klein

Melinda Tankard Reist

Selena Ewing

NB: Copies of *Giving Sorrow Words*, *Defiant Birth* and *RU 486: Myths, Morals and Misconceptions* will be provided in hard copy to the secretariat to provide more detailed evidence for our position and to aid committee members in their consideration of the matter.