HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr JP Kelly MP
Mrs T Smith MP

Staff present:

Ms S Cawcutt (Research Director)
Ms K McGuckin (Research Director) Ms T Struber (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO THE ABORTION LAW REFORM (WOMAN'S RIGHT TO CHOOSE) AMENDMENT BILL 2016 AND INQUIRY INTO LAWS GOVERNING TERMINATION OF PREGNANCY IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 2 AUGUST 2016

Brisbane

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Committee met at 8.56 am

CHAIR: Good morning, ladies and gentlemen. Before we start could I request that mobile phones be turned off or switched to silent? I now declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and the inquiry into laws governing termination of pregnancy. I would like to acknowledge the traditional owners of the land on which we are meeting today and acknowledge their elders past, present and emerging.

My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, deputy chair and member for Caloundra; Mr Joe Kelly, member for Greenslopes; Mrs Tarnya Smith, member for Mount Ommaney; Mr Aaron Harper, member for Thuringowa; and Mr Sid Cramp, member for Gaven. I welcome witnesses and members of the public. I thank you for your interest in the committee's inquiry. I note that Rachel Carling-Jenkins, member of the Legislative Council in the Victorian parliament is here also. Welcome.

The purpose of this public hearing is to hear from invited witnesses about matters in the committee's terms of reference, which includes: examination of the Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016, introduced by the independent member for Cairns, Mr Rob Pyne; and consideration of aspects of the law governing termination of pregnancy in Queensland in accordance with the terms of reference provided to the committee by the parliament. Copies of the terms of reference are available from staff.

I have a few procedural matters before we start. The committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee, which takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. Witnesses have previously been provided with a copy of the instructions to committees regarding witnesses from the standing orders and we will take those as read. Hansard will record the proceedings and witnesses will be provided with a copy of the transcript. This hearing is also being broadcast on the parliamentary website. If there are any media present, I ask that you adhere to my directions as chair at all times. Can I mention that photos may be taken, but photos should only be taken by members of the media. Please do not take photos from the public gallery.

I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. Members of the public may be admitted to or excluded from the hearing at the discretion of the committee. Could I also remind witnesses to please speak into the microphone? As witnesses have been advised, the committee has read your submissions. It would assist the committee to hear additional information or explanation from witnesses today. We have allocated most witnesses 30 minutes, including a five-minute opening statement and time for the committee's questions. However, additional time has been allocated for our first witness.

PERMEZEL, Professor Michael, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

CHAIR: I welcome Professor Michael Permezel, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. We had hoped to hear from Professor Permezel at our July hearings but that was not possible, so I thank you very much for attending here today. Would you like to make an opening statement?

Prof. Permezel: Firstly, thank you very much for inviting me here and allowing me to speak on behalf of the college. The first thing I would like to say is that I am speaking on behalf of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and not my hospital nor my university, so if that aspect could be respected.

The important issue to put before the committee is that I am not a provider of termination of pregnancy services or abortion services; I work as a busy obstetrician in a tertiary hospital. I am dealing on a day-to-day basis with women with foetal abnormalities and the very complex issues that they face. I am very much in this space but not as a provider. If you will excuse matters technical around termination of pregnancy—it is not what I deal with, but I deal with complex pregnancies.

The issues I think are pretty clear and I hope summarised reasonably well in the document we provided. Decriminalisation is extremely important from our point of view. The issue of decriminalisation, as are all these matters, is complex. However, while it remains in the Criminal Code we believe that is a major disincentive to the provision of services in any jurisdiction. Women are undoubtedly being denied these services because of lack of availability, and being on the Criminal Code contributes to that lack of availability.

When you work as an obstetrician in a tertiary hospital dealing with women with complex foetal abnormalities, it is just so important that there is an availability of late pregnancy termination. As stated in the document, there are issues where the woman just should not be forced to be making decisions early in pregnancy, and those issues are clear in the documentation I provided. There are viral infections, most recently Zeka, where the woman cannot possibly know what the outcome is early in gestation and has to be given the option of deferring that decision. It would be terrible if she is forced to make an early decision and then lives without ever knowing what the outcome would have been if she continued.

Other issues that support the availability of late termination include the twin pregnancy. If one twin has an abnormality and the other does not, forcing her to make a decision at a time early in pregnancy exposes that healthy twin to the risks of early birth whereas if she can defer that decision—one twin may have a terrible lethal abnormality that cannot possibly survive, but if she is put in a position where she has to make the decision early then she is exposing the healthy twin to the risks of extreme prematurity. It is such an awful position for the law to put the woman in.

The third situation is, of course, that the person who cannot access early scans, early MRIs, which is like a more detailed imaging of the foetus, the person who finds it most difficult to access this is someone in the resource poor situation. If you restrict termination of pregnancy to early pregnancy, then you are discriminating against the most vulnerable women in society because they just cannot get to these services in a timely manner.

Another issue is one of who makes the decisions. Victoria has gone with two doctors after 24 weeks, and we would be prepared to wear that minor limitation to counselling or extension beyond privacy. However, matters of termination of pregnancy, particularly to do with foetal abnormality, are so intensely private. Jurisdictions that have gone to panels—it is just so unfair to a woman who desperately wanted this baby but is faced with some foetal abnormality that she perceives as untenable to have to present that situation to a committee. For her extremely personal matters to become more public before a broad panel is just so unfair to that woman who desperately wanted the baby but unfortunately is faced with a lethal foetal abnormality.

Conscientious objection is something that we feel strongly about. We absolutely respect the right of all practitioners to have a conscientious objection, but it is extremely unfair to women for them to be placed on a roulette wheel where they cruise around a circle of practitioners and cannot access the service, and by the time they find someone who can provide the service the gestation is advanced and the issue of termination becomes a lot more complex than it would have been had the first practitioner directed her to somebody without such a conscientious objection.

I do not know where Queensland sits on the issue of exclusion zones. My understanding is that this has not been a huge issue in Queensland, but it certainly has in Victoria, Tasmania and New South Wales; that is, women presenting for these services have been affronted in the most appalling way, in my view, as they attempt to access services. You would be aware of staff and patients being intimidated in other states, so we would certainly support that women and staff involved with these services have right to some degree of privacy. An exclusion zone unfortunately seems to be necessary.

The last thing I would like to say in this introduction is with regard to reporting. We think it is very important that good data is collected right across the whole of women's health—the whole of health per se perhaps—but in this area we really need to know how we are performing. Australia's teenage pregnancy rate is around 10. It is not the highest in the world by any means. In parts of Africa and so forth it is over 100, but Scandinavia and countries providing very efficient family planning services have got their teenage birth rates down to around five per thousand. I really think we need to know where we are with the provision of termination of pregnancy services, and good data

collection is an important part of that. We really should be using teenage pregnancy as a barometer not just of health services but of societal health. How are we doing as a society in a range of services we are providing, right through to secondary school education, support of teenagers and our adolescent care. The teenage pregnancy rate is one parameter that can be used to assess that. We will only get to monitor our performance if we collect good data around termination of pregnancy.

Thank you very much for allowing me to make those initial comments. I am happy to take any questions.

CHAIR: Thank you very much for the submission from the college and also for appearing here today. We know that you are very busy; thank you for those opening comments. I have a number of comments arising. I refer to the overall submission which was very succinct—and I thank you—from the college. The key statement there is that the college supports the decriminalisation of abortion, and that is clear. The follow-on statement is that the college supports the private member's bill as it is stated, but when it talks about the rationale it says that the regulation of termination should occur under health laws rather than be a crime. I suppose the issue is the private member's bill does not propose anything but to remove elements of the Criminal Code, so is it the opinion of the college that it is sufficient in its current form, or not?

Prof. Permezel: It will work differently in different jurisdictions. I am not totally familiar with the structure of Queensland law, but it is our view that the administration of issues around termination of pregnancy should be administered through the medical board, through APHRA—the health regulation agency—and the Medical Board of Queensland as they are in other states through the Medical Board of Australia and their different committees in each of the states. Where there are concerns, it is those bodies that appropriately administer termination of pregnancy.

CHAIR: When you say health laws—

Prof. Permezel: There are laws around APHRA and the Medical Board of Australia.

CHAIR: Thank you for that clarification. If I can move to the subject of late termination, which of course is a particularly emotive and vexed issue. With the submissions that we have received to date I think it would be fair to say—although I know that everything that we say in the committee is contested by different parties—that the issue has been greater with regard to how the public interest is best served and protected around what constitutes and meets the threshold for late term rather than in those very, very sad cases where there is a significant and complex medical issue present. How do you think that we best find the appropriate threshold which provides safeguards for the public interest—and I know it would be very rare—about somebody maybe going in and saying, 'I'm 32 weeks. I don't really want a girl' or 'I don't really want a boy', and those very, very sad cases of a woman who has a complex pregnancy or issue herself?

Prof. Permezel: The first thing is that we can look to how the law has performed in other states, and I gather you do have a copy of the Victorian and Tasmanian reports. I was involved with the Victorian legislation and I also appeared in this matter before the Tasmanians a lesser time ago. Those pieces of legislation have been in for a long time and in theory would allow what you have just spoken about. The reality is that that does not happen and has not happened, as far as anybody is aware, in Victoria or Tasmania. The legislation has functioned very well in that women faced with these terribly difficult situations—the foetal infections I spoke about; the complex foetal abnormalities I have spoken about where they do not know until late pregnancy what the outcome is likely to be; the co-twin, where one is perfectly normal and the other severely affected—have been all been enabled by the Victorian and Tasmanian legislation.

As far as we are aware the situation you spoke of, a woman flippantly deciding that because of financial reasons she not going to continue with a 32-week pregnancy, just does not exist. It is reassuring for humanity that women just do not do that. It just does not happen. Women just do not go in and flippantly want a 32-week pregnancy. I have been doing obstetrics for 33 years and I have never seen that. It just does not happen. It is only women in absolutely desperate circumstances who seek late termination of pregnancy. If there were an extraordinary one in 10 million who decided for whatever reason they were going to do that, they would never find a provider to perform such a termination of pregnancy. Although theoretically you can create all sorts of concoctions of what could happen and what might happen, the reality is that women never request it in such a circumstance and no provider would ever provide it in such a circumstance.

CHAIR: I suppose in those circumstances of very complex medical issues where a woman would need a late-term abortion it is currently available in Queensland. Coming back to the other issue, I appreciate it would be very rare, but I raise it because I think it is a significant anxiety in the community. People have raised the issue of late-term abortions a lot in submissions and written

submissions. My views would accord with yours in that I could not imagine a situation in which a woman may choose to do that, but a number of obstetricians have mentioned to me the very, very rare case where such a situation has arisen and it was not accessed because of the exact reason you said. They said, 'No, that's not something that I would be involved with.' Anecdotally, what would prevent it in the proposed legislation? What would give some comfort to the community that, if a provider could be found who would support that and the request was made, it would not occur under the proposed legislation?

Prof. Permezel: I do not think that I can say that such would never occur. If you look at legislation, there are all sorts of terrible things that can be done within the framework of legislation both within health and outside health. The reality is that no provider is going to perform that under such a circumstance. How do you put some barriers around that? What Victoria has done is make it two providers. The experience over the last eight years in Victoria is that it has been impossible to find one provider, and it would be even more impossible to find two. If one in a million providers is going to do it, then your chance is one in one by 10 to the 12th of finding two providers who are going to do it. It really is just not going to happen in such a circumstance. Even though enabled by the legislation in theory, it is just not going to happen.

As soon as you try and put restrictions around the circumstances for late termination, then you are getting into very difficult territory where many women are going to be denied by whatever restriction you impose. There are also other complexities that then come in. I work at a hospital where many women—or most women—chose to continue with the pregnancy, and as soon as you legislate that it is okay to have a termination of pregnancy if you have X, Y or Z, then the woman who is continuing with X, Y or Z is offended by the fact that her condition is on the list that qualifies for termination of pregnancy. I just do not think you can get into specifics. Unfortunately, we have to rely on the professionalism of health providers and also, happily, on the constitution of women that they do not go seeking late termination of pregnancy except in the most extreme circumstances.

CHAIR: With regard to the protection of women who may seek a late abortion, when you said a medical professional would not perform it or make a decision that was not in the best interests of the woman too, why would not they not? Is that premised on your clinical guidelines? What guidance is there?

Prof. Permezel: A couple of things. One is that there are ethical boundaries that would affect this area and one is gender selection, which I gather has been raised before. You would have seen that IVF was in the papers in the last week around termination of pregnancy, and any issues around gender selection in our view are abhorrent and to be opposed. Can anyone prevent gender selection completely? No. Even if you legislated in this country people could go offshore, but what we need to do is educate, educate and educate around the virtues of all sorts of families: balanced, all boys or all girls—they are all fine. I think it is about education, but I think it is very difficult to legislate. It is unethical to have that on the basis of gender selection. What was the other part of your question?

CHAIR: I was just asking about your clinical guidelines.

Prof. Permezel: In terms of the other issue that I think inhibits termination of pregnancy in many circumstances, the ethical position is that a doctor has to act in the best interests of the patient with whom he or she is dealing. I refer to the example you raised. If a patient did come—in my experience they hardly ever do—with, 'I'm 18 weeks and I have a scan showing it's a boy and I have decided I'm having a termination because I wanted the other one'—I have never seen this; I believe it hardly ever happens, but just say that happened—it cannot be in the best interests of the long-term health of that woman to provide a termination of pregnancy, because of the regret and the issues that woman will have for the next month and the remainder of her life. I would find it impossible for anyone to say that they acted in the best interests of the health of that patient in performing a termination of pregnancy in that circumstance.

CHAIR: I would think it would be extremely rare as well. I am certainly not asserting that it is not. It is more just the anxiety, I think, in the community. My final question is around better data. This is a consistent argument that is made for decriminalising—not necessarily in support of the private member's bill but certainly in terms of the broader reference that we have. It appears very valid to me in that we just do not have consistent data to really understand why women are making the decisions they are making. Are there better ways they could be supported to whichever choice they make? Are there just better ways we could be supporting the community? The figures in the submission of the next witness around unplanned pregnancies are really interesting. Is it your view that only when you decriminalise and therefore open up a more broad and open discussion can you have better data around the issue? Is that not a fair statement to make?

Prof. Permezel: I think decriminalisation is a very important part of good data collection. As I said in my opening statement, I think the fact that it is in the Criminal Code is very inhibitory for practitioners. There are very many potentially good providers of all sorts of services who are inhibited by it being in the Criminal Code. The fact that it is in the Criminal Code certainly inhibits good data collection. As I said in my opening remarks, we really need to know where we are at in terms of particularly teenage pregnancy but also all issues around family planning. How are we as a community doing in providing family planning services? They are different in each jurisdiction. I do not want to see a competition between states as to how they are doing in teenage pregnancy, but maybe we should know how we are doing when you look at secondary school education in terms of family planning, when you look at other measures of society—how well we support our homeless adolescents and so forth. This is not the measure, but it is one of many measures that society should be looking at to see how we are performing. Why do Norway, Sweden and Denmark do so much better than us in teenage pregnancy? We should be looking at that and trying to match them. We should try to beat them. It is not fair to our community that we do not even know what is going on.

CHAIR: Thank you. I would love to understand the answer to that question, too. In the spirit of being collegiate, I will now invite the deputy chair to ask questions.

Mr McARDLE: Bipartisan approach to politics! Professor, thank you very kindly for coming here today and for your presentation. I want to talk about Criminal Code sections 224, 225 and 226, which are removed by the Pyne bill. Those sections generally are interpreted to include knowledge by the woman of what is taking place. For example, section 224 says that any person who administers anything to cause a miscarriage is guilty of a crime. That is normally meant to have the woman understand what is going on. When you remove sections from any legislation there can be, shall we say, unforeseen consequences. If you take that section out, what happens where a woman is pregnant and the partner or a family member, without her knowledge, administers something that causes a miscarriage? Section 224, in its current format, would allow that person to be prosecuted for a crime, but the amendment to take it out removes that right to prosecute. When you remove things from any legislation, there can be consequences that flow that we need to be acutely aware of. One thing would be that in those circumstances, where a woman does not know about a tablet or a substance that has been given to her that causes a miscarriage, there is no penalty provision in the Criminal Code.

Prof. Permezel: I am not a lawyer; I have a family history of law. I am getting the drift of your meaning. I think you are making a very good point, so thank you for that. It is not one that I have addressed before. First of all, obtaining a substance that is going to cause a miscarriage is not going to be easy, although it is available and there would be means over the internet that currently are not allowed. I suppose it is theoretically possible that someone may obtain such a drug. If they did and they administered it to, say, their sister unknowingly, the woman would definitely have a case under civil law, clearly. Something has occurred to her, inflicted by somebody else, that has caused her pain and suffering, so she definitely has a civil case. I would argue that she has a criminal case as well under assault and battery, as she has been caused an injury by somebody else. Again, I am not a lawyer, but in my view it is an injury that she has incurred—something that she did not wish to happen to her body that has been inflicted by someone else. Why would such a circumstance not be liable under other aspects of the Criminal Code, for example assault and battery?

Mr McARDLE: That would be right, but of course the penalty for an assault is much lower than for termination of a pregnancy in section 224. Section 226 also says 'any person who unlawfully supplies to procure an abortion'. By removing that very severe penalty of three years imprisonment, a person who supplies to a third person who then gives to a woman without her knowledge would be guilty of an offence under that section. By taking that out, the penalty—

Prof. Permezel: The same would apply, would it not? 'I'll load the gun. You fire it.' The person 'loading the gun', or supplying the abortifacient, is an accomplice to the crime of assault on that woman—that is, causing her physical harm that she did not wish. I take on board that you believe that the penalties under assault and battery are insufficient compared to the current penalties under section 224. I am very surprised at that. In my understanding of assault and battery, certainly from what you read in the newspapers, people can have decades in jail for assault and battery. If the woman desperately wanted the pregnancy and the mother-in-law—

Mr McARDLE: I will not comment upon that!

Prof. Permezel: If the woman desperately wanted the pregnancy and it was administered by somebody against her wishes, that is a terrible assault on her body and I would have thought the court would impose the highest possible penalty, similar to a bashing in the street.

Mr McARDLE: If I follow through your logic, you would argue, then, that the Criminal Code would already impose sanctions of this kind, so why remove them?

Prof. Permezel: The Criminal Code will do it when it is done against the woman's will. Assault and battery is when this is an assault on her body against her will. If it is something that she is seeking—termination of pregnancy—then it is no assault.

Mr McARDLE: I agree. I agree entirely.

Prof. Permezel: You are a lawyer, are you, Mr McArdle?

Mr McARDLE: Yes, I am. I agree with your logic entirely: it is not an assault. Correct. The next issue I have is the case of Q, the 12-year-old girl. That 12-year-old girl was deemed to be competent. Her parents supported the application. The doctor supported the application. The only one who did not was the Queensland health department, as I understand. They raised the issue of Gillick competence in the court. Q is a very unusual case. How does removing sections 224, 225 and 226 deal with that issue when the question was one of competency?

Prof. Permezel: I agree. Obviously I am external to the issues of Q, but I have read some of the correspondence relating to that matter. The college certainly supports the issue of Gillick competence, and whether Q was Gillick competent or not is a matter for people who are more familiar with that case to decide. The issue with Q that I would like to point out—it is my understanding that Q was 12 years of age—

Mr McARDLE: Correct.

Prof. Permezel: The correspondence I read were the consequences in terms of mental health of Q. Something that was not in the correspondence that I read—it may well have been raised in other areas—was the physical health of Q. One of the tragedies of humanity worldwide is under-age pregnancy in Africa, parts of Asia and so forth. It is just terrible that 12- and 13-year-olds—11-year-olds—are having pregnancies and proceeding with pregnancy. Mostly, because their pelvis has not adequately developed, they end up with obstructed labour, obstetric fistula—lifelong leaking of urine, sometimes faecal matter as well—from under-age pregnancy. That is not going to happen to Q because Q is going to have a caesarean section—almost certainly, because her pelvis is not big enough to get a baby out—but she is going to have a scar on her uterus from the age of 12. I do not know how many pregnancies Q plans to have. Caesarean section at the age of 35 is a very safe operation for somebody having just one or two more pregnancies, but for Q, at the age of 12, to already have a scar on her uterus is a major issue—not to mention the risks of pregnancy. At 12, she has an underdeveloped cardiovascular system. We would think that in Australia about one in 10,000 women will die in pregnancy as a consequence of the complications of late pregnancy. That would be far more common in a 12-year-old with an underdeveloped cardiovascular system than, say, a 25-year-old mature woman without known medical complications. Just as an aside on Q, it is not just about mental health; it is about the physical aspects as well. The issue of consent we believe is of Gillick competence, and it is up to those practitioners to determine at the time whether Gillick competence is present or not.

Mr McARDLE: But removing it from the Criminal Code would not deal with the Q question, would it? It is a completely separate question entirely, is it not? It is a competency question, is it not?

Prof. Permezel: That is my understanding. Again, I think that is more of a legal inference than a medical one. Gillick competence is very important. I am peripheral to these issues because I do not have anything to do with termination of pregnancy of 13-, 14- or 15-year-olds, but they are extremely complex. The committee would be aware that incest is sometimes involved. Many 15- and 16-year-olds are entirely independent of their parents and it is totally inappropriate to be going back to a parent that they might have broken association with many years ago and saying that the parent somehow has jurisdiction over the child. That association may have been broken because of incest. It is an extremely important principle which I think was a House of Lords ruling, was it not?

Mr McARDLE: Yes, initially. My final question is again about the question of data. I agree with you on that point. Modern technology is moving ahead in leaps and bounds. The morning-after pill is now quite commonly used among young women. We can collect data from private clinics and from public hospitals, but can we ever be certain that what we do, given the rapid advances in technology and medicine, will accurately reflect terminations that are taking place? How accurate can we really be with that data?

Prof. Permezel: It is very good point. We cannot be certain. There will always be a small number of cases that will be missed. But how much better would we be if we knew what was happening in our private hospitals, in our public hospitals and in our clinics than now when we have

no idea what is happening? The issue of the morning-after pill, you can argue whether that is a termination of pregnancy or not. Our view would be that you are preventing implantation and the pregnancy never established in the first place. You would not necessarily have that data. In fact, you would not have that data. You might get some idea of prescriptions for morning-after pills, but you would not know because obviously most times the morning-after pill is taken they are not pregnant anyway; they are just one episode of sexual intercourse and there was not a conception but they took it just in case there was. I think that section is an entirely different issue—the morning-after pill and so forth. Actually having some data—what is happening in our private hospitals, what is happening in our clinics and what is happening in our public hospitals—we would be so much better off than where we are now where we know nothing.

Mr McARDLE: You would advocate public reporting of data akin to South Australia?

Prof. Permezel: Yes, and I would want every jurisdiction to do it so that we can see the strategies. Many times I am frustrated by our different jurisdictions, but one advantage we have is we have clinical trials out there, we have six different ways of approaching things like family planning, school education and so forth, and we can see what works and what doesn't. They are doing really well in Queensland; what are they doing in Queensland that has their teenage pregnancy rate down?

Mr KELLY: Thank you, Michael, for your presentation and your submission. We have had a number of witnesses and evidence tendered in relation to the long-term impacts of terminations. I have read your college's guide to termination for health professionals and looked at some of the studies behind that that have been referred to in that. We have also had people proffering a study by David Fergusson, which is a Christchurch longitudinal study. The impression I get from the document that your college has produced is that in terms of mental health there are no significant short or long-term effects of termination. However, the other study indicates that there is. Could you comment on the college's view in relation to that?

Prof. Permezel: Yes. A couple of things: the Fergusson study is longitudinal so it is not controlled for the circumstances whereby women find themselves in a position requesting termination and clearly there are women disadvantaged and much more prone to mental health issues who find themselves in that particular circumstance. I think that the thing that is missed is, again from my perspective dealing with foetal abnormalities, there is absolutely no question that these women are absolutely distraught. They desperately want this baby, but either option is just terrible for them.

I think one thing that I have not heard spoken about much is that in terms of ongoing pregnancies and maternal death—I mentioned before one in 10,000 women die in childbirth in Australia; it will be very much the same in Queensland—now the commonest cause of death around childbirth is actually suicide. There may be depression and misery after termination of pregnancy and undoubtedly many women do feel sadness at the pregnancy loss. It remains a massive problem at the end of pregnancy. If you can excuse me one anecdote: as a person dealing with foetal abnormalities I visited a clinic where they provide late termination of pregnancies so I knew where these women were going and how it was being performed. I spoke to the person in charge of that clinic and asked her what they provided in counselling. I thought if I am going to send you my patients I want to know you are looking after them. She said, 'Look, actually we don't provide much in the way of counselling. You just see the women leave this clinic with this massive weight lifted from their shoulders and you can just feel the relief when we have provided the service.' She said, 'No, wait on, wait on, the women with foetal abnormalities, boy, I have to spend so much time with them. It is a desperately wanted child and they've just had the misfortune to have this terrible thing happen to them so they need a huge amount of support.' I think that is something that is missing. I think, in general, termination of pregnancy has the opposite effect. For some women who are placed in a dreadful situation you can actually improve their situation, their outlook, but for the woman with a foetal abnormality where she is faced with dire consequences whichever way she goes she just needs so much support whichever route she takes.

Mr KELLY: There was a suggestion made that the college and the document that you produced, which seemed to me to be based on a fairly extensive systematic review, was somehow driven by a political agenda and corrupted and influenced by a political agenda. Do you stand by the research and the evidence in that document the college has produced and what would your comment be in relation to that statement?

Prof. Permezel: I am actually quite surprised at that. What our college is, I don't know how this committee works, is a bunch of people sitting around a table, like 24 on our women's health committee, consulting with their colleagues at their hospitals, but we are all faced with these terrible situations on a daily basis, women coming in in the most dire of situations, and certainly, especially prior to the change in Victoria prior to 2008—I am a Victorian—women in extraordinarily difficult

situations of the law or the circumstances preventing them. You just want to do everything you can for this person sitting opposite you who is faced with this terrible situation, not for me but sometimes it is social, attending other clinics, for me it is a complex foetal abnormality, you just want to do everything you can to help this desperate individual and for the law to prevent you doing so is just extraordinary. You just want to compassionately look after your patient and that can be restricted. Everybody sitting around developing the guidelines is doing it from that position. Very clearly we want to help the health care of women.

Mr KELLY: In Queensland we have termination of pregnancy regulated by the Criminal Code with some extensions via common law. The situation described by the member for Caloundra in relation to that section on assault and battery, it would seem to me we could still end up relying on the Criminal Code for other elements and perhaps some defences developed in future under common law. In your statement, not so much in your submission, you said we should be doing something about data collection, we should be doing something about access. We have just heard that the legislation does not deal with the issues that are created by the case of Q and Gillick competency and it does not deal with conscientious objection. Given all of those things, this bill removes three sections of the Criminal Code, it does not articulate anything in relation to these other matters; would you characterise this as true abortion law reform?

Prof. Permezel: I think, as we say in our submission, it is a major advance to take it out of the Criminal Code, but there are issues that other jurisdictions have had to deal with: there are issues around data collection, there are issues around an exclusion zone around clinics and there are issues around conscientious objection. We absolutely support the current legislation and we really hope that it gets through, but maybe, and it doesn't have to be at the same time, further developments can deal with issues like these that I have raised. I am not familiar with how this particular issue will be handled by the Queensland parliament, but I think further developments should not be a barrier to this particular legislation going through.

Mrs SMITH: I am conscious of the time so I just have a couple of quick questions, Professor. In your opening comments you made the statement that women are denied termination services. What are your comments with regard to in Queensland over 10,000 abortions were performed last year?

Prof. Permezel: Obviously I do not work here, I cannot speak of the numbers in Queensland, but certainly in Victoria, particularly prior to 2008, there were many women who had difficulty accessing termination. What happens is they go from provider to provider, that is, most commonly a general practitioner, but it could be a specialist with a conscientious objection, and then by the time that they find the service they are seeking the gestation can pass at which it becomes acceptable to the woman to proceed with termination of pregnancy. If you come from that particular ethical perspective you would regard that as a good thing, but if you are a clinician trying to care for the patient and she may be in a particular circumstance where her request for termination of pregnancy had originally been a very genuine one, then as a compassionate, caring health professional it really disturbs you if the system, the law, led to her being flicked from practitioner to practitioner to practitioner and she never got the service that she was requesting.

Mrs SMITH: We actually had the opportunity to speak to a doctor who performs terminations up in Cairns. In his own words he performed quite a large number of terminations. Over the last 20 years no-one has been charged, either doctor or patient, and most women are not aware that there are legal ramifications. If that is the case and 10,000 abortions are being performed every year in Queensland, why would we seek to change the Criminal Code?

Prof. Permezel: I think it is quite definite that the Criminal Code does inhibit practitioners performing termination of pregnancy. Certainly it is not particularly relevant for me with my practice, but many of my colleagues, particularly at the college, are in private practice. They have the patient, they might have delivered two or three children from this particular women, maybe they are giving them assistance with various gynaecological issues, and lo and behold for whatever reason there might be a serious foetal abnormality in the third pregnancy after having two children. There are many practitioners who are inhibited by the Criminal Code. Sure, there are some that ethically will want to refer elsewhere, but there are some who are inhibited by the Criminal Code and deflect that woman to an abortion service provider. That is not good for the woman in terms of continuity of care. Something that—I was going say infuriate—perhaps it does infuriate me that a woman who desperately wanted this child and is now put in a position where her request for termination, faced with lethal abnormality, is now regarded as such a bad thing that 'my own doctor cannot even look after me, I have to go to somebody special because I am doing some outrageous thing.' These women just need so much better support from their own obstetrician or gynaecologist rather than being sent

somewhere else because 'I cannot do it, the law does not allow me', and so forth. I think it does on an individual basis. I know what you mean, but the law does tend to congregate it in these clinics and it is so much better if it is the caring individual practitioner that is providing the service and not necessarily massive clinics.

Mrs SMITH: You were talking about doctors' ethical standards et cetera. Is there an obligation on the doctor to look at the unborn and what the responsibilities are there, because ultimately that is also part of the doctor's patient, I guess, especially when we start getting to 24 weeks.

Prof. Permezel: All practitioners will have different ethical positions. As an obstetrician gynaecologist dealing with early pregnancy, it is difficult to understand an ethical position, where we actually can now look at the sperm entering the egg. The sperm sitting outside the egg, that is nothing; when the sperm is in the egg, it is something. When things are so transparent now to us it does not make a lot of sense, an ethical position where there is nothing and then there is everything. Clearly the way the community approaches it is not an all-or-none phenomenon. Those of you familiar with in vitro fertilisation, storage of frozen embryos, all this technology, it is no longer 'no life', 'life'. Clearly there is a gradual development through embryonic development where the qualities that we understand with life are progressively gained through the gestation.

We absolutely respect there are many doctors, a clear minority, that have an ethical position of 'no life', sperm enters egg, 'life' and that is it. We respect to that ethical position, they cannot play merry-go-round with a patient and flick it to somebody else who has that ethical position so that the poor patient goes round and round until by the time she finds a provider who will give her the services, or at least speak to her about the services that she is requesting, it is late gestation.

Mr CRAMP: I have a whole page of questions, but I will not do that to the committee. Professor, I have questions regarding the college's position. Yesterday, RU486 was discussed. A previous witness's experience was outlined, in which there was no information provided by many doctors regarding the fact that RU486 can be reversed. That can leave some patients with the predicament that the next day, when they decide they want to reverse the process, it is only by sheer chance that they contact the right clinic or group and are provided with that information. From the college's position, should gynaecologists, obstetricians or any doctors be required to provide that information in the interests of full transparency about what can be done after they take that medication?

Prof. Permezel: I am not a provider of abortion services, I have never administered RU486 myself and I am not familiar with the concept of reversal. It is my understanding that it cannot be reversed. There are a number of issues. There is the Fergusson paper. There are some issues out there and so-called evidence, but when it is scrutinised by the experts in the field it is found not to be true. Let us just say that it is true: absolutely. If that were to be true, the college believes in fully informed consent.

Mr CRAMP: Yesterday, we spoke to people from a clinic who have had actual patients—

CHAIR: I am sorry, member for Gaven: it was a counselling service, not a clinic.

Mr CRAMP: My apologies.

Prof. Permezel: If it were to be true, that should be part of the information. There would need to be good evidence. The committee needs to be very careful about some things. The issue of breast cancer is just rubbish. That has been scrutinised time and time again by experts. There is no good evidence that breast cancer is associated with termination of pregnancy. There are these issues that are put forward by vested interests and I think the committee needs to be very careful before they accept that evidence. It needs to be scrutinised by a panel of independent experts.

Mr CRAMP: I am sorry, Michael, but in the interests of time, what is the college's position on this: we have heard information regarding late-term viable babies being born post failed termination. I asked a medical specialist about this. If a child comes out with viable signs in late-term pregnancy—and they are few and far between—what is the college's position on therapies such as resuscitation and O2 being provided to those babies and allowing those babies to live? At what age would that be considered reasonable by the college?

Prof. Permezel: The issue of viability and late termination of pregnancy needs about half an hour. The short answer is that the way termination is performed beyond 20 weeks in most jurisdictions is by the administration of a lethal injection while the baby is still in utero. The mother then proceeds with a birth, by whatever means is appropriate. If she has had three caesareans before the birth of the stillborn baby, it may well be by caesarean section. If she has had vaginal births or she is having her first baby, the birth will usually be by vaginal birth. The baby would be stillborn because of the prior lethal injection.

It is now incredibly uncommon that someone would proceed—and I do not know of a case where someone would proceed—with a late termination of a live baby. Exactly as you have illustrated, it places the paediatricians, the parents, everybody, in an extraordinarily difficult position. My experience is that, prior to 2008, where we did perform terminations of pregnancies for severe and lethal foetal abnormalities, the paediatricians then provided care and comfort to the baby, under supervision, with the mother holding the hand of the baby as it gradually passed away from whatever lethal abnormality was present.

Mr CRAMP: We were told by another medical specialist that an antenatal specialist would start providing resuscitation and oxygen therapy at around 27 weeks to a failed or incomplete termination. Would that be correct, in the college's view?

Prof. Permezel: You mean a paediatric specialist?

Mr CRAMP: Any medical specialist who is present at that birth. We were told the antenatal specialist, I believe—it was over a week or two ago.

Prof. Permezel: As I have said, the vast majority, if not all, babies born in late pregnancy with a termination of pregnancy for whatever lethal foetal abnormality—it might be severe microcephaly with Zika. That is an issue that we might have to confront sometime; maybe with people coming back from the Olympics. These are stillborn babies. If the baby is born alive—

Mr CRAMP: I am sorry, I need to correct you, Michael. The two cases that I am talking about from Queensland did not involve foetal abnormalities. They were two live babies. I do not want your position; I want the college's position. At what age would you consider it to be proper protocol to provide those children with oxygen therapy and resuscitation therapy?

Prof. Permezel: Absolutely. You are saying there was no foetal abnormality. Any viable foetus is appropriately assessed by the neonatal paediatrician. The baby should be born in a tertiary facility with neonatal paediatric support. I have never been associated with nor do I know of a healthy normal baby born alive where there has not been full facilities provided.

Mr CRAMP: You really do not have an age? As long as it was born viable, you would seek to have that oxygen and resuscitation—

Prof. Permezel: It is not my decision. It would be the decision of the neonatal paediatricians and the parents.

Mr CRAMP: What is the college's position?

Prof. Permezel: The college's position it that it is a decision of the neonatal paediatricians and the parents.

Mr CRAMP: Lastly, how was this submission put together? Was it put to all of your members or was it appointed to a person? I ask in the interests of conscientious objection, because I know a number of your doctors and specialists would be participants in conscientious objection. I am wondering if it was put to them before it came forward?

Prof. Permezel: No. We have a women's health committee, consisting of about 24 members, which reports this to council, which in turn reports it to the board. There are different people on council and they report to the six members. The council is comprised of representatives of their different jurisdictions and the information is placed on the website. I can receive communications. Sitting there as the prominent thing on the college website is the college statements, of which this is one. I receive numerous emails. I have received maybe two emails with regard to the termination of pregnancy statement. I receive a lot more emails about Zika virus, at the moment.

CHAIR: A final question from the member for Thuringowa.

Mr HARPER: Michael, I too have a page of questions, but I thought that we were over time. It comes down to this: yesterday, we heard a lot of opinion from the religious side of things—all life is precious—and today we have the medical opinion before us. It becomes one of those challenging issues throughout the community. We have to be respectful of everybody's viewpoints and try to find a way forward. I come from a health background. I really hear what you are saying about the compassion that is required to look after women who must face the most challenging of circumstances. I really do appreciate you being up-front with some of the background that you bring. RANZCOG itself supports decriminalisation with no regulation, whatsoever.

Prof. Permezel: Absolutely.

Mr HARPER: Conscientious objection, no limit on late gestation—I do worry about sex selection in other countries. Are you aware of any—

Prof. Permezel: I am not aware of this in Australia, but of course we worry about it. It is an issue for every community everywhere to oppose gender selection, but termination of pregnancy legislation is not the way to oppose that. We need to educate our community and support our community. I have these arguments with friends—it is not an argument, but how can we go about educating people on the virtues of both genders. I was speaking to someone earlier about a cousin I have not seen for 40 years. She lives in Queensland. She is one of six girls from the most fantastic functional family. We really need to work as a community to abhor gender selection. A lot of the bad things in the community you can change by changing the culture. Just get the community to regard it as abhorrent in every sphere.

Mr HARPER: I appreciate your opinions today. Thank you very much for sharing them.

CHAIR: Professor Michael Permezel, thank you very much for coming today. We are over time, but that is indicative of how many questions we had for you

Prof. Permezel: Thank you very much for the opportunity.

CHAIR: I now invite Dr Fiona Mack to the table.

MACK, Dr Fiona, True: Relationships and Reproductive Health

CHAIR: Dr Mack, would you like to make an opening statement?

Dr Mack: To start with, I acknowledge the traditional owners of the land on which we meet and pay our respects to elders past, present and emerging. My name is Fiona Mack. I am here to represent the submission to the committee from True: Relationships and Reproductive Health, formally known as Family Planning or FPQ. Since its inception in 1972, Family Planning Queensland has been a pro-choice body supporting a woman's right to her own reproductive autonomy. True is a not-for-profit semi state government funded organisation that provides sexual and reproductive health care at both clinical and educational levels. Through our affiliation with other Australian state and territory family planning organisations, we are acknowledged leaders in the field of contraception. We are particularly expert on contraception complicated by background medical conditions and effective communication with young people around their sexual health and birth-control needs.

True undertakes and publishes research relevant to our work and, with family planning associations in Australia, publishes this book, *Contraception: an Australian clinical practice handbook*. This book contains the go-to guidelines on all matters contraceptive for Australian doctors and health practitioners. Our clinical services for men and women are run by nurses and doctors and offer contraceptive counselling and provision, testing and treatments for sexually transmitted infections, low fertility care, antenatal care, cervical cancer screening and colposcopy services, well women checks, menopause management, sexual difficulties, counselling and common community gynaecological issues. True is also a major provider of education in the area of sexual reproductive health, teaching GPs, nurses, medical students, teachers and others in our area of expertise.

Through dealing at a clinical level with women with unplanned pregnancies who are seeking to end those pregnancies, it has long been obvious to our organisation that there is great confusion within the general community regarding the law around abortion in Queensland. We have come to understand how this impacts on timely access to termination. At the other end of the spectrum, through our educational services we have also found that medical and nursing professionals have no clarity on the issue either. This uncertainty often results in medical professionals giving inaccurate advice and information to women.

For the first 43 years of its history, True did not provide abortion services. We only referred clients externally to termination clinics. That changed in November last year, when our Ipswich clinic began to offer medical termination of pregnancy up to nine weeks gestation. The Ipswich clinic was chosen for this new service because of its geographical location in an area of high socioeconomic disadvantage. As the leader in best practice guidance for GPs in sexual and reproductive health, our organisation also saw this as an opportunity to model holistic care for women through all stages of their reproductive life. As the senior medical officer at the True Ipswich clinic, I have been the doctor providing these abortions.

One of the arguments that the pro-choice voice has been making for the removal of abortion from the Criminal Code is that while it remains there it creates an unfair two-tiered level of access to abortion for Queensland women. There is one for the wealthy and there is another for those living in poverty and disadvantage. I would like to share just one case from the Ipswich service to illustrate this point.

A 34-year-old woman, married with a five-year-old daughter, was diagnosed with breast cancer in April this year. She was also simultaneously diagnosed as being in an early pregnancy. The doctors and surgeons at the public hospital caring for her would not proceed with the treatment most likely to save her life while she remained pregnant, because the chemotherapy and radiotherapy required would have serious adverse effects to the pregnancy. Instead, she was offered an alternative substandard treatment option of a mastectomy at the time, await the delivery of the pregnancy, another seven months away, and then finally start the appropriate chemo and radiation therapy.

The woman chose to end her pregnancy in order to receive the most effective treatment. She chose the treatment that would be most likely to ensure her survival, to enable her to continue to mother her existing five-year-old daughter. However, she did not have the financial capacity to afford a private abortion and her public doctors would not provide her with one, despite the existence of the Queensland Health's termination therapy guidelines.

This is the story of just one woman and there are hundreds of others every year whose voices are not being heard at this inquiry. True believes that repealing the relevant sections from the legal code is a major step required in the pathway to achieve equitable abortion access for all

Queenslanders. Until then, True, as an organisation, will continue to offer excellence in contraceptive care and education as we attempt to reduce the rate of unintended pregnancy, while still acknowledging that every contraceptive method has an inherit failure rate and for that reason abortion will always be required in a holistic sexual and reproductive healthcare service.

CHAIR: Thank you very much for your opening statement, Dr Mack.

Mrs SMITH: My first question is around the story you have just told us. That is a really sad story, but is that not also reflective of the doctors maybe not following the guidelines and procedures as much as the circumstances for the ethical care of a patient?

Dr Mack: Yes, but I think that we are aware that only one per cent of abortions in Queensland are actually conducted in the public health system. That is one per cent of 10,000. That means that the public health system is not carrying through on its capacity to provide abortions for women. We think that that is because of the confusion and grey area around the fact that the code still exists.

Mrs SMITH: At our first hearing a couple of weeks ago in Brisbane we had a number of specialist and medical representatives come and speak with us. From what I understood, there were over 11,000 abortions performed in private clinics and about 297 performed in public hospitals. My issue is around the safeguards for women. In supporting the private member's bill we would be removing all safeguards. As I said to Professor Permezel and other witnesses, the law has obviously not stopped people. The laws obviously did not stop your organisation setting up a termination clinic in Ipswich. In over 20 years neither patients nor doctors have been charged. There are still safeguards with the current law standing as it is. In your opinion why do we need to change the law?

Dr Mack: It was only from 2009 that we could provide medical termination once Mifepristone, RU486, was passed by the TGA and is now on the PBS. That is why as an organisation we have now been able to offer that. It is a very limited service. It is only available up to nine weeks. I am not sure that I would argue that there has not been a Queensland woman prosecuted under the code. In 2010 Tegan Leach from Cairns was prosecuted under 225.

Mrs SMITH: I understood that to be because they sought to import an illegal drug more so than the abortion?

Dr Mack: Not at all. She was prosecuted and tried under 225—that is, that she had tried to procure an abortion. It had absolutely nothing to do with the importation of drugs. In 1984—it is outside your 20-year time frame—two doctors Bayliss and Cullen were charged with providing an abortion. I remember that case well as a young doctor setting out in my career. I was appalled. I am still appalled at the other end of my career that this can still happen in Queensland.

Mrs SMITH: One of the issues we are looking at is community expectations. I note that you quote a survey back in 2003. In May this year the Australian Family Association commissioned a survey through Galaxy. We heard the results yesterday. Those results would certainly be very much at odds with the findings of your 2003 survey. It indicated—and I do not know off the top of my head—that something like over 60 per cent of people surveyed were not comfortable with a late-term abortion, for example. I am interested because that is in stark contrast to your 2003 survey. I would be interested in your comments.

Dr Mack: I am not sure how gold standard evidenced based a Galaxy poll is so I would refute that that is good evidence. I think that if you looked at the Hilda study, which looks at Australian households, it would give a better endorsement that 85 per cent of Queenslanders believe that abortion should be freely available and accessible. What was the other part to your question?

Mrs SMITH: I cannot remember actually.

Dr Mack: I think that a Galaxy poll probably is not the evidence base to be looking at. I guess this also brings us back to the previous witness's concept that it is data that is really important. It is only hearsay and evidence when we are looking at things like Galaxy polls. We need to know exactly what is going on so that as a medical society and as a community we know where we are headed, as the professor was saying.

Mr HARPER: Dr Mack, thank you for your evidence today and for sharing that particularly difficult case. I am sure you have plenty more in your career that you would be aware of. I concur. I put the same question to the groups yesterday in relation to the Galaxy poll and whether that is evidence that would stack up. Coming from a health background, I like evidence based research.

We have before us from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, whom we just heard from, an abstract from the *Medical Journal of Australia* 2010 which talks about over 1,000 respondents with quite a significant 87 per cent of them indicating

abortion should be lawful in the first trimester. It goes further to say that 61 per cent support abortion unconditionally depending on the circumstances. You could refer to that. I think that that does hold some weight. At the end of the day, people will be making their decision on this based on the evidence before the committee.

Dr Mack: There will never be the capacity to remove the emotion from this debate, but level 1 evidence is a good rule to start with.

Mr HARPER: Absolutely, I do agree. My question goes to regulation in the bill that is before us and simply decriminalising it. Do you think that we should have some regulation in terms of gestational periods and conscientious objection?

Dr Mack: I believe that conscientious objection can exists. As the professor was saying, each professional has their own ethical judgements to make and moral stance to take. We would argue that a conscientious objector must refer his or her patient to a non-conscientious objector. They should be mandated to refer their patient to someone who can help them—either give information or provide the termination service. The regulations around this area should be with the health professionals and the health commission as it sits in Victoria. As has happened with the Victorian model, the best way forward is to completely repeal it from the code.

Mr HARPER: So you would prefer to see it under the Health Act?

Dr Mack: Yes, as with all other medical procedures.

Mr HARPER: We heard comments, as was mentioned by the member for Mount Ommaney, regarding the number of abortions that were carried out in public hospitals versus private clinics. We have heard arguments yesterday that if decriminalisation occurred the public health system would be burdened with having to carry out, I do not know how many, abortions. What is your comment on that?

Dr Mack: I think as a health professional that our health departments and our public health system have a duty care to women in whatever state of pregnancy or health they are in. As a community, as a health organisation and as a government we should have to be responsible for the care of those women.

Mr HARPER: Do you think if this were decriminalised and the public health system were able to assist women that that would be an advantage to people in rural and remote settings where access to clinics—

Dr Mack: They are the women who would most greatly benefit from this as well as women of social and economic disadvantage—that is, rural and remote and socially disadvantaged women. There is also the fact that it becomes a holistic method of care. As the profession was referring to as well, your termination of pregnancy, as unfortunate as it is for the time that you are seeking it, can be done by your hospital in your community without you being sent out to strangers to care for you at this really vulnerable time in your life.

ACTING CHAIR: Thank you very much for your time today, Dr Mack.

APOSTOLELLIS, Mr Alexis, Chief Executive Officer, Marie Stopes International Australia

DE VOS, Ms Natalie, Director, Clinical Services, Marie Stopes International Australia

ACTING CHAIR: I welcome our next witnesses. Thank you for being here today and thank you also for your submission. I would now ask one or both of you to make an opening statement for a combined time of five minutes.

Mr Apostolellis: Firstly, I acknowledge the traditional custodians of the land on which we stand and pay our respect to their elders past and present. Thank you to the committee for inviting us here and thank you for your work in investigating the abortion law reform bill 2016. We appreciate the opportunity to participate and provide information on our experience as a service provider of safe abortion and post abortion care in Australia and in Queensland. In the interests of time, I will refer to Marie Stopes International as MSI henceforth.

MSI operates a network of Dr Marie clinics as well as a non-for-profit pharmaceutical company MS Health, which is responsible for the registration of Mifepristone in Australia. I would like to focus on three talking points. Firstly, our commitment to patient care and meeting the individual needs of every patient. Secondly, the safety and regulation of abortion services at MSI. Thirdly, our experience in providing termination services up to 24-weeks gestation. After talking through this we would welcome any questions from the committee to me and Natalie de Vos, our Clinical Services Director.

I would like to start with our commitment to patient care meeting the individual needs of every patient. The global mission of MSI is children by choice not by chance. As such, choice and quality are fundamental to everything that we do. It is about what is most suitable for each individual and each couple. We provide caring and non-judgemental health care and are proud to delivery high-quality services that are effective, safe and maximise a positive patient experience. In light of this, our termination of pregnancy patients are able to access decision based counselling, pre-care nurse advice, post-procedure counselling and 24-hour nurse after-care services. All of these services are provided at no additional cost to the patient.

If a patient decides not to proceed, in 99.9 per cent of cases no payment is required by MSI. For those patients who do choose an abortion, it is mandatory for them to meet with an MSI nurse on their own to ensure they are not being coerced by a partner or a family member. We pride ourselves on providing timely and high-quality services to meet the needs of our patients.

My second point is the safety and regulation of abortion services at MSI. In Australia there are policies and guidelines in place for abortion services at a national, state and organisational level. For example, there are national guidelines, including the development and dissemination of statements and guidelines on safe abortion by RANZCOG, which you heard from earlier, and the risk management plan mandate by the TGA for the medications required to have a medical termination of pregnancy in Australia. At the state level Queensland Health developed guidelines on abortion services in 2013. Furthermore, there are MSI's clinic protocols and processes for all the clinical services we provide, including surgical and medical termination of pregnancy. Our surgical facilities are all fully accredited and licensed here in Queensland. We are committed to the shortest patient waiting times possible so as to reduce the risk of later gestation and minimising clinical risk and patient anxiety. Our work is underpinned by strong governance to maximise safety and minimise risk.

Regarding services up to 24 weeks, the vast majority of abortions in Australia, including by MSI, are performed in the first trimester. In Victoria, MSI provide termination of pregnancy services up to 24 weeks gestation. It is the only Australian private provider of abortion after 20 weeks gestation. Termination or pregnancy procedures of 20- to 24-week gestations comprise 0.5 per cent of all the terminations MSI did in Australia in 2015. Almost half of the women accessing post 20-week terminations at MSI travel interstate to Victoria.

Women accessing abortion services at MSI after 20 weeks have a range of individual complex circumstances and different reasons for terminating pregnancy, with most women having multiple reasons for needing the service. Our patients' reasons for accessing abortion services after 20 weeks include delayed pregnancy or diagnosis; mental health problems such as depression, anxiety and substance abuse; relationship breakdown and loss; family violence; sexual assault; foetal abnormality, often identified at around 20 weeks; lack of understanding of the Australian healthcare system; and barriers to accessing abortion care earlier in the pregnancy. As a provider of termination of pregnancy services up to 24 weeks gestation, MSI can attest to the need for specialised reproductive health services despite the small number of terminations occurring post 24 weeks.

In conclusion, just to reiterate, MSI is committed to meeting the needs of women accessing abortion services through high-quality services and support services such as counselling, pre care and after care. Maximising patient safety is of the utmost importance for MSI. Our termination of pregnancy services is highly regulated at a national, state and organisational level. In Victoria, as mentioned, we provide services up to 24 weeks, of which 20 to 24 weeks only account for 0.5 per cent of all terminations by MSI in Australia. Thank you again. We welcome your questions.

CHAIR: Thank you for your opening statement. I invite the member for Greenslopes to open questions.

Mr KELLY: Thank you very much, Alexis and Natalie, for your submission and for taking the time to be here today. On page 3 of your submission you note, 'Over a third of Australian general practitioners acknowledge that they do not completely understand the abortion legislation in their state or territory.' Is it true to say that across-the-board in Australia, regardless of what approach a state or territory has taken to regulating abortion, there is still confusion around the laws in that particular state and territory and up to a third of general practitioners?

Mr Apostolellis: I think a third is a national statistic—in some states it would be fewer and in some states it would be more. There is still confusion. In New South Wales abortion is still in the Criminal Code, so that could be a large proportion of GPs, as well as Queensland. In Victoria, it would be fewer, and we know that from the work we do with the registration of mifepristone. We know which prescribing doctors have gone online to do the course and we know which doctors are starting to prescribe. We know that there is a higher uptake in certain states. That is probably due to the legislation.

Mr KELLY: On page 1 in the fourth dot point you talk about unsafe abortions. I, too, have read a great deal of information about the situation globally. Could you comment on what the situation is here specifically in Australia? Are there statistics around women seeking unsafe options for abortion in those states, particularly where the abortion continues to be criminalised?

Ms de Vos: I am not aware of any statistics that show that.

Mr KELLY: There has been commentary—I hesitate to call it evidence, but there has certainly been commentary—that organisations such as your own are driven by a profit motive and as such have a vested interest in increasing the number of terminations. How do you respond to that and what is your objective in terms of terminations in the longer term?

Mr Apostolellis: Absolutely. That is a great question. I am glad you asked it. Marie Stopes International is a global charity. In Australia we are branch of that global charity. We operate a social business model. We do not have any shareholders. We are governed by members. Any of our so-called surpluses—which is what we call it, as opposed to profits—go back to either continuation of health care here in Australia or in the region of the other countries that we support which is roughly 38 countries around the world.

Our primary mission when we say, 'Children by choice'—which it is—'not chance,' is the provision of contraception services. That stands in Australia as well. We would love to live in a world where contraception is there, but we know it is not there for everyone and we know that there is failure of contraception in various forms and at different rates. We will then provide safe access to termination.

In terms of any profit motive, absolutely not. We would love to be able to work our way out of business, if that makes any sense. We are probably one of the stronger providers of contraception in terms of offering contraception and encouraging contraception at the time of termination which is often done at a reduced cost or at almost no cost where possible. That is where a lot of our funds go back into.

The other example I think I should point out is that the registration of mifepristone in Australia was taken up by Marie Stopes International through MS Health. Our primary purpose is around access and reducing the cost for women. If we were purely profit driven, we would not have brought that in because our surgical facilities would essentially become less utilised, which is what is happening.

Mr KELLY: You mentioned protections you put in place when you are providing what I would consider to be normal counselling, building the basis for informed consent which I think any medical or health practitioner has to do. You mentioned you put in place some safeguards around ensuring that people are making decisions free from coercion. We have had a number of people raise concerns around that issue. How well equipped do you feel that particularly your medical staff are to gain

informed consent and be relatively confident that that has been a decision of that patient alone without undue influence from other third parties?

Ms de Vos: We are very confident with our medical staff, both our nurses and our doctors, in their ability to assess the clients and to judge whether they are being coerced by a partner. Quite often anecdotally I am told—I would be called by our centre managers who will say, 'I have a patient here and they don't want the abortion but their partner does want the abortion but the patient is saying, "I don't want to have it."' We will work with the centre managers around that. We have every confidence in our nurses and in the nursing assessment process, as well as in the process assessed by our doctors, that they actually can attest that there is no coercion.

Mrs SMITH: I was just interested in following on from that. How often does coercion actually occur?

Ms de Vos: It is very rare. I do not have statistics on it. It is not data that we collect. It is anecdotal. We will see incident reports if it has occurred, but it is really from nurses, the centre managers, ringing me to discuss the issues around it. If the doctor—and the doctor ultimately makes the decision—feels that the patient does not want that abortion, they will not proceed. That is fully supported by the organisation.

Mrs SMITH: You were saying in your opening comments that if women choose not to proceed—they obviously come and have a discussion with you and you provide them with all of the options available including adoption.

Mr Apostolellis: Counselling is offered even prior to them coming to the clinic on a particular day. All three options are talked through with the patient on the counselling side—that is, parenting, adoption or termination.

Mrs SMITH: Do you have a rough idea of how many people then do not proceed?

Mr Apostolellis: We do not have the statistics, but we know about a third of our patients take up counselling options prior to their appointment. Anecdotally, I would say on the day, if we have a list of 20 patients, we have maybe one or two patients who decide not to. That is even after any counselling sessions.

Mrs SMITH: I am not too sure from your submission and even from your presentation whether you are completely supportive of the bill that is currently before us in that it removes all of the sections from the Criminal Code. Do you think that there should be some safeguards in place? The reason I ask that is that when we were in Cairns one of the doctors indicated that they had started up a telephone service—basically you could have an abortion over the phone. We look at technology and where we are going forward with these options. Is it not responsible to at least have some safeguards in place for the likes of maybe women who are being coerced or for the likes of women who find themselves in that situation but then do change their mind, because that does occur? Can you give me your thoughts on that and on the bill as it currently stands?

Mr Apostolellis: Just to be clear, we support the 2016 law reform bill entirely. We do believe that abortion should be removed from the Criminal Code. We think that causes confusion for both our patients and for a number of doctors. There is always a threat of some sort of jail time, even though we talked about it earlier to say that it does not always happen or it has not happened or there were cases years ago where potentially it could happen, but it is there. Why is it there if terminations are happening in Queensland?

We think that the various health regulators—APHRA and the health commission—do a fantastic job in the regulation of health provision in Australia across all procedures. I think for sexual and reproductive health it is the same and it should be the same. We do not know why abortion or terminations should be listed separately in the Criminal Code.

Regarding your point about telehealth or telemedicine, I think it is fantastic. Technology has moved things, particularly in rural Queensland where we know telehealth is probably streets ahead of a lot of other parts of the country because it is required. Technology will continue with that. Marie Stopes International also does facilitate what we call a tele-abortion service. We have all the relevant safeguards in place. We have talked it through and presented it to the TGA, with them approving the process as well. We believe, again, the health authorities and bodies can regulate to make sure that it is a safe procedure.

Mrs SMITH: You made the comment that this should fall under health because it is a medical procedure. Yesterday we heard a number of submitters say it is different to any other medical procedure given that there is a child's life, depending on how one views when it is classed as a child,

but the foetus is a second life and there are rights of the child that are not being considered. I would be interested in your response to that.

Mr Apostolellis: Marie Stopes supports the rights of a woman to choose around her reproductive healthcare needs, and that is our position. We are aware there are different debates on when conception is or is not and at what stage viability is or is not, but we are primarily focused on the choice of the woman and see that as a basic human right.

Mrs SMITH: But you can understand that people do not view this as just as another medical procedure.

Mr Apostolellis: My understanding is that a small percentage of people do have that view, yes.

Mr HARPER: Good morning to both of you. Thank you very much for your presentation this morning. I think you have hit the nail on the head, particularly in your comments around contraception. Hopefully, if we increase the success rates of that, we decrease the rates of abortion in this country. I am interested in your opinion on the bill as it stands in regard to the regulation of gestational periods. Should there be some regulation similar to other jurisdictions like Victoria—24 weeks?

Mr Apostolellis: We are not a legal entity. We do not have a view on the shape or form of how laws can be produced. In terms of the framework, we think that the way Victoria works works well. We do not think a panel of doctors helps. Two doctors could reduce that potential minute risk, as Professor Permezel pointed out. We think that legislation around safe access zones is extremely fantastic in Victoria, as well as in the ACT and Tasmania. We think conscientious objection something similar to Victoria is a fantastic outcome. If there is anything in terms of the legislative framework, those are the areas that we would like to see progressed after decriminalisation.

Mr CRAMP: Thank you very much for coming in today. I am interested in your comments that you take women aside by themselves to make sure they are not coerced. We have heard a bit about coercion. My colleague the member for Caloundra has put it quite aptly several times. In instances where the partner is known and it is not a case of rape or any illegal activity, is there any circumstance with your clinic where the father's or partner's opinion or position is taken into account?

Ms de Vos: No, basically the choice for a termination of pregnancy is with the woman who is making that choice. There is no circumstance where, if the father either wanted to keep that pregnancy or discontinue that pregnancy, it would be taken into consideration either way. If a father wanted the mother to have a termination and you allowed them to take that opinion in, you could very well be facilitating coercion. We sit straight down the line where it is the woman's choice and it is the woman's right to make that choice.

Mr CRAMP: I was very interested in the alternate view: where a woman is seeking a termination and the husband or partner is wanting to keep the baby. Have you had any such cases?

Ms de Vos: I only know of one which, again, is anecdotal which has come through from advice from our call centre where the partner did want to keep the baby and was trying to find out which clinic the mother attended, but under our privacy laws we cannot release or discuss any information regarding a patient unless we have been given consent by that patient, and we have strict adherence to that.

Mr CRAMP: You said that you offer patient services. I have been very interested in the process regarding psychological and welfare counselling especially post termination. Can you explain in a brief fashion—I understand that we do not have all day—what psychological counselling you provide for the patient, both pre and post termination but especially post termination?

Ms de Vos: The counselling is completely voluntary by the patients particularly post termination. We offer access to the service. They can choose to take that up or not pre and afterwards. With terminations between 20 and 24 weeks, we have them attend the clinic and attend face-to-face counselling for all of those cases. I am not a counsellor. Whilst it sits under Marie Stopes, it is run almost as an independent component of Marie Stopes International. I could not tell you what they discuss within those counselling sessions. We would need to refer that back to one of our counsellors.

Mr CRAMP: No, that is okay. I was more interested to see if you offer counselling. It is provided by independent professional counsellors?

Ms de Vos: Yes, they are all professional counsellors and it runs as its own service.

Mr CRAMP: If a woman identifies that she has regrets—I am sure there must be some statistic in regards to that—do you continue that counselling or is it only a certain amount of time post termination?

Ms de Vos: They may refer through to another service if they feel that they cannot continue to provide that, but we would provide that service if required.

Mr CRAMP: My last line of questioning is in regard to the information being provided to government entities. As a private clinic, can you take me through what you provide to the government in regards to your numbers, your stats and terminations—data, I guess, because we are talking about data? Do you think it should be provided to MPs? Do you think private clinics should at least be providing some information for this hearing around this legislation? It is a two-part question.

Mr Apostolellis: The second part we have no issue with. If that was a requirement by the committee, we would welcome that. We think data is incredibly useful, and we think it would be fantastic so we can measure how well we are doing, particularly on the contraception front. We support the mandatory collection of data through private clinics and private hospitals, just like South Australia does. That is the only reliable paper that we have to ascertain, and again I think Professor Permezel is right: we have all these separate experiments you can do in terms of how well public health is doing. We have to wait for that South Australian data, but it is just around South Australia. We do not know if it is because they are doing a fantastic education program that termination rates are going down.

In terms of Queensland, there is no data collection. I think we all know that. The only type of data that goes through to Queensland Health—it is not really Queensland Health; it is through Medicare—is the item code number which you can make an estimate on. We claim Medicare rebates on a particular code number which goes through and that gets reported on monthly by state and nationally.

Ms de Vos: We also have the same requirements for private health reporting on numbers through the door, but we do not just provide an abortion service; we provide other sexual health contraceptive services and that is included in that data.

Mr Apostolellis: We would have overall numbers. We have the Medicare item numbers which would be reported. Medicare item numbers do not include private patients, overseas students or visitors that might not be able to access Medicare. The other sets of numbers that we know we have available is the use of Mifepristone in a particular state or territory.

Mr CRAMP: I would like the committee's consensus. Would that data be helpful in regard to our deliberations, or is that something we could take on notice?

CHAIR: We have the PBS data.

Mr McARDLE: Is the data that you send to Queensland Health the Medicare data alone or do you send more data?

Ms de Vos: We do the ICD 10 codings. All private hospitals are required to do that.

Mr McARDLE: They are put into Queensland Health in a booklet form, are they not?

Ms de Vos: I think it is done electronically.

Mr McARDLE: So each year you would put forward certain—

Ms de Vos: Each month we put it through.

Mr McARDLE: If we ask you to undertake to table the last five years of that data, what would it encompass outside the Medicare data?

Ms de Vos: I would need to take that on notice. I do not know the differences in the data reporting well enough to be able to answer that question today.

Mr McARDLE: If we asked you to table data for the last five years that you give to Queensland Health, could you do that?

Ms de Vos: Yes, we could do that.

Mr McARDLE: Could we propose that Marie Stopes undertake to table data for the last five years up to and including the last month reported—

Ms de Vos: Yes.

Mr McARDLE:—to the committee equivalent to the data you forward to Queensland Health on a monthly basis for that period of five years?

CHAIR: My understanding is that much of that data is privileged or confidential under the act. I think it would be fair to give you until Thursday to consider what you can and cannot provide and come back to the committee.

Mr McARDLE: So Thursday of next week?

CHAIR: Thursday of this week to give us a sense of what you can provide. I appreciate that it may take longer than that to—

Ms de Vos: Particularly if we are de-identifying particular data, I need to look at that data.

Mr McARDLE: I think the chair correctly raised the point: are there legal implications as to what you can and cannot do outside the issue of privacy? My other question is this: are you funded by the state government or the federal government? How is your funding derived?

Mr Apostolellis: In Queensland we are not funded by any Queensland Health department or state funding at all. It is a fee for service. As I mentioned prior, we are a social business so we need to be able to run from fees generated. The claims we get back is really through Medicare item numbers and then there is an out-of-pocket cost for the patient.

Mr McARDLE: What fee do you charge or do you have a scale based upon criteria?

Mr Apostolellis: It is a scale. It depends on gestation and location. For example, we run clinics in Rockhampton and Townsville. We need to fly doctors to those clinics to provide those services because local doctors are not capable of doing the procedure in Rocky and Townsville.

Mr McARDLE: Visiting clinics?

Mr Apostolellis: Yes.

Mr McARDLE: What is the range in regard to your fee? What is the lowest fee you would charge based upon population, density and capacity to supply up to the most difficult?

Mr Apostolellis: The out-of-pocket fee varies from $300 to $600 or $700 for a first trimester procedure.

Mr McARDLE: That would be in Rockhampton, would it?

Mr Apostolellis: Yes, that is right.

Mr McARDLE: $300 to $700 would be the out-of-pocket range?

Mr Apostolellis: Yes.

CHAIR: There is one minute left so I will see if I can get all my questions into one minute which will be impossible but I will be very disciplined. I am interested in the statement that you make about the rate of abortions in Australia versus overseas. It is the third dot point under 'global considerations' and you make a comparison of Australia versus the Netherlands. What are they doing that we are not doing? What do you attribute that to? Do you have any views?

Mr Apostolellis: I think one of the largest is the access to contraception and the normalisation of the procedure. It is interesting that the Netherlands does have one of the lowest rates, and our understanding is that it is around basic sexual and reproductive rights and access to SRH services.

CHAIR: I think you would argue contraception is readily available in Queensland. My colleague the member for Mount Ommaney made the point that there are 10,000 to 15,000 abortions per year. I believe there are issues of access in rural and regional locations; others may dispute that. Would you not think that those are fairly readily accessible in the metropolitan areas here, and in which case why the difference?

Mr Apostolellis: They are in metropolitan areas, I would agree. I think there are still some access issues around price and choice of contraception as well. We know, again anecdotally, the most effective contraception methods are what we call LARC, long-acting reversible contraception.

CHAIR: Like the bar?

Mr Apostolellis: Like Implanon, an IUD, a Mirena—those are not easily accessible in Australia. Most GPs do not provide that service because it takes a little bit longer, it does not exactly fit in the billing with Medicare items, the procedure takes a bit longer and it is a skill. Our clinics do provide that service, but we know anecdotally from various states, including Queensland, that there is a public waiting list if you want a Mirena or an IUD of three to six months. By that time, you are pregnant. That is probably one of the primary reasons why it is accessible but the choice is not always accessible, and the most effective means of contraception is not accessible.

CHAIR: So it is not readily accessible from general practitioners. With the bar, for instance, you said that your clinics do that. Do they need to have private consultations with gynaecologists? How are women accessing those services?

Ms de Vos: We provide a stand-alone contraceptive service. Women can be referred to our service to receive an IUD or an Implanon or a Mirena insertion. From my understanding—again, it is only through discussions as I have worked in the industry—a lot of doctors do not have the skill to insert these devices, although I believe that is improving. But I also understand there is still the tendency for GPs to put women on to the contraceptive pill and we do know that there is a higher failure rate with the contraceptive pill. It seems to be around access and where do I get an Implanon.

CHAIR: A high rate of failure with oral contraceptives and prophylactics perhaps? Is that what is readily being used? Is that different from the Netherlands? Are you saying they are using longer term contraceptive methods?

Mr Apostolellis: Potentially; I am not sure about the Netherlands.

Ms de Vos: We don't know.

CHAIR: That is okay. Not sure is a fair answer. There are a lot more questions we could ask but our time has expired. Thank you very much for coming and thank you for your submission.

Proceedings suspended from 10.44 am to 11.04 am

CALO, Ms Brooke, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors, teleconference

HAYES, Ms Trish, Counsellor, National Alliance of Abortion and Pregnancy Options Counsellors, teleconference

CHAIR: The committee will now resume its hearing. I welcome Brooke Calo and Trish Hayes, counsellors with the National Alliance of Abortion and Pregnancy Options Counsellors. I always wonder about how much detail I should give you. Have you been following proceedings of the committee at all?

Ms Calo: We have been trying to, but in between I am also at work, so I have clients as well that I have been working with this morning.

CHAIR: As long as you understand that we have six members present and we are obviously talking today to various stakeholders about the bill before the Queensland parliament. Without using any more of your precious time, can I invite you to make up to a five-minute opening statement and then the committee will ask questions?

Ms Calo: I will be reading the majority of the opening statement. Thank you, committee members, for the chance to represent via teleconference the views of the National Alliance of Abortion and Pregnancy Options Counsellors, otherwise known as NAAPOC. We would also like to pay our respect to the Yuggera and Turrbal people on whose land we are meeting and pay our respect to elders past, present and emerging.

My name is Brooke Calo and I am a co-founding member of NAAPOC and a social worker with 16 years experience including 10 years experience working in the area of unplanned pregnancy counselling and support. I am based in South Australia and employed by South Australian Health at the Pregnancy Advisory Centre.

Ms Hayes: My name is Trish Hayes and I am also a co-founding member of NAAPOC. I hold a Bachelor of Social Work and a Masters in Community Development as well as other degrees. I have over 13 years experience working in the areas of maternity social work, abortion and unplanned pregnancy counselling, and sexual assault counselling and research at the Women's Hospital and am now a senior counsellor at Marie Stopes International and I am also a sessional lecturer in social work at Victoria University.

Ms Calo: NAAPOC was established in 2014 as an alliance of pregnancy options counsellors who have joint expertise and interest in unplanned, unintended or unwanted pregnancy and abortion counselling and the provision of pro-choice information, women centred counselling and referral services. NAAPOC has four founding organisations represented and a membership of 12 professional counsellors, all of whom have many years combined experience and who hold tertiary qualifications and membership to relevant professional associations as referred to in our submission.

NAAPOC was formed for the main purpose of supporting and strengthening the professional field of pro-choice pregnancy options and abortion counselling by sharing knowledge and a commitment to ongoing professional development. NAAPOC's other purposes include our aim of increasing the visibility and understanding of pro-choice counselling. Eligibility for NAAPOC membership requires counsellors to uphold values and provide counselling and support that is consistent with evidence based information as identified by leading health, human rights and psychological entities. NAAPOC believes that women have the right to freely determine their reproductive health choices, and counsellors work from a perspective that advocates for women to have access to information and services that include the full range of reproductive rights and options. NAAPOC hopes that our submission is one of many that shows the committee that law reform and improving access to abortion and to support services are essential in providing safe, affordable and accessible services for women in Queensland and, indeed, all of Australia. By removing abortion from the Criminal Code, it recognises that unplanned and unwanted pregnancy is a common life course event in women's reproductive lives. In turn, we hope decriminalising abortion further will contribute to further destigmatising abortion for the almost one in three Australian women who have an abortion at some point.

We support that the governance of abortion services can be achieved through existing health care act provisions and that counselling is not imposed nor used as a delaying tactic for the majority of women who do not need, want or seek it. It is important for us to advise the committee that the name NAAPOC represents exactly what it is that we provide: abortion and pregnancy options counselling. We feel that it is important to acknowledge that the work we do as counsellors is from a pro-choice perspective. Pro-choice counselling does not impose a value set upon women that is not

her own. It is about helping her understand her own values and how she makes a decision in her framework. It is not imposing our values upon her. Pro-choice counselling entails discussion and reflection upon all reproductive outcomes for women in the course of them seeking support related to unplanned pregnancy. This includes provision of accurate information related to all her reproductive options, which includes abortion. We believe very strongly in reclaiming the word 'abortion' and its so-called negative imagery that parts of the community who do not support women's rights to make decisions over their own bodies and lives have attempted to do over the course of time. There have been assertions made in attempts to professionally discredit those who work in or refer to abortion services that suggest we are pro-abortion in feeling that we must have a conflict of interest or only refer women for abortions or, at worst, coerce women into abortions. We would like to reassure the committee that these suggestions are utterly false and have no credible basis.

A counsellor's role is not to make a decision for a client nor lead them into one direction or another. A professional, non-judgemental approach to counselling includes effective skills of communication, which aims to strengthen the individual in making their own self-determinations. A professional counsellor does not suggest, advise or persuade. It is considered unethical to provide inaccurate information or give opinion. This goes against the standards and regulations of our professional associations. Rather, professional counselling encourages the client to take responsibility for making their own life choices, provides crisis intervention when needed, engages in problem-solving techniques which attempts to aid a client making decisions based on their own values, beliefs and individuality. Counselling includes explanation of all the options clients are considering and discussion about possible impacts upon their lives and supports the person with no judgement or hidden agenda through the choice they are making.

Referrals to appropriate follow-up services are also made as required—to antenatal care services, abortion services and adoption services. The role of a counsellor involves deliberately not adopting an expert opinion in relation to other people's lives. Rather, it puts the person, their knowledge and their skills at the centre of conversations and facilitates the person's own ability to make decisions based on what is best for them. Thank you. Trish and I will both answer questions where we are able.

CHAIR: Thank you very much for the opening statement. It was exactly on five minutes. I was about to say you were on time, so thank you. I invite the member for Gaven to open questioning.

Mr CRAMP: Thank you very much, Trish and Brooke. It is Sid Cramp, member for Gaven. I am just trying to get an idea. How many members do you currently have in your organisation?

Ms Hayes: We currently, at last count, have approximately 12 members from four different states across Australia.

Mr CRAMP: With regards to your organisation—I am asking this from an organisational position, not from your individual perspective obviously—what are your thoughts around providing counselling? Should it be done by the clinics administering if there is a person seeking an abortion? We have had some groups including medical clinics, such as the previous witnesses, who say that their psychological counselling is done independently by an independent group. Some have professed that independent counselling and allowing women to make an informed choice for education should be done independently of the termination clinic. Do you think it is okay to be done by a doctor or the clinic?

Ms Calo: I am happy to start the answer. I think that counselling services are different from state to state and are different in different settings. Certainly in the setting that I work in, I am co-located in an abortion service and so are counsellors who work in the Royal Women's Hospital in Victoria. This can be helpful and useful because we can be made available to women on the day of a termination, both prior to and after a termination if it is required. Where co-location is not possible, clinics can refer to a number of support services in their state, which includes access to the national Pregnancy, Birth and Baby helpline, which provides 24/7 support to all Australian women.

Ms Hayes: Can I continue on with that answer? I would also say that I think there is a role for both the federal and state government funded services to provide counselling, but there is also a role for counsellors within clinics who are all bound by their own regulatory code of professional conduct. For example, I myself am bound by the Australian Association of Social Workers' code of ethics and conduct, which requires me to work in a particular manner with clients. I think that is part of the question. The other part is that there is a difference between informed consent counselling, which is the process of a nurse or a doctor going through the risks of a medical procedure, the procedure itself and the final consenting process—there is a difference between that type of counselling and therapeutic counselling, which is really helping a woman explore her decision or, if she has already made the decision, giving her support around whatever decision she has made.

Mr CRAMP: You just noted that there should be some involvement with state and federal governments. Was that Trish who stated that?

Ms Hayes: Yes.

Mr CRAMP: I have brought this up previously. Do you think there is an area that the Queensland government could step in as a regulator and make sure that there is independent advice, even in booklet form, to be provided to patients seeking an abortion so it can assist them with making an informed decision or not?

Ms Hayes: I am happy to start answering this question. I think that the excellent service that Children by Choice in Queensland, which is somewhat state government funded to my understanding, already provides plays a fantastic role in supporting and counselling women around their options when women feel that they need extra support. We know that not all women actually need counselling around an abortion or an unplanned pregnancy.

In fact, the stats from the MSI report in 2008 showed that 75 per cent of women who had experienced an unplanned pregnancy did not want counselling. They were able to make the decision with the support of a partner, a friend, family member or parents, but should they want counselling they want it to be available. I think that is a role that expert organisations such as Children by Choice and state based or federally government funded pro-choice organisations can play.

Ms Calo: To add to that question around the provision of information that is independent, I think if you did a quick search on the Children by Choice website, the Pregnancy Advisory Centre website or the Royal Women's Hospital Pregnancy Advisory Service website you will see an array of information related to all options and decision-making resources that are already easily accessible to women of all states over the internet, plus written information is also part of the counselling that we would provide here in relation to all options. I think that those things already do exist.

Mr CRAMP: My last question, and I have put this to previous witnesses, is about informed consent and informed choice. Should financial circumstances or socioeconomic circumstances play a part in a woman's decision to terminate a pregnancy? I am just wondering from the organisation's perspective if you have any insight into this from different parts of the country?

Ms Calo: I think that financial issues for women and their partners who live in dire financial circumstances of course play a part in considering whether or not they are able to parent a child or parent more children. Having been lucky enough never to live on the poverty line myself, I cannot speak from direct experience of what that feels like. But I have spoken to many women and couples over the years who certainly consider that it is not financially viable to parent another child or parent a child at a certain stage of their lives, even with some of the supports that are available through government supports. I would strongly support women to make decisions that they value as important rather than impose what we or others might believe are the reasons of importance.

Mr CRAMP: We spoke about the relaxation of adoption regulation and red tape and the promotion of adoption. Would it assist women in those circumstances to know that they have an opportunity to help a childless couple or a couple seeking adoption?

Ms Calo: I did hear some of those assertions yesterday. The majority of women in our experience state they do not want to consider the option of adoption, often highlighting in counselling that this option carries the greatest risk for them for longer-lasting negative emotional impacts. On top of that, it is not a woman's responsibility to provide children for other people—continuing a pregnancy to term only to relinquish a child at the end of that—if this goes against her values or it is something that she feels she cannot cope with. I think some of those questions may be best answered by the adoptive sector.

Ms Hayes: I support what Brooke is saying. That is certainly my experience of over 13 years of counselling women both in maternity and abortion services. I could count on my hand the number of women who have raised adoption as a possible viable option for them. Most women see an unplanned pregnancy as a responsibility, so they have to make a responsible decision about the welfare of both themselves and any potential child and adoption does not fit with that model for them. They believe that the negative consequences of adoption for both the child and for themselves are such that they just do not want to take that course of action.

Mr HARPER: Thank you for your time this morning. Most of your work is done around the counselling side of things. I imagine that you would see most of your clients early in their stages of pregnancy; would that be correct?

Ms Calo: The majority of clients that we see are early in the first trimester of pregnancy. That does not mean that sometimes we might spend a number of weeks working with that client, so she progresses in her pregnancy as she is making a decision. Certainly the majority are early in the pregnancy, yes.

Mr HARPER: In the case of foetal abnormalities, in the second trimester as it becomes a lot more difficult you would offer counselling support for those women. I am wondering with the bill at hand before us if NAAPOC has a position on gestational periods and whether there should be some regulation around that with regard to the bill before us?

Ms Calo: In South Australia—and I do make the assumption that perhaps it does happen in other states—we work very closely with another sector in the clinical genetics counselling component which is run out of one of the major South Australian hospitals. That service provides a lot of counselling where women have a diagnosis of a foetal abnormality, but we work in conjunction with them for referrals if that is necessary and provide support to women who then may attend our service as a result of that. The maternal foetal medicine units in most obstetric hospitals in Australia also take on a fair chunk of that work.

Ms Hayes: I concur with my colleague Brooke. Most of the counselling workup around a foetal abnormality diagnosis is done in the major obstetric hospitals with their genetic or foetal management units. Usually we liaise with the particular genetic counsellors or social workers or doctors involved before the woman is actually referred for the really difficult decision she would have to make around having a termination.

Mr HARPER: In summary, should there be any regulation to the bill before us or do you simply support decriminalising?

Ms Calo: I support decriminalising. I believe that regulation is regulated through practice standards of health care departments and there does not need to be any regulation of it in the Criminal Code: it already exists.

Ms Hayes: Again I agree with my colleague. I would also add that, as I think Professor Permezel said this morning, we need to offer support and good evidence based support to women at any stage of a pregnancy where it becomes unviable or untenable. Of course that will include gestations where women have had to wait to 20 weeks to have the diagnosis, so I absolutely support decriminalisation without a particular gestational limit.

Mr McARDLE: Thank you for your submission. Can I just start by looking at the data that you do collect for the organisations you are involved with. Do you have any inkling or data on the number of women who go to organisations and raise the issue that what they are seeking may be a breach of the Criminal Code, or is that a point that is never really raised until such time as it may be brought up by the organisations themselves to alert the woman to the potential problems?

Ms Calo: Yes, I heard questions about that either yesterday or earlier this morning, I cannot remember when. I do not have any specific data here about how many times a woman might say, 'Is this in the Criminal Code? Is it legal to have a termination?' My anecdotal experience, having worked in this sector for 10 years, is that it does happen. It does not happen all the time that women query, 'Is this legal?' or 'Is this in the Criminal Code?' Certainly women do express surprise when they find out that it is in the Criminal Code. In my experience this often adds to the sense of stigma attached to them feeling able to consider the option of termination as an equal reproductive choice.

Mr McARDLE: Without putting words into your mouth, would you agree that it is rarely raised by the lady who comes to the organisation to seek advice, and more often than not it is the organisation that will raise the point with the woman in question?

Ms Calo: I am not sure that it is rare, but I do not think it is common. I think it is somewhere in the middle. I think some women are really keen to understand and know that. I do not believe that we here make a point of saying, 'Abortion is located in the Criminal Code.' If women ask, 'Why do I have to go through this informed consent process? Why do I have to see two doctors?' then there would be an explanation as to why.

Mr McARDLE: The corollary of that is after women are advised there is an issue in relation to the Criminal Code here in Queensland, how many then determine not to have an abortion?

Ms Hayes: I could not speak to the Queensland stats and I am pretty sure Brooke could not neither.

Ms Calo: No, I cannot speak to the Queensland stats. You may be able to ask that information of some of the counsellors who work in Queensland.

Mr McARDLE: Is it your experience that there are very few women in your jurisdiction who then walk away after being advised of the law as a currently stands, or is it a matter that they accept that, the advice is given and women then continue on to have the termination? Is that a determining factor?

Ms Calo: I do not believe that it has ever been a factor in a woman saying, 'This was my decision, but now that I know it is located in the Criminal Code I have changed my mind.' No, I have never had that conversation with any woman.

Mr McARDLE: The next point I want to raise is the question of exclusion zones. We have not had the issues in Queensland that I think do exist in Victoria and other states across the nation. Do you believe that exclusion zones are important, if not to cater for what does exist as a concern, then to guard against what may happen?

Ms Calo: Can I just clarify what you mean when you say that you have not had the same concerns in Queensland that are concerns in Victoria?

Mr McARDLE: There has not been an outpouring, as I understand it, of demonstrations outside abortion clinics in this state as we have been led to believe exist in other states, including Victoria.

Ms Hayes: I would say that you would again need to ask Children by Choice about that. I believe they have had experience of women being harassed on their way to clinics in Queensland. I think that the idea of exclusion zones is an important factor in considering women's experiences. Here in Victoria at one of our private clinics, as some of you may know, over 10 years ago an anti-abortion protestor shot the security guard. I think that, having worked in the Victorian sector for a long time, the women and staff who work in those clinics are subjected to some of the most vile abuse and harassment in the same way that other reproductive decisions—for example, to continue a pregnancy—are not. Yes, I think they are a really important component to consider, perhaps either in this legislation or as an adjunct to this legislation.

Ms Calo: As I said, I have worked at this centre for 10 years and not a week has gone by when I have not had to walk past a group of protesters who regularly congregate around our gates—at least two or three times a week. Women who come to this centre are exposed to those people and I certainly support regulation, as part of the code or as an adjunct to the code, that includes an exclusion zone. It is deeply distressing as a worker, so I can only begin to imagine—and certainly I have had experiences of women talking about how deeply distressing it is for them.

Mr McARDLE: Thank you very much.

CHAIR: Thank you, Brooke and Trish. Our time for questions has expired. Thank you very much for participating in the hearing today.

Ms Hayes: Thank you.

Ms Calo: Thank you very much for having us.

MARSH, Ms Kate, Communications Coordinator, Children by Choice

TOOKER, Ms Sian, Counsellor, Children by Choice

CHAIR: Welcome. Kate, I invite you to make an opening statement of up to five minutes.

Ms Marsh: Thank you for the opportunity to speak this morning. We would like to acknowledge the Jagera and Turrbal people on whose land we meet and pay our respects to elders past, present and emerging. I am Kate Marsh, the communications coordinator for Children by Choice, and I am accompanied by my colleague Sian Tooker, a member of our counselling team.

Children by Choice has supported over 200,000 women across Queensland since our service began in 1972. I would like to note that there is a founding member of Children by Choice here witnessing proceedings today. I pay my respects to her. We are a statewide, independent, all-options pregnancy counselling, information and support service. We are the only organisation of our kind in Australia. We are partially funded by the Queensland government to deliver counselling and education services. All of our counsellors are tertiary qualified and our staff are overseen by a highly credentialed management committee made up of academics and professionals working across the medical, legal, psychology and community sectors.

We are a pro-choice service, which does not mean pro abortion but it does mean that we support the right of every pregnant woman to make the decision she feels is best for herself. We support women who wish to continue their unplanned pregnancies with as much dedication as we support women who wish to end them, and our clients include women of all ages, all backgrounds and faiths, and all income brackets. Unplanned pregnancy does not discriminate. We trust women to use their own beliefs and values and ethics to make decisions, and we respect each woman as the expert in her own life. Nobody can know better than the pregnant woman herself what she needs or wants or is capable of.

Around two-thirds of the work of our counselling team is in providing information and support around abortion. About a quarter of our clients say that finding information on or support for abortion has been an issue for them. When the availability of reliable information on abortion is limited, it should be no surprise that a disproportionate number of our client conversations focus on this need.

In the 2015-16 financial year our counselling team supported over 1,700 clients via 4,500 calls, emails and face-to-face appointments. A quarter of that work was in decision-making counselling. Less than three per cent was for counselling after an abortion. One-third was with women reporting violence and seven per cent was with women reporting both domestic and sexual violence, highlighting the prevalence of forced sex within relationships that are also violent in other ways. These figures of course only represent the women who disclose this to us, and the real figure may be much higher, as the stark reality is that no woman can freely consent to sex when she is afraid of her partner. Sexual violence in domestic violence relationships is what Sian refers to as the dirty secret of the dirty secret, and many women are ashamed or embarrassed to disclose this, even in a safe space.

Around 10 per cent of our work last year was with Aboriginal and Torres Strait Islander women. This overrepresentation points to the systemic disadvantage that makes accessing sexual and reproductive health services so difficult for this group of women, and we are glad that the Institute for Urban Indigenous Health will be appearing before the committee later today to speak more to this.

A lot of focus in the media and community around this inquiry has been about abortion at higher gestation. In relation to this I would like to state clearly that the number of women last year we spoke to about self-induced abortion was double the number of women we spoke to who were considering terminating a post-20-week pregnancy. It is our belief that the fact that there are women in Queensland in 2016 who are considering or attempting to induce their own miscarriage because they cannot access a safe abortion should be of far greater concern than the mythical women who would seek abortion into the third trimester if this bill is passed. Also more numerous than our clients with post-20-week pregnancies were those presenting with suicidality, sexual assault, homelessness, severe mental or physical health problems or in situations of extreme violence. Most of them were unable to access a publicly provided abortion.

Almost half of the work of the counselling team last year was in financial support for abortion access. In the past two years our financial assistance program has provided almost $180,000 in financial assistance for abortion and contraception to 568 Queensland women, 70 per cent of whom have children. We are happy to answer questions.

CHAIR: Thank you very much for that opening statement, Kate. It is very nice to meet you. We have heard the name 'Children by Choice' many times in other people's submissions and also by different witnesses to the committee, so it is nice to meet you as representatives of the organisation. Thank you for the work that you do in regard to supporting women.

We are sitting here obviously talking about women across Queensland and what is in their best interests and what is not, but I am very interested to hear what you are seeing in the real women you are actually dealing with. What are some of the trends and the things that you are seeing that have led women to come to you? You mentioned violence as a cause. I appreciate that those are just the ones that have reported. On the statistics you provided, what are the other 60 per cent of women coming for? What has led to their need to come?

Ms Marsh: As I said, a large majority of them were seeking accurate information about their options, which includes abortion. Women do want to carefully consider what their options are, and part of that depends on having accurate and evidence based information on what all those options entail. As I said in my statement, a lot of women find that information, particularly in regard to abortion, very difficult to find through other avenues, so we find that a lot of women are contacting us specifically for information on the availability of abortion, particularly the cost and where they might have to go to access the procedure. An increasing amount is around domestic and sexual violence, which my colleague can probably talk to more clearly.

Ms Tooker: I would add that a decision about a pregnancy is not made isolated around one particular issue. Often there is one issue that flows into many other issues. The member to Gaven earlier mentioned financial issues. That is rarely an isolated factor. There are often other issues that are related to that. These are often quite complex decisions.

With regard to the violence that we hear about from our clients, we hear a lot about women who are coerced into pregnancy and coerced into continuing pregnancies. These are women who were raped to be forced to be pregnant. I have heard women describe how the man involved in the pregnancy has told them he is going to make her pregnant so that she will be tied to him for life. I have spoken to women who have several children and have never had control over their own reproductive autonomy. Every child they have has been a result of rape. When they are getting in touch with us it is finally a chance for them to assert some reproductive autonomy. I have spoken to a woman who has been tied up and her IUD forcibly removed. The experiences that women share with us are terrible in the extreme, and those are certainly some of the emerging trends, which is a very nice way of putting it, that we see in the clients who contact us.

As we have mentioned, there is a range of issues that come into play. It is not violence as an issue by itself; there are other issues that come in as well—mental health, physical health, women who are carers for people who are disabled. There are so many and so complex. I am certainly happy to take more questions.

CHAIR: One of the key concerns by some people in the community who have written to us is that if we follow the private member's bill, really, we are just making abortion available for convenience and making it easy and who really minds about the outcome. Can you talk about your views, given the women that you are talking about in your service—if they are coming just for pure convenience?

Ms Marsh: I think convenience is rather a demeaning term to talk about with regard to this particular issue.

CHAIR: Can I say, that is not my view.

Ms Marsh: I fully appreciate that. Women make these decisions in a really considered way, taking into account a lot of different factors. No woman's decision will be the same as another's. I think belittling it to a state of convenience is really overlooking women's internal and external thought processes and decision-making processes that they go to mostly before they even come to us. They are already considering their existing children, the existing family members they are looking after, what their job prospects might be if they continue or do not continue and so on. I do not think convenience is ever a reason women would cite to us for seeking a termination.

Ms Tooker: As a counsellor I have never spoken to a woman who has not put thought into the decision she is making. It is not some flippant choice that they make. Often, the woman puts herself last in the decision-making. As Kate mentioned, around 70 per cent of our client contact is with women who already have children, and they often centre the needs of their children first and foremost. They are considering the needs of their partner. Sometimes they may be considering the needs of a parent who needs additional care. Part of what we do within counselling is help them lift up what their own needs are, in addition to everyone else's needs they are considering.

CHAIR: Are some of those factors of such grave concern to them that they feel they need to consider termination as an option? Are we providing enough support in Queensland to women who feel pressured under these sorts of circumstances?

Ms Marsh: To feel pressured into terminating?

CHAIR: Are we providing enough support so that they do not feel there is only one option—if it is socio-economic or support or care or—

Ms Marsh: I think women explore all of those options themselves before they make the decision to terminate, and they are the best person to make the assessment over where that support is available and if they feel that support is adequate for them to consider continuing a pregnancy. In some cases, women just do not want to be pregnant again. They do not want to carry another child and no amount of external support is going to change their mind when it comes to that decision.

CHAIR: The comment was made by a stakeholder in Cairns that many women have already made their decision, balancing and talking to people around them. Do you find that most women who are coming into contact with your service are at a point where they have actually arrived at an informed decision themselves, or are they really seeking some information from you to assist in that, or is it fifty-fifty?

Ms Marsh: As I said, only around a quarter of our work is what we would classify as decision-making counselling. A large percentage of the rest is women seeking information themselves to help them go away and make that decision without our input. A lot of women talk to partners, family, friends. They do not need necessarily that external counselling support, but they do need information to help them come to a decision themselves.

Ms Tooker: We provide client centred, non-judgemental, non-directive counselling. That means that we trust women to be able to raise the issues with us that they need to talk through, and we also invite them to raise further issues that they may want to talk to. If we recognise that there may be some signs of ambivalence or anything related to that, then we will query that further. We are a woman centred service and we trust women to have that capacity to reflect on their decision-making and to seek support.

CHAIR: I really appreciate that, because ambivalence is something that has been raised by some different submissions around a concern that other services or those who provide termination procedures—that some women may have gone in ambivalent and felt that they were not given the space and time. I think that is so important, given I also think women balance these sorts of issues when they are making a decision.

What information is provided in your service? What information do you feel is necessary for a woman to make a genuinely informed decision about her options? The reason I specifically ask this question is that yesterday a booklet was tabled that previously was administered in the ACT. It had 1999 on the booklet. I am not sure when they stopped using it.

Ms Marsh: It was 2002.

CHAIR: The question in my mind when I looked at that is: if I was placed in the position of having to make a decision—there were photos in that book about foetal development. It is obviously debated hotly that she has a right to know, to be fully informed and make a fully informed decision. Then there would be others who would say that there is some level of guilt inherent in that. Can you tell me what you think?

Ms Tooker: The woman has the right to have information available to her and she has the right to have counselling support services available to her. No-one else has the right to impose anything upon the woman that she has not chosen for herself. That is my initial thought there.

Ms Marsh: I would also say that those in favour of the provision of mandatory information packages for women considering termination generally come at it from an anti-abortion perspective. We have certainly seen that in the United States, particularly those states where there are mandated information provisions for women prior to a termination. Those sometimes consist of medically inaccurate facts and statements and, as you say, images which can be quite distressing and aimed at perhaps changing a woman's mind from a guilt perspective, which is something that we certainly don't support.

CHAIR: What information do you give?

Ms Tooker: It depends on what the woman is asking for. They certainly receive informed consent counselling at the clinics, but they may ask for information about what types of procedures—this is if they are wanting information about abortion—and information about adoption and parenting

and so on. In relation to abortion it may be about the types of procedures available to them, what gestation procedures are available, where they are able to access termination of pregnancy. We often have quite existential conversations in decision-making counselling about where the woman believes life might begin. She might want information about foetal development and so on. We are a woman centred, client centred service so it comes back to what the woman needs and we help her build the tools to also identify what she needs.

CHAIR: Thank you. I do appreciate that. I come at that from the point of view that as a woman all of my decisions around pregnancy have been premised on what you would hope would be informative information. Even in the process of the inquiry we have received a large volume of information and many issues have been contested in that. My greater concern is that you would hope that there would be obviously empirically based, evidence based but also consistent information. My concern is that many people have also talked about that women have been given inadequate information.

Ms Tooker: I can certainly speak to that. I have spoken to many women who have been very distressed after being given inaccurate information. I have also spoken to women who have consulted Dr Google and been exposed to manipulated images and videos online which has caused them significant distress. The outcome for those women is not that they choose not to have an abortion, it causes them heightened anxiety and distress and it causes them to have an abortion at higher gestation because of the delay as they process that distress which is at greater financial cost to them, it may mean they have to travel either intrastate or interstate. The consequences of that sort of—I find it hard to find words for that—behaviour by certain people towards women who are trying to just make the best decision for themselves is really quite appalling.

CHAIR: I have more questions but I will hand to the Deputy Chair.

Mr McARDLE: Thank you, ladies, for coming in and for your submission as well. The figures you quote in your report, are they Queensland or national figures?

Ms Marsh: You will have to be specific as to which figures.

Mr McARDLE: 200,000 women you supported.

Ms Marsh: In my opening statement, yes, 200,000 across Queensland since we began in 1972.

Mr McARDLE: If you go to appendix 1, page 57, you have the stat there that one in three women in Australia will have an abortion at some point in time in their life. I think you quote the South Australian Health Department. It is a bit hard to read. It is tiny font.

Ms Marsh: It is.

Mr McARDLE: Do you know how they derive that figure? We have posed that question before and we have been told that it is a very high figure and has some doubt cast upon it. What method did they use to come to that figure or are you simply relying upon the data contained in the report?

Ms Marsh: The South Australian Health Department publishes annual data on the number of terminations performed in that state, and a variety of other factors associated, such as gestation and age of the woman et cetera. They look at the rate of terminations per age group, so under 20, 20 to 24 and so on, and then my understanding is that the estimate on how many women will experience an abortion in her lifetime is looked at by calculating if a woman had progressed through each of those age groups what are her probability factors in terms of experiencing an unplanned pregnancy and therefore proceeding to an abortion.

Mr McARDLE: Do they extrapolate that data based upon South Australia to a national average, do they?

Ms Marsh: Yes, that is exactly right. The up to one in three is South Australia. My memory from the last report, which was 2013 data, was that around 27.9 per cent of women would choose to have a termination at some point in her lifetime based on the South Australian figures.

Mr McARDLE: That is them looking at their own data and making the extrapolation across the nation.

Ms Marsh: No, they are saying that for South Australia specifically. We extrapolate it.

Mr McARDLE: You extrapolate it?

Ms Marsh: There is no other data to be used. South Australia has the only reliable abortion statistics that are captured anywhere in Australia.

Mr McARDLE: You take the data and from that and you then extrapolate that, your own organisation, as to what that means across the nation.

Ms Marsh: Most people working in this space will use South Australian data as a guide.

Mr McARDLE: I am not arguing the point, I am just saying it is not a study undertaken by South Australia, it is your extrapolation of the data from South Australia?

Ms Marsh: That's correct.

Mr McARDLE: You also make the comment on page 5 that you are concerned about the number of women who are seeking their own termination procedures because they cannot access a safe procedure. I will come back to the point in a moment about the figures you relate to in the appendix. Is that a matter of education as much as it is a matter of capacity to access?

Ms Tooker: It is a matter of desperation.

Mr McARDLE: That then leads to you have here 118 women—

Ms Marsh: No, 118 contacts.

Mr McARDLE: Three quarters of those relate to women who experience domestic violence or sexual violence. I am not for one second trying to denigrate that data, don't get me wrong. I am trying to get some context around the figures.

Ms Marsh: I can give you some updated data seeing that is last financial year.

Mr McARDLE: That is fine. The figures are relatively the same. It doesn't really change my point.

Ms Marsh: It is actually up to about 90 per cent are experiencing violence.

Mr McARDLE: Would you agree with me that those women are in a desperate situation, particularly if the pregnancy comes from a domestic violence scenario where there is a massive controlling element, and sexual violence, it could be rape or incest, where again you have the great imbalance in power. Does that in any way impact upon the capacity of these ladies to seek that advice? Are they caught in a web of control by a male or a family member that makes it more difficult for them to access that information? Just in a context, I am not trying to be derogatory in any way, shape or form.

Ms Tooker: Of course not. The short answer is yes. Kate has a better head for statistics, but we know that women who are experiencing violence or, I should say, having violence perpetrated against them, are more likely to seek help at a higher gestation simply because they have been denied access earlier in the gestation because of the power and the control that is happening in the relationship and because sometimes the man involved in the pregnancy is wanting to enforce the pregnancy upon her and prevent her from accessing a termination service.

Ms Marsh: The other thing I would say is that most of the women in that situation are unable to access a procedure through their public hospital and so they are looking at very high out-of-pocket costs in order to access a procedure and for some women, particularly the ones, as you mentioned, who are experiencing that high rate of control and surveillance around their lives, $700 is an extraordinary amount of money for them to come up with and it is just impossible. Unfortunately Dr Google comes into play and it is DIY.

Ms Tooker: It is not just current partners, it is ex partners who stalk them, rape them and carry on with their everyday lives and just keep on finding them.

Mr McARDLE: One of the things is that in this state, of course, the public hospital system provides one per cent of terminations and it is normally late terminations as well, not in the first trimester.

Ms Marsh: That's correct.

Mr McARDLE: That therefore means the data we have available to us is scant and, more importantly, the data available to us does not reflect reality. Would you agree that that data should become, one, public—

Ms Marsh: Yes.

Mr McARDLE: Two, released on a regular basis—

Ms Marsh: Yes.

Mr McARDLE: And all data should then be analysed by an independent body away from government so that we can get a better trend about what is happening, why it is happening, where it is happening and what is not happening?

Ms Marsh: We would absolutely love to see some publicly available data and it is something we have said on numerous occasions to different bodies over the years. Without data we cannot know if health initiatives are successful, we cannot know if we are lowering the rate of unplanned pregnancy or it is rising and we cannot know where women are who need to access services in order to be able to plan for those services for women to be able to access. There are a vast range of health policy measures that are just impossible to measure without accurate public data.

Mr McARDLE: My final question is this: if a lady comes to you and she says, look, I am not certain if I want a termination or an abortion, what I want is information on both sides of the question. You provide pro-choice and pro-life information?

Ms Tooker: It is not dichotomised like that in counselling.

Mr McARDLE: No, certainly. Simplistically?

Ms Tooker: As I mentioned, it is woman centred so we explore what the woman's needs are, her values, the ethical framework she works within. We might go through a simplistic way of putting it, a pros and cons for both options, we might look at what support service is available to her for each option that she is considering. We also provide referrals as well. For example, it might be a woman who is considering continuing the pregnancy but she is very worried about potential custody issues that might come up with the man involved who is violent and so on. We would refer her on to a supportive legal service where she can get accurate legal information about custody issues and so on. We make referrals, we provide the information that we are able to give and support the woman to make whichever decision she makes.

Another thing I will add to that is we don't always know what decision a woman has made. Part of the feedback she might give us at the end of the call is, 'Okay, I think I know how I'm going to think through this now. Thanks. I'm going to go away and I know I can talk to these people', and she has got what she needs to make her own decision, but we don't know what that is.

Mr McARDLE: But you would give her balanced information.

Ms Marsh: The short answer is we would discuss her options in terms of parenting, adoption, abortion if that is what she wants to discuss.

Mr KELLY: Thank you for your submission and presentation. I am interested in your opening statements and your submission around self-induced abortions. What methods are people using?

Ms Marsh: It is a variety and it depends on the woman and her circumstances, but it can range from trying to source abortion medication online through to self-imposed physical acts at home—getting someone to punch me in the stomach; I'll throw myself down the stairs through to the—

Ms Tooker: The use of substances.

Ms Marsh: Drugs, alcohol, substances, herbal medications, some types of fruit and vegetables are rumoured to induce miscarriage. It is a variety of acts. Often women will attempt more than one. It is often unsuccessful but it does make them very ill and it can put their lives in danger.

Mr KELLY: I was going to ask about that. In relation to attempts, successful or otherwise, of self-induced abortion, do you have statistics or data on adverse outcomes for women who are engaging in that practice?

Ms Marsh: No.

Mr KELLY: How would you respond to evidence that was tabled in a submission and supported by an appearance yesterday that suggests that there is no link between abortion becoming legal and safety?

Ms Marsh: I would point at a wealth of evidence from international bodies that actually says that the legality of abortion doesn't impact its incidence, it impacts on how safe it is. We know that ourselves in Australia. Before abortion became available through hygienic and safe providers in the seventies it was one of the biggest causes of death and disability in Australian women of reproductive age.

Ms Tooker: For women who are desperate and whose local hospital will not provide a safe procedure, and I have had women say this to me, they will take matters into their own hands and name what they'll do.

Mr KELLY: Can you explain the very large differences in the number of abortions that are performed in the private sector versus the public sector?

Ms Tooker: May I offer a case example?

Mr KELLY: Sure.

Ms Tooker: This is a client who I am working with at the moment and she gave me permission yesterday to share her story with the committee. I am very grateful to her for allowing her voice to be shared with you because I think not many women's direct voices have been.

Mr KELLY: This would be the first, I think.

Ms Tooker: I will not use her real name. I am going to call her Shayna for no particular reason other than that is what came into my head. She is a 19-year-old Aboriginal woman in her first trimester of pregnancy. She and the man involved in the pregnancy are separated. She grew up with significant domestic violence in her household and she has a history of being involved in child protection and homelessness and so on. She has quite a number of mental health diagnoses that impact on her day-to-day functioning and that includes post traumatic stress disorder. She has a history of self-harming and suicidal behaviours including a recent suicide attempt. She has been very clear she doesn't want to go through an adoption process and she has outlined exactly why she doesn't want to continue the pregnancy and parent. She asked the GP for a referral to the major public hospital in her area for an assessment for therapeutic termination of pregnancy. When I spoke to her yesterday for an update she told me that the GP told her that abortion was illegal and she didn't know what Shayna was talking about when it came to asking for a referral. The GP didn't ask her why she wanted to end the pregnancy, which is a fairly significant missed opportunity to provide support to a very vulnerable young woman.

Shayna asked me to share with you how she felt in that experience. She felt numb, she felt shocked and she felt scared because she did not know what would happen next because of what she had just been told about the law. She felt misunderstood and like the GP had a biased view. Her word for it was that the delay that is coming about because of this is detrimental to her because it increases the gestation of the pregnancy. She wants you to know that everyone is different and every situation is different.

Mr KELLY: Is the problem with the referral from the GP or is the problem with the service offered or not offered by the public health system?

Ms Tooker: It is two-tiered. One is that she has a GP who has told her it is illegal and then, if that client was not in touch with us, she would be left with, 'What do I do now?' The second problem is that I have spoken to so many woman who have been inpatients in public hospitals for psychiatric issues, including suicide attempts, who have been told by hospital staff that they will not provide them with a social abortion and said, 'You need to go to a private clinic'. Those include women who, when they are not in the psychiatric ward, are homeless or are in a domestic violence shelter. That is where this state is failing women.

Mr KELLY: I have a final question in relation to counselling. We have had many discussions in relation to foetal abnormalities being a reason for termination. Are there any additional conversations that are had with somebody who may have found out that the foetus has an abnormality, although it would not be what I would consider to be a fatal abnormality, and they are considering a termination nonetheless? How do you approach that as a councillor?

Ms Marsh: It makes up quite a small percentage of our work. As we have said earlier, generally women who are considering termination at later gestation in Queensland, particularly those with foetal diagnoses, are doing so within the hospital system. Hospitals have their own specialist genetic councillors, midwifery teams, et cetera, who can talk through the potential for what that diagnosis means and do some of that support with women. We would generally deal with quite a small percentage of women in that situation.

Ms Tooker: For those clients we support—and I can bring a few to mind now—again it comes back to us being a woman-centred non-judgemental service that takes into consideration the woman's own unique and individual circumstances. We are guided by her values and what she believes is important. For some women, they may have very strong values about quality of life. They may also have reflections around what capacities and strengths they do have and do not have. They bring those into the decision-making process. In answer to your question, we provide woman-centred non-judgemental counselling as professionals.

Ms Marsh: I would add, as an endnote to that, many women when they are making that decision are considering the quality of life of the potential child or the baby that they are carrying. They are thinking about helping it avoid pain where possible. That is one of the biggest considerations that they are using.

Mrs SMITH: I want to get an understanding: you said that last year you had about 1,700 clients. Do most of those make a one-off call to get information? Can you break it down to the next group that require a couple of phone calls or a face-to-face? I want to get an overall picture of what you do.

Ms Marsh: Because we are a state-wide service, the majority of our work is done over the telephone. The majority—probably over half—would be single contact; people simply looking for information. That could be the location of a service, cost of a service or what the process is for adoption, et cetera. We know that for the women with complicating factors—those reporting sexual violence, suicidality, attempted self-abortion; those really complex factors in women's lives—the more of those that they are reporting, the more contacts it will take with our service for them to resolve an issue or for them to access the service they seek. Women reporting suicidality or attempted self-abortion will take, on average, 10 to 12 contacts with us before they are either able to access a service or we can provide them with some support to resolve those issues.

Mrs SMITH: Is that all done by telephone?

Ms Marsh: Most by telephone. Around 10 per cent is done face to face.

Ms Tooker: I would add, in relation to a point made by the member for Thuringowa, that women in remote regional and rural areas often require a lot more support. Some of them do not even have access to ultrasound services in the area that they are living and have to be flown out just for those services. Quite a deal of work can go into supporting them and linking them into other support services.

Mrs SMITH: When they contact you, do you ask them how they found out about you? Have they mainly looked at the internet or do people get referred to you from other services?

Ms Marsh: Yes.

Ms Tooker: We have statistics on that. We will just find them.

Ms Marsh: For the last year financial year, 2015-16, we had around 400 referred by GPs, one from a phonebook—so that is the age that we are in—quite a lot of internet and word of mouth is generally our biggest referral point, and also other another NGOs.

Mrs SMITH: In your opening statement, you said that postabortion counselling made up about three per cent of people. Was that where somebody had gone and had the abortion and then felt regret? What was the postabortion counselling referring to?

Ms Marsh: It is quite a variety of issues. It can depend greatly on the circumstances in which the woman sought the termination, the gestation at which she did so and the support services she was able to access before.

Ms Tooker: Certainly we know, and this is supported by research, that women who have experienced stigma and silencing and have not been able to seek support around their decision may look to us to find someone who is willing to listen and not judge them. We offer postabortion counselling to women we speak to and the clinics refer to us for postabortion counselling as well. Sometimes the women we have spoken to who may have presented with quite complex issues may stay in touch with us following the procedure. That is generally not about regret. It is about finding room in their lives for that decision and all the other complex factors that have gone along with it. It may be grief and loss around the death of a partner. I have spoken to women who have had family members murdered. It may be all sorts of complex issues that are related to that abortion. It is about supporting them to find room for all of that in their life and make sense of it all, and sometimes that is an ongoing process.

Mrs SMITH: With that being on an ongoing process, is there a timeframe where you go, 'This probably is not our area any more. Can we refer you to somebody else?' Is it down to the individual?

Ms Tooker: It is very much based on the individual. It also depends on the issues that they are presenting with. For example, if there is a woman with fairly complex mental health issues and if it looks like it is veering from being postabortion counselling to that area where she is actually really talking about her mental health, we would be making that on-referral so that she gets that more intensive ongoing support.

Ms Marsh: We are supporting a young woman at the moment, for example, who has been coming to see us for around six months for postabortion counselling. There is no indication on our side or hers that that support would come to an end at any time soon.

Mrs SMITH: Out of curiosity, I note you said before that a lot of your work is just that one time. You probably do not have any figures on how many people end up proceeding with a pregnancy versus how many people end up—

Ms Marsh: No. As Sian said, often we do not know what the outcomes of women's and couple's decision-making is, after they have spoken to us. But we do know from surveys of women who have experienced unplanned pregnancy that parenting is the most commonly chosen option. Just over half of women, according to a survey that NSR did in 2006, will choose to continue with an unplanned pregnancy. It is only around 30 to 35 per cent who will choose to terminate.

Mr HARPER: Thank you, Sian and Kate, for the work that you do with Children by Choice and for your submission today. My wife tells me I am going deaf. I think it is something to do with my previous occupation with sirens and helicopters. You gave an alarming figure in your opening statement about self-abortion. Can you confirm: I heard 17 or 70?

Ms Marsh: In regards to self-abortion? It is double the number of women who speak to us about post-20 week termination.

Mr HARPER: I wrote down that figure and I wanted clarification.

Ms Tooker: We mentioned it was 70 per cent of the women that we talk to already have children. That might be it.

Mr HARPER: That clarifies that. As it stands, the bill before us decriminalises abortion through the removal of sections 224 and 226. I understand you support that.

Ms Marsh: Absolutely.

Mr HARPER: I am trying to keep a very balance view. Should there be regulations around mandatory counselling, gestational periods and conscientious objection?

Ms Marsh: We absolutely support the availability of independent counselling. I would not support making that a mandatory requirement. In regard to conscientious objection, we understand there is some concern in the community around conscientious objection. We would probably support a clause similar to Victoria's. On gestational limits, we would prefer to see no limits legislated. We believe that these are adequately regulated through practice frameworks and professional standards and Queensland Health guidelines, for example. Again, understanding that there is some concern in the community around later gestation termination, whether that be well founded or not, we would understand if the committee were to propose a limit similar to Victoria's, so 24 week on request and then post-24 with the approval of two doctors, as long as the requirements to be met for later than that cut-off point were not too onerous for women to meet. Absolutely we would not support a panel situation as happens in Western Australia, for example.

Ms Tooker: I will add a couple of points, one with regards to conscientious objection. I certainly support people having the right to conscientiously object. They all have their own ethical framework. It is really important, though, that they do refer on to a non-conscientious objector. With regards to the panel idea, there are some women who, when they hear the hurdles they have to go through to access a public termination of pregnancy, it is just too onerous for them, particularly for women who have been through trauma experiences. The idea of having to tell yet another person about the trauma they have been through and retraumatising themselves in the process, they just say, 'No, I have to find the money. I cannot do this.'

Mr HARPER: Thank you very much, ladies.

CHAIR: Time is limited and we are over time, but I appreciate that the committee has many questions so I want to give the member for Gaven an opportunity before we finish.

Mr CRAMP: One of the previous witnesses who spoke to us by telephone dropped you in it regarding adoption. They suggested I speak to you about adoption. I think there could be many positives to come out of this conversation. It does not matter which side of the fence you sit on; it is worth talking about. One of the things that I have heard through previous witnesses is about adoption. I would love to hear your thoughts on adoption as an option and then I will ask the same question that I asked previous witnesses, about relaxing the regulation and red tape around that. First of all, what are the organisation's thoughts on what you offer in regards to adoption as a choice?

Ms Tooker: We are a pro-choice counselling service. That means that we support women to consider whichever option they believe may be best for them and that includes adoption. I have recently provided counselling to a woman in regards to that, where she was tossing up between adoption and parenting. We recognise that Adoption Services, which is part of the Department of Communities, are the experts in the field of how adoption processes unfold and they provide direct support to women who are deciding on the option of adoption. We certainly encourage clients who are considering that option to make direct contact with Adoption Services and build their information about what the whole process entails. We certainly provide an overview of the process. We explore their ethical framework, their values, any concerns they might raise.

As we have mentioned previously, adoption is often the first option that they cross off the list. There are two reasons. One is that they have a very strong concern for the wellbeing of any child that they may go on to give birth to. For many of these women, the idea that a child may grow up thinking that their parent abandoned them is not a choice they want to make. Also for these women, they do not want to choose to go through a pregnancy and go through a major medical event, which is birth, particularly for those women for whom birth has actually been a traumatic experience in the past. We help them evaluate their options. We provide appropriate on-referrals.

Ms Marsh: I would add to that that adoption is generally the first option that women rule out. The majority of women we speak to already have children so placing a child up for adoption is not really a feasible option for them. It means splitting up their family, which is not something they are prepared to do.

I would also add that it is not the regulation around adoption that prevents women from making that decision. Sian has articulated that much better than I could have. We know from our relationship with adoption services—and we do work with them quite closely—that what some people call the regulation around adoption is actually a series of measures put in place to support pregnant women or women who have just given birth to make sure they are providing free and informed consent to that process, that they have considered their other options and that they are comfortable with their final decision to adopt.

That means that there are multiple counselling sessions involved. There are revocation periods where consent can be withdrawn. We know from adoption services that the availability of those supports actually encourages people who may have considered adoption to decide to keep their baby or their child and parent as a family because of the support they have been offered through that process.

Mr CRAMP: It was not so much around the regulation I was asking about. When women cross adoption off the list, do you think it would assist if regulators, like the state government, worked to change the image of adoption to put it in a more positive light about what it can offer childless couples and we worked on the perception that it is not about abandoning a child? I wondering about your thoughts on that?

Ms Tooker: There are a few things that spring to mind there. One is what Brooke mentioned earlier and that is that no woman is responsible for providing children to other people. If a woman wants an abortion and we say, 'No, you cannot have that,' we are not talking about just adoption, we are talking about enforced pregnancy, and that is not okay. It needs to come back to the woman and what she believes is going to be best for her. Often what she is taking into consideration there are children she already has and the life and quality of life for any child she may give birth to if the pregnancy continues.

Ms Marsh: In relation to your question around public perception, there could absolutely be some work done there. We do have a poor history of adoption processes in Queensland and across Australia with a history of forced adoption and forced removals of babies at birth from unmarried women—

Mr CRAMP: It certainly was not about forcing it on a woman, it was about public perception.

Ms Marsh: I understand that. There is still some stigma attached to adoption because of that. I do not think that that would be enough to allay women's concerns about their own personal circumstances to really change considerably the number of women who would consider it as an option.

Ms Tooker: For some of the women I have spoken to about adoption, which involves some education, there is such a sigh of relief from them when they realise that there is that regulation and support because adoption in Queensland has a pretty dark history. We still have women within our community who have experienced forced adoptions. Some of those stories still linger in the community and some people today believe that maybe that is still how it happens. We can provide some education around that and point out that adoption processes have changed and they are now centred around supporting people through the process.

CHAIR: Kate and Sian, thank you for your time today and for your submission and for being willing to answer so many of our questions.

TAFT, Professor Angela, Public Health Association of Australia.

CHAIR: Thank you very much for your patience, Professor Taft. Would you like to make an opening statement of up to five minutes and then we will open up to questions?

Prof. Taft: I want to begin by saying that the Public Health Association's principles on this particular issue, as many issues, are really around prevention of the problem. I have 20 years of research in two major areas of relevance to this committee. One is violence against women and children and the other is the planning and promotion of planned parenting and prevention of unwanted and unplanned pregnancy.

In this instance, I am part of some work being undertaken where we looked at what GPs in this country are doing and finding that they are overwhelmingly prescribing the pill. If you are actually serious about prevention of unwanted and unplanned pregnancy, you want to have the most effective forms of contraception in place. We are working to try to change the culture within general practice to encourage long-acting reversible contraception which is a much more effective way to prevent unwanted pregnancy and to prevent abortion.

The Public Health Association has always been arguing that good governance and good government around this issue is around a plan for sexual and reproductive health. That includes good sex education, planning for contraception and informing populations. I have done a study, for example, about emergency contraception over the counter when it became available. We looked at a random population sample and found that over half of the women were not aware that it was actually available over the counter. There is a lot of work that we need to do.

I also want to talk about access and equity. We started our submission to you talking about access and equity. This is an issue that I have actually done some Australian research on. I draw your attention to an article we published in 2007 in the *Australian and New Zealand Journal of Public Health*.

I have done a lot of work with the longitudinal study of women's health in Australia. It is a national representative sample, but it obviously includes a representative sample of Queensland women. What we were looking at was who the pregnant women are in this country and what are their characteristics? In doing so, we looked at their levels of education, their occupations, their health insurance cover, their country of birth, where they lived.

What we found actually backs up a lot of the kind of submissions that you would have, I imagine, which is that women who have abortions in this country are more likely to be disadvantaged. They are more likely to have a lower level of education than women who do not have abortions. They are more likely to be in a trade or in blue collar work. They are less likely to have health insurance.

Most importantly, we also looked at the level of violence because that is a particular interest of mine. In fact, we saw that women who have experienced non-partner violence are 46 per cent more likely to have a termination. If they have violence from a partner but not recently they are twice as likely to have a termination. If they have had recent violence they are three times as likely to have a termination. This shows very clear what influence violence has. It is a much stronger influence than all the sociodemographic factors.

We also looked at the outcomes of those pregnancies. Somebody put to me before that if we keep the law will that not protect women who are experiencing violence. I want to say absolutely not. What happens with women who are experiencing violence is that they are more pregnant more often, they are more likely to miscarry and they are more likely to have a preterm birth or a still birth as well as abortions. Abortion is only one of a spectrum of very poor pregnancy outcomes that women experiencing violence have. Something that became very clear from our data was that they were also more likely to give birth at a younger age, more likely to be pregnant at a younger age et cetera. I want to bring that to your attention.

In terms of access and equity, we have just completed a study with over 2,000 clients of Marie Stopes. One of the things that has happened in this country, not before time, is that we are actually able to offer women a medication abortion. Marie Stopes clinics provide that for the most part. They are training up general practice. Many of us who actually support a woman's right to have options, as they have had in France and the UK for 20 years with no problem and safely—safely because the earlier a woman is able to terminate the healthier it is for her and her future fertility—thought it would be more affordable and more accessible and that that would be a good thing.

We actually looked at over 2,300 women attending Marie Stopes clinics around the country to see whether in fact it was more accessible and it was more affordable. This has not been published. It is actually under review by those at the public health journal in Australia. We were looking to see whether women actually had to sacrifice funds in order to get an abortion in this country. I am wanting to share this with you—and I am very happy to send it either confidentially—

CHAIR: The statement you are making is very interesting and we definitely want to hear it, but I advise that you have about 30 seconds remaining. I am sure you can use some of it in response to questions as well.

Prof. Taft: We know that Aboriginal and Torres Strait Islanders are over-represented. Over one in 10 are from outer or remote Australia. Only 30 per cent are choosing a medical abortion. The important thing is that one in 10 had an overnight stay. It is very expensive. Sixty-eight per cent obtained financial assistance from one or more sources to help pay. Over a third had to forgo one or more payments, most often for bills, followed by 35 per cent for food or groceries. One in three women expressed difficulty in paying.

Some 16 per cent of women were undergoing an abortion after nine weeks. We were very keen to know who they are and why they are having that difficulty. They were: women who had to travel four or more hours—they were three times as likely; women who had no knowledge of the medical option; and women who had experienced difficulties in financing it. I will stop there.

CHAIR: You cited a study that is published. Was that attached to your submission?

Prof. Taft: No.

CHAIR: Would you mind furnishing the committee with that?

Prof. Taft: I am happy to leave it.

CHAIR: Leave is granted to table the study.

Mrs SMITH: I was interested in hearing the stats in the report that you have done. Maybe that can be sent to us confidentially?

Prof. Taft: Yes. I am hoping it will be published soon.

Mrs SMITH: There are two points that I am interested in getting your comment on. No. 1 relates to point 11 of your submission where it says that Australian and international experience shows that removing legal barriers to abortion do not affect the abortion rate? Would you like to expand on that?

Prof. Taft: That is right. I would draw your attention to the Romanian situation. It was one of the clearest pieces of evidence that demonstrates this. Ceausescu made it illegal to have an abortion. Women had the same proportion of abortions but they died more frequently.

I come from Victoria. I cannot give you the stats. I can draw your attention to the fact that our government is planning to look at their access and equity around this. They are doing it currently. Your colleagues might have some guide to planning. As far as I understand, there has been no great rise in abortion in Victoria. It simply means that we are able to train professionals more in something that is effectively not criminal. We are able to do more effective planning for services. I think that the Romanian instance was the one that illustrates this. In Victoria I have met doctors who remember the sceptic abortion wards in Victoria before we brought the common law in—the Menhennitt ruling.

Mrs SMITH: I would note that when we refer to Romania we are probably not comparing that to Australian health standards. That was back in the 1970s. I remember seeing the *60 Minutes* program on the orphanages and all of rest of it. I am probably going to stick to Australia. If at the end of the day it makes no difference to the rates—and I put this to other submitters—and the second point we have heard in a number of conversations is that most women are not even aware that there are any legal issues surrounding that—

Prof. Taft: Until the police come because somebody has alerted them. If you have police who have a strong religious or other objection that is when it happens. It is not a matter of when a woman raises it herself because the majority do not know that it is common law and it exists in the Criminal Code. In this state and in Western Australia a police person has actually said, 'You have done something illegal.' That is the only instance.

I would argue that the other advantages to decriminalising is better health planning but, more importantly, our ability to train our nurses, our midwives and our medical students in doing a procedure that is not criminal and the ability of GPs to feel that they actually can prescribe medication abortion with support from hospitals because it is not an illegal procedure. It is not to do with the women; it is to do with the providers, I would argue.

Mrs SMITH: I think it was quoted that over 10,000 termination procedures occurred in Queensland last year, so women have the ability to access abortions quite safely. There appears to be no police knocking on anybody's door that we aware of for the last 20 years.

Prof. Taft: However, it is expensive. What our evidence actually shows is that women are going to a private provider because it is not being provided in public hospitals because it is an illegal procedure and you cannot therefore do it. In fact, what is happening is that people who are coming later are coming from rural and remote areas and are facing financial hardship. In my mind it should be a public right. Like a miscarriage, like pregnancy, like abnormalities, it is a spectrum of pregnancy. It is a spectrum of a woman's reproductive life. We should be providing publicly funded facilities across that spectrum. That should be a right in our health service. We are not doing it. Therefore, it is expensive, difficult to access and it is causing the more disadvantaged women in our communities difficulty to get there on time and to have something safer.

Mrs SMITH: We were given some fees probably two or three weeks ago at our previous hearings. The morning after pill if you are on a healthcare card is $6.

Prof. Taft: No. I actually do quite a lot of work—it depends on what you mean by 'morning after pill'. If you mean ulipristal and levonorgestrel, which is an emergency contraception—a lot of people refer to that as the morning after pill—it is somewhere between $20 and $40.

Mrs SMITH: They were the quotes that I was given, so that is in *Hansard*.

Prof. Taft: And I have done research on—

Mrs SMITH: It was $6. It was up to $40 without the healthcare card. Some areas bulk-billed or charged nothing for medical or surgical procedures for termination right through, as we have heard today, to $700. Just to get an idea of the costs, that is what we were given from one of the medical professionals. My point is that you were saying that access should be available.

On the other side, what about the Mater hospital, which is run by a Catholic organisation? We heard very clearly yesterday what the Catholic position is on termination. How does that work then for them to be able to not provide a service that they are in conflict with over their own religious beliefs? Where do you stand on that, likewise with conscientious objections?

Prof. Taft: I think that this is a difficult issue. I would have to look back at our submission—I am pretty sure because I was involved in writing the policy. I think that what we would argue there—it is difficult. We have the same experience in Victoria in that the state government has contracted out services. A lot of the people who come forward are religious organisations and not only do they refuse terminations but they also refuse to tie tubes to give vasectomies. A whole range of things are refused in the public health system. I think that is a very difficult issue for government. I can see the problem with that.

I do think, however, that if existing services which otherwise provide very good quality services for birthing, for example—I know Mater's work, as I do a lot of birthing work as well—have a conscientious objection then it should be required that they then refer. The trouble is that often that is not the case with religious organisations because of their objection. I think that is a bit devil in the deep blue sea. I like the Victorian law that if you have a conscientious objection you are publicly required to make that visible so that a woman does not need to go in there and have you tell her that you do not agree with what she is trying to do. It is quite visible that you object.

Mr KELLY: Thank you, Professor Taft, for your presentation. I am looking at page 6 of your submission and the issue that has been raised in relation to mandatory requirements for counselling. I have a couple of quick questions in relation to that. I am a registered nurse. Is there any other procedure where a patient or anybody connected to that patient is forced to undergo counselling in relation to that procedure?

Prof. Taft: Not being a clinician, I could not answer that. I imagine that there are quite a lot of procedures for which that would not be mandatory, no. I think the idea that you would mandate that a woman see pictures of foetuses is somewhat cruel really. Our organisation is against mandatory services. I think that Children by Choice gave a very clear indication of what I would consider to be good practice.

Mr KELLY: In your submission you say that, if a government were to go down this path, this would go against the professional standards of the Psychotherapy and Counselling Federation. Would that mean then that we would have counsellors seeking conscientious objection from being forced to provide mandatory counselling?

Prof. Taft: I would imagine so. I am not a member of the Psychotherapy and Counselling Federation but I could quite easily see that they would take a strong objection, yes.

Mr KELLY: If we approach terminations from a public health perspective with an objective of reducing overall terminations, which many people who have given evidence have supported as a goal, what difficulties are created from a public health professional's perspective in terms of implementing an array of policies and programs aimed at achieving that when abortion remains in the Criminal Code?

Prof. Taft: I think I have outlined some of those. I will perhaps reiterate them—that is, professional organisations would find it difficult to provide proper training in all options for abortion, providing medication abortion, providing surgical abortion. There is the planning. As the member for Mount Ommaney presented, you already have existing services that have conscientious objections to providing those services. Yet they are funded by taxpayer funds and they are publicly provided services. The difficulty is actually in saying, 'We should be providing a full range of services. How are we going to do that? Can we do it offsite?' There are ways to think about that. They are the difficulties I see.

Another one is finding, I hope, evidence for better ways of providing contraception and more effective contraception, getting our GPs and all of our services in the community to encourage more effective forms of contraception. I know similar problems exist in providing good sex education in schools. Informing young people about contraception, emergency contraception and their rights to termination and their choices within termination, face the same hurdles because there are strong religious beliefs against most of those things. That is what I would see as the barriers.

Mr KELLY: Based on your knowledge and research of this issue around the world, has the practice of criminalising abortion achieved a reduction in terminations anywhere in the world in any jurisdiction?

Prof. Taft: Not anywhere I have ever seen and looked at the data for.

Mr CRAMP: This is something I meant to ask the previous witnesses. Many people have stated that counselling should not be mandatory, but the question has come up a few times: should the offer of counselling by services be mandatory?

Prof. Taft: I think it is highly desirable myself. I do not know about making it mandatory. I do not feel qualified to make that call. In a way I am a social scientist who researches these issues. Counselling is not my field. I think that certainly in the Public Health Association we look for good quality counselling that includes all options, as Children by Choice demonstrate, but I do not think it should be mandatory. I agree—and certainly the women that I know and have spoken to who seek abortions or certainly who are experiencing violence know—it costs them a lot to get to the service and by then they know what they want and really they are asking about it. I do not think it should be mandatory, but I do think it should be strongly encouraged, and it would be in the Psychotherapy and Counselling Federation. I think that good professional training in counselling would do exactly that.

CHAIR: I have one final question, Professor Taft. You may want to take this on notice. I would be very interested in knowing of any or being provided with any reputable domestic recent studies in regard to the effectiveness and failure of contraception.

Prof. Taft: Yes.

CHAIR: I would be really interested to have a look at that. We have had those sorts of statistics cited and I have to be honest and say I found that fairly surprising and terrifying. I would be very interested to look at that because I think it is something that is not necessarily discussed that openly, given that if you look at the information provided with many of these contraceptive measures—the most common being prophylactics and the pill—you see the number 99 per cent.

Prof. Taft: If they are taken accurately. Young women forget pills. One pill you can forget and then you find yourself pregnant. One in four condoms breaks. I can send you the most recent Sex in Australia study that La Trobe University have conducted. This is what happens. It happens all the time, let alone—

CHAIR: Thank you. I would appreciate that study. What has been cited is that it does not require a missed pill or necessarily an illness or a known break in a condom—that there is actually just a higher incidence of failure. If you would not mind providing that, I would appreciate it. Thank you very much for your time. Thank you for your submission.

KERR, Ms Katherine, Social Worker, Women's Legal Service

LYNCH, Ms Angela, Acting Coordinator, Women's Legal Service

CHAIR: I welcome Ms Katherine Kerr and Ms Angela Lynch from the Women's Legal Service. Katherine, will you be making an opening statement?

Ms Kerr: I will. Thank you for the opportunity to contribute today. I would like to acknowledge the traditional owners of the land on which we meet and elders past, present and emerging. The Women's Legal Service provides specialist legal and social work support to Queensland women regarding family law, child safety and domestic violence. We are a front-line service.

Over the past month 88 per cent of our clients have identified experiencing domestic violence, with 54 per cent of all clients stating that their safety is at immediate risk. Forty-seven per cent of our clients have an income less than $26,000 a year and 71 per cent have an income less than $52,000 a year. Seventy-five per cent of our clients have children.

We do not collect specific data on the types of violence that our clients experience but, through consultation with our solicitors and social workers on the presenting issues for their clients, we know it ranges from the immediately life-threatening or repeated incidents of physical assaults and strangulation to sexual violence and rape, to yelling, screaming, name calling and emotional abuse, to psychological manipulation and gaslighting, to financial control and monitoring and stalking both physically and through technology.

Most of our clients are fearful for the safety of their children if and when they are in a perpetrator's care and are worried about the impact on their children of witnessing the violence directed at her or the violence the perpetrator directly threatens or imposes against the children. We know from what clients have told us and the case work that we assist with around parenting matters and domestic violence that children often become tools of control and manipulation to ensure women remain in violent relationships or that the father is able to continue his abuse beyond separation.

We have clients who are currently parenting children who are the result of rape by their former partners who have been conceived when our client has not felt able to ask for contraception or suspect their partner has interfered with their birth control or condoms. We have clients who have been pressured into continuing with pregnancies who have felt they had no option to do anything but continue with the pregnancy, who hoped a child would improve their relationship and who could not access the abortion their wanted due to their partner's control, denial of support or a myriad of other issues preventing their access to the procedure.

We also have clients who in the very early stages of their pregnancy with a violent partner have accessed legal advice on what their potential family law obligations will be to better understand how much contact they will need to have with their partner if they continue with the pregnancy and how much exposure any future child would have to his violence. These clients are aware that continuing with a pregnancy in an abusive relationship is fraught with risk and threatens both their safety and the safety of any future children. Women's Legal Service is aware that pregnancy places a woman at an increased risk of domestic violence and that physical violence in an abusive relationship often begins during a pregnancy or, if violence already existed, increases in severity.

We recognise that, where a relationship is equal and respectful, women choose to involve their partner in their decision-making regarding pregnancy. However, our focus and area of expertise is in working with women experiencing domestic violence, and often where the decision to continue with the pregnancy or not poses risks for the women. We also recognise that for women experiencing reproductive coercion the pregnancy itself has become a way for the perpetrator to control the woman, and as such it would be unsafe for the man to be involved in any part of the decision-making process. We respect that women are capable and able to make the best decision for them in their circumstances. This is the context in which women in violent relationships may make a decision to terminate their pregnancy. Women's Legal Service respects that choice and acknowledges that it must be supported and facilitated.

CHAIR: Thank you for your opening statement and thank you for the work that Women's Legal Service does on behalf of women in the community. I know that I refer people to you who are in great need.

Mr HARPER: You are absolutely right, Chair. The distinction that you have raised here between domestic violence and the abortion bill before us is quite clear. I gather you would have some good data to suggest that for people who are in domestic violence situations there is a higher abortion rate.

Ms Kerr: There is certainly data out there that I am aware of. I do not have the numbers in my head. I am aware that Children by Choice has done some research into those rates and there is additional data to suggest that women seeking abortion have a higher percentage of identifying domestic violence than the population.

Mr HARPER: With the bill that is before us, can you comment in relation to regulations on conscientious objection, gestational periods and mandatory counselling?

Ms Kerr: In the current bill there is a complete removal of abortion from the Criminal Code. We would suggest that any further regulation regarding gestation periods or conscientious objection would be better suited to health regulation under health law rather than under criminal law.

Given that we do support a woman's right to choose and to know what is best in her circumstances, as has already been submitted to the committee, we would suggest that around conscientious objection there should be a requirement that a woman be referred to an appropriate service. We believe, especially around domestic violence, that this is particularly relevant due to the barriers that the control or abuse she might be experiencing might have an impact on her capacity to visit multiple services, and that is certainly an issue that we do see already. If he is monitoring her movements or she is needing to account for her time, needing to go to a number of different services can get too hard and those barriers can become insurmountable. Having a clear pathway is very important.

Mr HARPER: They are good points; thank you very much.

Mr CRAMP: Thank you very much for coming in today and for your submission. You said that a lot of your work is around domestic violence. As has been stated before, one of the main actions of this bill would be to remove sections 224, 225 and 226 from the Criminal Code. Can you explain how that is going to assist victims of domestic violence, especially in situations where they are being coerced to have a pregnancy or perhaps to have a termination?

Ms Kerr: Specifically for women who are being coerced into having a termination, that is more of an issue in practice than an issue at law. Best practice procedures within the clinic would be screening for domestic violence. They do need to be assured that a woman is making that decision for herself and is not being pressured into that. As far as current barriers that the criminal law poses for women experiencing DV, there are a number of issues around access, particularly for women outside of the south-east corner or aware from the coast of Queensland. Criminalisation creates a lot of confusion and potential discomfort for providers in terms of being able to provide the procedure but also being aware of what their rights would be, whether they would be opening themselves up to any prosecution. That means there are fewer providers who are able to provide that and there is less accurate information around what is available. As I said before, that can create very profound issues for a woman in a violent relationship where she might need to make one phone call and have access to accurate information rather than a series of phone calls around what her rights might be.

As was mentioned before, we know that women experiencing domestic violence do present at a higher gestation, and often that is because of a lot of that control that exists as part of her daily life in terms of accessing that information. Hopefully, one of the key roles that decriminalisation would play would be to overcome some of those barriers for her.

Mr CRAMP: A question was posed in a previous hearing that perhaps the removal of section 225, which is around prosecution of the woman involved, would provide adequate protection. I would be interested in your thoughts in regards to that from a legal perspective.

Ms Kerr: A lot of the barriers around access are around medical practitioner uncertainty. It is not necessarily around the woman herself; it is around those barriers which confusion around the law creates through having medical practitioners open to prosecution.

Ms Lynch: I have nothing else to add.

Mr CRAMP: I am happy to take the chair's advice if I am straying too far from this inquiry, but I would be interested to know in regards to protecting women in these situations around falling pregnant or being forced into having a termination, could we look at improvements in other areas of the Criminal Code—perhaps harsher sentencing or whatever that may be—in regard to domestic violence situations where women are subject to this sort of behaviour and action?

Ms Lynch: I think the Bryce report has made a number of recommendations in relation to the Queensland response to domestic violence including the notation in criminal matters when it was a domestic violence relationship so that in future court proceedings judges are aware of that and can see patterns. In relation to the trials that are happening at Southport, the acknowledgement that it is not only a civil matter but also a criminal matter and the police response in relation to that is being looked at at the moment.

Ms Kerr: On top of what Angela has said, law reform and legislation is not the only way to address the issues of domestic violence that we are currently experiencing. There are a lot of other things that we can do. Access to contraception is often compromised for women in domestic violence relationships. We know that there are perpetrators of abuse who deliberately sabotage birth control with the intention of causing a woman to fall pregnant. Increasing knowledge and awareness for women on diverse and alternative methods of contraception that may be safer for women in DV to use—some of the long-acting reversible contraceptive methods—as a way of attempting to regain some of that control over her fertility would certainly be an avenue to explore further.

Ms Lynch: What the Bryce report was very strong about was that it is an all-of-community response in relation to the issue of domestic violence in Queensland. Often in relation to law reform people do just think of the domestic violence act and the Criminal Code, but it is a range of legislation and a range of awareness. We have to become much more aware of this issue across-the-board. It is on these issue of abortion law reform where you may not have ever thought that this is an issue, but the people on the ground just know that it is.

Mr KELLY: Thank you, Angela and Katherine, for your presentation. I thank the organisation for the work you do every week in my electorate in the local courthouse. I want to ask you questions around the notion of a compulsory cooling-off period. I know you are not clinicians per se—apologies if you are—but is there any other health or medical related procedure where anybody, male or female, is required to have a mandatory cooling-off period that you are aware of?

Ms Kerr: There is not one that I am aware of.

Ms Lynch: Not that I am aware—buying a house.

Mr KELLY: To me, a mandatory period of cooling off suggests that a woman making a decision about abortion is doing so in a state of mind that is not rational. We are imposing on her a period and saying, 'You need to cool down, calm down and make a rational decision.' Am I wrong in that presumption? In your experience, you have obviously dealt with many women in difficult situations. Are women capable of making a rational decision even when they are in quite difficult and stressful situations?

Ms Kerr: Yes, I think that is a very fair assumption that it is suggestive with a cooling-off period that a woman is not in a headspace or capable of making that decision rationally. In the Women's Legal Service social work team, our entire case load is filled with women who are experiencing domestic violence who are under profound amounts of stress due to their experiences, and our experience has shown us that these women are very capable of making big, complex decisions under horrible circumstances. I agree with you: I think that women are able to make very big decisions under a lot of pressure and are still able to very clearly assess that it is the right decision for them in their circumstances at that time.

Ms Lynch: Often women only have a small window of opportunity to get out to make the phone call, so it is very important that we meet women where they are at in these circumstances of violence and can respond and have the information for them appropriately.

Mrs SMITH: I am very keen to get your opinion on one particular area, and I put this scenario to you: we are talking about women's choice and I am talking about conscientious objection. You have a female doctor who absolutely objects to being involved in a termination and you have the patient coming to her requesting a termination. In that circumstance, whose views or whose rights are more important and how does that get resolved? Is there an answer?

Ms Kerr: My answer would be that that doctor has a duty of care to that patient and they have a duty of care to refer the client or the patient to an appropriate service. While medical practitioners are often very privy to all of our personal matters, especially if you have a long-term GP, the patient is still the expert in their life. They still know what they need. As has already been submitted, women are making these decisions in full consideration of their circumstances, in full consideration of what they want to be able to offer as a parent and what they are currently able to offer, and those might be completely unable to meet. I would always support the right for someone to be uncomfortable with the idea of providing a termination of pregnancy, but I do not believe that gives them the right to refuse to offer that service to a patient who is seeking that with their own expertise in their own life.

Mr McARDLE: I have an observation to begin with. You make the comment about the Bryce report and what parliament is doing now. That is the end result of what has taken place in many cases. It is a matter of trying to put the assets or the income or the finances in the front end with children at an early age to develop respect for each other and growing up that could potentially deal with domestic violence in a broader sense.

My question is this: if a lady comes to your service, she is pregnant and she raises the question of domestic violence being the cause one way or another to her falling pregnant, what do you do in those circumstances? Do you play a role in determining whether that termination should occur? Do you refer on to another organisation or body? Do you refer her on or give her the option to go to pro-choice or pro-life, or are you pro-choice and refer her to pro-choice bodies? I ask out of curiosity because I do not know the background to the organisation.

Ms Lynch: I would refer her to our social workers, so I will defer to Kath to answer that.

Ms Kerr: In a situation like that it is most likely that our solicitors would refer to the social work program. Our role is to provide support and safety planning for women experiencing DV. Depending upon her gestation, we do not know whether she has left the relationship or not or whether she is still in a relationship. Our first priority would be to provide safety planning with her and to check how she is feeling about the pregnancy and what information or any referrals she might be wanting at that time. We would then make the referrals as directed by her. We do often suggest that women consult their GP or their health clinic for information around their pregnancy and around what their options may be. We are also aware of counselling services such as Children by Choice if she is wanting some decision-making support as well. Whether she decides to continue with her pregnancy or to have an abortion, there are going to be a number of safety concerns for her. Our social work service would immediately be concerned with if she chooses either option, what other things do we need to take into consideration to ensure that she is going to remain as safe as possible in these circumstances?

Mr McARDLE: I have a final question. The ladies who come to you in that situation where there is domestic violence, they are pregnant—and the dynamics around that domestic violence situation are very complex. How many say to you that they want to have a termination but are concerned about the Criminal Code aspects, or is the dynamic of the domestic violence situation so entwined with where they are at that point in their life that they simply need advice as to what is the best thing to do for them?

Ms Kerr: We would not give advice about what is the best thing for them to do; that is for them to decide. I have never had a client raise the Criminal Code with me as a concern in her decision-making.

Mr McARDLE: Thank you very much indeed.

CHAIR: Thank you very much for coming today and thank you for your submission. We appreciate it. The committee will now suspend proceedings until 1.30 pm.

Proceedings suspended from 1.02 pm to 1.33 pm

BRADLEY, Ms Amanda, Pro-Choice Queensland

GORTON, Ms Carla, Pro-Choice Queensland

CHAIR: The hearing will now resume. I welcome Amanda Bradley and Carla Gorton from Pro-Choice Queensland. Would you like to make an opening statement?

Ms Gorton: I would like to begin by acknowledging the traditional owners of the land on which we are gathered today, the Jagera and Turrbal people, and pay our respects to elders past, present and emerging. My name is Carla Gorton. I was born and I currently live in Far North Queensland. I am here today as a member of Pro-Choice Queensland, which encompasses organisations and individuals across our large state. With me is Amanda Bradley, the Manager of Children by Choice, who also holds the role of the Secretariat of Ending Violence Against Women Queensland and is also a volunteer for Pro-Choice Queensland.

As I said, Pro-Choice Queensland is a collective of people across Queensland. We are currently engaged in a campaign 'It's not 1899' in regard to the Crimes Act in Queensland and the criminalisation of abortion and in response to the introduction of the private member's bill to the Queensland parliament. Pro-Choice Queensland is supported by more than 50 professional organisations and peak bodies from the health community, legal and social services sectors including Health Consumers Queensland, the Public Health Association of Australia, Maternity Choices Australia, Public Health Association, Women's Legal Service, White Ribbon Australia, Human Rights Law Centre as well as a whole range of community organisations working at the coalface with women.

With that in mind, we would like to acknowledge the extensive work and investment this parliament has dedicated to addressing violence against women. We know there is a commitment by this committee in working towards building a culture for women that believes and includes women's autonomy, respect for women and their autonomy of decision-making and control over her own life. That is also why we support this bill for decriminalisation. Pro-Choice Queensland supports the availability of safe and accessible abortion services to all Queensland women, especially those experiencing the most disadvantage. We believe that laws criminalising abortion are the single biggest barrier to women's access to abortion services and, I would also add, to a holistic discussion of sexual and reproductive health services in Queensland.

Firstly, we would like to point out that the law is from the 19th century. It dates from a time before women had the right to vote, before pregnancy tests and ultrasounds, and before flushing toilets or a lot of other things that we take for granted today. Medical practice has come a long way since then as well as community opinions, and these laws no longer reflect the reality of Queensland in the 21st century and the reality of clinical service provision. Today, high-quality health care is recognised to be evidence based and it is supported by best practice in the recognition that healthcare systems are stronger with patient centred care and where patients can make informed decisions.

We also believe that the law impedes access and is significantly worse for women experiencing disadvantage than for others. If a woman lives in a major metropolitan area and is well resourced, she will generally be able to access a procedure, albeit with a high out-of-pocket cost. For women in remote and regional areas and those with limited financial resources or other disadvantage, there are extremely high barriers to access.

Thirdly, unplanned pregnancy is a reality for Australian women. It is estimated that almost half of all pregnancies are unplanned. Therefore, abortion is also a reality for women. As you have heard, no contraception is 100 per cent effective and can fail even when used correctly or consistently. Every woman who is not planning a pregnancy knows the sense of uncertainty that accompanies a late period, and women have 35 to 40 reproductive years during which they need to control their fertility. This is just an everyday reality for women in Queensland.

Finally, Queenslanders, we believe, are ready for reform. Certainly I would not see this move by Queensland to decriminalise abortion as a bold move. Every other jurisdiction in Australia—every other state and territory—has already made this move except for New South Wales, and they also have a bill to decriminalise abortion that has been presented to the parliament. I do believe that it is a sound move.

We acknowledge that there is a spectrum of views on the issue, but we also know that community attitudes are very supportive of change. Through the work that Pro-Choice has been doing and through our member organisations, we have spoken with thousands of Queensland women. They are quite surprised that it is still in the Criminal Code and they are ready for this change.

Finally, no woman makes this decision lightly—just like anyone would not if they were faced with an unplanned pregnancy. If we do not trust women with this decision, we do not trust women full stop.

CHAIR: Thank you for your opening statement.

Mr McARDLE: Thank you for coming today and for your submission. Far North Queensland—does that mean Cairns?

Ms Gorton: Yes, I am living in Cairns.

Mr McARDLE: It is a lovely city. You mentioned women in regional and remote Queensland and there are barriers there. There are several barriers, are there not? The law is not the only barrier; there is the availability of GPs, how far you live from a GP and the technology available as well. You say that the criminalisation is a factor, but there are many other factors in regional and remote Queensland that make it more difficult for a woman to obtain a termination of pregnancy.

Ms Gorton: We are still putting forward evidence that it is one of the major barriers. Both Amanda and I are involved in education for health practitioners and GPs, nurses and community workers and they find the law confusing. As you say, you may live in a remote area where the doctor only visits so frequently or you may be a distance from a hospital or a health service, but at that health service those medical practitioners are feeling confused and not supported at the moment because of the legal situation. The committee, I think, would find it difficult if you had someone coming to you today asking: is abortion lawful or unlawful in Queensland? You would actually have to have quite a lengthy conversation with them to explain that. That is the conversation we have to have with health providers all the time. I agree with you; there is a whole range of factors, but this is a significant barrier.

Ms Bradley: I would wholeheartedly agree with that.

Mr McARDLE: To me it seems the case that whatever jurisdiction we are in—Queensland, New South Wales, South Australia and the like—there is that confusion—I will use that word—in regard to what the law is concerning termination. I do not know that—using your words—that confusion in this state is simply an issue of this state alone. To me, it seems to flow through all jurisdictions that there are doctors, clinicians and other professionals in the medical field who are uncertain as to where the law stands.

Ms Bradley: I think that is right. I think MSI spoke to that a little bit this morning in the context that their research was national and they could not differentiate at that point whether or not those practitioners were in one state or the other. It is also interesting when we have locums moving from state to state for women crossing borders.

Mr McARDLE: Or overseas trained doctors for that matter.

Ms Bradley: Or overseas trained doctors, exactly. I think there is a lot of confusion. There could be some thinking that federal legislation might be a better place for this to be discussed.

Mr McARDLE: Harmonisation, not legislation—

Ms Bradley: Absolutely, and in one sense it has been because Medicare rebates exist for abortion provision. I have heard federally ministers of government talk about it being a state issue and it is an issue for states to be discussing—

Mr McARDLE: I understand why they do say that, too.

Ms Bradley: Absolutely, because I imagine this whole process for you guys has been very fraught. You are on a very steep learning curve. Women faced with the abortion and doctors faced with the opportunity of providing abortion services and contraception services are confused around what that looks like and how they can do it in a client centred manner.

Mr McARDLE: If we accept that there is the confusion that has been explained across the jurisdictions, the argument that is being put forward here is that the Criminal Code in this state is creating confusion. That is no different to Victoria or other jurisdictions as well. If that is the case, there is still confusion whichever way you go.

Ms Bradley: There is a difference between confusion and the willingness to prosecute someone.

Mr McARDLE: Sorry, I was using your word. You said 'confusion', not me.

Ms Bradley: Absolutely, but I think—

Mr McARDLE: The point I am making is that if confusion exists across jurisdictions, I have difficulty accepting that Queensland is unique when you are using the same word 'confusion' as I am on a nationwide basis.

Ms Gorton: I will try to explain that. I think decriminalise of abortion will improve the situation in Queensland. That is the opportunity that the Queensland parliament has today. When you mentioned South Australia, they were the first Australian state to take action in 1969 to change their laws. Each state and territory was based on the 19th century law of Offenses Against the Person Act from the UK, and they overturned them in the 1960s. There has been a progression in every state, and that is why it is different. The decisions were made at different times in each state. Victoria had a very good process, and that is why a lot of people have said to look at the Victorian example, because that happened more recently than every other state and territory whether it was the 1980s, the 2000s or the 1960s. They have all been different, but in 2016 I really do not think that Queensland can shy away from this issue any longer. I think it will keep coming forward and we will keep moving forward. I hope that we do have greater consistency and that parliaments will go back and revisit the decisions they made in the past so it is more of an equitable system for women across Australia.

Mr McARDLE: At some point in time we might find a federal government who will take the issue on, but I expect it might be some time down the track.

Ms Gorton: Interestingly enough, at the federal level when the restriction was removed on medical terminations on RU-486, Mifepristone, there was support across the political spectrum. We saw parliamentarians from the National Party, the Liberal Party, the Labor Party and the Democrats bring that bill forward, so there was an ability to cross party political lines in support of a health issue that affects women. Regardless of their political views and regardless of their religious faith, women are in a common situation: unplanned pregnancy does not discriminate.

CHAIR: Thank you for your opening statement and thank you for your submission. To what do you attribute the reason that Queensland still has the current legislative regime we do given the debate that has been going for so long?

Ms Gorton: I think it is a combination that no member of parliament has ever brought forward a bill to decriminalise abortion until now, and I think on the other side there has been community demand to do it at different times, but I do not think that has been strong until now. I think now we do have a strong coalition through Pro Choice Queensland that has brought forward the evidence and that has brought forward the spokespeople. I think it is both within and outside parliament, and I think you need both of those factors to achieve reform.

Ms Bradley: I think the other thing is that parliaments across the world tend to be slightly more conservative than the constituents they serve. Abortion is a very difficult topic to talk about and it is a brave government that has this conversation. I think the fact that we are having it is a tremendous step forward.

CHAIR: You are right: it is a very vexed issue. I think the number of submissions that the committee has received will come as no surprise to you. I think we have received about 1,500, which is far in excess of the normal number we would receive. I think all of the reform is interesting; it is not necessarily shared by the Queensland public. I think it is fair to say that, without trying to divide them into how many for and how many against—I do not think that is necessarily a genuine reflection about the issue—there are strongly-held intractable divergent views in the community. Personally I am very respectful of both and the fact that many Queenslanders' views would be nuanced in the middle. There is always great complexity in both ends of the spectrum being respectful of each other. As parliamentarians, given that we have a responsibility to balance the divergent views of the community and best represent them, how do you feel that we should approach an issue such as this?

Ms Gorton: After the hearings this week you will obviously prepare the report to go to parliament. If you choose to base your report on a number of those submissions, then you will be judging that those submissions are worthy; that they are of high quality evidence and research; and they are rigorous. You really have to weigh it up. It is not just the number of submissions that you receive; it is whether those submissions should be reflected in public policy and lawmaking. Then you will be justifying that, I imagine, in your report.

People have to be motivated to bring forward a submission and they have to feel strongly. As you say, there are a lot of people in that middle space who believe that services are available and they are not moving for change or, conversely, arguing against change but they still expect high-quality health services within the state, and that is what we are hearing. People want to know the services are available when they require them, so they are not as engaged in the lawmaking process.

Ms Bradley: If I can just say a couple of things: firstly, you never know how you are going to respond to an unplanned pregnancy until you are faced with one. People can write submissions based on personal belief systems, but they do not know what they might actually do until they are really faced with the prospect of being 47 and pregnant, when you have grown children and you have been diagnosed with a foetal abnormality. You never know how people are making decisions, and to step into a personal decision I think is really fraught.

The other thing is that I can have a personal view on a number of issues, but if I base my decisions in law on personal views I do not necessarily think that is a good way to go. My background is public health. I am a health promoter; those are the roots of my trade. I would love law to be made on best practice and high-quality, evidence-based research. I think there has been a little bit of confusion about what we define as evidence before the committee as well. There has been, 'We have been presented with this evidence,' and I think presenting a piece of paper to you could be described as evidence in a court of law, but when we talk about evidence-based practice we talk about high-quality clinical research. The gold standard obviously is controlled trials. If we are talking about that as the gold standard, then that is how we should be making law. You may have heard that I am a Kiwi by birth.

Mr HARPER: There is nothing wrong with that!

Ms Bradley: I found it interesting that about 10 years ago the New Zealand government outlawed child smacking as a form of punishment. It was incredibly contentious. Public opinion was very much, 'This is my home. This is my child. I will discipline my child how I feel is the right way. You cannot tell me how to discipline my child.' That was very strongly the public opinion, and there was public opinion polling done that reiterated that opinion over and over. Yet the medical bodies, the child poverty groups—

CHAIR: I will get you to sum up because I know time is against us.

Ms Bradley:—came together and said, 'Best practice says that smacking is not a good way to resolve discipline. We would like you guys to think about making it illegal.' It was a right-wing government at the time, and they made the call to go with the evidence over public opinion, which was very interesting.

Mrs SMITH: Following on from the evidence, one thing that has been presented to us over the course of all of our hearings is the lack of available evidence or data. If we are to make an informed decision, we first probably need data or more evidence to make that informed decision. If the law currently stands but has not been accessed in over 20 years—

Ms Bradley: 2009 was the last prosecution.

Mrs SMITH: There was no jail term.

Ms Bradley: No, but she was brought before the court.

Mrs SMITH: If I may continue with my question. The fact is that there were 10,000 abortions performed last year and the evidence which we have heard suggests that, whether it is criminalised or decriminalised, there is no increase or decrease in the number of abortions. My question is: why should we move away from the current situation?

Ms Gorton: I will address two points: evidence and prosecution. I do not think any court in Queensland today would succeed with a conviction on these laws. I think that is what we have seen. That is what we saw in Cairns in 2009 to 2010. I do not think any jury or judge would make a conviction of a jail sentence, so we have a law that cannot be implemented. But what there is is a threat. As was mentioned earlier today, police can bring charges forward at any time. They can do that tomorrow. They did that eight years ago in my hometown. The couple who were charged had to wait 18 months until it went to trial. For 18 months they had those charges hanging over their heads. They had their photographs in the paper and on the TV. They had their community knowing that they were being charged with this, and doctors have been charged. Doctors were charged in Queensland in 1986. At any stage charges can be brought forward, but we know that there is unlikely ever to be a conviction. I think that is a bad law, and that is a classic example of a law that, under a Law Reform Commission, should be repealed or reformed.

In terms of evidence, what we have in the absence of complete data is very highly qualified clinicians who are presenting the data from Queensland. They have published in a range of medical journals and they presented at state and international conferences about the work they do in medical and surgical terminations in Queensland. Other states—Victoria, ACT and Tasmania—have all proceeded based on the evidence that is available in Australia today. I think it would be unusual for the Queensland committee to find against decriminalisation on the basis that there is not sufficient evidence.

Mrs SMITH: My next question to you is with regard to community expectations. Your submission states—

Reliable opinion polling consistently shows that the community supports a woman's right ...

You quote views on abortion carried out by Auspoll in 2009. That would be at odds with the Galaxy poll that was done in May this year where, for example: 66 per cent of people agree that an unborn is a person with rights at 20 weeks and 55 per cent agree that abortion takes a human life. Views on current law: 39 per cent say it is too restrictive; 42 per cent say it is about right; and 11 per cent say it is not restrictive enough. My point is that within the community based opinion polling and the submissions that we have received there are still quite a number of diverse and very strongly held views. Following on from what the member for Nudgee said, I believe that as a committee we have to consider all of those views and not brush one off as opposed to the other.

Ms Gorton: I think it would not be reasonable for the committee to rely on one single poll for community opinion. I think you need to look at all of the polling and then get a general perspective from that polling. Katharine Betts is a researcher in Australia who has looked at post-election polling, and a question around abortion has been included post every federal election. That gives us a longitudinal study of attitudes. I would recommend her research to the committee.

I would also note in relation to the Galaxy poll that was conducted in Queensland in 2016 that when people were asked their opinion they were not told first what the legal situation is in Queensland. As you know, if you ask someone in the street today, they are quite surprised to find that abortion is still illegal in Queensland. If you do not tell people and you then ask them, 'Should the law be more liberal or should it be changed or is it about right?,' people say, 'I know someone who had an abortion. It must be about right.' If you do not say to people that it is in the crimes act from the 19th century that women can have seven-year jail sentences and doctors can have 14 years and then ask them what they think about it, you are not giving them all of the information.

I would also point out that when the Victorian Law Reform Commission looked at this issue—the exact same questions that were asked in the Queensland Galaxy poll in 2016 were asked in Victoria in 2008—they found the questions to be negatively loaded and not balanced. That was the finding of the review of that polling.

Mr HARPER: Amanda and Carla, thank you very much for being here today and for your submission. The Auspoll also said that 85 per cent of the population did not believe that the government should be involved in the abortion decision. If not us, who? I take your point. I have a medical background—25 years as a health professional. Any interventions I made in the Ambulance Service, pre hospital, were based on evidence based research. In my mind, we need to look at evidence based research but also meet community expectations and have an understanding of general thoughts. Most of the people who would oppose your views—pro life versus pro choice—seem to be hanging a fair degree of the argument on the idea that life is precious—I respect everybody's views—and also around the gestational age. There seems to be a fair bit of argument around gestational age. Can you give us your opinions on whether some gestational age limits should be applied to the bill as it stands?

Ms Gorton: I think in the area of abortion—it is a very private matter for the woman and partner or family—the issue is not discussed widely. The evidence of medical practitioners is what you should listen to in terms of gestational age. There is nothing within the criminal law or indeed in the health act looking at gestational age, so I think if the committee was going to recommend any addition on gestational age, again, you would need to base that on evidence and where you are drawing those limits and those lines.

While that comes up as a concern, it is not reflected in reality. The reality is that most abortions occur within the first trimester—the vast majority, between 90 and 95 per cent, on the data that we have, acknowledging that it is not totally complete. When we are looking at later gestation, as the evidence has been given from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, there are particular reasons that occurs. It is best managed between the clinician and the woman, not the criminal law—or, indeed, weeks gestation within a health act that mandates that something be that way. As soon as you do that, you will not account for the individual difference and the woman's life that is in front of you today. I really believe that it is a concern that can be explained but it would not add to the practice.

I believe that we have very high quality medical care in Queensland. Our doctors are all registered and operate within a very high code of ethics, and they are regulated as well. Other jurisdictions in Australia do not have gestational limits, but we do not see any sort of wild variation

happening. I really do not think we have to mandate something. The position of Pro-Choice Queensland is that we do not recommend gestational limits, but if the committee wants to look at examples we would point them to the Victorian example as something that is reasonable and working.

Ms Bradley: I know that you have talked about gestational limits considerably. I completely and utterly support what Carla has just said. There is nothing stopping a woman right now at 32 weeks gestation presenting to her doctor with a foetal abnormality and saying, 'I want a termination of pregnancy.' That does not change if it is decriminalised. It does not stop a woman right now at 32 weeks gestation with a healthy foetus saying, 'I've changed my mind.' There is nothing currently in the law doing that. What stops it is doctors not being willing to provide terminations up to that point. I agree: it is a life. I am the mother of four boys. I would have loved a girl. No. 4 was lucky last chance at a girl. What would happen if a GP or an obstetrician was presented with a woman at 32 weeks gestation who says, 'I've changed my mind. I don't want to have this baby anymore.' That doctor would be thinking, 'There is something really serious going on for this woman and I need to help her'; 'She needs a psychiatric assessment'; 'What is going on in her personal life that might have led her to this decision?' That is what would happen now and I think that is what would happen under decriminalisation.

Mr CRAMP: Ms Bradley, earlier you stated that, in consideration of this bill, law should play more of a part than people's belief systems—

Ms Bradley: Evidence should be.

Mr CRAMP: Not so much belief systems in changing this law; is that right?

Ms Bradley: We can all hold personal belief systems, but if the law ascribes to one personal belief system that means that everyone has to hold the same belief system under the law. We live in a pluralistic society. I think Father Frank Brennan talked to this beautifully. If I was Catholic, which I am not, I might hold a belief that life starts at conception and if I was presented with an unplanned pregnancy then I would choose to continue with it. The law would let me do that. We are not advocating for women to be lined up in rows and forced to have abortions that they do not want to have.

Mr CRAMP: I just wanted some clarity around it, because part 4 of your submission is titled 'The community is ready for reform'. Then I look over to page 5 and it is shown in bold 'to reflect current community attitudes and expectations'. What are your thoughts around the fact that the very reason we are looking at this is not really about law; it is actually about community expectations and people's belief systems, regardless of which side people are looking at it from?

Ms Bradley: Yes. What we would say is that opinion polling shows that women should be able to choose, that women should be in control of their own lives. That is the belief system we are coming from.

Mr CRAMP: The one thing I have found right throughout this inquiry—I think someone stated it earlier—is that we are on a steep learning curve. One thing I have noted is that for every statistic and every survey, someone can present me with one that is a polar opposite. I have had both sides of the argument state their surveys and their statistics are 'gold standard'. That is the key term from both sides. What are your thoughts on that?

Ms Bradley: I think you should get some independent advice on that.

Mr CRAMP: We are taking it from all sides, I can assure you. We are taking plenty of advice.

Ms Bradley: 'Gold standard' is usually a randomised controlled trial. In the context of abortion it is incredibly difficult to do because we cannot get women pregnant and then say to one random group, 'You lot have abortions and we'll see how you perform,' and, 'You lot don't have abortions and we'll see.' It is impossible.

Mr CRAMP: It was not so much about the questions; it was just about the premise of your argument that this should be about law. I am saying that this is very much about opinion and polling and statistics from that polling.

Ms Bradley: I think you should look at the highest quality of evidence you can possibly look at.

Mr CRAMP: From both sides of the argument?

Ms Bradley: Evidence. I am not saying 'on both sides'; I am saying that you should look at the quality of the evidence that is presented and ask, 'Has it been published in a peer reviewed medical journal?,' and hold that as the evidence that is the highest.

CHAIR: The time for questions has expired. Thank you for appearing today.

KING, Ms Olivia, Vice-President, Young Queenslanders for the Right to Choose

MARCHESI, Ms Kate, President, Young Queenslanders for the Right to Choose

CHAIR: Welcome. Kate, I invite you to make an opening statement and then we will go to questions.

Ms Marchesi: Firstly, I would like to thank you for the opportunity to speak here today. It is a great privilege for both of us. My name is Kate Marchesi and I am the president of Young Queenslanders for the Right to Choose. I am also the Queensland co-convenor for Australian Lawyers for Human Rights, who have also submitted to the inquiry in favour of decriminalisation. Here with me today is our vice-president, Olivia King. I would firstly like to thank the traditional owners of the land and pay my respects to their elders past, present and future.

We at Young Queenslanders for the Right to Choose represent over 770 young Queenslanders, the majority of whom, including ourselves, are university students who believe in the right to choose and in abortion decriminalisation. We were formed earlier this year, in May, to support the introduction of Rob Pyne's bill to decriminalise abortion in Queensland. Our purpose is to engage with young people on the issue of reproductive choice and to raise awareness around the issue of abortion decriminalisation. We have organised events attended by hundreds of Queenslanders including the rally outside Parliament House on the day the bill was introduced and recently hosted an expert panel discussion here in Parliament House on abortion law reform. We do not work in the area of unplanned pregnancy, we are not medical practitioners and we are not lawyers; however, we do represent an important voice which has not yet been heard in this debate: young people and in particular young women.

The overwhelming response to the campaign from young Queenslanders has been one of shock and disbelief that abortion is a crime in Queensland. There is a great disconnect here between the law and practice as well as the law and community expectations. A question we are asked frequently is: how can abortions be illegal when they are performed around Queensland every year? Up to one in three women will have an abortion in their lifetime. A lot of people asking this question either have had an abortion themselves or know someone who has. It has been very concerning for us to hear that Queenslanders are genuinely unaware that they or someone they know could have committed a criminal offence. I add: that threat of prosecution is not as far removed as some have commented repeatedly here today. The 2010 case of R v Brennan and Leach involved charges brought under sections 225 and 226—the sections we are talking about.

Discussions around pregnancy and pregnancy termination must always start with the lived experience of women. So far this debate has failed to do that. Those who are opposed to decriminalisation of abortion have instead decided to focus their efforts on distributing inaccurate and purposefully inflammatory material around abortion procedures, in particular around later gestation abortions, and promoting an incorrect reading of human rights as they apply to abortion.

Our submission to the inquiry addresses the various arguments for decriminalisation including the failure of law to reflect practice and community expectations, equitable access to health services and the impacts for disadvantaged individuals. Our submission, however, only scratched the surface of the wealth of international and domestic research on these issues.

Putting aside the complexities of the debate, we would like to bring it back to two fundamental questions: should individuals be criminally liable—that includes being publicly prosecuted and dragged through that experience—convicted and imprisoned for up to seven years for having an abortion; and, secondly, should practitioners face the same criminal liability for performing termination procedures? If your answer to that is no, then regardless of your view on the morality of abortion it must be decriminalised. The reality is that criminalising abortion does not decrease the number of abortions, it only pushes desperate people towards unsafe procedures and creates a system where access is determined according to your wealth, where you live and the colour of your skin. Decriminalisation would mean equitable access to health services for all Queenslanders—that is, services that are affordable, available outside the south-east region and without unnecessary delay.

We support the decriminalisation of abortion and repealing the sections of the Criminal Code which relate to it for both the patient and the practitioner. Ideally we would like to see no gestational limit set, but if this were necessary we advocate for the adoption of the Victorian model where abortion procedures are legal until 24 weeks, after which point referral by two doctors is required. We also strongly advocate for other regulations such as exclusionary zones around clinics for the safety of patients and workers. Thank you.

CHAIR: Thank you for that opening statement

Mr KELLY: Thank you, Olivia and Kate. It is a pleasure to have young people involved in this hearing and a pleasure to have young people concerned about any political issue and taking the time to be involved. I have a couple of questions. You are a little closer to school age than I am. We have had a lot of discussion around public health approaches to try to prevent unwanted pregnancies and terminations. Are you able to give me any indication as to whether current practices in sex education, relationship education at the school level, or even the public health information that is available to young women and men heading into post secondary school options, whether that is work or further study, is adequate, effective and having an impact on the decisions that young people make?

Ms Marchesi: I can certainly speak about school experiences with sex education. I can say for certain that abortion was never mentioned in my sex education. Adoption and parenting were the only two options other than abstinence. I think that is very inaccurate of the options that are available, obviously, and is inaccurate of generally what should be in a sex education program.

Ms King: I would add, because Kate and I both had very different schooling experiences—

Ms Marchesi: Sorry, that was at a public school as well.

Mr KELLY: Thank you. I was going to ask you that.

Ms King: I was privately educated and in my sex education abstinence was the only option that was presented to us and any extra information we were provided with was about the nuts and bolts of your biology and any biology, but not into too much detail about the male anatomy. It was not until I got to university the following year that I finished school that I actually learnt about different options and alternatives because the idea of having sex outside marriage was just not discussed therefore we weren't exactly educated about it. I would definitely say that my experience would not be adequate for anyone else. It wasn't adequate for me, at least.

Mr KELLY: It sounds very similar to mine. You raised the issue of the case in Cairns. I do not want to talk about that specifically, but let us talk more about the hypotheticals and specifically in relation to this legislation. If we move away from obtaining a medication for abortion, what are your thoughts on a general member of the community, with no licence to practise medicine, no qualifications, no understanding of what they are obtaining, obtaining medications over the internet and administering that to anybody for any particular condition?

Ms Marchesi: Obviously that is not a desirable situation to be in and I myself would only be in that situation out of desperation, which I believe is the situation that happened up in Cairns. At the time RU486 was not available. If it was I think that would have been a very different story.

Mr KELLY: On page 2 of your submission, and I think also on page 3, you list a number of recommendations. You make suggestions around the Victorian model and you outline the unrestricted access up to 24 weeks, referral by two practitioners et cetera, exclusion or safe access zones and counselling—not mandatory, I note. Does the private member's bill as it is currently written address those issues?

Ms Marchesi: No, but I think it is a very important first step. As I said, ideally we would like to see no gestational limit set and the reason for that being the flexibility around foetal abnormality, particularly at later stages of gestation. As we said, we strongly advocate for exclusion zones. We feel that is very important for the safety of women accessing these clinics, and not always for the purposes of abortion. They do also provide reversible contraception, as well as STD checks. So it is not always women accessing termination services who are affected by that. It is the workers as well, of course. So, no, the bill does not address those concerns but I think that it is also not contradictory to them as well.

Mr KELLY: Finally, we have heard some evidence—and I mean that in the sense of information given to this committee rather than clinical evidence, and I appreciate the distinction was made—around issues of access to contraception in particular. In your short time as an organisation, would you have been able to form an impression on whether or not there are significant issues, particularly for younger women and men, accessing and obtaining (a) good information about contraception options and (b) a full range of options in terms of contraception?

Ms Marchesi: Yes, definitely. At a high school age, which is typically when this information is given, the only information that I was given is that there is such a thing as a pill. You can take it, it is 100 per cent effective was the information that I was given. Of course, that is not true and there are a lot of other options as well. I think, importantly as well, the men and women were divided up when this information was given and that information was not given to the men. I think that is also a shortcoming of sex education programs as well, not involving the men in that conversation about the responsibility of contraception too.

Mr KELLY: Are you both at university now?

Ms Marchesi: Yes.

Ms King: Yes.

Mr KELLY: Is there any active information on university campuses in this day and age about sexual health and opportunities for people to obtain information, support, advice and services?

Ms King: At our university there is a university campus doctor. You know about that from the website if you go looking. As far as sex education goes, not—

Ms Marchesi: There are free condoms given out on market days.

Mr KELLY: That is good.

Ms Marchesi: That is also good, but aside from that there is nothing that is greatly advertised that has come to my attention in my five years of attendance.

Mrs SMITH: I have just a couple of questions for you this afternoon. Is Young Queenslanders for the Right to Choose associated with any political party?

Ms Marchesi: No.

Ms King: No.

Mrs SMITH: You made reference to the Victorian model and you would like to see laws around the Victorian model for Queensland to consider.

Ms Marchesi: In terms of exclusion zones, yes.

Mrs SMITH: Exclusion zones and I think you said gestation.

Ms Marchesi: That is not our first preference, but if the committee determined that gestational limits should be set then we would point them toward the Victorian model, yes.

Mrs SMITH: Where do you sit on the conscientious objectors?

Ms Marchesi: Where do I sit? I think it is important that doctors are able to exercise their own ethics, but in saying that, I do not think that that should affect their duty to their patients. I think that practitioners should have a duty to refer to a practitioner or service who is known not to share that objection.

Mrs SMITH: When we talk about human rights, the rights of the foetus or the child, do you have any particular views on that?

Ms Marchesi: Yes, which is mirrored by the United Nations, which is that the right to life does not apply to the unborn. The unborn lacks legal personhood. The right to life has been decided in international and domestic cases to apply from birth. Insofar as the rights of the child, we do have the Convention on the Rights of the Child. The child is defined as existing from birth and the rights of the child not attaching to or extending to the rights of the unborn.

Mrs SMITH: We are saying we do not want to see any practitioners charged. I think you made that comment in your statement. Yesterday a couple of the doctors raised the issue that in Victoria people who objected because of their religious beliefs, and they were medical practitioners, could then be prosecuted because of their beliefs by not then referring people on. Do you think that is equally fair or are we just getting into another circumstance of where people's rights are then starting to come into question? I guess what I am trying to say is aren't we then facing the same circumstances as people being charged because of their beliefs?

Ms Marchesi: No, because you are not dragging a woman through court for exercising reproductive choice. I think a doctor's first duty is always to their patient. If they don't choose to abide by that first duty then so they should.

Mrs SMITH: They should be prosecuted?

Ms Marchesi: Not necessarily be prosecuted, but I think they should abide by their first duty which is to their patient. If they fail to do this then they are not exercising best practice.

Mrs SMITH: Where do we then stand in the case of the religious institution, such as the Mater Hospital, for example, where again it is a religious belief? We heard from the Catholics yesterday their views on contraception and a range of other things, including abortion. Will we get into the situation and what is your view then on them being able to not perform them?

Ms Marchesi: If they are a health facility I think they should be able to provide the best practice to their patients. In saying that, I am not a public health expert so I am not familiar with how that would exactly work.

Mr HARPER: Thank you, Kate and Olivia, for coming here representing young Queenslanders. Out of your 770 members, I think you said, no doubt you have come to a conclusion that you want to remove sections 224 through to 226 from the Criminal Code. Is there a percentage out of your members? Do you actually have some data?

Ms Marchesi: Have we surveyed our members?

Mr HARPER: Yes.

Ms Marchesi: No, we have not surveyed them. It is sort of an assumption that if you are a member of Young Queenslanders for the Right to Choose that you support the right to choose. I think those three sections are in direct contradiction to that.

Mr HARPER: It is generally accepted in Queensland that abortion can be provided in order to protect a woman's health, physical and mental wellbeing. There are on average 10,000 to 14,000 abortions performed in Queensland each year. They use section 282 as a defence to perform those. Whilst it does not specifically relate to an abortion, it attempts to define it as a lawful medical procedure. What are your thoughts on that? Should we take out 282 as well within the confines of the argument?

Ms Marchesi: No, because it doesn't relate specifically to abortion. It has just been applied in the common law in an effort to find a section which would relate. No, I don't think it is related to the sections that we are trying to repeal here.

Mr HARPER: Do you think that doctors use that currently as a defence to perform the 10,000 to 14,000 abortions?

Ms Marchesi: I am not a doctor, but I think, first, that doctors are operating in a legally uncertain space, and, second, they are relying on that vagueness, I suppose, to offer them some protection to care for their patients and to provide terminations where legal.

Mr HARPER: Specifically, do you have any thoughts on gestational age limits within the bill?

Ms Marchesi: It is our opinion that ideally there should be no gestational limits set. If there were gestational limits set, we would recommend the Victorian model, which is 24 weeks.

Mr CRAMP: I am trying to get an understanding of your group. You have 770 members. Are you registered anywhere as a group? How did you gain your membership?

Ms Marchesi: It is mostly either through a following on social media or registration for our events. We have a list of members, as well.

Mr CRAMP: Are you a registered organisation, in regards to being an incorporated association?

Ms Marchesi: An unincorporated association.

Mr CRAMP: The member for Mount Ommaney talked about the child's rights, which was my main question. I am okay, thank you.

CHAIR: We are right on time. Thank you very much for coming today. I know that many people find it intimidating to come before the committee, so I very much appreciate that you have come today, also as young Queenslanders, to give us your views. You should come to hearings more often. Talk to your colleagues. Thank you.

I invite Dr Caroline Harvey and Ms Jody Currie of the Institute for Urban Indigenous Health to come to the table.

CURRIE, Ms Jody, Chief Executive Officer, Institute for Urban Indigenous Health

HARVEY, Dr Caroline, Institute for Urban Indigenous Health

CHAIR: Welcome, and thank you for coming before the committee. Dr Harvey, will you be making an opening statement?

Dr Harvey: We were going to combine that, if that is possible?

CHAIR: Absolutely, as long as it is no more than five minutes combined.

Ms Currie: I thank you for the opportunity to talk with you today and to put our things forward. My name is Jody Currie. I am the CEO of the Aboriginal and Torres Strait Islander Community Health Service. I am a traditional owner. This was my great great grandfather's country. My nana's country is in the Logan River. I have never left my country and I have been blessed that my family has always stayed in country. I am very lucky. I was the last Queensland maternal and peri-natal quality counsellor. I was the cochair of the subcommittee there. I am currently the CEO of the second oldest Aboriginal medical service in the country, Brisbane ATSICHS. We have services across the region. We are a member of the Institute for Urban Indigenous Health. We provide a service across our region for 28,000 Aboriginal and Torres Strait Islander people. At the last census, there were 60,000 Aboriginal and Torres Strait Islander people in the South-East Queensland region, which makes up 38 per cent of the state's Aboriginal and Torres Strait Islander population. I have also worked across Cape York for the Apunipima Cape York Health Council and I have also worked with Cape York Partnerships. That is my spiel.

Dr Harvey: My name is Caroline Harvey. I am the senior regional GP at the Institute for Urban and Indigenous Health. I have worked in women's health for most of my career and about half of that has involved caring for Indigenous women. I would also add that I am a medical expert and published researcher on contraception, so if there is time and you have particular questions around contraception I am happy to take those, as well.

Our submission supporting the bill to remove abortion from the Criminal Code is based on our concerns about the profound inequity that exists in the current service provision in Queensland and how that impacts on the majority of Aboriginal and Torres Strait Islander women who do seek termination of pregnancy. I think this has been raised before, but from questions I think there is still some misunderstanding about this.

The criminalisation of abortion creates uncertainty and misinformation amongst health providers and the community, and results particularly in public hospitals turning women away or creating arduous lengthy assessment processes. This is despite the Queensland Health guidelines. It ends up as the interpretation of individual medical practitioners or health services or hospital bureaucrats on what is lawful under the sections of law that we have been talking about. What results is a highly discriminatory two-tier system of access, where women in regional and metropolitan centres with knowledge and financial means—any of us in this room, our daughters, our wives, our friends—can readily access a termination of pregnancy, while women living in poverty and/or with more complex medical problems that require the care of the public system have extremely high hurdles to jump in order to access that same service.

Aboriginal and Torres Strait Islander women already face significant health and socioeconomic disadvantages, and the majority of our patients rely on the public health system when they do need a procedure that is not available in the kind of primary care services that we provide. The most disadvantaged of those may already be living in poverty, facing domestic violence, psychological stress, chronic disease, overcrowding in housing, homelessness and interaction with child protection authorities, including child removal. Therefore, for those women who make the difficult and often courageous choice to terminate a pregnancy, to limit their family size, to care for their children and other members of their family, to keep their heads above water or for other reasons, for young women, for those who want to break a cycle of intergenerational trauma, why should this not be available to them in the same way it is to others?

I have one brief story—and you have heard a few stories—from one of our clinics to highlight some of the issues about public hospital access. A 15-year-old Aboriginal young woman presented, requesting referral for a termination at seven weeks gestation. She was affected by developmental delay. She was trauma affected, using amphetamines and had an planned pregnancy. The circumstances of the pregnancy were not even clear, but may have involved some sort of coercion or assault. With discussion and family support, and a considerable amount of time, the GP agreed with her and the family's decision to terminate the pregnancy and contacted the local public hospital to arrange a prompt referral for the procedure. However, the gynaecology registrar at the hospital

declined to accept the referral, stating somewhat bizarrely that they would only consider it if a definite foetal abnormality was found. In Queensland, foetal abnormality is in itself not legal grounds for lawful termination of pregnancy, so clearly this doctor, employed within Queensland Health, does not understand the law and seemed oblivious also of the relevant Queensland Health guidelines.

In summary, we do support the decriminalisation of abortion in Queensland and see the necessary addition of public hospital provision as just one part of the service pathway mix, but that will only ever occur with the absolute legal clarity that decriminalisation will bring. We also support that the procedure can be regulated through existing health guidelines and some points made by others, I think repeatedly, about the need for data collection, so I will not go into that any further.

CHAIR: Thank you, Dr Harvey. Ms Currie, I apologise. You are not formally on my program, so I was unaware that you are the CEO. I formally acknowledge you as the CEO of the Institute for Urban Indigenous Health. Thank you for opening comments, too.

Mr HARPER: Welcome, Jody and Caroline. Thank you for your submission. We have heard both sides, pro-life and pro-choice, over the past few weeks. Jody, I have worked in rural and remote areas in Queensland. I would like to hear some of the stories that you may have come across in your time working in Indigenous communities involving the struggles. Can you share with us some of the experiences that you have seen in those areas?

Ms Currie: I think again across Queensland it is the point for our people about being able to access services and not actually having any real capacity to know how we best do that. My family was born on Palm Island, I have family in the Gulf Country and family in Logan. Actually, how we engage with the service system is a scary thing. I will say on the issue of hospitals, for a mob coming in from Cape York down to Cairns Hospital, there is the issue of removal rates of Aboriginal and Torres Strait Islander children from unborn notifications. Six years ago in the Logan Hospital—not to pick on Logan Hospital; this happens in places across the state—83 per cent of Aboriginal women presenting at the hospital were put on unborn notifications to child protection. Forty-seven per cent of children in care are Aboriginal and Torres Strait Islander children.

For Aboriginal women in general and particularly those from remote and rural settings, going into a hospital or to a GP is a daunting thing. On whether or not to decriminalise abortion, most people do not really talk about it as such. Probably, they do not think about it much. For the practitioners, it is about being able to engage with our people, particularly those from remote communities, but from everywhere. On the barrier of whether or not it is within the Criminal Code, they do not know how—I do not mean to sound like it is no good, but they struggle with being culturally appropriate with us, anyway. We struggle with having the capacity to engage with them, because we do live in separate worlds, certainly for those from remote communities coming into a mainstream thing. It is very daunting and it is very difficult. That is both for the Aboriginal woman and also for the practitioner. If there is a point in relation to terminations or abortions, I do not know how that conversation could even begin, if it was needed for the health of the woman. Really, the thing for me, talking with mob, is that it is not appropriate for it to be criminalised for practitioners and clinicians. They are trying their best to provide a service for people, but to have that extra barrier is of no benefit to us, I do not think. Does that answer your question?

Mr HARPER: Certainly it does. Thank you very much.

Mr CRAMP: Thank you very much for presenting here today, ladies. Jody, you very much centred your answer around my concerns as someone who is learning very quickly, especially about Indigenous rights and culture, from a parliamentary perspective. This is to both of you: is there a need for this parliament and this committee to look at the fact that there may be some stand-alone issues in regards to Indigenous culture and rights on this issue? Do we need to look at that as a part of the whole combined thing? Do we need to separate that and speak to the Aboriginal elders about rites of passage in relation to the abortion issue? That is a very general question, I know. There is a starting point here.

Ms Currie: For me personally, the issue in relation to Logan, for argument's sake—I am not so sure about Cape York—half the population is under the age of 19. That is ABS data from the last time. We will have new data. It is the most densely populated area, second is the Moreton region. Cape York, again from ABS data last time, had 15,000 people. You have 9,000 in Logan and 8,500 in the Moreton region.

I think on the issue of Aboriginal and Torres Strait Islander people being supported to talk about teenage pregnancy, which some may see in relation to rites of passage—and this is only the world according to Jody Currie—anecdotally, looking at our community, my opinion is neither here nor there. I do not know about mainstream. I would say conservatively in our community the thing about the

pro-life based stuff is very high in comparison to mainstream. There is this thing for us around babies and other things. It is then the point that for mainstream society after they invented contraception there was this thing about women and teenage pregnancy and it was a whole push. I think for us, as Aboriginal and Torres Strait Islander communities, to have a conversation, there needs to be some resourcing or some effort from parliament actually put into that conversation about what do your family structures look like, what does it look like to have a strength-based family? Again, we always love babies. As we say, it does not matter when they come. Is it really the best thing or is it the easiest thing—maybe that is a better way to say it—to have five kids under the age of 20, for everybody all round? I do not say that in a judgemental way. For us, there are rites of passage and culture and this thing of family and the extension of family. That is a good conversation for us to have. Whatever the decision is around the legislation that the parliament makes, for mainstream fellas you have the ageing population; we have such a young population. I hope that answers your question.

Mr CRAMP: It did. I will disagree with you on one point, Jody. I think your opinion is very valid. I would not downplay it, especially considering your position and your leadership, especially with your people. It is interesting that you put that forward. Personally, I think it is something that the committee really needs to look at and take on board. Thank you.

Dr Harvey: Could I add from the perspective of a health provider, something that I struggle with in my particular workplace is adapting my understanding and my cultural competence around the issue of pregnancy. I think the conclusion that I draw, though, is, as in every community, there are a range of views. Our role as providers and health professionals and legislators is to be aware of the need to continually gather information and adapt the way we work. In my experience, the number of women who choose abortion is less in the clinics that I work in now than in some of the other environments I have worked in. Those who do choose it do so for similar reasons and need similar support.

Mr KELLY: Thank you for the making the time to come along today and for your submission. As a nurse, I would like to acknowledge all the Indigenous health workers I have worked with over the years. They have certainly been of more value to me as a clinician perhaps than the patients. I appreciate the work that they do. I am particularly interested in women in more remote communities. Do they face additional challenges in relation to obtaining reproductive health services, particularly contraception and terminations if they are so desiring of those?

Dr Harvey: Yes, in my experience.

Ms Currie: Absolutely. Again, a conversation for us to have as a community is around the reproductive rights of women—contraception and so on. That is one part of it. There is also the issue of violence within our communities and the isolation of that and the use of pregnancy as a way of controlling women. This occurs in our most marginalised communities, whether they be remote areas or urban and rural areas, those areas with lower socio-economic groups, those densely populated areas. There needs to be access to good reproductive education and health. We need to empower both men and women. That is a thing that I focus on very much. I speak with young men all the time about condoms. They very much enjoy that conversation. Men also need to be responsible for what it is that they doing around contraception.

Mr KELLY: Do you think the legislation regulating abortion in the Criminal Code adds to the challenges either for Indigenous women in urban areas if they are socio-economically disadvantaged or in remote areas in terms of access to contraception and abortion et cetera?

Dr Harvey: From my perspective as a doctor, as a service provider, it does. In Queensland public hospital access is an issue. As Jodie said, public hospitals may not be the most friendly place for a woman to go to anyway, but if she requires a general anaesthetic or has complex medical or mental health problems as well and would benefit from the facilities of a public hospital they are not available to her. Equally, the private clinics may not be somewhere where she can readily go. If she has to find $600 or $700 then she may not be able to go there and may then present at a later gestation.

I think the services that support women at later gestation to find even more money and have a more risky procedure could attest to that. If you miss that opportunity to engage with a service and to provide what is needed for Aboriginal women at that time then you may miss the boat and things are significantly delayed with often devastating consequences.

In terms of the young woman I spoke about here I do not know what the outcome has been for her. She has been denied public hospital access and had to start on the merry-go-round of trying to get somewhere and trying to get money together. She has probably been lost to the system. I do not know the outcome, but it is probably not going to be good.

Mr KELLY: In terms of the regulation of abortion in the Criminal Code, as a health practitioner in this area would you say that it contributes to a culture whereby women feel uneasy about discussing abortion and abortion related issues more generally in the community, both in the Indigenous community and more broadly?

Dr Harvey: I think indirectly. As Jodie said and quite a lot of people have said—including the young women presenting before us said—a lot of women or the community do not actually realise it is not legal. What then takes place around this—the reluctance of this to be included in medical training, the reluctance in our public hospital systems for our obstetricians and gynaecologists to be trained in this area, the reluctance of people to talk about it, the shame that then follows—is very clearly linked to that illegality.

CHAIR: There being no further questions, I thank you both very much for bringing a particular view that we have not had brought to the committee inquiry to date. It is very valuable for us.

MOHLE, Ms Beth, Secretary, Queensland Nurses' Union

TODHUNTER, Dr Liz, Research and Policy, Queensland Nurses' Union

CHAIR: I welcome the representatives of the Queensland Nurses' Union. Ms Mohle, would you like to make an opening statement?

Ms Mohle: Thank you very. Firstly, I would like to acknowledge the traditional owners of the land on which we meet and pay our respects to their elders past, present and emerging.

We acknowledge that termination of pregnancy is a complex health issue. There are a range of views on the ethical acceptability of termination of pregnancy and we respect those views. We ask that those with a different view to ours also respect our view.

We are the largest union in Queensland, with around 90 per cent female membership. We know and accept that there are a few members who may not hold the view that we have expressed in our submission. However, like any of our political or social policies, there will always be those who dissent from the union's position. This is the democratic foundation of union governance and operation.

We did not arrive at our position on this matter without careful consideration. The QNU council requested the union's policy committee consider the bill and report back. In making its determination, council was informed by the decision of the policy committee, briefing papers and empirical evidence where available.

As the state secretary, I reported back to our annual conference in July on the deliberations of the council. The policy committee provided conference with a written account of its debate. QNU council discussed and approved our submission to this inquiry. These were unprecedented, yet necessary, steps in ensuring our membership was aware of the council's deliberations and decisions.

Our written submission only addresses the issue of decriminalisation, which is the intent of the bill. It does not address the other five terms of reference within the scope of the inquiry. However, to give the committee some guidance in these areas, we can state that in respect to the first term of reference regarding existing practices in Queensland—the termination of pregnancy by medical practitioners—we would suggest that more reliable and transparent data capture is required. The committee has heard previously that there are about 200 to 250 procedures in public hospitals and around 11,000 in the private sector, but this is not definitive. Much further work is needed to understand the scope of this issue and why unwanted pregnancy occurs.

Secondly, we agree with the points raised by Professor Milligan in her appearance before the committee on 13 July. Any further legislation or regulation should be drafted in the public interest to reduce harm to the individual, those who perform or assist with the procedure and the public. It will be the work of this committee and the legislative drafters to determine the specific details.

In respect to the third term of reference, we recognise the need to modernise and clarify the law to reflect current community attitudes and expectations. At this time, we feel the interests of the woman and those who assist her are best served where abortion is not a criminal offence. Women need safe, quality care for all their productive and health needs. This should be reflected in any consequential legislation.

In our view, term of reference 4 around legislative and regulatory arrangements in other Australian jurisdictions for regulating terminations based on gestational periods is the most vexed. At this stage the QNU council has not given consideration to this matter and I am not in a position to advise the committee. As we have consistently stated, we support the aim of the legislation to decriminalise abortion. Currently, we understand, there are no gestational limits on termination in Queensland although laws in other states do set parameters.

Finally, term of reference 5 is to provide counselling and support services for women. We see termination of pregnancy within a broad context that includes education, independent counselling and support services for the whole area of reproductive health. Increased education and access to services are critical for women of all ages and for all their health needs. Particular attention must be paid to ensuring equitable access to reproductive health services across Queensland, especially for the most disadvantaged women, including those from rural and remote areas, Indigenous women and those from lower socio-economic backgrounds.

We acknowledge the job of this committee is not an easy one. We thank you for having the courage to address this contentious issue. Legal reform is long overdue, but that in itself will not change the views of those in the community with deeply held beliefs. Decriminalisation will, however, provide dignity to women who face these situations and the health practitioners who assist them.

CHAIR: Thank you for your opening statement and for the submission. I know that the QNU always makes submissions to our inquiries so we appreciate that. I was interested in the process that you went through. Having more than 53,000 members I would imagine that, were you to speak everyone, it would have been much like our inquiry has been where there are some strongly and deeply and divergent views held. Can you talk a little about that? Have you been contacted by people? What has the feedback been like through your process?

Ms Mohle: We anticipated that there may be a question in regard to that. Our council is made up of 26 nurses and midwives who are elected every four years and broadly represent the whole cross-section of our members and from all across state. We certainly do report on what we have done. I addressed the annual conference last month quite explicitly on this and got no questions from any of the delegates from around the state in relation to this issue. Our policy committee also reported on it in their report to the annual conference. It dealt with that in the written form of the report.

Since it has become public in terms of the committee process there have been articles in the *Courier-Mail* and the *Catholic Leader*. We have only had three contacts from members—two via email and one by phone. That was around concern in relation to the position we have taken. One community member made contact with the union. We have followed up with those particular members and even the member of the community to explain to them why we have taken that position. In terms of the number that represents 1.0053 per cent of our membership who have made contact with us in relation to the matter.

CHAIR: Given you represent so many people on the front-line of health care in Queensland I wanted to know about the feedback you might have been given that might be valuable or of assistance to the committee with regard to termination generally? There obviously has not been much because you mentioned that you have not had much contact.

Ms Mohle: No, we have not. We have only had contact from three members and one community member who are opposed to our view. The feedback from members, certainly when it was discussed at council and in the policy committee—and Liz can speak to that in a second—was that it is well and truly time for this not to be seen as a criminal matter. It is a health issue. That was a firmly held view of our council at the time. Liz might want to talk about QPC.

Dr Todhunter: The policy committee considered the matter quite rigorously. We had a very respectful and mature debate about this issue. It was unanimous across-the-board that the time has come.

CHAIR: When you say unanimous across-the-board and the time has come what was that feeling premised on? What was the key concern that you feel is not being addressed by the current legislation that this bill does address?

Ms Mohle: The key concern is the fact that this whole matter should not be framed as a criminal matter. It has no place being in the Criminal Code and it is health issue between a woman and her doctor or health provider.

CHAIR: Does the QNU feel that other than taking away the criminality—I absolutely heard you that that is a key issue—that there would be other benefits for women of having a different legislative regime in the area of terminations in Queensland?

Ms Mohle: It would certainly remove a lot of uncertainty in regard to health practitioners because it really is a dog's breakfast the way that the legislation is written now. In fact, it is a lie really in terms of what is actually happening. A blind eye is being turned in terms of prosecuting. It certainly would give a lot more certainty to health providers who are engaged in terminations.

We really do want to stress that it should not be viewed narrowly as termination. It is about reproductive health more broadly and we have to situate this in that context. We need to be doing a lot more to support women and educating women in regard to reproductive health, particularly women, as I said in my opening remarks, from disadvantaged communities, particularly those women who might have difficulty in accessing reproductive health services from rural and remote communities, those from lower socio-economic groups, Indigenous women and women from non-English-speaking backgrounds. We want to situate the debate not in these narrow terms of just termination. It needs to be viewed more broadly. It is about the rights of women to have access.

As a candidate for the presidency of United States recently said, abortion should be safe, legal and rare. That is the way that we would like to see it situated. It needs to be that women need to have access to far—no matter how well planned, as we know, unplanned pregnancies can happen. No fertility treatments give absolutely 100 per cent protection against pregnancy. There is more that we can do to make sure that women are afforded the respect that they are due in terms of their reproductive rights.

CHAIR: Given some of the statistics that we have received—there are about 10,000 to 14,000 terminations per year—do you feel that changing the legislative environment within which we are operating could help—you mentioned 'rare'—in reducing the numbers? If so, what are some of those things we could be doing better? You may not have had the benefit of listening earlier—I know you have both very busy doing other things. Some of the advice or evidence or information we received this morning was a comparison of European countries and Australia and how some have a lower abortion rate. They felt that that was partially due to more accessible quality information and contraception et cetera.

Ms Mohle: That is absolutely why we think that it needs to be viewed much more holistically. There is a lot more that nurses and midwives can be doing in that regard too in terms of the scope of the role that we can play in assisting the education of women in regard to that. As I said, we do not want it to be viewed as narrowly as only being about termination. We think there is a lot more that can be done that can further reduce the number of terminations through the appropriate education of women.

Ms Todhunter: While ever it is illegal, we do not know what we are dealing with. I think the lack of proper empirical evidence points that. On the one hand—and I have heard a little bit of the evidence—we have a situation where people are saying, 'If you make it legal, the flood gates are going to open.' The other side of the coin is that it is happening now so what difference does it make? I think that we have to stop judging women, take the criminal element out of it and get some proper empirical evidence so we know what we are dealing with. Then we can provide proper services.

CHAIR: Finally, I have a comment, which I should not make because I am meant to ask questions. I noted with interest in your submission that you mention in regard to conscientious objection the policy of the Australian Nursing and Midwifery Federation. Obviously you are a very strong advocates for nurses, but I felt that that was a very balanced and affirming policy—I know that there has been a lot of discussion about conscientious objection—knowing many nurses myself, as you know, being related to many, the protection that you clearly articulate in your submission for those who may hold that view and really respecting that.

Ms Mohle: We absolutely wanted to make that point, that we respect people who hold different views. This has been a longstanding policy. It was endorsed in 1994 by the federation. The QNU, as a state branch of the ANMF, endorses the policies on a regular basis. If we have not provided that to the committee, we have a copy of it here.

CHAIR: It is in your submission too, as a summary.

Mr McARDLE: Thank you, ladies, for in coming today and for your submission. Beth, when you were speaking you combined both inquiries into one—that is, the bill itself and then the terms we were given by the parliament. I think you see the question well beyond the Pyne bill. You see the question about how we make a new system that covers all the issues, not just decriminalisation but issues such as data collection, exclusion zones, counselling and the like. Am I right in saying that when you support the bill you support the bill as far as it goes but you want to see more? You want the second tier of inquiry to dovetail into a potential new bill that covers a lot more than just the Pyne bill or are you simply saying the Pyne bill should go through and then an adjunct would need to be put in place to deal with other issues?

Ms Mohle: I do not know whether it would be necessary for further legislative amendment beyond that. We are saying that our fundamental issue is that it should not be viewed as a criminal matter, as we have said, and it needs to be viewed as a health matter. So we support decriminalisation. We believe that it does not begin and end there. There is a lot more that we can be doing in terms of health policy. It may not necessarily necessitate legislative amendment to do that. As I said before, there is a lot that can be done in terms of our nurse and midwifery led clinics to improve access to reproductive health services for women in Queensland. There is a lot that can be done, Mr McArdle, which will not require further legislative changes.

Mr McARDLE: The issue of objection based on conscience issues would require legislation, wouldn't it? How could you enforce that in relation to your own submission about a nurse not being forced to undertake a procedure that is against her own ethical standards or own moral belief?

Ms Mohle: We have made a submission to the committee saying that conscientious objection needs to be taken into consideration. We would assume that it would be within the terms of reference of this committee to make recommendations in that regard, that further legislative amendments related to that particular issue of conscientious objection are also required to protect other people's rights.

Mr McARDLE: You would require legislation to do that. That is my point.

Ms Todhunter: Or possibly regulation.

Ms Mohle: Or regulation, yes.

Mr McARDLE: That is still the same—going through the parliament, if I can put it that way. It would be the same for data collection. You would have to have some sort of regime for the data to be publicly available.

Ms Mohle: It could be done under the Health Act.

Mr McARDLE: Exactly, through legislation.

Ms Mohle: It may not necessarily be this legislation.

Mr McARDLE: I appreciate that. There is more to the issue from your perspective than simply decriminalisation. There are more things you want to have done—

Ms Mohle: It is a threshold issue.

Ms Todhunter: Yes, it is a threshold issue.

Mr McARDLE: The other thing I raise is this: the public health system involvement in this state in regard to terminations is minimal compared to, say, South Australia. Would you like to see that broadened? I understand that 99 per cent of terminations occur in the private sector and one per cent in the public sector. Is that an issue that you see we should be addressing here?

Ms Mohle: I think you need to be looking at the issue of equitable access to reproductive health services to answer that question. I think that some people, particularly from rural and remote communities, are disadvantaged by the fact that so many procedures occur in the private system.

Mr McARDLE: We have heard today that in Rockhampton you will pay the gap of $700 for a termination. The public system would do two things: it would allow the public greater access to termination on the same basis and would it not also give a sense that, if the government is supporting the procedure, the procedure by way of an ethical or legal standard has a better standing in the community's eyes?

Ms Todhunter: I think you could draw that inference from that.

Ms Mohle: You could draw that inference from that.

Ms Todhunter: As one of your submitters earlier today said, the government has a duty of care to all of its citizens. If it became legal then it would be reasonable to expect that it was offered through the public system.

Ms Mohle: One thing we certainly do not want to see happen in regard to this issue is handballing between the federal and state governments in terms of whether it is covered by the Medicare schedule or whether it is covered by Queensland Health in terms of funding. We do not want to see the funding arrangements driving the determinations here, as we all know, so aberrantly often happens in health—an argument about who is going to pay for it, whether it is going to be the state or federal government.

Mr McARDLE: Exactly. Do you have a point of view on exclusion zones around clinics? They have them in Victoria, as I understand.

Ms Mohle: That is something that our council has not considered as such. I did some reading over the weekend in terms of other submissions to your inquiry and I have heard some good evidence from others in terms of other states. Victoria, Tasmania and ACT deal with exclusion zones. It is not something particularly that we have covered. We just dealt with the threshold issue of decriminalisation. If you are after my personal view—and it is only my personal view, not the view of the QNU—I think that that is very necessary.

Mr KELLY: Thank you, Beth and Liz, for your presentation and for being here today. Just picking up on the issues around conscientious objection, to what extent beyond the practitioner who is directly involved in a procedure should the rights of conscientious objection extend? For example, if we take a surgical procedure, there is potentially anaesthetic technicians and other staff who help set up the theatre. Would they or should they have the right to also express a conscientious objection to participating or supporting this procedure in your view?

Ms Mohle: Our policy relates to nurses and midwives who are involved in the procedure. That extends to any of our members who might have deeply held moral or religious beliefs. I do not want to necessarily speak on behalf of other occupational groups, but I would say that it should still extend to anybody who similarly holds such beliefs. I think it is fairly easily dealt with in the health setting.

Mr KELLY: We heard some evidence yesterday in relation to unsafe abortions and some strongly stated positions that in fact maintaining abortion in the Criminal Code does not lead to women seeking unsafe abortion options in Australia. Are you able to provide any guidance in relation to that based on the information you have received from the midwives who are members of your union?

Ms Mohle: I cannot personally speak on that because I am not a midwife. Our assistant secretary is unfortunately in Bali right now. She is on annual leave. She would have been here if she were in the country. She would be able to provide some firsthand experience because she has been a longstanding practising midwife in rural Queensland at Mareeba. I am sure that our midwifery reference group could give firsthand evidence with regard to those practices. If the committee would like to hear further information about that, I am sure that we could provide further information from either our midwifery reference group or from Sandra when she gets back from leave.

Mr KELLY: That is fine. We have also had a number of discussions around mandatory counselling or counselling in general. Obviously in the current situation it would be medical officers who are providing information and seeking informed consent. There is potential there for women to be approaching midwives seeking advice.

Ms Mohle: Midwives are reproductive specialist health nurses as well.

Mr KELLY: Absolutely, and maternal and child health nurses.

Ms Mohle: Maternal and child health nurses as well.

Mr KELLY: Are these types of midwives and nurses qualified and able to give sound advice in relation to these matters to women who are seeking advice and guidance from them?

Ms Mohle: Absolutely they are, and they are already doing so in the community at present. I think there is a need for more of them to be providing that sort of support.

Mr KELLY: I know you are not—actually I do not know. I assume you are not a lawyer.

Ms Mohle: No, I am not lawyer. I can state that categorically.

Mr KELLY: I do ask your opinion in relation to mandatory counselling. If we force patients or people seeking any health procedure to undergo mandatory counselling, does that have any impact on whether consent can be considered truly informed?

Ms Mohle: In my view, absolutely. It could be seen as badgering. It just would be totally unacceptable—

Ms Todhunter: I think the committee heard some evidence earlier on today that some women are perfectly capable of making a decision without having to have counselling. It is forcing yet another regime on women who are already in a position where they are somewhat vulnerable and going through a whole decision-making process themselves. I think, on the basis of the evidence you heard earlier on today, mandatory counselling may not be the best option.

Mr KELLY: Liz, can you think of any other health procedure where a patient is required or mandated to have counselling or receive information or advice before going through that procedure?

Ms Todhunter: Beth would be best placed to answer that.

Ms Mohle: No, I am not aware of it. I wonder what the view would be if you had to have mandatory counselling before vasectomies and things like that.

Mr KELLY: I could give you an opinion on that.

Ms Mohle: There is certainly counselling that is required in terms of rare genetic conditions, but I cannot think of any circumstances where that would be warranted.

Mr KELLY: I have one final question. There is quite a significant difference in the number of terminations performed in the public and the private sectors. Do you have any insight into why such a significantly greater number of terminations is performed in the private sector versus the public sector? Does this have an impact on access for women?

Ms Mohle: It certainly has an impact on access for women. I think Mr McArdle just gave an example of how much it costs in terms of out-of-pocket expenses in Rockhampton. There is certainly inequitable access to services based on the fact that it is largely available in the private system. That is why we particularly stress the need for that to be looked at, because women from disadvantaged groups, particularly women from rural and remote communities, are greatly disadvantaged and their reproductive health rights should be viewed in exactly the same way as a woman from a metropolitan area should be.

Mr KELLY: Thank you.

Mrs SMITH: I have a quick question for you on conscientious objections which I have asked other people about over the last couple of days. I will use Mater Mothers' Hospital as an example. Does this extend to an organisation such as the Mater if they chose because of their beliefs that they should not have to provide termination services? Is that your view, or how do you see that playing out?

Ms Mohle: I read some of the transcript in relation to that in terms of other people who have given evidence. Our policy only relates to our members, but there is argument for organisations who hold similar views that there should be a requirement for people to be referred on to other services. I would personally think that that would be appropriate for organisations to be—

Ms Todhunter: It is not just in respect to this matter either. Conscientious objection is across-the-board; it is not particularly with respect to abortion.

Ms Mohle: The only time that conscientious objection came up for me as a nurse was in relation to ECT for mental health. As I say, it is not only in relation to this sort of procedure. There are other procedures where people might hold conscientious objections too.

Ms Todhunter: There are things like immunisation. That policy is across-the-board. Our policies are not enforceable in the general community; they are our views. They are the views of the QNU council and what we see as best practice.

CHAIR: There being no further questions, thank you both for appearing before the committee today.

HARDIMAN, Ms Leah, Representative, Maternity Choices Australia

CHAIR: Welcome. We are missing a few members, but if you do not mind we will give you an opportunity to make an opening statement and then we will ask some questions.

Ms Hardiman: Thank you for having me here today. Our organisation supports a woman's right to choose across all aspects of pregnancy and we support the removal of sections 224, 225 and 226 from the Queensland Criminal Code. There has been a recurring theme in the online submissions and hearings from yesterday and today that women are valuable and deserve recognition and respect. The current Criminal Code denies women that. I would like to acknowledge that this is a heated debate on both sides. It is emotional and at most times a difficult subject to talk about.

I would like to bring the focus back to women—the acknowledgement that a woman is capable of making decisions about her life and her body, decisions that are free from coercion from those with deep seated beliefs or an agenda to drive. In our submission I did not articulate that those women's stories that we shared were only representative of women who were able to access abortion services in the private sector and not of those women who were unable to access an abortion.

At this stage there is no quality data in Queensland in relation to abortion. We believe that the removal of these three sections would enable better information to be collated and distributed. Information is a gaping hole for women accessing independent information, and clinicians and governments being able to target health services that may be at a higher risk of unwanted pregnancies. We do not know the pathways for many women. We do not know how many women tried to access services and were unable to and so continued with an unwanted pregnancy. There is no current measure of the social, emotional, financial and health implications that this has on the future of that woman and child.

What we do know is that women's bodies are not vessels for adoption, guardianship or foster care for those unable to have children. There are many women who have decided that they do not ever want children and it is not their responsibility to bear children if that is not their wish to do so. We reject the suggestion made by others that the current legislation is a safeguard for women to hold up and use in defence in a domestic violence situation to their aggressor. If a partner is being violent, they are breaking the law and showing utter contempt for the law.

Maternity Choices Australia supports the proposal of mandatory counselling being offered. We do not believe that counselling outside of abortion providers should be mandatory as we have serious concerns about the availability, resources, funding or lack thereof to provide specialised counselling services in a timely manner. With counselling services in mind, I would like to address the notion of informed consent. Informed consent is a subjective term and relevant to the information held by the individual clinician or counsellor. We believe that it is important for women to access an organisation like Children by Choice to enable them to broaden the conversation they would probably already be having with a clinician. Women need resources and non-judgmental support when deciding whether to continue with a pregnancy or not. It was discussed yesterday during the session here that general practitioners could be upskilled in this area by completing a course. We saw a GP address that by acknowledging that their scope of practice is broad and there would be thousands of important things that they could know better. The health service needs to be working closely with NGOs to support women.

I would like to acknowledge that nobody knows what is best for a baby more than the pregnant woman. Many terminations are very much wanted and longed for pregnancies. If those concerned with community and values feel that it is okay to dictate and undermine the right of another's bodily autonomy, that is our biggest failure as a community. If this bill passes—and we hope that it does—any new regulations should be contained within our health legislation. I would hope that passing this bill would see an improvement in services and at the very least a reduction in barriers such as misinformation and stigma. There would also be the opportunity for better controls and safeguards. I would hope that this would be in collaboration with all stakeholders whilst keeping women at the centre of care. A law that could lead to seven years in prison is not the answer.

CHAIR: Thank you very much for your opening statement, Leah.

Mrs SMITH: I love how happy you are.

Ms Hardiman: This is a really good opportunity, and I am glad that everybody is being heard—yesterday and today—and the clinicians and lawyers who gave evidence previously. I think we are at a good place.

Mr CRAMP: Thank you, Leah. That is a very positive way to end the day.

Mr McARDLE: Don't ask any questions!

Mr CRAMP: I think we will just end it there!

CHAIR: As a constituent of mine, Leah is always this bubbly.

Mr McARDLE: And right.

Ms Hardiman: And right all of the time.

CHAIR: Yes, of course all constituents are right.

Mr CRAMP: I find your position and your commentary interesting. You said that you believe in mandatory counselling being offered. Do you mean the offer of counselling being mandatory?

Ms Hardiman: Yes.

Mr CRAMP: And then it is the woman's choice to take it up?

Ms Hardiman: Counselling being mandatory by the clinician to offer but knowing that there are limitations within our health service to provide that service to women.

Mr CRAMP: You identify that as well. Is there an onus on the regulator—being the state government—to look at that? If we are going to offer these services, we had better ensure that there is the proper financing for current practising counsellors and those people who can provide that informed choice to the woman, or do we make sure we have people coming through who can take up that challenge in our universities or perhaps take it up as a career?

Ms Hardiman: I think it is a workforce issue. On many times we have been told when dealing with perinatal infant mental health and other counselling services that are required that there is not too much of a workforce issue. They believe the placements are just not available within the Queensland government.

Mr CRAMP: A lot of people have said they want to see the current criminal provisions removed. We have had varying answers to the next question. Should there be safeguards and checks in place under the Health Act and health legislation? You have identified that possibly there is room for safeguards and checks to make sure that a woman is making an informed choice.

Ms Hardiman: Absolutely.

Mr CRAMP: I am happy for you to expand a little more on that. From your organisation's point of view has there been any input from members? What is the organisation's thoughts around what safeguards and checks there should be? If we take out criminality, what do we have in there to make sure (a) a woman can make an informed choice in a safe environment and (b) how do we protect her from rogue practitioners or if something goes wrong in that sense?

Ms Hardiman: That is a really tricky question. That is why I went on to talk about informed consent and why I addressed that because informed consent is subjective. To safeguard informed consent, we have not done that in maternity, yet it is not in criminal law. There are safeguards in place in terms of 'do not harm' with doctors. I think all stakeholders need to come to the table to see exactly what that should look like. I do not think one person has the answer to that. I think that takes a lot of people at the table or at least all key stakeholders—RANZCOG, Children by Choice, any of the NGOs that have presented yesterday and today, and the QNU. I do not think what needs to be in there can be answered just by me, to be honest.

Mr CRAMP: What about the pro-life groups? There have been connotations around them being religious groups, but from my understanding from what I have learned there are quite a few experts who have a differing point of view. Should we have a holistic approach and a comprehensive approach where everyone comes to the table?

Ms Hardiman: Absolutely. I consider myself a Christian as well. I have these views as a Christian. Our group does not affiliate with any religious or political party, but personally for me I think everybody should be at the table because I think everybody has something to offer and we have seen that here. There are different perspectives that were raised yesterday. I do not think we are too far from the same vision with respect and autonomy for women. Everybody spoke about it yesterday. People spoke about it today. Clinicians talk about it. I think if it is done right it can be done well.

Mr CRAMP: I have one last question—and I do this with the hope that the member for Caloundra is going to ask the question because he seems to ask a lot of mine before I get the chance. The member for Caloundra brought this up today and I brought it up today. I am interested to hear each organisation's thoughts about the opinion of the partner in the relationship. A lot of the time it is a male partner and father of the child. As long as it is consenting and there is no illegal activity such as rape, where does the man's opinion or input fit in, or even the ability to get some counselling and understanding around the situation?

Ms Hardiman: I imagine that would happen within a partnership. If it was a partnership and there was no domestic violence, I would imagine that the conversation would be quite open between a woman and her partner about what the decision is. I do not think that women make this decision in isolation or by themselves without considering all of the factors around them. I think they definitely consider their partners, and if it is someone who is in their life it would be a decision with them. I think if they chose counselling then the partner should go along if he wants to. That is really a case-by-case basis because everything is really different from one person's story to another. Some are similar, but they are really personal.

Mr CRAMP: Does the organisation have a particular position on that involving the male in the relationship?

Ms Hardiman: It is always the woman's choice. When we are talking with regard to maternity services and what is happening in the labour ward and what is happening pre pregnancy and post pregnancy, we say it is ultimately the woman's choice about what happens with her body. Ultimately, that is the answer. The final decision will lie with the woman and we support that.

Mr KELLY: Thank you for attending today. I say thank you for the very real stories that you put in your submission. I think they do a particularly good job of highlighting the very challenging decisions but very sound decisions faced by women contemplating a termination. Sadly, no women who have had a termination have come forward and given evidence directly that we know of to the committee. Do you think that speaks to the fact that the criminalisation of terminations creates a culture where women are not able to discuss terminations freely and openly?

Ms Hardiman: Absolutely. There is a lot of stigma associated with it. People are scared of being called names. They are scared of being called anything like racist. People do not like those terms and those labels. When they are called a killer or they do have that negative connotation associated with a life decision which is a very difficult life decision to make—I am not sure. To be honest, I think we are a way off removing any stigma from this, but I think this is the first step. There is going to be a lot of social and cultural work to do around this where women are actually supported in this decision and do not feel judged by the community.

Mr KELLY: I spent a lot of my career working in an environment and in occupations that are female dominated. The amount of time I have spent in the tea room has generally been in the company of women. I have heard many and varied conversations, but I have never heard anybody ever discussing issues around abortion. Obviously they may not do that when there is a male nurse in the room. Do you think that if people do not feel comfortable discussing abortion and issues around reproductive health more generally that impedes the capacity for people to learn from their peers and gain collective wisdom?

Ms Hardiman: It definitely does. We have seen the barriers. It is not out yet, but the Queensland Sexual Health Strategy definitely has identified—it will be out soon; submissions closed recently—the barriers related to reproductive services and barriers to services in general and in conversations. There was an element of the Sexual Health Strategy that deals with pregnancy. That was related to women who have STIs in terms of the disclosure around that and their ability to then get antenatal care or to want to seek it because they are embarrassed about having to discuss something really intimate with a different person each time.

Mr KELLY: I note that your organisation is a national organisation. Do you have a chapter in each state or do you have some sort of national governing body? How do you communicate around the country?

Ms Hardiman: I am the national president. We are a 100 per cent volunteer organisation with no funding. We have groups in most states that work together. There are committees in most states and we have an overarching national committee and then we have state committees. We do not have anyone in the Northern Territory to be honest. We function the way that most organisations do with monthly meetings. I do this all day every day; it is what I do and it is what a lot of people are doing. They are in the position to do it as well as they have someone else financially supporting them.

Mr KELLY: Given that a number of states within a reasonably short time frame have actually shifted their legislation and moved away from criminalisation of abortion, what is the feedback you get from those states that have gone down that path in terms of the improvements, if there are any, in terms of access for women, particularly in vulnerable groups, to full reproductive health services and safe access to clinics? What is the feedback you get? How have things changed in those states?

Ms Hardiman: They do not see it as something dirty to talk about. It has been a little while for some of those. When we speak to Victoria, they do not have nearly as much stigma attached to it as we do and I think that is a major improvement. It is hard for me to speak about numbers, but members feel safe accessing it. I think one of the things that scares women in Queensland is that they do not feel safe trying to access that service. That is the general feedback.

Mrs SMITH: I was going to follow on more about what your organisation actually does. I saw the personal stories. What does the organisation do?

Ms Hardiman: There are a few different things that we do: lobby federal and state governments for improved maternity services, primarily continuity of care—I will not get into the politics of all of that. We help advocate one on one for women who are unable to access services that they would like to access. For instance, one woman wanted to hold her baby after she had a caesarean and they said, 'There is air-conditioning in the room. You can't.' I just called up someone in whatever state she was in and liaised with the director of obstetrics and we got it sorted. There is a lot of ground stuff; there is a lot of advocacy work to do case by case. On a state level, we work with—quite a few of us actually really like data. I have gotten into the data side of things. We work with the Queensland government and other state governments and then federally with the Australian Institute of Health and Welfare and the Independent Hospital Pricing Authority. What we do is quite broad and it just grows. There are the quality councils in each state for maternity services and perinatal and maternal mortality and morbidity. It is pretty broad. It is across all levels. One of the main things that we tried to do is to have good succession planning and to train up other consumer representatives throughout Australia. One of the biggest problems is that this issue is so broad to get across that we want more people doing it and more people having the knowledge so that they are able to be informed to do the lobbying that needs to be done.

Mrs SMITH: Your organisation does not actually provide—would I ring you if I was pregnant? Who would contact you and how would they contact you? Why would they contact you?

Ms Hardiman: It is all different. Women contact us when they are pregnant because they are trying to access services. For instance, they might want to know what their options are in their community, what are their models of care. Routinely we have seen—and we have seen the data from the Queensland centre for mothers and babies, which is now defunct—that there was a large proportion of women who were not told about their models of care when they went to their GP. It was pretty much, 'Do you have private health insurance or not? If you do, these are the obstetricians you have to choose from. If you do not, here is a referral to the public hospital.' There was nothing more than that, whereas the maternity system is a lot more intricate than that. That is some of the ground work we do. Then in relation to the states we are contacted by them to be on committees as consumer representatives. We do some work with the Australian safety and quality commission as well around the standards of accreditation for hospitals.

Mrs SMITH: I want to touch on your comments in regard to the stigma around abortions and terminations. Would you not think—and I just ask—that most women make the decision to go ahead with the termination and they then just want to get on with their lives and do not feel the need to share that experience again further down the track with future partners or future kids? A lot of people do not want to talk about it simply because that is it. I am just trying to understand—

Ms Hardiman: It is private and personal.

Mrs SMITH: That is what I am saying. Where is the benefit then—

Ms Hardiman: Of reducing it?

Mrs SMITH:—of drawing out people to want to—it does not necessarily mean that people will want to sit around talking about their experiences.

Ms Hardiman: No, I do not think that they necessarily would, but there are definitely cases where women need to do that as well, where they do need to drill down to what happened and what their decision was, and those conversations are hard to have. Also because you do not know what someone else's personal beliefs are when you are talking to them—not that you are necessarily going to change their personal beliefs, but we would hope that there would be more understanding as to why a woman who was 20 weeks pregnant and found out she had lymphoma stage four needed to terminate that pregnancy without feeling that she should have forfeited her life for that baby.

Mrs SMITH: I come back to the fact that you have shared a lot of stories in there, especially the lady who was 90. Obviously she felt the need at the age of 90 to share her story.

Ms Hardiman: We still talk about it.

Mrs SMITH: That has not changed regardless of whether or not we have laws in place because we are clearly sharing those stories.

Ms Hardiman: Yes, but not openly though. That is de-identified; no-one is ever going to know who that is. As Mr Joe Kelly said, there is no-one here in front of you who has had an abortion saying, 'I've had an abortion and this is what happened,' and there is a reason for that, and that stigma is the reason. They are worried. They are. It is illegal. It is something women should be worried about.

Mrs SMITH: That is your view. I do not know if I necessarily share that.

Ms Hardiman: That is the beauty of this.

Mrs SMITH: I think people do not want to talk about it because they think, 'It is nobody else's business and I don't wish to share it.'

Ms Hardiman: Absolutely, and that should be respected. If women do not want to talk about it, of course they should not have to talk about it. It is their decision and it is their body. I agree with that.

Mr HARPER: Thank you, Leah, for your presentation on behalf of Maternity Choices today. In your submission you did touch on late abortions, and I have tried to get a balanced view from everyone who has come before us. As we heard yesterday, quite a few of the faith based submissions talked about the late-term gestational periods. Does your organisation have a view on whether there should be some reservations or regulations around the bill in terms of late gestational periods?

Ms Hardiman: I guess that is where it should sit in the health legislation when we talk about late—I guess similar to what Victoria has. I have not lived in Victoria, but I know that as well as what other people do. My overarching thought is that there needs to be some sort of general respect that a woman is not making that decision lightly; she has not got to five months of pregnancy and then thought, 'Don't know if I want to keep this baby.' I think that is the sort of stigma that I would like to move away from as well, that women are going to choose at any moment to say, 'I'm 36 weeks pregnant. Don't want to be pregnant anymore,'—women do not actually do that—or, 'I don't want this baby anymore.' If they do say that, at 36 weeks they are moving on to other options by then. I do think that women need to be given the respect that we are intelligent people who can make good decisions. I think that they would be working with a clinician at that stage as well. This is the problem with data. We are all sitting in front of you telling you our opinions and our beliefs and what we have seen—and I guess that is why you hold these things—but it is still limited.

Mr McARDLE: Thank you very much, indeed, for your submission and your words here today. Am I right in saying that you believe the Criminal Code itself posed a stigma in regard to abortion, or did I mishear that?

Ms Hardiman: I think that it does, but that is not the biggest problem. It does not belong in the Criminal Code. Women should not be prosecuted.

Mr McARDLE: What is the biggest problem; the fact that it is potentially a criminal offence?

Ms Hardiman: Yes, there is a potential for a woman to end up in jail for making that choice.

Mr McARDLE: The fact that the Criminal Code exists in its present form regarding terminations, do you say, does not give a stigma to an abortion? The reason I say that is—

Ms Hardiman: It would.

Mr McARDLE:—there have been many people here yesterday and today who said they are shocked that no-one knows about the Criminal Code and have no comprehension of the Criminal Code existing. When I asked a witness earlier how many in fact, upon being told that, decide not to terminate, I was told none in that person's experience. Does that surprise you?

Ms Hardiman: No, not really. No, that does not really surprise me.

Mr McARDLE: You then made the comment that people will still be called a killer. That is more to do with a moral position in relation to abortion than the Criminal Code, is it not?

Ms Hardiman: Yes, it is.

Mr McARDLE: The Americans are prime examples of that. The American system is much more polarised than we are, both orally and by way of physical action. You made the point about stigma, but the stigma is more associated with a person's moral belief that a person who has an abortion, irrespective of what the law says, is a killer; would that be right?

Ms Hardiman: Yes.

CHAIR: In the absence of data should we be waiting to establish a new regime, or is that absence of data a reason we should be establishing a new regime?

Ms Hardiman: It is in the absence of data that there needs to be a new regime. The data will not happen without this change. We work on data. Other people with MCA and I work on data all the time. To give you an example if I can, because I do not want to keep everyone here all afternoon, I am sitting on a committee—most of it is confidential—with the Australian Institute of Health and Welfare. We cannot produce stats for women who have lost their babies for many, many different reasons. Some are preterm, some are at term. We cannot tease out that data currently because of terminations. We cannot give women true informed decisions about mode of delivery, vaginal or caesarean, because these laws exist. We have to get rid of these laws to enable that data to come. We cannot do it any other way; therefore, until that happens we are unable to give women an informed choice throughout maternity in general.

CHAIR: There being no further questions, the time allocated for this hearing has expired so we will draw proceedings to a close. Thank you very much for coming before the committee. I am sure I will see you in my electoral office in the near future to talk about continuity of care and many other matters.

Ms Hardiman: Next Friday.

CHAIR: See you next Friday! I thank all of today's witnesses for their contributions. The committee appreciates everyone's assistance at today's hearing as well as all hearings before today. The proofed transcript of today's hearing will be published on the committee's web page as soon as possible. Witnesses will be sent the proofed transcript and are invited to make any necessary corrections. I would like to thank Hansard for their assistance today and our secretariat. I declare the hearing closed.

Committee adjourned at 3.48 pm