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Re: Submission to the *Abortion Law Reform (Women's Right to Choose) Amendment Bill and Inquiry into laws governing termination of pregnancy in Queensland*

To Members of the Committee

Thank you for receiving my submission to the *Abortion Law Reform (Women's Right to Choose) Amendment Bill and Inquiry into laws governing termination of pregnancy in Queensland.* I appreciate the time and effort Members of the Committee and their support staff are giving to this Inquiry.

Background to this submission

I work as a counsellor for Children by Choice, Queensland's only standalone, pro-choice pregnancy counselling service. I am a member of the National Alliance of Abortion and Pregnancy Options Counsellors (NAAPOC), which is also making a submission to this Inquiry. I hold a Bachelor of Psychological Science (Honours) and a Graduate Diploma of Applied Law. Inevitably, my experiences as a pro-choice counsellor and in other roles in the social and community services sector will influence my personal submission to the Inquiry.

This submission primarily addresses the first, third and fifth terms of reference.

The voices of women

The public debate that has ensued following the introduction of the Bill to the Queensland Parliament has featured many voices shouting opinions about abortion. I am concerned that only a few of these voices have spoken for the Queensland women who are central to this debate and its outcome. I do not intend to speak for Queensland women, but to amplify the voices of women who have spoken to me.

Abortion is an extremely stigmatised choice[1]. The stigma directed at woman who consider abortion or choose to have an abortion can be harmful to those women, and is associated with adverse mental health effects and the internalisation of harmful messages about the self[2]. Unlike stigma, abortion itself is not inherently harmful to a woman's physical or mental well-being, as evidenced by extensive research[3].

This stigma is evidenced by the online vitriol and judgement that has been unleashed since the introduction of the Bill. It reinforces the silencing of generations of women who have sought only to make the best choices they can in consideration of their own personal circumstances. In the interests of the well-being of Queensland women, I ask the Committee to make recommendations based on evidence-based research from the scientific community, rather than on the mere opinions (i.e. not evidence-based) of those who represent a minority of the Queensland population[4].

In the sentences below, I try to give voice to experiences that disadvantaged women in Queensland may have when they try to proceed with their choice to have an abortion. These stories are drawn from many conversations with many different women over time in my experience as a pro-choice counsellor and demonstrate the need to modernise and clarify the law, i.e. to remove abortion provisions from Queensland's *Criminal Code 1899*, so that abortion can be safely and legally provided to women in need.

The voice of an Indigenous woman, who has to travel great distances from her remote community just to access an ultrasound. *She faces so many barriers to making her reproductive choice. What would it be like to walk her shoes?*

The voice of a woman who has experienced terrible domestic violence, including sexual violence, perpetrated against her by a partner or ex-partner. *She lives in the catchment area of a hospital that doesn't provide "social abortions" so she faces the additional stress of raising money to access a private abortion.*

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[1] Norris, A., Bessett, D., Steinberg, J., Kavanaugh, M., De Zordo, S. & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Womens Health Issues,* 21(3 Suppl): S49-54. Retrieved from https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf;
Kumar, A., Hessini, L. & Mitchell, E. (2009). Conceptualizing abortion stigma. Culture, Health & Sexuality, 11(6): 625-639. Retrieved from http://www.ipas.org/en/Resources/Ipas%20External%20Publications/Conceptualising-abortion-stigma.aspx

[2] *Ibid*

[3] See, for example, American Psychological Association, Task Force on Mental Health and Abortion. *Report of the Task Force on Mental Health and Abortion.* Washington, 2008. Retrieved from http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf;
Cohen, S. (2013). Still true: Abortion does not increase women's risk of mental health problems. *Guttmacher Policy Review*, 16(2). Retrieved from https://www.guttmacher.org/sites/default/files/article_files/gpr160213.pdf;
World Health Organization, Department of Reproductive Health and Research. (2012.) *Safe abortion: technical and policy guidance for health systems.* Second edition. Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

[4] Betts, K. (2009). Attitudes to Abortion: Queensland and Australia in the 21st Century. *People and Place,* 17(3), 25. Retrieved from http://hdl.handle.net/1959.3/67153

The voice of a homeless woman who engages in sex work to raise money for a private abortion *because her local hospital does not usually consider termination of pregnancy for circumstances other than fetal abnormality and she does not have the money to afford a private abortion.*

The voice of a woman with complex mental health and substance abuse issues*. These grounds are not considered significant enough for her request for a termination of pregnancy at the local hospital to be assessed.*

The voice of a woman living in a domestic violence refuge or unstable housing who asks a doctor for help to access an abortion *and discovers the doctor does not want to help her or does not have the knowledge to help her.*

The voice of 'Q' *as articulated by Dr David MacFarlane in his eloquent submission to the Inquiry, a case I have only read about.* ***Q is not alone in her difficult experience of abortion access in Queensland; the voices of other young women must be added to her voice.*** *This is how the presence of abortion in the* Criminal Code 1899 *affects the lives of women.*

The voices of many women I know personally*, who are not criminals and who, for many different and personal reasons, have made wise and considered decisions to end a pregnancy.*

Stories such as these point to terrible social injustices that exist within our society which need to be addressed. Some anti-choice individuals and groups posit that rather than providing abortions these underlying issues must be addressed and that in the meantime pregnancies should be forced to continue. They do not use the words "forced pregnancy", but this is what it means to deny a woman the right to choose abortion when she believes this is the best choice she can make.

My response to this is that the underlying issues of child abuse, gender inequality, violence, poverty, unemployment, homelessness and discrimination must be addressed. And safe, legal and accessible abortion services must also be made available to those women who decide to end a pregnancy. The voices that I have shared demonstrate how disproportionately the criminalisation of abortion affects women who are vulnerable, financially distressed and/or geographically isolated. Their struggles must be heard by the Inquiry.

Anti-choice individuals and groups often suggest that these women should choose to continue the pregnancy and proceed with adoption. No person has the right to coerce another person into continuing a pregnancy or to assume that the experience of pregnancy and birth will be a positive one. The United Nations has determined that the denial of safe and legal abortion services is a breach of human rights[5], and I agree with this determination. *I recall the voices of a number of women who have shared with me their experiences of*

[5] Méndez, J. (2013). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. United Nations: Geneva. Retrieved from http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

traumatic and life-threatening births of their children, and the terrible fear they experienced at the thought that their existing children might be left without a parent. It is entirely understandable that these women chose abortion when a subsequent pregnancy occurred. I also recall the voices of women who have chosen to continue a pregnancy and to proceed with adoption; what is important is that all of these women are able to make their own choice, based on their own self-knowledge.

I recommend the Committee consider the work of the Turnaway Study, led by Dr Diana Greene Foster at the University of California[6]. This study continues to produce high quality, peer-reviewed, evidence-based research which highlights the effects of unplanned pregnancy on women's lives and the effects of not being able to access abortion when women make the choice to have an abortion.

The imaginary women

Anti-choice individuals and groups have made outrageous claims that removal of abortion provisions from the *Criminal Code 1899* would allow for abortions throughout pregnancy up until birth[7]. The claims are false, as demonstrated by the following:

- Section 313 *Killing unborn child* remains in the *Criminal Code 1899* and there has been no proposal that this section be removed. Under law, abortions cannot be provided up until the point of birth.
- Private abortion clinics in Queensland are licensed by Queensland Health. The maximum gestation for surgical abortion provided in a private abortion clinic in Queensland currently is 20 weeks. Abortions provided at gestations of 22 weeks or higher can only be provided by a service with a level 6 capability under the Clinical Services Capability Framework, i.e. public hospitals meeting the criteria for this level[8]. Where higher gestation abortions are provided in these hospitals, they are provided in accordance with well-documented assessment and decision-making processes that involve qualified and experienced staff[9].

It is therefore unnecessary to specify gestational limits at law as these are already effectively managed within a health regulation framework. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recently released a

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[6] See http://www.ansirh.org/research/turnaway-study

[7] See, for example, e-Petition: Say no to the most dangerous abortion laws in the world. Retrieved from https://www.parliament.qld.gov.au/work-of-assembly/petitions/closed-e-petitions

[8] Department of Health. Fundamentals of the framework: Clinical services capability framework v3.2. Retrieved from https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/cscf-fundamentals-of-the-framework.pdf;
Department of Health. CSCF companion manual v4.3: Termination of pregnancy services. Retrieved from https://www.health.qld.gov.au/publications/system-governance/licences/private-health/cscf-comp-terminat-pregnancy.pdf;
Department of Health. Fact sheet 2 – Explanation of service levels: Clinical services capability framework. Retrieved from https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/CSCF-fs1-service-levels.pdf

[9] Queensland Maternity and Neonatal Guideline: Therapeutic Termination of Pregnancy, 2013. Retrieved from https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf;
Robertson, J. (2016, 22 June). Live births after abortion misleading Queensland legal reform debate, says specialist. *The Guardian.* Retrieved from https://www.theguardian.com/world/2016/jun/22/live-births-after-abortion-misleading-queensland-legal-reform-debate-says-specialist

statement in support of the availability of higher gestation abortions in particular circumstances, such as serious fetal abnormality, and raising concerns about legislating gestational limits[10]. At any gestation, a medical professional retains both the right to conscientious objection and the responsibility to refer on to another medical professional who does not hold a conscientious objection to the treatment proposed[11]. Therefore conscientious objection provisions are not required at law.

Further to this evidence, a key question must be answered: who are these imaginary healthy women whom anti-choice individuals and groups believe would choose to terminate healthy pregnancies in the trimester prior to birth? Are these imaginary women Members of Parliament or their significant others? Are these imaginary women the women who they see at work, at the school gate, on the bus, in the supermarket? Are they friends or relatives? Who are these imaginary women? They are not women I know. These claims seem to be underpinned by a disturbing distrust of women as individuals and as a group.

The women whose reasons are 'not good enough'

Approximately one per cent of abortions in Queensland are provided in public hospitals[12]. In my experience communicating with hospital staff, terminations of pregnancy in hospitals are primarily provided on the ground of fetal abnormality. I hold significant concerns regarding the use of this as the sole ground for assessing a woman's request for termination of pregnancy.

The first of these concerns relates to the provisions that termination of pregnancy in Queensland is only lawful if the woman's physical or mental health is at risk of serious harm, with due regard given to her psychosocial circumstances[13]. Terminating a pregnancy on the basis of fetal abnormality alone therefore is not lawful. In order for these pregnancy terminations to be lawful, they must be justified on the grounds of risk of serious harm to a woman's mental and/or physical health, with due regard given to her psychosocial circumstances.

In instances where a hospital uses this justification, but fails to provide termination of pregnancy in other situations, a two-tier system is created, where women who have been diagnosed with a fetal abnormality have a 'good enough' reason for termination of pregnancy. Women who may have other physical and/or mental health issues and

[10] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Position statement: Late termination of pregnancy, 2016. Retrieved from https://www.ranzcog.edu.au/college-statements-guidelines.html

[11] Queensland Maternity and Neonatal Guideline: Therapeutic Termination of Pregnancy, 2013. Retrieved from https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf;
Australian Medical Association Position Statement: Conscientious Objection, 2013. Retrieved from https://ama.com.au/system/tdf/documents/AMA_position_statement_on_conscientious_objection_2013.pdf?file=1&type=node&id=40602

[12] Dr Tony O'Connell, the Chief Executive of Queensland Health's Centre for Healthcare Improvement, in response to media enquiry from Wendy Carlisle from the ABC. Cited in 'Abortion on Trial', broadcast on *ABC Radio National* on 7 Novemeber 2010. Full transcript available online at http://www.abc.net.au/radionational/programs/backgroundbriefing/abortion-on-trial-in-queensland/2982710

[13] Queensland Maternity and Neonatal Guideline: Therapeutic Termination of Pregnancy, 2013. Retrieved from https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf

psychosocial issues are therefore deemed to not have 'good enough' reasons for requesting an abortion. Instead, in my experience, they are deemed by some hospitals to be requesting a termination of pregnancy on "social" grounds, a judgement which I believe minimises the experiences of women living with significant and life-threatening mental health and/or physical health issues, alcohol and other substance abuse issues, domestic and/or family violence issues, and other complex issues.

I query what statement is being made about disability and diversity when certain hospitals only offer termination of pregnancy on the ground of fetal abnormality. When the woman is central to the decision about a pregnancy, this value-laden systemic approach is removed. The woman is best placed to decide what her strengths, capacities and values are regardless of whether the circumstances involve a fetal abnormality, mental health issues or myriad other reasons.

A similar argument can be made in circumstances where individuals or groups state that abortion is not acceptable except in circumstances where the pregnancy is the result of rape. This value-laden systemic approach negates the woman's expertise in her own life and diminishes her voice in the decision-making process. The decision to either continue or end a pregnancy arising from rape is a decision for the woman to make; it is not for others to determine the acceptability or not of her decision.

Provision of counselling and support services for women

It is my considered view, as a pro-choice counsellor with experience in the field, that pro-choice, non-directive and evidence-based counselling should be available to women and significant others on a voluntary basis. Mandatory counselling has not been demonstrated to be effective and there is evidence to suggest that this is used as a strategy to dissuade women from abortion and to coerce women into continuing a pregnancy[14].

Robust scientific research indicates that the majority of women who have an abortion demonstrate emotional wellness following the abortion[15]. There are women who are less likely to cope well following an abortion and risk factors, such as pre-existing mental health issues and holding values inconsistent with abortion, have been identified[16]. It is important that these women have support available to them when required.

As a pro-choice counsellor, I have provided counselling to women who had sought pregnancy options counselling support from services the women did not know were anti-choice. The anti-choice nature of those services was revealed to the women via comments

[14] Joyce, T. & Kaestner, R. (2000). *The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion*. Family Planning Perspectives, 32(1): 4-13. Retrived from https://www.guttmacher.org/about/journals/psrh/2001/01/impact-mississippis-mandatory-delay-law-timing-abortion

[15] Royal Australian & New Zealand College of Obstetricians & Gynaecologists (RANZCOG), 'Termination of pregnancy: a resource for health professionals', November 2005, Victoria, p.4
Retrieved from http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html;
American Psychological Association, Task Force on Mental Health and Abortion. *Report of the Task Force on Mental Health and Abortion.* Washington, 2008. Retrieved from http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf

[16] *Ibid*

made to them by anti-choice counsellors who judged them as individuals (e.g. "murderer"), judged their consideration of the option of abortion (e.g. "killing") and provided misinformation (e.g. regarding abortion procedures). The distress these women experienced in response to this "counselling" is significant. I strongly encourage the Committee to recommend that all pregnancy counselling services be required to (a) demonstrate transparency regarding their position on abortion in all their publicly available literature and advertising, so that women and significant others can make an informed choice about which services they access; and (b) demonstrate that they provide evidence-based best practice pregnancy options counselling to their clients.

There are some who describe a "pro-choice" position as being "pro-abortion", which is a nonsense term. As a pro-choice counsellor, I have supported women who have chosen abortion, women who have chosen adoption and women who have chosen parenting. In many circumstances I do not know what choice a woman has ultimately made, because seeking counselling was just one part of her decision-making journey that supported her to develop strategies to make a decision.

False equivalences failing women

A false equivalency, or logical fallacy, occurs when two or more points of view are given the same weight, even though one or more points of view are supported by rigorous evidence and the other point(s) of view is(are) merely opinion. Stridently and repetitively speaking an opinion does not imbue it with evidentiary weight.

The debate surrounding abortion law reform in Queensland and Australia, and internationally, is mired in false equivalencies. This is easily demonstrated by reviewing many of the anti-choice submissions received by this Inquiry which fail to even attempt to provide evidence to support the claims made, or if references are made, they are to out-dated, debunked and/or unreliable sources.

It is one thing for a person to reflect on their own values and to conclude that they cannot support a woman's right to access abortion. I disagree with this point of view and believe it is harmful to women, however I respect that an individual may hold a point of view that is different to my own. It is utterly repugnant however when anti-choice individuals and groups attempt to manipulate others into sharing their point of view by promoting misinformation, pseudo-science and, in some cases, outright falsehoods.

I ask the Queensland Government not to indulge these false equivalences and instead, as representatives of a secular state, rely on evidence and expert testimony.

Women and religious faith

Some of the objections to abortion are grounded in religious beliefs and have been articulated in some of the submissions received by the Inquiry. However religious faith and support for reproductive choice can co-exist. As examples of this, I draw the Committee's attention to two organisations: Catholics for Choice[17] and the Religious Coalition for Reproductive Choice[18]. The existence, membership and activities of these organisations

[17] http://www.catholicsforchoice.org
[18] http://rcrc.org

demonstrate that anti-choice statements about abortion based on religious beliefs are not representative of all people who share membership of the same religious faith.

My voice

I am a Queensland woman of reproductive age. I have a lived experience of mental and physical health issues. These issues have, at times and for extended periods, significantly impacted on my quality of life. Given these issues and other personal considerations it is possible that, if I fall pregnant, I may decide to have an abortion. I can only imagine the harmful effects I would experience if I was denied the right to have an abortion and was forced to continue a pregnancy. I am fortunate that I am able to access the resources needed to travel interstate or internationally to have an abortion. What if I did not have access to those resources? What if I lived in poverty, was homeless or was unable to travel to access an abortion procedure? What if I could not safely tell anyone about my hopes and fears and the choice that I had made? This scenario reflects the disparity between those women who have access to resources and those who do not; yet another discriminatory two-tier system fostered by the presence of abortion provisions in the *Criminal Code 1899*.

Conclusion

Women throughout history have made the choice to have abortions. As a state, we can support women to access safe and legal abortion procedures when that is their choice. Or, we can maintain the abortion provisions in the *Criminal Code 1899* and continue to condemn women to being silenced and stigmatised; Queensland can continue to punish women – ourselves, our mothers, sisters, daughters, friends, colleagues and others – for daring to make their own choices. Therefore I am adding my voice to the voices of so many other women to ask the Members of Parliament to support the *Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016,* to rely on evidence and not hysteria, to listen to women and to trust us, and to trust in the medical professionals who support us.

Yours sincerely

Siân M. Tooker