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SUBMISSION TO THE HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE ON:

THE HEALTH (ABORTION LAW REFORM) AMENDMENT BILL 2016

Cherish Life Queensland

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Preamble

Cherish Life Queensland believes that every human, born or unborn has an intrinsic right to life by virtue of our humanity. We all share a common human nature that is unique from the time of our conception. Modern embryological science now can clearly demonstrate that a new life comes into being from the time of conception. This new life is not just an extension of the mother; this new life (with gender determined from the beginning) has his or her own DNA footprint, and is programmed to develop a personality and physical body uniquely different from any other human being, past, present and future.

This new life will bear family characteristics; maybe he or she will inherit a musical talent, have blue eyes, or a penchant for things mechanical – but this new life will be uniquely different at the same time. The new life simply needs to be provided with the food and shelter to grow and develop. This little human needs 9 months of gestation before he or she changes address from within to outside of the mother's womb.

Cherish Life Queensland also cares deeply about the well-being of women, men, children and families and is concerned about the impact of abortion on every level of our society.

Cherish Life Queensland welcomes the opportunity to make a submission on the Health (Abortion Law Reform) Amendment Bill 2016. We thank the Queensland Parliament for its commitment to engage with the community about matters so fundamental as that of the:

1. Human rights of the unborn, and the impact that possible abortion legislation enacted in our Parliament would have on our existing responsibilities as signatories of the International Human Rights Convention.
2. Physical and psychological harm of abortion and the need for mothers to make an informed consent.

3. The harm to mothers self-aborting.
4. Late-term abortions and the artificial creation of a 24-week time limit that somehow impacts on the abortion decision-making process.
5. Rights of doctors and nurses to work in accord with their own consciences.
6. Issues around the implementation of 'safe zones' around abortion clinics.

This submission will address all of these issues and make recommendations in relation to them. However, this Bill also has further implications that need to be addressed. This submission will therefore extend to include a review.

7. The lack of alternatives offered to women when facing an unplanned pregnancy that stop them from having real choices.
8. The lack of research and information known about the practice of abortions in Queensland. Further research is required before we will be able to determine the efficacy of any changes to our current abortion practice.

To support the recommendations below, Cherish Life has provided a comprehensive view of the matters under consideration by the Queensland Parliament in the following sections.

1. Human Rights Obligations

If the bills before the Government are passed, we would be required, just like Victoria, to insert a special clause into a future human rights charter stating: **Nothing in this Charter (Human Rights Charter) affects any law applicable to abortion or child destruction**. Allowing Government the authority to declare subjectively who is human or not, then having to make exceptions in the UN Declaration of Human Rights is not progressive.

Recommendation

The power and authority to define which members of the human family are valuable and worthy of protection and which may be disposed of is inconsistent with universally accepted human rights. This Parliament should not accept laws that create exceptions to our obligations, based on subjective measures such as physical attributes or externally determined 'value'.

Supporting Information

Further information can be found in Appendix 1: Human Rights Obligations.

2. Informed Consent: Physical & Psychological Harm

Denying or downplaying the real and well-documented psychological and physical risks induced abortion poses to women's reproductive health may better suit the ideology that believes abortion is a liberating, consequence-free procedure, but it is a lie that harms women. Like the tobacco-lung cancer link that was also denied in the presence of evidence, the psychological and physical risks such as the Abortion Breast Cancer (ABC) link may continue to be denied, for what appears to be ideological, political and economic reasons (Lanfranchi, et al., 2013).

If women have the right to choose, they should have the right to make a fully informed choice. Consent should be based on medical evidence of the known physical risks, and the substantial evidence into the psychological harms, of induced abortion. Deception is coercion, not liberation. Failing to ensure women are fully informed represents a failure of our duty of care, making legislators culpable for the trauma, injury, and suffering women will endure.

Recommendation

We need legislation to ensure women receive:

- The truth about human development, the methods of abortion, the physical and psychological risks of the procedure, and the alternatives
- Mandatory access to neutral pre and post abortive counselling
- Mandatory waiting periods to ensure they have time to consider their options and make decisions free from pressure and coercion

Supporting Information

Further information can be found in Appendix 2: Informed Consent, Physical, and Psychological Harm.

3. Women Performing an Abortion on Herself

The Health (Abortion Law Reform) Amendment Bill 2016 under section 20 Only qualified health practitioner may perform abortion, states “a woman does not commit an offence by (a) performing an abortion on herself, (b) consenting to, or assisting, in the performance of an abortion on herself.” We are assuming section (a) and (b) are in relation to medical abortions although this is not clear. It also conflicts with the statement above; only qualified health practitioners may perform abortions. Mr Joe Kelly MP raised this inconsistency at a committee hearing. Given the risks of Mifepristone, the pain associated with medical abortions and the distress women often feel due to seeing the foetus, we recommend that women always be medically supervised while undertaking a medical abortion.

Recommendation

Any induced abortion should be conducted only under medical supervision in order to minimise the risks to the health and welfare of the mother.

Supporting Information

Further information can be found in Appendix 3: Women Performing an abortion on herself.

4. Late Term Abortion & Protecting Babies Born Alive

Australians are very conflicted about the morality of abortion with a majority believing it should be a last resort. In Queensland, 53% either want the law to stay as it is, or are in favour of making it stricter (Galaxy poll for Australian Family Association, May 2016, *What Queenslanders Really Think About Abortion*).

Half of all late term abortions, post 20 weeks, in Victoria are for psychosocial reasons, such as financial, educational, or relational, that is, terminating the life of a healthy viable baby in the womb of a healthy mother (*2012 and 2013 Victoria's Mothers, Babies and Children* report from The Consultative Council of Obstetric and Paediatric Mortality and Morbidity). Sadly, this is perceived as an easy solution to maternal stress. This is not what Queenslanders want, as 85% of Queenslanders are opposed to abortion after 20 weeks, and 72% are opposed to abortion after 13 weeks (Galaxy poll, May 2016).

Recommendation

The current abortion law in the Criminal Code should remain intact. Changing existing legislation to allow unlimited access to abortion before 24 weeks and then with the consent of two doctors post 24 weeks would be contrary to the will of the people of Queensland. Social support services for the mother, or in extreme cases delivery with subsequent active treatment for the child, rather than death, would be a more humane and culturally acceptable response to women's desperation.

Legislation similar to the Infant Viability Bill 2015 in Victoria, which would ban outright abortion after the age of viability, while allowing for any emergency procedure necessary to protect the mother's life or physical health, should be instituted in Queensland. Legislation similar to the Born-Alive Infants Protection Act of 2002 in the US, which extends legal protection to any infant born alive after

an induced abortion and mandates for all reasonable steps to taken to preserve the child's life is also urgently required.

Supporting Information

Further information can be found in Appendix 4: Late Term Abortion and Protecting Babies Born Alive.

5. Conscientious Objection

For conscientious objection to be honoured fully, the law could not compel doctors to refer their patients to another doctor who would provide abortion, as that would make the doctor complicit in the abortion. If a doctor believed abortion was not in the best interests of his or her patient, he or she is actually under an ethical obligation not to refer.

Recommendation

The current wording of this clause in the Bill does not compel doctors or any other health professional to refer or participate in abortion. It therefore protects the freedom of Queensland health professionals to exercise their right to conscientious objection. This should not be subverted in any way.

Supporting Information

Further information can be found in Appendix 5: Conscientious Objection.

6. Civil & Political Rights & Buffer Zones

Abortion remains a contentious political and moral issue and as such, those who passionately believe in the right to life of the unborn, the health and wellbeing of women and the cultural fabric of our state must have their political communication protected as required in the Australian Constitution and through the International Covenant on Civil and Political Rights. Women should not be deceptively protected from the truth of human development by withholding the facts about what the act of abortion does to the preborn human. Deception is not empowering for women; it is patronising paternalism.

Further, the current practice of pro-lifers to gather, pray and offer assistance to women seeking abortion cannot be considered harassment in any way. They simply stand quietly and eagerly, hoping and praying for an opportunity to interact with a woman on the way to the abortion clinic and who appears reticent. They want to give that woman hope, to tell her of the supports available to her and her child. It is a ministry of love.

Recommendation

Protected areas or exclusion zones represent an imposition of one belief system on another and are therefore an unacceptable proposal. Attempting to hide the truth by calling it harassment and preventing groups from offering alternatives to women facing a crisis pregnancy is a deception that is not in fact empowering for women but rather patronising state paternalism.

Criminalising freedom of speech is a totalitarian imposition of one belief system on all Queenslanders and should be rejected.

Supporting Information

Further information can be found in Appendix 6: Civil and Political Rights and Buffer Zones.

7. Real Choices

For a woman to be able to make a real choice she must have options from which to choose. This new bill, according to Mr Pyne, is a compromise on total decriminalisation to expand the permissibility of abortion, in an attempt to gain support for more access to this one option of abortion for women with an unplanned pregnancy. A woman needs a range of options to consider. 87% of Australians want to see the number of abortions reduced (Southern Cross Bioethics Institute national opinion poll by Sexton Marketing Group, 2005).

Recommendation

The abortion bills before the committee lack a holistic approach to the needs of women facing an unwanted pregnancy. They do not reflect real choice. The public is strongly of the view that abortion should be reduced through more comprehensive social policy. If we are a progressive society that is inclusive of women's rights, we must therefore consider policies that give women and families greater support and empowerment.

This includes maternal support and flexibility, educational support, counselling, adoption as a real option and support for re-entry into the workforce.

Supporting Information

Further information can be found in Appendix 7: Real Choices.

8. Inadequate Data Available

The Committee report into the first Pyne bill highlighted the lack of quality data on induced abortion. There are limitations on the data available on the incidence of abortion in Queensland. RANZCOG noted in 2005 that there is no national monitoring of abortion in Australia, so accurate national data is not available. We agree that in order to truly understand, measure and implement best practice it is paramount that quality and transparent induced abortion statistics are collected and made publicly available for research and accountability purposes.

The lack of data also was highlighted in the most recent 2016 Queensland Maternal and Prenatal Mortality and Morbidity report.

> *"We believe that the reported number of mothers who suicide in association with pregnancy is underestimated and is actually greater than is counted in these figures, as there is a lack of available information regarding the number of miscarriages and terminations of pregnancy in Queensland.*

The Australian Institute of Health and Welfare states:

> *"The lack of data on induced abortion in Australia represents a gap in health statistics." (Grayson, et al., 2005).*

How are we therefore able to make any determination about the future impact of decriminalisation of abortion on the health and well-being of the Queensland population, in particular the women of childbearing age when we have no data about current practice?

Further, there appears to be no research into the abortion practices of other First World countries similar in demography, educational levels, and standard of living as Australia; or the consideration of the possible impact of abortion on our domestic violence rates.

Recommendation

In order to truly understand, measure and implement best practice, it is paramount that quality and transparent induced abortion statistics are collected and made publicly available for research and accountability purposes. Until this happens, we are not in a position to determine the best way forward.

It is also important to review the abortion practices in other First World Countries to glean an understanding of what informs best practice. Further, we need to assess the possible implications of more accessible abortion on our domestic violence rates.

Supporting Information

Further information can be found in Appendix 8: Inadequate Data Available.

9. Conclusion

Denying or downplaying the real and well-documented psychological and physical risks induced abortion pose to women's reproductive health may better suit the ideology that believes abortion is a liberating consequence-free procedure, but it is a lie that harms women.

If women have the right to choose, they should have the right to make a fully informed choice. Consent should be based on medical evidence of the known physical risks, and the substantial evidence into the psychological harms of induced abortion. Deception is coercion, not liberation. Failing to ensure women are fully informed represents a failure of our duty of care, making legislators culpable for the trauma, injury, and suffering women will endure.

Women must be provided with the whole truth so they can be prepared, and not find themselves like Madeleine (her story is in appendix 2) who was not informed about the truth of the development of her unborn child before she made the decision to abort. Women deserve real choice including supportive, life-affirming options, neonatal palliative care and a society determined to tackle the primary cultural causes that see one in three Queensland women seeking an abortion in their lifetime.

Rather than the Victorian and ACT model, look at European and US Jurisdictions

According to the explanatory notes this bill is based on legislation in Victoria and the ACT. The committee reported on various Australian state legislation as a means of comparison. It did not review the abortion laws of other first world countries.

The Committee in its report on the first bill highlighted the broad consensus that access to counselling is important, pre and post-abortive counselling support, informed consent counselling and expanding options to ensure women can make

a fully informed decision. These safeguards have not been included in the bill before the committee. Nor is there any discussion of mandatory waiting periods for women to pause and reflect before making a decision.

Gestational Limit

We thought it may be helpful to review the abortion laws in some European countries. We found that abortion for any reason in Germany, Belgium, France, Denmark, Switzerland, Austria, is only up to 12 weeks. After 12 weeks, the guidelines are quite strict.

- Germany: Between 12 and 22 weeks on grounds of medical necessity, grave danger to the mother's life that cannot be averted another way.
- Belgium: After 12 weeks it is on grounds of: risk to the mother's life, severe incurable foetal abnormality illness.
- France: After 12 weeks, two doctors having consulted with their multidisciplinary team, determine whether there is serious risk to the life of the mother or incurable foetal defect.
- Denmark: After viability (21 weeks) there is a 4-person committee and their decision has to be unanimous.
- Switzerland: After 12 weeks on the grounds of "profound distress".

Pre and Post Abortion Counselling

- Germany: Mandatory counselling is required for all women seeking an abortion.
- Belgium: Doctors by law have to inform patients of the alternatives to abortion and the risks of abortion. There is also mandatory follow up 3 weeks after an abortion is performed.
- France: An offer of counselling is mandatory before and after the procedure. The sessions are mandatory for minors.
- Switzerland: Mandatory counselling and patients are informed of the alternatives and organisations which can help them.

Waiting Period

- Germany: Waiting period of 3 days.
- Belgium: Waiting period of 6 days
- France: Waiting period of one week
- Netherlands: Waiting period of 6 days

Rates of Abortion per 1000 women

Germany	6.1/1000
Belgium	9.2/1000
France	15.2/1000
Switzerland	6.4/1000
Australia	19.7/1000

"Woman's Right to Know"

Is a phrase used to describe legislation in the United States that requires that a woman give her informed consent before having an abortion. These bills generally incorporate two components:

1. Requiring that specific information be provided to the woman before she undergoes an abortion. This may also include neutral counselling and;
2. A reflection period of 1-3 days, allowing the woman to consider the information provided to her. The U.S. Supreme Court has upheld these laws as constitutional and 32 states have Women's Right to Know (informed consent for abortion) laws in effect.

What types of information are generally provided to women under this law?

This law requires that the abortionist (or a qualified, designated person) provide specific information to the woman seeking an abortion at least 24 hours prior to performing the abortion. This information generally includes:

- the name of the physician who will perform the abortion
- a description of the abortion procedure to be used
- the possible physical and psychological risks associated with abortion
- the medical risks associated with carrying the child to term
- alternatives to abortion
- the probable gestational age and anatomical characteristics of the unborn child at the time of the abortion (this can include access to ultrasound imaging and heartbeat monitoring).

Any changes to abortion legislation should be reflective of research evidence and international best practice. Women must have a clear understanding of what it is they are choosing, because they have to live with the consequences of their decision, physically and psychologically.

In 2005, a major four-phase study undertaken by Sexton Marketing Group for Southern Cross Bioethics Institute sought to engage with Australians to find out what ordinary people thought about abortion. 87% believed it would be good to reduce the numbers of abortions, with almost universal support for reductions through social policies rather than restrictions through law. Furthermore, there was almost unanimous; 99% support for neutral counselling prior to abortion and 78% of those believed it should be mandatory. 98% of respondents believed women should be advised of any health risks involved in abortion. Finally, almost universally, participants believed in legal access, but that it should not be unrestricted or for trivial reasons and that it was the role of government to provide women with support services (Fleming & Ewing, 2005).

A law like “Woman’s right to know” ensures women can make informed decisions with due consideration of their future physical and mental health, are supported with pre and post abortive counselling and have the opportunity to consider all

their options without undue time pressures. Queensland women, like Madeleine, should never have to say, “Why didn’t anyone tell me the truth?”

The most important question that must be answered by this committee, by all members of Parliament and by our society at large is:

WHAT ARE THE UNBORN? This question should be the decisive question in any abortion reform discussion. You cannot terminate something (we would say someone) before you first know what (we would say who) it is you are advocating for destruction. If we are a truly civil society built upon the idea that every member of the human family has inherent dignity and inalienable rights then we had better be sure the unborn are not human persons. Abortion is only a compassionate moral solution to a serious social issue IF the unborn are not human persons with rights.

This submission argues using objective science and human rights philosophy that the unborn from the earliest stages of development are unique living whole human beings, who share a common human nature, like us, that makes them full members of the human family with the non-derogable right to life. There is no essential difference between the embryo we once were and the adult we are today that justifies killing us at that earlier stage of development.

Abortion not only destroys human beings with potential, it harms a huge number of women in the process. The evidence has been clearly laid out. There are serious physical and psychological consequences for women from abortion. While not all women claim they suffer post-abortion grief, a great many do and women should be informed of the risks. Furthermore, there is ample evidence demonstrating the abortion-breast cancer link as well as many other physical risk factors, which should also be explained as part of a fully informed consent process.

Additionally, in order to ensure women make a fully informed choice, free from coercion, that they can live with, they should have a clear understanding of what the unborn are and the various methods of abortion. Deception is not liberty.

They should be provided with pre and post-abortion neutral counselling, mandatory waiting periods and access to real choice and genuine support services.

If we truly want to reduce our abortion rate using social policy initiatives then we must facilitate the collection of thorough, transparent, accountable, and publically available abortion statistics. Such data is vital to see where we are and provide the statistics necessary to research what works to reduce the number of women seeking abortion.

Thirty years ago in the Brisbane District Court, Justice Fred McGuire said:

> *"The law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn. It should rightly use its authority to see that abortion on whim or caprice does not insidiously filter into our society. There is no legal justification for abortion on demand."*

However, today we are considering the idea that Parliament has the power and transcendent authority to decide which humans are valuable based on arbitrary characteristics rather than human rights absolutes. This is insidious indeed. In addition, this bill allows Parliament to dictate arbitrarily what views citizens are allowed to express about abortion and how they are allowed to participate in public political discourse in certain areas. This would be a sign of totalitarianism and a dangerous precedent. Dangerous to society, fatal to the unborn and entrapping to women (Beckwith, 2015; Koop & Schaeffer, 1983; Weikart, 2016).

Finally, abortion is the intentional destruction of a distinct living whole human being, which is a serious moral wrong. Abortion discriminates against a group of small developmentally immature human beings using dangerous semantics. This undermines the whole foundation of human equality. Abortion therefore could be considered one of the greatest destroyers of freedom, justice, and peace in the world. We may not see the fruit of it immediately. However, the devaluation of humanity and the intrinsic value of every member of the human family can be

seen clearly in our culture through many of the social issues we are facing today. Consider the words of Mother Teresa:

> *But I feel that the greatest destroyer of peace today is abortion, because it is a war against the child, a direct killing of the innocent child… by the mother herself.*
>
> *And if we accept that a mother can kill even her own child, how can we tell other people not to kill one another? How do we persuade a woman not to have an abortion? As always, we must persuade her with love and we remind ourselves that love means to be willing to give until it hurts… So, the mother who is thinking of abortion, should be helped to love, that is, to give until it hurts her plans, or her free time, to respect the life of her child. The father of that child, whoever he is, must also give until it hurts.*
>
> *By abortion, the mother does not learn to love, but kills even her own child to solve her problems… The father is told that he does not have to take any responsibility at all for the child he has brought into the world. That father is likely to put other women into the same trouble. So abortion just leads to more abortion.*
>
> *Any country that accepts abortion is not teaching its people to love, but to use any violence to get what they want. This is why the greatest destroyer of love and peace is abortion (Andsrusko, 2016).*

Ultimately, it will be the truth that transforms. If we truly want to reduce abortion and empower women, then we must change our behaviour. Our behaviour is influenced by what we believe and it is those ideas that put moral chains on our desires and actions. Until we tell the truth about the unborn, about what abortion is and what it does to the preborn, until we admit the harms abortion does to women, we will continue in wilful ignorance slowly destroying our conscience through deception and with it respect for all human life (Reagan, 2010). We will

change our sexual behaviour and begin to truly honour women and value the intrinsic worth of all human life when society knows the TRUTH of who the unborn are and the INJUSTICE of abortion (Klusendorf, 2009; Koop & Schaeffer, 1983).

9. Supporting Evidence

Appendix 1: Human Rights Obligations

The Universal Declaration of Human Rights came about after the horrific treatment and extermination of certain groups of people through the world wars.

> *In 1945, the United Nations was created, with a dream of securing peace and justice in the world by international co-operation. Part of the Charter of the UN – Article 55 – called for the establishment of a set of universally accepted and observed basic human rights, so that people would never again have to go through the abuses that they had just suffered. (Australian Human Rights Commission, 2010)*

Yet, in the name of progress we are debating whether a certain group of people, in this case pre-born human children, can be denied their right to life, and therefore be exterminated for any reason up to 24-weeks' gestation and up to birth with the agreement of two doctors who believe that it would be riskier to continue the pregnancy.

It was claimed in the Queensland Parliamentary Committee report into the first Pyne bill that Australia has not specifically recognised the rights of the foetus. It suggested that the Commonwealth Government has expressed a view that the right to life under the International Covenant on Civil and Political Rights (ICCPR) was not intended to protect life from the point of conception but only from birth. We believe this is a contextual misinterpretation of the statements by Mr Peter Arnaudo, then Assistant Secretary, Human Rights Branch, Attorney-General's Department, in response to questions posed in a Committee hearing by Senator Simon Birmingham in 2008, regarding the right to life and pregnancy terminations. Mr Arnaudo did not say what the treaty does or does not mean for abortion, which

was Senator Birmingham's question, but rather simply said what the department thought about it (Commonwealth of Australia, 2008).

Human rights were founded on the following idea:

> *Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind…. (United Nations, 1948)*

Therefore, in light of this principle, and in contrast to that 2008 Commonwealth Government departmental view, Cherish Life Queensland supports the view of the eminently respected researcher Rita Joseph, author of *Human Rights and the Unborn Child'*. In her response to a Senate Standing Committee on the Legal and Constitutional Affairs Human Rights Bill Inquiry she stated:

> *Views are also invalid if they abrogate any of the defining principles of human rights—inclusion, inherency, inalienability, equality and indivisibility. Given these most basic defining principles as the agreed philosophical foundation of International Human Rights Conventions, it would seem more useful perhaps to ask the question "What evidence do you have that the unborn child was excluded from human rights protection?"*
>
> *Human rights for the unborn children, having been recognised right from the beginning, cannot now be de-recognised. They certainly can't be de-recognised by re-interpretation through a 21st century ideological bias seeking to justify current laws that accommodate the appalling notion that mothers have ownership and disposal rights over their unborn children (Joseph, n.d.).*

It is indisputable that human rights apply to the unborn.

- The Universal Declaration of Human Rights recognises the need to special safeguards and care, including legal protection before as well as after birth.
- Article 6 of the Convention on the Rights of the Child affirms the child's right to life and state parties are obligated to ensure to the maximum extent possible the survival and development of the child.
- Rights apply to all members of the human family and especially to children "without any exception whatsoever" and "without discrimination of any kind"
- The ICCPR confirms that for all members of the human family, every human being, including the unborn, has the inherent right to life, to be protected by law from arbitrary deprivation, and that this right is non-derogable (United Nations, 1966; United Nations, 1948; United Nations, 1989; ADF International, 2010; Kiska & Pier, 2012)

Claiming a foetus is not a member of the human family and therefore has no human rights because it is not clear when life begins; or that the terms child, human or person do not include the foetus as outlined in the Committee report, is dangerous semantics. What kind of foetus is it? Two human parents make a human foetus. If a common human nature does not make us human, when do we magically gain child, human or person status? Does a change in location, 20 cm down a birth canal bestow on a foetus humanity and personhood? These questions **must** be answered before any reform which would make abortion more accessible.

If being human at any stage is not adequate to give us inalienable rights and intrinsic value, then the idea of human rights is destroyed and with it the ideas of justice, peace and freedom. Dr Jakob Cornides of the European Commission in a recent issue of the *International Journal of Human Rights*, criticises proponents of the right to abortion who exclude the unborn by relying on "inventing and distorting reality" and through the "manipulation" of human rights language. We do not start out as one thing and morph into humans at a later stage. We are humans with potential from conception, not potential persons.

This lie has devalued humanity to a point where undertaking barbarous acts of dismemberment, poisoning, lethal injection or cranial decompression on the unborn is discussed as liberation, with attempts to silence dissent.

Apparently, women's liberation and equality is intimately connected to their freedom to not be pregnant (Health, Communities, Disability Services and Domestic Family Violence Prevention Committee, 2016). Abortion (perceived as a necessary must in this argument) places almost sole responsibility of the sexual revolution on women's bodies and minds (Kuby, 2015). Abortion therefore requires a woman to succumb to an ideology that robs the unborn child's intrinsic right to life.

It is unconscionable to believe we have the power and authority to define which members of the human family are valuable and worthy of protection and which may be disposed of. The fact that we would be required, just like Victoria, to insert a special clause into a future human rights charter stating, *'nothing in this Charter (Human Rights Charter) affects any law applicable to abortion or child destruction'* is a dangerous precedent (Victorian Government, 2006). Just because other jurisdictions have done this does not make it right or progressive.

Appendix 2: Informed Consent: Physical & Psychological Harm

Informed Consent or 'Women's Right to Know'

There is a huge corpus of empirical data demonstrating the potential physical and psychological harm of abortion on Women. It can no longer be overlooked. This has led to 35 states in the United States of America enacting Informed Consent for Abortion Laws. Under what is termed a 'Woman's Right to Know' it is now mandatory that a woman receives pre-abortion counselling at least 24 hours before the abortion in which the following information is given her:

- the name of the physician who will perform the abortion
- a description of the abortion procedure to be used
- the possible physical and psychological risks associated with abortion
- the medical risks associated with carrying the child to term
- alternatives to abortion
- the probable gestational age and anatomical characteristics of the unborn child at the time of the abortion, which can include access to ultrasound imaging and heartbeat monitoring.

In some states, this includes neutral counselling and a cooling-off or reflection period of 1-3 days allowing the woman to consider the information provided to her. The U.S. Supreme Court has upheld these laws as constitutional.

These 'Woman's right to know' laws ensure women make informed decisions with due consideration of their future physical and mental health, are supported with pre and post abortive counselling and have the opportunity to consider all their options without undue time pressures. Any changes to Queensland's abortion laws need to incorporate similar opportunities for women.

Physical Harms

Induced abortion violently interrupts the natural progression of pregnancy, which has real physiological consequences for the woman's body. The early 18th century feminists understood the power of nature. Mary Wollstonecraft, who was part of the early fight for women's emancipation, wrote in 1792, "Nature in everything deserves respect, and those who violate her laws seldom do with impunity." Three centuries later science has proven Mary's assertion correct (Foster, 2007).

The various techniques used to destroy and remove the developing human being pose significant risks to women's immediate and future reproductive health - risks that make a mockery of the deceptively repeated claim that abortion is a safe, simple, and consequence-free procedure. The following risks, the Committee reported, were cited by submitters:

- Uterine perforation
- Cervical incompetence
- Infection
- Future infertility issues
- Future premature birth
- A causal link to breast cancer
- Death

Additionally, the Australian Christian Lobby suggested adverse effects of medical abortion. The use of mifepristone (RU486) was attributed to adverse outcomes including surgical intervention after the treatment failed, infection, haemorrhage, and the death of "at least one Australian woman." This evidence was disputed by Dr Darren Russell from Cairns Sexual Health Service.

However, it is important to note that a comprehensive publication by Real Choices Australia, citing a 1998 UK study found "women rated medical abortions as more stressful and painful than surgical abortions. Nightmares, flashbacks, and unwanted thoughts related to the procedure were reported.

"Medical abortions sometimes result in the delivery of a live foetus (small human being). Seeing or feeling the foetus is a particularly distressing experience." The idea that women could conduct their own Mifepristone abortion without medical supervision, as outlined in the new Pyne health reform bill, is negligent and dangerous to women.

Abortion Breast Cancer Link

The Committee acknowledged the view by some submitters that abortion is linked to an increased risk of breast cancer. However, they also stated that many organisations such as RANZCOG, Children by Choice, AMA and the Australian Cancer Council dispute such a link exists.

There is ample evidence demonstrating that the way normal breast anatomy responds to the physiological reality of pregnancy, as well as the multiple statistically significant studies demonstrating a link between abortion and breast cancer, clearly show that abortion poses a significant risk to women's reproductive Health.

The 2013 book *Complications* by Professor Angela Lanfranchi M.D., FACS (who is a breast surgical oncologist and Clinical Assistant Professor of Surgery at the Rutgers Robert Wood Johnson Medical School), Ian Gentles and Elizabeth Ring Cassidy states:

> *After several years of intensive research we are more than ever persuaded of the urgency of communicating this information to medical professionals, counsellors and to women contemplating having an abortion…*
>
> *There are now 56 studies that show a positive association between abortion and breast cancer, of which 35 are statistically significant…*

The fact that induced abortion significantly increases the risk of breast cancer deserves to become widely known to the public.

Dr Angela Lanfranchi reports that there is real statistical data from USA, France, China, Japan and India that show that women have a 30% - 40% greater chance of getting breast cancer if they have had an abortion (Lanfranchi, et al., 2013) (Lanfranchi & Fagan, 2014).

In fact, a number of states in the United States, including Texas, Louisiana, Montana, and New Hampshire have legislated that women be informed of the Abortion Breast Cancer (ABC) link (Celock, 2012). There also have been a number of legal cases in the US where women have successfully sued their abortion provider for failing to disclose the ABC link. These cases as well as an extensive analysis of the ABC link and other complications for women from induced abortion, including infection and infertility, miscarriage, autoimmune diseases, premature birth and maternal mortality, also can be found in the book *Complications*, by Lanfranchi, et al.

While many still dispute the evidence and deny such a link exists, it is difficult to refute the evidence with genuine intellectual honesty. The Abortion Breast Cancer link has been well-documented in international biological and epidemiological research. Queensland women considering abortion must be fully informed of the real risks induced abortion poses to their future reproductive health before consenting to an abortion. Women have a right to know the truth about induced abortion, through a fully informed consent process.

Psychological Harm

Abortion is not like any other surgical procedure. It embodies within questions about our strongest convictions of right and wrong, about the meaning of life and our place in the world. This is why, as the Committee acknowledged, "there was a common view among stakeholders that a decision to have an abortion is a serious one. One stated, 'no woman wants to have an abortion,' another concurred, stating that 'no woman takes this decision lightly'."

In its report on the first Pyne bill, the committee concluded that "despite some variation in results, it is clear that there is no established causal relationship between abortion and mental health outcomes." The only reason such a conclusion could be reached is that not enough research had been undertaken.

It takes but a few mouse clicks to sites like, [redacted], [redacted], w[redacted], [redacted] or to read books such as *Giving Sorrow Words* and *Real Choices*, to know the thousands upon thousands of stories of women's trauma and anguish after abortion. Stories like Macie who said: "Never in my life have I felt so empty. It took me a long time to realize that what I did didn't make me un-pregnant; it made me a mother to a dead child" and Christina who said: "Suddenly it was over. What life was once there was now gone by my command. Painfully, I felt a rush of relief followed by an intense grief that took my breath away. I felt selfish and ashamed" and Jess who said: "She told me to pretend it never happened and get my life together. I felt so nauseous and terrible. I was so numb. I did not want to do it, but **I felt I had no choice**" (emphasis added). Another wrote: "I'm just grieving like crazy." Another said: "I don't understand why I am not getting better, but worse all the time! I am so depressed" (Mathewes-Green, 2013; Reist, 2000; Vitz, 2010).

Madeleine Wiedemann, who shared her story of post-abortion grief at the Abortion Rethink Parliamentary Panel event in Brisbane on August 8, 2016, said:

I was told at 8 weeks the foetus was a ball of cells no bigger than half my little finger nail. But that's not true. Several years later while studying anatomy and physiology I was shocked to learn that at 8 weeks, when I aborted, the baby would have been 3cm long and every organ functioning, its heart beating. What I was told was wrong and the discovery horrified me. I have heard other women recall the exact same language used in their pre-abortion counselling. ***This is not empowered informed consent****, nor unbiased counselling to help women make choices of reproductive freedom [emphasis added].*

After my abortion I was given a pamphlet to take home. It said due to hormones you may experience several days of heightened emotions, but no further grief. So when I began to feel sadness, I felt I could not possibly go back to that clinic because there was no room for my experience there. I felt disenfranchised, as if my right to experience regret was not permitted. I suffered years of depression and anxiety and struggled with post-natal depression, struggling to connect with the children I had later given birth to (Weidemann, 2016).

This experience of misinformation is again highlighted by Professor Evelyn Vitz of New York University as well as in a 1998 UK Mifepristone comparison study which identifies how women suffer distress from seeing the foetus and recognising that "it was not a blob of cells but rather a tiny, pale-grey baby" (*Real Choic*e, 2016; Vitz, 2010).

The stories above may be anecdotal , and we concede it is difficult to scientifically evaluate subjective emotional experience. However, as was recently noted in 2016 Queensland Maternal and Prenatal Mortality and Morbidity report, "It is particularly important that we show a greater appreciation for the potential for depression and other mental health issues, particularly in association with the termination of pregnancy" (Department of Health, 2016).

The relational power between a woman and her unborn child is one of the most powerful of all and perhaps this is why there is a disconnect between the empowerment narrative of abortion and the actual emotional outcome (Vitz, 2010; George, 2005). As stated above, the Committee highlighted in its report on the first Pyne bill that no woman really wants an abortion. Yet the real emotional impacts continue to be dismissed while appearing to be disturbingly widespread. As a society we are forcing women to bear the burden of abortion alone and then denying the reality of their lived experience of post-abortion trauma that manifests in some of the following ways (Ring-Cassidy & Gentles, 2003; Kumar Gill & Martin, 2016; Mathewes-Green, 2013):

- Post-traumatic stress disorder
- Self-harm
- Drug and Alcohol abuse
- Suicide
- Depression
- Relational problems

It is estimated, according to Medicare and comparative statistics, that there are 10,000-14,000 abortions each year in Queensland, the vast majority, 97%, being undertaken for psychosocial reasons (Children by Choice, 2016). Real Choices Australia collated an information booklet titled, *The Facts: What Women Need to Make a Real Choice about Abortion*. Its research found that 30% of women who had abortions experience mental health disorders, with up to 20% suffering severe negative psychological complications. Furthermore, women who have abortions are 6 times more likely to commit suicide than those who give birth (*Real Choice*, 2016). A 2012 study in the journal *Dialogues in Clinical Neuroscience* found that risk of complicated grief was especially high after termination of a pregnancy due to foetal abnormality (Kersting & Wagner, 2010). Dr Greg Pike, now of the University of South Australia, in his article *Unscathed Abortion and Mental Health* outlines that one category of abortions does seem unequivocally linked to increased risk of mental health problems and that is when there is a foetal abnormality (Pike, 2011).

Prenatal Diagnosis journal has reported that women who terminated their pregnancy following a prenatal diagnosis of a lethal foetal defect, reported significantly more despair, avoidance, and depression than women who continued with their pregnancy. The article concluded:

> *Abortion does not resolve cases where a lethal foetal anomaly exists; abortion destroys one of the patients — the youngest. Patients and their families can and should be offered the option of perinatal hospice to support them in the same way we do families with an adult member for whom treatment has become futile (Charlotte Lozier Institute, 2015).*

The lead author of this submission (Kara Thomas, Director of Research, Policy and Advocacy) personally chose not to terminate a child with a fatal foetal abnormality. She says: "Carrying my son Christopher was a difficult pregnancy, the grief was long enduring, intense and does not end after birth; it just gets easier to live with over time. Termination was suggested. However, as a mother I knew I had to give my child the opportunity to be loved and to have a 'Mummy hug'. He died in my arms a few hours after he was born. We have photos, the family held him and I grieved for a son I had the opportunity to love and whom had the opportunity to be loved."

Abortion in this situation does not change the outcome. It just steals our chance to embrace the joy in the suffering and the hope of loving even when it hurts. Abortion silences grief. It does not bring healing. Abortion, especially for foetal abnormality, poses an increased threat to the mother's future reproductive health because it often happens later in pregnancy.

As Dr Elizabeth Johnson stated in her 2015 article, *The Reality of Late-Term Abortion Procedures*, the stresses that led women to seek abortions:

> *…are not fundamentally alleviated or ameliorated by late-term abortion. Indeed, late-term abortion places these women at greater risk of surgical complications, subsequent pre-term birth, and mental health problems, while simultaneously ending the life of an unborn child (Johnson, 2015).*

Finally, we refer the Committee to a review of the literature which shows empirical evidence on the effects of abortion on the mental health of women, published by Dr Priscilla Coleman, 2011, Professor of Human Development and Family Studies at Bowling Green University in Ohio, which cites scientific studies identifying abortion as a risk factor in:

- Suicidal behaviour
- Depression
- Anxiety
- Substance abuse.

Among these empirical studies was a gold standard 30-year longitudinal study published in the *British Journal of Psychiatry* in 2008 by Fergusson, D. M., Horwood, J.H. and Boden J.M (Fergusson, et al., 2008). A self-described 'pro-choice atheist and rationalist', Dr David M. Fergusson, Professor of Psychology at the University of Otago in Christchurch, New Zealand, undertook his first investigation with the expectation that his cohort data would prove that the apparent link between abortion and mental health problems would be explained by pre-existing factors. Instead, his data revealed that abortion was an independent "risk factor for the onset of mental illness."

The study found abortion increased the risk of suicide ideation by 61%, the risk of major depression by 31%, the risk of anxiety disorder by 131%, the risk of alcohol dependence by 188%, and the risk of illicit drug dependence by 185%. While retaining a pro-choice position, Fergusson's research has convinced him that:

"Abortion is a traumatic life event; that is, it involves loss, it involves grief, it involves difficulties. And the trauma may, in fact, predispose people to having mental illness."

Interestingly, as this ties in with the cover-up of abortion complications revealed by the documentary *Hush*, Fergusson also reported experiencing difficulties getting his study published, since the results contradicted the prevailing view that abortion does not have mental health consequences. Claiming that his studies are normally accepted the first time, Fergusson reported that the first of his studies on abortion was rejected by four journals because of the controversial nature of his findings. He also was asked to not publish the results by New Zealand's Abortion Supervisory Committee, the government agency responsible for regulating compliance with the country's abortion laws. He refused to comply with the request because he felt it would be "scientifically irresponsible" to hide the findings.

Either this Parliament must be convinced beyond any doubt that abortion is not linked to mental health issues, or it must err on the side of caution. Causal or correlational, 1 in 3 Queensland women who have at least one abortion in their lifetime equates to a serious impact on our state's human capital and consequently social and economic capital. Therefore, the well-documented mental health risks of abortion should be disclosed to women as part of a fully informed consent process as has been legislated in other jurisdictions (George, 2005; Benson Gold & Nash, 2007).

Appendix 3: Women Performing an Abortion on Herself

Abortion, whether medically or surgically induced, is an intrusive interruption to the normal biological functioning of the body of a pregnant woman. It is a serious procedure. There is already a recorded case in Australia of a maternal death due to self-administration of Mifepristone. There is also the risk of haemorrhage and infection. Medical supervision is required to ensure safety of the patient. We do not want further deaths due to lack of medical care.

Further, there are reports that many women experience profound psychological grief and shock when they self-deliver their own pre-born child following a self-induced abortion using the Mifepristone abortifacient. Any illusion that this foetus is "just a lump of cells" is shattered. This experience is highlighted by Professor Evelyn Vitz of New York University as well as in a 1998 UK Mifepristone comparison study" (*Real Choice*, 2016; Vitz, 2010). It found "women rated medical abortions as more stressful and painful than surgical abortions. Nightmares, flashbacks, and unwanted thoughts related to the procedure were reported. Medical abortions sometimes result in the delivery of a live foetus (small human being)."

The mother confronted with the reality of seeing her dead child then has to deal with her unexpected emotional reaction. She should not be alone unattended at a time such as this. She needs counselling and support.

Society has failed women when it fails to provide the support and services a woman needs to overcome an unplanned pregnancy and to navigate a way forward that allows her to embrace motherhood. It fails her further when it condemns her to undertake the drastic action of self-administering an abortifacient and then potentially having to be confronted with her dead child. To allow a woman to self-abort is not humane. Surely we can do better.

Appendix 4: Late Term Abortions & Providing Medical Assistance to Babies Born Alive

In drafting this bill, Mr Pyne acknowledged there was community concern about late term abortions. Late-term abortion is generally regarded as a termination after 20-week gestation. The Committee report outlined that in Queensland most late-term abortions are due to fatal foetal abnormalities. However, statistics from Victoria, where abortion is legal to 24 weeks for any reason and beyond 24 weeks with the approval of two abortion doctors, demonstrate some disturbing outcomes.

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity reports on the Victorian situation:

- In 2010 there were 366 post 20-week terminations including 191 for psychosocial indications. 24 babies were born alive and left to die.
- In 2011 there were 378 post 20-week terminations including 183 for psychosocial indications. 40 babies were born alive and left to die.
- In 2012 there were 330 later-term abortions including 132 for psychosocial reasons. 53 babies were born alive and left to die.
- In 2013 there were 358 late-term abortions including 179 for psychosocial reasons. 43 babies were born alive and left to die.

Under current Victorian law, these babies have no medical rights, so the only attention they received was the periodic checking by a nurse so that the accurate time of death could be recorded.

Two years after abortion was decriminalised in Victoria, Channel 7 News on 17 April 2010 reported that the number of late-term abortions performed at one hospital, the Royal Women's Hospital in Melbourne, had risen six times from one per fortnight before decriminalisation to three a week.

Earlier this year in the Victorian Parliament, the Infant Viability Bill was debated. This legislation would have included the provision that a baby born alive from an abortion procedure would receive life-saving medical treatment. However, sadly the Parliament voted against this bill. This defies belief.

Given the Queensland community is so strongly opposed to late-term abortions, effective laws must be put in place to prohibit abortion past the age of viability and to protect those babies who are born alive after an induced abortion.

The Health (Abortion Law Reform) Amendment Bill states that an abortion beyond 24-weeks' gestation would require a doctor in consultation with a second doctor to agree that the continuation of the pregnancy would pose a greater risk of injury to the woman's physical or mental health than if the pregnancy were terminated.

Firstly, this provision is just a con job to trick the public into thinking the legislation would protect viable babies. This is a ruse, as the second doctor is not required to see or speak to the patient, or even look at her file. Also, the second doctor does not have to be independent so it could be that two doctors from the same private abortion facility that would profit from the procedure would approve the late-term abortion. Short-sightedly, the Bill specifically states that if this requirement for approval by a second doctor did not happen, it would not be an offense for the doctor who kills the viable baby. There would be no penalty. A law without consequences is no law at all.

Secondly, there is no medical reason to perform abortion after 24 weeks of pregnancy, as there is never a situation in which a viable unborn baby needs to be killed to save the mother's life. For example, if the mother has a serious condition such as pre-eclampsia (the symptoms of which include high blood pressure and fluid retention) and the pregnancy needs to be ended, the best way to do this typically is by caesarean section which would result in the health issue being resolved quickly, the mother recovering and her baby being given every chance to survive with the best neo-natal care. There is no need to put the mother's health further at risk by the necessary delay involved in performing a late-term abortion through feticide, which involves killing the baby in the womb by

an injection of potassium chloride into the heart, and then inducing labour whereby the mother delivers a dead baby several days later.

Where psycho-social factors are cited as the reason for the need of a late-term abortion that would result in a perfectly formed and viable dead baby being aborted, there are other options. Social support services for the mother, or in extreme cases early delivery with subsequent active care and possible short, long or permanent placement (including the option of adoption) of the child away from the mother would be a more humane and culturally acceptable response to a women's desperation in these psycho-social situations. Every tribe and nation has a culture that works for the benefit of its members whereby unwanted children are placed with extended family members or childless couples. This is a tried and tested option that, with the rising rates of infertility, is even more attractive now.

The use of late-term abortions by parents to gender select is of concern. When Mr Pyne was questioned by Mr Sid Cramp MP of the Committee into the Health (Abortion Law Reform Amendment) Bill on how the bill prevented gender selection abortion, he said gender selection abortion was "appalling", that there was no evidence it happens and he predicted that it would never happen in Queensland. Unfortunately, it most certainly does happen, and not just overseas where there are over 200 million missing females from countries including India and China, but it also happens right here in Australia where late term abortions are legal.

In 2013, Dr Mark Hobart faced disciplinary action in Victoria for refusing to refer an Indian couple where the woman was 19 weeks pregnant for gender selection abortion (Devine, 2013). This couple obtained an abortion of their baby girl from another medical practitioner but then Dr Hobart was reported to the relevant medical authority for breaching the legal duty to refer under Victorian law.

A 2015 SBS Radio investigation into pre-natal sex selection uncovered stories and statistics suggesting that some members of Australia's Chinese and Indian

communities may also be engaging in sex selective abortions, leading to an estimated 1,395 fewer females born to Indian and Chinese families in Australia between 2003 and 2013 (Jain, 2015). The world is missing 200 million women, approximately 1500 of them Australian women, aborted just because they are girls (Tsvirko, 2015).

If abortion is virtually legal for any reason through all nine months of pregnancy, because according to the Committee report the right to life does not apply to the foetus as it is not a human being/person, then gender selection abortion will happen. However, may we enquire why Mr Pyne considers gender selection appalling? "Non-human" female foetuses are just as "non-human" as those other female and male foetuses aborted for financial, educational, career or lifestyle aspirations.

Both of these Pyne abortion bills currently before the Queensland Parliament go against the global trend which appears to be in favour of greater restriction to abortion, not greater access. For example, 43 states in the US prohibit abortion after a specified point in pregnancy, most commonly from 20 to 24 weeks. There is now a federal push to ban late-term abortion across the US. In Europe, abortion on demand is only permitted during the first trimester, after which restrictions and regulations increase the later a pregnancy progresses (Carling-Jenkins, 2015).

Late term abortions of viable babies are routinely done using:

- Lethal injection to induce cardiac arrest and followed by induction where the woman gives birth to a dead baby.
- Induction of premature labour. Live births are common and babies are left to die.
- Dilation and extraction which involves dismembering the foetus to pull it through the cervix.
- Cranial decompression method also known as partial birth abortion where the baby is pulled from the mother's womb feet first then the base of the

neck is pierced and the brains suctioned out, then the head is removed and the baby is born dead.

The US Supreme Court in 2007 outlawed partial birth abortion and there is currently a bill before Congress, introduced by Senator James Lankford, to ban dismemberment D&E abortions nationally. D&E, which makes up 97% of second trimester abortions, is the intentional dismembering of a living unborn child and extracting such unborn child one piece at a time from the uterus (Johnson, 2016; Guttmacher Institute, 2016).

Warren Hern, a late-term abortionist, states:

> *"We have reached a point in this particular technology (D&E abortion) where there is no possibility of denial of an act of destruction by the operator. It is before one's eyes. The sensation of dismemberment flow through the forceps like an electric current." (Klusendorf, 2009)*

D&E is currently banned under the Unborn Child Protection from Dismemberment Act in six U.S. states – Kansas, Oklahoma, West Virginia, Mississippi, Alabama, and Louisiana. Justice Kennedy said in the Supreme Court's 2007 Gonzales opinion upholding the federal ban on partial-birth abortion, that D&E abortions are "laden with the power to devalue human life".

Scientific developments that allow us to monitor the baby in utero have been able to establish beyond doubt that a baby experiences great pain when being torn apart and killed. There are now laws to protect these unborn children from experiencing great pain when being killed by dismemberment through the administration of pain relief (Andrusko, 2016). The Pain-Capable Unborn Child Protection Act is the law in 14 states– Alabama, Arkansas, Georgia, Idaho, Kansas, Louisiana, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Texas [known as the Preborn Pain Act], West Virginia and Wisconsin.

There is strong community opposition to late-term abortions

While there has been some questioning of opinion polls in the Committee report, it is simply not the case that the recent Galaxy poll in Queensland showing 85% opposition, last year's Galaxy poll in Victoria showing 64% opposition and a national poll by Markets Facts in 2005 showing 86% opposition to late-term abortion are all unreliable (Australian Family Association, 2016; Carling-Jenkins, 2015; *What Australians Really Think About Abortion*, AFRTLA, 2005).

Increasing access to abortion further along in pregnancy requires addressing the various abortion methods used and whether we as a society think such acts are acceptable. When should an effective limit prohibiting late-term abortion be placed, given it is never necessary to save the mother's life? For mid-term and late-term abortion, will all methods be permissible to achieve the outcome of killing the foetus? Will we provide the unborn with pain relief? Will lifesaving treatment be given to babies born alive? These are questions that must be addressed in any reform.

Appendix 5: Conscientious Objection

In the event that abortion was decriminalised, the rights of doctors, nurses, allied health professionals and axillary staff, not to perform or assist in performing an abortion would need to be legally protected. Respect for a conscientious objection is a fundamental principle in our democratic country. For conscientious objection to be honoured fully, the law could not compel doctors to refer their patients to another doctor who would provide abortion, as that would make the referring doctor complicit in the abortion. If a doctor believed abortion was not in the best interests of his or her patient, he or she is actually under an ethical obligation not to refer.

We are pleased that the wording of this clause in the Bill does not compel doctors or any other health professional to refer or participate in abortion. This should not be subverted.

Appendix 6: Civil and Political Rights, and Buffer Zones

Abortion remains a contentious political and moral issue. Those who passionately believe in the right to life of the unborn, the health and wellbeing of women and the cultural fabric of our state must have their political communication protected. This is implied by the Australian Constitution and protected through the International Covenant on Civil and Political Rights (United Nations, 1966; AHRC, n.d.). This right is at risk of being denied with the introduction of protected areas or exclusion zones.

There were claims highlighted in the Committee's first report stating:

> *...women considering or receiving an abortion should not be subjected to harassment, bullying, intimidation or harm through protests, communications, distribution of offensive materials or other acts of aggressive behaviour, and are entitled to sufficient protection of their personal safety and privacy, by the law, in such situations. (The Australian Centre for Health Law Research)*

It is just not true that members of the public who volunteer with groups such as the Helpers of God's Precious Infants, harass and intimidate women seeking abortion. The imposition of exclsuion zones around abortion clinics not only raises serious questions about freedom of speech in a democratic society but it also goes against the very fabric of society. Is it not our desire to reach out and assist our neighbour in need, to journey with our fellowman through their joys and in their hard times that knits us together into caring communities?

There are two reasons why people pray, protest and provide supportive alternatives for women seeking abortion. Firstly, it is because many people recognise the scientific embryologic truth that from the earliest stages of development the unborn are distinct living and whole human beings and so abortion is a killing of that little human. The second reason is that they recognise

the severe pain and anguish being experienced by many of the mothers presenting for abortion. People who stand and quietly pray outside abortion clinics are hopeful that they can offer help to the expectant mother in her crisis and so avert her from making a mistake she may regret and grieve over.

One of the guest presenters at our Cherish Life Conference in May 2016 was a woman called Nancy Cairo from Melbourne and she told us her story. With her permission, we have paraphrased it here.

Nancy caught a taxi to the abortion clinic and as she arrived she saw the pro-life people with their signs. She recalls that as she got out of the taxi a little old lady walked towards her and handed her a pamphlet and said "Do you really want to do this?" Nancy said "No" and started crying. The lady then said: "Do you want to come over and have a talk?" Nancy and the lady went and sat in the lady's car and she phoned another lady called Ann.

Ann came and was a gentle person, so easy to talk to. Nancy said she told her about her partner who was pushing her to abort their baby. Nancy then said: "Ann helped me to realise that I didn't have to do what he was telling me to do. She gave me her phone number, told me about available services, organised some pregnancy clothes, a baby basket full of things for the baby and she kept in touch. I knew I had her as someone I can call on when I needed someone to talk to.

"Recently my daughter turned 5 and Ann came to her birthday party. We both think of her as our very special friend, and my daughter tells me she loves Ann. When I think back at how close I came to aborting my daughter I am overwhelmed with gratitude to have her in my life."

The following statement from Paul Hanrahan, Executive Director of Family Life International, demonstrates the heart behind the help:

> *"So-called safe access zones - "buffer zones"- are built on the lie that people attending abortion mills are harassed, threatened, and intimidated. Those who pray outside these places are there to offer women a real option. The great majority of women entering abortion mills say they have no choice. We have provided that choice to thousands of women around Australia who have accepted our assistance and now have children they would otherwise be mourning. Those women … are being denied the support that is offered freely by kind-hearted, socially responsible citizens who have a right to their freedom of speech, which is being denied also. This is totalitarianism being ushered in to protect the sacred cow of abortion, despite the overwhelming evidence of its harmful effects on women and their partners, on families in general and the wider community they are part of, not to mention the unborn human child who pays the ultimate price for this ideology with their life."*

Current legislation protects us from the state intruding into the realm of individual conscience and belief, providing a statesman's balance in a democratic pluralist society - where there is access for those who believe abortion is permissible. Att the same time it allows dissenters the freedom to peacefully engage in public political opposition to change hearts and minds by telling the truth about abortion and the unborn and supporting vulnerable women facing a crisis pregnancy. It is the truth that transforms. Criminalising dissent would be a totalitarian imposition of the pro-abortion ideology on all Queenslanders.

Appendix 7: Real Choices

Real choice indicates more than one option. My Pyne's abortion bills offer no other choice to a woman experiencing an unplanned pregnancy than the greater access to abortion. This second bill, following on the heels of Mr Pyne's second bill, is simply a poorly formed attempt to gain support for more access to abortion. There is a need to look beyond this option and consider crisis pregnancy from a whole person holistic framework.

Holistic health care is a comprehensive person-centred care system which takes into account the physical, emotional, social, economic, and spiritual needs of a person (Carling-Jenkins, 2015). The Committee report highlighted that many submitters suggested that support for pregnant women should be improved through greater flexibility to allow them to continue with educational aspirations. After birth, to support women who may not see other alternatives, submitters suggested the provision of family-based care and support, on-site child care at university or vocational training facilities, mother mentoring programs for vulnerable women, and family friendly workplaces (Department of Health, 2016). Furthermore, addressing the need for supportive neonatal palliative care service would be beneficial for women facing a fatal foetal diagnosis.

Incorporating a holistic framework either through legislative principles or policy reform is reflective of the public view that abortion should be reduced through social policy (Fleming & Ewing, 2005). Holistic crisis pregnancy care is about real choice and real care that acknowledges the complex issues women face (Mathewes-Green, 2013). Social reform rather than abortion law reform reflects a pro-woman life-affirming whole person approach.

Appendix 8: Inadequate Data available

The Committee report highlighted the lack of quality induced abortion data. Cherish Life Queensland agrees that in order to truly understand, measure and implement best practice it is paramount that quality and transparent statistics on induced abortion are collected and made publicly available for research and accountability purposes.

Children by Choice states:

> *"The lack of accurate information about abortion rates also makes it difficult to plan for service delivery and to monitor whether public health interventions are successful in reducing the unplanned pregnancy and abortion rate, at both state and national levels" (Children by Choice, 2016).*

We support the above statement by Children by Choice and advocate that further research and data collection is required and this must include domestic violence data and a review of overseas practices.

Domestic Violence Research is Required:

There are thousands of anecdotal stories of women aborting because they feel they had no choice (also published stories such as those found in 'Giving Sorrow Words' by Melinda Tankard Reist). These women may be pressured/forced/bullied by the father of their baby who is reluctant to face the long years of financial obligation that the current Child Support Act would impose on him. He is often assisted by his militant mum (the child's paternal grandmother), wishing to protect her son from this financial drain. There are also many reports of the girl's own parents (more often her mother) pushing her towards an abortion as they see this unexpected pregnancy interrupting the plans they have for their daughter. The pregnant girl's wishes often seem to get lost in these circumstances.

With the current abortion practices in Queensland a pregnant girl has to withstand the coercion to abort for the first twelve weeks only. After this time the law provides an umbrella of protection; she knows, and her coercers know, that she has passed the time when an abortion can be legally performed. To decriminalise abortion up to 24 weeks and then to allow it post 24 weeks with the sign-off of two colluding doctors is hardly protecting a pregnant woman in her most vulnerable time.

These forced abortions tell a story of a potential link between domestic violence and abortion. When does pressure become coercion and pushing become physical violence? This aspect requires research as it could well be that by expanding the opportunity for abortions we are in fact placing our vulnerable pregnant women at risk of domestic abuse.

There has never been a time in our Queensland history when there has been such a strong societal will to reduce, and hopefully eradicate, domestic violence. Any future legislation needs to be considered in relation to the potential impact it would have on our domestic violence rates. If we are not to rely on the huge corpus of anecdotal stories about women being pressured against their will into having an abortion, then greater research and collection of empirical data is required before we potentially put women at increased risk of domestic violence by extending the availability of abortions.

International Research is Required:

A comparative study of the abortion practices in other developed countries with similar demography, education, and standard of living is required before Queensland jumps into enacting such draconian legislation as Pyne is proposing.

Germany, Belguim, France, Denmark and Switzerland all have greater restrictions on the practice of abortion, and safeguards in place to protect women from making an uninformed decision.

Poland is currently reviewing its abortion laws to restrict abortion to only those situations where a mother's life is in jeopardy. The US has been steadily introducing legislation that reduces the occurrences of uninformed abortions, and late-term abortions employing inhumane practices of extraction.

We need to review the abortion protocols in these and other progressive countries before we make an informed determination about the implications of Mr Pyne's proposed changes on the State of Queensland.

General Information

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This document is authorised and approved by Julie Borger, President, Cherish Life Qld

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