WOMEN'S FORUM AUSTRALIA

THINK•ACT•MAKE A DIFFERENCE

SUBMISSION ON 'COMMUNITY CONSULTATION: ABORTION LEGISLATION IN WESTERN AUSTRALIA'

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

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

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

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

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

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

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

[2] Above n18, Finer.

The current law and efforts to remove criminal penalties for unlawful abortions

6. As the discussion paper notes, WA was the first Australian state to decriminalise abortion in 1998. Under section 199 of the *Criminal Code*, abortion is lawful in WA, as long as it is performed by a medical practitioner in good faith and with reasonable care and skill, and the performance of the abortion is justified under section 334 of the *Health (Miscellaneous Provisions) Act 1911*. It will be considered justified if:

    - the woman concerned has given informed consent (including receipt of counselling); or
    - the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or
    - there would be serious danger to the physical or mental health of the woman concerned if the abortion is not performed; or
    - for the woman concerned, the pregnancy is causing serious danger to her physical or mental health.

7. If the pregnancy exceeds a gestational period of 20-weeks, the abortion may not be performed by a medical practitioner unless two medical practitioners, who are members of a Ministerial appointed medical panel, have agreed to the abortion. The abortion must be carried out in a facility approved by the Minister for Health.

8. One of the key aims of the proposed law reform is to fully decriminalise abortion and remove it out of the *Criminal Code*. However, the only penalties that remain in the *Criminal Code* relate to a medical practitioner who unlawfully performs an abortion or to a person who is not a medical practitioner who performs an abortion.

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

10. Criminal penalties for women seeking an abortion in WA were abolished during its 1998 abortion law reforms. Women's Forum Australia is, in principle, against the criminalisation of women who have had an abortion. We consider that there are systemic issues which mean that women are not provided with all the support or information available so that they can make a real choice, and due to various pressures, often feel like abortion is their only choice. In our view, it will generally be counter-productive and unjust to charge women under such desperate circumstances, particularly in light of the suffering that many women also experience after abortion.

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

12. Cases such as *R v Smart* (1981) and *R v Sood* [2006] NSWSC 1141, which involved unlawful late term abortions and the dangerous mistreatment of patients, affirm the need to retain the offences for unlawful abortions in the *Criminal Code* as a matter of

justice, deterrence and protection for women. Without such protections, doctors like Dr Smart and Dr Sood may not face adequate penalties, will likely face less scrutiny, and will be less deterred from performing unsafe abortions that benefit them financially. Women would also have to bring their own proceedings, rather than have the protection of the criminal law.

Consultation Questions

13. We address the relevant consultation questions set out in the Discussion Paper below.

Question 13. In relation to obtaining informed consent for abortion and the requirement for mandatory counselling, which option do you support?

Option 1: No change. Retain the existing provisions requiring mandatory counselling in order to obtain informed consent for abortion, as per the Act.

14. In Western Australia (WA), the law specifically requires that a woman has given "informed consent" to an abortion.[3] This is defined to mean consent freely given by the woman where:

    - a medical practitioner has provided counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term and

    - has offered the opportunity of a referral to appropriate and adequate counselling about such matters.

15. Specific requirements for informed consent prior to abortion are also common in European countries and in a large number of US states.

16. The current informed consent requirement in WA is the bare minimum needed to support women in giving informed consent to an abortion and it is one that puts WA ahead of other Australian states and territories when it comes to informed consent protections. Nevertheless, we believe it could be stronger.

17. Informed consent is a legal and ethical right for anyone who undergoes a medical procedure. Given the pressures and lack of support that often drive women to seek an abortion, as well as the physical and psychological risks inherent in abortion, robust safeguards to ensure women are giving fully informed consent, freely and voluntarily, are required. Women seeking to end their pregnancy often experience a sense of desperation and a lack of a real choice. This is a situation that is unique to abortion, as compared with other procedures. As women in these circumstances are often at their most vulnerable, it is of utmost importance that they are provided with as much information as possible about the termination before choosing to consider it.

18. Obtaining informed consent from patients should be a standard part of all good medical practice, however there are countless stories of women who underwent an abortion without giving fully informed consent (whether because they had a lack of information or were not fully free in their decision).[4] This is an issue of such grave importance to women that it should be addressed and enforced.

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[3] *Health (Miscellaneous Provisions) Act 1911*, s334(5).

[4] *Giving Sorrow Words* by Melinda Tankard Reist gives an account of just a small proportion of many such stories.

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

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

    - an offer for independent counselling (it is critical that the counselling offered is independent of the abortion provider from which the woman is seeking an abortion to manage any conflict of interest on the part of the provider, who has a financial interest in terminating the pregnancy); and

    - a waiting period to allow the woman sufficient time to process the information she has received, to take advantage of whatever counselling and support she requires, to understand and weigh up her options and, ultimately, make a fully informed decision.

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

21. A stronger informed consent provision, which specifically outlines the framework of safeguards for ensuring and protecting a woman's informed consent, would align with the practice in other jurisdictions, which appropriately recognise the significance of the decision to abort a child.

Question 14. In relation to the requirement for two medical practitioners to be involved before a woman can have an abortion, which option do you support?

Option 1: No change. Retain the requirement for a pregnant woman to consult with a medical practitioner who is not the medical practitioner who will perform or assist with the performance of the abortion.

22. The current requirement acts as a further safeguard for women who are seeking an abortion. Please see response to Question 19.

Question 15. In relation to health practitioners having a right to conscientiously object to participating in an abortion, which option do you most support?

Option 1: No change. Retain current provision allowing a person, hospital, health institution or other institution to conscientiously object to providing abortion care, without any requirement to refer the patient to a practitioner who is willing and able to assist.

23. It is not unreasonable that, due to various risks of harm to mother and child, some doctors may be opposed to terminating pregnancies on the basis that abortion falls

outside their conception of medicine as a healing profession. It is also widely acknowledged that doctors have a range of ethical views depending on the developmental stage of the foetus or gestational period of the pregnancy.

24. Requiring a health practitioner with a conscientious objection to abortion to refer the patient to a practitioner who 'is willing and able to assist' would not only “contradict one’s very objection to the request in the first place” or cause a doctor to be “complicit in harm”, but it would rightly “cast doubt on the objector’s sincerity”.[5]

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

Question 16. In relation to the gestational age limit at which an abortion can proceed without additional requirements, which option do you most support?

Option 1: No change. Retain additional requirements from 20 weeks gestation.

26. 20 weeks gestation is already considered a ‘late term abortion’. At around 22-24 weeks the baby is viable, with the youngest recorded babies surviving at just 21 weeks. Not only do late term abortions pose serious dangers to women, there is no conceivable medical justification if a baby is at a gestation where it could be delivered and born alive.

27. Advocates of abortion argue that late-term abortions are rare and undertaken only when a woman’s life or health is at risk or where the unborn child suffers from a fatal condition. Yet, a 2013 study undertaken as part of one of the largest studies on abortion in the US, suggests that only a very small proportion are for foetal anomaly or life endangerment.[6]

28. A 2004 study from the pro-abortion Guttmacher Institute found that the most frequent reasons cited for having an abortion *at all gestational ages* included: “that having a child would interfere with a woman’s education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%)."[7]

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

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

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[5] Gerrard J.W. (2009), Is It Ethical for a General Practitioner to Claim a Conscientious Objection When Asked to Refer for Abortion?, *Journal of Medical Ethics* Vol 35, No 10, pp 599–602.
[6] Foster D.G., and Kimport K. (2013), Who seeks abortions at or after 20 weeks?, Perspectives on Sexual and Reproductive Health, Vol 45, No 4, pp 210-218: https://onlinelibrary.wiley.com/doi/epdf/10.1363/4521013.
[7] Finer L.B et al (2005), Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives, Perspectives on Sexual and Reproductive Health, Vol 37, No 3, pp 110–118: https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf.

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

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

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

34. Removing protections against late term abortions is dangerous for women and for "reforms" that seek to 'modernise' the current law, they are out of step with common practice in other jurisdictions,[8] with medical knowledge of foetal viability and pain,[9] and with medical advances including progress in neonatal care.[10]

Question 17. In relation to additional requirements for abortions beyond the gestational age limit (i.e. late term abortions), which option do you most support:

Option 1: No change. Retain the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e. late abortions).

35. We believe that removing this requirement would remove an important safeguard for women seeking late term abortions. Please see response to Question 16.

Question 18. In relation to the requirement for Ministerial approval for a health service to perform late term abortions, which option do you support?

Option 1: No change. Retain the requirement for Ministerial approval for a health service to perform late abortions

36. We believe that removing this requirement would remove an important safeguard for women seeking late term abortions. Please see response to Question 16.

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[8] For example, in many European countries, abortion is only allowed up until 10-12 weeks, after which there are strict conditions that need to be met for an abortion to be.
[9] Doctors on Fetal Pain, www.doctorsonfetalpain.com .
[10] Salter J., "Premature babies: How 24 week-old babies are now able to survive", The Telegraph (17 November 2014): http://www.telegraph.co.uk/women/womens-health/11121592/Premature-babies-How-24-week-old-babies-are-now-able-to- survive.html; "Premature babies", Better Health Channel, https://www.betterhealth.vic.gov.au/health/healthyliving/premature-babies#.

Question 19. Other comments on the proposed reform of the WA legislation regarding abortion.

Abortion harms women – more research needed to inform any law reform

37. Women's Forum, since its 2005 research report entitled "*Women and Abortion*"[11], has continued to monitor research around the world relating to the harmful impact of abortion on women.

38. Abortion carries with it risks of physical harm. While carrying a pregnancy to term also carries physical risks, this does not underscore the importance of recognising and disclosing to women the physical risks of abortion. Risks of physical harm from abortions include infection, haemorrhaging, cervical and uterine damage, and subsequent miscarriage.[12] Physical complications increase significantly for each week of the pregnancy.[13] This increased risk to women depending on the relevant gestational period is another reason why any amendment to the laws surrounding abortion should consider whether abortion should be permitted at all after a certain time.

39. Medical abortion (involving only the use of drugs) is often perceived to be safer and less traumatic. However, a UK study found that women found it more painful and stressful – in particular, seeing and feeling the aborted foetus was distressing.[14] Another UK study stated that women were often not told that they would see the foetus, and then "*some people look and they are so upset because it's a perfectly formed little baby and they didn't expect it to be like that*".[15]

40. Women who have abortions are also at a more increased risk of maternal death or suicide. The Queensland Government has recognised this risk, stating:[16]

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

41. In terms of psychological harm, most researchers agree that at least 10-20% of women suffer from severe negative psychological complications,[17] which impacts a high number of Australian women, given it is estimated a third of Australian women will terminate at least one of their pregnancies.

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[11] Ewing S (2005), "Women and Abortion: An Evidence Based Review" (published by Women's Forum Australia).
[12] Betterhealth.vic.gov.au. (2019). *Abortion procedures - surgical*. <https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-surgical> [Accessed 12 Aug. 2019].
[13] Diedrich J. and Steinauer J. (2009), Complications of surgical abortion, *Clinical Obstetrics and Gynecology*, June Vol 52, No 2, pp 205-212.
[14] Slade P., Heke S., Fletcher J. and Stewart P., Termination of pregnancy: patients' perceptions of care, *The Journal of Family Planning and Reproductive Health Care*, 2001: 27 (2): 72-77.
[15] Lipp A. (2008), A woman-centred service in termination of pregnancy: a grounded theory study, *Contemporary Nurse*, December, Vol 31, No 1, pp 9-11.
[16] Queensland Maternal and Perinatal Quality Council Report 2013, State of Queensland (Department of Health), September 2013, p.16
[17] Coleman PK and Nelson ES, The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes, *J Social and Clinical Psychology*, 1998:17(4): 425-442.

42. Risks of psychological harm from abortion include depression, anxiety, suicidal behaviours and substance use disorders.[18] In depth interviews with women have shown that these psychological harms are often long-term, emerging months or years after the abortion. While these reactions are often cited as "normal" by health professionals, we need to ask ourselves whether decisions which have such significant psychological effects on women are truly empowering.

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

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

Further protections needed

45. Any reforms to WA's abortion laws should also include protections:

- for women who are coerced into abortions
- for underage women/girls seeking an abortion
- against discriminatory abortions i.e. on the basis of disability or sex
- for babies who are born alive after an attempted abortion

46. You can refer to our submission on the 2019 NSW abortion law reforms for more information on our position regarding these four issues, and on the proposed WA reforms more generally.[19]

47. Please let us know if you require any further information.

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

[19] Women's Forum Australia, Submission to the Standing Committee on Social Issues Inquiry into The Reproductive Health Care Reform Bill 2019 (NSW).
https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf