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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
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Canberra ACT 2600

By email to community.affairs.sen@aph.gov.au

Dear Committee Members,

Submission on Federal Inquiry into the Universal Access to Reproductive Healthcare

Thank you for granting us an extension of time with which to provide this submission.

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 and girls, with a particular focus on addressing behaviour and practices that are harmful and abusive to them. Such issues include the sexualisation and objectification of women and girls particularly in media and advertising, violence against women, pornography, prostitution and trafficking, abortion, adoption, surrogacy, and harmful gender policies and practices.

Women's Forum Australia welcomes the opportunity to contribute to the Senate's inquiry into 'universal access to reproductive healthcare' in Australia and is available to answer questions if requested.

Yours faithfully,

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Rachael Wong
CEO, Women's Forum Australia

Background

1. In all Australian states and territories abortion is legal and effectively available throughout all nine months of pregnancy with little restriction.[1] As one of the most common medical procedures in Australia, with between one quarter and one third of women experiencing an abortion in their lifetime,[2] and nearly 90,000 performed in Australia each year,[3] it is also readily accessible.

2. Despite this reality, the Australian Greens believe we need more abortion. In the wake of the US Supreme Court's decision to overturn Roe v Wade in June which nullified the country's constitutional right to abortion, the Greens used the opportunity to call for a Federal Senate inquiry into 'universal access to reproductive healthcare'.

3. While the Terms of Reference refer to 'reproductive healthcare' more broadly, the Greens' media release makes it clear that the focus of the inquiry is on abortion, with the goal to make it easily and freely accessible throughout Australia, particularly in regional and remote areas.[4]

4. However, if anything, the reversal of *Roe* should prompt reconsideration of our abortion on demand approach, rather than be used to justify greater abortion access.

5. *Roe* was an ideologically motivated decision that interpreted a right to abortion in the US Constitution where one doesn't exist, distorted the Court's constitutional jurisprudence, and led to the US having some of the most permissive abortion laws in the world. Indeed, even pro-choice legal scholars agree that it's legal reasoning was deeply flawed.[5] Its reversal does not make abortion illegal in the US, but allows states to decide whether to radically allow abortion through all nine months of pregnancy or to restrict it.

6. There is no doubt that *Roe* – a decision which effectively legitimised abortion on demand – has had devastating consequences for women and their unborn children. Millions of women have had the trauma of abortion piled upon often already difficult and painful circumstances, and millions more children have had their humanity denied and their lives ended. Furthermore, readily available abortion has stalled decades of progress for women's rights and welfare (discussed further below).[6]

Terms of reference

7. The inquiry's Terms of Reference invite submissions on "Barriers to achieving priorities

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[1] See for example, commentary in our submission on the 2019 NSW Reproductive Health Care Reform Bill. https://www.parliament.nsw.gov.au/lcdocs/submissions/64887/0046%20Womens%20Forum%20Australia.pdf

[2] Children by Choice, 'Abortion Rates in Australia'. https://www.childrenbychoice.org.au/resources-statistics/papers-reports/abortion-rates-in-australia/

[3] Louise A Keogh, Lyle C Gurrin and Patricia Moore, Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data**,** Med J Aust 2021; 215 (8): 375-376. https://www.mja.com.au/system/files/issues/215_08/mja251217.pdf

[4] Australian Greens, 'Greens move for abortion access Senate inquiry', 28 September 2022. https://greensmps.org.au/articles/greens-move-abortion-access-senate-inquiry

[5] Ryan T. Anderson and Alexandra DeSantis, 'Roe was wrong the day it was decided. The Supreme Court did the right thing', News Week, 24 June 2022. https://www.newsweek.com/roe-was-wrong-day-it-was-decided-supreme-court-did-right-thing-opinion-1719085

[6] Erika Bachiochi, 'The feminist revolution has stalled. Blame Roe v. Wade', America Magazine, 1 November 2021. https://www.americamagazine.org/politics-society/2021/11/01/roe-wade-casey-texas-heartbeat-law-241725

under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies", with particular reference to eight key areas and "any other related matter" (emphasis added). We address several of these areas below.

8. Given the inquiry's clear focus on abortion, our submission will also largely focus on abortion.

A. Cost and accessibility of contraceptives

9. More and more research is surfacing regarding the risks of contraceptives to women's health. For example, a recent study of one million women in Denmark found a substantially increased risk of depression among women who used hormonal contraception with the highest rate occurring in teenage girls.[7]

10. As Alexandra DeSanctis from the Ethics and Public Policy Center notes, depression is not the only possible side effect for women who use hormonal contraception:[8]

> *"A number of studies have shown that women on the pill have a higher risk for developing breast cancer; the World Health Organization has classified many hormonal contraceptives as class-one carcinogens. There are reports that Plan B One-Step, an emergency contraceptive that can function as an abortifacient, necessarily causes systemic side effects in every woman who takes the drug. Hormonal contraception clearly poses terrible risks to women's health".*

11. The risk of blood clotting associated with combined oral contraceptives is of course another risk, with somewhere between 5 and 12 women per 10,000 being affected.[9]

12. Intrauterine contraceptive devices (IUDs), a type of long-acting reversible contraceptive, come with their own problems. These include increased risks of infection, irregular bleeding, cramping, ovarian cysts and uterine perforation.[10] Recent lawsuits brought against Bayer Pharmaceuticals over its Mirena IUD demonstrate just how devastating IUDs can be, with thousands of women claiming serious physical harm, including organ perforation and intracranial hypertension (fluid buildup near the skull).[11]

13. Given the harmful risks associated with hormonal contraceptives, we need to ask whether increasing access to them is really in women's best interests. Birth control, in particular the Pill, has become such a rite of passage for young women that many don't quite know how their reproductive system works and many are not aware of the toll it

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[7] Charlotte Wessel Skovlund, Lina Steinrud Mørch, Lars Vedel Kessing et al, Association of Hormonal Contraception with Depression**,** JAMA Psychiatry 2016; 73(11): 1154-1162. https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2552796

[8] Alexandra DeSantis, 'Double standard: Male birth-control study cancelled due to side effects, National Review, 31 October 2016. https://www.nationalreview.com/corner/male-birth-control-study-cancelled-after-side-effects/

[9] Therapeutic Goods Administration, 'Update – Dienogest and risk of venous thromboembolism', 23 June 2021. https://www.tga.gov.au/news/safety-updates/update-dienogest-and-risk-venous-thromboembolism

[10] Stephanie Watson, 'IUD Side Effects', WebMD, 17 April 2021. https://www.webmd.com/sex/birth-control/iud-side-effects#:~:text=An%20IUD%20slightly%20raises%20your,after%20you%20get%20the%20IUD

[11] Toni Matthews-El, 'Mirena IUD lawsuit update December 2022', Forbes Advisor, 28 September 2022. https://www.forbes.com/advisor/legal/product-liability/mirena-iud-lawsuit/

takes on their bodies.[12] As natural fertility educator and author Jane Bennett says, "'We have such an issue around the potential of unwanted pregnancy that we like to skip over many issues with the pill...It's definitely been either ignored or under-appreciated."[13]

14. Rather than simply pushing for greater access to contraception, women would be better served with greater education about its risks, and the natural, non-harmful ways of delaying pregnancy.

B. Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas

15. As noted above, abortion is already widely accessible in Australia. Not only is greater access unnecessary, it is counterproductive to women's health and to "empowering choice" for women. This is because:

    i. Abortion harms women
    ii. Greater access to abortion will not address the underlying issues women face, and will further disincentivise addressing such issues
    iii. Telehealth 'medical abortions' present particular risks, especially for women in regional and remote areas

16. Conversely, greater access to pregnancy care and support is critical to empower women with real choice when facing an unplanned pregnancy. We consider further these four points below.

i. Abortion harms women

17. Women's Forum Australia, since its 2005 research report entitled "*Women and Abortion*"[14], has continued to monitor research around the world relating to the harmful impact of abortion on women.

18. 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.[15] Physical complications increase significantly for each week of the pregnancy.[16]

19. 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.[17]

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[12] Tamara El-Rahi, 'All-natural please, except for birth control', Women's Forum Australia, 16 December 2019. https://www.womensforumaustralia.org/all_natural_please_except_for_birth_control
[13] WH Staff, 'Is the Pill changing how you think?', Women's Health, 18 December 2019. https://www.womenshealth.com.au/the-pill-side-effects/
[14] Selena Ewing, 'Women and Abortion: An Evidence Based Review', Women's Forum Australia, 2005.
[15] Better Health Channel, 'Abortion procedures – surgical'. https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-procedures-surgical
[16] Diedrich J. and Steinauer J. (2009), Complications of surgical abortion, *Clinical Obstetrics and Gynecology*, June Vol 52, No 2, pp 205-212.
[17] 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.

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*".[18]

20. Women who have abortions are also at a more increased risk of maternal death or suicide. The Queensland Government has recognised this risk, stating:[19]

> "*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."*

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

22. Risks of psychological harm from abortion include depression, anxiety, suicidal behaviours and substance use disorders.[21] 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.

23. 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.

24. From our research, it is evident that abortion harms women. More 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".

ii. Greater access to abortion will not address the underlying issues women face, and will further disincentivise addressing such issues

25. Greater access to abortion will do nothing to address the social inequities that drive women to seek abortion in the first place.

26. For our society to be genuinely pro-woman on the sensitive issue of unplanned

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[18] 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.
[19] Queensland Maternal and Perinatal Quality Council Report 2013, State of Queensland (Department of Health), September 2013, p.16
[20] 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.
[21] 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.

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.

27. Women who abort often cite reasons such as fear of intimate partner violence,[22] coercion from their partner or others, study or career pressures, and a lack of financial and emotional support.[23]

28. A study from the pro-abortion Guttmacher Institute found that the most frequent reasons cited for having an abortion 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%)."[24] In addition:

> *"[Q]ualitative data from in-depth interviews portrayed women who had had an abortion as typically feeling that they had no other choice, given their limited resources and existing responsibilities to others."*

29. Women who seek late-term abortions are often in particularly vulnerable situations with a limited support system. Another study Guttmacher 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]." [25]

30. Abortion under these circumstances is not choice, it is desperation.

31. Not only will greater access to abortion not address the underlying issues that drive women to seek abortion in the first place, it will further disincentivise addressing such issues.[26]

32. Ready access to the Band-Aid solution of abortion has removed the incentive for governments, employers and men to properly support women who are facing an unintended pregnancy, and to provide a humane response to the underlying issues that drive women to seek abortion in the first place – a lack of financial, practical or emotional support, inflexible study/work arrangements, unaffordable housing and childcare, domestic violence and so on.

33. As a result, women still have to contend with outdated, male-oriented systems that are

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[22] 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.

[23] 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.

[24] Ibid.

[25] 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.

[26] Rachael Wong, 'The world women and children deserve', The Spectator, 9 July 2022. https://www.spectator.com.au/2022/07/the-world-women-and-children-deserve/

not designed to adequately accommodate and support them or their children during pregnancy and motherhood. This in turn has fed the lie that abortion is necessary for women's equal participation in society and that children are an obstacle to women's success and flourishing.

34. 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.

35. 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.

iii. Telehealth 'medical abortions' present particular risks, especially for women in regional and remote areas

36. The National Women's Health Strategy referred to in the Terms of Reference says that one way to "Strengthen access pathways to sexual and reproductive health services across the country, particularly in rural and remote areas" is to "Invest in and support the development and expansion of telehealth services and new models of care".

37. Those pushing for greater access to abortion in Australia, have persistently advocated for the "expansion of telehealth services" in the context of the RU486 abortion pill (also known as a 'medical abortion'). RU486 is the common term for the anti-hormone Mifepristone, which blocks the effects of progesterone, a hormone needed to provide nourishment to the baby during pregnancy. This drug is administered in combination with Misoprostol, another drug administered 36-48 hours later, which relaxes the cervix and induces contractions so as to expel the baby.

38. The push for telehealth medical abortions (or 'tele-abortions') is so that women – particularly rural women – can more easily obtain the abortion pill from their GP (including via mail after a phone consultation) and undertake the abortion themselves at home, without having to travel long distances to metropolitan areas.

39. There are however, significant health risks associated with taking RU486. The Therapeutic Goods Administration states that common adverse side effects include: "nausea, vomiting, diarrhoea, dizziness, gastric discomfort, abdominal pain, headache, vaginal bleeding, uterine spasm, fatigue, chills / fever, effects related to the abortion itself include prolonged post-abortion bleeding, spotting, severe haemorrhage, endometritis, breast tenderness, heavy bleeding and fainting."[27] It notes that "bleeding and pain is even more intense with a medical termination".

40. If the medical abortion fails to complete – which happens in at least 2-7% of cases –

[27] Therapeutic Goods Administration, 'Registration of medicines for the medical termination of early pregnancy', 30 August 2012. https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy

the woman will then need to undergo a surgical abortion.[28]

41. This is to say nothing of the psychological impact of abortion, particularly in the case of a medical abortion, which is a much more drawn out process and where the woman may have to deal with the above side-effects alone. She may also be confronted and traumatised by the experience of seeing the foetus being expelled.

42. To quote Edouard Sakiz, the former chairman of Roussel-Uclaf, the French company that developed RU486: "As abortifacients procedures go, RU486 is not at all easy to use… a woman who wants to end her pregnancy has to live with her abortion for at least a week using this technique. It's an appalling psychological ordeal."[29]

43. The irony is, that reasons given for expanding women's access to medical abortions (for example because women live remotely or they cannot afford to travel to a clinic) may be the very reasons that this method is more hazardous for them. Women experiencing adverse side effects or complications but without access to adequate medical care, particularly for those who live in regional or remote parts of Australia, can be caught in a very perilous situation. The risks of haemorrhage, infection, incomplete abortion, or unintended late-term abortions, are all serious complications which can be fatal without proper access to medical treatment or care.

44. Recent stories and data from the UK demonstrate the particular safety risks of receiving the abortion pill via a telehealth consultation and undertaking 'at-home abortions'.

45. This year, a sixteen-year-old girl in the UK described the horror of at-home abortion after a telehealth consultation miscalculated her gestation by 12 weeks.[30] Savannah (not her real name) had a phone consultation with a British Pregnancy Advisory Service abortion clinic, who determined that she was less than 8 weeks pregnant. When she collected the abortion pills from the clinic, they did not scan or examine her, and after taking them at home, she felt "really bad" pain.

> *"My relative called another ambulance because when I was pushing, my boyfriend could see feet," Savannah said.*
>
> *The baby had been born with a heartbeat and they had both been taken to hospital. It was concluded she had been between 20 and 21 weeks pregnant.*
>
> *Savannah said she had been left traumatised.*
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> *"If they scanned me and I knew that I was that far gone, then I would have had him," she said.*

46. Savannah's story is not an anomaly. According to UK politician Carla Lockhart:

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[28] Ibid.
[29] *Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005*, Second Reading, Baldwin, 16 February 2006. https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22chamber/hansardr/2006-02-16/0046%22;src1=sm1
[30] Dr Faye Kirkland, 'Clinics call for at-home abortions to continue', BBC News, 30 March 2022. https://www.bbc.co.uk/news/health-60912656

> *"Similar reports have been made by the body that comprises all senior NHS doctors and nurses who fulfil statutory child safeguarding functions in the NHS, the National Network of Designated Health Care Professionals for Children. Specifically, it has recorded 47 cases of early medical abortions that resulted in mid-to-late pregnancy terminations, across all ages, since the start of the pandemic in March 2020. Six involved girls and in half of those cases and 12 instances in total, there had been signs of life."*

47. Early medical abortions UK lead Dr Helen Daley, a consultant paediatrician, said: "We've had young people say they are depressed, anxious, afraid to go out, months after the event. We've also had staff being hugely traumatised."

48. Savannah's story was published on the same day that the House of Commons in the UK voted to make its controversial 'medical abortion at home' scheme in England permanent. Critics of the scheme point to the inherent risks for women, especially those vulnerable to coercion or medical complications:[31]

> *"This scheme, introduced out of desperation during COVID, allowed abortion vendors to place women's safety at risk by sending abortion pills out in the mail to them (or potentially to their abusers). This required no face to face consultation, a critical safeguard against coerced abortion, life-threatening ruptured ectopic pregnancies and a litany of other possible risks. It was a devastating decision for the safety of the most vulnerable women.*
>
> *"Abortion providers used to reassure women at risk of coerced abortion – often domestic abuse or sex trafficking victims – that they would be seen in person to ensure they were not being forced into it. Some of them still do. But telemedicine cannot possibly provide the privacy necessary to ensure this, since someone else could easily be in the room dictating the woman's answers. Since a quarter of abortions are coerced by men, the removal of this safeguard was brilliant news for abusers, traffickers and abortion providers. It was not so good news for vulnerable women."*

49. Concerns about women's physical safety have also been raised by women who have taken the pills:[32]

> *"A nurse who experienced extreme complications from an 'at-home' abortion that required follow-up surgery expressed her shock that "the UK, with all of our research and expertise, would approve this… it just feels like we are going backwards and that… covid is an excuse to not treat women with respect"."*

50. Data collected about the reporting of complications following at home abortions during the temporary operation of the UK scheme (between June 2019 to May 2020) found it was considerably underreported, and revealed that more than 10,000 women participating in the scheme "ended up needing hospital treatment to deal with the side-

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[31] Calum Miller, 'Time to close Pandora's Box', The Critic, 22 February 2022. https://thecritic.co.uk/time-to-close-pandoras-box/

[32] Carla Lockhart MP, 'At-home abortion is a disservice to women', Politics Home, 29 June 2021. https://www.politicshome.com/thehouse/article/athome-abortion-is-a-disservice-to-women

effects".[33] This equates to 1 in 17 women or approximately 20 a day. The author of the study, Kevin Duffy, stated that the results reveal "serious flaws in how complications are reported and how taking abortion care out of clinics and allowing women to take both abortion pills at home significantly increases safety risks". It was only through leaked emails and freedom of information requests that the true extent of the risks to women became known:[34]

> *"Other alarming cases are well known from a leaked NHS email last year. This included more ruptured ectopic pregnancies and resuscitation for major haemorrhage. The lack of examination and ultrasound prior to abortion meant that babies could be aborted at any gestation at home, putting the mother at risk of dangerous late-term abortions with no medical supervision, and allowing the possibility of fully developed babies being born alive after attempted abortion. The e-mail noted cases of infants being born at up to 30 weeks' gestation, and a murder investigation for a baby who was born alive and subsequently died. All of these were in one region alone."*

51. None of these concerns were addressed by the UK government as it pushed ahead with this service on a permanent basis.

52. In Australia, Marie Stopes Australia and Clinic 66 are two abortion providers that offer tele-abortions (also referred to as abortion online). However, despite this most recent study from the UK, and publicly available data from the Therapeutic Goods Administration (TGA), the practice continues to be promoted by abortion providers as safe and effective, downplaying the potential for side effects and complications.

53. For example, the Marie Stopes Australia website understates the rate of incomplete abortion,[35] stating that this occurs in 1-4% of cases. Similarly, the Abortion Online website (which is closely aligned with the Clinic 66 sexual health clinic) states (in a somewhat confusing way) that in "5% of cases, medical abortion is not straightforward, though has a 98% success rate".[36] It further states that in "1-2% of cases of medical abortion, a surgical procedure is required to complete the process". Both websites are in contrast with the TGA's website, which cites 2-7% chance of incomplete abortion, necessitating a surgical abortion.[37]

54. This latest study from the United Kingdom provides valuable information about the reality of the abortion pill and its risks for women. Informed consent cannot be said to have been provided unless women are given accurate information, and downplaying the potential risks of medical abortion will only serve to ultimately harm women. The medical profession and abortion providers are putting women at risk by promoting this practice and not providing accurate information about its harmful side effects and complications.

55. Instead of greater access to a drug with painful, dangerous and traumatic side-effects, rural women (and all women) need greater access to high quality pregnancy care,

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[33] Women's Forum Australia, 'Thousands of women hospitalised in UK following DIY abortions', 2 December 2021. https://www.womensforumaustralia.org/thousands_of_women_hospitalised_in_uk_following_diy_home_abortions
[34] Above n, 31.
[35] Marie Stopes International Australia, 'Abortion services'. https://www.mariestopes.org.au/abortion/medical-abortion/
[36] Abortion Online, 'Tele-abortion: frequently asked questions'. https://www.abortiononline.com.au/faqs-about-medical-abortion-at-home
[37] Above n, 27.

information and support, so that they are not deceived into thinking that abortion is their best or only choice when faced with a difficult or unplanned pregnancy.

iv. Greater access to pregnancy care and support is critical to empower women with real choice

56. Now that states and territories across Australia have decriminalised abortion, 'equality of access' has become a focal point of abortion advocates. And yet, there are broader considerations that need to be addressed when discussing 'equality of access': how can we support women who find themselves pregnant in difficult circumstances and want to continue their pregnancies? What are the real needs of women who find themselves experiencing an unexpected pregnancy? Is greater access to abortion really the highest priority?

57. There is a desperate need for greater support for women seeking non-abortion care and assistance in the context of experiencing an unplanned or unexpected pregnancy. At no level of government in Australia is such care properly supported or provided. To the extent that such care and support is available for non-abortion options, it is generally done through the activity of small not-for-profits and some limited services provided by religious based organisations.

58. One example of such not-for-profits, is Diamond Women in NSW,[38] who do an incredible job offering free, compassionate and non-judgemental care and support to women who are struggling with an unplanned pregnancy or suffering after an abortion. Their website reads:

> *"We are a group of dedicated professionals and individuals that seek to support and empower women in their unexpected pregnancy journey, focused on reducing the incidence of mental health disorders during the perinatal period. We create a safe space for you to navigate all the information, options and support available to you whilst committed to your journey."*

59. Their services include everything from providing information and resources, to counselling and mentoring. The work of such organisations is invaluable when it comes to providing care and assistance for women wanting to continue with an unplanned or unexpected pregnancy.

60. We need to stop promoting abortion as a catch-all, magic bullet solution to the issues facing women. It is time to start a conversation about the complexities surrounding unplanned or unwanted pregnancies, and at the very least, offering women support that addresses the underlying issues that may be drivers of requests for abortion.

61. If our government is serious about genuinely empowering and supporting women, its focus cannot simply be on expanding access to abortion; instead, there must be commitment to a woman-centred approach that provides holistic support to women facing unplanned pregnancies.

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[38] Diamond Women. https://www.diamondwomen.com.au/

C. Best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

Protections against coercion, particularly for women experiencing domestic violence

62. With regard to trauma-informed service delivery, it is critical that health practitioners are aware of the risk of coerced abortion facing vulnerable women, particularly those in situations of domestic violence.

63. Some commentators say that greater access to abortion will help women experiencing domestic violence. However, this does not take into account women who may be at risk of coercion. Moreover, abortion does not in any way undo or address domestic violence and in the case of women suffering domestic violence, abortion heaps further violence and trauma upon these women.[39]

64. Past polls in NSW and Queensland show that one in four people knows at least one woman who has been pressured into having an abortion. In 2017, NSW saw two shocking cases of NRL players who had coerced their girlfriends into having abortions.[40] In 2018, during parliamentary hearings on the Queensland abortion bill, an abortion provider admitted to performing abortions on women she knew were being coerced.[41]

65. General requirements for informed consent cannot act as a wholesale safeguard for all women, particularly women experiencing intimate partner violence or women at risk of coercion. Particularly as coercion may appear in the absence of any other form of physical or sexual violence.[42] This increases the difficulty of detection in the absence of appropriate screening and in the absence of training.

66. It is widely accepted that there is an association between intimate partner violence and reproductive coercion.[43] Further, the *Pregnancy Care Guidelines* ("the guidelines") produced by the Department of Health recognised that "[v]iolence in pregnancy poses significant risk for women".[44] In 2013, the Australia Bureau of Statistics reported that 22% of women who were pregnant at some time during a relationship experienced violence with their current partner, with 13% reporting that violence occurred for the first time during pregnancy.[45] The guidelines also reported that intimate partner violence is associated with adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations and delayed pregnancy care.[46]

67. Some recent international studies have recommended that reproductive coercion be identified and treated as separate or a "specific behaviour associated with the coercive

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[39] Rachael Wong, 'Abortion won't stop domestic violence', The Australian, 8 August 2019. https://www.theaustralian.com.au/commentary/abortion-wont-stop-violence/news-story/acf48960b83b865d9578ddf49a15753c

[40] Rachael Wong, 'Abortion coercion: the NRL still has a long way to go in its treatment of women', Online Opinion, 20 March 2017. www.onlineopinion.com.au/view.asp?article=18914.

[41] https://www.facebook.com/WomensForumAustralia/videos/2415358878711240/UzpfSTYzMjAxODI3NzoxMDE1NzYzOTUwNjMwODI3OA/

[42] Clark et al (2014); Northridge et al (2017).

[43] Grace and Anderson (2018).

[44] Commonwealth Government Department of Health, 'Pregnancy Guidelines, Chapter 29: Family Violence, 21 November 2018.

[45] ABS (2013).

[46] World Health Organisation (2013).

control that underpins" domestic violence or intimate partner violence.[47] In some cases reproductive coercion has been identified as an indication of abusive behaviour, while others suggest it could be "a secondary form of control in addition to physical abuse".[48] In other studies, reproductive coercion is defined as form or tactic of intimate partner violence (as opposed to a distinct phenomena).[49] The correlation between pregnancy, intimate partner violence, coercive behaviours and abortion must be understood and acted upon.

68. Further, a medical practitioner is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. They also identify health-care providers as the professional they would most trust with disclosure of abuse.[50] The World Health Organisation recommended that all health professionals be trained in "first-line response" to family and intimate partner violence. The steps are to: listen, believe, inquire about needs, validate the person's experience, enhance safety and offer ongoing support.[51]

69. Reproductive coercion appears to have only recently become the subject of focused study in Australia, with studies published in academic literature in 2018 and 2019. One study concluded "pregnant and postpartum women need to be screened for partner violence that compromises women's decision-making power regarding their reproductive rights".[52] The result of a recent study in Queensland, which explored "the prevalence and associations with reproductive coercion", suggested that whilst a number of women experienced reproductive coercion independently of other forms of domestic violence, the majority of women experienced reproductive coercion in circumstances of domestic violence.[53] It was suggested that such results support the need for screening (and re-screening) of reproductive coercion within a health care setting and "as a distinct part of screening for violence during a health care relationship".[54] Another study suggested the lack of robust evidence as well as the poor understanding and awareness within the community as contributing towards the issue of reproductive coercion being neglected in policy, research and practice.[55]

70. In light of that research, protections for women at risk of intimate partner violence and/or coerced abortion are critical. Any reforms should include robust screening safeguards, as well as reforming the criminal law to include anti-coercion legislation. Criminal penalties should apply to any person who intentionally coerces or attempts to coerce a woman into undergoing an abortion against her will, as well as any doctor who performs an abortion on a knowingly coerced woman. No woman should be coerced into terminating a pregnancy she wants to keep. Such coercion is abhorrent and the criminal law should recognise this.

71. It is strongly recommended, even in the absence of law reform in this area, that further research and consultation is conducted with respect to the following:

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[47] Douglas and Kerr (2018).
[48] Ibid.
[49] Ibid.
[50] World Health Organisation (2013).
[51] Ibid.
[52] Bauleni et al (2018).
[53] Price et al (2019).
[54] Ibid.
[55] Tarzia (2018).

- developing a clear understanding around how reproductive coercion is defined and situated, together with coerced abortion, within a broader framework of violence against women;

- understanding the association of reproductive coercion (and coerced abortion) with other forms of violence; and

- developing Australian-based studies into the issue of reproductive coercion (and coerced abortion) as a basis to develop evidence-based guidelines for all health practitioners and to determine what a "best practice" or "first line" response should look like and how to implement it.

72. Whilst our submission is focused upon the need to consider coerced abortion, we recognise that reproductive health care issues are broad and complex and must be understood within their relevant broader frameworks to ensure women are truly protected.

Protections against sex-selective abortion

73. With regard to culturally appropriate service delivery, it is important that abortion providers are aware of the discriminatory practice of sex-selective abortion and how it is more prominent in certain cultures.

74. Sex selective abortion is a well-known problem in China and India, where son-preference cultures have resulted in extremely skewed sex ratios. Sex discrimination carried out via abortion is well documented and has resulted in millions of "missing" girls in some societies.[56] As many as 200 million women and girls are missing worldwide as a result of gendercide. A 2019 study found that sex-selective abortion accounts for over 23 million of these missing females.[57] The practice of sex selection has been widely condemned.[58] Moreover, it is widely known that women from son-preference cultures face pressure and coercion to abort their daughters.

75. There is evidence that sex selective abortion is already occurring in some parts of Australia. Take for example, the high-profile case of Dr Mark Hobart who refused to perform a sex-selective abortion in Victoria,[59] or the investigation by SBS that found a

[56] Hvistendahl, M., 2011, Unnatural Selection: Choosing Boys Over Girls and the Consequences of a World Full of Men, Public Affairs Publishing. See also: "It's a girl": http://www.itsagirlmovie.com; The Economist, "The War on Baby Girls", 4 March 2010: http://www.economist.com/node/15606229; United Nations Population Fund, "Gender-Biased Sex Selection": http://www.unfpa.org/gender-biased-sex-selection;

[57] Fengqing Chao, Patrick Gerland, Alex R. Book and Leontine Alkema, Systematic assessment of the sex ratio at birth for all countries and estimation of national imbalances and regional reference levels, PNAS 2019; 116(19); 9303-9311. https://www.pnas.org/content/116/19/9303

[58] See for example: Agreed Conclusions on the Elimination of All Forms of Discrimination and Violence Against the Girl Child, Commission on the Status of Women, 51st Session (26 February – 9 March 2007), resolving that we should, "Eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection, which may have significant repercussions for society as a whole."
http://www.unwomen.org/~/media/headquarters/attachments/sections/csw/51/csw51_e_final.pdf.

[59] Miranda Devine, 'Doctor risks his career after refusing abortion referral', Herald Sun, 5 October 2013. http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion- referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5

higher number of boys than girls being born in some ethnic communities in Australia.[60] There is also the more recent study from La Trobe University which indicates that in Victoria – a state which reformed its abortion laws to allow abortion on request for any reason in 2008 – sex selective practices are taking place, with an alarmingly higher number of boys being born than girls in some ethnic communities.[61]

76. As well as protecting young girls from violence and discrimination before they are even born, an approach which acknowledges that sex-selective abortion is more prevalent in specific cultures and which seeks to detect and prevent sex-selective abortion, would also afford some protection to women from son-preference cultures who are coerced into aborting their daughters.

77. During the debate on NSW's 2019 abortion law reforms, one politician raised the concern that linking the motivation of sex-selection to certain communities could lead to discrimination and racial profiling of women of colour and immigrant women. However, the reality is that sex-selective abortion *is* practiced in particular ethnic and migrant communities. What they profiling, we call screening, which is a safeguard for these women as well as their unborn daughters. Of course, any screening process must be undertaken sensitively and respectfully, but by turning a blind eye, we are failing women and girls who fall victim to sex-selective abortion.

Protections for underage women/girls

78. Best practice approaches also need enhancing when it comes to the support and protection of underage women who request an abortion.

79. In Australia, age of consent laws are designed to protect children and young people from sexual exploitation and abuse.[62] It is illegal for a person to have sexual intercourse with a person under the age of 16 years. Further, the legal age for marriage is 18 years.[63] These laws are not arbitrary; their intent is to ensure that that the law protects those in our society (that is, children) who are particularly vulnerable to sexual abuse or coercion.

80. Our laws should not turn a blind eye to the fact that, in most circumstances where a woman who is under the age of 16 years (a minor) is pregnant, a crime has been committed. The pregnant woman is not the perpetrator of that crime, yet she bears the consequences. Further, in no circumstances should a medical practitioner assume that such a crime is of minor significance in a modern world; quite the contrary. In a world where almost 1 in 5 women has suffered sexual violence since around the age of 15,[64] a medical practitioner has a greater obligation to take all steps possible to ensure that a pregnant minor who arrives at a clinic requesting an abortion is safe from any potential abuse or coercion.

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[60] SBS, 'Could gender-selective abortions be happening in Australia?', 28 August 2015. https://www.sbs.com.au/news/could-gender-selective-abortions-be-happening-in-australia

[61] Edvardsson K., Axmon A., Powell R. and Davey M. (2018), Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015, *International Journal of Epidemiology*: https://doi.org/10.1093/ije/dyy148; Aisha Dow, 'The 'missing girls' never born in Victoria', The Age, 12 August 2018. https://www.theage.com.au/national/victoria/the-missing-girls-never-born-in-victoria-20180811-p4zwxe.html?_ga=2.153057081.1038406648.1539284571-2039037577.1506596324.

[62] Child Family Community Australia, 'Age of consent laws', 2021. https://aifs.gov.au/cfca/publications/age-consent-laws

[63] *Marriage Act 1961* (Cth), s 11.

[64] Australian Bureau of Statistics (ABS), 'Personal Safety, Australia', 2016. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0

81. Although there are others, for this reason alone, any reforms should require that a parent of a child under the age of 16 who has requested a termination should be notified. The absence of such a requirement in the abortion laws of most Australian states and territories functions as a shield for perpetrators of abuse such as rape, or incest. If in the circumstances it is not in the best interests of the minor for their parent to be notified, notification should instead be provided to a grandparent, legal guardian, or state authority.

82. Our laws should also be concerned to ensure that pregnant minors have the best, and most accessible, support available to them. It is evident that for an adolescent, the realisation of an unplanned pregnancy, whether later terminated or not, is in most cases an alarming event which has the potential to significantly impact their lives. The situation calls for both material and emotional support from the people closest to them.

83. Except in exceptional circumstances, the direct source of adult support for most adolescents is a parent, grandparent or legal guardian (hereinafter referred to collectively as 'parents'). Whether the decision made by the adolescent is abortion, parenting or adoption, parents are far more likely to have the material resources to ensure that their child receives the best care possible. They are more likely to be in a position to offer information and knowledge that may assist the medical practitioner in providing that care and ensuring informed consent. Given the usual concern a parent has for their child, parents are also the most likely candidates for the provision of emotional, psychological or any other support necessary to facilitate the best outcome for the child.[65]

84. Parents are also best placed to monitor complications arising from any medical procedures that may be performed. As noted above, risks of physical harm from abortions include infection, haemorrhaging, cervical and uterine damage, and subsequent miscarriage.[66] Risks of psychological harm include depression, anxiety, suicidal behaviours and substance use disorders.[67] Where these risks manifest, meaningful support is more likely to be available where parents are fully aware of them; there is also evidence to show that parental involvement laws are associated with a reduction in suicide rates among females.[68] Our laws should make every effort to avoid situations where adolescents are left to face these risks alone.

85. A further purpose of laws which require parental involvement in decisions impacting children or adolescents, is to recognise the particular vulnerability of adolescents' cognitive immaturity in the face of important decisions. Paediatric studies commonly indicate that adolescents do not attain adult levels of competence to make decisions until at least 18, with some even indicating that full maturity in executive brain functioning isn't reached until much later, in the early to mid-20s.[69] The law recognises this by affirming that there are some important decisions with potentially significant

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[65] American College of Pediatricians, 'Parental Involvement and Consent for a Minor's Abortion', 2019. https://www.acpeds.org/the-college-speaks/position-statements/parental-involvement-and-consent-for-a-minors-abortion

[66] Above, n 15.

[67] 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.

[68] In one study published in the Economic Inquiry journal, the enactment of parental involvement laws was proven to be associated with an 11-21% reduction in the number of 15 to 17 year old females committing suicide. Sabia JS, Rees DI. "The Effect of Parental Involvement Laws on Youth Suicide. *Economic Inquiry*. 2013; 51 (1): 620-636.

[69] Giedd, JN. Structural magnetic resonance imaging of the adolescent brain. *Ann NY Acad Sci*. 2004; 1021:77-81.

consequences that children or adolescents should not be permitted to take for themselves.

86. Capacity to consent to medical treatment is as low as 14 years in NSW.[70] In other states like South Australia, only a person over the age of 16 may consent to medical treatment as though they were an adult.[71] Consider the gravity of a situation where a 14-year-old becomes pregnant and requests an abortion, and the emotional and psychological impacts such a situation is sure have on that adolescent's still developing cognitive functioning. We cannot simply assume that other laws allowing consent to medical treatment from the age of 14 are sufficient, or even that such an adolescent has full decision making capacity in the circumstances; instead, we should be doing everything we can to ensure that the adolescent receives appropriate protection and support.

87. The majority of states in the U.S. require some parental involvement in a minor's decision to have an abortion, whether by requiring parental consent or parental notification.[72] In Western Australia, a child under the age of 16 will not be deemed to have given informed consent to an abortion after 20 weeks unless a custodial parent has been informed that the abortion is being considered, and has been given the opportunity to participate in a counselling process and consultations between the woman and her medical practitioner.[73]

88. In view of the considerations outlined above, we recommend reforms which includes the following requirements be met in the case of a woman under 16 seeking an abortion:

- Before a medical practitioner performs an abortion on a woman under the age of 16, the practitioner must consider whether the woman may have been the victim of a crime involving sexual abuse, the subject of coercion, or is otherwise in need of protection.

- If the medical practitioner observes any of these indications, the medical practitioner must comply with the mandatory reporting obligations in respect of minors in need of protection.

- The medical practitioner must give at least 24 hours' notice to one of the parents or legal guardian of the person seeking the abortion and that person must have been provided the opportunity to participate in a counselling process or a consultation between the person seeking the abortion and their medical practitioner.

- If there are indications that the person to be notified has been the perpetrator of abuse, assault, coercion or other violence against the person seeking the abortion, the medical practitioner must instead comply with mandatory reporting

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[70] *Minors (Property and Contracts) Act 1970* (NSW), s 49.
[71] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 6. In other Australian jurisdictions, requirements consistent with the *Gillick* competence test apply (i.e. a 'mature' minor may consent to medical treatment provided they fully understand the nature of the procedure and its gravity and effects).
[72] Guttmacher Institute, 'Parental Involvement in Minors' Abortions', 2019. https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions
[73] *Acts Amendments (Abortion) Act 1998* (WA) s 334(5).

obligations in respect of minors in need of protection, before performing the abortion.

- A woman may also apply to the relevant court for a waiver of the notice requirement.

89. The proposed reform does not raise the age of consent to medical treatment, but simply ensures that a pregnant adolescent under the age of 16 has the necessary support and protection available to them.

D. Sexual and reproductive health literacy

90. As noted above, more information and education needs to be provided to women regarding the risks of hormonal contraception and abortion, as well as regarding non-harmful alternatives, in order to empower true choice and to ensure women are giving fully informed consent. The nature of abortion requires more extensive information and safeguards.

91. 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 or treatments. 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.

92. 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).[74] This is an issue of such grave importance to women that it should be addressed and enforced.

93. In Western Australia, the law specifically requires that a woman has given "informed consent" to an abortion,[75] and specific requirements for informed consent prior to abortion are also common in European countries and in a large number of US states.

94. To ensure that women seeking an abortion are empowered with real choice and control, our view is that any reforms should centre around empowering women to give fully informed consent, which would include:

- Ensuring women are provided with crucial information, including: the relative physical and psychological risks of abortion; 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; the alternatives to abortion, including referrals, where appropriate; information about foetal development and the opportunity to view ultrasounds;

[74] *Giving Sorrow Words* by Melinda Tankard Reist gives an account of just a small proportion of many such stories.
[75] *Health (Miscellaneous Provisions) Act 1911*, s 334.

- Ensuring women are offered independent counselling. It is critical that the counselling offered is independent of the abortion provider from which a woman is seeking an abortion to manage any financial or ideological conflict of interest on the part of the provider; and

- Ensuring women have sufficient time to process the information they have received, to take advantage of whatever counselling and support they require, to understand and weigh up their options and, ultimately, make a fully informed decision.

95. 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.

96. Reforms requiring more robust informed consent, which specifically outline 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.

E. Any other related matter – data collection

97. Good policy should be based on evidence, which is supported by effective data collection practices. Accordingly, data collection around critical aspects of abortion are necessary for government to:

- better understand the physical and psychological impacts of abortions on women and provide them with any support they need;

- hold abortion providers to account and ensure transparency around the care they give is made public;

- understand the trends in relation to abortions, particularly if they are impacting specific groups of women in society (for example, those experiencing intimate partner violence, women of particular ethnicities or indigenous women);

- help to better inform women about the health impacts of abortion to ensure informed consent is genuine when they make their choice; and

- ultimately, create policies that give real support and choice to women facing unplanned or difficult pregnancies.

98. Currently, there is no standardised national data collection around abortion in Australia. Thus, understanding the prevalence of abortion in Australia and its impacts on women's health is not straightforward.

99. We recommend that data collection on abortion is standardised and reported throughout Australia, and should include the following:

- Details (name, address, qualification) of doctor(s) who will perform the abortion;

- Details of the woman seeking the abortion (including name, address, age);

- The ethnicity or Indigeneity of the woman, to understand whether abortion particularly impacts certain groups of women and to allow government to ascertain whether they need additional socioeconomic or other support;

- Whether the woman has been referred to counselling independent of the abortion provider and has attended counselling;

- Whether the woman has been the subject of intimate partner violence and whether she has been provided any relevant support services to assist her;

- Reason for undertaking the termination and diagnosis. This includes detail on whether it is on medical grounds relating to mother or child or another reason (which must be specified);

- Total number of previous pregnancies (including live births, still births, miscarriages and terminations);

- Whether sterilisation of the woman occurred;

- Whether there were any post-operation complications (such as haemorrhaging, sepsis, perforation or trauma to the uterus or maternal death);

- Estimate of gestation age of the foetus;

- Method of abortion (including whether it is surgical, medication only, etc).

100. To protect the privacy of a woman seeking an abortion, Women's Forum Australia also recommends that any information notified under a mandatory reporting regime is de-identified and the privacy of the woman seeking the abortion is protected as "health information" under privacy laws.

101. Facilitating women's health and wellbeing in the long term must involve evidence-based approaches that rely on the collection of detailed and accurate data in order to inform public health policy.

Conclusion

102. Women's Forum Australia strongly believes that any law or policy changes that truly seek to promote women's welfare in relation to abortion and hormonal contraception must take into account evidence of the harmful impact of these interventions on women's health and the current lack of informed consent. With regard to abortion, they must also bear in mind the lack of support for women seeking abortions in Australia.

103. Any reforms should be directed at addressing these pressing issues, rather than exacerbating an already flawed system by legislating for greater access.

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