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Submission to the Queensland Law Reform Commissio
Law Reform Relating to the Termination of Pregnanc

By 'Abortion Rethink, QLD' - 13 February, 201

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About *Abortion Rethink*

Abortion Rethink is a grassroots initiative that began in Queensland in 2016, as a community response to a need for a neutral platform to showcase stories and community views on the issues arising from the Pyne Bill debates. Since then, *Abortion Rethink* has been a unique reference tool for evidence based information and a voice channel used by thousands of women, medicos and MPs across Australia to share their abortion experiences and views.

We have grown rapidly and have actively collated content from the coalface of the discussion to equip lawmakers with the very latest, cutting edge material that speaks to questions about proposed changes to abortion laws, in response to community concerns.

Abortion Rethink welcomes the opportunity to share with the Queensland Law Reform Commission (the 'Commission'), the views of Queenslanders on abortion and current Queensland law and Queenslanders own experiences with abortion. Our submission also contains the necessary questions and parameters that must considered in any change to Queensland abortion law, particularly as they pertain to women's health.

Our mission is to protect the rights and health of pregnant women and stop any exploitation of them and other members of our community when it comes to abortion legislation in Australia.

Introduction

Over the past few years, *Abortion Rethink* has evaluated research and personal stories from Australians impacted by an unplanned pregnancy or abortion experience. This has included women and members of the medical profession.[1] Based on this, we believe that any new legislation or modification to the regulatory framework regarding abortion in Queensland needs to take into account the body of evidence about the risks of termination of pregnancy and negative health outcomes for some women, the reasons why women seek abortion, and evidence of the substandard practice of many abortion providers.

Current law in Queensland, through criminal penalties, exist to afford women the best protection possible against malpractice or unscrupulous providers who may provide an abortion for any reason throughout a pregnancy and not only in consideration of the best interests of women's health. Current criminal sanctions also act as a strong deterrent to others who may supply drugs to women to perform an abortion on themselves. Removal of these criminal sanctions for illegal abortions would significantly weaken protections for Queensland women that they have enjoyed for over a century.

We want any legislative or regulatory change to empower women with all the information and alternatives upfront, so that they can make a well-informed decision – and one that they won't regret for the rest of their lives.

We are also concerned about legislation upholding the rights of all healthcare workers to conduct themselves according to their own ideologies and belief of best practice.

Current Practices in Queensland concerning abortion

In Queensland today, it is legal for women to have an abortion when it is in the best interests of their physical or mental health. Women have the freedom to undergo an abortion with the assistance of a medical practitioner for reasons to protect their health and this is a safeguard for women's health under current law.

Queensland women may also access financial assistance to have an abortion, as the federal government provides Medicare subsidies for surgical procedures. The 'abortion pill', RU486 is also subsidised for Australian women under the Pharmaceutical Benefits Scheme (PBS).

[1] We have referenced such stories throughout our answers to better illustrate our rationale but have changed the names in some cases for privacy reasons.

Hence, abortion is affordable and accepted as practiced legally in Queensland today. Women and doctors are able to act with certainty within the confines of the law.

Queensland women currently have the option of a legal abortion available to them in the best interests of their health; what women in this state are not well provided for however, is adequate support services to give them the option to continue a pregnancy in difficult circumstances.

Medical practitioners are currently not well-equipped to offer women the full range of support services that should be available to women to give them a real choice between termination of pregnancy and alternatives. Even where counselling is provided, this counselling is, in itself, inadequate as it does not offer holistic pre and post-termination care for these women.

Queensland Women's Experiences of Abortion: Accessibility and Care

The stories we have heard from women in Queensland and New South Wales also (mentioned by reason that New South Wales has a very similar abortion law to Queensland), confirm that:

- It is not difficult for women to access abortion in these states.
- Many women report feeling coerced or pressured by their male partner or others to have an abortion. Some research cites the number of women experiencing pressure to have an abortion is as high as 73%.[2] Recent polling commissioned by *Abortion Rethink* in Queensland revealed that 26% of Queenslanders know one or more women who had been pressured to have an abortion.[3]
- Many women have unwanted abortions as a result of lack of support and/or domestic violence. These women feel they had no option but an abortion in answer to the difficulties and pressures they were facing and were not aware of support services that would have allowed them to continue their pregnancy.

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[2] Coleman, P.K.,Boswell, K., Etzkorn, K., Turnwald, R. (2017). Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experiences. *Journal of American Physicians and Surgeons*, 115. Available online at http://www.jpands.org/vol22no4/coleman.pdf

[3] Abortion Rethink and Australian Family Association (AFA). February 2018. *Abortion Study*. Research conducted by YouGov Galaxy, commissioned by Abortion Rethink and AFA. http://www.abortionrethink.org/images/Results_of_new_Galaxy_opinion_poll_of_Qld_voters_on_abortion_-_February_2018_-_final_version.compressed.pdf

- Many women report that the pre-decision counselling they were offered was inadequate; that not enough time or due process was provided by doctors to ensure that this is what would be best for their health, nor to offer equal support to continue a pregnancy.
- Some women suffer negative mental health effects after an abortion, ranging from persistent negative emotions to serious mental health problems. Queensland women suffering these effects report they were not able to access adequate post abortion care.

Questions from Queensland Law Reform Commission:

Who should be permitted to perform or assist in performing terminations*

Q-1 Who should be permitted to perform, or assist in performing, lawful terminations of pregnancy?

Registered medical practitioners with appropriate qualifications and training should be permitted to perform, and assist in performing, lawful terminations of pregnancy in Queensland. This is consistent with the views of the Queensland community; 92% of Queenslanders surveyed in a poll commissioned by *Abortion Rethink* in February 2018, believe that a woman requesting an abortion should always be seen in person by a qualified doctor.[4]

In the interest of best protecting women and also in consideration of the child, it should remain a criminal offence for an unqualified person to provide a termination and a criminal offence for a qualified person to provide an unlawful termination.

With regard to medical practitioners being criminally responsible for illegal abortions, it is important to keep in mind that the reasons these provisions exist in the criminal code was first and foremost to protect women from illegal and dangerous procedures.

These provisions have afforded women real protection under Queensland and similarly New South Wales law. In the recent *R v Sood* case in 2006, Dr Sood was deregistered as a medical practitioner in New South Wales following the uncontested findings of the New South Wales Medical Tribunal in relation to five women on whom she had performed abortions which lead to extremely serious consequences for the health of those five women. In addition to her deregulation as a practitioner, Dr Sood was able to be prosecuted under the specific abortion-related provisions of the criminal law, as her conduct amounted to criminal conduct in the circumstances.

Consideration should be given to the modern availability of abortion pills, available even by post through the internet. These pose serious health risks, even death, to vulnerable women, who may not see a doctor prior to taking pills supplied to them and whom may be pressured to take by others. It is essential women see a practitioner to confirm the pregnancy, location and gestation. There should be strict legal provisions that prohibit the supply of abortion pills except through a qualified medical practitioner and severe penalties for doing so. The current criminal

[4] Ibid.

penalties under s.226 (Supplying drugs or instruments to procure abortion) offer the best protection for women and should remain as law.

Medical abortion pills shouldn't be available over counter for the same reasons: that all women seeking an abortion should first be seen and treated by a qualified medical practitioner. Hence, pharmacists should not be permitted to assist in performing terminations by supplying abortion pills over the counter.

We have examined the experiences of thousands of women and these are very much affected not only by the care and competence of the person performing or assisting in the procedure itself but also those who are responsible for the woman's care both before and after a termination, We therefore call upon the Commission to consider who should be permitted (or not permitted) to assist pre and post-termination so that women are afforded the best, holistic care possible surrounding termination of pregnancy.

Pre-termination care

All women should have the opportunity for informed consent, i.e. consent which is freely given after the relevant information has been received and understood. Many women however say that they do not feel they were fully informed or supported in all options before a termination.

Considering these experiences of women and the potentially lucrative nature of the abortion industry, only counsellors and social workers independent of abortion providers should be permitted to assist women pre- termination.

This is consistent with the current widespread belief of 90% of Queenslanders that before having a termination, a woman should receive free independent counselling so that she can make a fully informed decision.[5]

Women should also be given the opportunity for a second opinion upon a recommendation for abortion. This should be required of all medical and psychosocial health practitioners assisting women pre-termination. In our response to Q.13, we examine the need for regulation of counselling in more detail and share the pre- termination experiences of Queensland women.

[5] Ibid.

Post-termination care

Post-termination trauma is a very real thing and we at Abortion Rethink spend a great proportion of our story collation working with women who are suffering from this.

Women have the right to prompt access to post abortion care and counselling, should they need it. Women who do experience negative mental health effects or trauma from a termination often do not want to return to where the termination took place. Also many women report that when they did seek help, the counsellor, psychiatrist or psychologist was not trained to treat their post-abortion grief or trauma. Hence there is a need for the Commission to ensure adequate regulatory requirements are in place to ensure medical and healthcare workers who are properly qualified in post-abortion care are available to assist women who need it post-termination.

An overwhelming majority of Queenslanders agree on the need for adequate post abortion care services for women. Nine in ten Queenslanders (90%) today believe that all abortion providers should be required to advise women prior to their abortions that they will refer them to free independent post-abortion counselling, if required. [6]

We address this important issue of post-termination care further in our response to Q. 13 on counselling.

Q-2 Should a woman be criminally responsible for the termination of her own pregnancy?

No, a woman should not be criminally responsible for the lawful termination of her own pregnancy and she is not criminally responsible for this under current Queensland law.

Section 225 of Queensland's Criminal Code applies to a woman who *unlawfully* administers to herself a means to commit an termination on herself. This provision acts as a strong deterrent to any woman who may contemplate performing a dangerous medical abortion on herself without the approval and treatment of a qualified practitioner. This is a protection for women against illegal abortions which may maim, damage or even result in their death.

[6] Ibid.

This provision in Queensland's Criminal Code which acts to protect women against unlawful abortions is just as important in modern times as when it was introduced and dangerous abortions posed a risk to women 100 years ago. In modern times we have seen the widespread, even prolific availability of the abortion pill. This is available in various forms, through the internet or pharmacists, where the drug misoprostol is supplied for other conditions, but can nevertheless be accessed by pregnant women over the counter. Controversial supplier of the abortion pill to women in countries where terminations are illegal, "Women on Waves" [7] give detailed instructions on how to deceptively obtain drugs that can perform an abortion through their local pharmacies.

The reality is that no woman in Queensland or New South Wales has ever been convicted of a felony for an illegal abortion since these laws have been in place, for over 100 years.

If new legislation removes criminal sanctions, how will it otherwise protect women from illegal abortions?

The poll commissioned by Abortion Rethink this month (Feb 2018) revealed that the majority of Queenslanders today (55%) think that Queensland's abortion law should remain the same (36%) or be stricter (19%).

With regard to decriminalisation specifically, only a minority of Queenslanders favour full decriminalisation. Those supporting some form of decriminalisation are divided on whether this should apply to everyone involved (45%) or just the woman having the abortion (31%).

Data on Queenslanders views of the law seems to conflict. On one hand, data shows a majority of Queenslanders are satisfied with the current law or think it should be stricter but on the other hand, it says Queenslanders support some form of decriminalisation. Obviously there is confusion about current law but rather than moving quickly to change it due to political pressure, we ask that the Commission recommends a public education campaign for community awareness building and to collect reliable data on public views.

The Commission cannot be confident that the changes it will recommend will be in line with community expectations and in the best interests of women if reliable data is not available from the public to support this.

[7] Women on Waves website. Accessed on 13 February 2018 at https://www.womenonwaves.org/en/page/6104/how-to-do-an-abortion-with-pills

Gestational limits and grounds

Q-3 Should there be a gestational limit or limits for a lawful termination of pregnancy?

The answer to this question should be considered fairly, from two perspectives:

1. What is in the best interest of a woman's health?
2. What about the rights of the child and questions about viability?

Gestational limits and women's health

It is important to consider the various reasons that women undergo abortion for each different stage of pregnancy

Foetal abnormality

The most commonly assumed reason for abortions at a later term, i.e. after 20 weeks, is an abnormality with the unborn child that may present health issues later in life or upon birth. Research has shown that terminating a pregnancy during the second or third trimester as a result of prenatal diagnosis is more traumatic for women when compared to live premature birth. [8]

It is also commonly assumed that 'foetal abnormality' relates only to life threatening conditions such as anencephaly, where the baby is expected to die at or soon after birth.

However, there have been cases where late term abortions have been legally performed in Australia for a 'foetal abnormality' that was no more serious than a deformed hand or cleft lip (easily corrected with modern corrective surgery).

Abortion Rethink recommends that any legislation covering this area should include specificities of any reasons to be given for termination, including whether a foetal abnormality condition is fatal (i.e. ancholyphy) or non fatal. Attention given to this distinction is of particular importance, seeing as the termination process for foetal abnormality is more traumatic for women if the condition of the unborn child was not serious enough to induce natural death without a termination.[9]

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[8] Kersting, A., Kroker, K., Steinhard, J., Hoernig-Franz, I., Wesselmann, U., Luedorff, K., Ohrmann, P., Arolt, V., Suslow, T. (2009). Psychological impact on women after second and third trimester termination of pregnancy due to fetal anomalies versus women after preterm birth - a 14-month follow up study. *Springer.* Available at https://link.springer.com/article/10.1007/s00737-009-0063-8

[9] Korenromp, M. J., Christiaans, G. C. M. L., van den Bout, J., Mulder, E. J. H., Hunfeld, J. A. M., Bilardo, C. M., Offermans, J. P. M., Visser, G. H. A. (2005). Long-term psychological consequences of pregnancy termination for fetal abnormality: a cross-sectional study. *Wiley.* Available at http://onlinelibrary.wiley.com/doi/10.1002/pd.1127/full

Terminations undertaken for non-medical reasons

Contrary to popular belief, research suggests that most women who have later abortions do so for reasons other than foetal anomaly.[10] Indeed, Australian records show that non medically indicated terminations are regularly taking place in the state of Victoria. This can be observed in the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2011 report, 'Victoria's Maternal, Perinatal, Child and Adolescent Mortality.'

This report states that a total of 378 post 20 week terminations took place in Victoria during 2011, with 183 of those terminations being carried out for psychosocial indications, or reasons unrelated to the health of the unborn child.[11] These statistics should be considered in light of the fact that abortions undertaken at advanced gestational age have been associated with higher levels of grief for the woman involved.[9]

Gestational limits considering the child

In the case of late-term abortions, some babies are born alive. In Queensland, in 2015 alone, there were 27 cases of babies born alive after failed late-term abortions, who later died after not receiving life-saving treatment.[12] In Victoria during 2011, a total of 40 babies were born alive after post 20 week terminations, and were left to die without intention to resuscitate.[13]

We ask - How does this experience impact women's mental health and wellbeing and how will the Commission ensure such women and babies are properly cared for under new legislation or regulations?

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[10] Steinberg, J. (2011). Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions - A Critical Review of Research. *Women's Health Issue Journal.* Available at http://www.whijournal.com/article/S1049-3867(11)00014-4/abstract

[11] Victorian State Government. Victoria's Mother's and Babies: Victoria's Maternal, Perinatal, Child and Adolescent Mortality 2010/2011. Available at https://www2.health.vic.gov.au/about/publications/researchandreports/Victorias-Mothers-and-Babies-Victorias-Maternal-Perinatal-Child-and-Adolescent-Mortality-20102011

[12] ABC News. *"Rise in Queensland babies surviving late-term abortions, figures show". 16 June 2016. http://www.abc.net.au/news/2016-06-15/babies-of-late-terminations-left-to-die-without-care/7512618*

[13] Victorian State Government. Victoria's Mother's and Babies: Victoria's Maternal, Perinatal, Child and Adolescent Mortality 2010/2011. Available at https://www2.health.vic.gov.au/about/publications/researchandreports/Victorias-Mothers-and-Babies-Victorias-Maternal-Perinatal-Child-and-Adolescent-Mortality-20102011

Views of the community:

In the poll commissioned by *Abortion Rethink* conducted this month, a strong majority of Queenslanders (62%) were of the view that an unborn baby at 23 weeks is a human person with human rights.

Queenslanders today on gestational limits on abortion:

- Most Queenslanders (60%) would not allow termination after 13 weeks;
- Half would not allow termination after 8 weeks;
- 21% said that termination should not be allowed at any stage in pregnancy;
- 14% would allow up to 5 weeks gestation;
- 15% would allow up to 8 weeks gestation;
- 11% would allow up to 13 weeks gestation;
- 6% would allow up to 16 weeks gestation.
- Only 7% would allow terminations up to 23 weeks
- Only 5% would allow terminations up to birth.

Australian jurisdictions that have in recent times legislated to permit abortion on demand have chosen upper gestational limits that range from 14 weeks in the Northern Territory [14] (2017), 16 weeks in Tasmania [15] (2013), 20 weeks in Western Australia [16] (1998), 24 weeks in Victoria [17] (2008) and no gestational limit in the Australian Capital Territory [18] (2002).

So there is a lack of consensus in Australia as to the gestational limit to which women should be able to demand abortion. What seems clear however, is that legislation passed in modern times has moved to make abortion on demand more restricted under higher and higher gestational limits. This appears to be in line with changing community views on abortion in line with advancements in scientific knowledge of the development of the unborn child, such that abortion should be more restricted and not less restricted in changes to abortion law.

A poll of people[19] in New South Wales commissioned by *Abortion Rethink* in 2017 showed they hold very similar views to Queenslanders on gestational limits:

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[14] *Termination of Pregnancy Law Reform Act 2017* (NT) s 7.
[15] *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 4.
[16] *Health Act 1911* (WA) s 334.
[17] *Abortion Law Reform Act 2008* (Vic) s 4.
[18] *Health Act 1993* (ACT) ss 81-2.
[19] Abortion Rethink. "*What NSW Really Thinks About Abortion."* May 2017. Research conducted by Galaxy Research, commissioned by Abortion Rethink. Available at http://www.abortionrethink.org/images/What_NSW_Really_Thinks_About_Abortion_Complete.pdf

- Most in New South Wales (60%) would not allow termination after 13 weeks;
- Half in New South Wales would not allow abortion after 8 weeks;
- 22% said that termination should not be allowed at any stage in pregnancy;
- 15% would allow up to 5 weeks gestation;
- 14% would allow up to 8 weeks gestation;
- 10% would allow up to 13 weeks gestation;
- 8% would allow up to 16 weeks gestation.
- Only 6% would allow terminations up to 23 weeks
- Only 5% would allow terminations up to birth.

In the view of Queenslanders other limits that should be imposed on lawful abortion are for:

- Sex selection terminations: Vast majority of Queenslanders (85%) are opposed.
- Cases where healthy woman is carrying a healthy baby: more than half (55%) of Queenslanders are uncomfortable with lawful abortion in these cases. 36% do not support and 19% are uncommitted.[20]

Further, in International jurisdictions, the question of pain capability, viability and other interests of the unborn child has been considered in most recent amendments to abortion laws.

How would new legislation provide for the palliation of unborn children in late term abortions, in the light of medical evidence of the pain capability of the preborn child after 20 weeks gestation?

Fundamentally, with so many questions in this area and lack of consensus amongst Australian jurisdictions, then the Commission simply should not legislate without further investigation to obtain more concrete answers, supported by scientific evidence, to justifiably address the above questions on limits to abortion.

Q-4 If yes to Q-3, what should the gestational limit or limits be? For example: (a) an early gestational limit, related to the first trimester of pregnancy; (b) a later gestational limit, related to viability; (c) another gestational limit or limits?

Please see answer to Q3.

[20] Abortion Rethink and Australian Family Association (AFA). February 2018. *Abortion Study*. Research conducted by YouGov Galaxy, commissioned by Abortion Rethink and AFA

Q-5 Should there be a specific ground or grounds for a lawful termination of pregnancy?

Under current Queensland law, the grounds for lawful termination of pregnancy in order to protect the life and serious risk to the mental or physical health of a woman is justifiable. With regard to any new legislation - whether more restricted or not - there should be consideration given to the following:

a/ Community beliefs and concerns

The majority of Queenslanders - 75% of the general population - believe that abortion can harm the mental or physical health of a woman, according to a February 2018 study. [21] It is telling to note that of those aged 18-34 years, an overwhelming majority of 81% have concerns about the harm to the physical and mental health of the woman undergoing the abortion. Any potential legislation should reflect this increasing concern and awareness of Queensland's younger generation.

b/ The need for accountability and responsibility by medical professionals

As discussed in the answer to Question 8, any legislation must ensure that medical professionals who may recommend termination to a woman are undertaking that recommendation with the woman's best interests at heart, including her right to full medical information and independent counselling, as well as any other available services that may offer alternate or additional solutions to the issues surrounding the pregnancy that appear to call for a termination. In the case of foetal abnormality, the very real possibility of a misdiagnosed case also needs to be considered. A second medical opinion, as discussed in Q. 8, provides a safeguard against such cases.

c/ The need for holistic, multi aspect services that assist women encountering problems in pregnancy, including those that may lead to termination.

Our assessment of stories and interviews with various counselling centres across both Queensland and Australia have highlighted that each case is unique and comes with complexities that are not merely resolved with an average counselling framework.

After a needs analysis, some circumstances may require a medical referral, ongoing friendship via a mentor or material assistance as well as counselling.

Attention needs to be given to the a more rounded practice model which takes in to account the specific needs of a case to ensure women are receiving the best possible support at a time they are most vulnerable. This is an approach that will better respect women's wellbeing from a mental, physical and pragmatic perspective.

21 Ibid.

Rosia contacted our page to tell us her story which saw her facing detention, experiencing a complicated, unplanned pregnancy with a man who had another whole family. She did not only require some counselling, but rather, mentoring, medical supervision, immigration liaison and more in order to meet her real desire to continue the pregnancy as she had been told it would be unlikely to ever conceive again.

Q-6 If yes to Q-5, what should the specific ground or grounds be?

For example: (a) a single ground to the effect that termination is appropriate in all the circumstances, having regard to: (i) all relevant medical circumstances; (ii) the woman's current and future physical, psychological and social circumstances; and (iii) professional standards and guidelines;
(b) one or more of the following grounds: (i) that it is necessary to preserve the life or the physical or mental health of the woman; (ii) that it is necessary or appropriate having regard to the woman's social or economic circumstances; (iii) that the pregnancy is the result of rape or another coerced or unlawful act; vi Review of termination of pregnancy laws
(iv) that there is a risk of serious or fatal fetal abnormality?

The grounds that exist in current Queensland law are acceptable.

Current law encompasses all of the above by justifiably balancing the rights of the woman to her life and health against the conflicting rights of the unborn child.

Also see answer to Q. 5.

Q-7 If yes to Q-5, should a different ground or grounds apply at different stages of pregnancy?

The grounds to preserve the life or physical or mental health of women are already covered in current law.

Any proposed new legislation should also consider new technology that allows successful medical care of younger and more premature babies, as well as newly available treatment of medical conditions within the womb, thus saving women from the negative outcomes that follow infant loss - whether voluntary or not.

When negotiating grounds for terminating as they relate to gestational limits, positive outcomes for the woman should at all times be the first priority. Whatever the particular grounds traditionally given for termination, the procedure should be considered with respect to other options and alternative treatments that are available to the woman.

Only by feeling that they may choose other treatment, with no additional risk to their health, are women truly able to give their informed and un-coerced consent to termination of pregnancy.

These additional treatments can include, but are not limited to:

a. Carrying to Term and Perinatal Hospice

This is an alternative treatment for women experiencing poor prenatal diagnosis. It consists of professional counselling and hospice care that allows parents to appreciate the life of their child no matter how long it lasts, allowing them to grieve in a holistic and integrated way. This has been shown to ease negative psychological effects which potentially may be worse with a deliberate termination.[22]

Evidence shows that this treatment is currently relatively rarely offered to women in as a real option that will lead to outcomes that are frequently less traumatic for women as late termination of pregnancy.

b. Accurate information about the future prospects of their health, pregnancy and child should they choose to continue.

There is a current lack of accurate and timely information for women facing challenging pregnancies. This lack of information can lead women to believe that abortion is the only feasible option, thus negating her right to informed consent.

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[22] Kersting, A., Kroker, K., Steinhard, J., Hoernig-Franz, I., Wesselmann, U., Luedorff, K., Ohrmann, P., Arolt, V., Suslow, T. (2009). Psychological impact on women after second and third trimester termination of pregnancy due to fetal anomalies versus women after preterm birth - a 14-month follow up study. *Springer.* Available at https://link.springer.com/article/10.1007/s00737-009-0063-8

Information on prenatal abnormality: *(links within to video interviews/ full written stories)*

Sarah Maroun is an Australian parent who contacted us with her story saying that she found the prenatal care she received from her GP after a prenatal diagnosis to be misleading and incomplete. She shares that "People are on the conveyor belt to abortion because they are not being given the correct information".

Another parent, Kathleen Simpkins found that "It was traumatic having to go in and say, 'No, we don't want to kill our child' to every medical appointment."

The CEO of Down Syndrome Australia, Dr Ellen Skladzien, states that it is "unethical" for families to be provided a screening test for Down Syndrome (which is usually followed with the advice & even pressure to terminate) but 'not given the appropriate information and support to accompany that test.' University of Sydney bioethicist Dr Tereza Hendl supports this view, stating that she supports further specialised information and counselling protocols to ensure prospective parents are better informed about their options.

Information on additional supports available

Foetal abnormality is of course not the only reason that a woman may consider abortion. Domestic violence, financial pressures, relationship issues and education and career pressures are all reasons she may seek an abortion.

These issues often present themselves in such a way that it appears the only option for the woman involved is termination for the sake of her mental wellbeing. A woman opting to terminate in this situation is however not choosing freely - she is being coerced by her circumstances into a decision that she may not have made, had she known there were other ways to resolve them.

Any abortion legislation should include protocols to ensure that women are informed of all and any relevant help available to them (and we have found that obstacles to continuing a pregnancy can be widely varied, meaning that the scope of this help will need to be broad in nature) before they make the choice to terminate.

For example, a woman who believes her only pathway to freeing herself from a violent relationship is to terminate the pregnancy that may tie her to her abuser, may also be unaware that she is entitled to free legal aid surrounding her safety and that of the unborn child.

Proposed sources of help for women could include…

- Legal aid for women negotiating threats of violence, domestic, mental or sexual abuse, housing, immigration & visa issues.
- Support and advocacy for women experiencing issues with medical coverage (e.g. immigrant women or international students who may not be eligible for Medicare), housing and employment.
- Social & government support to assist women in caring for any other children they may have, and whose care requirements may mean that a woman feels unable to successfully parent an additional child
- Counselling and information if the preborn child is suspected to have health difficulties (as discussed above).
- Relationship counselling for women who may be contemplating termination in light of the status of their relationship.
- Family counselling for women facing pressure or disapproval from their parents, partner or others.

Consultation by the medical practitioner

Q-8 Should a medical practitioner be required to consult with one or more others (such as another medical practitioner or health practitioner), or refer to a committee, before performing a termination of pregnancy?

Yes.

In our exposure to the stories of women and medicos in the field, we have found that a second opinion from an appropriately qualified specialist, delivered in a way that is respectful of the woman's circumstances and right to information, can empower her to make her choice in a way that is holistic and informed.

In speaking with women we have found that the initial advice to abort can come in a very unexpected and distressing way. Women have told us of receiving inaccurate information at an initial consultation that later turned out to be out of date or not relevant to their particular case.

Many women have relayed to us that when advised to terminate they were never offered alternate options or additional medical protocols, as in Monique's experience.

Monique was abruptly told by the obstetrician at her 20 week scan that her baby had abnormalities and was immediately offered a termination, with no other information or details being offered. When she asked questions about her baby's condition, the doctor continued to only inform her that abortion was available, causing her considerable distress.

She states: "To be asked 4 times in 4 days, with three of those being in a row, if I wanted to terminate my child was the worst thing that had happened to me up to that point in my life."

It was only by Monique's repeated insistence that they be given additional information were they referred to a specialist. After receiving a second opinion from the specialist at another hospital, delivered with respect and consideration for their circumstances, Monique found herself with a much greater sense of confidence in her choice to continue the pregnancy with additional medical care.

Sharon also experienced this lack of appropriate medical professional support when she received a negative prenatal diagnosis. Abortion was immediately offered when the condition was discovered at her 20 week ultrasound. Only after she firmly stated that she did not wish to pursue this path did the doctor mention other medically recommended options available to her. Choosing to utilise these other options, Sharon carried her pregnancy to term where she gave birth to a healthy baby who presented no sign of the diagnosis made at the 20 week scan.
A second opinion adds further context and accuracy around the facts that influence a woman's choice to continue or abort a pregnancy.

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We spoke to Sarah, who was advised to abort her first trimester pregnancy in order to ensure that a broken ankle healed properly. Upon seeking a second opinion from a specialist, it was found that there were other medical protocols available to her and that an abortion was not the only option for her continued health and wellbeing.*

Had Sarah not had the opportunity to hear alternate options and accurate information from a second practitioner, she could have agreed to a treatment where she was not aware of all relevant facts, and therefore it would not have been her fully informed consent.

Medicos can make mistakes:

Further medical examination by an alternate doctor or team of doctors can shed new light on a vulnerable situation and assist in avoiding medical error.

Point Cook parents Yvette and Mali Ozkavak were told by their medical team to terminate when their unborn baby was diagnosed with Trisomy 18, or Edwards Syndrome, a condition that causes severe developmental delays. Choosing to continue the pregnancy nonetheless, they were stunned and relieved to find that upon delivery their daughter, Ella, was perfectly healthy, with no sign of the abnormalities that doctors said two separate tests showed up.

The couple, although overjoyed to find that Ella was healthy, have warned other parents to question any advice they may be given to terminate for abnormality and to seek additional advice, noting that their excellent ultrasound technician had been very helpful to them throughout the pregnancy.

Aussie mum Fiona Vanderhook had a near identical experience. At 5 weeks of pregnancy a trainee doctor advised Mrs Vanderhook that her baby was no longer alive and to induce a miscarriage using the drug misoprostol.

The abortion failed and the baby was found to be alive, but was diagnosed with 'water on the brain', very possibly caused by the misoprostol.

A senior obstetrician at Canberra Hospital pushed Mrs Vanderhook to undergo an abortion as late as 31 weeks. Fortunately in this case Mrs Vanderhook was able to seek additional care from a total of six other specialists, all of whom advised that she was most likely to give birth to a healthy baby if she continued the pregnancy. She chose to do so, and later delivered a healthy baby boy. The Vanderhooks' barrister believes that the hospital was attempting to avoid millions of dollars in damages should the baby be born with a medical condition caused by the misoprostol.

Could such additional medical support also present a measure of safety for doctors who may misdiagnose a case and therefore open themselves up to liability at a later stage?

If yes to Q-8: Q-9 What should the requirement be?

For example: (a) consultation by the medical practitioner who is to perform the termination with: (i) another medical practitioner; or (ii) a specialist obstetrician or gynaecologist; or (iii) a health practitioner whose specialty is relevant to the circumstances of the case; or (b) referral to a multi-disciplinary committee?

We believe the medical practitioner performing a termination should consult with:

(a)(i) - The woman's usual GP for history and case management.

(a)(ii) - A specialist OB/GYN in particular instances where an abortion is being considered for a medical reason related to the pregnancy - e.g. loss of amniotic fluid, placenta praevia, etc.

E.g. One woman, Rebecca*, relayed to us that she had been referred to have an abortion because of the potential serious complications of having a biocorunate (horn shaped) uterus with the baby developing in one of the horns. When an independent crisis pregnancy support agency put her in touch with another OB/GYN, she discovered she was lucky even to be pregnant at all and that birth was a possibility with good management. Her baby was born healthily via C-section at 38 weeks.

(a)(iii) - In some instances, referral to a multi-disciplinary committee who could look holistically at the needs in the case might be important.
For instance, one woman shared her story with us about being referred for an abortion by her GP who was concerned about a number of factors such as:

- Socio economic (she was on the dole in housing commission);
- She had undergone an MRI without knowing she was pregnant;
- She had taken depo provera injections 2 weeks post implantation;
- She was a heavy smoker;
- Her partner was in another state (but supportive);
- She was 42 years old.

However, the woman wanted to continue the pregnancy because of her extreme anxiety she had developed following a previous abortion experience. Before proceeding with the termination, her assigned mentor worked with the clinic to assess whether there was a way to support her.

This case is an example of where a referral to a multi-disciplinary committee may have been in the woman's best interests.

Q-10 When should the requirement apply? For example: (a) for all terminations, except in an emergency; (b) for terminations to be performed after a relevant gestational limit or on specific grounds?

Abortion Rethink recommends a multidisciplinary approach for all terminations. A system needs to be developed with a collective of concerned specialists. This system should best serve all women experiencing an unplanned pregnancy to ensure they have access to the support services, facts and medical help that will empower them to make a fully informed choice, at any time in pregnancy.

Conscientious objection*

Q-11 Should there be provision for conscientious objection?

Yes.

When a profession becomes legally enslaved to the state for its actions, it loses its freedom to practice according to what is best for the patient at the time, says GP Dr Roberta Leary.

Dr Roberta emphasises that doctors have a duty to safeguard the wellbeing of their patients at all times, and that state interference in this sacred doctor-patient relationship would be to the detriment of the patient who relies on the doctor to give them their considered opinion of their particular case.

In what other part of medicine does the State force a doctor to be involved with a procedure that he or she does not believe to be in the best interests of the patient?

As Dr Roberta Leary asks: "Where else in Australia are we saying, 'Let's make it illegal for a whole body of people to follow their conscience'?"

'We can safeguard the fact that doctors will have the best interests of our patients at heart, but we can never safeguard that the State will.'

It is often mistakenly assumed that the objection many doctors have to being involved with abortion is based solely on religion. Dr Abdulrazak Mohamed states that freedom to practice according to conscience is a worker's right:

'If you are asked to do something that you don't believe is a part of your profession, then you should have the right to say yes or no."

Dr Mohamed adds that patients have the freedom to choose, and that doctors also deserve to have that freedom.

Medical students echo this belief:

'We are taught that patients must have a high degree of autonomy. I believe that as doctors we also need to have that level of autonomy.' - Medical student Bernadette Phua

The number of doctors with a conscientious objection to abortion is also frequently underestimated. A study by Marie Stopes International Australia in 2004 found that up to one in four GP's had a conscientious objection to abortion.[23]

Dr Bryan Kenny , a QLD Ob/Gyn, states: *'It behoves the government to remember that there are many people affected by this legislation.'*

Even if a doctor does not have a conscientious objection to abortion per se, but believes that an abortion is not the best treatment in a particular case and therefore declines to perform or refer for it in the best interests of the patient, could he or she still be liable if provisions in legislation do not allow for conscientious objection?

As stated by Dr Bryan Kenny, those potentially impacted by a lack of conscientious objection legislation include not only doctors and nurses, as is usually assumed, but in addition anyone involved with the abortion process. This can include, but is not limited to, pharmacists, theatre staff, recovery nurses, receptionists, office managers, suppliers and

[23] Marie Stopes International Australia. (November 2004). *General Practitioners: Attitudes to Abortion.* Prepared by Quantum Market Research and Marie Stopes International Australia.

medical students. Their potential role in the carrying out of a termination of pregnancy is no less ethically involved than that of the doctor or nurse.

Robyn, a pharmacist from Tasmania where conscientious objection has been a part of abortion law since 2013, shares that she has nonetheless frequently found herself harassed and pressured by her fellow medical professionals as a result of her upfront, stated objection.

A pharmacist of 20 years experience and holding three degrees, Robyn has been accused of 'not being a team player' and of 'putting pressure on the other staff' for claiming her right to not be involved with prescribing the RU486 abortion pill.

It is unacceptable that our healthcare professionals should find themselves in a hostile work environment simply as the result of exercising their rights. We recommend that the strongest safeguards be legislated to ensure that the rights of all healthcare workers be upheld.

It is also imperative that we consider the professional rights of Queensland's rurally located medical professionals. A doctor who is seeking a second opinion or further advice from a specialist in order to ensure the best care for his patient should not have this right removed from him or her as a result of geographical location. To do so would be to deny the duty of the doctor "to safeguard the best interests of the patient at all times" (Dr Roberta Leary).

Will doctors who have a conscientious objection to abortion become reluctant to practice in geographically isolated areas if they may be forced to partake in such practices, adding a substantial burden to a health system that is already at crisis as far as a ready supply of rurally located doctors?

(a) Are there any circumstances in which the provision should not apply, such as an emergency or the absence of another practitioner or termination of pregnancy service within a reasonable geographic proximity?

We believe that conscientious objection should always apply, except in the case of a present emergency where complications have arisen from a previous abortion attempt or it is necessary to prematurely deliver the baby to save a woman's life.

(b) Should a health practitioner who has a conscientious objection be obliged to refer or direct a woman to another practitioner or termination of pregnancy service?

No.

Rationale:

It is a mark of respect and professional confidence in the other's abilities for a doctor to refer a patient to another practitioner, seeing as the second doctor is acting in lieu of the first. This entrusting of a patient's health and wellbeing is not taken lightly. To refer is to be implicit in the medical treatment that the patient will undergo as a result of that recommendation. If a doctor believes that a procedure is not in the best interests of his patient, or it is one to which he has a conscientious objection, he or she should not be forced to become a part of the process by ensuring that another doctor carries out the procedure in which he or she does not wish to be involved, or does not consider in their professional opinion to be appropriate for the patient's condition.

Counselling

Q-13 Should there be any requirements in relation to offering counselling for the woman?

Yes.

Rationale:

Absolutely, at the very least there should be regulatory requirements for women, not only pre-termination but also post-termination. A statutory duty to ensure informed consent in Queensland may be warranted, as it exists in Western Australia.

In Western Australia there is significant emphasis on informed consent. Doctors are required to provide women with counselling on the risks of both abortion and proceeding with the pregnancy, to offer a referral for counselling for both options and to inform women of both post abortion and post birth counselling.[24]

[24] See *Health Act 1911 (WA)* s 334(5).

Informed consent: A statutory duty? There is enough evidence, both through international studies and local anecdotal evidence, including that received by *Abortion Rethink*, that a significant number of women are not receiving adequate pre-decision counselling and support before an abortion.

Anything less than a woman feeling she can continue a pregnancy if she wishes, is a form of coercion over her decision. The reality is that many Queensland women are not experiencing a 'choice' when it comes to the abortion decision. Indeed, as of February 2018,[25] an average of one in four Queenslanders personally know one or more women who were pressured or coerced into having an abortion by others.[26] This statistic does not include those women who feel that, owing to their financial, health or other circumstances, they cannot continue a pregnancy. We ask - how many women in Australia today actually **freely** choose abortion?

How will the Commission and the Queensland government ensure they are truly supporting a woman's right to choose through new legislation on abortion?

Abortion Rethink recommends the Commission should consider the example of Western Australia which passed a statutory duty on those providing terminations to provide informed consent. The counselling requirements for informed consent in Western Australia are spelled out in Section 334 of the Health Act. There are additional requirements for informed consent with respect to dependent minors.

Pre-termination counselling

How will new legislation ensure all women have the opportunity to give fully informed consent and have all their options made available to them ?

When a woman discovers she is pregnant unexpectedly or discovers an unexpected anomaly with her planned pregnancy, many emotions ensue.

A common theme running through the hundreds of women who shared their stories via our site and social media pages is that when they sought counselling from an abortion provider, they felt more pressured to continue toward a termination outcome rather than feeling supported to consider all options available to them.

[25] Abortion Rethink and Australian Family Association (AFA). February 2018. *Abortion Study*. Research conducted by YouGov Galaxy, commissioned by Abortion Rethink and AFA.

[26] Abortion Rethink and Australian Family Association (AFA). February 2018. *Abortion Study*. Research conducted by YouGov Galaxy, commissioned by Abortion Rethink and AFA.

The “crowning insult”, as Germaine Greer, the mother of modern feminism puts it, “is that this ordeal is represented to her as some kind of privilege: her sad and onerous duty is garbed in the rhetoric of a civil right.”

Numerous women have shared with Abortion Rethink their experiences of feeling that abortion was their duty, including Sophie:

> “It was a shock to me to fall pregnant just when I was getting started in a promising professional career, and only several months into a new relationship. Socially speaking, it didn’t seem appropriate for me to have a baby.
>
> My boyfriend talked about us having a baby in the future, but for now, he did not want a baby at all.
> I found the whole experience very traumatising, since I felt like I had to make a decision that was best for him and for what was expected of me as a young professional woman, not for myself.
> Initially I felt fine after the procedure and relieved that it was over. Unfortunately, throughout the coming months, I found myself experiencing unexplainable grief and sadness, leading to depression, suicidal thoughts and eventually, the quitting of an exciting new job in order to regain my health.
>
> When I shared my abortion experience and outcomes with a counsellor, she brushed aside my concerns, telling me that that two had ‘nothing to do with each other’. I felt invalidated and as though I had no reason to feel this way.
>
> It really angers me that women such as myself - I’ve spoken to quite a few who have similar experiences with abortion - are told to rejoice in our freedom of having a choice, rather than admit our suffering.”

How will legislation protect women from abortion coercion?

If we are really worried about women’s wellbeing then shouldn’t we be looking at legislation that provides them with independent counselling and support when facing a difficult pregnancy?

At first presentation of a termination enquiry, a woman should be presented with the opportunity for informed consent, this being consent which is freely given after the relevant information has been received and understood.

However, this is not currently occurring in many cases and so is an issue that needs to be addressed well in advance of considering the issue of access to termination of pregnancy.

Also on the issue of informed consent, terminations of pregnancy are clearly a lucrative business for some providers. Yet research shows the most common place for women to obtain counselling was an abortion clinic, with nearly half of the women who did get counselling (45%) obtaining it there." Due to vested interest, it is not unreasonable to say that some providers may not be inclined to comprehensive share all the information they should with women on their pregnancy and development of the child.[27]

Our polling research shows that the overwhelming majority of Queenslanders (86%) support the idea that women considering abortion should receive information on development of the unborn child, the nature of the procedure, the physical and psychological risks associated with termination of pregnancy and the support available should she wish to continue with the pregnancy.

This informs our opinion that any clinical practice permitted by law to perform abortions, (many which already exist in Queensland operating under current law), should always require someone with unbiased counselling training to work alongside or 'assist' the client and physicians to present a strict process of informed consent which encourages a woman to first work through all her needs and options.

Post termination counselling

How will new legislation ensure all women who need post-abortion care receive it?

For a long time the research has been clear,

> *"There is virtually no disagreement among researchers that some women experience negative psychological reactions post-abortion"* - Dr Gregory Wilmonth, Editor, Journal of Social Issues, 1992.

In 1992, an entire issue of the Journal of Social Issues was dedicated to research on the psychological effects of abortion.

[27] What Women Want: When faced with an unplanned pregnancy. Prepared by WebSurvey, Commissioned by Marie Stopes International Australia, November 2006.

In 1995, the Beijing Declaration and Platform for Action (UN), signed by 189 governments, including Australia states:

> *"Where abortion is available, women must have prompt access to post abortion counselling."*

Queenslanders agree with this too:

> *"Nine in ten Queensland voters (90%) believe that all abortion providers should be required to advise women prior to their abortions that they will provide free independent post-abortion counselling if requested."*

Negative psychological reactions that some women experience after abortion include suicidal thoughts and behaviours; depression; anxiety; PTSD; substance abuse and persistent negative emotions. Scientific studies (from around the globe) that identify abortion as a risk factor in suicidal behaviour - a least 8 studies; depression - at least 17 studies; anxiety - at least 18 studies and substance abuse - at least 15 studies.[28]

The consequences for those women who regret their abortion or experience mental health problems associated with their abortion can be profound and may last a lifetime and responsibility fall to domestic lawmakers to ensure their rights to health and health services are met and they have prompt access to adequate post abortion care services, including for mental health.

Some women experience a terrible post abortive pathology that is colloquially known as the "replacement child theory" … where they seek to replace their child by getting pregnant on purpose, go through the same feelings of inadequacy and then terminate as a form of self-harm.

One of the women we interviewed, Nicole, had eight terminations under current law and claims it was so easy for her. She says it wasn't until she began grappling with the underlying reason for her multiple abortions that she discovered a documented post-abortive pathology can include the desire to "replace the baby" and then self harm again. But she says it angers her now that when she presented her history to the clinic "not one person picked up on this fact and asked me whether there was an underlying reason for this devastating repeat behaviour."*

[28] Coleman, P. *Does Abortion Cause Mental Health Problems?* (2012). World Expert Consortium for Abortion Research and Education. Availabe at http://realchoices.org.au/wp-content/uploads/2012/07/Causal-evidence_abortion-and-mental-health.pdf

Nicole wasn't informed of the range of risks associated with whichever abortion procedure she was about to undergo (medical or surgical.) She, like many women we work with, was never given information regarding the development of her baby and felt the abortion provider wasn't prepared to provide support or counselling regarding concerns post-abortion. Many, like her, are even subjected to undue pressure to undergo an abortion.

This need for space before going ahead with a termination is also the view of a strong majority of Queenslanders today: 80% show strong support for a cooling off period of several days between making an appointment for an abortion and the actual procedure.[29]

QLRC WP No 76 vii Protection of women and service providers and safe access zones*

Q-14 Should it be unlawful to harass, intimidate or obstruct: (a) a woman who is considering, or who has undergone, a termination of pregnancy; or (b) a person who performs or assists, or who has performed or assisted in performing, a lawful termination of pregnancy?

Yes. It is already unlawful under current Queensland laws to harass, intimidate people from carrying out what they are legally entitled to do, i.e. in this case a lawful termination of pregnancy.

One of the most common complaint in post abortive stories shared to our website and social media pages is that of women feeling harassed and abused by a partner into having a termination against their will.

Abortion Rethink are concerned that we must also protect women from abortions they do not want and their right to choose free from intimidation.

How will new legislation protect women from being coerced or pressured into an abortion?

[29] Abortion Rethink and Australian Family Association (AFA). February 2018. *Abortion Study*. Research conducted by YouGov Galaxy, commissioned by Abortion Rethink and AFA.

Criminal sanctions are a strong deterrent for those who may pressure a woman into an abortion or perform an abortion that may damage her health. We have heard from women who have used limits on abortion under current law as a safeguard to say to others that they cannot now legally get an abortion (which they do not want).

Q-15 Should there be provision for safe access zones in the area around premises where termination of pregnancy services are provided?

No. No provision of so called "bubble zones" need be made.

Our view is founded on the following reasons:

1. **Women deserve real choice.** Some women are helped outside abortion clinics to have a choice other than termination; a choice they would not be offered otherwise. (See stories below).
2. ***There is no evidence of women in Queensland being harassed around premises where termination of pregnancy is provided.***
3. ***There are already sufficient laws.*** Current laws in Queensland are already sufficient to protect women and others from any harassment or offensive behaviour outside clinics.
4. ***A provision for 'bubble zones' may be unconstitutional.*** The recent High Court decision of *Brown and Hoyt v Tasmania*[30] in 2017 struck down bubble laws pertaining to protesting outside businesses in Tasmania. The decision in *Brown* is relevant to the validity of safe access zone laws in Queensland as these would clearly fall within the meaning of 'political communication', with abortion obviously being a matter of political interest in Queensland.
5. ***How would such a provision hence consider the Constitutional rights and rights under International law of Queensland citizens to freedom of assembly and freedom of speech?*** Australia is signatory to the *Universal Declaration of Human Rights* and the *International Covenant on Civil and Political Rights* which declare an individual's right to freedom of peaceful assembly and freedom of opinion and expression. Under Australian law, freedom of political communication is a right implied in the Australian Constitution. How would such a provision be j ustified as it infringes upon the rights of ordinary Queensland citizens, particularly considering that adequate laws against harassment already exist?

In an extensive and consultative review with conducted of this specific issue, we spoke with multiple women and families helped outside abortion clinics in Australia, several of whom have given permission to share their stories with you:

[30] *Brown & Anor v The State of Tasmania* [2017] HCA 43, 88 [22].

Stories of women & families assisted outside premises where terminations are performed

Aashika and Surya

Aashika and Surya, a young couple from Nepal, felt empowered to continue their pregnancy after encountering some "lovely people" nearby the abortion clinic they were headed to. They received the assistance they were actually seeking: financial, medical care and legal support regarding their immigration status.

Aashika is currently studying nursing at UTS whilst Surya works to support his family. Their daughter was born in January 2016 and continues to be a delight to them both.

Huma and Ali's Story

A young Indian couple, Huma and Ali, have residency in Australia and were worried that they wouldn't be able to afford another baby. After hearing of the support available to them whilst outside a clinic in New South Wales, they decided to continue the pregnancy.

They were particularly grateful for the help given to them, both before and after the baby's birth, since abortion was forbidden according to their Muslim faith and they found this conflict of values very psychologically distressing.

Amie's Story

A new arrival to Australia and a single mum to a young child, Amie was overwhelmed to find herself unexpectedly pregnant.

Amie found the prospect of a termination psychologically distressing owing to her social-cultural background. She shares: "I grew up in a family where that was forbidden."
Nonetheless Amie felt she had no choice but to abort. Approaching the clinic she was stunned to meet a group of local people offering help to women in her situation. She gladly accepted their offer of financial, medical, legal and emotional assistance, and began to look forward to the birth of her child.
Amie went on to discover that she was actually expecting twins. Her daughters were born premature but received excellent care at a Sydney Hospital. Sadly, the older of the twins passed away from an infection at just three weeks old.

Amie shares that even though she lost her daughter, she found the whole supported holistic process of being able to honour and grieve her life very healing and therapeutic.

She was particularly appreciative of the arrangements made for a Baptism in the hospital by her baby's bedside and a 'beautiful funeral'.

Amie's surviving daughter, Emily, is now three years old and doing very well.

Pala's Story

Immigrants from Nepal, Pala and his wife felt they had no choice but to abort when they found out they were having a baby just after getting married:

"Our private health insurance wouldn't cover the expenses [for the baby's delivery] because it would cover only after twelve months. So we had no choice and went to the abortion centre to abort the baby which we didn't wanted to do. It was our first child.

But we found these beautiful people, Kathy and Anne, who were offering help to those people who don't want to abort their baby, with financial or any other kind of help they wanted. They helped us, not only financially, but also psychologically with what we went through.

Now we have our baby. He is one year old - very healthy. We are very grateful, and thankful to these people. Without the help of these people we couldn't have imagined having our baby."

Footpath Support Workers share the 'why' behind what they do via our online portal:

Holly: https://www.youtube.com/watch?v=Px--Bae36R4

'So often the only person in a woman's life to tell them they have a choice, that they matter and their baby matters, is a person outside the clinic. Harassment is already legal. Why remove options?'

Natasha: https://www.youtube.com/watch?v=weejlcsR13s

'I encourage anyone thinking about this legislation to come and spend a morning in front of an abortion clinic….You will see young girls, very frightened, clearly not there through any wish of their own. Often the helpers (outside) are the only people to offer ……Do we really want to live in a society where a whole group of people have only one right - the right to remain silent?'

Angela: https://www.youtube.com/watch?v=2EmSCi6XNmE

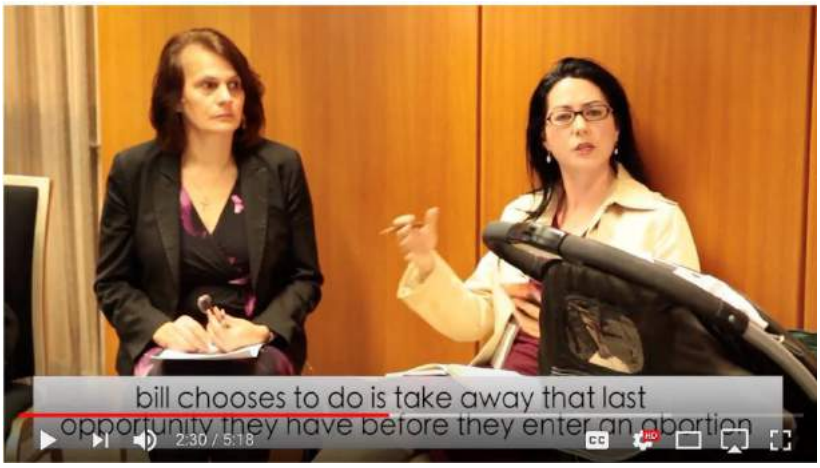
'In my experience, women who have had an abortion, whether I've spoken to them or just known them in my own personal life, will tell you they had the abortion because there was no choice, there was no other way out. To me, I think that that means that as a community we've failed these women...That surely to be pro choice, you want these women to have other realistic, viable options.'

If yes to Q-15: Q-16 Should the provision: (a) automatically establish an area around the premises as a safe access zone? If so, what should the area be; or (b) empower the responsible Minister to make a declaration establishing the area of each safe access zone? If so, what criteria should the Minister be required to apply when making the declaration?

No, for the reasons given in answer to Qu. 15.

Q-17 What behaviours should be prohibited in a safe access zone?

Safe access zones are unnecessary. There is no evidence from anywhere in Australia that women are being harassed or intimidated outside premises that perform abortions and that safe access zones are necessary to form part of legislation on terminations of pregnancy.



Last year *Abortion Rethink* held a panel at New South Wales Parliament House on a private member's bill to enact 'bubble zones' around abortion clinics. We heard from people helped outside clinics and that they had not been harassed or intimidated in any way.

Video of event here: http://www.abortionrethink.org/events

Q-18 Should the prohibition on behaviours in a safe access zone apply only during a particular time period?

No.

Q-19 Should it be an offence to make or publish a recording of another person entering or leaving, or trying to enter or leave, premises where termination of pregnancy services are performed, unless the recorded person has given their consent?

The same laws should apply as for other public spaces. There is no evidence of intimidation or harassment of this nature outside premises that provide terminations of pregnancy in Australia.

Collection of data about terminations of pregnancy

Q-20 Should there be mandatory reporting of anonymised data about terminations of pregnancy in Queensland?

Yes because there is no standardised or controlled data collection of women's experiences around abortion in Queensland. The most accurate numbers available to researchers are an estimation of between 10,000 - 14,000 terminations per year in the state.[31]

How can the commission confidently recommend a change in law that will be best for women, without accurate data to support it?

Questions we still have no quantitative information about include:

- How many Queensland women have abortions?
- Why do they have abortions?
- Do Queensland women have access to the support they need in pregnancy to give them a real choice between continuing or having an abortion?
- What complications, physical or mental, do Queensland women experience as a result of abortion?
- Do Queensland women feel adequately cared for in difficult pregnancies and beyond, regardless of outcome?

These are the questions we believe are crucial for the Commission to answer but for what we have not seen adequate evidence to support a change in law that would *lessen* controls over abortion.

Provisions need made so that any change in law does what it should: improve, not weaken, care for women.

[31] Children by Choice (2018). *Australian Abortion Statistics.* Available at https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics

Final Statement

On the back of our coal face observations of six independent crisis pregnancy support centres around Queensland, coupled with historic research and the very latest polling data available, *Abortion Rethink* confidently advises the Commission that the following provisions are critical for the health of women in abortion law reform:

- In the absence of any reliable data on termination of pregnancy in Queensland, Queensland law should not be 'reformed' without the required information to know what changes will be in the best interests of women and the community. A standardised and controlled system of data collection on termination of pregnancy in Queensland should be recommended by the Commission for prompt development and implementation.

- The Queensland community at large does not want a change to Queensland's abortion law. Queenslanders do not support changes to abortion law that would make legal abortion less restrictive or to remove the current criminal provisions that protect women. Current law is operating satisfactorily to allow women access to safe, affordable abortion for their physical or mental health.

- If the Commission is to recommend a change to law however, according to its Terms of Reference, this should be to strengthen legislatorial and regulatory protocols surrounding abortion. Better controls need to be in place for Queensland women, particularly over providers of termination of pregnancy, to improve the quality and availability of services for their care and health in all circumstances of pregnancy and beyond.

- Other Australian states where abortion law has been 'modernised' have not made adequate provisions at a statutory level (or regulatory changes) to ensure that all women are free to make fully informed decision regarding their pregnancies, in the absence of coercion or pressure and with the necessary information and support offered them. This includes women facing a prenatal diagnosis of abnormality.

- A change in law should also ensure that all women who have abortions in Queensland have immediate access to adequate post-abortion counselling. Other Australian states that have changed their abortion laws in recent times have not adequately provided for post abortion care.

- Furthermore, Queenslanders are strongly opposed to sex selection abortions and late term abortions. These should be prohibited or restricted under any change to Queensland law, more so than the current law allows.