OUR BODIES OUR CHOICES

Submission to the Parliament of New South Wales

Legislative Council Standing Committee on Social Issues

Inquiry into the Reproductive Health Care Reform Bill 2019

August 2019

Our Bodies | Our Choices

ACKNOWLEDGEMENTS

Our Bodies Our Choices would like to thank all of the members of the public, advocates, and experts, who shared their experiences and expertise, and who otherwise made contributions in the preparation of this submission.

Our Bodies Our Choices acknowledges that as Australians, wherever we are in Australia, we live and work on Aboriginal land. We pay our respects to Elders past and present and express our desire for a just settlement, including treaty and reparations.

Our community is diverse, and our committee reflects that. We acknowledge the trans people, non-binary people, people of colour, people with disability, culturally and linguistically diverse communities, and people from rural and remote communities who make up our community – and the additional impacts of the current criminalisation of abortion health care on their access to reproductive freedoms.

CONTENT WARNING: We warn that many of the examples of provided in this submission based on the lived experience of members of the New South Wales public may be distressing to readers.

Contact:
Claire Pullen
ourbodieschoices@gmail.com

TABLE OF CONTENTS

ABOUT US

Our Bodies Our Choices is the community campaign to decriminalise abortion in NSW. Our Committee reflects the diversity of the community we represent and work with – made up of women of colour, people with disability, people living in both metro and regional areas, spanning different ages and parenting stages and sexualities.

We support people and groups outside Sydney in their community work as well, providing media advice and digital support, as well as campaign strategy and feedback, in their work to decriminalise abortion.

Over the past year, our online community has grown to an audience of over 4,200 people (across Facebook, Instagram, Twitter and email). This community has actively supported our campaign through digital action (sharing posts, petitioning, emailing, donating and making submissions). They have trusted us with their own stories – to be able to tell them and represent them. They have also consistently shown up, to launches and information sessions and fundraisers, to rallies and to debates, all over NSW.

In the past month alone, our Facebook page has had a reach of 102,344 with 24,325 post engagements. Our Twitter impressions for the same time period have exceeded 667,000 with 8,969 profile visits and 439 mentions. Our online reach and engagement is reflective of our continued and extensive engagement with the community and their ongoing support of Our Bodies Our Choices as the community campaign to decriminalise abortion. Our reach also extends to our traditional media presence in commercial and other media outlets (radio, online and print) and in new media (podcasts, webinars, Twitter Q&A) for both the NSW and Australian market across all demographics.

EXECUTIVE SUMMARY

Our Bodies Our Choices (OBOC) welcomes the opportunity to contribute to the Legislative Council Standing Committee on Social Issues Inquiry into the Reproductive Health Care Reform Bill 2019. OBOC commends the Independent Member of Sydney, Mr Alex Greenwich MP, for tabling the Bill into the NSW Legislative Assembly, and his co-sponsors.

In responding to the Inquiry's Terms of Reference, from 6 August 2019:

A. The provisions of the Reproductive Health Care Reform Bill 2019 be referred to the Standing Committee on Social Issues for inquiry and report

OBOC acknowledges the referral of the Bill to this committee.

B. The Bill be referred to the committee upon receipt of the message on the bill from the Legislative Assembly

This bill passed the Legislative Assembly on 8 August 2019. We commend the committee for their commitment to a timely opening of the online portal and posting of the inquiry page.

C. The committee report by Tuesday 20 August 2019.

We commend the committee for their commitment to the timely production of their report.

Our submission falls into two parts. We took the view that what would be most useful to the committee was an overall picture of the community response to the bill, and an overview of amendments that may be part of consideration. This is drawn from the proceedings in the Legislative Assembly.

Part 1: COMMUNITY RESPONSES

As soon as we became aware this inquiry would take place, we created an online portal for our community to tell us what they wanted this inquiry to know. We ran this portal for a week and garnered 77 responses. Qualitative analysis has been conducted on these responses, and the key themes and illustrative comments have been identified. The key themes associated with lived experiences of abortions have also been reported. Quotes from responses have been included in purple text boxes throughout this submission.

Part 2: UNSUCCESSFUL AMENDMENTS AND ISSUES OF CONCERN TO MEMBERS OF THE LEGISLATIVE COUNCIL

The second part of our submission is a response to the substance of amendments moved and defeated in the Legislative Assembly, and reflections of public comment from MLCs.

RECOMMENDATIONS

RECOMMENDATION 1: It is our recommendation that there should be no amendments regarding gender selection, as these might require doctors and health practitioners to racially profile then surveil some patients, or surveil all patients, for gender preferences, as this could create a further barrier to abortion.

RECOMMENDATION 2: It is our recommendation that there should be no amendments that might require a pregnant person to participate in compulsory counselling regarding their choice to access abortion.

RECOMMENDATION 3: It is our recommendation that no amendment be made that would allow a health practitioners' refusal to provide abortion care as a de facto denial of abortion care, and the bill in its current form is appropriate.

RECOMMENDATION 4: It is our recommendation that no amendment be made to reduce the gestational limit in the bill.

PART 1: COMMUNITY RESPONSES

Demographic characteristics of respondents

There were 78 respondents to the online form. Questions were asked about where they lived and whether they identified as a person of colour, person with disability, or if they lived in rural or regional New South Wales. Respondents were from a wide range of locations, including rural and regional areas, and many had since moved to cities or interstate:

Albury	Kiama	Pymble
Armidale	Kilaben Bay	Randwick
Balmain	Lake Macquarie	Redfern
Beechworth, VIC	Lismore	Ryde
Blue Mountains	Marrickville	Seaham
Bondi	Mascot	Strathfield
Brisbane	Melbourne, VIC	Sydney
Bulli	Mid North Coast	Terrigal
Castle Hill	Naremburn	Umina Beach
Coogee	Newcastle	Unaderra
Coonabarabran	Newtown	Wagga Wagga
Deniliquin	Northern Beaches	Wallsend
Epping	Northern New South Wales	Waterloo
Erskineville	Pambula	Western Sydney
Goulburn	Penrith	Wollongong
Hawkesbury	Petersham	Woodford

Three respondents identified themselves as a person with disability, two as people of colour, two as LGBTIQ, as well as a range of culturally diverse backgrounds such as Korean-Australian, Latina, Japanese, immigrants and second generation immigrants. Although age and gender weren't asked for specifically, most respondents identified as female with a small group of respondents who identified themselves as male, and the responses indicated a range of ages from late teens through to retirees who were veteran pro-choice campaigners.

Methodological approach to analysis

Summative content analysis was conducted, with community responses coded according to themes as they emerged. Most community responses contained a number of different themes. The reference counts provided indicate the number of times a theme was raised. Example text is provided which are particularly indicative of that theme. The responses were given in answer to the question: "What should we tell MPs about why decriminalising abortion is important?"

Top five themes

1. People should have the right to choose

The top rated theme from respondents was that a pregnant person should have the right to choose what happens to their body. Pregnancy and childbirth can be difficult and life altering events, even when undertaken willingly. Nobody should be forced to be pregnant, or to have an abortion if they do not want one, against their will. They should be given full autonomy over their reproductive health decisions. Women should have the right to make decisions about their own bodies and their lives. – 43 references

"THERE IS NO PLACE FOR SUCH DISCRIMINATORY AND OUTDATED LAWS IN THIS DAY AND AGE THAT ERASE THE REPRODUCTIVE RIGHTS OF ANY HUMAN THAT IS CAPABLE OF BEARING A CHILD.

IT IS A FUNDAMENTAL HUMAN RIGHT – NOT A LUXURY – TO HAVE AUTONOMY OVER OUR OWN BODIES."

2. Abortion should not be criminalised

The second highest rated theme from respondents was that abortion should not be a crime, and that it should be removed from the NSW Crimes Act. The choice to have an abortion should not restricted, or made in under the apprehension of legal risk and uncertainty.

One of the key reasons given was that criminalising abortion does not stop people from having abortions. Instead, it restricts their access to safe abortions. One respondent provided her family's lived experience of what happened when an unsafe abortion claimed her grandmother's life.

"MY GRANDMOTHER'S DEATH AT 35 YEARS OLD WAS RESULT OF UNSAFE TERMINATION. MY MOTHER, 8 YEARS OLD AT THE TIME WAS ONE OF FIVE CHILDREN AND WAS CLUELESS AS TO THE DETAILS OF HER MOTHERS DEATH. SHE LOST CONTACT WITH HER SIBLINGS AS THEY WERE SCATTERED ACROSS FOSTER HOMES AND ORPHANAGES... I WANT EQUAL ACCESS FOR ALL WOMEN TO SAFE TERMINATION WHEN AND IF THEY NEED IT"

Another woman with a lived experience of abortion noted: *"I distinctly recall the fear that resulted from the understanding that I was 'breaking the law'. I'm ashamed to think of how many more women have since had to make that same decision under the very same archaic legislation."* – 32 references

3. Abortion is healthcare

A large number of respondents identified abortion as a medical procedure, and an element of healthcare. As such it should be regulated as health care rather than in the Crimes Act. – 23 references

"ABORTION IS AN ELEMENT OF HEALTH CARE, NOT A CRIMINAL ACT, AND IT SHOULD BE LEGAL, SAFE, AND ACCESSIBLE."

4. The laws are archaic and outdated, it is time for NSW to change

There were numerous comments made about the current laws around abortion, as outdated, archaic and holding NSW back. Many noted that the majority of Australians support safe and legal access to abortion, and that NSW is well behind other countries and states across Australia in this respect. As one respondent noted: *"Do the right thing. Legalise abortion. We do not live in the 1800s anymore – it's time the law reflects that."* - 21 references

5. Religious ideologies and beliefs should not determine the law

Respondents noted that Australia is a secular nation which includes people of many religions, as well as many who are not religious at all. As church and state are separate, people should be able to make choices about their healthcare without the influence of other's religious ideology, morals or beliefs. - 17 references

"PEOPLE OF FAITH DO NOT HAVE TO ACCESS THIS SERVICES, BUT NOR SHOULD THEY PREVENT OTHERS FROM DOING SO."

Apart from these top five themes, there were a number of other topics which were commonly raised, including:

- Concerns for foetuses do not tend to translate to concern for children born to those who cannot afford to support them: some respondents noted that there seemed to be more concern over policing women's choices, without commensurate regard for social policy to support children and young people, such as improved paid parental leave, a living wage, and subsidized child care. – 14 references

- Abortion healthcare should be more affordable and accessible for people across all of NSW: This includes for pregnant people with disability, in regional and rural areas, and for people of different socio-economic statuses. It was noted that access to termination should be equal, not only available to those with support and resources. – 13 references
- Many are tired of men legislating and controlling women's bodies and choices – 7 references
- Pregnant people have the right to privacy when making a very personal choice: outside of consultation with a healthcare provider, it is no one else's business – 7 references
- Misinformation and fear mongering about abortion is rampant: some respondents noted that there is scaremongering and misinformation being spread by 'pro-life' advocates, particularly in relation to late-term abortions. "*I implore politicians to only deal in facts and listen to people with experience in this matter, and to health care professionals*." – 5 references

Lived experiences of abortion

Eighteen people shared their stories of seeking or having an abortion. The most common theme across their stories was that they were impacted by stigma and judgement on religious or moral grounds, and many found themselves in situations where they were denied dignity and understanding. Many were denied help by medical professionals.

"THE DOCTOR REFUSED TO TALK TO ME ABOUT IT AND SAID IT'S AGAINST HIS RELIGION AND I NEEDED TO LEAVE HIS ROOM IMMEDIATELY. HE MADE ME FEEL LIKE THE WORST HUMAN BEING FOR GOING AND FINDING OUT MY OPTIONS AND I LEFT IN TEARS AND WE HAD THE BABY."

It was also a common theme that people seeking a termination already had children, or went on to have children later in their lives. Many fell pregnant while using contraception.

Some were in unstable, abusive or violent relationships. Some had mental health issues. Some fell pregnant at a very young age, and some had been raped.

"MY PARTNER PHYSICALLY ASSAULTED ME A FEW HOURS AFTER HAVING HAD THE PROCEDURE."

There were three second-hand accounts of experiences with friends or family members who had died as a result of an unsafe, illegal abortion, or who had committed suicide

because they were not able to access a safe and legal abortion, and so had taken their own life rather than deal with the stigma attached to being a teenaged mother.

These people with lived experiences also provided feedback on what made their experience negative, and what they would wish to see changed, so that future generations would not have to endure the difficulties that they had to face in seeking an abortion, for reasons varying from mental health, to violent relationships, to the tragedy of losing a much wanted pregnancy.

"I ENDED AT 23 WEEKS FOLLOWING DIAGNOSIS OF [genetic defect] AND HOLOPROSENCEPHALY... THE DECISION TO END MY THIRD PREGNANCY WAS NOT MADE LIGHTLY. WE RESEARCHED OUR CHILD'S CONDITIONS, SOUGHT INFORMATION FROM DOCTORS, SPECIALISTS, AND GENETIC COUNSELLORS AND MADE THE DECISION WE FELT WAS BEST TO SAVE OR CHILD PAIN AND SUFFERING AND FOR OUR FUTURE FAMILY. WHILE I GRIEVE HIS LOSS, I BELIEVE WE MADE THE BEST DECISION WE COULD IN THE CIRCUMSTANCES WE FOUND OURSELVES IN.

EVERYONE'S CIRCUMSTANCES ARE DIFFERENT. SINCE ENDING MY OWN PREGNANGY, I HAVE MET MANY WOMEN WHO HAVE ENDED PREGNANCIES DUE TO FOETAL ABNORMALITY, EACH ONE HAS MADE A LOVING DECISION WITH THE INTERESTS OF THAT CHILD AND OF HER FAMILY AT HEART. DECRIMINALISING ABORTION WILL REDUCE THE NEED FOR WOMEN IN THESE CRICUMSTANCES TO TRAVEL, SOMETIMES TO OTHER STATES, AND REDUCE THE STIGMA ASSOCIATED WITH ABORTION AND ALLOW THEIR GRIEF AND LOSS TO BE ACKNOWLEDGED. BEING ABLE TO HAVE THE PROCEDURE IN A PUBLIC HOSPITAL WILL REDUCE THEIR COSTS AND ALLOW WOMEN TO BE CLOSER TO THEIR FAMILIES. IT WILL GIVE DOCTORS GREATER CERTAINTY ABOUT THEIR LEGAL STATUS."

PART 2: UNSUCCESSFUL AMENDMENTS AND ISSUES OF CONCERN TO MEMBERS OF THE LEGISLATIVE COUNCIL

Over the course of last week, the Legislavie Assembly considered a number of amendments. Some were passed and some were rejected. For the sake of brevity, we will deal with those amendments that were not passed thematically as we suspect they are likely to from part of the Members of the Legislative Council's (MLCs) considerations of the bill. Concerns similar to those embodied by these unsuccesful amendments have also been expressed publicly by some MLCs.

THEME ONE: Gender selection

It is our recommendation that there should be no amendments regarding gender selection, as these might require doctors and health practitioners to racially profile then surveil some patients, or surveil all patients, for gender preferences, as this could create a further barrier to abortion.

Several MLAs made reference to the 2018 study, Male-biased sex ratios in Australian migrant populations: a population-based study of 1,191,250 births 1999–2015.[1]

It is important to note, and the women of colour on the OBOC committee in particular note, that discussions around gender selection are often mired in racism. People who seek to criminalise abortion often refer to 'migrant communtities' as an unreconstructed monolith of barbaric gender practices. In some cases, those who seek to rely on gender selection as an argument against abortion adopt the garb of feminism, proposing to save girls and girl babies and that the full equality of women must mean the banning of abortion. We reject this notion.

The reality of gender selection is more nuanced.

The 2018 La Trobe study found there is a skewed gender ratio in births to first-generation mothers of Indian and Chinese birth. Lead researcher and epidemiologist Dr Kristina Edvardsson said this skew towards boys indicates prenatal sex selection, following migration from countries where these practices have been documented.

However, the study did not find that this meant gender-selective abortion was taking place in Victoria, nor that the problem persisted into further generations within the migrant community. There is some evidence from Canada that second-generation migrant communities may not continue the trend of gender selection,[2] but some do, in specific contexts around prior live births of daughters and prior abortions.[3]

The La Trobe study essentially found that in some migrant communities whose country of origin had a history of gender selection there was some persistence of this preference among first generation migrants.

Prenatal gender selection need not mean abortion. It can also mean section of embryos through IVF. Gender selection through IVF is banned in Australia, except in cases where a child's gender may help avoid the transmission of a genetic abnormality or disease. In Victoria, such cases are assessed through the patient review panel, which considered 69 applications for sex selection between 2010 and 2016.[4]

Lead author of the La Trobe study Dr Edvardsson said "We have no evidence to suggest that medical practitioners are allowing this to happen in Victoria."[5]

There are language and cultural barriers to migrant communities accessing health care.[6] There are barriers for migrant women accessing reproductive and sexual health services.[7]

"I COME FROM A VERY CONSERVATIVE CHINESE FAMILY, WHERE SEXUALITY IS NEVER DISCUSSED AND QUITE FRANKLY IT IS DELIBERATELY SUPPRESSED.

AS A RESULT I HAD NO GUIDANCE IN SEXUAL HEALTH, FAMILY PLANNING OR SEX IN GENERAL. I WAS QUITE RISKY WITH MY SEXUAL BEHAVIOURS. IF I WERE TO HAVE BECOME PREGNANT, THIS WOULD HAVE BEEN THE END OF MY FAMILY RELATIONSHIPS, AND THE END OF MY CAREER. BY THE MANY BARRIERS THERE ARE TO ABORTION, IT WOULD HAVE VERY DIFFICULT TO OBTAIN ONE.

I AM CURRENTLY IN MEDICAL SCHOOL AND WERE I TO HAVE BECOME PREGNANT AND AN ABORTION WERE NOT POSSIBLE, THIS WOULD HAVE BEEN THE END OF MY CAREER. PLEASE DECRIMINALISE ABORTION SO THAT GIRLS LIKE ME HAVE EVERY OPPORTUNITY TO ADVANCE THEMSELVES AND THEIR CAREERS. PARENTAL GUIDANCE AND EDUCATION REGARDING SEXUAL HEALTH IS OFTEN INADEQUATE, SO BY MAKING THESE BARRIERS, YOU ARE TAKING AWAY OPPORTUNITIES FROM GIRLS LIKE US".

Gender preference and selection is far from a problem only of certain migrant groups. In 2017, the NHMRC published updated guidelines on the use of IVF for gender selection.[8] The NHMRC was considering allowing gender selection of pre-implantation embryos, but ultimately decided against. During that time, a great deal of media attention focused on people[9] who shared that they had spent $30,000[10] to $50,000[11] to travel to countries that do allow gender selection. They all selected for girls, and one provider suggested this was the case in 70% of their Australian clients.[12] One report held that the number of Australians travelling to do so had doubled in the last five years.[13] Interestingly, there is some evidence from the US that suggests where embryo gender selection takes place there, the preference is for girls as well.[14]

The evidence seems to suggest that banning gender selection has been no more successful that banning abortion. India, for example, where sex selective abortion was banned in 1994, still has a persistent problem of gender preference.[15] In Australia, gender selection appears to be available and in many cases challenges the stereotype of using abortion to select for boys and instead be about the use of overseas IVF to select for girls.[16] It is also unrelated to regulating abortion as a crime.

Research suggests that individuals who choose to undergo sex selection do so in order to have a child who will enable them to have a certain type of childrearing experience. Their underlying assumption is that a child of the sex they seek will conform to the stereotypical roles and norms associated with that sex. However, the current state of the evidence does not support the assumption that the ability to enjoy certain activities and to have certain relationships can only be realised with a child of one sex.[17] Nor does it suggest that attempting to ban gender-selective abortion has any utility or practical effect.

Gender selection may also be necessary in cases of genetic defects which are sex-linked. One of our community shared her story regarding a sex-linked disease in her family.

"MY MOTHER SOUGHT HELP TO CONTROL HER REPRODUCTIVE OPTIONS IN THE LATE 1940S AFTER BIRTHING TWO BABIES ALREADY. THE MALE DOCTORS TOLD HER THEY COULD DO NOTHING FOR HER UNLESS IT WAS AT RISK TO HER LIFE. SHE WENT ON TO HAVE FIVE MORE BABIES AND LOVED THE SEVEN OF US ALL.

FINDING OUT WITH THE SIXTH CHILD THAT SHE WAS A CARRIER OF A GENETIC DISEASE THAT WOULD CAUSE THE MALE CHILD TO HAVE A SHORTENED LIFESPAN YEARS IMPACTED US ALL. EVEN MORE SO WAS THE KNOWLEDGE THAT SHE LIVED WITH FOR THE NEXT 70 YEARS, AND THAT WE AS HER CHILDREN AND GRANDCHILDREN ALSO HAVE TO DEAL WITH, WAS THE KNOWLEDGE THAT SHE COULD ALSO HAVE PASSED THIS DEFECTIVE GENE ONTO HER DAUGHTERS. THEY COULD THEN IN TURN, PRODUCE A MALE CHILD WITH THIS DEGENERATIVE AND INCURABLE DISEASE AND A FEMALE CHILD WHO COULD CARRY ON THAT GENE AGAIN.

THINGS ARE DIFFERENT TODAY ON SOME LEVELS BUT NOT ON OTHER LEVELS. THE DISEASE IS NOT ERADICATED ALTHOUGH OUR FAMILY HAS SELECTIVELY MADE REPRODUCTIVE DECISIONS TO REMOVE THIS FROM OUR FAMILY AT THIS POINT. CAN YOU IMAGE WAITING TO SEE IF IT MIGHT AGAIN POP UP IN FUTURE GENERATIONS AND CAN YOU IMAGINE THE RANGE OF DECISIONS THAT HAVE HAD TO BE MADE, AND CONTINUE TO BE MADE, SOME RIGHT AND PERHAPS SOME REGRETTED PERHAPS BY MY FAMILY"

THEME TWO: Compulsory counselling

It is our recommendation that there should be no amendments that might require a pregnant person to participate in compulsory counselling regarding their choice to access abortion.

The argument for compulsory counselling is framed as concern for women. The Turnaway Study in the US (so called because they studied women denied abortion access, or 'turned away') found the opposite to be true.[18]

The results of the Turnaway Study show that when women are forced to become parents when they are denied abortion, their health suffers, as does that of their children.

There is no evidence that induced abortion has any significant impact on persistent and serious mental health issues.[19]

We want children to be loved and properly cared for and women to control their own lives, including the timing, spacing and care of children. Women can be trusted to make their own decisions. Some will choose abortion, and others will not.

Criminalising abortion means that women are not treated as though they have the capacity to make their own decisions, weigh consequences, and act in accordance with their own conscience. Compulsory counselling sits as part of a "discriminatory vision of women's decision-making ability, characterizing women as relatively incapable of rational, responsible decision making and in need of special guidance from the state regarding the exercise of their reproductive rights."[20]

There are several variations on the anti-choice argument that women don't know what's best for them, such as 'women are being pushed into abortion and not given all the options' and 'women don't understand the decision they are making.' Other variations include laws that force unnecessary ultrasounds or 'counselling' for anyone getting an abortion. These laws are examples of abortion exceptionalism, in which abortion is singled out for more restrictive government regulation as compared to other, similar procedures.[21] As Vandewalker puts it, "Various justifications are offered for abortion-specific regulations, but at heart they are driven by moral opposition to abortion and legislators' desire to come as close as possible to banning it without enacting a law that will be struck down as unconstitutional."[22]

Pregnant people and those who can fall pregnant are trusted every day to open bank accounts, have major surgery, drive cars, and crucially as the main providers of care to children[23] and elderly family,[24] they make decisions on behalf of others too. This is the only medical decision where people argue the state should make decisions on behalf of women who are unable to know their own mind.

"I HAVE MANY FRIENDS, FAMILY AND COLLEAGUES WHO HAVE SHARED THEIR ABORTION STORIES WITH ME AND HAVE EXPRESSED HOW THE CRIMINALISATION OF ABORTION HAS IMPACTED THEM. FROM HAVING TO TRAVEL INTERSTATE TO ACCESS AFFORDABLEERMINATION, TO THE UNNECESSARY SHAME AND STIGMA THEY WERE MADE TO FEEL.

I WAS CONCERNED BY THE PROPOSED CHANGE THAT WOULD SEE WOMEN BE RECOMMENDED TO COUNSELLING BEFORE MAKING A DECISION TO TERMINATE A PREGNANCY. WE ARE NOT FORCED TO UNDERGO COUNSELLING BEFORE WE GO TO THE DENTIST OR THE IMMUNOLOGIST."

These arguments belittle women and position us as incompetent decision-makers.
We are supportive of policies for better maternity support, for example increased paid parental leave, free or better-subsidised childcare, and better health services, but not every woman wants to be pregnant, give birth and parent. To choose not to parent is not an aberrant choice that requires professional interrogation.

Decriminalising abortion and improving access means women are able to decide without coercion how to exercise their rights.

THEME THREE: Conscientious objection

It is our recommendation that no amendment be made that would allow a health practitioners' refusal to provide abortion care as a de facto denial of abortion care, and the bill in its current form is appropriate.

Our community shared stories of being rejected from care by doctors who would not provide them with the abortion care they sought.

"THE DR REFUSED TO TALK TO ME ABOUT IT AND SAID IT'S AGAINST HIS RELIGION AND I NEEDED TO LEAVE HIS ROOM IMMEDIATELY. HE MADE ME FEEL LIKE THE WORST HUMAN FOR GOING TO FIND OUT MY OPTIONS AND I LEFT IN TEARS AND WE HAD THE BABY. AT THE TIME I WASN'T SURE IT'S WHAT I WANTED BUT THAT APPOINMMENT REALLY WAS THE SHOVE THAT MADE OUR MINDS UP AS WE THOUGHT THERE WAS NO OTHER OPTION WITHOUT JUDGEMENT AND SO WE HAD THE BABY"

Abortion access in NSW is uneven, concentrated in our cities and expensive. Fewer doctors prescribe medial abortion in regional areas. In 2015, the majority of rural and remote areas of NSW had between 1 and 10 medical prescribers in each of the seven rural or remote health districts in the State. Comparatively, in each of the eight metropolitan health districts there were between 20-40 prescribers.[25]

Travel to a metropolitan area for an abortion can make up anywhere upwards of 1/3 of total costs – accommodation and childcare are imposed on pregnant people who must travel as well as the provider's fees. A woman travelling from regional or rural NSW can expect to pay upwards of $1,000 for abortion care.

The Queensland Law Reform Commission noted that:

> "It was observed by respondents that, in regional and remote settings, conscientious objection might operate as a barrier to accessing termination services, even if there were a requirement to refer the woman elsewhere. It was submitted that enabling access to safe and affordable termination services (including when there is no alternative service within a reasonable geographic proximity) should override any refusal of care based upon conscientious objection. Another respondent stated that: "All Australians should have the same access to healthcare and allowing conscientious objection in remote settings and other such instances in which there are limited resources and professionals available would prevent equitable access to necessary health resources."[26]

The ability for doctors and health practitioners to refuse services to patients must not be used to impose a de facto ban in places where they may be the only medical practitioner available.

There is consensus about the appropriate balance. As the Queensland Law Reform Commission report found,

> "In the Australia Capital Territory, South Australia and Western Australia legislation provides generally that a person is not under a duty (by contract, or by statutory or other legal requirement) to participate in a termination. In the Northern Territory and Victoria, an objecting practitioner must refer a woman to another practitioner who is known not to have a conscientious objection to termination. In Tasmania, the legislation combines these approaches."[27]

"MY REFERRING GP TOLD ME I WAS STUPID FOR THE CIRCUMSTANCES IN WHICH I BECAME PREGNANT- WITHOUT BOTHERING TO IDENTIFY THE SUBTLE COERCION I WAS EXPERIENCING, AS I WAS DEALING WITH MY REACTION, AND MY PARTNER'S REACTION, TO MY HAVING BEEN RAPED. WE SHOULD HAVE BEEN TREATED WITH DIGNITY AND RESPECT, WHATEVER WE DECIDE IN ANY CASE. BUT ON TOP OF THAT, A BIT OF RESPECT AND EMPATHY COULD GO A LONG WAY TO IDENTIFYING SOME OF THE IMPORTANT ST THAT WE WOMEN COULD USE SOME HELP ADDRESSING.**

STIGMA RELATED TO ABORTION DECISIONS OR CONTRACEPTION USE IS DAMAGING, AND AN OBSTACLE TO THE STEPS SOCIETY SHOULD TAKE TO VALUE WOMEN AND PROMOTE OUR REPRODUCTIVE HEALTH, IN ITS FULLEST SENSE"

The bill strikes the right balance between doctors who wish to refuse services and the right of patients to access the care they need.

THEME FOUR: Gestational limit

It is our recommendation that no amendment be made to reduce the gestational limit in the bill.

The majority of abortions take place early in a pregnancy- often during the time people don't tell their friends and family they are pregnant because of the likelihood of miscarriage.

It is estimated that no more than 3% of abortions take place after 20 weeks gestation.[28] The figure may be as low as 0.7%. Where second and third trimester abortions take place (as they do currently in NSW) they usually involve a multi-disciplinary team, in a hospital setting, involving doctors, nurses, foetal medicine specialists, social workers, and the hospital's ethics staff (as available and appropriate in each different hospital setting).

This gestational age allows diagnosis and testing not available earlier in a pregnancy. These scans can take place over a span of weeks and depend on foetal size (as well as availability of health practitioners).

The Bill in its current form is more restrictive of late second trimester and third trimester abortions as it increases the involvement of doctors. There are some in our community who are opposed to the bill as they see this bill as restricting autonomy.

Most have an understanding of the sort of medical diagnoses and outcomes that are behind what is a difficult choice made by very few people. A number of such examples were given last week by members of the Legislative Assembly.

Several members of our community shared their stories of choosing to have a second or third trimester abortion. These are people who made thoughtful and difficult choices and who have supported others to make these decisions. Lowering the gestational limit will not assist people and families in making well-informed decisions in the very small number of cases where such circumstances arise.

I'VE HAD AN ABORTION FOR [GENETIC DISORDER]. HARDEST TIME OF MY LIFE AT 19.5 WEEKS GESTATION. BEST THING TO HAVE DONEFOR HIM AND US AS A FAMILY.

I'VE ALSO SUPPORTED 2 WOMEN WITH THEIR EARLY FIRST TRIMESTER AORTIONS. BEST THING THEN AND NOW FOR THESE WOMEN. I WAS A MIDWIFE AND MY FRIEND A REGISTERED NURSE.

WE ARE NOT CRIMINALS.

As anti-choice groups and people have shifted their message to incorporate elements of feminism, so too have they sought to co-opt the language of disability rights. The women with disability on the OBOC committee reject this appropriation.

This argument is based on the idea that many abortions are performed because a foetal abnormality is detected, that these abortions should not be allowed as they discriminate against people with disability.

It is meant to de-legitimise certain types of abortion and force advocates to argue in a framework where some abortions are 'good' and others are 'bad'. It is also meant to suggest people with disability advocates who, in the normal course of things, advocate for greater bodily autonomy and control, argue for reducing the autonomy and control of women. As we have seen during the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, the rights of people with disability to reproductive (and other types of) autonomy are routinely abused.

In NSW, all abortions are currently a crime, albeit in a legal grey area. We believe all people should have the choice to control their reproductive lives. We are in solidarity with people with disability, and particularly women with disability, who have their reproductive autonomy removed. This is far more common that most know.[29]

The OBOC committee and community includes people with disability who are abortion advocates. We understand why this topic can be fraught in our disability community, but advocacy for people with disability and for abortion rights have the same grounding: the inviolable right of people to make decisions about their own bodies. The question is not just one of whether or not second and third trimester abortions should be allowed, but the right of people with disability to make their own decisions about pregnancy and parenting.

That decision should rest with the person who is able to become pregnant and not the criminal law.

"PEOPLE WITH DISABILITY NEED REPRODUCTIVE JUSTICE, AND THAT INCLUDES ACCESS TO SAFE, AFFORDABLE AND LEGAL ABORTION SERVICES.

MY DISABILITY HAS MEANT THAT I HAVE LONG KNOWN THAT I COULD NOT HAVE A VIABLE PREGNANCY, NOR DELIVER A LIVE BABY IF I EVER GOT PREGNANT. THIS MEANS THAT ACCESS TO SAFE, LEGAL AND AFFORDABLE ABORTION SERVICES IS AN ISSUE I CARE PASSIONATELY ABOUT FOR ME, AND FOR OTHER PEOPLE WITH DISABILITY WHO CAN BE PREGNANT"

I URGE MPS TO PASS THIS BILL, AND REMOVE ABORTION FROM THE CRIMES ACT."

Our community feedback indicates there is little patience for the notion people get to 22 or 24 weeks of pregnancy and decide to have an abortion on a whim.

AS A NURSE LOOKING AFTER LADIES HAVING TO DECIDE WHETHER THEY WANT TO HAVE A TERMINATION OF PREGNANCY, THESE LADIES DON'T DECIDE ON A WHIM,

IT IS A HEARTFELT DECISION FOR THEM.

IT IS NOT A CRIME. NSW NEEDS THIS AND IT'S ABOUT A WOMAN'S CHOICE.

The general community position is also more nuanced. When Textor et al studied attitudes to second and third trimester abotrtion, their findings demonstrated considerable nuance in community views.

From *Australian attitudes to early and late abortion*[30]

Circumstance	Should face sanctions	Should **not** face sanctions	Can't say
When continuing the pregnancy would involve greater risk to the life of the woman than termination	11%	78%	11%
When there is evidence that the baby is suffering such severe abnormalities that it would be unlikely to survive long after birth and that medical treatment would be unlikely to prolong its life	11%	78%	11%
When continuing the pregnancy would involve greater risk of injury to the physical health of the woman than termination	13%	78%	11%
When the pregnancy was caused by rape or incest	13%	73%	14%
When there is evidence the baby is suffering severe abnormalities that would result in a very serious intellectual or physical impairment	14%	72%	15%
When continuing the pregnancy would involve greater risk of injury to the mental health of the woman than termination	17	67	16
When there is evidence that the baby may be mentally impaired	19	61	21
When there is evidence that the baby may be physically impaired	21	59	21
When the woman has a major drug addiction	22	58	20
When the woman is a minor (aged 15 years or under) and did not realise or admit earlier that she was pregnant	26	53	21
When the woman is a minor (aged 15 years or under	26	51	23
When the woman's partner is abusive and is likely to be abusive to the child	33	39	27
When the woman did not realise or admit earlier that she was pregnant	35	38	28
When the woman's partner died or left her during pregnancy	45	30	25
If, for any reason, the woman decides that she does not wish to have a child at that point in her life	45	31	23
When the woman or family cannot afford to raise the child	42	30	28

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