

CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

DEVELOPMENT OF A
QUEENSLAND WOMEN'S STRATEGY

SUBMISSION
DECEMBER 2015

ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, deliver sexual and reproductive health education sessions in schools, and offer training for GPs and other health professionals on unplanned pregnancy options.

Children by Choice supports women's access to all options with an unplanned pregnancy, including abortion, and have been involved in helping women access these options since the service began operation in 1972. Children by Choice is the only independent, not-for-profit women's service dedicated to unplanned pregnancy in Australia. Children by Choice is recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to access to reproductive health services with regard to unplanned pregnancy.

Our vision: all women can freely make their own reproductive and sexual health choices.

Key values that underpin our work are:

- pro choice and woman centred
- ethical and evidence based
- non-judgemental and unbiased
- confidential and respectful
- commitment to social justice, diversity and equity, and
- the right to self determination.

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RECOMMENDATIONS

- The new Queensland Women's Strategy must recognise that abortion is a fundamental right and that women must be free to choose abortion without coercion or pressure, or threat of prosecution.
- The Queensland Women's Strategy must facilitate the removal of abortion from the state's Criminal Code, and ensure equitable access to contraceptive and abortion services for women and girls across the state. This includes access to publicly provided pregnancy terminations for those most in need.
- The Queensland Women's Strategy should support well-resourced local women's centres and regional provision of ante-natal and termination services. Local services should be assisted by the extended provision role of nurses, specialist fly in/fly out services and telephone based services.
- Women and their children in every Australian community must be able to access a women's safe space. While this policy should work towards all women being safe in their homes and in public, at night and during the day, the need for refuge must be recognised in policy and well resourced in practice.
- The Queensland Women's Strategy should emphasise the importance of gender analysis tools in the development of all government policy and procedure.
- Any data used to support the development of the new Queensland Women's Strategy must be evidence based. In areas where there is a lack of reliable, gender disaggregated data, the strategy must implement measures to provide this data as an essential platform.
- The Queensland Women's Strategy should provide for the gender disaggregation of comprehensive statistics on health and welfare, not only between men and women, but between groups of women and groups of men, to allow for analysis of the effectiveness of health policies for women, and identify further areas of need.
- A Queensland Women's Strategy should support and build upon the Queensland Sexual Health Strategy currently being developed.

INTRODUCTION

Children by Choice welcomes the Queensland Government's commitment to developing a statewide Women's Strategy, which we believe could be an important step in addressing gender inequality.

As a member of the Ending Violence Against Women Queensland peak body we endorse that submission to this consultation and all the recommendations contained therein.

While the focus of our service delivery is sexual and reproductive health (in particular pregnancy options and access to services), we operate from a social determinants of health framework. This recognises that many underlying factors, such as housing, employment, and education contribute to health outcomes.¹ As part of our work supporting women experiencing unplanned pregnancy, we discuss many of these issues with our clients, and some issues – in particular, violence – have a significant impact on women's reproductive health and choices.

We believe that any measures taken to improve gender equality in Queensland are positive ones and should be supported. However, the focus of our submission is in two of the five areas highlighted for this consultation: safety, and health and wellbeing.

¹ See for example *Development of a New National Women's Health Policy Consultation Discussion Paper 2009* Department of Health and Ageing, Commonwealth Government Canberra p14-15.

SAFETY

The Office for Women will of course be aware of the enormous impact of violence on the lives of Queensland women. This is well established, and is supported by the 'Not Now, Not Ever' report and recommendations of the recent Special Taskforce headed up by Dame Quentin Bryce on domestic violence in Queensland.

We are very supportive of the recommendations of the Taskforce being adopted; however, there are gaps in the topics addressed by the Taskforce which we wish to address in this submission, namely the intersection between domestic and sexual violence, and the relationship between domestic violence and reproductive health.

Many sexual assaults take place within current relationships or are perpetrated by ex-partners, and yet sexual violence is often ignored in discussions around intimate partner or domestic violence. The report from the Special Taskforce on Domestic Violence released earlier this year, while defining intimate partner sexual violence as part of the broader issue of domestic violence, did not offer any in-depth discussion of how prevalent the issue is or how to reduce it or better support victims. Women themselves describe the additional stigma and shame attached to being a woman who has been sexually assaulted, in addition to one who has been physically or mentally assaulted by a partner.

The relationship between domestic violence and poor reproductive health outcomes is well established. As well as the other outcomes of domestic violence for women and children, it has a particular reproductive health context.

VIOLENCE AND REPRODUCTIVE HEALTH

The World Health Organization reports that intimate partner violence may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, and pregnancy complications.²

There is evidence that unintended pregnancies are up to two or three times more likely to be associated with intimate partner violence than planned pregnancies.³ Reproductive coercion may be one mechanism that helps to explain the known association between intimate partner violence and unintended pregnancy. Reproductive coercion refers to a range of male partner pregnancy-controlling behaviours. See our fact sheet on reproductive coercion for more information.

It is important to note that some women in violent relationships may experience coerced abortion; although there is some available evidence relating to poor mental health outcomes for women in these circumstances,⁴ there is little data on the prevalence of coerced abortion in Australia, and what exists is largely anecdotal.

Children by Choice is a pro-choice service and under no circumstances supports a pregnancy termination without the express wish and consent of the pregnant woman herself.

TYPES OF VIOLENCE

Women may experience a range of different types of violence during pregnancy, including physical, sexual and emotional violence, by a variety of people. For the purposes of this submission, the following describes the types of violence women report to our counsellors.

² C Garcia-Moreno, A Guedes and W Knerr (2012) *Understanding and addressing violence against women: Intimate partner violence* World Health Organisation Department of Reproductive Health. Available online at http://apps.who.int/iris/bitstream/10665/77432/1/WHO_RHR_12.36_eng.pdf/.

³ E Miller, R Decker, H McCauley, D Tancredi, R Levenson, J Waldman, P Schoenwald and J Silverman 'Pregnancy coercion, intimate partner violence and unintended pregnancy' *Contraception* 2010 Volume 81 Issue 4. Online at [http://www.contraceptionjournal.org/article/S0010-7824\(09\)00522-8/abstract](http://www.contraceptionjournal.org/article/S0010-7824(09)00522-8/abstract).

⁴ American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the Task Force on Mental Health and Abortion*. Washington, DC. Available online at <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>

Domestic violence: behaviour within an intimate partner relationship that is used to entrench power and control over the other person. This behaviour may manifest in a number of physical, sexual, emotional, financial, or psychological ways.

Sexual violence: forced or coerced sex, or rape, either within an intimate partner relationship or by another person. This includes sex which was coerced using emotional violence and manipulation, threats or use of physical violence, and situations where a woman was unable to properly consent to sex due to the influence of alcohol or drugs or due to an intellectual or cognitive disability or extreme youth.

Reproductive coercion: interference with reproductive autonomy that denies a woman's decision-making and access to options. This behaviour may be deliberate or indirect, and can manifest in a number of different ways. These behaviours can include birth control sabotage (where contraception is deliberately thrown away or tampered with), threats and use of physical violence if a woman insists on condoms or other forms of contraception, emotional blackmail coercing a woman to have sex or to fall pregnant, or to have an abortion as a sign of her love and fidelity, as well as forced sex and rape.

In some cases, multiple forms of violence are used by a woman's partner in the context of their relationship.

D, 22, was brought to Australia by her 50 year old boyfriend after an online relationship lasting some years. He told her he would help her go to university in Australia and after her parents died, she had no immediate family left at home to support her. When she arrived in Australia her boyfriend took her to a caravan park in a regional Queensland town – her new home. Far from sending her to university and supporting her to find work, he locked her in the caravan and wouldn't allow her out except to go to church and the store. The only money she had was what he gave her. He made her have sex with him every day, even though she told him she didn't want to. He refused to use contraception and she had no access to any, but even so he told her if she became pregnant he would send her back home to her poverty-stricken country, where her extended family wanted her to undergo female genital circumcision against her will. When she became pregnant she was too afraid to tell him in case he 'hurt' her. A friend from church gave her our number and we helped her financially and logistically to figure out how she was going to access the abortion she needed – the first step to escaping her relationship. She's now in Brisbane receiving the help of specialist services for survivors of violence who are also helping navigate her immigration status.

PREVALENCE OF VIOLENCE IN PREGNANCY

Many women face an increased risk of intimate partner abuse during pregnancy,⁵ and unintended pregnancy occurs more commonly for women in abusive relationships.⁶

Women are at greater risk of violence from intimate partners during pregnancy or after separation.⁷

Data also shows that using medical contraception to control fertility is often complicated for women in abusive relationships.⁸

National data exists to show one in three women has experienced physical violence and one in five has experienced sexual violence,⁹ although there is not a lot of information about women who experience both physical and sexual violence by an intimate partner.

⁵ K Chibber et al, 'The Role of Intimate Partners in Women's Reasons for Seeking Abortion' (2014) 24(1) *Women's Health Issues* e131; Lynn Meuleners et al, 'Maternal and foetal outcomes among pregnant women hospitalised due to interpersonal violence: A population based study in Western Australia, 2002-2008' (2011) 11(70) *BMC Pregnancy and Childbirth*.

⁶ E Miller, B Jordan, R Levenson and J Silverman, 'Reproductive Coercion: Connecting the Dots Between Partner Violence and Unintended Pregnancy' (2010) 81 *Contraception* 457; Available online at <https://www.arhp.org/publications-and-resources/contraception-journal/june-2010>.

⁷ J Campbell, D Webster, J Koziol-McLain et al. 'Risk factors for femicide in abusive relationships: results from a multisite case control study' *American Journal of Public Health* 93(7), 2003, pp. 1089–1097

⁸ C Williams, U Larsen, and L McCloskey, 'Intimate Partner Violence and Women's Contraceptive Use' (2008) 14 *Violence Against Women* 1382. Online at <http://vaw.sagepub.com/content/14/12/1382.abstract>.

⁹ See the Our Watch website for an overview of Australian data around violence against women and children: <http://www.ourwatch.org.au/Understanding-Violence/Facts-and-figures>

OUR SERVICE DATA

In 2014-15, 30.5% of contacts to our counselling and information service in Queensland disclosed violence (domestic violence, sexual assault, and/or reproductive coercion). In 2009-10, this figure was 6%.

7.5% of all our contacts in 2014-15 reported both sexual and domestic violence, highlighting the prevalence of forced sex within ongoing relationships which are also abusive in other ways.

Our contacts who identify as Aboriginal and/or Torres Strait Islander are significantly more likely to report violence than our general client base; 55% of ATSI contacts reported violence in 2014-15.

We sometimes talk to women who have attempted or are considering attempting to induce their own abortion at home (for more information about this see [page xx](#) of this submission). Of those contacts, 76% reported violence.

Our client data also shows that women reporting violence are over-represented in later gestation presentation, which has repercussions no matter which pregnancy option they choose: if they wish to continue the pregnancy, they will have missed vital early antenatal care and testing, while if they would prefer to terminate the pregnancy, abortion procedures are more costly and harder to access in the second trimester.

For more information on our clients and their experience of violence, you can read our latest Annual Report on our website at www.childrenbychoice.org.au.

IMPACTS ON WOMEN OF VIOLENCE DURING PREGNANCY

The Turnaway Study being conducted by the University of Southern California examines the impact of being denied abortion for women in the United States. This longitudinal study shows that women who seek and are denied an abortion are more likely to remain in violent relationships than women who are granted access.¹⁰ There is no reason to suggest the results would be different in an Australian study of the same type, although no local data exists.

Pregnancy and co-parenting may impact on a woman's capacity or willingness to leave the relationship due to:

- a fear she may lose her children in a custody battle, or that her partner will then have court-ordered unsupervised contact time with them without her there to intervene and potentially protect them from physical violence or worse;
- a fear that he may carry out threats to harm her, their children or himself if she leaves;
- a concern that she won't be able to take care of herself and the children alone, either economically or psychologically after being subjected to the perpetrator's emotional abuse undermining her belief in herself and her abilities;
- an awareness that she will need to find accommodation suitable for children, and financially support herself; and
- a belief that children need two parents.

Consequently, a pregnancy can be an impetus to end or leave an abusive relationship when considering the possibility of a child being exposed to his violence and control, or inform a decision to terminate when considering the life-long connection that a child would create between them.

WOMEN'S EXPERIENCES

A pregnancy in the context of a violent relationship which is unwanted by the pregnant woman herself can be extremely distressing. Certain themes are recurring in the conversations we have with clients who report violence:

- Overall strain and distress as a result of the violence: women say they are 'at breaking point'. The children they have are as much as they can handle given what they have been through.

¹⁰ S Roberts, M Biggs, K Chibber, H Gould, C Rocca, D Greene Foster, 'Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion' *BMC Medicine* 2014, 12:144. Available online at <http://www.ourwatch.org.au/Understanding-Violence/Facts-and-figures>.

- Child Safety involvement as a result of the violence: women report that they can't handle the mental health impact of having another child removed like they did the last one, due to violence in the relationship.
- A desire to escape a relationship due to violence: women see ending the pregnancy as another strategy for cutting ties with the man involved, and of being less likely to be subjected to further violence if there is no child connecting them.

In these circumstances a termination may be the preferred option of the pregnant woman directly as a result of the violence she experiences, in terms of not wanting to parent with the perpetrator and therefore expose a child to potential violence also, or wanting to make her ability to disentangle from the perpetrator easier. Continuing a pregnancy to become 'co-parents' can further entrench a connection between the woman and the perpetrator, which may continue regardless of the context of the relationship itself and can become a tool for further manipulation through family court proceedings.

Given this, access to and affordability of termination procedures can be entwined with a woman's ability to escape domestic violence. Issues that are so often present in violent relationships, including surveillance, manipulation, and financial or other control, further restrict a woman's capacity to access a termination, even if she is doing so to attempt greater safety for herself and any existing children. These behaviours also impact on her ability to access suitable contraception; Long Acting Reversible Contraceptives (LARCs) are less open to interference by an abusive partner and provide women with greater control of her fertility, but also involve multiple doctor appointments and usually a significant upfront cost.

As co-parents in a domestic violence context, a woman's ability to ever be safe from that perpetrator's violence against her and/or her children is significantly compromised. If women choose to access abortion in the context of domestic violence, it needs to be available.

HEALTH AND WELLBEING

REPRODUCTIVE HEALTH AND HUMAN RIGHTS

This section of our submission is underpinned by the United Nations definition of health as:

*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*¹¹

In addition to this underlying definition of health, our submission is also guided by the definition of sexuality and sexual rights, being that:

*[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.*¹²

Sexual and reproductive health rights encompass many areas of basic human rights. The right to health and healthcare, the right to information, the right to life, the right to live free from discrimination and the right to privacy are all inherent in comprehensive access to sexual and reproductive health rights. Of course there are many aspects to this broad area of health rights, including access to good maternity care, sexual health services, contraception and sexuality education. It also includes access to safe and legal abortion - arguably the most contested of sexual and reproductive health rights.

¹¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

¹² From the Beijing Declaration and its Platform for Action (1995). Cited in: O'Rourke, 2008. *Time for a national sexual and reproductive health strategy for Australia*. Sexual and Reproductive Health Strategy Reference Group, Public Health Association of Australia, p3.

ABORTION LAW IN QUEENSLAND

In Australia it is estimated that more than 80,000 women a year will access health care services for the purpose of pregnancy termination.¹³ It is also estimated that as many as one in three Australian women will experience abortion in their lifetime.¹⁴ Despite the prevalence of abortion in Australia, it remains the subject of criminal law in most states and territories:

Queensland & New South Wales: Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.

Australian Capital Territory: Legal, must be provided by medical doctor.

Victoria: Legal to 24 weeks. Legal post-24 weeks with two doctors' approval.

South Australia: Legal if two doctors agree that a woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Unlawful abortion a crime.

Tasmania: Legal to 16 weeks on request, and after that point with the approval of two doctors.

Western Australia: Legal up to 20 weeks, some restrictions particularly for under 16s. Very restricted after 20 weeks.

Northern Territory: Legal to 14 weeks if 2 doctors agree that woman's physical and/or mental health endangered by pregnancy, or for serious foetal abnormality. Up to 23 weeks in an emergency.

As this shows, Queensland has some of the most restrictive (and archaic) abortion legislation in Australia. Our Criminal Code statutes relating to abortion date from 1899 and are worded thus:

Section 224. *Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.*

Section 225. *Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.*

Section 226. *Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment for 3 years.*¹⁵

Case law from a 1986 District Court ruling has created the prevailing view that abortion can be lawfully provided in order to protect a woman's life or her physical or mental health,¹⁶ but the access that has resulted from this could be described as tenuous at best; health practitioners and services are often unclear about the legality of abortion and high barriers to access therefore exist for women.

¹³ A Pratt, A Biggs, L Buckmaster *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection* Parliament of Australia Parliamentary Library, Social Policy Section, 14 February 2001, p2.

¹⁴ A Chan, J Scott, A-M Nguyen, L Sage *Pregnancy Outcome in South Australia 2008*. Pregnancy Outcome Unit, SA Health, Government of South Australia, Adelaide 2009 p62.

¹⁵ Queensland Criminal Code 1899. Available online at <http://www.legislation.qld.gov.au/legisln/current/c/crimincode.pdf>.

¹⁶ N Cica, *Abortion Law in Australia* Parliament of Australia Library, Research Brief 1, 1998-1999.

Several recommendations have been made to the Queensland Government regarding the decriminalisation of abortion in this state, which have not been implemented.¹⁷ As a result, abortion remains a crime (incidentally in the Offences Against Morality chapter of the Criminal Code, alongside incest, bestiality and the creation and distribution child pornography). The penalty inscribed by the Queensland Criminal Code for creating child pornography is the same as for a doctor providing unlawful abortion: 14 years jail.¹⁸

The most recent charges under these statutes were laid in 2009, when a young woman was prosecuted under s225 for procuring her own abortion, along with her partner under s226 for providing her with the medications to do so.¹⁹ Both were acquitted but while Criminal Code statutes remain, so too does the threat of prosecution for women accessing abortion and for doctors providing it.

ABORTION ACCESS IN QUEENSLAND

Due in large part to this regressive and restrictive abortion law, pregnancy termination services are only available on a very limited basis in major public hospitals in Queensland towns and cities, and rarely in public hospitals in regional and rural areas. While guidelines around the provision of therapeutic abortion by Queensland hospitals were released in 2013, only an estimated 1% of the state's pregnancy terminations each year are provided by public facilities. Children by Choice often supports clients reporting extreme violence, sexual assault, homelessness, suicidality and other serious mental health concerns, and other exacerbating life circumstances, who are unable to access a publicly provided abortion and must try to access a service through the private health system. For many, this is unattainable without significant assistance.

Although there is a Medicare rebate available for pregnancy termination it falls far short of covering the cost of provision of service, including meeting licensing, accreditation, quality control and nursing staff costs.

Therefore, the majority of women accessing termination of pregnancy in the first trimester of pregnancy (14 weeks since last menstrual period) face significant out-of-pocket costs.²⁰

Medication abortion is now more widely available than in the past as GPs are able to offer it through their practice if registered and appropriately trained, but it can still be difficult to find a provider as no public register of trained GP providers exists. Medication abortion is also available through private abortion clinics licensed by Queensland Health.

Medication abortion through a GP has approximate costs of \$350-\$580 upfront. Women are then eligible for a Medicare rebate. The cost of the medication itself is extra to this (between \$12 and \$50 depending on whether you have a Health Care Card). At abortion clinics, women can expect to pay between \$400 and \$800 depending on location (regional clinics have higher costs), with a rebate of less than \$100 available to them via Medicare.

Surgical abortion is provided through ten private clinics licensed by Queensland Health to provide pregnancy termination. Seven of those are in the south east corner of the state. A surgical abortion at less than 12 weeks gestation has an out-of-pocket cost of \$350 to over \$900 depending on location. Prices increase steeply each week from around 14 weeks gestation; only a small number of clinics (all in the south east corner of the state) provide terminations between 16 and 19 weeks gestation and these procedures can cost as much as \$4000 for Medicare card holders.

The cost of surgical termination procedures has more than quadrupled since 2000 in Queensland. In the vast majority of cases, the poorest of women in Queensland cannot access pregnancy termination services free of charge, even in circumstances of rape or other violence.

Women on low fixed incomes find meeting these costs within the short time frame increasingly difficult. Many women who are dependent on Centrelink and family assistance payments already struggle to financially provide for existing children and family members. Many women are in transient housing due to domestic

¹⁷ Bodies including the Royal Australian College of Obstetricians and Gynaecologists, the Public Health Association of Australia, Sexual Health and Family Planning Australia, the Doctors' Reform Society and other health organisations have publicly stated positions recommending the removal of abortion from Queensland's Criminal Code.

¹⁸ Queensland Government, Brisbane. Schedule 1 The Criminal Code, Part 4 Acts injurious to the public in general, Chapter 22 Offences against morality. Reprinted 2010. Available online at www.legislation.qld.gov.au.

¹⁹ J Walker and V Hyde 'First illegal termination case for 25 years' *The Australian*, 12 September 2009.

²⁰ For full information on the cost of abortion in Queensland, visit our website: <http://childrenbychoice.org.au/if-youre-pregnant/considering-an-abortion/termination-costs-in-queensland>

violence or poverty, and some already have children who have been removed from their care by state child protection agencies.

Children by Choice and a handful of agencies can offer limited financial assistance to these women, however often the amount we are able to provide falls short of the cost of procedure (as well as travel and accommodation for rural and remote women) and the timeframe for accessing services closes. This means very low income women can be forced to continue with an unwanted pregnancy which is likely to lead to a continued cycle of poorer health outcomes for the woman and her family.

In 2014-15 we provided almost \$90,000 through our financial assistance program for abortion access.

In 2014-15, 60% of our contacts were in relation to financial assistance for abortion. This has risen from 40% only two years previously. Our webpage 'How much will an abortion cost?' is consistently our most highly viewed website content, and makes up around 15% of our entire website traffic.

Women requesting financial assistance report three main issues impacting on their ability to access an abortion:

- The extreme difficulty in accessing a termination through the Queensland public health system;
- The high out-of-pocket costs of abortion procedures in private clinics and the inflexibility of providers in negotiating payments;
- High costs associated with travelling to access a procedure for women in rural and regional areas of the state.

These three issues are the same top three as reported by clients requesting financial assistance when the Fund began in 2000.

All Queensland women deserve the right to access a safe and legal abortion, not just those who live in metropolitan areas or who have access to financial resources. The right to bodily and psychological integrity is one of the most fundamental. We recognise that control over reproduction is an issue on which people hold strong opinions, and that those opinions can differ. However, on the issue of abortion, credible polling consistently shows more than 80% of Australians to support a woman's right to choose and believe a government should not be involved in the abortion decision.^{21 22} The right to safe and legal abortion has been recognised by many bodies, including Amnesty International which has urged all countries to repeal laws which allow women to be persecuted or criminally charged for seeking abortion.²³ The Parliamentary Assembly of the Council of Europe has also called on member states which have not already done so to decriminalise abortion.²⁴

As with so many issues, the barriers created by the continued criminalisation of abortion are higher for some specific groups of women.

Rural, regional and remote women

As a Queensland state-wide telephone counselling service, Children by Choice regularly encounters gaps in the geographic location of services available on the ground for women. GPs cannot be viewed as the complete answer in reproductive health, as women can feel embarrassed or uncomfortable talking to their GPs around sexual and reproductive health issues. A study into young rural women's attitudes to sexuality and sexual health in 1999 found:

'In regard to seeking advice from doctors on sexual health issues, over half the young women [surveyed] believed they could not see a doctor without everyone knowing and, for 21%, that they could not trust a doctor to maintain their confidentiality'.²⁵

More professional development is needed to ensure all doctors and health workers have a solid grounding in sexual and reproductive health issues and that their care extends beyond diagnosis and treatment of existing

²¹ K Betts 'Attitudes to Abortion: Australia and Queensland in the Twenty-First Century' *People and Place*, Vol 17, No 3, 2009 pp25-39. Available online at <http://search.informit.com.au/documentSummary;dn=240856454287648;res=E-LIBRARY>. Accessed 28 April 2010.

²² *Queensland voters' views on abortion* Report prepared by Auspoll, commissioned by Children by Choice, May 2009.

²³ Amnesty International defends access to abortion for women at risk Amnesty International 2007. Available online at <http://www.amnesty.org/en/library/info/POL30/012/2007>. Accessed 28 April 2010.

²⁴ Committee on Equal Opportunities for Men and Women, Parliamentary Assembly of the Council of Europe, 18 March 2008. Available online at http://assembly.coe.int/ASP/NewsManager/EMB_NewsManagerView.asp?ID=3643. Accessed 28 April 2010.

²⁵ L Hillier and L Harrison 'The girls in our town: Sex, love, relationships, and rural life' *Challenging rural practice: human services in Australia*. Geelong: Deakin University Press 1999 p4.

STIs to include patient education, risk monitoring and mental health issues. A program to provide training to health professionals in regional areas around sexual health for young women was included in the first phase of the Victorian Government's Women's Health and Wellbeing Strategy (2002-2006) with evaluations showing marked improvements in this area as a result.²⁶

Women in rural, regional or remote areas are often faced with large amounts of travel to access services, and this situation is particularly apparent in relation to reproductive health services. In a large state like Queensland which has a great number of geographically-isolated communities, the situation is dire for many women. With only three clinics outside the southeast corner of the state offering surgical pregnancy termination services, women in regional or remote areas face large distances and increased costs for accessing the same procedure as their urban sisters. This is exacerbated by the difficulties some women face in accessing help through patient travel assistance schemes to cover the costs of women travelling for an abortion, as well as the fact that many have to also pay for accommodation costs on top of the higher out-of-pocket cost for the procedure in regional centres.

Z lived in a remote area of Queensland. She was so scared people in her community would find out she was pregnant she did not even want to disclose her location to our counsellor over the telephone. She was sure she was pregnant but did not want to see her local doctor for a test, so concerned was she about lack of privacy. No pregnancy tests were available though the only local pharmacy.

She had decided she could not continue with the pregnancy and was willing to come to Brisbane, at a considerable cost financially, to access a termination. She was willing to risk the fact that she may not be pregnant and would travel all that way at considerable expense, for nothing. Nobody from her community would be travelling with her, and she had nobody with whom to stay in Brisbane.

She, like many other women from areas around the state, went through the process of travelling a great distance and undergoing a termination alone. She then travelled from the clinic to a hotel in a taxi, alone, and stayed there, alone, for a few days before making the journey home with an invented story to explain her absence.

The shame and stigma some women still feel to be attached to abortion and their overarching desire for secrecy prompts many women every year to undergo this experience by themselves without support. This stigma is a direct consequence of the continued criminality of abortion in this state.

Women in rural and remote areas also have more trouble accessing contraception, particularly emergency contraception. Similar access difficulties apply to antenatal care. Rural women are at a direct disadvantage when compared to women in metropolitan areas, for no other reason than their geographic isolation.

Women experiencing domestic or sexual violence

Children by Choice speak regularly to pregnant women who report sexual and/or domestic violence who are unable to afford a privately provided abortion but have been turned away from public hospitals.

N was a refugee who was diagnosed with a pregnancy at a Catholic public hospital. She disclosed to the hospital social worker that she had been sexually assaulted by a friend of her family; she was 13 at the time of the assault and had turned 14 only a week before her presentation at the hospital. N had been a virgin before the assault and the social worker was concerned she was suffering from post-traumatic stress from her refugee experiences, now compounded by the sexual assault. The hospital had refused to offer a termination or refer her to any facility that may have provided one for her. The social worker was extremely distressed at the hospital's treatment of her patient and called us to help facilitate access to a privately provided termination. Funds were provided to the patient from Children by Choice and other community organisations in order to pay for this procedure.

V, 31, suffers from Multiple Sclerosis and cataracts in both eyes, and was steadily losing her sight as these worsened. When we were contacted by a social worker on her behalf in late 2010, she was six weeks pregnant after being sexually assaulted by her carer. She was booked in for cataract surgery in two weeks time at her local public hospital to restore some of her sight, when they informed her the surgery could not proceed if she was pregnant. The same hospital where she was receiving

²⁶ Department of Human Services *Women's health: everyone's business – Victorian Women's Health and Wellbeing Strategy Phase Two 2006-2010* p8. Victorian Government, Melbourne 2006. Available online at <http://www.health.vic.gov.au/vwhp/publications>. Accessed 15/04/2010.

treatment for both her MS (which was worsening due to the pregnancy) and her cataracts, refused to provide a termination, despite a strong referral from V's GP and the facts that she was a sexual assault victim, had a disability, and was at risk of losing her sight if she had to postpone her cataract surgery. Children by Choice helped V negotiate a significant price reduction with her closest clinic and paid for the remainder of the procedure cost through our financial assistance program.

The failure of the health system to provide adequate and appropriate care in terms of abortion provision is reflected in the system's lack of comprehensive preventative care for women presenting at emergency after confirmed or suspected cases of sexual assault.

B presented to Children by Choice seeking financial assistance to terminate an eight week pregnancy. She had no recollection of the sex which led to the pregnancy: she had been at a friend's house one night and had woken up in hospital with no memory of how she got there. Hospital staff told her she had been dropped off there the night before, and appeared to have been drugged. B started vomiting after she woke up, and they advised her to stay in hospital a few more hours. In that time nobody came to see her or to speak with her. When she stopped vomiting she left the hospital. When she called us, B said that she had not spoken to anyone about this before, and didn't know if she had been screened for STIs at the hospital. They had not advised her to get checked or suggested she seek support of any kind, nor had they provided or advised her to seek emergency contraception. B was left looking for several hundred dollars to pay for a health service which a) would have been unnecessary if the health system had provided basic preventative care, and b) was not provided by a public hospital.

For women experiencing domestic violence, further hurdles may be encountered by the failure of some DV support services to provide assistance around abortion access.

G, aged 31, lived in a regional centre and was into her second trimester when she discovered the pregnancy. Her decision to end the pregnancy hinged on the extreme violence she had experienced the hands of the man involved in the pregnancy and a desire to cut all ties with him for the sake of her safety and that of her other children. The out of pocket costs for the procedure and associated travel amounted to approximately \$3000. Although she was already accessing a domestic violence support service in her local town, and that service had brokerage funds available for client support, the service decided to ask their funding body, the Queensland Department of Communities, for permission to use this brokerage to assist their client to access a pregnancy termination. The Department denied permission as the procedure was 'illegal'. Children by Choice counsellors provided both a donation and a no interest loan from our service as well as significant staff time in advocacy to other services and clinics, in order to assist this woman to access a termination and cut ties with her perpetrator.

Women with high-risk pregnancies

Women with serious health risks, often already facing financial instability due to ongoing healthcare costs relating to existing conditions, can experience further financial hardship due to the lack of publicly provided procedures.

R, aged 26, sought our assistance to terminate her fourth pregnancy in late 2012. Along with financial pressures and the struggle to parent three quite young children on her own, she had also been diagnosed with pulmonary embolism – blood clots in her lung – as a result of the pregnancy. She'd experienced this in her previous pregnancy and it required careful medical management including travel to a specialist hospital prior to the birth of her child. R obtained a letter of referral from her GP recommending termination on the grounds that the embolism posed a significant threat to her health and was potentially life-threatening, her local hospital dismissed her request for a termination without considered clinical assessment or referral. Only through a small grant from us and withholding a week's rent could she find the required \$400 dollars for a private clinic procedure, worsening her already precarious financial situation.

Women with no access to Medicare

Women studying or holidaying in Australia, or those living in the community on Temporary Protection Visas or awaiting a decision on their visa status, often have no access to Medicare and therefore face very high out-of-pocket costs for reproductive healthcare. Terminations provided through private clinics have out-of-pocket costs of \$850 - \$4500 for non-Medicare Card holders, depending on gestation and location, and public hospitals charge a fee even if they deem a woman eligible for a service.

K was a 13 year old whose family was in Australia temporarily. She was raped by her older sister's boyfriend and at first contact with us was 8 weeks pregnant. Queensland Health licencing restrictions on private abortion clinics prevent them operating on under 14s without a paediatric licence, which only one clinic in Queensland holds. She was severely underweight and therefore needed to be operated on in a hospital environment. Her nearest public hospital assessed her and decided that although she satisfied the criteria for a lawfully provided procedure, as her family had no access to Medicare there would be an upfront, out-of-pocket cost of \$2400. A sexual assault support service agreed to provide some financial support for K to help her access this service but were not able to contribute the entire cost of the procedure. An urgent appeal to Children by Choice donors was the only way K was able to access a termination.

IMPACT ON WOMEN OF INACCESSIBLE ABORTION

Aside from the consequence of financial distress and debt levels for disadvantaged women seeking abortion services, there is an emerging issue impacting Queensland women as a direct result of inaccessible abortion services: attempted self abortion.

International evidence is conclusive: when women can't access safe and legal abortion services they seek out unsafe or untried abortion methods, or attempt to induce a miscarriage themselves.²⁷ Before safe abortion clinics began opening in Australian cities in the early 1970s, unsafe abortion was one of the main causes of maternal mortality and permanent disability in women of reproductive age.²⁸

After our counselling team at Children by Choice began reporting anecdotally that they seemed to be taking calls about attempted self-abortion more frequently than was usual, we began capturing this information as part of our client data collection in 2014. In the first half of that year, we had contacts from or in relation to 19 self-abortion attempts.

In 2014-15, we had 118 conversations about attempted self abortion. Methods that women in Queensland have reported to us include pills bought online, intentional violence (throwing themselves down stairs, punching themselves in the stomach or asking someone else to), excessive quantities of alcohol or other substances, and a myriad of other 'DIY' methods found online.

T, aged 30, was supporting her unemployed partner on her Centrelink benefit, as well as her three children, when she found out she was pregnant. T told us she was already struggling financially and had been relying on food vouchers from the Salvation Army to get by, making the required \$450 seem an impossible target. She said the stress of trying to find the money for an abortion had her punching herself repeatedly in the stomach in the hope of giving herself a miscarriage, and that the stress was also causing more arguments and violence in her relationship. We gave her a donation and a No Interest Loan which together covered half the cost of the procedure.

It is doubtful any of these attempts were successful but it is certain that none were safe. There is no way of knowing if medications bought from online retailers are what they claim to be; one specialist has opined that up to half of all medical abortion drugs sold online are not medical abortion drugs at all. They may be placebos or they may be much more harmful, but there is no way of knowing. Risks also exist with alcohol and substance abuse as a means to try and induce miscarriage, as they do with intentionally inflicting violence or asking another person to.

H is a married mother of two young children, the youngest just a year old, who called us for help with her unplanned pregnancy. H estimated her gestation to be at 5-6 weeks. Her husband was raised a strict Catholic and against using any form of contraception; he also refused to discuss the option of abortion with her despite being aware of H's reluctance to parent again so soon. He also worked out of town, and was not actively involved in parenting. In attempts to induce a miscarriage H had starved herself and consumed very high levels of caffeine and alcoholic spirits. This had been unsuccessful, although it had made her very ill. H had tried home methods of abortion as she was unaware of the private clinics providing abortion in Queensland until her phone call to us, and the availability (albeit limited) of medication abortion – which seemed to her “more natural”.

²⁷ See for example S Cohen 'Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide' *Guttmacher Policy Review* Fall 2009, Volume 12, Number 4. Available online at <https://www.guttmacher.org/pubs/gpr/12/4/gpr120402.html>.

²⁸ C de Costa (2010) *Never Ever Again* Boolarong Press, Brisbane.

It is truly horrific that women in this state, in the twenty-first century, in a country with an allegedly first-class health system, feel they have no option but to resort to these dangerous and primitive methods to end their pregnancies instead of being able to access safe and legal care.

We remain extremely concerned that women are putting their lives and health at risk due to the inaccessibility of abortion procedures in Queensland.

CONCLUSION

Children by Choice sincerely hopes that the new Queensland Women's Strategy can lead to a healthier future for Queensland women.

This submission and our recommendations envision a future where:

- Women are involved in and collaborate with government to control, develop and implement strategies to improve their own lives;
- Equity across state boundaries and compliance with the best international standards are a way of life;
- An acceptance of cultural diversity recognises the woman as the expert in her own life;
- Rural women can easily access comprehensive reproductive health services;
- Young people are well informed about their sexual and reproductive health choices;
- All women are safe;
- Policy and practice in women's health are well supported by a wide range of evidence; and
- Women are well resourced financially to achieve good health outcomes.

It is acknowledged that there may be costs involved in making the appropriate changes in legislation, health policy and practice. However, there are high financial and social costs involved in allowing many of these reproductive health inequities to continue, and clear benefits in addressing them.

A woman's ability to choose if and when to become pregnant or give birth has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems, prevent pregnancies among older women who also face increased risks, and enable women who wish to limit the size of their families to do so.

In addition, improving equitable access to abortion and contraception enables women to enter or remain in the labour force and to devote more resources to each child, thereby improving family nutrition, education levels and living standards. Having fewer, healthier children can reduce the economic burden on poor families and allow them to invest more in each child's care and schooling, helping to break the cycle of poverty.