CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

Submission on Abortion Legislation – Proposal for reform in Western Australia

17/12/2022

ABOUT CHILDREN BY CHOICE

Children by Choice provides counselling, information and education services on all pregnancy options, including abortion, adoption, kinship and alternative care and parenting. We provide a Queensland-wide counselling, information and referral service for pregnancy. Nationally we deliver sexual and reproductive health education sessions in schools and youth centres and offer training for GPs and other health and community professionals on pregnancy options, reproductive coercion and post abortion counselling across Australia.

We also advocate for improvements to law and policy that would increase access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for reproductive and sexual health.

Our pregnancy options counselling service assists 1800-2400 women and pregnant people each year in Queensland through our funding from the Department of Justice and Attorney General. This represents about 15%-20% of abortion seekers in Queensland.

Our education and community engagement team provides training and information to 1900 professionals and students each year.

Our 2022 programs included a Multicultural project, co-designing digital, video and print resources for 4 language groups on pregnancy options, contraception and reproductive coercion. We also partnered with WWILD Sexual Violence service to co-design resources designed for health professionals working with women with intellectual disabilities. Children by Choice have partnered with Women's Health Tasmania to deliver education and professional development in a Tasmanian context. We recently finished a 3-year Queensland Rural, Regional and Remote Abortion Access project which supported access to abortion in marginalised areas.

Our Queensland Abortion and Contraception online map was launched in 2021 in a move to increase transparency and accessibility of abortion and contraception services to the general public and those supporting people seeking services.

Children by Choice has continued to advocate for access to legal, safe, timely, compassionate healthcare and protections for reproductive rights in conjunction with supporting bodily autonomy and reproductive justice.

We developed an Australian position statement after the US overturned Roe v Wade with over 700 individuals and organisations signing on to voice their support for reproductive rights in Australia. We called upon state and territory Health Ministers to embed essential reproductive healthcare into our public health services.

Children by Choice is a member of the Queensland Sexual Health Clinical Network termination of pregnancy working group and is involved in the development of an action plan for Queensland Health provision of abortion in public and primary health settings.

We are representatives on many committees and working groups, ensuring that reproductive health and rights are part of submissions and consultation with government and other stakeholders, such as:

- Women's Health Services Alliance of Queensland
- Ending Violence Against Women Queensland

- SPHERE Coalition for sexual and reproductive health
- QCOSS Women's Equality Network
- Equality Rights Alliance
- Queensland Abortion and Contraception Community of Practice
- QCOSS CEO Network

Our vision is that people can freely and safely make their own reproductive and sexual health choices without barriers.

Our Annual Reports and Strategic Plan are available on our website at www.childrenbychoice.org.au.

CONTACT

Daile Kelleher
Chief Executive Officer
Children by Choice

07 3357 9933 (ext 1)
0409 625 189
DaileK@childrenbychoice.org.au

We consent to this submission being published on the inquiry website and shared publicly online.

We welcome an invitation to speak to this submission and provide further evidence at an upcoming public hearing.

Executive Summary

Children by Choice welcomes the government consultation on abortion legislation reform in Western Australia and the commitment to protect the reproductive rights of women and people who can become pregnant in WA, including equitable access to abortion services.

In 2022 Children by Choice released research on 3 years of pregnancy options counselling data following the implementation of the Queensland Termination of Pregnancy Act 2018 – *Termination of Pregnancy in Queensland post-decriminalisation: a content analysis of client records from an all-options pregnancy counselling organisation (Cleetus et al., 2022).* [1]

This research found that the key reasons people contacted our service post decriminalisation of abortion were for financial assistance, information on termination of pregnancy and support for decision making. Facilitators and barriers affecting access to termination of pregnancy included affordability, violence, stigma, knowledge and information.

Our key recommendations were that future models of care must eliminate barriers by developing public models of service provision, investing in workforce development, fully utilising the capacity of that workforce, and creating stronger connections between sexual and reproductive health and intimate partner violence services.

The Queensland Government is currently developing an 'Action Plan' for access to abortion in the state, due to be released in April 2023, despite the fact that the Queensland Termination of Pregnancy Act passed in 2018. Findings from our research show that despite decriminalisation, the intersectionality of power and choice affecting reproductive rights in Queensland continues, especially for priority populations. Queensland and WA face similar challenges in addressing the healthcare needs for people in regional and remote areas so there can be learnings from the Queensland experience of abortion law reform, implementation and access.

We urge the McGowan Government to learn from other jurisdictions who have reformed their abortion legislation that the implementation of the legislative reform must be collaborative and consultative with consumers, providers, public and private systems and services such as Children by Choice and ensure all public hospitals provide compassionate termination of pregnancy care for all termination of pregnancy care post legislative change.

As outlined in the National Women's Health Strategy 2020-2030 [2] priority area 1 – Maternal, sexual and reproductive health is a priority for Australian women and girls and must be considered within the social and cultural context of women's lives. It is not simply about the absence of disease, but refers to a state of physical, mental and social wellbeing across all stages of life. Factors contributing to maternal, sexual and reproductive health include the role of women in society and the control women have over their own bodies, reproductive choices and lifestyle. This highlights the need for women and girls to be informed of, and to have access to, safe, effective, affordable and acceptable forms of abortion care, health services and support.

A key priority area for action is increasing access to sexual and reproductive health care information, diagnosis, treatment and services, with a measure of success being equitable access to pregnancy termination services. Specifically, the National Women's Health Strategy 2020-2030 prioritises working towards universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their

bodies, including contraception and options for addressing unplanned pregnancies, including access to termination services.

The overturning of Roe v Wade in the United States in 2022 threatening access to legal abortion for millions of women and girls, caused great concern among many in Australia and started a much-needed conversation about the community expectation that abortion should be legal, safe and accessible. The McGowan Government must do everything it can to enshrine safe access to compassionate abortion services for women and pregnant people. As a progressive government, we call on the government to work with relevant stakeholders to ensure all women have access to abortion and contraception services, and pregnancy options counselling as well as post abortion counselling.

Abortion care in Australia is broadly inconsistent. While in some cases people feel supported to make the best personal choices, others face unnecessary physical, emotional and financial barriers and distress. All Australian Governments have the ability to tackle the barriers of affordability and lack of support and information for people seeking abortion care. All Australian governments need to come together to develop a clear path forward, so that anyone in Australia who seeks abortion care can access it in timely, compassionate and safe setting.

Children by Choice has detailed relevant research and evidence from our service on the questions asked for this community consultation on abortion legislation in Western Australia below.

In addition to the questions raised by the Discussion Paper and in line with the desired outcome of the abortion legislation reform, Children by Choice has a number of recommendations consistent with achieving the priority areas set out in the National Women's Health Strategy 2020-2030, with 6 key recommendations for Western Australia below. We believe our key recommendations will ensure the legislative reform is implemented effectively and avoid creating additional barriers to accessing abortion.

Our Key Recommendations:

1. Establish an implementation advisory committee with representatives from public, private and primary healthcare as well as consumer groups
2. Funding a independent service to provide information, referral, funding and all options pregnancy counselling and post abortion support to ensure access to primary, public and private healthcare is clear and barriers are reduced.
3. Support the workforce by establishing an independent telephone information and referral service for health care professionals supporting their patients linking them to safe, credentialled providers of termination services. This would help healthcare professionals meet their obligations under any conscientious objection legislation and reduce delays to compassionate abortion care.
4. WA map of abortion and contraception services, such as the one on Children by Choice website for Queensland and 1800 My Options for Victoria.
5. Develop a public health education campaign for health professionals and the general public on abortion, contraception and reproductive coercion and abuse to improve health literacy, destigmatise abortion and support screening of reproductive coercion and abuse.
6. Increase research and data on abortion access and barriers in Australia by collecting and reporting on data.

Questions

Informed consent and mandatory counselling requirements

Regulatory options in relation to informed consent and mandatory counselling requirements

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

Option 2: Remove existing legislated provisions requiring mandatory counselling in in order to obtain informed consent. Medical practitioners would continue to be required to obtain informed consent in line with existing standards of care and professional obligations.

Children by Choice support Option 2

As a provider of an all-options pregnancy counselling service in Queensland, Children by Choice would not be supportive of mandatory counselling before or after a termination of pregnancy. Professional counselling should always be freely available for those who choose to access it but should not be mandatory. We support the availability of genuine, professionally provided, unbiased all options pregnancy counselling for anyone who wishes to access it.

We have concerns about legislating the requirement to offer counselling due to the lack of clarity of what this requirement would entail (for example, what sort of counselling and by whom), the lack of legislative requirements for transparency in pregnancy counselling, and the lack of necessity for the offer of counselling to be a legislative provision.

Pregnancy counselling services in Australia are not legally required to disclose if they are run on an anti-abortion basis and are not subject to the trade practices legislation that regulates misinformation and false advertising. This allows services to provide inaccurate and sometimes intentionally misleading information on abortion and its availability to women when exploring pregnancy options and can make it extraordinarily difficult for women and pregnant people to know that they are accessing a genuine all options service, or for medical professionals to be confident that is what they are referring patients to, particularly when the names of such services provide no hint of their position.

Informed consent counselling seeks to ensure that the patient understands the nature and the purpose of a medical procedure, its alternatives, the possible complications, and the likelihood of these complications occurring. It also ascertains that that the patient is making the decision to proceed with the treatment voluntarily. As with other medical procedures, informed consent counselling is a standard part of public and private termination of pregnancy services.

The Victorian Law Reform Commission [3] examined the issue of mandatory counselling in its inquiry into the state's abortion laws in 2008 and found that mandated counselling would be unnecessary and ineffective. The Commission's report concluded that: "Compelling a person who has already determined a course of action to attend counselling is unlikely to do much good, but has the potential to do harm. Mandating counselling may result in women having to travel long distances for multiple medical assessments and counselling sessions before they can proceed. This would exacerbate existing inequities. Any new abortion law should not contain a requirement for mandatory counselling or mandatory referral to counselling."

Requirement for two medical practitioners to be involved before a woman can have an abortion

Regulatory options in relation to the requirement for two medical practitioners to be involved before a woman can have an abortion

Option 1: No change: Retain the existing provisions requiring two medical practitioners to be involved before a woman can have an abortion.

Option 2: Amend provisions to allow only one health practitioner to be involved (excludes late abortions).

Children by Choice support Option 2

Requiring two medical practitioners to be involved before a woman can have an abortion creates significant barriers, especially for those living in remote or regional Australia.

Clients contacting Children by Choice from regional, rural and remote Queensland seeking pregnancy decision making support and abortion access, when compared with those in metropolitan areas, required more contact with our counsellors, needed greater financial support, were more likely to report domestic violence (38% vs 32%) and sexual assault (17% vs 13%), and travelled more than five times the distance (205km vs 41km each way) to access abortion services (CbyC client data, 2017).

At a time of severe stress no woman or pregnant person should be forced to undergo repeat examinations or consultations, either face to face or by telehealth, with multiple medical professionals. The decision of one medical professional to provide a termination, along with the consent of the pregnant person, adequately ensures that access to an abortion is not delayed and further stress is avoided.

Legal and social barriers that impede access to safe abortions are detrimental to the health and survival of women and girls; thus, constructing policies ensuring access to safe abortion services should be an urgent priority. Placing undue hurdles between women and access to abortion care is associated with undesirable health outcomes. Evidence-based changes to policy and practice that break down barriers and build new roads are required to enable women to access the healthcare they need. [4]

Professional standards and guidelines as well as current practice will ensure specialist involvement where it is clinically indicated and appropriate.

Conscientious objection

Regulatory options in relation to conscientious objection

Option 1: Retain current provision allowing a person, hospital, health institution or other institution to conscientiously object to providing abortion care, without any requirement to refer the patient to a practitioner who is willing and able to provide abortion care.

Option 2: Provide updated provisions to allow health practitioners to conscientiously object with clear and unambiguous directions to refer the patient to another health practitioner who is willing and able to provide abortion care.

This provision would not allow a health practitioner or institution to invoke conscientious objection if the abortion is required to manage an emergency health care event.

Children by Choice support Option 2

While Children by Choice would like to see no legislation for conscientious objection as we believe that all qualified practitioners should provide abortion care, we understand the need for balancing an individual's right to choose not to be involved in abortion care with the right of the woman seeking an abortion.

As detailed in Keogh et al research (2019) [5] that while legislation for conscientious objection aims to protect the right of a woman to access an abortion, doctors had directly contravened the law by not referring; attempted to make women feel guilty; attempted to delay women's access; or claimed an objection for reasons other than conscience. Use or misuse of conscientious objection by Government telephone staff, pharmacists, institutions, and political groups was also reported.

Any conscientious objection provision should not be applicable to administrative staff, services, facilities, organisations or corporate entities.

Health services should ensure that their patients access to lawful procedures is not limited or removed due to conscientious objection. It is the position of Children by Choice that these matters are best dealt with using policies and clinical guidelines.

A practitioner with a conscientious objection to termination of pregnancy should be legally obligated to refer a pregnant person to another practitioner who does not hold a conscientious objection and will be able to provide termination of pregnancy care in a timely manner, without discrimination or delay.

Legislation should also require conscientious objectors to publicly disclose this position (for example on their clinic website), to allow them to practice as they choose while at the same time prioritising women's right to timely and supportive information and care.

Institutions should plan their workforce to ensure they have people who are not conscientious objectors able to provide care in public hospital settings. Healthcare professionals in primary, public and private systems should complete training so they are informed and educated on their obligations for any conscientious objection legislation.

Additional requirements for late abortions

Regulatory options in relation to gestational limit for additional requirements

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

Option 2: Increase the gestational age at which additional requirements will apply from 20 weeks to 24-weeks gestation.

Children by Choice support Option 2

Children by Choice does not believe a legislated gestational limit for lawful termination of pregnancy is necessary, and would note this view aligns with that of the Royal Australian and New Zealand College of Obstetrics and Gynaecologists and other peak medical and legal groups. However, we recognise that community concern exists in regards to 2nd and 3rd trimester terminations. Children by Choice supports a gestational limit for termination of pregnancy of 24 weeks on request, in line with other jurisdictions in Australia.

Although the lack of mandatory data collection means we must rely on estimates for termination statistics, all available information strongly suggests that the vast majority of terminations in Australia occur within the first trimester of pregnancy. A small proportion of terminations (about 1%) are performed after 20 weeks' gestation, usually because of late diagnosed major structural anomalies, genetic syndromes, severe fetal growth restriction, or maternal conditions in which continuation of the pregnancy would be significantly detrimental to the mental or physical health of the woman (Rosser et al., 2022). [6]

Although people seeking abortions presenting into the second trimester make up a minority of those seeking termination of pregnancy, they are more likely to be experiencing disadvantage or distress. Their circumstances are more likely to include maternal and fetal health concerns, violence and coercion, financial or other disadvantage, dramatic and unforeseen changes in life circumstances, and obstructed access to earlier termination through geographic isolation and/or unsupportive health practitioners. Later recognition and diagnosis of pregnancy can also be more common in younger women and in those whose pregnancies have resulted from contraceptive failure, as some contraceptives can mask the symptoms of early pregnancy.

Ultrasound screening for fetal health is routinely recommended around midway through pregnancy, at 18-21 weeks gestation, and many anomalies are not diagnosed until this time (Todros et al., 2001). Implicit in this practice is that if those tests return an unexpected or negative diagnosis, women and couples will be supported to make a decision regarding the pregnancy given the knowledge that testing has afforded to them. Many women and pregnant people are then shocked to discover that this decision is not legally theirs to make, depending on the legislation.

A legislated gestational limit of less than 24 weeks would impact significantly and unfairly on vulnerable pregnant people and their families and should not be considered as part of this review.

Ministerial Panel decision maker in late abortions

Regulatory options in relation to a Ministerial Panel

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

Option 2: Remove the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e. late abortions) but require an additional medical practitioner to be consulted.

Children by Choice supports Option 2

This requirement would align most closely with legislation in most other jurisdictions which take a staged approach to termination of pregnancy, albeit at differing gestations.

It is also the option which provides the pregnant person with the most autonomy and creates the least burdensome and intrusive process in order for a termination to be accessed.

Requirements for specialist consultation would impact far more heavily on rural and remote women and pregnant people and their medical practitioners, potentially further delaying access. These are the patients already most heavily impacted by access barriers to termination. As detailed above, regional, rural and remote people seeking abortion face additional barriers of increased travel distances (205km vs 41km for metropolitan people) and complexities that would be compounded with additional medical intervention.

Professional standards and guidelines as well as current practice will ensure specialist involvement where this is clinically indicated and appropriate, as pointed out by multiple submitters to the Queensland parliamentary inquiries in 2016 [8], including the Australian Clinical Psychology Association and practising maternal fetal medicine specialists from several Queensland hospitals.

Children by Choice strongly opposes the legislative requirement for consultation or approval via a committee.

A 2002 review of the current WA model [9] conducted and published by the WA Department of Health into the impact of that state's post-20 week legislative requirements reported that (a) the requirement for a panel to meet and discuss cases seeking approval after 20 weeks has created further delays in accessing services where approved; and (b) that pregnant women felt that decisions on whether to continue or terminate a pregnancy were more highly pressurised and had to be made in haste or with incomplete information, where negative or inconclusive diagnoses were received not long before the 20 week limit would impact their options.

Ministerial approval for a facility to conduct late abortions

Regulatory options in relation to health service approval to perform late abortions

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

Option 2: Remove the requirement for Ministerial approval for a health service to perform late abortions.

Children by Choice supports Option 2

Any delays to accessing timely and compassionate termination of pregnancy will have negative health impacts on the pregnant person.

The United Nations states that the expectation in human rights law that abortion regulation would be evidence based and proportionate [10], and the requirement to not regulate abortion in a way that violates women and girls' right to life, jeopardises their lives, subjects them to physical or mental pain or suffering, discriminates against them, or arbitrarily interferes with their privacy [11]. The United Nations Working Group on the issue of discrimination against women in law and in practice has noted that "[b] arriers to accessing lawful abortion that are not based on medical needs … are discriminatory" [12]

As mentioned above, the current WA Ministerial model creates delays in timely access and puts pressure on women to make decisions about their pregnancy outcome.

Health services operate within professional and clinical guidelines and should not require Ministerial approval to deliver healthcare services.

Note on language

Throughout this submission we use the terms women, pregnant women, women and girls, and pregnant people interchangeably to refer to all those who are or can become pregnant, regardless of their gender identity.

Attachments

- Children by Choice Annual report 2021-22
- Termination of Pregnancy in Queensland post decriminalisation research paper
- Reproductive Coercion and Abuse among Pregnancy Counselling Clients in Australia research paper
- Rural, Regional and Remote Abortion Access Project reports 1,2 & 3

References

1. Cleetus, M., Lazarou, M., Tooker, S., Jenkinson, B., & Dean, J. A. (2022). Termination of pregnancy in Queensland post-decriminalisation: a content analysis of client records from an all-options pregnancy counselling organisation. *Sexual Health*. https://doi.org/10.1071/sh22059
2. Australian Government, Department of Health, National Women's Health Strategy 2020-2030, (2018) https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030.pdf
3. Victorian Law Reform Commission, Law of Abortion Final Report 15, (2008), https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/VLRC_Abortion_Report.pdf
4. The PLOS Medicine Editors (2022) Why restricting access to abortion damages women's health. PLoS Med 19(7): e1004075. https://doi.org/10.1371/journal.pmed.1004075
5. Keogh, L. A., Gillam, L., Bismark, M., McNamee, K., Webster, A., Bayly, C., & Newton, D. (2019). Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. *BMC Medical Ethics*, *20*(1). https://doi.org/10.1186/s12910-019-0346-1
6. Rosser, S., Sekar, R., Laporte, J., Duncombe, G. J., Bendall, A., Lehner, C., Portmann, C., McGrath, P., Lust, K., Ganter, P., & Kumar, S. (2022). Late termination of pregnancy at a major Queensland tertiary hospital, 2010–2020. *Medical Journal of Australia*, *217*(8), 410–414. https://doi.org/10.5694/mja2.51697
7. Todros, T., Capuzzo, E., & Gaglioti, P. (2001). Prenatal diagnosis of congenital anomalies. *Images in paediatric cardiology*, *3*(2), 3–18.
8. Queensland Parliament, Report No. 24, 55th Parliament, Health, Communities, Disability Services and Domestic Violence Prevention Committee, Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland, (2016) https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2016/5516T1337.pdf
9. Western Australian Parliament, Review of Provisions of The Health Act 1911 and The Criminal Code relating to abortion as introduced by the Acts Amendment (Abortion) Act 1998, (2002) https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/Data-collection/PDF/Report_Abortion_Legislation_Review_WA_2002.pdf
10. UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Interim Report to the General Assembly (2011) (UN Doc. A/66/254).
11. Human Rights Committee, General comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life (2018) (UN Doc. CCPR/C/GC/36).
12. Human Rights Council, Report of the United Nations Working Group on the Issue of Discrimination against Women in Law and in Practice (2016) (UN Doc. A/HRC/32/44).