

ABORTION LAW REFORM (WOMEN'S RIGHT TO CHOOSE) AMENDMENT BILL 2016

CHILDREN BY CHOICE SUBMISSION TO THE HEALTH, COMMUNITIES, DISABILITY
SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

JUNE 2016



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INTRODUCTION

Children by Choice is pleased to make this submission to the Health, Communities, Disability Services, and Domestic and Family Violence Committee's inquiry into abortion law reform.

As an organisation, we have over 40 years' experience in unplanned pregnancy and reproductive choice. We have supported over 200,000 women during this time with decision-making counselling, accurate information about their options, referrals to health services and community organisations, post-abortion support, and/or financial assistance to access abortion and contraceptive services.

We are a pro-choice, all options, woman-centred service. We support and trust women to make the best decision they can with an unplanned pregnancy, for themselves and their families. Women are the experts in their own lives. Nobody else can know better than the pregnant woman herself what is best for her in her situation.

This submission supports the removal of abortion from the Queensland Criminal Code.

It is our position that the Criminal Code statutes on abortion are outdated, unclear, and out of step with contemporary clinical practice and community expectation. In addition, we believe that criminalising a procedure which only women need (and which it is estimated that more than one in four Queensland women will have during their lifetime) is discriminatory and places undue burden on some of our most vulnerable women.

We will provide evidence in this submission that our criminal abortion laws cause distress and damage to disadvantaged women, and result in a class-based system where well-resourced women are able to access abortion with relative ease, while those experiencing violence, poverty, or homelessness, those living in rural and remote Queensland, and those with serious health concerns, have unreasonably high barriers to cross in order to access the same services.

The length of this submission is testament to the amount of evidence we have provided to support our positions. Given the emotive nature of this issue, we urge the Committee to base their position on the best reliable evidence base, and not give undue weight to value-based or ideological opposition to abortion that is not supported by peer-reviewed, unbiased research, or representative of the majority of community attitudes to abortion. In an area so fraught by emotional reactions, it is critical that our legal and policy response be based on fact, not opinion. While every citizen is welcome to their own opinion on this (and any issue), that does not entitle them to claim it as fact, nor to impose their own beliefs on others.

KEY POINTS

We support the removal of abortion from Queensland's 1899 Criminal Code.

Current criminal law provisions create uncertainty for doctors and health professionals. This is illustrated by estimates that only around 1% of Queensland abortion procedures are performed in public hospitals (see page 17), and by feedback we have had from GPs and hospital professionals about the confusion the law creates and the resulting disincentive for clinicians to become involved in abortion provision (page 26). We regularly support women across Queensland to access abortion through the private sector because their public hospital is either unresponsive or has refused to provide a procedure for them (page 18). These cases involve women pregnant after sexual assault, women with severe or life-threatening health conditions, women hospitalised because of domestic violence, women with chronic mental health problems including self-harm and attempted suicide, and women with serious substance abuse issues. These are not isolated cases.

No data on abortion rates in Queensland exists, but it's estimated that between 10,000 and 14,000 abortions take place each year, and that the majority of those are provided through private free-standing abortion clinics (page 53). These procedures are professionally and safely provided, and the practices themselves are all licensed through Queensland Health and have strict compliance standards in order to be able to practice (page 11). The licensing and practice frameworks are similar to those which regulate other medical practices, and would continue to operate were there to be a change in the criminal status of abortion.

Unfortunately these services have a high out-of-pocket cost, which impacts Queensland's disadvantaged women the most (page 19). We provide hundreds of dollars in financial assistance each week to women struggling to meet the cost of a procedure; in 2014-15 our financial assistance program totalled almost \$90,000 in support for women to access abortion and long acting reversible contraception (Appendix 1, page 57). Women impacted the most by high abortion cost are those in rural and remote areas of the state and those reporting violence.

Just as women in rural and remote parts of the state are disadvantaged in terms of abortion access compared to their sisters in cities and major centres, Queensland women are disadvantaged when compared to women living interstate. Queensland and New South Wales are the only two states which have not reformed their abortion law, and retain legislation largely based on a UK statute written in 1861. In addition, Queensland is one of only three Australian jurisdictions where a woman can be charged for procuring an abortion, and Queensland is the only state where a woman has been charged for an abortion in the 21st century (page 22).

Reliable opinion polling consistently shows that the majority of the community supports a woman's right to choose abortion, and does not believe abortion should be a crime (page 27). Professional and medical bodies also support the decriminalisation of abortion, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Public Health Association, and the Family Planning Alliance of Australia, among others (page 29).

When provided by qualified medical professionals in hygienic premises, as occurs in Australia, abortion is one of the safest medical procedures and also one of the most commonly performed. Despite claims to the contrary, there is no link to future infertility, breast cancer, or psychological harm from abortion. There is a well established evidence base on each of these issues and reliable, peer-reviewed science does not support any claims that abortion harms women (page 51).

An issue of great concern to us in regards to safety and abortion, however, is the increasing numbers of conversations our counselling team are having with women who have attempted or are saying they will attempt to induce their own abortion, because of the difficulty in accessing a safe and professionally provided procedure (Appendix 1, page 57).

Children by Choice respects the right of individuals to hold their own values and beliefs in regards to abortion and would therefore support a conscientious objection clause similar to Victoria's, where practitioners whose values do not support are required to refer onward, with the explicit exception that where a woman's life is in immediate danger, a practitioner should not be able to object to performing or being involved in a termination procedure (page 32). These situations are exceedingly rare but do arise, and it is vital that women's lives are prioritised over the moral objections of clinicians and support staff.

We support the availability of professional, free, non-directive counselling for women considering abortion, but not as a mandatory requirement (page 47). Studies show that the majority of women who've experienced an unplanned pregnancy do not want to speak to a counsellor, but that 80% feel any counselling offered must be all options (page 48).

We also support the introduction of exclusion zones around abortion provider premises to protect women from harassment and intimidation, as have been legislated in some Australian jurisdictions (page 34). Parental notification schemes for minors are unnecessary (the majority of young women seeking abortion will involve at least one parent in their decision), and create additional barriers to access for young women who may have good reason to fear the reaction of a parent or have inadequate support or knowledge to follow a legal process to have this condition waived (page 30).

A great deal of political and media attention in regards to this bill has been focussed around the issue of 'late term' abortions. 'Late term abortion' has no accepted medical definition and use varies, but the phrase is generally used to describe abortions which take place after 20 weeks gestation (page 36). In particular, claims have been made that women would have abortions at eight months gestation for no medical reason, and that the numbers of abortions performed at over 20 weeks

would skyrocket, were abortion to be decriminalised, and also that currently babies are being born alive and 'left to die' after 'late term' procedures in Queensland abortion clinics (page 43).

All these claims are categorically untrue and show incredible disrespect to the women who make the difficult decision to end a pregnancy at these gestations, and to the medical professionals who care for them. Terminations at or after 20 weeks gestation make up a tiny proportion of all abortions – between 0.5% and 2% depending on which estimate is used (page 38) – and in jurisdictions where law reform has occurred, there has been no corresponding increase in terminations performed later in pregnancy (page 39). At Children by Choice we see around 2000 clients a year. Not one requests a termination at these gestations because she has changed her mind. Invariably women in these situations have severe and debilitating life circumstances surrounding their decision to seek a termination – most often because of a devastating fetal diagnosis or maternal health complication. No clinic in Queensland provides terminations at 20 weeks gestation or later (and in the whole country, there is only one private clinic offering services between 20 and 24 weeks gestation). After this gestation, all abortions, without exception, are performed in hospitals (page 37), in the most compassionate and caring way possible, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists – whose members are the ones delivering babies in hospitals – supports them being legal and available.

If the Parliament finds itself unable to support a complete decriminalisation of abortion, we urge them to adopt a model based on Victoria's *Abortion Law Reform Act 2008*. This model allows for abortion on request to 24 weeks gestation, with additional conditions to be met after this time, and also includes a conscientious objection clause. The model was proposed by the Victorian Law Reform Commission after its extensive examination of the law of abortion and related issues in 2007-08. The Commission produced a comprehensive overview of the evidence relating to current practice, community opinion, minimum legislative requirements, and associated issues like counselling and consent, which we highly recommend to the Health Committee. We applaud the Commission's approach to using the best reliable evidence to inform their policy recommendations and hope this committee inquiry into the same issues in Queensland yields a similar result.

RECOMMENDATIONS

That the Committee recommend the repeal of s224-226 of the Criminal Code, to decriminalise abortion in Queensland.

That if the Committee finds itself unable to recommend complete decriminalisation, it supports the adoption of a legislative model based on Victoria's Abortion Law Reform Act 2008.

That any additional conditions which must be met for abortion after a legislated gestational period not be overly onerous or impose an undue burden on pregnant women seeking abortion.

That genuine unbiased all options counselling is made available for women who require it, provided by tertiary trained professionals, and that pregnancy counselling organisations receiving government funding for be required to publicly disclose if they are anti-abortion or will not refer for abortion services.

That there will be no legislated mandatory counselling requirement for women seeking abortion included in any reform.

That exclusion zones around abortion provider premises be included in any legislative reform to protect staff, patients and their support people.

That any legislative reform includes a conscientious objection clause which:

- requires medical professionals opposed to abortion to refer women seeking assistance to another provider who does not hold an objection;
- includes an exception for medical emergencies where a woman's life is at immediate risk; and
- requires conscientious objector GPs to publicly disclose this position on their clinic website and premises, to allow them to practice as they choose while at the same time prioritising women's right to timely and supportive information and care.

That the Committee give weight to well supported submissions by expert practitioners and groups and to the availability of reliable, peer-reviewed research into abortion to inform their position on legislative reform.

EXPLANATORY NOTES AND DEFINITIONS

Surgical abortion: Can be provided from around 5-6 weeks gestation onwards. In the first trimester the procedure itself takes between three and ten minutes, however the average length of time spent at a clinic is between three and four hours because this includes pre and post operative care. A different procedure technique and timeframe applies for abortions after about fourteen weeks. They can also be more difficult and expensive to access after this time.

Medical abortion: This uses the drugs mifepristone (commonly known as RU486) and misoprostol to induce a miscarriage. Medical abortion is only available to nine weeks gestation, and women will need to attend a followup appointment with their provider in most cases, around two weeks later. Medical abortion is sometimes referred to as medication abortion, and can be provided by GPs who have undergone training to prescribe it, as well as in abortion clinics and hospitals by certified prescribers. It is available earlier in pregnancy than surgical abortion but can only be prescribed to 9 weeks gestation.

Gestation: Gestation is calculated from the first day of the last menstrual period (LMP), not from the date of fertilisation or implantation, or from the date of the sex that led to the pregnancy. This can cause issues for sexual assault victims in particular, who may not be aware of this and therefore can think they are at 2-3 weeks lower gestation than they actually are. It can also be difficult for women with irregular menstrual cycles to estimate their gestation without blood test and ultrasound results.

Late term abortion: Late term abortion has no accepted medical definition and can have a range of meanings. Some people and groups define late term abortion as post-14 weeks, others post-18, etc. We use the gestational age in weeks of the pregnancy or refer to the trimester, depending on the context. We would encourage the Committee to avoid the use of late term abortion given the flexibility of its meaning and the value-laden nature of its use.

ABOUT OUR WORK

Children by Choice was founded in 1972 to advocate for legal abortion, and to assist pregnant women with information about their pregnancy options.

Since that time we have supported over 200,000 women with decision making counselling, accurate evidence based information about abortion, adoption and parenting, referrals to health and support services, and/or financial support to access abortion or contraception.

We are the only independent, stand-alone pro-choice pregnancy counselling service in Queensland.

We are funded by the Queensland Department of Communities to deliver counselling and community education. Other activities, including policy advocacy and our financial support program, are delivered with the help of grant funding, donations from supporters, and volunteer hours.

COUNSELLING

We support around 2000 individual clients each year through our counselling work. In recent years our number of contacts has risen but the number of clients has remained relatively stable, demonstrating that women are requiring more assistance to resolve their issues.

The majority of the work of our counselling team is in abortion access, as that is the main reason women contact us for help. In 2014-15, 60% of our contacts were in relation to financial assistance for abortion; 51% were looking for information about abortion procedures, and 40% for where they could go to have a termination. This mirrors the traffic to our website, where the most viewed page is 'how much is an abortion in Queensland?' (15% of our web traffic is accounted for by this page), and the five most highly viewed pages are all abortion law and access related and account for almost half of all our website traffic.

Accurate information on abortion legality and availability can be difficult to access for women and their families; this results in part from the stigma still attached to abortion, which continued criminality helps perpetuate. Around 30% of our contacts report that finding accurate information on abortion is a key issue for them, so it should be no surprise that a disproportionate number of our contacts focus on this need.

Key statistics from our 2014-15 Annual Report include:

- 30.5% of the work of our counselling team was with or on behalf of women reporting violence, and 7.5% was with or on behalf of women experiencing both domestic and sexual violence;
- Almost \$90,000 was provided through our financial support program to help women access abortion and/or long acting reversible contraceptives;
- We had 118 conversations with women who had attempted or were planning to attempt to induce their own miscarriage because they could not access a safe procedure – three quarters of these contacts had experienced domestic and/or sexual violence;
- 52% of our contacts were Health Care Card holders;
- 64% of our contacts said the cost of abortion was a barrier to access, while one in five said their location was a barrier to abortion access.

COMMUNITY EDUCATION

As part of our community education programs, we deliver sexuality and relationships education to young people through schools and youth centres, and professional development training for the health and community sectors.

Most of our work with young people is centred around those disengaged from mainstream education and is delivered through alternative education programs, community organisations, and behavioural support groups. Over 300 young people took part in these programs in 2014-15.

In 2014, thanks to grant funding, we launched our know4sure website for young people. Through consultations and our work with young people, we know that young women are likely to confirm a suspected pregnancy early but then not know what to do next, or who to tell. The know4sure site is aimed at helping them with information about their options, tips for disclosing to parents, decision-making tools, and practical information on things like pregnancy tests and Medicare cards. The site has been promoted through youth workers across a wide range of organisations and feedback from them has been very positive.

Our professional development work encompasses a variety of platforms and audiences. In 2014-15 over 2200 participants took part in training events we ran or presented at. Training is focussed on capacity building with health and community sector professionals working with women around unplanned pregnancy, including school based youth health nurses, GPs, social workers, and public hospital health and allied health professionals. Our most recent conference was held in 2015 in Brisbane and attracted over 175 professionals and students from across Australia, with 94% of attendees rating it as 'above average' or 'excellent'.

In 2013 we were invited to assist with the development of the Queensland Health Maternity and Neonatal Clinical Guideline for Therapeutic Termination of Pregnancy. This is the first statewide Guideline issued on the provision of termination of pregnancy in Queensland hospitals (see page 12). In 2015-16 we were contracted by Queensland Health to lead the development of consumer information on the Guideline, in consultation with other key stakeholders. We have also delivered training both in-person and via videoconference for professionals working in public hospitals on the implementation of the Guideline, at several sites across Queensland.

Our most recent Annual Report, for 2014-15, is included as an appendix to this submission (page 57), for more information on our work or our service. You can also see our website at www.childrenbychoice.org.au.

EVIDENCE: EXISTING REGULATION OF TERMINATION OF PREGNANCY IN QUEENSLAND

Commentary around the proposed bill has included some assertion that if abortion law is repealed – ie, sections 224-226 are removed from the Criminal Code – that the practice of abortion in Queensland will be entirely unregulated. This is categorically untrue.

The provision of abortion in Queensland is heavily regulated in both public and private health facilities, in practices and frameworks which sit alongside, but are not at all dependent on, abortion being retained in criminal law.

PRIVATE CLINIC PROVISION

The vast majority of terminations in Queensland are carried out in private day surgeries. There are ten of these surgeries across the state; seven of which are in the southeast corner, and one each in Cairns, Townsville and Rockhampton.¹ These clinics generally provide both medication and surgical pregnancy termination, along with other sexual and reproductive health services including vasectomy procedures and the provision of Long Acting Reversible Contraceptives (LARCs).

All these clinics are licensed by Queensland Health, under the Clinical Services Capability Framework (CSCF) for Licensed Private Health Facilities, with which they must comply. This is the same framework all private health facilities in the state are licensed under. According to Queensland Health:

The CSCF outlines minimum requirements for the provision of health services in Queensland public and licensed private health facilities, including minimum service, workforce, support service, legislative and non-mandatory requirements and risk considerations.²

Clinics providing abortion are guided by the *Perioperative Services – Day Surgery Services, Maternity Services, Anaesthetic Services, Surgical Services, and Termination of Pregnancy Services* companion modules of the CSCF (v4.3). As part of this licensing framework a number of specific conditions must be met. Specific to the *Termination of Pregnancy Services* module are that:

- procedures must be performed in accordance with the Criminal Code;
- all pregnancies must be confirmed by pregnancy test or ultrasound;
- clinical indicator data must be provided to satisfy accreditation and other reporting obligations;

¹ A list of Queensland abortion providers is available on our website at www.childrenbychoice.org.au, including all private clinics and some GPs.

² 'About the CSCF', available on the Queensland Health website at <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/about/default.asp>.

- patient information should include ‘legal, financial, psychosocial and medical implications prior to procedure’.³

There are additional conditions which must be met in order to provide services for patients under the age of 14, including:

- mandatory psychological counselling from a qualified health professional, which must be fully documented in patient’s medical record;
- involvement of paediatric and mental health services for assessment of capacity to consent; and
- a paediatric license.³

Only two clinics in Queensland hold the necessary paediatric license to treat young women aged under 14 years old. Unless these young women can access one of these clinics (located in Nambour and Cairns), a public hospital is their only possible avenue for access. This is discussed further on page 14.

No clinic in Queensland is licensed to provide abortion at or after 22 weeks gestation,⁴ and none provide past 20 weeks gestation due to self-imposed practice restrictions.⁵ Past this point in pregnancy, women seeking abortion have only two options: a hospital, or interstate travel.

Only two clinics (one in Brisbane and one on the Gold Coast) provide abortion to 19 weeks and 6 days gestation. The others cease providing services at 14 to 18 weeks depending on the clinic. This is due to the lack of providers trained and willing to provide terminations beyond this point in pregnancy. There is no reason to expect that this would alter were abortion to be removed from the Criminal Code. We encourage the Committee to speak with doctors providing these services to discuss this for themselves.

There is also no indication the licensing conditions would change under the proposed law, as the gestational limits currently imposed by the CSCF are not tied to current legislation.

HOSPITAL PROVISION

Provision of abortion services in public and private hospitals in Queensland is regulated through the Maternal and Neonatal Clinical Guideline on the Therapeutic Termination of Pregnancy (TTOP).⁶ This Guideline was released in 2013 by Queensland Health and aims to provide guidance to medical professionals working in public and private hospitals on when termination may be lawfully provided and how to follow best clinical practice.

³ Termination of pregnancy services CSCF companion manual 4.3, by Queensland Health. Available online at <https://www.health.qld.gov.au/publications/system-governance/licences/private-health/cscf-comp-terminat-pregnancy.pdf>.

⁴ Maternity services module CSCF v3.2 (page 2), issued by Queensland Health. Available online at <https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/cscf-maternity.pdf>.

⁵ Gestational limits for all Queensland abortion clinics are listed on our website at www.childrenbychoice.org.au.

⁶ *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy* available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

The Guideline stipulates, among other things, that:

- pregnancy termination can be lawfully performed by medical practitioners in Queensland, if there is a serious risk of harm posed by pregnancy, to a woman's life, physical or mental health;
- women presenting at a public hospital requesting a termination of pregnancy should be assessed by a practitioner who does not hold a conscientious objection to abortion, as to whether they are eligible;
- when assessing the risk of harm, a medical practitioner should consider the social, medical and economic factors impacting on the woman's life and health. In addition, risks that may not be present at the time of assessment by the doctor but that could arise during the pregnancy or following the birth of a child can be considered.

Interestingly, this last point is at odds with Criminal Code statutes and case law relating to the lawfulness of abortion in Queensland, as it stipulates that social and economic factors are able to be included in the practitioner's assessment along with medical factors.

According to the Guideline, all Hospital and Health Services (HHS) should provide access to therapeutic termination of pregnancy services to women living within their region. Where service level capabilities are insufficient to provide pregnancy termination services, timely referral and transfer procedures to a hospital service with the requisite capabilities should be established.⁶

The Guideline also sets out suggested approval mechanisms for abortion procedures in hospitals, and specifies that in all cases at least two medical specialists must be involved (and that one must be a specialist obstetrician). For 'complex cases' (which could involve a number of factors including the pregnant woman's medical, social or economic circumstances, her capacity to consent, mental health, age, or the gestation of the pregnancy), the Guideline suggests that other professionals should be involved and that depending on the circumstances of the case, the review team may include a social worker, psychiatrist, obstetrician, GP, maternal fetal medicine specialist, paediatrician, lawyer, ethicist, religious officer or sexual assault worker.⁷

While the Guideline is quite clear around a number of issues regarding the provision of abortion in Queensland hospitals, and does its best to provide clarity for practitioners, its impact of course depends on how rigorously and consistently it is implemented. While some hospitals have implemented the guideline, there is no monitoring of this process and no funding allocated for implementation, so provision remains fragmented across the state and can still be extremely difficult to negotiate at some hospitals, as we will illustrate later in this submission (see page 17).

We also note that in the Committee's briefing with Rob Pyne, Member for Cairns, on 15 June, questions were raised about providing a framework for medical professionals to assess the potential risk to a pregnant woman in regards to either continuing or terminating her pregnancy. Specifically, the Committee asked:

In relation to your first reading speech, you state quite clearly that if the bill passes, the decision for the doctor would quite simply need to be that continuing the

⁷ Page 9 of the Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

*pregnancy poses a bigger risk to the woman than terminating it. How, given that your legislation puts no regulation in place, does the doctor determine if that is the case, and does your legislation provide any guidance or any tests for a doctor to make that decision, and what are the nature of the risks that they're testing, and how would we measure those? How would the doctor measure those risks?*⁸

Firstly, Mr Pyne (and therefore the Committee in using this statement) is mistaken in stating that if abortion statutes were to be repealed, 'the decision for the doctor would quite simply need to be that continuing the pregnancy poses a bigger risk to the woman than terminating it.' If criminal abortion law is repealed, abortion becomes lawful when the woman provides her consent, and that is the only legal condition that would need to be met.

However, the point of risk of harm is worth considering in light of the fact that the Committee seems interested in examining a staged process to law reform, whereby abortion would be lawful (presumably) on request up until a certain point in pregnancy, and after that with additional conditions such as the approval of two medical practitioners. In these cases, professionals would indeed examine the risk of harm to the woman from both continuing her pregnancy and from terminating it, in order to help assess whether or not they would provide her with a procedure.

It would depend on the wording of the bill to pass parliament, but if it included the necessity for an assessment of the risk of serious harm, a legal definition for 'serious harm' would need to be provided, as none currently exists. This is an ongoing cause of confusion for medical practitioners in hospitals based on our clients' experiences of not being provided with terminations because they don't meet a practitioner's own definition of what constitutes 'serious harm', despite there being issues such as rape or incest, repeated suicide attempts, or extreme domestic violence. See page 18 of this submission for more details.

The Guideline is also very clear in relation to providing abortions to young women, including those aged under 14, and sets out best practice standards for assessing young women for capacity to consent to a procedure.⁹ However, hospital legal advice on several occasions has differed to the parameters set out in the Guideline, indicating ongoing confusions about the requirements of law. This was very clearly illustrated by the recent and highly-publicised case of 'Q', a 12 year old forced to seek Supreme Court approval in Rockhampton in April for an abortion.¹⁰

Q had spoken extensively with several practitioners at her local hospital, who all supported her request for an abortion and believed she had the necessary capacity to provide informed consent. They were not permitted by a hospital executive to provide Q with an early abortion at the hospital, with the executive in question claiming there was 'no evidence' that the legal test for abortion had

⁸ At the time of writing, the footage from this public hearing was available on the parliamentary website, on the page for the Abortion Law Reform (Women's Right to Choose) Amendment Bill 2016, at <https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDVFVPC/inquiries/current-inquiries/AbortionLR-WRC-AB2016>.

⁹ Page 11 of the *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy* available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

¹⁰ See for example 'Queensland doctor in abortion case says more teenagers face 'appalling' choice', *The Guardian Australia*, 16 June 2016. Online at https://www.theguardian.com/world/2016/jun/16/queensland-doctor-abortion-more-teenagers-face-appalling-choice?CMP=share_btn_fb.

be ‘formally met’ and it was therefore necessary to obtain a court order before the termination could be performed. Dr David MacFarlane, the obstetrician involved in Q’s case, has made a submission to this inquiry with extensive information on this case, which we will not repeat here for the sake of brevity. However, we fully endorse Dr MacFarlane’s submission, and applaud him for being willing to speak publicly about the injustices Q faced as a direct result of the unclear nature of Queensland’s abortion law and his concern for other young women who may be forced to seek court approval as a result of the precedent set by Q’s case. Our conversations with clinicians and allied health staff in public hospitals since the case became public indicate a heightened sense of confusion about the legal and regulatory requirements for young women of her age, creating an urgent need for clarity and law reform.

As noted earlier in this submission, only two private clinics in Queensland are legally able to offer services to young women aged under 14, and as demonstrated by Q’s case, the conditions some hospitals force them to meet are onerous and damaging. Young women of this age are potentially at high levels of physical risk from carrying a pregnancy to term as their bodies are not yet fully matured, as well as any associated mental health concerns that may arise. In addition, our clients experiencing pregnancy aged 14 or under report higher levels of sexual coercion and assault than our general client base, with the man involved in the pregnancy more likely to be older and therefore in a position of power. It is immensely tragic and unfair to force these young women to continue with pregnancies given their vulnerable situations and the heightened risks to their physical and mental health, yet that is what the current state of provision for this cohort sometimes results in.

MEDICATION ABORTION PROVISION

In 2012 the Therapeutic Goods Administration (TGA) approved the use of mifepristone and misoprostol for the use of early medical abortion in Australia.¹¹

Medical abortion is only available to be prescribed to 8 weeks and 6 days gestation, under the licensing conditions set out by the TGA.¹² This is a national framework and again, completely independent of Queensland abortion legislation, apart from the specification that prescribers of mifepristone must do so in line with abortion legislation in their state or territory.

This framework covers medical abortion in all practice settings, including hospitals, clinics, and GPs. Specialist practitioners who hold a Fellowship or Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists are able to prescribe medical abortion as part of their existing practice, given their extensive training and qualifications. General practitioners, and providers working within Queensland clinics who are not specialist O&Gs, must undergo training to

¹¹ *Registration of medicines for the medical termination of early pregnancy* Therapeutic Goods Administration, 30 August 2012. Online at <https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy>.

¹² Australian Register of Therapeutic Goods ID 210574 (MS-2 Step composition pack) product information available online at the Therapeutic Goods Administration website: [https://www.ebs.tga.gov.au/servlet/xmlmillr6?dbid=ebs/PublicHTML/pdfStore.nsf&docid=77FFC395C0EC491DCA257E5F004236DF&agid=\(PrintDetailsPublic\)&actionid=1](https://www.ebs.tga.gov.au/servlet/xmlmillr6?dbid=ebs/PublicHTML/pdfStore.nsf&docid=77FFC395C0EC491DCA257E5F004236DF&agid=(PrintDetailsPublic)&actionid=1).

become certified prescribers.¹³ All patients have access to the national 24 hour post-care telephone service provided by MSHHealth, regardless of the practitioner who prescribed them the medication.

Without completing this training, medical practitioners are unable to prescribe medical abortion in any practice setting. We advise the Committee to seek out further information on the training and conditions set down under the licensing conditions of the TGA from MSHHealth, the holder of the TGA distribution license for medical abortion in Australia.

REGULATION OF GESTATIONAL LIMITS

We note the Committee's concern that if abortion were decriminalised without the imposition of legislated gestational limits, there would be nothing to regulate the provision of abortion at any gestation.

As outlined above, there are various regulatory frameworks currently in place which would continue to operate were law reform to take place. For example, clinic licensing frameworks permit the provision of abortion to 22 weeks gestation (although none of them provide to this term). This is independent of the current criminal law provisions on abortion.

It should also be emphasised that there are currently no legislated gestational limits for abortion in Queensland. Sections 224-226 do not mention any gestational limit at which abortion is lawful or unlawful – it is equally unlawful (according to these sections) at any gestation, and the Criminal Code is therefore not what prevents women seeking abortion into the second and third trimesters for healthy pregnancies, or what prevents doctors from providing these procedures.

We highly recommend the Committee seek out the expertise of practitioners involved in abortion provision later in pregnancy to discuss with them the parameters of their practice and in what circumstances women seek these procedures.

¹³ *Mifepristone followed by misoprostol for terminating early pregnancies* Consumer Medicine Update by NPS MedicineWise, 1 February 2015. Online at <http://www.nps.org.au/publications/consumer/medicine-update/2013/mifepristone-misoprostol>.

EVIDENCE: ACCESS TO ABORTION

Existing practice and its interaction with criminal abortion law unsurprisingly has several implications for access to services, which we will also discuss in this section of our submission.

The current legislative framework has a severe impact on some women's access to abortion services in Queensland.

PUBLIC HOSPITALS

There is very limited access to termination in the Queensland public hospital system, and generally only women with severe fetal anomaly or extremely extenuating personal circumstances will be eligible.

In South Australia, over 95% of terminations are provided through public hospitals,¹⁴ while in 2010 Queensland Health estimated that only around one percent of all terminations were performed in public hospitals.¹⁵ This is supported by data provided to us by Queensland Health on request in 2015 regarding the numbers of terminations carried out in public hospitals as follows:

Financial Year	Surgical Terminations
July 2010 - June 2011	150
July 2011 - June 2012	143
July 2012 - June 2013	160
July 2013 - June 2014	180

Given that estimated 10,000 to 14,000 are performed in Queensland each year (as per our introduction to this submission; see page 53 for information on abortion statistics), the numbers provided through public hospitals seem to make up an incredibly small proportion.

¹⁴ W Scheil, K Jolly, J Scott, B Catcheside, L Sage, R Kennare *Pregnancy Outcome in South Australia 2013*. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2015. Available online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/62e89b004aca1fd38486dc0b65544981/15116.1+Pregnancy+Outcomes+Report+A4-FINAL.pdf?MOD=AJPERES&CACHEID=62e89b004aca1fd38486dc0b65544981>.

¹⁵ Dr Tony O'Connell, the Chief Executive of Queensland Health's Centre for Healthcare Improvement, in response to media enquiry from Wendy Carlisle from the ABC. Cited in 'Abortion on Trial', broadcast on *ABC Radio National* on 7 November 2010. Full transcript at <http://www.abc.net.au/radionational/programs/backgroundbriefing/abortion-on-trial-in-queensland/2982710>.

It was hoped the release of the Therapeutic Termination of Pregnancy Guideline in 2013 would result in more uniform and open access to terminations in public hospitals for women with exacerbating circumstances - those experiencing domestic or sexual violence, homelessness, or physical or mental health problems, for example. While some hospitals have implemented the guideline, there is no monitoring of this process and no funding allocated for implementation, so provision remains fragmented across the state and can still be extremely difficult to negotiate at some hospitals.

Until the release of the Guideline in 2013, there had been no statewide guidance for facilities and staff on when termination may be provided in a public hospital.¹⁶ As many health professionals consider Queensland abortion law to be unclear, the result of this lack of guidance was an adhoc approach to public provision that allowed hospitals and individual practitioners to apply their own interpretation of the law, or their own religious or values systems, when it came to abortion provision. This culture of individual decision-making has persisted in some hospitals despite the release of the Guideline and means that most women who seek abortion in public hospitals will be unsuccessful and have no option but the private system.

Public hospitals (like many other services) operate within catchment areas, and women seeking abortion through the public system cannot present to a hospital outside her catchment. This can have a devastating impact on women in vulnerable situations if her local hospital is opposed to providing abortion services. There are several such hospitals in Queensland. In recent years, staff and volunteers from Children by Choice have supported several women who have been turned away or refused services from one hospital in the greater Brisbane area, including a 14 year old refugee pregnant after sexual assault, a woman being treated for a life-threatening cancer, and a woman whose baby died in utero. The 14 year old had been 13 when the assault occurred, and already had PTSD from her experiences in refugee camps before coming to Australia. The cancer patient had to check herself out of the hospital and remove her intravenous morphine drip in order to access a medical abortion, for the hospital to allow her to continue with her cancer treatment. And the woman whose 16 week scan revealed no fetal heartbeat and no amniotic fluid (which have no other diagnosis but fetal death) was told to 'go home and pray' and come back in a couple of days. The hospital did not want to help her speed the natural and inevitable miscarriage process, as they believed it to be tantamount to abortion.

These three cases are by no means the only ones of significance involving this hospital in recent years, and situations like these are unfortunately not unique to this hospitals One regional Queensland Health public hospital refuses to accept referrals from GPs to even assess women for abortion, including in cases of women pregnant after sexual assault; another, in the greater Brisbane region, has previously informed our service that they are 'a conscientious objector hospital'.

¹⁶ Correspondence between the ABC and Queensland Health, cited in 'Abortion on Trial', broadcast on *ABC Radio National* on 7 November 2010. Full transcript at <http://www.abc.net.au/radionational/programs/backgroundbriefing/abortion-on-trial-in-queensland/2982710>.

This leaves women in the catchment areas of these hospitals with few options: they can try and find a GP who provides medical abortion if the pregnancy is less than 9 weeks gestation, go to a private clinic, or travel interstate. No other public provision pathway is available to them.

Access through private clinics is also somewhat fraught for various reasons, which we will examine below. A similar situation exists for the small number of known GP providers of medical abortion, which in any case is only available to nine weeks gestation. Once a provider is located, women may need to arrange travel and accommodation in order to access a procedure.

For women who do face long travel distances, the Patient Travel Subsidy Scheme should offer some financial reimbursement to help cover travel costs. Applications for assistance need to be signed off on by a Hospital Superintendent. Children by Choice has supported several clients whose applications have been denied either because of anti-abortion hospital personnel, or because the Superintendent or other hospital staff believe PTSS assistance is not available for travel for abortion 'because it's illegal'.

PRIVATE CLINIC ACCESS

Procedures offered through private clinics or day surgeries have out-of-pocket costs attached, and these costs have in some cases almost quadrupled since 2000. The minimum out-of-pocket cost for most first trimester surgical abortion procedures in Brisbane is now approaching \$500, and later procedures can cost in excess of \$3000.¹⁷ Despite mifepristone being listed on the Pharmaceutical Benefits Scheme, medical abortion provided through most clinics has a similar cost attached to a surgical abortion.¹⁸ This is not the result of the law, but it does create an unfair burden for women in extreme poverty or those who even under current legislative restrictions, should be able to access a public procedure.

As stated earlier in this submission, only two Queensland clinics – one in Brisbane and one on the Gold Coast – provide services up to 19 weeks and 6 days. The others cease offering services at between 14 and 18 weeks depending on the clinician; each clinic determines its gestational cut off in accordance with their clinician's training and the conditions of their license under Queensland Health, as mentioned earlier in this submission.

In addition, the scarcity of trained providers (a byproduct of both continued criminalisation of abortion and the stigma that criminalisation helps perpetuate)¹⁸ means that several of the doctors providing terminations through private clinics practice in more than one location. Clinics in Rockhampton and Townsville operate one day a week with clinicians flown in from Brisbane and interstate. This considerably adds to the cost of procedures in these facilities and can cause delays for women accessing services as they may need to wait for an available appointment. This in turn increases the gestation at which they may be able to access a procedure and can significantly

¹⁷ Information on the cost of abortion procedures in Queensland is available on our website at www.childrenbychoice.org.au.

¹⁸ See for example 'How medical schools are failing to educate doctors in abortion care' *Daily Life*, 24 November 2015. Online at <http://www.dailylife.com.au/health-and-fitness/dl-wellbeing/how-medical-schools-are-failing-to-educate-doctors-in-abortion-care-20151124-gl6vg1.html>.

increase the cost at which they do so – or alternatively push them over the gestational limits for those clinics, meaning their only option is to travel to Brisbane or the Gold Coast.

While we do not expect that law reform would have a major impact on the provision of abortion through private clinics (for reasons stated above), clarification around the law should allow hospitals to provide more procedures for women in situations of distress and disadvantage, making the process much less demanding for those women and facilitating earlier access to procedures.

GENERAL PRACTITIONERS

As outlined above, GPs are allowed to provide medication abortion through their practice after completing online training, obtaining suitable medical indemnity, and finding a pharmacist to stock the medication.

In Queensland, it is unknown how many GPs have undergone the training or where they are located as no publicly available list of these GPs exists. We are aware of around 15 such providers across the state. Only six of these have consented to be listed publicly on our website; the remainder are happy to accept referrals from our service but undertake no advertising of any kind. While we can refer women to these practices, it relies on women finding our service so we can in turn refer them, or them finding a practice from cold-calling GP clinics in their area. Again, there can be high out of pocket costs attached to accessing these services through a GP, and medical abortion is available only to 8 weeks and 6 days gestation.

EVIDENCE: ISSUES WITH CURRENT ABORTION LAW IN QUEENSLAND

IT'S UNCLEAR

Although abortion remains in our Criminal Code (s224-226), it is generally accepted to be lawful if performed to protect a woman's life or prevent serious harm to her physical or mental health.¹⁹

This understanding rests on case law from 1986 (*R v Bayliss and Cullen*) and on section 282 of the Criminal Code which attempts to define a lawful abortion:

A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill a surgical operation on or medical treatment of:

a) a person or unborn child for the patient's benefit; or

b) a person or unborn child to preserve the mother's life;

*if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all circumstances of the case.*²⁰

The existence of s282 is often pointed to as evidence that the law is not in need of reform.

However:

- McGuire's ruling in *R v Bayliss and Cullen*, while laying out grounds for when an abortion is supposedly lawful, was the decision of one judge in one court. It provides no guarantee that a different judge in a different court would come to the same decision in a similar case.
- Section 282, the section on which doctors providing abortion would rely for a defence were they to be charged under s224, provides no clarity around when an abortion is lawful other than when the provider deems it 'reasonable, having regard to the patient's state at the time and to all circumstances of the case'. No further legal grounds to be met are specified.
- Doctors would need to be charged and brought before a court in order to invoke s282, so it provides no legal protection against prosecution, but only makes it slightly easier for doctors to defend themselves against such a charge before a court. Prevailing opinion in legal and political circles may be that s282 is clear enough to enable doctors to practice, but the scarcity of providers and the reluctance of hospitals to offer the procedure points to doctors themselves not having the same belief.
- Justice McGuire himself said his ruling in *R v Bayliss and Cullen* served to 'illustrate the uncertainty of the present abortion laws of Queensland' and stated that a 'more imperative authority (either the Court of Appeal or Parliament)' would be needed to make changes to clarify the law.²¹

¹⁹ See for example the explanation of lawful abortion provided on page 6 of the *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy* available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

²⁰ *Queensland Criminal Code 1899*. Online at <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CriminCode.pdf>

²¹ *R v Bayliss and Cullen* (1986). 9 Qld Lawyer Reports 8 (Dist Court) McGuire J at 45

- Neither s282 nor a similar defence is available for a woman charged under s225. If charged with an unlawful abortion, she is not able to make a legal defence argument that *she* formed a reasonable belief that an abortion ‘reasonable’ given her circumstances.

As pointed out in the key points of this submission, Queensland is one of only three Australian jurisdictions where a woman can be charged for having an abortion, and Queensland is the only state which has charged a woman for abortion in the 21st century (*R v Leach and Brennan, 2010*).

Tegan Leach and Sergei Brennan were charged under sections 225 and 226 respectively, in Cairns in 2009. When the case finally came to trial in October 2010, the court heard that on discovery of the pregnancy, the couple had decided they were too young to become parents and decided to have an abortion. Leach was reportedly nervous of a surgical procedure, so Brennan arranged for his sister in the Ukraine to send medical abortion drugs to the couple through the mail. The couple were acquitted by the jury after less than an hour’s deliberation, on the grounds that the medications could not have been considered noxious to Leach.²²

Contrary to much of the media commentary around this case, the couple were not charged with importing the medications themselves, or with using them without professional medical oversight. They were charged with the fact of the abortion itself. The case and the resulting judgement prompted some discussion over whether this effectively decriminalised the use of medical abortion drugs in Queensland, but this has never been clearly resolved.²³

For a better understanding of how the law impacts abortion practice we highly recommend ‘Manufacturing mental illness (and lawful abortion): doctors’ attitudes to abortion law and practice in new South Wales and Queensland’. This study based on interviews with 22 doctors providing abortion in Queensland and New South Wales to explore their knowledge and application of relevant abortion laws in their jurisdiction:

*All respondents to some degree expressed concern about the implications different interpretations of case law might have for them if they were charged with the crime of abortion; this was aptly summed up in the words of one respondent that ‘case law is a dangerous way to decide things and it’s very unsatisfactory’. Most reported having given some thought to the possibility of their personally being charged with a crime.*²⁴

²² See for example S Elks ‘Jury frees abortion couple in less than an hour’, *The Australian*, 15 October 2010. Available online at <http://www.theaustralian.com.au/news/nation/jury-frees-abortion-couple-in-less-than-an-hour/story-e6frg6nf-1225938906094>; J Wainer ‘Abortion case proves need for law change’, *The Age*, 18 October 2010. Available online at <http://www.theage.com.au/it-pro/abortion-case-proves-need-for-law-change-20101017-16p0u>

²³ C de Costa ‘Cairns abortion trial: guarded optimism for reform process’ *Crikey*, 15 October 2010. Available online at <http://www.crikey.com.au/2010/10/15/cairns-abortion-trial-guarded-optimism-for-reform-process/>

²⁴ C de Costa, H Douglas & K Black (2013) ‘Making it legal: Abortion providers’ knowledge and use of abortion law in New South Wales and Queensland’ *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2013 Apr;53(2):184-9. Abstract online at <http://www.ncbi.nlm.nih.gov/pubmed/23347292>.

IT VIOLATES HUMAN RIGHTS

Human rights groups around the world continue to advocate for the removal of laws criminalising abortion. Amnesty International has urged all countries still holding these laws to repeal them;²⁵ Human Rights Watch continues to document the result of criminalised abortion and lack of abortion access.²⁶

Significant barriers to abortion access have recently been found by the United Nations to violate women’s human rights. The Committee may be aware of a June 2016 ruling by the UN’s human rights committee that Ireland’s restrictive abortion legislation subjects women to cruel, inhuman and degrading treatment. The committee examined the case of one woman who was forced to travel to the UK to have an abortion in 2011, even though the fetus she was carrying had anomalies that were incompatible with life – ie, would die during the pregnancy or shortly after birth. They ruled that the fact she had to ‘travel to another country, at personal expense, was separated from the support of her family, and return while not fully recovered’ violated her human rights.²⁷ The committee further ruled that Ireland should ‘amend its law on voluntary termination of pregnancy...to ensure compliance with the covenant [on civil and political rights], including effective, timely and accessible procedures for pregnancy termination in Ireland.’²⁵

In late 2011, United Nations Special Rapporteur for Health Anand Grover released a report examining the interaction between the right to health and criminal laws relating to sexual and reproductive health. In it, he stated that the right to sexual and reproductive health is a fundamental part of the right to health. He also stated that criminal and other legal restrictions on abortion violate the right to health, and that the application of such restrictions as a means to achieving public health outcomes is ‘often ineffective and disproportionate’. The report urged all UN member states to decriminalise abortion.²⁸

The World Health Organisation recognises that

*women are frequently denied access to sexual and reproductive health care and services in developing and developed countries. This is a human rights violation that is deeply engrained in societal values about women’s sexuality.*²⁹

²⁵ ‘Protecting the rights of women: Kate Gilmore speaks’ *Human Rights Defender* 9 August 2007. Available online at <http://www.amnesty.org.au/svaw/comments/2420/>.

²⁶ See for example *A State of Isolation: Access to Abortion for Women in Ireland* Human Rights Watch 2010. Available online at <https://www.hrw.org/report/2010/01/28/state-isolation/access-abortion-women-ireland>.

²⁷ *Ireland abortion ban subjected woman to suffering and discrimination* – UN experts United Nations Human Rights Office of the High Commissioner, 9 June 2016. Online at <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20077&LangID=E>.

²⁸ *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Available in full on the United Nations website at http://www.un.org/ga/search/view_doc.asp?symbol=A/66/254

²⁹ *Health and human rights*; Fact sheet No 323, by the World Health Organisation, December 2015. Available online at <http://www.who.int/mediacentre/factsheets/fs323/en/>.

While Australia has no national human rights mechanism, Victoria and the Australian Capital Territory both have instruments designed to protect the human rights of those within their jurisdictions. In the ACT, this is the Human Rights Act 2004;³⁰ in Victoria, the Charter of Human Rights and Responsibilities 2006.³¹ Interestingly, these were the first two jurisdictions in Australia to decriminalise abortion.

IT'S DISCRIMINATORY

The principle of non-discrimination inherent in international human rights mechanisms (including the *Convention on the Elimination of All Forms of Discrimination Against Women*, to which Australia is a signatory), characterises the refusal of medical procedures that only women require, such as abortion, as sex discrimination.³²

This is probably unsurprising due to the fact that when our abortion laws were promulgated in 1899 women did not yet have the right to vote, and the concept of the right to freedom from discrimination was still some decades from being promoted, let alone legislated.

As the law also heavily influences access to services, women already experiencing disadvantage are worse off. This includes women in rural and remote areas of the state, and women living in poverty, in particular.

In relation to long travel distances for rural women seeking abortion, a GP who has spent over 20 years working in rural and remote communities across far north Queensland writes:

This law was not designed to limit access to vital health services for women from remote areas, but now it does. It discriminates heavily against women in remote and regional areas. One in three Queensland women has had an abortion and this is a choice that must be available to all women, equally. The law as it stands effectively limits the access of rural and remote women to abortion services and ensures that abortion is only a choice for those who have sufficient funds to travel.

I have no end of examples of why women end up in situations requiring abortion, but suffice to say humans are not perfect, contraception is not perfect and there will always be a requirement for abortion. I am ashamed - and feel that legislators should share this shame - when women quite literally beg for an abortion. Why are Queensland women in this position, where they feel they must beg for the most common of gynaecological procedures?

Keeping this straightforward and necessary procedure in the outdated 1899 Criminal Code means I spend a great deal of my time explaining case law to

³⁰ *Human Rights Act 2004* is available online at <http://www.legislation.act.gov.au/a/2004-5/current/pdf/2004-5.pdf>.

³¹ *Victoria's Charter of Human Rights and Responsibilities* is available online at <http://www.humanrightscommission.vic.gov.au/index.php/the-charter>.

³² R Cook, B Dickens (2003) 'Human Rights Dynamics of Abortion Law Reform' *Human Rights Quarterly* 25 (2003) 1-59, John Hopkins University Press.

frightened women and how it applies to an individual, rather than discussing contraception and where it has gone wrong for each woman.

It seems the powers that be are quite happy for pregnant women and doctors to bear the fear and risk associated with managing pregnancy termination under current legislation in Queensland.

Typically, rural women who want to terminate an unplanned pregnancy find that either their procedure is significantly delayed, or that they are forced to carry the pregnancy to term. The implications of this, in terms of education and employment opportunities, are life-long.

Please, let medical practitioners discuss all the options for managing unplanned pregnancy with our patients without the fear and stress of illegality, so that we can spend our time on prevention, not legal jargon and ramifications.

In Queensland, the near impossibility of accessing public abortion services means most women must access a private clinic, and for rural and remote women this presents additional challenges along with the high cost of procedures. The map below shows the locations of all Queensland abortion providers known to Children by Choice. Several of these are GPs providing medical abortion (and therefore only available for women with pregnancies less than nine weeks gestation), and not all are publicly listed as abortion providers, so even women living in those locations may not be aware there is an abortion providing doctor nearby. It's clear that for women in many parts of the state, long travel distances are necessary to reach a provider, particularly those in western or central Queensland, or the Gulf communities.



One survey of women living in rural and remote New South Wales who had had an abortion reported that:

Rural women in this study experienced many barriers to accessing an abortion. Women travelled 1–9 hours one way to access an abortion in clinics. Several women borrowed money for the abortion fee. Five themes were identified: finding information about the provider; stigma, shame and secrecy; logistics involved in accessing the clinic related to travel, money and support; medical and surgical abortion; and ways rural women could be better supported in this process. Suggestions to improve rural women’s access to abortion services included more affordable services that were ‘closer to home’ as a way to reduce travel and cost, and to normalise abortion as a women’s health rights issue.³³

IT PERPETRATES STIGMA

These access issues are not things we expect law reform to affect. What we can confidently predict, however, given feedback from GPs who do provide through their practice, is that decriminalising abortion will encourage more doctors to start offering medical abortion – thereby making early abortion more accessible for women in their local communities, which is surely preferable to them undergoing a surgical procedure at a later gestation away from home at considerable expense.

As one doctor puts it:

[I]n Queensland where we’ve radicalised termination because we don’t make it a normal part of practice. If we trained in - if everyone here trained in Britain then obviously it’s a normal part of your day to day practice. You would accept making a choice to do O&G that you would look after bad outcomes or unwanted pregnancy as well as good outcomes and wanted pregnancy. Or anything in the middle. We’ve allowed abortion to be radicalised in Queensland. It is radicalised. I don’t think most people training in O&G or working in O&G realise they themselves have allowed a perception of it being a radical act to creep in.³⁴

Another, a GP providing medical abortion on the Gold Coast, writes:

Now with the availability of medical termination (the taking of tablets that induce a miscarriage at an early stage, and always before 9 weeks), this option would potentially be far more accessible to those that need it, but is hindered by the fact that uptake by doctors remains extremely low which is largely due to concerns over the current legal position on termination in Queensland.

³³ FM Doran & J Hornibrook (2016) ‘Barriers around access to abortion experienced by rural women in New South Wales, Australia’ *Rural and Remote Health* 16: 3538 2016. Online at http://www.rrh.org.au/publishedarticles/article_print_3538.pdf.

³⁴ H Douglas, K Black, C deCosta, ‘Manufacturing Mental Illness (and Lawful Abortion): Doctors’ Attitudes to Abortion Law and Practice in New South Wales and Queensland’ (2013) 20 *Journal of Law and Medicine* 560-576.

EVIDENCE: COMMUNITY ATTITUDES AND EXPECTATIONS

As a Committee member pointed out in the first public hearing of this inquiry (on 15 June 2016 in Brisbane), different opinion polls show different results on the question of community sentiment on abortion.

We strongly encourage the Committee to refer to the report of the Victorian Law Reform Commission published in 2008, *Law of Abortion*.³⁵ Chapter Four of the report involves an academic examination of five major opinion polls on abortion for methodology, question design, and reliability. Their analysis found that given some limitations in data, the available evidence suggests that a majority of Australians support a woman's right to choose.³⁶

The VLRC analysis found that two academic surveys, the Australian Election Study (AES) and the Australian Survey of Social Attitudes (AuSSA):

“present the strongest estimates of what Australians think about abortion.

The AuSSA waves from 2003 and 2005 suggest that approximately 80% of Australians support a woman's right to choose...fewer than one in 20 respondents to the AES said that abortion should not be allowed under any circumstances.”³⁴

Children by Choice is aware that Committee members have been sent the results of a 2016 Galaxy Poll commissioned by the Australian Family Association, claiming the majority of Queenslanders did not support abortion. The Committee may not be aware that the questions used as the basis of this polling were almost identical to those used in a 2005 survey commissioned by the Australian Federation of Right To Life Associations (AFRTLTA). The Victorian Law Reform Commission examined the AFRTLTA survey as part of their inquiry in 2008 (as above) and concluded that it 'raises concerns about question design' and that some of the questions were 'negatively loaded' and 'not balanced':

“This approach to question design increases risks that the survey question itself will shape responses, particularly among respondents without strong or well-formed views on the matter....In other words, because of the way some questions were framed and worded...AFRTLTA results may tend to overstate opposition to abortion.”³⁴

In addition to the VLRC report, we would highlight two additional sources on community attitudes to abortion which are Queensland-specific or include Queensland-specific data.

A review of over 20 years of data on attitudes to abortion published in October 2009 found that

“more than half the electorate in Australia and in Queensland support freedom of choice, and a further third support the availability of abortion in special

³⁵ Available through the Commission's website at <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>.

³⁶ Online at <http://www.lawreform.vic.gov.au/content/4-surveys-attitudes>.

circumstances... As far as attitudes are concerned, Queensland is no different from the rest of Australia.”³⁷

The review, conducted by Swinburne University researcher Dr Katharine Betts and published in *People and Place*, also found that on average only approximately 4% of the Australian community are opposed to abortion in every circumstance; Betts states that ‘Such opposition as there is is concentrated among a few religious groups and among people aged 75 and over.’³⁵

The second resource we highlight for the committee is *Attitudes to Abortion*, a survey we commissioned through Auspoll in May 2009.³⁸ The poll surveyed 1016 Queensland voters (segmented and weighted to be representative of population by gender, age and location) and included the following results:

Q: Are you aware that abortion is a crime in Queensland, for which a woman can be jailed for up to seven years?

A:

Yes: 35%

No: 65%

Q: In Queensland, abortion is still on the law books as a serious crime for which a woman can be jailed for up to seven years. A Queensland woman has been charged this year for an abortion offence, and faces possible time in jail. Which is closest to your view?

A:

The law should be changed so abortion is no longer a crime: 79%

Abortion should remain a criminal offence: 21%

These results are not too dissimilar to results from a September 2015 poll of NSW voters commissioned by Greens MLC Dr Mehreen Faruqi, which found 76% of respondents were unaware abortion was in the NSW Crimes Act, and that 73% supported its removal from the Act so it would no longer be criminalised.³⁹

³⁷ K Betts “Attitudes to Abortion: Queensland and Australia in the 21st Century” *People and Place* vol 17, 2009. Available online at <http://researchbank.swinburne.edu.au/vital/access/manager/Repository/swin:14400>

³⁸ Full polling report available to download from the Pro Choice Qld website at www.prochoiceqld.org.au/abortionfacts

³⁹ Polling available on Dr Faruqi’s website at <http://www.mehreenfaruqi.org.au/first-ever-polling-of-abortion-issues-in-nsw-shows-overwhelming-support-for-abortion-law-reform-and-exclusion-zones-across-political-party-affiliation/>

EXPERT GROUPS

The Royal Australian College of Obstetricians and Gynaecologists,⁴⁰ the Public Health Association of Australia,⁴¹ and Sexual Health and Family Planning Australia (now called the Family Planning Alliance Australia),⁴² all advocate for the decriminalisation of abortion and equity of access to abortion services.

A 2010 survey published in the Medical Journal of Australia found that 85% of practicing obstetricians and gynaecologists are not opposed to abortion, and 90% of these doctors agree that abortion should be available through the public health system in all states and territories.⁴³

The Australian Medical Association Queensland said in 2009 that current abortion laws are unclear and do not provide certainty for doctors or for women, stating that Queensland's "abortion laws are a barrier to a doctor's first duty - best patient care".⁴⁴

⁴⁰ S Elks and R Barrett "Peak medical body urges repeal" *The Australian*, 15 October 2010. <http://www.theaustralian.com.au/national-affairs/peak-medical-body-urges-law-repeal/story-fn59niix-1225938903649>

⁴¹ Public Health Association of Australia Women's Health Special Interest Group *Abortion in Australia: Public Health Perspectives* 3rd edition, 2005. Online at <http://www.nevdgp.org.au/info/topics/pregnancy/abortioninaust05.pdf>

⁴² *Time for a national sexual and reproductive health strategy for Australia, 2008*. Written by Sexual Health and Family Planning Australia, the Public Health Association of Australia, and the Australian Reproductive Health Alliance. Available online at <http://familyplanningallianceaustralia.org.au/wp-content/uploads/2015/09/Time-for-a-national-srh-strategy-call-to-action.pdf>.

⁴³ CM de Costa, DB Russell and M Carrette 'Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' *Medical Journal of Australia* (2010; 193 (1): 13-16). Online at <https://www.mja.com.au/journal/2010/193/1/views-and-practices-induced-abortion-among-australian-fellows-and-specialist>

⁴⁴ Australian Associated Press "Doctors call for abortion law certainty" *Brisbane Times*, 27 October 2010. Online at <http://www.brisbanetimes.com.au/queensland/doctors-call-for-abortion-law-certainty-20101027-173tt.html>

EVIDENCE: LEGISLATION IN OTHER AUSTRALIAN JURISDICTIONS

The Committee's information paper published as part of this inquiry includes a comprehensive overview of abortion law in other Australian jurisdictions, which we will not recreate here.

We would emphasise however that although abortion law is now different in each state and territory of Australia, all jurisdictions started with legislation modelled on the UK's 1861 *Offences Against The Person Act*.⁴⁵ Every jurisdiction in the country except Queensland and New South Wales have fully or partially reformed this legislation (as has the United Kingdom itself), starting with South Australia in 1969.⁴⁶

Queensland is one of only three jurisdictions in Australia where it remains possible for a woman to be charged for having an abortion.⁴⁷

There are parallel issues dealt with through legislation in some jurisdictions, including gestational limits, conscientious objection, parental notification for minors, exclusion zones, and referrals for counselling. The issue of legislated gestation issues is examined on page 36 of this submission, and counselling on page 47. Others are addressed here.

Again, we encourage the Committee to refer to the Victorian Law Reform Commission's comprehensive examination of these issues and their recommendations.

PARENTAL CONSENT OR NOTIFICATION REQUIREMENTS

In Queensland, it is accepted that minors may be capable of providing informed consent for medical procedures if they are sufficiently mature, using the Gillick competency model. This model is based on the United Kingdom's *Gillick v West Norfolk & Wisbech Area Health Authority* case, which has been approved by the High Court of Australia through a 1992 case known as *Marion's Case*.⁴⁸

Medical practitioners are able to provide contraception or abortion to young women aged 18 and under if they are deemed Gillick competent. This means they have a "sufficient understanding and

⁴⁵ N Cica, *Abortion Law in Australia* Parliament of Australia Library, Research Brief 1, 1998-1999. Online at http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp9899/99rp01.

⁴⁶ *Current law in Queensland and other Australian jurisdictions*, Information paper published by the Queensland Parliament Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, June 2016. Online at <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/AbortionLR-WRC-AB2016/14-infop-16June2016.pdf>.

⁴⁷ See for example C de Costa & H Douglas 'Explainer: Is abortion legal in Australia?' *The Conversation*, 30 September 2015. Online at <https://theconversation.com/explainer-is-abortion-legal-in-australia-48321>.

⁴⁸ *Can young people under 18 make their own decisions?* Fact sheet by the Youth Advocacy Centre, online at <http://www.yac.net.au/wp-content/uploads/2012/10/Can-YP-make-their-own-decisions.pdf>.

intelligence to enable him or her to understand fully what is proposed".⁴⁹ Practitioners are able to make this assessment on a case by case basis, often using the HEADSSS assessment.⁵⁰

Practitioners may encourage a young person seeking access to contraception or abortion to involve her parents or guardians, but when a competent young person refuses to include them in her consultation or treatment this must be respected. Where parents or guardians are involved it is important that the medical consultation allows space for the young person's consent to be discussed without a parent or guardian present, in order to manage potential issues of coercion.

While a parent or legal guardian generally would have legal authority to consent to most treatment on behalf of a young person deemed not Gillick competent, termination of pregnancy generally requires a court, acting in the best interests of the young person, to authorise the treatment in Queensland.⁵¹ As such a young person's parents are not able to consent to a termination of pregnancy on her behalf.

The law in Western Australia stipulates that a young woman aged under 16 must meet additional requirements to access a termination of pregnancy:

*Either a custodial parent of the minor must have been informed that an abortion is being considered and given the opportunity to participate in counselling, or an order from the Children's Court of Western Australia must be obtained dispensing with the requirement to inform and include the custodial parent in the process.*⁵²

A review into the workings of the WA law, published in 2002 by the state health department, found that in the four years to 2002, 26 applications to the Children's Court for an order had been made, and all had been approved – ie, the requirement for parental notification had been waived, proving that when young people seek to avoid parental involvement, authorities recognise there is just cause for this approach. The review states:

*Reasons given for granting an order to exclude custodial parents from being informed of the intended abortion were varied and included fears of violence, retribution, cultural and religious reasons.*⁴⁹

The review goes on to note that:

Concerns were raised that although the Children's Court procedures were working well for urban dwelling dependant minors, this may not be the case for all rural and

⁴⁹ *Gillick v. West Norfolk & Wisbech Area Health Authority* (1985) 3AU ER 402.

⁵⁰ An overview of the HEADSSS assessment tool is available on the website of the Royal Children's Hospital Melbourne, at http://www.rch.org.au/clinicalguide/guideline_index/Engaging_with_and_assessing_the_adolescent_patient/#headds.

⁵¹ *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy* p11. Queensland Health, 2013. Available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

⁵² *Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion, as introduced by the Acts Amendment (Abortion) Act 1998*. Western Australian Department of Health, June 2002, p25. Online at <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>.

regional areas. One example cited is that it is particularly difficult for dependant minors in far north Western Australia, where the magistrates visit only once every four weeks, to make timely applications. Other examples were provided in relation to difficulties that minors, without the benefit of a female custodial parent, may experience if they are from a culture where men are not traditionally involved in issues which are seen as “women’s business”. Additionally, minors in some areas do not have knowledge of legal aid services to assist them in the legal processes.

It is our position that similar barriers would apply in Queensland were a parental notification clause to be legislated as part of the reform of abortion law and we do not therefore support the inclusion of any such requirement.

In support of this, we also submit that the Victorian Law Reform Commission, which examined the issue of parental notification and consent in 2008, and found that:

‘The existing law governing consent and confidentiality for young people is adequate. No further legislative reform is required.’⁵³

In addition, most young women involve a parent already without such a legislative requirement. Research from the UK in 2005 found that over 70% of young women aged under 16 presenting to abortion services had informed one or both of their parents of the pregnancy and their decision, and that reasons given for not informing a parent had included fear of reactions or repercussions.⁵⁴

CONSCIENTIOUS OBJECTION FOR MEDICAL PROFESSIONALS

Children by Choice respects the right of individuals to hold their own values and beliefs in regards to abortion and would therefore support a conscientious objection clause similar to Victoria’s, where practitioners whose values do not support are required to refer onwards. We note that this legislative requirement, though heavily protested by anti-abortion groups as being ‘coercive’, is in line with the advice the Australian Medical Association provides to its members around conscientious objection:

- *inform your patient of your objection, preferably in advance or as soon as practicable;*
- *continue to treat your patient with dignity and respect, even if you object to the treatment or procedure they are seeking;*

⁵³ *Law of Abortion: Final Report* Victorian Law Reform Commission, Melbourne, 2008, p136. Online at the Commission’s website at <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>.

⁵⁴ *Abortion and young women: issues of confidentiality* Marie Stopes International United Kingdom, London, 2005. Online at <http://www.shnwales.org.uk/Documents/485/Abortion%20%26%20young%20women%2C%20issues%20of%20confidentiality%20Marie%20Stopes.pdf>.

- *refrain from expressing your own personal beliefs to your patient in a way that may cause them distress; and*
- *always provide medically appropriate treatment in an emergency situation, even if that treatment conflicts with the doctor's personal beliefs and values.*⁵⁵

If a conscientious objection clause is legislated in Queensland it must have the explicit exception that where a woman's life is in immediate danger, a practitioner should not be able to object to performing or being involved in a termination procedure. These situations are exceedingly rare but do arise, and it is vital that women's lives are prioritised over the moral objections of clinicians and support staff.

Ideally, we would like a legislated requirement for public disclosure for conscientious objectors in general practice. This could be achieved by a waiting room sign and information on the practice's website to let patients know that 'Doctor A' or 'Practice B' does not refer for abortion. This would allow doctors to practice in according to their conscience, while also allowing a woman considering her options to choose a practitioner who will be responsive to her needs. Forcing her to 'shop around' for a non-objector prioritises doctors' value systems over her right to respectful, accessible and timely information and care; she should not have to undergo additional appointments to find a doctor who will assist her with her options as this adds to the cost and timeframe of her decision making and service access. Clients of Children by Choice who have unknowingly made appointments with objector doctors have also reported being lectured about their options; this can be very distressing for the women involved, and a lack of public disclosure certainly provides anti-abortion doctors with the opportunity to do this.

A survey of Australian GPs in 2004 found that 26% of Queensland GPs self-identify as being anti-abortion.⁵⁶ Some doctors are quite open about using their consultations with pregnant women to attempt to convince them to continue pregnancies despite their patient's express wish for termination: see for example the website of the Victorian group 'Doctors Conscience', who refuse to comply with the legislative requirement for referral,⁵⁷ or this excerpt from a recent article by a doctor on abortion provision:

"As I began working in general practice, I knew that one day soon I'd be forced to balance a patient's request for an abortion against my strongly-held religious belief, so I sought advice from my church leaders. Everyone at church was unanimous and told me that it was my moral duty to stop women from having abortions. I wasn't convinced that this issue was as black and white as they portrayed, so I spoke with a trusted medical colleague and asked how she handled patient requests for abortion.

⁵⁵ *Conscientious Objection* Policy Statement, Australian Medical Association, 2013. Online at <https://ama.com.au/position-statement/conscientious-objection-2013>.

⁵⁶ *General Practitioners: Attitudes to Abortion* Prepared by Quantum Market Research and Marie Stopes International Australia, November 2004.

⁵⁷ The *Doctors Conscience* website is available at <http://www.doctorsconscience.org/>.

She declared it was her obligation to speak up for the unborn fetus and prevent any abortions from happening. Her opinion didn't stray too far from my church leaders' advice, but she revealed to me her Three Step Plan on influencing women.

Step 1 — Gently coax the patient with phrases like “there's always a way of raising a child”, or “you can always adopt out your child”.

Step 2 — Be more forceful by saying “you'll feel guilty for the rest of your life”, “don't be so selfish”, or “I can't believe you want to kill your own child”.

Step 3 — If the patient still wouldn't change her mind, she'd put her foot down and tell her that she disagreed wholeheartedly with abortion. She would refuse to treat them any further and ask them to see another GP with less morals.”⁵⁸

Doctors like this are still technically complying with the conscientious objector clause but at cost to their patients.

The Queensland Health Maternity and Neonatal Guideline for the Therapeutic Termination of Pregnancy also has some excellent practice recommendations around conscientious objection,⁵⁹ although as stated earlier in this submission, the Guideline is in varying states of implementation around Queensland so these recommendations are not always adhered to.

EXCLUSION ZONES

In the past three years, Victoria, Tasmania and the Australian Capital Territory have all passed and enacted legislation establishing exclusion zones around abortion provider premises.⁶⁰

Creating exclusion zones to protect patients and employees of pregnancy termination services from offensive and obstructive behaviour by protesters is an important and necessary initiative. These measures aim to prevent that behaviour while not impinging people's right to protest via a range of usual protest means. We support the right to protest, but firmly believe that the appropriate place to protest abortion law is outside the parliament, not outside a health service where the presence of vocal protesters can be distressing and intimidating for women and staff.

⁵⁸ Dr B McKay 'How my patients changed my mind about abortion' *News.com.au*, 13 May 2016. Online at <http://www.news.com.au/lifestyle/parenting/babies/how-my-patients-changed-my-mind-about-abortion/news-story/f1755873541cfc919f9921c9497a4f3b>.

⁵⁹ *Queensland Maternity and Neonatal Clinical Guideline: Therapeutic Termination of Pregnancy*. Queensland Health, 2013. Available on the Queensland Health website at <https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf>.

⁶⁰ *Current law in Queensland and other Australian jurisdictions*, information paper published by the Queensland Parliament Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, June 2016. Online at <https://www.parliament.qld.gov.au/documents/committees/HCDSDVFVPC/2016/AbortionLR-WRC-AB2016/14-infop-16June2016.pdf>.

Most providers of pregnancy termination services have extensive experience with protestors being obstructive, abusive and violent toward patients, their support people, staff and passers-by, as this 2016 article from The Age on the Victorian legislation illustrates:

Laws passed last year making it illegal to harass people within 150-metres of abortion providers came into effect on Monday.

For the first time in 25 years, the group of anti-abortion protesters who have picketed the Wellington Parade abortion clinic six days a week were absent and women were able to enter the building without first being forced to run the gauntlet.

"Usually we have patients coming in who are crying, we may have partners who are angry, we might have children who are upset," clinical psychologist Susie Allanson said on Monday. "Today has been delightfully uneventful." ⁶¹

The Guardian reported in 2014 that the patients of one regional NSW abortion provider had 'ended up self harming or even attempted suicide because of harassment from protesters', who have gathered every day the clinic operates for more than ten years.⁶²

Many clients of Children by Choice anecdotally report concerns about their safety and privacy due to harassment by protesters outside clinics.

We strongly recommend legislated exclusion zones around abortion providing premises in Queensland to protect the staff, patients and support people using those services.

⁶¹ B Donnelly 'Women avoid pro-life protesters for the first time in decades' *The Age*, 2 May 2016. Online at <http://www.theage.com.au/victoria/women-avoid-prolife-protesters-for-the-first-time-in-decades-20160502-gok1gl.html>.

⁶² M Davey 'Albury's only abortion clinic: protests 'push women to point of self-harm' *The Guardian Australia*, 9 December 2014. Online at <https://www.theguardian.com/world/2014/dec/09/women-seeking-abortions-harassed-by-protesters-to-point-of-suicide>.

EVIDENCE: LATER GESTATION ABORTIONS

LEGISLATED GETATIONAL LIMITS IN OTHER AUSTRALIAN JURISDICTIONS

Three states have some type of gestational limit imposed through legislation: Tasmania, Victoria and Western Australia. In Tasmania and Victoria, the legislation allows for abortion on request to a certain point in pregnancy (16 weeks in Tasmania and 24 weeks in Victoria), and after that point with the approval of two doctors.⁶³

In Western Australia, two medical practitioners from a panel of six appointed by the Minister for Health have to approve a termination after 20 weeks gestation, on the grounds that the pregnant woman or her fetus has a severe enough medical condition to justify the procedure. These decisions are final and no appeal process exists. In addition, only one hospital in the state has been approved by the Minister to provide these procedures.⁶⁴

It is the position of Children by Choice that if a staged process to law reform is to be pursued and a gestational limit legislated, that the model followed should be Victoria's, in terms of the limit imposed and the conditions to be met for terminations after this time.

As stated earlier in this submission, many severe fetal anomalies, including those incompatible with life, are not able to diagnosed until the mid-pregnancy scan, generally provided at around 18-20 weeks gestation. In some cases, additional testing will need to be carried out in order to provide an accurate diagnosis. Depending on a pregnant woman's location and her model of antenatal care, this could take days or weeks. A limit of 24 weeks for termination access is more compassionate in these cases as it does not force women and couples to make extremely quick decisions in relation to a negative or unclear fetal diagnosis.

In addition, the WA requirement for a panel to meet and discuss cases seeking approval after a gestational limit has been passed creates further delays in accessing services where approved.⁶¹

A 2002 review conducted and published by the WA Department of Health into the impact of that state's post-20 week legislative requirements included the following:

When a diagnosis of foetal abnormality has been made a few days prior to 20-weeks, women have reported the following experiences:

- *a feeling that their decision to terminate the pregnancy is pressured by a time factor, as once the pregnancy is deemed over 20-weeks the decision is no longer theirs alone;*

⁶³ *Current law in Queensland and other Australian jurisdictions*, information paper published by the Queensland Parliament Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, June 2016. Online at <https://www.parliament.qld.gov.au/documents/committees/HCDSDVFPC/2016/AbortionLR-WRC-AB2016/14-infop-16June2016.pdf>.

⁶⁴ *Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion, as introduced by the Acts Amendment (Abortion) Act 1998*. Western Australian Department of Health, June 2002. Online at <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>.

- *the situation of these women and their ability to make a decision was seen to be aggravated by their perceived sense of uncertainty as to whether they will have access to termination once the 20-weeks has passed;*
- *a diminished sense of personal control in making important life decisions;*
- *concerns that decisions may be made in haste or be fear based, with potential psychological implications; and*
- *concerns about the subjectivity of the panel decision or possibility of judgment. There were also reports of emotional distress following diagnosis of foetal abnormality inhibiting the ability to reach an informed decision.*

When the Ministerially appointed panel declines a request for an abortion post 20-weeks the following sequels were reported to the review:

- *limited psychological support/counselling available;*
- *inadequate funding for counselling allocated for women whose abortions are declined;*
- *unique issues of guilt and grief associated with continuing a pregnancy following a declined request for abortion; and*
- *conflicting feelings in utilising counselling through KEMH when the request has been declined by the panel at KEMH.⁶⁵*

LATER GESTATION ABORTION RATE

Much of the commentary surrounding this proposed legislation has focussed on ‘late term abortion’, claims the numbers of these procedures will increase under decriminalisation, and that there will be no regulation of such procedures if criminal abortion law is repealed.

The phrase ‘late term abortion’ has no accepted medical definition and is generally used to provoke an emotional response. Although individual interpretations of the phrase differ, in the context of the Queensland debate it appears to most often refer to abortion performed at 20 weeks gestation or greater.

It is critical to recognise that only a small proportion of terminations are carried out at 20 weeks gestation or later, and that the vast majority at this gestation in Australia are performed in hospitals.

⁶⁵*Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion, as introduced by the Acts Amendment (Abortion) Act 1998.* Western Australian Department of Health, June 2002, p22. Online at <http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>

A report by the Australian Institute of Health and Welfare estimated in 2005 that 0.7% of all abortions nationally were performed at or over 20 weeks gestation.⁶⁶ Data from South Australia shows that in 2013, 2.0% of the state's terminations were performed at or over 20 weeks gestation.⁶⁷ For more information on abortion rates and estimates see page 53 of this submission.

To the best of our knowledge, in the entire country only one private clinic exists which provides abortion between 20 and 24 weeks gestation. All other procedures at these gestations or above are provided in public or private hospitals.

It is our understanding that of the patients accessing services at this gestation in this clinic in Victoria, around half travel from interstate for the procedure. It is also our understanding that procedures at 20 to 24 weeks gestation make up around 0.5% of all abortions nationally by this provider (through 17 clinics in 5 states and territories).

We provide over 100 referrals interstate for our clients each year. Around half of these referrals are due to gestational access issues.

While no national data on abortion procedures exist, there is a Medicare item number available for use in second trimester terminations (beyond 13-14 weeks gestation), item 16525:

'MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease.'

16525 is the item code attached to termination procedures carried out in private abortion clinics after 13 weeks gestation.

Data from the Medicare website indicates that from 2005 to 2015, there were 8154 rebates provided nationally under this item number:⁶⁸

⁶⁶ N Grayson, J Hargreaves & EA Sullivan 2005 *Use of routinely collected national data sets for reporting on induced abortion in Australia*. AIHW Cat. No. PER 30. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 17). Online at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442458945>.

⁶⁷ W Scheil, K Jolly, J Scott, B Catcheside, L Sage, R Kennare *Pregnancy Outcome in South Australia 2013*. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2015. Online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/62e89b004aca1fd38486dc0b65544981/15116.1+Pregnancy+Outcomes+Report+A4-FINAL.pdf?MOD=AJPERES&CACHEID=62e89b004aca1fd38486dc0b65544981>.

⁶⁸ Data extracted from the website of the Department of Human Services at http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp; search results as reported on http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?PROGRAM=%2Fstatistics%2Fmbs_item_standard_report&DRILL=ag&group=16525&VAR=services&STAT=count&RPT_FMT=by+time+period+and+state&P_TYPE=calyear&START_DT=200501&END_DT=201512



You are here: [Statistics](#) > [Medicare Item Reports](#) > Report processed

Requested Medicare items processed from January 2005 to December 2015

Click on the item hyperlinks below to get the patient age/gender breakdown of that particular item

Item	Calendar Year	State					Total	
		NSW/ACT	VIC/TAS	QLD	SA/NT	WA		
		Services	Services	Services	Services	Services		
16525	2005	249	307		120	62	32	770
	2006	224	307		116	72	58	777
	2007	247	307		114	67	55	790
	2008	245	328		106	70	45	794
	2009	220	304		123	59	40	746
	2010	216	275		128	54	36	709
	2011	224	259		110	54	42	689
	2012	247	294		101	54	26	722
	2013	213	301		113	70	47	744
	2014	217	260		128	55	42	702
	2015	230	281		111	49	40	711
	Total	2,532	3,223		1,270	666	463	8,154

As shown in the table above, in all states except WA, the number of rebates provided for these procedures has fallen slightly over this time period, including Tasmania and Victoria where abortion law reform has occurred during this timeframe. While these statistics do not include procedures offered in public hospitals, given the data which we have provided earlier in this submission about the low numbers of terminations which occur in hospitals, it is our contention that the Medicare statistics demonstrate the low level of demand for these service irrespective of the legal framework around abortion in each state.

It is often claimed by anti-abortion groups that the numbers of 'late term abortions' in Victoria has increased by ridiculous numbers since law reform occurred in 2008. The Medicare data above shows that in the private sector this is certainly not the case; figures supplied by the *2012 and 2013 Victoria's Mothers, Babies and Children* report released this year provide additional proof that these claims are completely unsubstantiated.⁶⁹

The report includes data from 2007 to 2013 on perinatal deaths ('stillbirths and live births with only brief survival' at 20 weeks gestation or higher), both related and not related to terminations of pregnancy. **The data for perinatal deaths for termination figures (shown overleaf) do not show steep increases over this seven year period, despite the anti-choice claims that this has occurred since law reform in 2008.** There was a spike in these numbers in 2009, but they fell again in 2010 and fell further in 2011. There was a spike in numbers of private clinic abortions in 2009 in Queensland as well (see page 55) so the 2009 figures are clearly not able to be attributed to changes in Victorian law.

Terminations of pregnancy at this gestation in Victoria are classified as being for either congenital abnormality or for psychosocial indications (which in essence means everything else, including maternal health complications, extreme violence, and other catastrophic life circumstances).

⁶⁹ The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2016) *2012 and 2013 Victoria's Mothers, Babies and Children (Section 2: Data, tables and figures)* p 196; Department of Health and Human Services, Victorian Government, Melbourne; May 2016.

Other characteristics of perinatal mortality

Table 13.39: Trends in maternal and infant characteristics relating to perinatal deaths (PND), Victoria 2007–2013 (%)

	Perinatal deaths not relating to termination of pregnancy for CA or MPI						Termination of pregnancy for suspected or confirmed CA						Termination of pregnancy for maternal psychosocial indications (MPI)								
	2007	2008	2009	2010	2011	2012	2013	2007	2008	2009	2010	2011	2012	2013	2007	2008	2009	2010	2011	2012	2013
	n=568	n=569	n=636	n=607	n=550	n=539	n=595	n=181	n=150	n=196	n=175	n=195	n=198	n=179	n=164	n=170	n=214	n=191	n=183	n=132	n=179
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Maternal age																					
< 20 years	5.8	4.9	6.1	5.1	5.6	2.8	6.6	2.2	2.0	2.0	2.3	2.6	2.0	0.6	38.4	36.5	26.6	28.8	31.7	25.8	21.8
20–24 years	13.3	14.4	13.8	13.3	12.2	12.4	12.3	12.7	13.3	7.6	12.0	8.2	9.1	5.6	29.3	30.9	32.7	31.4	25.7	28.0	31.8
25–29 years	25.3	25.8	24.2	25.7	25.3	24.5	25.5	25.4	32.0	21.9	26.9	27.7	26.8	22.9	15.2	12.4	19.6	19.4	21.9	17.4	14.5
30–34 years	28.3	14.4	24.1	28.3	28.9	32.1	26.9	26.0	26.0	42.3	31.4	30.3	33.3	37.4	5.5	9.0	9.3	11.0	12.0	13.6	16.2
35–39 years	21.9	25.8	23.9	19.8	22.2	20.8	22.4	28.7	21.3	23.5	21.7	25.6	20.7	24.6	6.1	4.5	7.5	6.3	4.4	8.3	11.7
≥ 40 years	5.3	6.7	7.9	7.1	5.5	7.4	6.4	5.0	5.3	2.0	5.1	5.6	8.1	8.9	2.4	3.4	4.2	2.1	4.3	6.0	2.8
Unknown	0.0	7.9	0.0	0.7	0.4	0.0	0.0	0.0	0.0	0.5	0.6	0.0	0.0	0.0	3.0	3.4	0.0	1.0	0.0	0.8	1.1
Place of residence																					
Victoria	97.5	97.7	95.3	98.2	96.5	96.7	96.1	94.5	95.3	87.8	92.0	90.8	96.0	98.3	35.4	37.1	46.3	48.7	45.9	48.5	43.6
Interstate	2.1	2.1	4.7	1.8	3.5	3.2	3.9	4.4	3.3	12.2	8.0	9.2	4.0	1.7	51.8	49.4	53.7	48.2	45.9	50.0	49.2
Overseas	0.4	0.2	0.0	0.0	0.0	0.0	0.0	0.6	0.7	0.0	0.0	0.0	0.0	0.0	10.4	11.2	0.0	3.1	8.2	1.5	7.3
Unknown	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.6	0.7	0.0	0.0	0.0	0.0	0.0	2.4	2.2	0.0	0.0	0.0	0.0	0

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2016) *2012 and 2013 Victoria's Mothers, Babies and Children (Section 2: Data, tables and figures)* p 196; Department of Health and Human Services, Victorian Government, Melbourne; May 2016. Online at <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/mothers-babies-children-report-2012-13>

In addition, we draw the Committee’s attention to the place of residence for women having these procedures, in the table on the previous page. The highest proportion of interstate residents over 7 years for perinatal deaths not related to pregnancy termination was 4.7% of the total; for women terminating pregnancies for ‘psychosocial’ indications, interstate patients made up 45.9% to 53.7% over the 7 years. These would include Queensland women travelling for the procedure as they are unable to access it in Queensland.

WHO HAS SECOND TRIMESTER ABORTIONS?

Our clients who present into the second trimester seeking abortion services are not doing so because they initially wanted to continue the pregnancy and have since changed their minds, or because they have known about the pregnancy for a long time but just haven’t bothered to make a decision yet.

Clients in this group generally have one or more of the following factors as part of their circumstances:

- They are very young (under 14) and therefore haven’t recognised the pregnancy earlier;
- They live with high levels of violence and control, and have been unable to seek support without their partner knowing until now;
- They are in rural and remote areas of the state and have experienced long delays in appointment times, delaying the confirmation of the pregnancy; or
- The pregnancy is wanted but they have received a devastating fetal diagnosis, maternal health complication, or other life-changes circumstances have arisen.

VIOLENCE, PREGNANCY, AND LATER PRESENTATION

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.

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.⁷⁰

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.⁷¹ 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-

⁷⁰ 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/.

⁷¹ 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).

controlling behaviours, from contraceptive interference through to forced sex and rape in relationships.

It is important to note that some women in violent relationships will experience coerced abortion; although there is some available evidence relating to poor mental health outcomes for women in these circumstances,⁷² 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. Abortion providers screen for coercion as part of gaining informed consent for the procedure; this is one of the reasons partners are not allowed to accompany women through the entirety of the process.

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.⁷³ There is no reason to suggest the results would be different in an Australian study of the same type, although it has not been replicated here so no local data exists.

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.

The following table shows the difference in gestation for contacts during 2014-15:

Gestation	Of our contacts reporting violence	Of our contacts not reporting violence
Under 6 weeks	7.7%	29.9%
6 to 11 weeks	52.6%	39.3%
12 to 15 weeks	19.0%	14.2%
16 to 19 weeks	17.2%	12.9%
20 weeks or more	3.5%	3.6%

⁷² 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>

⁷³ 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>.

LATER GESTATION TERMINATION FOR FETAL REASONS

Children by Choice is aware that specialist medical practitioners with extensive experience in this field, Dr Caroline de Costa and Dr Carol Portmann, are making submissions to this inquiry, and thoroughly endorse the contents and recommendations of those submissions.

Pregnant women in Queensland and indeed across Australia are now offered a variety of screenings at different points in pregnancy as a matter of routine. Most women will avail themselves of this opportunity. 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.

Pregnancies terminated at 20 weeks gestation or later because of fetal anomalies make up a small number of all terminations. These pregnancies have been diagnosed with severe health problems, largely those deemed 'incompatible with life' – ie, they have no chance in resulting in the birth of a healthy baby. Despite our best advances in medical care, there are conditions which are not treatable in newborns, as Professor Caroline de Costa explains:

For example where the fetus is diagnosed with a severe congenital heart condition or absent kidneys or missing large parts of the brain: while in the uterus the mother's heart or kidneys do the work for the fetus, but once born there is no alternative but to allow nature to take its course.

The alternative [to intentionally ending the pregnancy] is for the pregnancy to continue to term with the parents knowing there is no hope for survival of the infant when born, and have the baby die at that point. It is not possible to transplant kidneys into newborns or to successfully perform surgery for certain kinds of heart abnormalities, or for anencephaly where the brain fails to develop.

Women making the decision to end much-wanted pregnancies in these tragic situations deserve the best possible care and support in their local hospital. Current abortion law and the implication for practice does not help achieve this.

In addition, there has been some disturbing coverage of this issue by some Queensland media following a Question on Notice from Cleveland MP Mark Robinson to Health Minister Cameron Dick, regarding the numbers of 'babies born alive' after abortion procedures at 20 weeks gestation in Queensland hospitals.⁷⁴

One article claimed 'no care was rendered' in these cases and that babies were 'left to die' following termination procedures in Queensland 'clinics'.⁷⁵

⁷⁴ Question on Notice No 779, asked on 11 May 2016. Answer tabled on 10 June 2016. Online at <https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2016/779-2016.pdf>.

⁷⁵ J Bavas 'Rise in Queensland babies surviving late-term abortions and being left to die, figures show' *ABC News*, 16 June 2016. Online at <http://www.abc.net.au/news/2016-06-15/babies-of-late-terminations-left-to-die-without-care/7512618>.

This piece was misleading on several counts. Minister Dick stated specifically in his tabled response to Mr Robinson's Question on Notice that all terminations at this gestation in Queensland occur in hospitals, not clinics. His statement also included that:

Care of a baby following birth is individualised to the specific circumstances, and informed by the choices of the family. In line with clinical guidelines, a range of pre and post terminal cares are provided. These may include physiological support of the baby to relieve potential for suffering, and psychological support for families including bereavement counselling.⁷⁶

As stated earlier, the majority of terminations performed at this gestation are for devastating fetal anomalies, many of which are categorised as 'incompatible with life'. There is no chance of these pregnancies resulting in the birth of a healthy baby. While the gestational age may align with the general point of 'viability' in some cases – 24 weeks, for example – these are not viable pregnancies.

Dr Carol Portmann is a maternal-fetal medicine specialist with many years of experience providing termination in both the public and private system, including later gestation termination. In response to the article mentioned above, she writes:

The [ABC] article was uninformed and written in a manner deliberately designed to be inflammatory and to evoke negative public opinion without providing any insight or information.

I choose two specific words/phrases used - "clinics" and "left to die". These words/phrases were used with no reasonable reference or information in the article.

Clinics would imply that these women were treated outside of a hospital, without hospital governance. There is no "clinic" in Queensland that is accredited to provide second trimester medical termination of pregnancy where live birth may occur. The private, non hospital associated clinics/day surgeries do not provide termination of pregnancy above 20 weeks of gestation, and do not use second trimester medical termination of pregnancy methods. All second trimester medical terminations of pregnancy occur in registered/credentialed hospitals be they private or public. In all cases, the care is provided by credentialed, trained Obstetricians under the oversight of medical administration.

Let us look at the phrases "born alive" and "let them die". Any baby born with a heartbeat at any gestation is "born alive". This does not mean that they show vigorous signs of life – babies less than 22 weeks do not breath, cry or show distress (in the majority of situations). They have a heart beat but that is all. These babies cannot survive – they are too premature, too underdeveloped. If these babies are born alive, they are treated with the same respect as any baby born at these stages. In terms of palliative care, this mostly means treating them with respect. To try to do anything to prolong their lives would be far more inhumane than to

⁷⁶ Question on Notice No 779, asked on 11 May 2016. Answer tabled on 10 June 2016. Online at <https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2016/779-2016.pdf>.

allow them to pass away peacefully and respectfully. Studies in Australia and overseas would suggest that less than 5% of medical terminations of pregnancy under 22 weeks should result in a live birth.

In some circumstances, a termination of pregnancy may occur after 22 weeks of pregnancy, in situations where the baby has severe and significant abnormalities. In many circumstances, the mother is offered a procedure where the baby is given medication to allow the baby to pass away peacefully before birth. In situations where this is not done, and the baby is born alive, the baby is provided with whatever is needed to allow them to pass away without distress or pain. This is usually in circumstances where the baby has severe physical problems that cannot be treated. These situations are unusual, uncommon and subject to significant medical and hospital oversight. In all cases, a number of doctors and other health care providers are involved to ensure that termination of pregnancy is legal, reasonable, ethical and appropriate for the woman and the circumstances.

The existence of termination of pregnancy in the criminal code complicates the care of women as it adds a layer of legal complexity on top of what is essentially a medical matter that should be managed between women and their health care providers. It is reasonable, appropriate and necessary for this debate to occur, and for termination of pregnancy to be placed in the hands of women and health care providers. Articles such as the one referred to here do not inform the public, they inflame and exploit uninformed public opinion to obscure the facts and distract from the issues that must be addressed with reason, information and compassion.

In support of this statement, we provide the following statistics from *Victoria's Mothers, Babies and Children report*, on perinatal deaths as a result of termination from 2012 and 2013 (the most recent year for which figures are available).⁷⁷ The report defines perinatal deaths as:

Perinatal deaths refer to stillbirths and live births with only brief survival and are grouped on assumption that similar factors are associated with these losses.

CCOPMM [Consultative Council on Obstetric and Paediatric Mortality and Morbidity] defines perinatal death to include stillbirth and neonatal deaths within 28 days of birth of infants of gestation \geq 20 weeks gestation or if gestation is unknown, of birth weight \geq 400 g.⁷⁶

⁷⁷ The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (2016) *2012 and 2013 Victoria's Mothers, Babies and Children (Section 2: Data, tables and figures)* p 181; Department of Health and Human Services, Victorian Government, Melbourne; May 2016.

Table 13.27: Perinatal deaths as a result of terminations in pregnancy, Victoria 2012

Cause of death PSANZ PDC	Stillbirths (Fetal death)	Neonatal death	Total
	n	n	n
Termination for suspected or confirmed congenital abnormality	145	53	198
Terminations for psychosocial indications	132	0	132
Total	277	53	330

Table 13.28: Perinatal deaths as a result of terminations in pregnancy, Victoria 2013

Cause of death PSANZ PDC	Stillbirths (Fetal death)	Neonatal death	Total
	n	n	n
Termination for suspected or confirmed congenital abnormality	136	43	179
Terminations for psychosocial indications	179	0	179
Total	315	43	358

As the above tables show, terminations of pregnancy at this gestation in Victoria are classified as being for congenital abnormality or for psychosocial indications (which in essence means everything else, including maternal health complications, extreme violence, and a host of other catastrophic life circumstances). The only terminations at these gestation which resulted in ‘live birth’ were those performed for abnormalities – ie, as stated above, where there are serious fetal complications which make the pregnancy unviable.

EVIDENCE: COUNSELLING AND SUPPORT SERVICES FOR WOMEN

There is an important difference between informed consent counselling prior to a procedure and therapeutic decision making or pregnancy options counselling.

INFORMED CONSENT COUNSELLING

Informed consent counselling seeks to ensure that the patient understands the nature and the purpose of the abortion procedure, its alternatives, the possible complications, and the likelihood of these complications occurring. It also ascertains that the patient is making the decision voluntarily. As with other medical procedures, informed consent counselling is a standard part of public and private termination of pregnancy services in Queensland. The Queensland Health licensing framework for private day surgeries, the Clinical Services Capability Framework, and the companion manual v4.3 for termination clinics, require that clinics offering termination of pregnancy procedures should include informed consent counselling prior to procedure. The provision of informed consent counselling in the private arena is already guaranteed through the clinic license process. In the realm of public provision informed consent is also specified in the Queensland Health Therapeutic Termination of Pregnancy guideline.

GP providers of medical abortion are required to gain informed consent using a prescribed consent form developed as a suite of resources by MHealth, the licensed distributor of the medication. For these reasons it is unnecessary for this form of counselling to be included in any proposed legislative amendments.

THERAPEUTIC PREGNANCY OPTIONS COUNSELLING

Therapeutic or pregnancy options counselling is there to assist with decision making in relation to a pregnancy. It has similarities to other sorts of counselling, drawing on evidenced based therapeutic techniques and approaches as with other forms of therapeutic counselling. It is provided by professionals who have formal training in these techniques and approaches such as counsellors, psychologists and social workers. It is non-directive and woman centred where by the woman is supported to answer the dilemma presented by the pregnancy, with the assistance of the counsellor as facilitator and guide. It includes:

- the provision of accurate information about the options available to the woman in relation to those she may be considering;
- support to articulate her ethics and values that may be informing aspects of her decision making, not just in relation to the ethics of abortion but in relation to other ethical components of her contemplation shaped by her circumstances;
- problem solving barriers to preferred options;
- reality testing options being explored;
- post-decision support and referral; and

- plans for self-care.^{78 79}

It may include participation by the man involved in the pregnancy as well as other people in the woman's family and support network.

This distinction between informed consent counselling and therapeutic counselling has also caused confusion in other jurisdictions, particularly Western Australia, where there is a legislative requirement for 'counselling':

*The requirements to be met before the woman can give informed consent are that a medical practitioner must provide counselling on the medical risks of terminating the pregnancy and of carrying the pregnancy to term and must also provide an opportunity of referral for further counselling about matters relating to the woman's decision.*⁸⁰

A review into the WA framework, carried out in 2002 by the state health department, found that:

*The main problem encountered is that the term "counselling" in section 334(5)(a) is being interpreted as "psychological counselling" needing to be offered by a specialist counsellor. Consequently some women are being sent directly to counselling services with a belief that it is mandatory for them to do so in order to access abortion services. In fact, the counselling that women require in section 334(5)(a) is in relation to medical risks and must be provided directly by the medical practitioner.*⁶⁸

While informed consent counselling can and should form part of abortion provision (as it does with other medical procedures), this is already occurring as part of practice and therefore needs no additional legislative measure.

For the rest of this section of this submission, 'counselling' refers to therapeutic counselling.

The vast majority of women experiencing an unplanned pregnancy do not want or need counselling in order to help them come to a decision. Most involve the man in the pregnancy, close friends, and/or family members in their decision.

A 2006 study of Australian women who had experienced an unplanned pregnancy found that 75% did not wish to speak to a counsellor about their decision.⁸¹

⁷⁸ A Baker (1995) *Abortion and Options Counseling: a comprehensive reference* Published by Hope Clinic for Women; Granite City, Illinois, US.

⁷⁹ A C Perrucci (2012) *Decision assessment and counseling in abortion care: philosophy and practice* Roman and Littlefield Publishers; Lanham, Maryland, US.

⁸⁰ *Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code relating to abortion, as introduced by the Acts Amendment (Abortion) Act 1998.* Western Australian Department of Health, June 2002, p16. Online at

<http://www.health.wa.gov.au/publications/documents/ABORTIONREVIEWmaster180602.pdf>.

⁸¹ *What women want when faced with an unplanned pregnancy* Survey conducted by WebSurvey, commissioned by Marie Stopes International Australia; 2006, p 7. Online at <http://www.mariestopes.org.au/wp-content/uploads/2014/07/KeyFindings.pdf>

The Victorian Law Reform Commission's examination of a possible mandatory counselling requirement recommended against such a legislative measure, stating that:

It is difficult to determine the practical value of a statutory requirement to refer to counselling, since referrals can already be made and such a provision could not compel women to undertake counselling.

While a compulsory referral for counselling might have symbolic value, it does little to further the underlying values of the existing practice. It risks delving into areas of clinical judgment and patient autonomy that need not be disturbed by the law.

While counselling is important, it is a clinical matter best left to professional judgment based on a woman's particular circumstances. The commission therefore believes that the law should not include a requirement for compulsory counselling, or for compulsory referral to counselling.⁸²

The 2006 study also found that the 81% of respondents believed that it is important that pregnancy counsellors referred for all options, including abortion.⁸³

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.⁸⁴

Unfortunately this allows these organisations to provide inaccurate and sometimes intentionally-misleading information on abortion and its availability to women experiencing an unplanned or unwanted pregnancy. These services do not refer for abortion and often offer counselling by volunteer or unpaid counsellors without formal qualifications. Children by Choice has supported many women who have unknowingly contacted an anti-abortion 'pregnancy counselling service' and been distressed by the experience. The Victorian Law Reform Commission report found that there was 'sufficient community concern' on this issue to warrant addressing, stating in addition:

The commission encourages the Minister for Health to initiate the development of uniform standards of practice to inform pregnancy and abortion counselling services, and to encourage accountability and quality.⁸⁵

⁸² *Law of Abortion: Final Report* Victorian Law Reform Commission, Melbourne, 2008, p 126. Online at <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>.

⁸³ *What women want when faced with an unplanned pregnancy* Survey conducted by WebSurvey, commissioned by Marie Stopes International Australia; 2006, p 7. Online at <http://www.mariestopes.org.au/wp-content/uploads/2014/07/KeyFindings.pdf>

⁸⁴ *Transparent advertising and notification of pregnancy counselling services Bill 2005*: overview of the Inquiry by the Senate Community Affairs Legislation Committee is available on the federal parliament website at http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pregnancy_counselling/report/c01

⁸⁵ *Law of Abortion: Final Report* Victorian Law Reform Commission, Melbourne, 2008, p 138. Online at <http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf>.

POST ABORTION SUPPORT

Children by Choice offers support for women struggling after an abortion as part of our commitment to providing a holistic, client-centred, unbiased support service.

The numbers of women who will need this support after having an abortion is small. Contrary to claims from anti-abortion groups, there is no long term emotional harm created by abortion in the vast majority of cases.

The American Psychological Association's Taskforce on Mental Health and Abortion reviewed 20 years of research and studies into the psychological effects of abortion and released its final report in 2008. It found no difference in the psychological effect of terminating an unplanned pregnancy and carrying that pregnancy to term.⁸⁶

Reviews of studies into the issue have found that the legal and voluntary termination of a pregnancy rarely causes immediate or long-lasting negative psychological consequences in healthy women,⁷⁴ and that greater partner or parental support improves the psychological outcomes for women.⁸⁷

A number of indicators have been consistently identified as risk factors for adverse psychological outcomes after an abortion. These include:

- Perceptions of stigma, need for secrecy, and low social support for the abortion decision;
- Choosing abortion despite strongly held moral or religious objections to it;
- A prior history of mental health problems; and
- Characteristics of the pregnancy, including the extent to which the woman wanted and felt committed to it.⁷⁴

In our experience, women who may need support after an abortion include those who have chosen to end a wanted pregnancy due to a devastating fetal diagnosis or maternal health complication, and those who may have been pressured by a partner or a parent into terminating a pregnancy and felt like they had had no other choice.

It is our position that post abortion counselling and support needs to be freely available for the small numbers of women who may need it, but that this should not be mandatory. This support should be offered by genuine all options or pro-choice services, as the negative view of abortion and stigma perpetuated by anti-abortion services can cause even more damage to women already suffering, rather than providing any alleviation for it.

⁸⁶ American Psychological Association, Task Force on Mental Health and Abortion. *Report of the Task Force on Mental Health and Abortion*. Washington, 2008. Available online at <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>

⁸⁷ The Women's (Royal Women's Hospital Melbourne), *Will I feel OK after an abortion?* Fact sheet. Available online at <https://www.thewomens.org.au/health-information/unplanned-pregnancy-information/issues-you-might-be-thinking-about/will-i-feel-ok-after-an-abortion/>

EVIDENCE: ABORTION RISKS AND HEALTH OUTCOMES

Children by Choice is aware that the Committee has received several submissions warning of the harm caused to women by abortion, and that polling has been supplied showing 84% of Queensland voters think abortion causes physical and mental harm. This is not at all supported by evidence and is more indicative of the success of long term anti-abortion propaganda than it is of the reliable evidence base on health outcomes for women after abortion.

In Australia, where abortions are performed by highly qualified health care professionals in very hygienic conditions, a pregnancy termination is one of the safest medical procedures and complications are rare.⁸⁸

Campaigns and organisations making claims about the serious harm caused by abortion distort research and often make false or intentionally misleading claims about abortion.

One such example is the submission made to this inquiry from Dr Timothy Coyle of Cairns.⁸⁹ Dr Coyle states he has been a qualified doctor for 45 years and has been practising as a GP in Cairns for 36 years. His submission includes several pages of ‘evidence’ of the harm caused by abortion, beginning with this opening statement:

National statistics on abortion show that 10% of women undergoing induced abortion suffer from immediate complications, of which one-fifth (20%) were considered major. [2] [3]

Of the two sources he quotes to support this claim, the first is not only dated (1985), but is not even Australian; using ‘nationally’ in this context seems misleading. In addition, the source states quite clearly in the opening paragraph that “in only two per cent was this considered to be major”. The second reference cannot be found anywhere online (and has no publisher details or date and place of publication), but the first page of Google search results for this listing brings up an entire page of anti-abortion websites, only one of which is Australian. His entire submission is full of similarly problematic statements and dated overseas reference sources.

The three most often used myths in misinformation campaigns are that an abortion will affect a woman’s future fertility, that it causes breast cancer and that there are long-lasting psychological impacts of abortion.⁹⁰

Extensive evidence exists to show none of these are true.

⁸⁸ *Safe Abortion: Technical and Policy Guidance for Health Systems* World Health Organisation (2nd ed.), Geneva 2012 p21. Available online at http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

⁸⁹ Submission no 10, listed on the inquiry website at <https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2016/AbortionLR-WRC-AB2016/submissions/010.pdf>.

⁹⁰ See for example the Victorian Law Reform Commission’s *Law of Abortion: Final Report* Melbourne 2008, Chapter 8, p117, at <http://www.lawreform.vic.gov.au/all-projects/abortion>. See also ‘Abortion: Did you know?’ on the website of Cherish Life (formerly known as Queensland Right To Life Association) at <http://www.cherishlife.org.au/Resource-Areas/Abortion/85>

The Royal College of Obstetricians and Gynaecologists (UK) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists state that “women who have an uncomplicated termination are not at an increased risk of being infertile in the future.”⁹¹

Organisations who reject a link between abortion and breast cancer include the World Health Organisation,⁹² the Australian Medical Association,⁹³ the Royal College of Obstetricians and Gynaecologists,⁹⁴ the Australian Cancer Council,⁹⁵ the American Cancer Society,⁹⁶ the Breast Cancer Network of Australia,⁹⁷ the National Breast and Ovarian Cancer Centre (US),⁹⁸ and the National Cancer Institute (US).⁹⁹

'Post Abortion Syndrome' is a term used by the anti-choice lobby but has not been widely accepted; the term is not recognised by the American Psychological Association or the American Psychiatric Association as a condition, nor is it found in the Diagnostic and Statistical Manual of Mental Disorders or the World Health Organisation's International Classification of Diseases.

The American Psychological Association's Taskforce on Mental Health and Abortion reviewed 20 years of research and studies into the psychological effects of abortion in 2008 and found that:

*"[T]he prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for non-therapeutic reasons as consistent with normative rates of comparable mental health problems in the general population of women in the United States."*¹⁰⁰

⁹¹ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A resource for health professionals* November 2005. Online at http://www.ranzcog.edu.au/editions/doc_view/480-termination-of-pregnancy-a-resource-for-health-professionals.html

⁹² World Health Organisation *Induced abortion does not increase the risk of breast cancer* Fact Sheet 240, June 2000. Reproduced on the Australian Women's Health Network website at <http://awhn.org.au/abortion-and-breast-cancer-policy/>

⁹³ 'AMA attacks Eric Abetz comments linking abortion to breast cancer' *The Guardian Australia*, 8 August 2014. Online at <https://www.theguardian.com/world/2014/aug/08/ama-attacks-eric-abetz-comments-linking-abortion-to-breast-cancer>

⁹⁴ *Briefing note: Scientific information on abortion* Royal College of Obstetricians & Gynaecologists (United Kingdom), January 2008. Online at <https://www.rcog.org.uk/en/news/campaigns-and-opinions/human-fertilisation-and-embryology-bill/briefing-note-scientific-information-on-abortion/>

⁹⁵ Cancer Council Australia Fact Sheet *Breast cancer*. Available online at <http://www.cancer.org.au/aboutcancer/cancertypes/breastcancer.htm>.

⁹⁶ *Is abortion linked to breast cancer?* Fact sheet by American Cancer Society, June 2014. Online at <http://www.cancer.org/cancer/breastcancer/moreinformation/is-abortion-linked-to-breast-cancer>

⁹⁷ *Myths about breast cancer* Fact sheet by the Breast Cancer Network of Australia. Online at <https://www.bcna.org.au/breast-health-awareness/myths-about-breast-cancer/>

⁹⁸ National Breast and Ovarian Cancer Centre. *Breast cancer risk factors: a review of the evidence*. National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2009. Available online at http://canceraustralia.gov.au/sites/default/files/publications/breast-cancer-risk-factors-review-evidence/pdf/rfrw-breast-cancer-risk-factors-a-review-of-the-evidence_1.15.pdf

⁹⁹ National Cancer Institute Fact Sheet *Abortion, Miscarriage and Breast Cancer Risk*. Available online at <http://www.cancer.gov/types/breast/abortion-miscarriage-risk>.

¹⁰⁰ *Report of the Task Force on Mental Health and Abortion*. American Psychological Association, Task Force on Mental Health and Abortion. Washington, 2008. Available online at <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>.

EVIDENCE: ABORTION STATISTICS

It is estimated that half of all pregnancies in Australia are unplanned and that half of those are terminated;¹⁰¹ also that between one quarter and one third of Australian women will experience an abortion in their lifetime.¹⁰²

There is no standardised national data collection on unplanned pregnancy and abortion in Australia, and different states have different laws and regulations – and therefore different reporting mechanisms – regarding abortion procedures. Queensland has no such reporting mechanism, so it is impossible to know exactly how many abortions occur each year in Queensland.

Given the data shortcomings, it's estimated that between 10,000 and 14,000 abortions occur in Queensland each year.

MEDICARE DATA

Surgical abortion is a rebatable procedure under Medicare.¹⁰³ However, the Medicare item numbers used to process abortions are not exclusively used for abortive procedures; they are also used with procedures used for treatment of miscarriage and for some other gynaecological procedures. Because there are no explanatory notes or subcategories assigned to these item numbers for the purposes of data collection, there is no way of knowing how many of these procedures are terminations and how many are not.⁹¹

Additionally, public hospital procedures are not processed using Medicare item numbers⁹¹ - not a large problem statistically in Queensland as the state health department estimates that only around 1% of our terminations are performed in public hospitals, but a bigger issue when looking at nation-wide abortion data for Australia.

Medication abortion is not covered by Medicare, although the medications are listed on the Pharmaceutical Benefits Scheme so some information about dispensed doses is available at a national level. There are however limitations with this data when looking at the state-based distribution statistics; in Queensland, for example, the data is artificially inflated because one large pharmacy group supplies prescription medicines used for medical abortion to service providers in other states, whilst processing the PBS prescriptions in Queensland.¹⁰⁴

¹⁰¹ C Rissel, J Richters, AE Grulich, RO de Visser, & A Smith, 'Sex in Australia: attitudes towards sex in a representative sample of adults', *Australian and New Zealand Journal of Public Health*, vol. 27, no. 2, April 2003, pp.118–123.

¹⁰² See for example A Chan, W Scheil, J Scott, A-M Nguyen, L Sage *Pregnancy Outcome in South Australia 2009* Pregnancy Outcome Unit, SA Health, Government of South Australia. Adelaide, 2011 p55. Online at <http://www.health.sa.gov.au/pehs/pregnancyoutcome.htm>.

¹⁰³ A Chan, L Sage 'Estimating Australia's abortion rates 1985-2003' *Medical Journal of Australia* 2005; 182 (9): 447-452. Online at <https://www.mja.com.au/journal/2005/182/9/estimating-australia-s-abortion-rates-1985-2003>.

¹⁰⁴ Information supplied to Children by Choice on request from distributor, 2015.

Given these shortcomings, using Medicare data alone can be very misleading. Public hospital abortion figures can be estimated using public hospital morbidity data, although one study found this over-estimated the number of publicly provided abortions (largely due to readmissions).¹⁰⁵

HOW ARE ESTIMATES CALCULATED?

Because of these data limitations, national estimates are difficult to compile and must be academically calculated. This is most often done using a combination of Medicare data, public hospital morbidity data, and private health insurance claims. The most recent estimate was calculated in 2005, before medication abortion was available in Australia.⁹²

The 2005 estimate found that 83 210 induced abortions were performed in a year, with women aged 20-29 years the most likely to present for abortion.⁹² The resulting estimated abortion rate in Australia was about 19.7 per 1000 women aged 15-44,⁹² which is relatively high when compared with other countries where abortion is legal and easier to access. For example, in 2005 Germany and the Netherlands both had abortion rates less than half that of Australia's,⁹² and both countries have easily accessible contraception and abortion services as well as comprehensive sex education.

While this estimate is widely used, however, the abortion rate could have altered considerably in ten years (as it has in South Australia, see below); additionally, the ability to calculate this using the methods in that report has changed with the increasing availability of mifepristone (medication abortion).

STATE-BASED ABORTION DATA

The only state to regularly collect and publish their abortion data is South Australia, where the state health department releases an annual report on the state's pregnancy outcomes. While their model of providing abortion procedures is vastly different from other states (SA is the only state where publicly provided abortions count for the majority of abortions), there is no reason to suppose the actual abortion rate differs hugely to other states, so their data is generally extrapolated to give a national estimate.

The South Australian data is also the source of the widely-used estimates that around one quarter of pregnancies are terminated and that up to one in three women will have an abortion at some point in their lifetime¹⁰⁶ although it should be noted that in the years since this became widespread the rates have lowered. The most recent report available, from 2013, suggests that 27.6% of women would have a termination based on their data from that year.¹⁰⁷

¹⁰⁵ A Chan, L Sage 'Estimating Australia's abortion rates 1985-2003' *Medical Journal of Australia* 2005; 182 (9): 447-452. Online at <https://www.mja.com.au/journal/2005/182/9/estimating-australia-s-abortion-rates-1985-2003>.

¹⁰⁶ A Chan, J Scott, AM Nguyen & R Keane (2002) *Pregnancy Outcome in South Australia 2001* Pregnancy Outcome Unit, Department of Human Services; p44; Adelaide, South Australia. Online at <http://www.sahealth.sa.gov.au/wps/wcm/connect/33893a00440851dd8721af5fc19a2cbb/Pregnancy+Outcom+e+in+South+Australia+2001.pdf?MOD=AJPERES&CACHEID=33893a00440851dd8721af5fc19a2cbb>.

¹⁰⁷ W Scheil, K Jolly, J Scott, B Catchside, L Sage, R Kennare *Pregnancy Outcome in South Australia 2013*. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2015. Available to download at

HOW MANY ABORTIONS TAKE PLACE IN QUEENSLAND EACH YEAR?

In 2015 we had two public health students on placement examine this question and attempt to pull together all the available data on abortion in Queensland. Their conclusion was that, due to a number of contributing factors including those outlined on this fact sheet, 'a statistically significant estimate could not be made'.

It is generally accepted that somewhere between 10,000 and 14,000 abortions take place each year in Queensland, but without standardised data collection and reporting it is impossible to narrow that broad estimate down any further.

We note that in June 2016 an answer to a Question on Notice to Health Minister Cameron Dick was tabled in parliament, outlining the numbers of terminations which take place in private clinics across Queensland each year as follows:¹⁰⁸

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
12,387	13,232	13,996	14,302	14,330	12,744	11,432	11,630	11,756	10,963	10,403

While these figures do not represent all terminations performed in Queensland (as they exclude public hospital procedures, and medical abortion provided by GPs and sexual health clinics), it seems possible that the numbers of abortions performed each year are falling, given the data from South Australia which shows a gradual decline. However, without more accurate data, this is supposition.

The lack of accurate information about abortion rates also makes it difficult to plan for service delivery and to monitor whether public health interventions are successful in reducing the unplanned pregnancy and abortion rate, at both state and national levels.

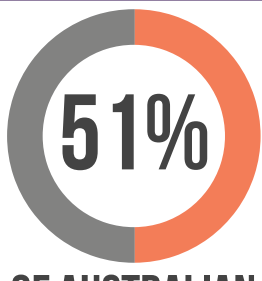
<http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/About+us/Health+statistics/Pregnancy+outcome+statistics/Pregnancy+outcome+statistics>.

¹⁰⁸ Question on Notice No 883, asked on 24 May 2016. Answer tabled on 10 June 2016. Online at <https://www.parliament.qld.gov.au/documents/tableOffice/questionsAnswers/2016/883-2016.pdf>.

CONCLUSION

Children by Choice supports the passing of this legislation, based on the reliable evidence used in this submission and the expertise of those involved in providing these clinical services to women.

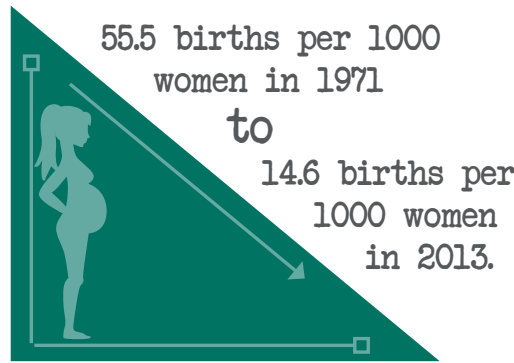
Laws criminalising abortion are outdated, unclear, and completely out of step with modern clinical practice and the attitudes of the majority of Queenslanders. It is time to bring our legislative approach to abortion into the 21st century – after all, it's not 1899.



OF AUSTRALIAN WOMEN HAVE HAD AN unplanned pregnancy.

Source: Marie Stopes

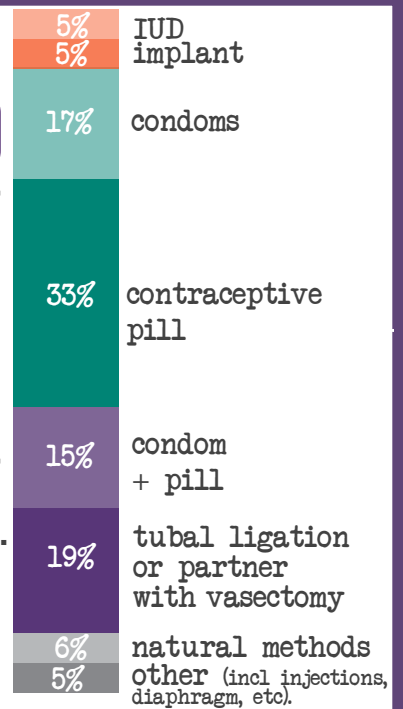
TEEN FERTILITY RATES IN AUSTRALIA HAVE DECLINED FROM



Source: Australian Bureau of Statistics, 2013.

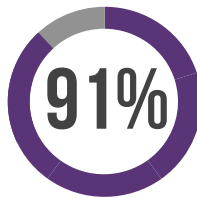
70%

OF SEXUALLY ACTIVE AUSTRALIAN WOMEN USE AT LEAST ONE METHOD OF CONTRACEPTION.



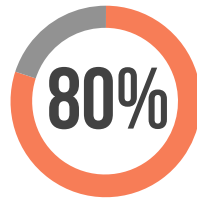
OF THOSE:

Source: Melbourne Institute



OF AUSTRALIAN PARENTS SUPPORT SCHOOL-BASED SEXUALITY EDUCATION

Source: Family Planning Queensland, 2011.



OF AUSTRALIANS support women's right to choose abortion

Source: Australian Election Study

CHILDREN BY CHOICE

ASSOCIATION INCORPORATED

ANNUAL REPORT 2014-15



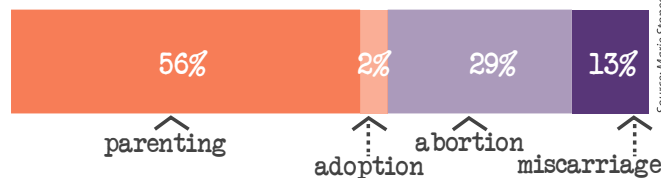
Source: South Australian Department of Health.

38%

OF FEMALE HIGH SCHOOL STUDENTS IN AUSTRALIA HAVE EXPERIENCED UNWANTED SEX.

Source: La Trobe University, 2009.

PARENTING IS THE MOST COMMON OUTCOME OF AN UNPLANNED PREGNANCY.

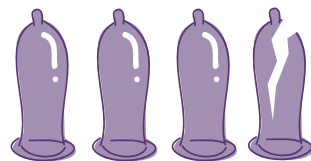


Source: Marie Stopes

47,000

WOMEN DIE EACH YEAR AROUND THE WORLD FROM UNSAFE ABORTION.

Source: World Health Organisation, 2010.



Almost 1 in 4 condom users report slippage or breakage - either of which can lead to pregnancy or infection.

Source: Australian & New Zealand Journal of Public Health

ALMOST 1 IN 4 WOMEN

IN VIOLENT RELATIONSHIPS EXPERIENCE VIOLENCE FOR THE FIRST TIME IN PREGNANCY.

Source: University of New South Wales.

17% OF AUSTRALIAN WOMEN HAVE BEEN SEXUALLY ASSAULTED SINCE THE AGE OF 15.

90%

OF THEM KNEW THEIR ATTACKER.

Source: Australian Bureau of Statistics.

Even if every couple used CONTRACEPTION PERFECTLY every time they had sex



there would still be SIX MILLION unplanned pregnancies each year

Source: World Health Organisation.



WAS THE AVERAGE NUMBER OF PREGNANCIES PER WOMAN, BEFORE THE ADVENT OF MODERN CONTRACEPTION.

Source: Vienna Museum of Contraception and Abortion

NO CONTRACEPTIVE METHOD IS 100% EFFECTIVE.

Our Vision

All women can freely make their own reproductive and sexual health choices.

Our Mission

To be the leading voice for women's reproductive choices in Queensland.

Our Values

Key values underpin the work of Children by Choice, across all areas of the Association. We are:

- Pro choice and woman centred
- Ethical and evidence-based
- Non-judgemental and unbiased
- Confidential and respectful
- Committed to social justice, diversity and equity
- Dedicated to self-determination.

Children by Choice acknowledge the traditional owners of country throughout Queensland and their continued connection to land and community. We recognise the three separate cultures of Aboriginal, Torres Strait Islander and South Sea Islander people.

As women, we believe that women need to respect traditional owners, to communicate this respect to them, and to recognise the dispossession of the land and its ongoing effects on Aboriginal peoples today.

As a women's service, we acknowledge the sorrow of the mothers of the Stolen Generations and apologise for the removal of their children by white Australians.

Children by Choice Association Inc
237 Lutwyche Road
PO Box 2005
Windsor Q 4030

07 3357 9933
www.childrenbychoice.org.au
ABN 51 809 774 188

We are open 9am to 5pm Monday to Friday, offering statewide pregnancy counselling, information and referral by phone or in person at our Windsor office. We also provide sexuality and relationships education for young people and professional development training and support for health and community sector professionals. We were founded in 1972.



YEAR IN REVIEW

by

Amanda Bradley
Manager, Children by Choice

and

Lorraine Pacey
President, Children by Choice

This year Children by Choice has lifted its game in organisational grit, innovation and vision. The most pressing challenge has been the dramatic 36 per cent increase in counselling service contacts, with the last quarter of the year being our busiest in recent history. Contacts related to violence made up over 30 per cent of our counselling work, an increase from 17.5 per cent last year. Our financial support program has also grown and almost 300 women have been supported to access both abortion services and, in one of our developing programs, Long Acting Reversible Contraception. The demand in counselling work has been matched by the provision of our community education program and we were privileged to deliver our biennial conference program in February, which was attended by 175 delegates from across Australia. We also faced the conclusion of the Know4Sure project funding and ensured its sustainability by transitioning it to our youth brand.

One advantage of being a smaller not-for-profit is our ability to monitor and respond to increased demand in nimble and resourceful ways. This year we have built our volunteer and student placement program, selecting and training over 15 volunteers and students to support both the counselling and education teams. Their commitment and dedication has been invaluable and meant that we have been able to dedicate our time directly supporting women and the services who contact us. We cannot thank these volunteers and students enough, you have been our rock!

We have also been fortunate to have significant financial support of both new and longstanding donors. This has enabled us to develop emerging projects; particularly expanding information and access to Long Acting Reversible Contraception, as well as ensuring women who experience violence can access a termination at low or no cost when that is their preferred reproductive choice.

In any well-functioning team, the work that goes on behind the scenes is the life blood of the organisation. Our management committee is made up of a dedicated group of professional, passionate members who support us by offering governance and leadership. Our staff are well qualified specialists in their own right which can be seen by their demand at a state and national level. We offer our immense gratitude to them.

We anticipate the next twelve months will continue the upward trend in contacts and reports of violence and we will be working hard to ensure we have the resources to manage this increase. We hope to grow the financial support we can offer women, particularly in partnership with clinicians providing Long Acting Reversible Contraception. Our website is already undergoing a restructure which will make information and resources more accessible to our clients and the services that support them. We continually look for opportunities to collaborate and make women's reproductive health services more accessible and we thank everyone who has contributed, no matter how small, to these efforts.

THE PEOPLE OF CHILDREN BY CHOICE

Our Management Committee

President	Lorraine Pacey
Treasurer	Ana Alexander
Committee members	Dr Fiona Mack Dr Heather McNamee Dr Caroline Harvey Prof Heather Douglas Merali Pedder Sara Stephens

Our staff

Manager	Amanda Bradley DipAppArts, MICDA
Resouce Manager	Selina Utting BA, MBA, AGIA
Counselling team	Liz BA, BSocWk(Hons) Kirsty BAppSocSc (Counselling) Sian BPsySc(Hons), GDAppLaw Kath, Carla, Susan
Relief counsellors	
Community education team	Pamela Doherty BA, MA(ComDev) Ashleigh Carrington BSocSc (HumServ) Kate Marsh DipDes

Our volunteers and student placements

Student placements	Abi, Marita
Counselling support volunteers	Rachel, Rosalie, Alan, Jodi
Legal volunteers	Kath, Kate
I.T. volunteer	Ross
Information and communications volunteers	Eniko, Amelia, Evangeline, Anna, Imogen, Di
Events volunteers	Erin, Fiona, Kelsey
Finance and admin volunteer	Hila

Our patrons

Senator Claire Moore (ALP, Queensland)
Senator Larissa Waters (Greens, Queensland)
Sue Boyce (Former Liberal Senator, Queensland)

Our funders



and a program grant from the

Samuel and Eileen Gluyas
Charitable Trust managed by



Our event partners





WHAT OUR CLIENTS SAY ABOUT US

The staff were nice and I feel safe - female client.

I am forever thankful for your kindness and support. X - female client.

It helped me and my partner come to a choice together - male partner.

For the first time in weeks I feel hope for myself - female client.

Concern on entering due to the female focus but this was quickly resolved when face to face counselling began - male partner.

The session was extremely helpful in moving forward - male partner.

A very comfortable experience at a difficult time - female client.

Really positive environment, loved that I could laugh & really be myself. So well done. Most positive & enriching counselling experience I've ever had - female client.

I really felt understood from an unbiased perspective. Extremely helpful - male partner.

We made sure we covered all my concerns & addressed them in a friendly supportive manner. Wasn't rushed or pressured. Well taken care of - female client.

I feel more comfortable about my decision. I feel much more empathetic towards my partner - male partner.

I was very in between my decision now I feel certain. My mind is not so jumbled. I feel that it's the right choice and will benefit me in the long run - female client.

OUR CLIENTS



85%
OF CONTACTS
WERE VIA PHONE



9% VIA EMAIL



4% IN PERSON



2% VIA TEXT



The number of contacts has risen by almost 75% in five years...



...but the number of clients has remained relatively stable.

This suggests that women are needing more assistance now than in the past to navigate the complexity of accessing services or finding support around issues relating to the pregnancy like violence, housing, or parenting support groups.



24% are schools, medical agencies, services, or government.

7% were 40 and over
32% were 30 to 39



21% were 19 and under
40% were 20 to 29

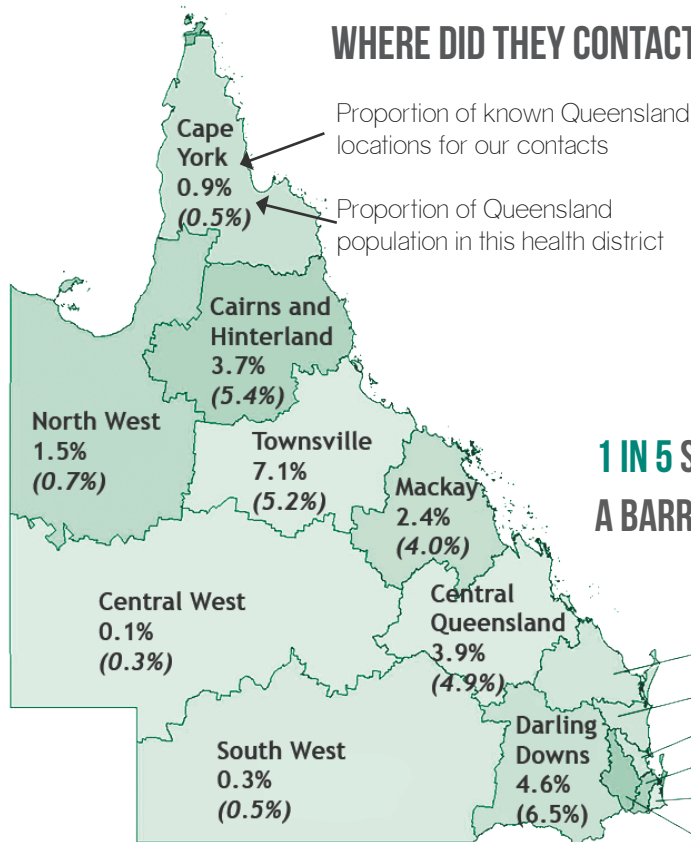
65% are pregnant women.

11% are relatives, partners, or friends.

* 70% of contacts disclosed their age or the age of the pregnant woman they called on behalf of.

OUR
WORK IN
2014-15:
SUPPORTING
WOMEN'S
CHOICES

WHERE DID THEY CONTACT US FROM?



90% OF CONTACTS
IN 2014-15 TOLD
US THEIR LOCATION.

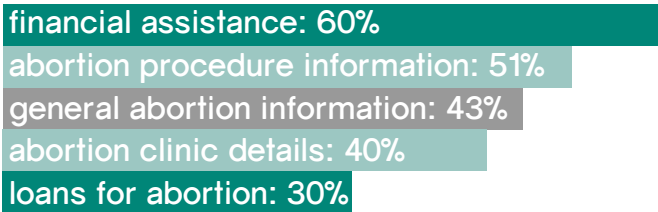
1 IN 5 SAID THEIR LOCATION WAS
A BARRIER TO ABORTION ACCESS.

Wide Bay: 2.7% (4.8%)
Sunshine Coast: 5.3% (8.5%)
Metro North: 26.9% (19.5%)
Metro South: 22.0% (21.7%)
Gold Coast: 12.2% (11.7%)
West Moreton: 6.7% (4.8%)

30.5%
OF ALL OUR CONTACTS
REPORTED AT LEAST ONE
FORM OF VIOLENCE.

7.5% OF CONTACTS
EXPERIENCED BOTH
DOMESTIC AND SEXUAL
VIOLENCE.

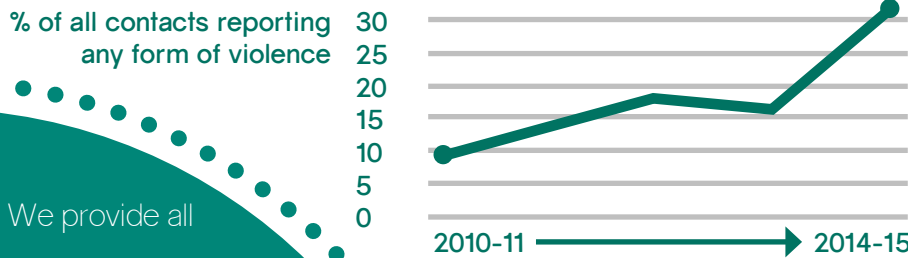
WHAT THEY WANTED TO KNOW:



Our website statistics also reflect the need for reliable information on abortion, with the four most commonly viewed pages consistently being those related to abortion procedures, cost, and clinic information.

30% of our contacts also report that finding accurate information on (or support for) abortion is a key issue for them, so it should be no surprise that a disproportionate number of our contacts focus on this need.

MORE CONTACTS ARE REPORTING VIOLENCE: Domestic violence, sexual violence, and reproductive coercion.



76% of all self-abortion contacts included reports of violence

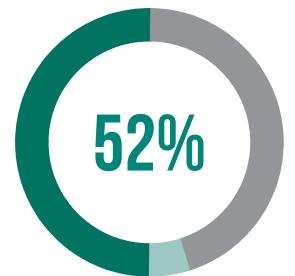
67% of all homeless contacts included reports of violence

21% of all suicidality contacts included reports of violence

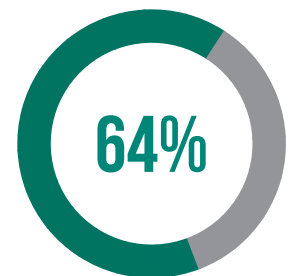
We provide all options pregnancy counselling and information for Queensland women, and are holistic, sensitive, and respectful in our response to our clients' needs. Our service extends to providing material aid and practical assistance to disadvantaged women to ensure equitable access to contraceptive and abortion services.

118 contacts included reports of attempted self-abortion or concerns that women would attempt this.

76% of these contacts also reported domestic and/or sexual violence.



of all contacts were **Health Care Card** holders. Another **5%** had no income.



of all contacts reported that **abortion cost** was a barrier to access.

FINANCIAL ASSISTANCE

Our financial assistance program has been running since 2000 to help disadvantaged women access abortion services. In the first year we provided \$2900 in small grants to women; the program has continued to grow ever since.

OF OUR FINANCIAL ASSISTANCE CLIENTS:

35% reported violence

70% had children

30 were provided with free long acting reversible contraception.

OUR NO INTEREST LOAN SCHEME LAUNCHED 4 YEARS AGO WITH \$20,000 IN CAPITAL. IT HAS SINCE PROVIDED \$71,663 IN LOANS.

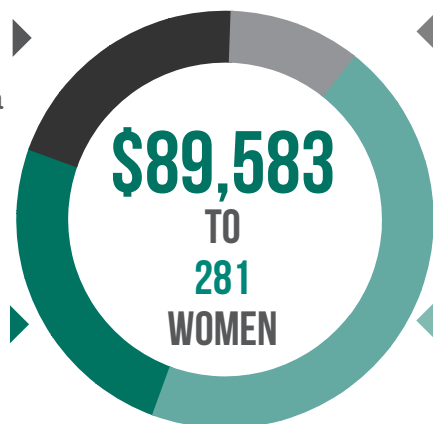
IN 2014-15 WE PROVIDED:

\$20,035 in negotiated discounts with providers

\$20,415 in grants from other organisations

\$7,188 in grants

\$41,945 in no interest loans



OUR WORK WITH YOUNG PEOPLE

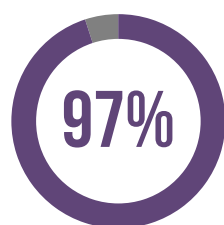


In 2014-15 we continued to focus our sexuality and relationships education on those young people most in need, including those disengaged from mainstream education. Disadvantaged young people are more at risk of experiencing poorer sexual and reproductive health outcomes than their peers, and are therefore more likely to experience unplanned pregnancy. Most of our education sessions this year were delivered in alternative schooling or behavioural support programs, community organisations, and young parenting support groups.

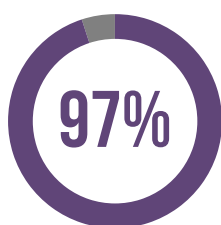
YOUNG PEOPLE SAID:

Everyone was answering and involved
 She made it funny and entertaining
 It was clear and simple
 It was helpful and relevant

YOUNG PEOPLE SAID THE MOST IMPORTANT THING THEY LEARNED FROM US WAS:



of young people said information was explained clearly



of young people said they knew more as a result of the session

OUR WORK IN 2014-15: EMPOWERING COMMUNITIES

KNOW4SURE PROJECT

Know4sure was a specific project aimed at encouraging young women to confirm suspected pregnancy early and then to follow up by making a decision and presenting for care. The project was initiated after an analysis of Children by Choice counselling data, which showed that our teenage clients were more likely to present later in pregnancy than women aged 20 or over, which has implications no matter which option they choose. The project was funded by the Samuel and Eileen Gluyas Trust managed by Perpetual, and commenced in early 2014 with a consultation phase, followed by the development of a youth specific website and accompanying workshop materials for workers to deliver to young women.

WHAT WE LEARNED FROM YOUNG WOMEN:

1. Pregnancy tests are pitched at a literacy level above some teens' comprehension.
2. Accessing a test is easy but interpreting and then accepting results can be hard.
3. Young women don't know what to do after a positive pregnancy test. What next? How to tell their parents?



know4sure.org.au

WAS LAUNCHED IN AUGUST 2014.

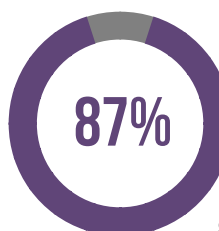
THE MOST POPULAR PAGES ARE:



Over

1000

health and community workers have received training in pregnancy support for young women as part of know4sure.



found this training to be 'very satisfying' or 'extremely satisfying'.

OUR WORK WITH PROFESSIONALS



We use a variety of methods to deliver professional development activities, training, and information to health and community sector professionals. Our focus is on capacity building with those organisations and individuals working with women around unplanned pregnancy, with a particular focus on those working in schools and health services, including hospitals. We travelled as far afield as Cairns and Melbourne in 2014-15 to deliver training and present at conferences, and our webinar was accessed by 120 users at 45 sites across Queensland.

25 SMALL GROUP PRESENTATIONS

8 CONFERENCE PRESENTATIONS

7 TRAINING WORKSHOPS

6 INFO STALLS AND POSTERS

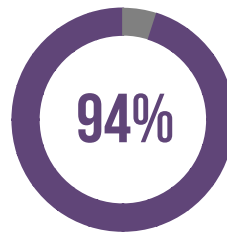
1 VIDEO-CONFERENCE

Our conference: Abortion in Australia 2015

Our Abortion in Australia conference took place on the United Nation's World Day of Social Justice on 20 February in Brisbane, along with two side events: a film screening of documentary 'After Tiller', and a Women's Health Breakfast for doctors and medical students. The conference was targeted towards health and community professionals working with women experiencing unplanned pregnancy and abortion, and those interested in or working in the field of reproductive health.

We provide sexual and reproductive health information to young people most at risk; and professional development training for health and community professionals to help them better support Queensland women's reproductive choices. We use multiple platforms to empower communities with reliable, accurate information on pregnancy options.

175 students and professionals from across Australia attended over the 3 days.



rated it as 'above average' or 'excellent'.

I arrived interested and I left feeling empowered, positive and excited for the future of women's reproductive rights.

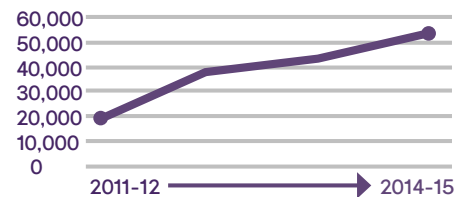
COMMUNITY EDUCATION

www.childrenbychoice.org.au



52,086 VISITS OF 3 MINUTES OR LONGER

of sessions 3 mins or longer



OUR BUSIEST SOCIAL MEDIA PERIOD: #40DAYSFORCHOICE (FEB 2015)

www.facebook.com/childrenbychoice

244,998 post views

The two most popular were an infographic about the link between abortion and breast cancer (spoiler: there isn't one), and our mothers' day message, which between them received over 20,000 views.

5 PAGES ACCOUNT FOR **50%** OF OUR TRAFFIC:

- ABORTION COSTS \$\$\$\$
- MEDICATION ABORTION
- ABORTION LAW & ACCESS
- ABORTION CLINICS
- SURGICAL ABORTION

WE'RE CONNECTED TO OVER 2000 SUPPORTERS VIA SOCIAL MEDIA

www.twitter.com/childrenXchoice

engagement up 300%

Most engagement continues to generate from live tweeting of our public forums and events, like our reproductive coercion forum in November and Abortion in Australia conference in February.

PREGNANCY AND VIOLENCE

In 2014-15, the focus of most of our change-making work was violence.

This was driven by the alarming increase in reports of domestic violence, sexual assault, and reproductive coercion by contacts to our counselling and information service.

Rates of contacts reporting violence have tripled in the past five years,

FROM 10%

TO 30.5%

of our contacts.

30%
of our contacts reporting violence are reporting multiple forms.

7.5%
of our total contacts report both domestic and sexual violence.

35%
of our financial assistance clients are experiencing violence.

Women reporting violence are more likely to present later in pregnancy than women not experiencing violence. 40% of contacts reporting violence related to women with second trimester pregnancies.

The Global Turnaway Study in the United States has found that women denied an abortion are more likely to still be in a violent relationship three years later than women who were able to access the abortion they sought.

We have been collecting data on the numbers of contacts who discuss self-abortion with us since January 2014. **76% of these contacts also disclose violence.**

SUPPORTING PREGNANT WOMEN EXPERIENCING VIOLENCE

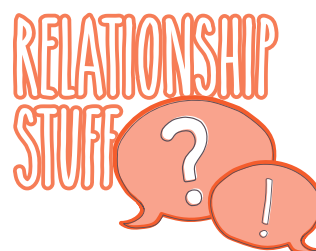
Women experiencing violence who seek to terminate their pregnancy as a means of helping them escape a violent relationship often face additional hurdles to access an abortion. They are more likely to present later in pregnancy than women who do not report violence, and if they are in an ongoing violent relationship can often be experiencing a degree of financial control or surveillance as well as physical types of violence that make accessing a service difficult. Women pregnant as a result of sexual assault often report additional trauma and distress.

In Queensland, these hurdles are compounded by the lack of publicly available abortion procedures. It is estimated that only around one per cent of the state's terminations are performed publicly, and that the majority of these are as a result of a fetal anomaly diagnosis. Women reporting violence, even that which is so severe it has caused hospitalisation, are often refused termination by public hospitals and face significant hurdles in finding the money to fund a privately provided procedure, particularly at later gestation.

Children by Choice has undertaken significant advocacy in this area, both at an individual level by providing extensive support to women seeking to access a public termination, and at a systemic level by engaging in professional development training with hospital social workers around implementing the statewide guideline for the public provision of abortion in their hospitals.

This work will continue in 2015-16 in the development of consumer information for women seeking abortion in the Queensland public health system, and the development of a domestic violence screening program for clinicians working in the private health sector, to ensure these women are better supported around issues of violence and connected with the support services they need.

As part of our work in violence prevention, a suite of resources on healthy relationships were incorporated into our know4sure project. The resources are specifically for young people and give information on what's normal, negotiating sex and contraception, and what to do if you or a friend is in a relationship that isn't healthy. It's at www.know4sure.org.au/relationship-stuff.



REPRODUCTIVE COERCION

What is it?

The term reproductive coercion is used to define a range of male partner pregnancy-controlling behaviours. These include birth control sabotage, where contraception is deliberately thrown away or tampered with, to threats and use of physical violence if a woman insists on contraception, to emotional blackmail coercing the woman to fall pregnant, or to have an abortion, and forced sex and rape.

SUPPORTING PROFESSIONALS TO RESPOND TO ISSUES OF VIOLENCE

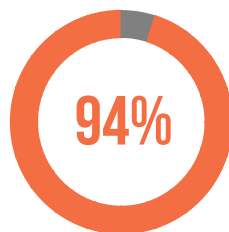


Pregnancy, Violence and Reproductive Coercion: Research, Results and Responses Forum

This forum was co-hosted by the Centre for Domestic and Family Violence Research at CQU, and featured specialist presentations from academics and practitioners on the connection between domestic violence, pregnancy and reproductive coercion, including international and Australian research into these issues and implications for professional practice. Speakers included Diana Greene Foster (Director of Research at Advancing New Standards in Reproductive Health, United States) via video link from Sydney, and Professor Kelsey Hegarty (Department of General Practice, University of Melbourne), as well as two members of our counselling team.

We work to change the social, legal, and policy framework to improve women's reproductive health, and remove barriers that women may face when seeking accurate information, support and services for their reproductive choices. This work is driven by the needs of our clients and is defined by our commitment to their right to self-determination.

60
domestic violence and women's health professionals attended.



said they were 'satisfied' or 'very satisfied' with the event.

That there is a clear link between reproductive coercion and domestic violence - this needs to be at the forefront for practitioners.



In November 2014, we presented our poster, 'Recognising the link: unplanned pregnancy and reproductive coercion,' to around 200 health professionals at the second National Sexual and Reproductive Health Conference in Melbourne.

Across 2014-15, we joined with our sister organisations working in women's health, sexual assault and domestic violence to form **Ending Violence Against Women Queensland (EVAWQ)**. This new peak is the only one in Australia which provides a united and representative statewide voice for the three sectors and will hold its inaugural Annual General Meeting in October 2015.

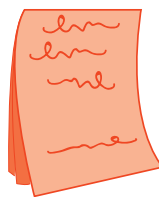


COMMUNITY EDUCATION ON VIOLENCE

Speaking publicly about our clients' experiences with violence, pregnancy and abortion access is one of the most powerful ways of raising community and political awareness, dismantling stigma attached to these issues and improving pathways for women. Information and client stories relating to pregnancy and violence are some of our most shared social media posts, and live-tweeting events like our Reproductive Coercion forum (above) allows us to expand access to this information beyond professionals and clinicians and into the broader community.



In November 2014, we had an article on reproductive coercion published by national women's news website Daily Life, "Male partner pregnancy-controlling behaviour: the emerging crisis point of violence against women".



In 2014-15 we made submissions to both state and federal government inquiries into domestic violence, highlighting the intersection between domestic and sexual violence and the importance contraception and abortion access as safety planning.

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2015

	Note	2015 \$	2014 \$
INCOME			
Donations		31,624	26,450
Grants		532,451	477,364
Interest received		5,339	7,238
Membership fees		2,012	3,598
Sundry income		20	2,754
Trading and operating activities		68,887	17,717
Total Income		640,333	535,121
EXPENDITURE			
Advertising and promotions		8,618	5,523
Audit fees		1,250	1,250
Cleaning		2,307	2,618
Client support services		73,757	52,367
Computer expenses		1,934	7,244
Consultancy		650	11,068
Depreciation		4,289	5,158
Employee entitlements		469,408	404,934
Fundraising expenses		1,632	517
Insurance		8,409	8,281
Meeting expenses		1,238	1,746
Printing, postage and stationery		7,875	9,086
Repairs and maintenance		24,757	5,789
Sundry expense		8,062	6,688
Telephone, internet and fax		17,208	8,476
Training and development		2,829	3,650
Travel and accommodation		9,575	2,338
Utilities		4,309	4,003
Total Expenditure		648,107	540,736
Surplus / (Deficit) before income tax expense		(7,774)	(5,615)
Income tax expense	1	-	-
Surplus / (Deficit) after income tax expense for the year attributable to the members		(7,774)	(5,615)
Other comprehensive income for the year, net of tax		-	-
Total comprehensive income for the year attributable to the members.		(7,774)	(5,615)

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2015

	Note	2015 \$	2014 \$
CURRENT ASSET			
Cash on hand		200	200
Cash at bank		109	4,535
Cash on deposit		240,012	318,397
Accounts receivables		8,726	5,851
Prepayments		-	6,543
Stock on hand		413	465
Total Current Assets		249,460	335,991
NON CURRENT ASSETS			
Property, plant and equipment	3	263,264	267,553
Total Non-Current Assets		263,264	267,553
TOTAL ASSETS		512,724	603,544
CURRENT LIABILITIES			
Accounts payables		12,976	5,551
PAYG payable		5,722	7,656
GST payable		10,526	8,638
Superannuation payable		9,522	9,808
Grants received in advance		24,768	118,124
Provision for employee entitlements		36,375	29,799
Total Current Liabilities		99,889	179,576
NON CURRENT LIABILITIES			
Provision for employee entitlements		31,384	34,743
Total Non-Current Liabilities		31,384	34,743
Total Liabilities		131,273	214,319
NET ASSETS		381,451	389,225
EQUITY			
Accumulated surplus		216,800	224,574
Asset revaluation reserve		164,651	164,651
Total Equity		381,451	389,225

The accompanying notes form part of these financial statements.

INDEPENDENT AUDIT REPORT

To the members of Children by Choice Association Incorporated.

Report on the Financial Report

We have audited the accompanying financial report of **Children by Choice Association Incorporated** (the association) which comprises the statement of financial position as at **30 June 2015** and the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date, a summary of significant accounting policies, other explanatory notes and the statement by members of the committee.

Committee's Responsibility for the Financial Report

The committee of the association is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Associations Incorporation Act 1981 Queensland and with Division 60 of the Australian Charities and Not-for-profits Commission Regulation 2013. This responsibility includes designing, implementing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the committee, as well as evaluating the overall presentation of the financial report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of Australian professional ethical pronouncements.

Auditor's Opinion

The financial report of **Children By Choice Association Incorporated** is in accordance with the Associations Incorporation Act 1981 Queensland including:

1. Giving a fair view of the Association's financial position as at **30 June 2015** and of its performance and its cash flows for the year ended on that date; and
2. Complying with Australian Accounting Standards General Purpose - Reduced Disclosure Requirements (including the Australian Accounting Interpretations) and the Associations Incorporation Act Queensland 1981.
3. Complying with Division 60 of the Australian Charities and Not-for-profits Commission Regulation 2013.


Jason O'Connor B.Com CPA
Registered Company Auditor (No. 353931)

Liability limited by a scheme approved under Professional Standards Legislation

Dated this *15th* day of *September* 2015.

Jason O'Connor B.Com CPA

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