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Briefing Paper: Reproductive Coercion: Coercion to Terminate a Pregnancy July 2018

Marie Stopes, one of Australia's biggest abortion providers recently released a draft White Paper entitled Hidden Forces: Shining a Light on Reproductive Coercion. As expected from an organisation heavily invested in marketing and delivering abortion services the paper has a very strong emphasis on coercion related to continuation of pregnancies with coercion to terminate barely warranting a mention.

In a culture where abortion advocacy is the dominant force the majority of published literature on reproductive coercion is biased toward coercion related to contraceptive sabotage and pregnancy continuation. It is no surprise therefore that the literature drawn on in the references to the White Paper rarely addresses coercion to terminate. For the most part coercion to terminate is no longer differentiated from coercion to continue a pregnancy, both being lumped together under the tidy label of 'pregnancy outcome control'.

The White Paper spends a lot of time within its 50+ pages lamenting a lack of clear definition of coercion. I suspect this will remain a long-term problem as abortion advocacy organisations seek definitions that meet their ideological objectives of keeping abortion positively framed. Acknowledging abortion coercion becomes hugely problematic for such groups, especially when coercion in these circumstances must also include many of the reasons that the majority of women seek abortion.

Most abortions occur in the setting of women lacking necessary resources to continue a pregnancy, whether these are practical, economic, relational or supportive. When this is combined with subtle or overt coercion by other people, and by a dominant discourse that offers abortion as a solution for these social inequities, it seems very obvious that coercion toward abortion must be significant.

With leading abortion advocates and providers denying the existence of the dozens of women who change their minds every year after commencing medical abortions, we have a baseline for how such ideologues view the existence or prevalence of coercion to terminate. *'These women simply don't exist'*.

While ignoring the prevalence of coercion toward termination, the White Paper makes a giant leap when it labels the Federal Government's 2006 pregnancy support counselling scheme a form of reproductive coercion because it doesn't allow abortion provider counsellors to access the Medicare rebate for counselling. They suggest that abortion providers, who only receive payment if a woman

proceeds to abortion, demonstrate no bias in decision making counselling and should therefore have access to the payment. Such counsel should form part of any medical or surgical informed consent process without the requirement for added funding to do so.

It is also interesting to see the way in which abortion advocates perceive threat from the very few, mostly unfunded and volunteer driven pregnancy support services which offer support for women who would choose to continue a pregnancy. In spite of the fact that not all of these services have a religious basis, and many of them are volunteer staffed by qualified professionals, they are deemed to be incapable of providing accurate information without bias. In fact they further suggest, in the absence of any evidence, that such services can inflict psychological harm on women.

There is a very interesting statement made in the midst of this section, in relation to pregnancy support counselling services: 'In no other sector can such unregulated practises occur without legal ramifications." I would argue that in no other sector of health care can women demand a medical or surgical procedure for no reason other than that they want one, and doctors be forced to provide access to it either directly or indirectly. Of course the preference within this White Paper is that no doctor ever be allowed a conscientious objection to abortion because this is also a form of reproductive coercion. Apparently women are autonomous, intelligent decision makers who don't need help or support in deciding whether abortion is right for them, but if they happen to come across a doctor who doesn't provide them with an immediate referral, they may be forced to *'continue a pregnancy against her wishes or seek abortion at a higher gestation'.*

While Marie Stopes is being encouraged to take this process of investigation into reproductive coercion forward, it is prudent to note their own record of ignoring any pressures toward abortion from their 2008 survey entitled Real Choices. In their questions on why women resolved their unintended pregnancies in particular ways, parenting, adoption, abortion, their response options reveal exactly what they are looking for. With multiple options to choose 'feeling pressured into' for questions on resolving an unintended pregnancy by parenting or adoption, not one option was provided for a woman to say she was pressured to abort. This alone typifies abortion advocates' interest in abortion coercion and the reasons why it is vital that we now highlight the very real and very prevalent experiences of women pressured to terminate. For this reason, this paper deals only with reproductive coercion related to pressure to terminate.

Coercion is more than just overt pressure

The majority (>95%) of terminations in Australia occur for psychosocial reasons including not having enough resources, whether financial or material, not feeling able to cope with a baby due to age or lack of support, fears about the impact of pregnancy and parenting on other life choices, as well as consideration for the needs of other people a woman cares for.

Abortion advocates cite such reasons, among others, as supporting the need for abortion, yet in reality abortion offers surgical or medical solutions to social and relational problems, meaning women are forced to decide between their social/economic wellbeing and the continuation of a pregnancy. The power of this subtle form of coercion becomes even more insidious for post-abortive women who experience regret, suffering or mental health problems following abortion as the discourse convinces them they made a real choice to terminate and therefore carry full responsibility. Post-termination counselling offered by abortion advocacy organisations are generally geared toward ensuring the right to abortion is upheld and therefore reframing the woman's experience toward understanding that she made an autonomous and free choice, regardless of her internal experience.

The dominant discourse is strongly abortion advocating, upholding abstracted rights as an ideal. Aspects of the discourse that contribute to its manipulative and coercive nature include alarmist statements, disinformation and the censorship of dissenting voices, regardless of the veracity of facts the latter present. The pervasive effects of the dominant discourse contribute to an environment where continuing a pregnancy is framed as a burden and parenting is experienced as an unsupported journey.

Alarmist, incorrect statements that abortion is anywhere from 14 – 100 times safer than childbirth feed into fears many women may have about birth, and are more like soundbites for abortion marketing. The same is true of alarmism inherent in statements that women will die without abortion access and that abortion access is the only way in which women can achieve 'true' equality.

Coercion exists in the absence of information

Pregnancy termination is a surgical or medical procedure, and therefore governed by guidelines for all other surgical or medical procedures. If abortion provision was practised according to guidelines for other health care it would not be necessary to address whether women are screened for coercive factors, as this should be considered a standard aspect of informed consent practise. Such practise includes that women have a full understanding of the risks and benefits of each option, that they understand and can access the full range of options, and that they are freely consenting. The fact that women are citing coercion as a factor in terminations they have undertaken is a sign that effective and expected screening and informed consent for pregnancy termination is falling short of that expected. Given the highly contentious nature of abortion, it would not seem unreasonable to hold such processes to a higher standard than those for other procedures, yet the opposite appears to be true in practise.

Post-abortive women who have sought counsel or advice through our service often describe very limited and inadequate processes of consent including:

- Group sessions, whereby they were given information and the opportunity to ask any questions only in a group context,
- Only seeing the doctor when they had already been prepped and ready for surgical termination,
- Being asked 'is this what you want?' as the only checking in with their wishes,
- Being 'counselled' in the presence of a pressuring partner, and
- Being given misinformation about the effects of mifepristone and their ability to withdraw consent and discontinue a medical abortion procedure.

Coercion exists in the walk-in – walk-out nature of abortion provision.

Most private abortion clinics operate on a walk in walk out model, whereby a woman phones to make an appointment and is scheduled for termination during the same appointment where she may also receive information and/or counselling. Abortion advocates argue vehemently against alternatives such as ensuring at least two appointments with an opportunity between them to fully consider options, citing the added burden on women of two visits. This is in spite of the fact that there are no other invasive surgical procedures such as termination that can be accessed on the day of request using such a model.

Coercion exists in labelling doctors who object to abortion as untrustworthy

When laws exist that state that a doctor who does not agree with abortion, whether for religious, ethical or medical reasons, cannot be trusted to provide accurate information about abortion, abortion discourse becomes the sole domain of those more concerned with 'rights' than with women themselves. When AMA guidelines advise doctors with a conscientious objection to end consultations with women considering pregnancy options, but then suggest that abortion providers may still decline abortion based on a woman's individual circumstances, the only conclusion is that one group of doctors is untrustworthy.[1]

Censorship within abortion discourse not only affects those who disagree with abortion, but also those who support abortion access, but still feel pressured to withhold information, use certain words, or in some way encourage abortion due to fears of impeding rights.[2] Such internalised censorship means that women have few sources of information about the potential of adverse impacts on their physical or mental health or their relationships. It also means they may view with suspicion any information, no matter how accurate, regarding adverse impacts of abortion.

Coercion exists in the absence of alternatives information

Abortion advocates frequently disparage supportive services established to provide women with material aid, emotional support and decision-making counsel, purely on the grounds of ideology. Where centres exist that offer to meet the identified needs of women, such as material aid, financial resourcing, emotional support, such information should be provided to women in order to provide them with alternative options. Yet, not only do these referrals not happen, but abortion advocates work to discredit and undermine the essential work undertaken by them to support women.

Key Recommendations

1. It is essential that coercion to terminate be seen as a phenomena in its own right, not packaged and hidden in euphemisms such as 'pregnancy outcome control'. The consequences of coercion to terminate are hugely significant on the lives of women and add considerably to the burden of mental health and other emotional issues that they experience.
2. Research on, and education about, coercion to terminate should be a priority at a time when the discourse is rapidly working to further reduce access to necessary supports for women, through legislation and ongoing censorship.
3. Access to independent (not provided by abortion providers) information about, and access to supportive services for women to continue a pregnancy needs to be strengthened and such services need to be more effectively resourced.

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1 Australian Medical Association: Conscientious Objection Policy document: June/July 2013

[2] Martin, LA., Hassinger JA., Debbink M. and Harris, LH. (2017). Dangertalk: Voices of abortion providers. Social Science Medicine, July (184). Pp. 75-83