Ph: 02 6059 5550 | Fax: 02 6059 6500
PO Box 157 Wodonga Vic 3689
Email: dgarratt@realchoices.org.au
www.realchoices.org.au

This paper argues against the decriminalisation of abortion in New South Wales as currently being proposed. Such moves are not only ideologically driven but are based on rampant disinformation which has no regard for the lived experiences of women impacted by abortion. Within this paper I briefly address five specific issues based on my recently completed PhD research:

- Disinformation regarding criminality of abortion
- Community Attitudes
- Conscientious Objection
- Abortion 'rights'
- Adverse Impacts of Abortion

I have also attached my Briefing Paper on Abortion Coercion.

## *Disinformation regarding criminality of abortion*

The proponents of this Bill, along with the dominant media would have the general public believing that every woman faces major hurdles to access abortion, and walks around under criminal threat thereafter. This is simply not true. The only criminal prosecutions to take place have been where a doctor has been completely incompetent which only demonstrates the need for such safeguards for women.

Most women not only have no trouble accessing abortion, but are completely unaware that it is not completely legal with the threshold for performing abortion set so low that women can access it for any reason at all without threat of legal repercussion. Even a short perusal of commentary in social media demonstrates how easy it is to access abortion and how little impact the legal status has,

> *'There are Marie Stopes clinics that advertise them on their website. Not illegal at all!'*
>
> *'It's technically illegal, but they are straight forward to get, no referral needed for private clinics.'*

*'No they aren't. They are perfectly legal not sure where you got your information from.'*

*'They are not illegal.'*

*'You can walk into ANY clinic that performs this procedure with an appointment and have the procedure done.'*

*'Yes, its "technically illegal" however, you do not need a referral, you will not be arrested, you will not be charged with a crime.'*

While some still advocate that abortion decriminalisation helps women 'feel' better about abortion, or gives them greater access, neither of these assertions hold up to any scrutiny. In fact, abortion advocates have lamented that perhaps they got it wrong in Victoria, with Leslie Cannold, former President of Reproductive Choice Australia, stating,

'*little has changed on the (abortion) service provision front'* she goes on to state that, '*Indeed, it may be that criminal sanctions on abortion don't cause abortion shaming and stigma.'*[1]

Some researchers have even admitted that abortion access may have reduced since decriminalisation in Victoria, *'Since abortion law reform, access to public services has shrunk. It's not getting better.'*[2]

## *Community Attitudes*

This Bill proposes to allow pregnancy termination without reason up to 22 weeks, and then up until birth for what ultimately will be any reason as well, as evidenced by the Victorian post 20 week abortion figures, where for a decade more than half of all late term abortions have been undertaken for psychosocial reasons, not health reasons.

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[1] Cannold, L. (2012). http://rightnow.org.au/opinion-3/abortion-shaming-what-the-law-does-and-doesn't-do/#disqus_thread

[2] Keogh, L., Newton, D., Bayly, C., McNamee, K., Hardiman, A., Webster, A. & Bismark, M. (2017). Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia. *Journal of Family Planning and Reproductive Health Care*; 43;18, 18-24

It is interesting that both the media and abortion advocacy organisations often perpetuate the myth that the majority of people support abortion on demand for women, based on research that does not ask detailed questions, or on the findings of research that misrepresent the actual data. The Victorian Law Reform Commission[3] identified five studies as having the greatest reliability, yet not one of these studies demonstrated majority community support for abortion past the first trimester. In fact, the most interesting aspect of at least one of these studies is the level of ambivalence and dissonance displayed when people were asked about 'abortion rights' and also provided context for abortion. In response to one question, 60% of respondents claimed to support a woman's right to abortion on demand, but 51% opposed abortion for financial or social reasons, increasing to 82% opposition abortion after 20 weeks for non-medical reasons.

When asked about professional sanctions as opposed to criminal sanctions for medical practitioners the same dissonance can also be seen. In an article published in 2010[4], abortion providers investigated the attitudes of Australians about abortion itself and about whether doctors should suffer professional sanctions for doing abortions. This article suggests that the general public is far more conservative about pregnancy termination when questioned about professional sanctions in specific circumstances than we are generally led to believe.

Whilst 61% believe that abortion should be legal in the first trimester, this figure reduces significantly to 12% for the second trimester and only 6% for the third trimester. This is hardly a call from the public for abortion on demand. In terms of professional sanctions for doctors for performing abortions, the same study reveals even less support for abortion in most social circumstances. The percentage of people supporting a lack of sanctions against doctors is significantly higher when asked about abortion for serious health and life threatening situations. But when asked about social circumstances, the numbers change dramatically.

42% of people believe a doctor should face professional sanctions for performing an abortion on a woman when she states that she cannot afford to raise the child, with 28% being uncertain. 45% of people believe a doctor should face professional sanctions for performing an abortion on a woman when she states that she does not wish to have a child at that time, with a further 23% being uncertain. Given that these circumstances encompass the majority of reasons why women have abortions, even in later trimesters, it would appear that the majority of the general public actually do not support abortion on demand for any reason, at any gestation, despite the misleading claims of abortion proponents.

[3] VLRC. (2008). Victorian Law Reform Commission: Surveys of Attitudes. Available at: https://www.lawreform.vic.gov.au/content/4-surveys-attitudes

[4] De Crespigny, Wilkinson, Douglas, Textor and Savulescu. (2008) Australian attitudes to early and late abortion, Medical Journal of Australia 2010 193: pp9-12 (Appendix F)

## *Conscientious Objection laws*

To legally enforce a requirement for any person to act against their moral beliefs and conscience is in itself morally reprehensible. It is also another example of abortion being place in an entirely different category to that of 'any other medical procedure' that a woman might request. Doctors are not legally required to refer a woman for an elective plastic surgery she requests, nor are they required to refer to another doctor who they know would make such a referral. A doctor may refuse such a request on conscience grounds, on understanding evidence of harm, or of recognising certain risk factors that may predispose a woman to negative outcomes.

A law that states that a doctor is unable to act in the best interests of their patients, based on what they understand the evidence to be and on what they know to be true about the health of their patient or even based on what they know or believe to be true about pregnancy termination ending the life of a human being, is an interference in medical care and personal ideology that cannot be tolerated.

What the law tells women when it forces doctors to refer, is that a doctor who may question abortion for any reason is a doctor who can't be trusted with your interests or wellbeing. The very strong message it sends to medical practitioners (even those who may in some or many circumstances support abortion) is that they may risk prosecution for even suggesting abortion may not be the best or most appropriate course of action for their patients. At what point can a woman trust that anyone will properly assess her for risk factors, screen her for coercion, or care in any way for her real needs? Such a law essentially puts her on a conveyor belt straight to an abortion clinic, where doctors who know nothing about her circumstances, her health history or her real needs, will perform their business, providing abortions.

## *Abortion 'rights'*

Pregnancy termination is not just a medical matter and in fact for 95% of women accessing termination, it is a social, economic or relational matter and nothing to do with their health or the health of the foetus or the exercising of freedom and autonomy. Abortion for the 95% is the best of what seems like bad options when women are forced to choose between full participation in their communities, professional worlds, or educational institutions, and their right to be full participants in these spheres AND bear children.

The argument that women have an inherent right to total control and autonomy of their bodies is not true. No human being has this inherent right. We have laws to protect people from drinking too much, from taking certain drugs, from self-harming, even when there is no question about the fact that it is only that person's body being impacted. We legislate all sorts of activities, both personal and social (such as piercings, tattoos, sunbeds, smoking and alcohol) in order to keep individuals safe and free from harm, even when that activity will only harm themselves and even when restriction from that activity interferes with one's bodily freedom and autonomy. To argue that abortion is the last bastion of freedom for women is just another deception that holds the interests of an ideology above the real freedoms or interests of individuals.

## *Adverse impact of abortion*

Today we have thousands of women living mostly in silence with adverse effects from abortion, some to such a degree that their lives are irrevocably negatively changed. There is substantial evidence in the literature that up to 20% of women experience serious and long term psychological harm from abortion, much of which I addressed in my PhD research and excerpt below.

Much of the research related to negative outcomes for women following abortion has focussed on the measurable mental health effects, including anxiety, depression, suicide, PTSD, and increased use of alcohol and illicit drugs (Coleman, 2011; Curley & Johnston, 2013; Dingle, Alati, Clavarino, Namman & Williams, 2008; Ferguson, Horwood & Boden, 2009). There now exists a substantial body of international evidence that abortion can lead to measurable mental health or behavioural impairment for a number of women (Coleman, 2011; Curley & Johnston, 2013; Dingle, Alati, Clavarino, Namman & Williams, 2008; Ferguson, Horwood & Boden, 2009). There are some well-accepted risk factors for the development of mental health problems following abortion including the following:

- Pressure or coercion to abortion (Broen, Moum, Bodtker & Ekeberg, 2005; Coleman, Coyle & Rue, 2010; Kero, Hogberg & Lalos, 2004; Taft & Watson, 2008)
- Conflicted, unsupportive relationship with the father (Allanson, 2007; Broen, Moum, Bodtker & Ekeberg, 2005; Coyle, 2010; Lauzon, Roger-Achim, Achim & Boyer, 2000)
- Ambivalence about the decision or high degree of decisional distress (Broen Moum, Bodtker & Ekeberg, 2006; Coleman & Nelson, 1998;)
- Prior mental health problems (Steinberg & Finer, 2011; Sit, 2007; Warren, Harvey & Henderson, 2010; Yilmaz, Kanat-Pektas, Kilic & Gulerman, 2010)
- Personal values conflict with abortion (Congleton & Calhoun, 1993; Kero, Hogberg & Lalos 2004
- The young age of the woman (Gissler, Berg, Bouvier-Colle & Buekens, 2005; Gissler, Hemminki & Lonnqvist, 1996; Major, Cozzarelli, Sciacchitano, Cooper, Testa & Mueller, 2000; Niinimaki, Suhonen, Mentula, Hemminkin, Heikinheimo & Gissler, 2011; Pedersen, 2008)
- Psychological investment in the pregnancy and belief in the humanity of the foetus (Fielding &Schaff, 2004; Hill, Patterson & Maloy, 1994; Mufel, Speckhard & Sivuha, 2002)

- Low self-esteem, low self-efficacy, emotional immaturity or instability (Cozzarelli, 1993; Faure & Loxton, 2003; Major, Cozzarelli, Sciacchitano, Cooper, Testa & Mueller, 2000)

Less measurable emotions including sadness, grief, anger, shame, embarrassment and abandonment can all feel debilitating and have all been described by post-abortive women in social media and accounts from post-abortion counselling (Burke & Reardon, 2002; Prommanart & Phatharayuttawat, 2004; Kersting, Reutemann, Ohrmann, Baez, Klockenbusch, Lanczik,& Arolt, 2004). The researcher's experience in hearing the stories of post-abortive women is that they often feel very isolated in their experiences, as the Dominant Discourse does not reflect or normalise negative experiences. Negative emotional experiences are often censored and dismissed as being irrelevant, fabricated, purely the result of social stigma or ignored. This censorship magnifies their sense that there may be something intrinsically 'wrong' with how they feel.[5]

It is ethically wrong to ignore this harm and add to the abandonment and betrayal of such women, whose real needs should have been assessed and addressed. Abortion is the 'simple' solution for those living outside the sphere of the woman's body, but it is only simple in the short term. This simple common procedure takes minutes, but the effects can last a lifetime and the cost to our economy in lost productivity, and support of women who are harmed is yet to be measured.

I address a number of pertinent issues in a range of short Youtube videos.

- Message to Legislators
- Conscientious Objection
- Abortion Coercion
- Censoring Dissent
- Safe Access Zones

It is not necessary for New South Wales to rush toward an act that other states of implemented just because it is the only state not to have done so. In fact, NSW government have a unique opportunity to fully examine the evidence, assess why it is that many countries are restricting abortion in light of evidence, and truly make the more progressive decision.

MP and Media enquiries

0412 562 298

[5] Garratt, D. (2019). Manipulative Dominant Discoursing: Alarmist Recruitment and Perspective Gatekeeping. Unpublished PhD thesis

Ph: 02 6059 5550 | Fax: 02 6059 6500
PO Box 157 Wodonga Vic 3689
Email: dgarratt@realchoices.org.au
www.realchoices.org.au

**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.

Debbie Garratt RN
Doctoral Researcher,
M.Ed., B.Ed, B.N.
Executive Director
Real Choices Australia Ltd

Further information: dgarratt@realchoices.org.au

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