Abortion Reform in Australia

A White Paper - June 2018
Policy Recommendations for Immediate Consideration by Governments of Australia, following Collaboration between Experts and Community Members from all sides of the Abortion Debate.

Important accompanying materials include:
www.abortionrethink.org/stories for all testimonials of people's experiences around abortion in some way
www.abortionrethink.org/summit-multimedia for specific videos of speakers' presentations at the summit.

This paper has been prepared by the ‘Abortion Rethink’ project from discussions held at the Australian Summit on Abortion Law Reform 2018:

This summit attracted experts from QLD, NSW, SA, VIC, TAS and Internationally (USA) in the areas of law, reproductive health, options counselling, social work, medical fields and in government. Leaders of discussions on policy recommendations contained in this paper were consulted for review before its publication.

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Executive Summary

The first Australian Summit on Abortion Reform was held in March 2018 at Queensland Parliament House.

This White Paper explains the outcomes of the summit, including policy recommendations for government. It provides a review of where Australia is on a national level, when it comes to health services for women in challenging pregnancies and beyond those pregnancies.

The White Paper identifies current limitations hindering the improvement of reproductive health services for women, current gaps in service provision and how Australia can improve its capabilities to meet those gaps, looking to significant improvement by 2028.

The outstanding success of the inaugural summit on abortion reform was made possible by the uniting of experts from across the nation and internationally. These experts, from various and related disciplines concerned with the issue of abortion reform, held different political views on termination of pregnancy.

They, along with members of the community, engaged in productive dialogue.

Present were Parliamentarians, members of the Secretariat to the Queensland Law Reform Commission, lawyers, obstetricians and gynaecologists, a provider of terminations, counsellors, social workers, psychotherapists, midwives, an advocate for those with disabilities and a number of women who spoke of their experiences of unplanned pregnancy or abortion.

The summit found that there are many ways governments could improve care for modern women and ensure they are given a true choice with an unexpected or problematic pregnancy, without even considering any change to current abortion laws in Australia. Currently a significant number of women in these situations do not feel they have a choice but that their only option is to terminate, due to lack of support in pregnancy or pressure from others.

What this Australian summit also provided was a snapshot in 2018 of the current situation nationally concerning termination of pregnancy, on law, accessibility of services, related pregnancy and post-decision support services and women’s experiences in this area.

Legal abortion is, in general, very accessible in Australia. This is despite inconsistencies between abortion laws in different states and territories.

Lack of national data on termination of pregnancy is a serious and pressing problem that needs to be promptly addressed by government. Data is necessary to properly assess the current abortion rate in Australia, the adequacy of current health services and proposed changes to policy and law making.

The top five issues concerning reproductive health care, as highlighted by the summit, are inadequate data, abortion coercion concerns, problems with informed consent and lack of pregnancy and post-decision support services.
Every one of these issues should be readily addressed by government. This could occur through the provision of better information, training, regulations, funding or other measures taken in health and social services.

As well as the top five issues, this paper gives an account of every policy recommendation raised by participants in the 2018 summit. Supporting information and specific recommendations are made to guide what action could be taken to make changes in the best interests of women’s health in Australia. These recommendations may be used by government agencies, advocacy groups, policy makers and any member of the collective effort working for women’s health in Australia.

There are issues of serious concern for women’s health in Australia. These should be properly considered and addressed by all political parties who are genuine about improving women’s health in an unexpected pregnancy and around a termination of pregnancy.
CHAPTER 1
Snapshot of 2018 - Termination of Pregnancy in Australia

1.1 Abortion laws in Australia

Abortion laws in the states and territories of Australia vary and are inconsistent. Nevertheless, currently in every state and territory of Australia, legal abortion can be safely and readily accessed by any woman if there is a serious risk to her mental or physical health.

“Abortion is available up until birth in all jurisdictions of Australia, subject to certain criteria.” - Anna Walsh

South Australia (SA), Western Australia (WA), Victoria (VIC), Tasmania (TAS), the Northern Territory (NT) and the Australian Capital Territory (ACT) have in previous years legislated for lawful termination of pregnancy and taken it out of the realms of criminal law. However, some situations relating to an unlawful termination, (e.g. if it is performed by an unqualified person), are still the subject of criminal law in every state and territory, except for the ACT.

Every legislative change has resulted in differences between the abortion laws of Australian states and territories. In particular, there are varying gestational limits for a legal abortion or gestational limits beyond which further restrictions apply. For example, in the ACT law, effective from 2002, there is no gestational limit for a legal abortion; whereas in the new NT law that came into effect in 2017, abortions are prohibited beyond 23 weeks (except to save the life of a woman), and not beyond 14 weeks without the approval of a second doctor.

1.2 Data on Termination of Pregnancy in Australia

There is no national data that provides accurate figures for elective abortions in Australia.

Australia’s most accurate data for one state comes from South Australia, which shows a 29% lifetime prevalence of legally induced abortion for women born around 1955. A higher figure was given (at least 31%) for women born in 1960-1980.

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1 Presentation by Anna Walsh at Abortion Rethink’s Summit on Abortion Reform, Brisbane. 2018. Anna Walsh is the Principal Anna Walsh Legal Consulting, Adjunct Associate Professor, School of Law, University of Notre Dame Australia and Adjunct Lecturer, College of Law New South Wales.

2 In this paper, the terms ‘abortion’ and ‘termination of pregnancy’ are used interchangeably and refer to any procedure that deliberately ends the pregnancy and aims at the death of the embryo or fetus (a direct abortion). Medically this is called an induced or ‘elective’ abortion.

In a large national randomised survey in 2001/2002 including all states and territories, of 6,838 women who reported ever being pregnant, 22.6% of women aged 16-59 years reported having an abortion. A survey of 1022 women in Australia on their experiences of unplanned pregnancy in 2006 by Marie Stopes, similarly found that 29% had an abortion.

Current estimates of Australia’s national abortion rate are not available. The last estimation of Australia’s abortion rate by the Australian Institute of Health and Welfare (AIHW) was 19.7 abortions for every 1,000 women of childbearing age. This review in 2005 was based on figures for the year 2003, 15 years ago; yet the AIHW has not provided an update on this estimate since 2005. A study by Chan and Sage in 2005, “Estimating Australia’s abortion rates 1985-2003” also reported Australia’s abortion rate to be 19.7. This study estimated that 84,460 induced abortions were performed in 2003.

In 2007, the Guttmacher Institute did a comparison of abortion rates in 2003 for countries across the world. Comparatively in 2003, the abortion rate in Australia was higher than the majority of European countries and Canada. Our abortion rate was more than double that of Belgium, Germany, the Netherlands and Switzerland.

With indications of such high previous rates of abortion in Australia, the onus is on our current governments to commence collection of accurate national data and reasons for termination of pregnancy. This data collection is woefully overdue and necessary to determine if the health and support needs of Australian women who access abortion are being met, as well as the needs of their partners and others. It is critical that routine collection of accurate national data on elective abortions commences in Australia as a matter of priority, in order to properly assess health services, policies and any future proposed changes in law.

1.3 Abortion services in Australia

Women readily access early terminations of pregnancy in all jurisdictions of Australia. The accessibility of mid-late term abortions varies significantly from state to state due to lack of necessary facilities to perform later procedures, ability or willingness of practitioners to perform and/or restrictions in law. For example, in Western Australia, abortions beyond 20 weeks are only likely to be permitted (by a statutory panel), for significant foetal abnormalities.

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The experiences of women shared at the summit were that although they sought an abortion in Queensland or New South Wales, which are considered to have Australia’s most restrictive abortion laws, accessibility was not a problem for them.

Medical abortions are available nationally to nine weeks gestation through Marie Stopes and the Tabbot Foundation. Women can connect with a doctor over the phone or via video call and have the medication mailed to them. Since 2015, licensed doctors, including GPs who meet training requirements, can also prescribe medical abortions for pregnancy up to 63 days.

In New South Wales, there are private abortion clinics operating in fifteen different locations across the state as well as terminations being available through some hospitals. In the Australian Capital Territory, two private clinics are approved to perform abortions.

In Queensland, abortion services are available through twelve different providers in Brisbane alone, excluding hospitals where terminations are also performed. There are five abortion providers in the Gold Coast and Tweed Heads area with another six providing abortions in regional Queensland, including the Sunshine Coast, Rockhampton, Townsville, Cairns and the Far North.

In the Northern Territory, there are four practices through which terminations are provided: the public hospital in Alice Springs, a private hospital in Darwin and two private providers.

In Victoria, there are private abortion facilities operating in nine locations. Women can also access abortions through the Pregnancy Advisory Service (PAS) at the Royal Women’s Hospital, as well as through private hospitals within a 20km radius of Melbourne.

In South Australia, abortions are available through the PAS, three public hospitals and a medical centre in metropolitan Adelaide and through eleven providers in regional areas of South Australia. Some private obstetricians/gynaecologists also offer abortion services.

In Western Australia, there are private facilities providing abortions in two different locations. Terminations are also performed at public hospitals.

In Tasmania, medical abortions are provided through a private provider and surgical abortions are available through a private gynaecological clinic in Hobart.

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1.4 Pregnancy support services in Australia

At any point in time during an unexpected or challenging pregnancy, a woman has only two options presently available to her:

1. Continue the pregnancy, or
2. Terminate the pregnancy.

Along with the option of termination, in the absence of a woman also being offered pregnancy support to help her overcome the often complex difficulties or circumstances that cause her to contemplate abortion, she is not being offered a real choice.

One-stop, holistic pregnancy support services are needed beyond ‘options’, or ‘non-directive’ counselling. This counselling gives information on a woman’s options with an unexpected or challenging pregnancy (traditionally narrowed down to ‘abortion, parenting, adoption or fostering’).

Counselling may identify the complex issues which are causing women to consider abortion but this service alone is unable to offer women ongoing support to work through problems she may be facing, so that she truly feels she equally has the option to continue a pregnancy if she wishes, as she has the option to terminate.

**Options counselling and pregnancy support services are different services.**

One-stop, client-centred pregnancy support services are currently very limited across Australia. This is due to a lack of government funding or promotion within usual care pathways. Organisations offering these services are independent, often registered charities and operating with limited funds and resources.

Nevertheless, the service providers recommended in this paper are of a reliable standard and endorsed by clients. See Appendix 1 for a list of recommended Pregnancy and Post Decision Support Services in Australia.

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15 The latest clinical guidelines written by a state/territory of Australia on termination of pregnancy does not even mention pregnancy support services or the need to inform women of these as part of their decision-making process. NT Clinical Guidelines for Termination of Pregnancy, http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/1305/1/NT%20Clinical%20Guidelines%20for%20Termination.pdf

See page 20 of these guidelines for a flowchart on “Termination of pregnancy service pathway summary”:

After “Provide Pregnancy Options Information”, it shows only one pathway which is “Request Termination” when there should be two care pathways – the other being “Request Pregnancy Support” (services for a challenging pregnancy). The other option that should also be included here is the woman requesting a second opinion.
CHAPTER 2
Summit Highlights and Top Five Issues

2.1 Summit Overview

The inaugural Australian Summit on Abortion Reform 2018 was a full day event, with a hundred people in attendance, as individuals or representatives of organisations.

Usually there is very little co-ordinated discussion on termination of pregnancy politically, and even amongst health professionals, due to the sensitive nature of the topic and perceived or actual ideological divisions between individuals who would otherwise be willing to collaborate on issues of women’s health.

It is important regular discussions start taking place on abortion to ensure that all information and research in the area is considered, in a critical yet fair manner and across political divides. Reliable information can be objectively agreed upon and should be shared with women. Dialogue between all stakeholders should also be used as a means to improve care for women in challenging pregnancies and around termination of pregnancy.

‘Abortion Rethink’ aims to provide a safe place for people to discuss termination of pregnancy. Hence, this summit was open to, and attended by, organisations and individuals with varying views and experiences around termination of pregnancy. Attendees came from a wide range of disciplines and professional backgrounds and included lawyers, politicians, counsellors, social workers, midwives, doctors, a provider of terminations, nurses, ethicists and researchers.
The morning session consisted of presentations and panel discussions on:

- Legal Context for Abortion Law Reform in Australia: Anna Walsh, Lawyer, Adjunct Associate Professor, The University of Notre Dame, Australia.
- ‘Options Counselling’ and Beyond Panel: Managers of the following Pregnancy Counselling and Support Centres - Gaye James, Esther’s House, Tasmania; Cristy Mock, Chloe’s Place, Queensland; Juliet Ballinger, Eva’s Place, Queensland; Stacy Allen, Zoe’s Place, New South Wales; Jennifer Gurry, Diamond Pregnancy, New South Wales and Cathy Marzahn, Pregnancy Help Australia.
- Regional Access to Termination and Pregnancy Support: Dr Alexandra Doig (MBBS).
- Medical Practice in relation to Termination of Pregnancy Panel: Dr Alexandra Doig, Dr Leah Torres (Ob/Gyn and provider of terminations) and Dr Bryan Kenny (Ob/Gyn).
- Prenatal Testing and Abnormal Screenings: Joelle Kelly, T21 Advocate.
- What about Post-Abortive Care?: Anne Lastman, Clinical Counsellor who has counselled people post-abortion for more than 22 years.

Following lunch, split sessions took place that looked at:

1. ‘Exploring the Options’ - this was to discuss the alternatives and supports to parenting. It involved a panel of counsellors and social workers with experience in adoption, fostering, parental responsibility transfers and parenting support programs.
2. ‘Medical Matters’ - this session was attended by medical professionals and lawyers to discuss practices around termination of pregnancy and how to improve the clinical response to complicated pregnancies.

Lastly, all participants collaborated in round tables that examined:

1. Informed Consent
2. Abortion Coercion and Domestic Violence
3. Maternal Support versus Isolation
4. Data Collection and Clinical Practice Auditing
5. Medical Support Options
6. Paternal Rights and Responsibilities
7. Abnormal Screenings/Prenatal Testing
8. Pre-Decision Support Protocols
9. Post Abortion Protocols
10. Safe Access Zones

The full recommendations that came out of the round table discussions are detailed in Chapter 3.

2.2 Top Five Issues and Recommendations

The following issues were identified as priority issues based on what was most discussed during the day and particularly what came out of hearing from women who spoke of their experiences with a challenging pregnancy. The recommendations for government under each issue are a summary of the full policy recommendations that came out of round table discussions on each issue. Full policy recommendations for each of the top five issues are contained in Chapter 3 and should be used to complement the information in Chapter 2, as well as the other areas discussed in the round tables.
The top five issues of the summit were clear, undisputed and should speak directly to government - but they do not call for change to current abortion laws, in Queensland or in any other state or territory.

The voice of participants from across Australia shared that these same issues exist nationally, whilst the shared experience of women and those working in different areas of women’s health highlighted the previously unrealized magnitude of these issues.

The top three out of these top five issues effectively mean that many Australian women are not being given a choice when it comes to unexpected or problematic pregnancies.

The following is a summary of each issue. Full policy recommendations from summit participants for each of these issues are provided in detail in Chapter 3.

2.2.1 Abortion Coercion

Abortion coercion in Australia is a serious and complex issue that needs addressing urgently. Abortion coercion needs defining and acknowledgement in the public health sphere.

Effectively, anything that causes a woman, with an unexpected or problematic pregnancy to feel her only option is to terminate, may be considered abortion coercion. It includes denial of needed support and/or services in pregnancy or beyond (e.g. where a woman otherwise feels unable to care for a child/another child). It includes coercion in the workplace or places of study, financial pressures and pressure from her partner and/or relations/friends/GP or Ob/Gyn to terminate.

Two women at the summit bravely shared their stories about being coerced by their partners into abortion. One of these women said that she felt pressured to terminate in every one of her eight abortions.

"I only wished in all of the unplanned pregnancies I faced that just one person had said to me, 'I'll help you' or 'I'll support you' or 'I'll point you in the right direction', not one and I've had eight abortions. That's a lot of situations that I've faced. Every single time, every single time, I was coerced, forced or abused into having an abortion." - Emma
“When I look back now I understand how emotionally abusive my boyfriend was, although I didn’t see it at the time. I was told there was no way I was having a baby and I was to book the abortion as soon as possible.

I had no one to talk to and I was really putting off booking the abortion. Finally at work, my partner began to send me abusive text messages, swearing at me, telling me I was ruining his life. I knew that I couldn’t go home to him without booking the appointment.”

- ‘Hannah’\(^{16}\)

Both sides of the political debate on abortion can and should agree that abortion coercion, in any form, is never acceptable and should not be happening in Australia.

As Dr Leah Torres, Ob/Gyn and provider of terminations said at the summit:

> “Any sort of reproductive coercion is appalling and it needs to stop and we need to figure out how to work together to ensure that coercion of any sort - financial, romantic, parental, whatever it may be, is not happening.” - Dr Leah Torres\(^{17}\)

There has been very little research into abortion coercion in Australia. In 2017, a study conducted by Marie Stopes Australia with abortion clinic health professionals reported that women disclose pregnancy coercion to clinicians on a weekly basis. With regard to abortion coercion, the study had an alarming finding:

> “Partners threatening to leave a relationship if a pregnancy was not terminated occurs at least weekly, often daily.”\(^{18}\)

Also very concerning was another finding of this study on the association between domestic violence and abortion:

> “Concealing a pregnancy and the subsequent pregnancy termination from a male partner due to fear of their partner was the most frequent type of reproductive coercion disclosed to health practitioners by women seeking abortion.”\(^{18}\)

In 2015, after the Children by Choice (CBC) counselling team reported increasing anecdotal evidence of reproductive coercion of clients, they commenced collecting data on this, alongside the collection of data on domestic violence and sexual violence, which they have been doing for some time. The definition given by CBC of ‘reproductive coercion’ is that it defines ‘a range of male partner pregnancy-controlling behaviours’, including coercing a woman to have an abortion.\(^{19}\)

\(^{16}\) Name changed for privacy reasons.

\(^{17}\) As shared by Dr Leah Torres, on a medical panel at the Australian Summit on Abortion Reform 2018.


This finding was retrieved from the Marie Stopes draft white paper on reproductive coercion: Marie Stopes Australia. Hidden Forces - Shining a light on reproductive coercion. p. 20. https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/

\(^{19}\) Children by Choice. Reproductive Coercion - What is Reproductive Coercion? [Reproductive coercion behaviours] … “can include birth control sabotage (where contraception is deliberately thrown away or tampered with), threats and use of physical violence if a woman insists on condoms or other forms of contraception, emotional blackmail coercing a woman to have sex or to fall pregnant, or to have an
The early findings of Children by Choice data regarding reproductive coercion include:

- Around one in seven contacts are women experiencing reproductive coercion;
- Three quarters of women experiencing reproductive coercion also report domestic violence;
- Around one third of all women experiencing domestic violence also reported reproductive coercion;
- Contacts reporting reproductive coercion were more than three times more likely to experience suicidality as the general contact base and almost twice as likely to experience mental health problems.

Children by Choice reports:

“Women experiencing domestic violence and unplanned pregnancy are more likely to present at a higher gestation than other women seeking assistance with reproductive choice. **Emerging data shows that this is even greater for women experiencing reproductive coercion, and that they are over-represented in those with pregnancies greater than 16 weeks.**”[20] [emphasis added]

This new data indicates serious numbers of women are affected by reproductive coercion, which includes abortion coercion. The findings of a 2017 Galaxy poll of 1,003 New South Wales citizens about abortion similarly found:

“26% reported knowing one or more women who had been pressured into an abortion.”[21]

Earlier Australian surveys that enquired into the circumstances of women who have had terminations also indicated that significant numbers of women in an unexpected pregnancy may have experienced coercion in some form and also showed an association with domestic violence.

An Australian study by Taft and Watson, published in 2007 analysed the responses of over 9,600 women from two surveys. It found:

“..the odds for termination of pregnancy for women who reported recent partner violence (17%) were more than four times higher than of non-abused women (4%).”[22]
Ten years ago, a 12-month audit published in 2009 of the records of 3018 women who contacted the Royal Women’s Hospital Pregnancy Advisory Service (PAS), Victoria similarly found:

“..16% seeking terminations disclosed experience of violence.”

Of particular note in this audit was the number of women who reported lack of support in pregnancy. It reported that 20% of women said they had experienced difficulties in gaining access to pregnancy support services. This included financial or health problems, geographical isolation, lack of transport or child care, being at school, safety fears, drug or alcohol problems or language concerns.

Hence, for 36% of women surveyed in this audit, abortion was associated with domestic violence and/or lack of support.23

It may be said with certainty, most people agree that a woman experiencing coercion to have an abortion is unacceptable. A New Zealand poll, taken in December 2017, reported that 76% of respondents said they support doctors being required to verify that a woman seeking an abortion is not under any coercion from a third party.24

The limited information available suggests a significant number of women in Australia may be experiencing some form of abortion coercion. Further investigation and response by Australian governments and medical bodies to this issue is urgently needed.

Recommendations for government in summary

Commonwealth government

It is paramount that the Commonwealth government commissions research into abortion coercion as a matter of urgency. The Commonwealth Department of Health should review the existing policies or procedures of abortion providers that seek to prevent abortion coercion. It should task an appropriate body to recommend improved controls over procedures at all points of contact with a woman experiencing an unexpected or challenging pregnancy, who is considering termination: this is for her safety and to eliminate abortion coercion in Australia. Research as a minimum should include: a definition of abortion coercion; explanation of forms of abortion coercion; comprehensive audits into women’s experiences around abortion, particularly when they also experience domestic violence.


State and territory governments

State and territory governments should commission research into abortion coercion in health services for which they are responsible, including surveys of women or audits of data on reasons for abortion. It should also consider external audits of women's experiences in privately run abortion clinics. All governments should consider the implementation of policies and measures to better protect women from abortion coercion. These should include education of health professionals on abortion coercion, screening requirements and referral to appropriate pregnancy support services. Protective measures need to be developed and introduced before any legislative changes are made to abortion laws in any jurisdiction. Particularly, changes that would weaken controls around abortion as this would potentially increase the risk of abortion coercion against women.

Further discussion and detailed policy recommendations concerning abortion coercion are made in section 3.1 of this paper.
2.2.2 Options Counselling vs One-Stop Support Services

Options or ‘non-directive’ counselling is not the same as support services that help a woman through whatever problems she is facing with an unexpected or problematic pregnancy, so she has the option to continue. Counselling may identify problems but it does not in itself help resolve those problems for a woman. Holistic pregnancy support services are currently very limited in Australian states and territories because most are not government funded, included in usual care pathways or given recognition for the important services they provide.

“We understand that counselling alone is inadequate in unintended pregnancies because of the many and complex needs that they present with.” - Juliet Ballinger, Co-ordinator, Eva’s Place, Qld.\(^{25}\)

The limited studies done on the reasons women have abortions in Australia, reveal complex-decision making.

[Women] “...described complex lives and social contexts within which they made decisions about abortion... They gave reasons... relating to the woman herself, the potential child, her sexual partner, existing children, the extended family and financial matters.”\(^{26}\)

It follows that due to the complex and deeply personal reasons women contemplate abortion, pregnancy support services should reflect this in offering client-centred/case managed care that caters for the unique situation of each woman.

“Support can come in many forms and we need to provide it.” - Stacy Allen, Manager, Zoe’s Place, NSW.\(^{27}\)

This is one of the reasons why one-stop holistic support services should be offered. If desired, the same support person will journey with the woman from initial contact, to assist in her needs during and even beyond a difficult pregnancy. As Christy Mock, Managing Director of Chloe’s Place in Queensland said at the summit:

“We offer a strength-based approach, believing that each woman is the expert in her own life and that only small change is necessary. Our pregnancy support workers conduct an initial psychosocial assessment to identify key needs and then work alongside the client to find appropriate solutions.” - Cristy Mock, Manager, Chloe’s Place, Qld.\(^{28}\)

\(^{25}\) Presentation by Juliet Ballinger at the Australian Summit on Abortion Reform 2018.


\(^{27}\) Quote from Stacy Allen on ‘Options Counselling and Beyond’ panel at the Australian Summit on Abortion Reform 2018.

\(^{28}\) Quote from Cristy Mock on ‘Options Counselling and Beyond’ panel at the Australian Summit on Abortion Reform 2018.
In the absence of adequate ongoing care being offered to women beyond counselling, that can meet their individual needs (e.g. emotional, relationship, practical, financial, social or parenting), many Australian women who face pregnancy in difficult situations feel they have only one option, which is to terminate. Again, denial of support to these women in crisis, is a form of coercion.

Currently very few independent options counselling services in Australia refer to holistic one-stop pregnancy support services. These support services are also not being integrated into usual health care pathways for women with a challenging pregnancy in Australia.

Legislative change to make abortion even more accessible may put even more pressure on Australia women with a problematic pregnancy to have an abortion, as their only available option in the absence of adequate support services.
Recommendations for government in summary

Commonwealth, state and territory governments should address the deficiency of support services to women with unexpected or problematic pregnancies as a matter of urgency.

**Commonwealth government**

The Commonwealth government should consider new Commonwealth grants for one-stop pregnancy support services. It should also consider the introduction of new Medicare codes/rebates for pregnancy support services, which would give financial incentive for these services to be offered wherever termination of pregnancy is also offered as an option.

**State and territory governments**

State and territory governments should review existing pregnancy support services according to criteria and standard of care. For those that meet the minimum requirements, these governments should promote these services and ensure that information is provided to women regarding where they can access them. Information could be provided where women are usually offered options counselling and through usual health care pathways. See Appendix 1 for a list of recommended holistic pregnancy support services in each state/territory.

State and territory governments should consider funding holistic one-stop pregnancy support services. See section 3.2 for detailed policy recommendations.
2.2.3 Informed Consent

The empirical evidence of women’s experiences of abortion in Australia, including that given in section 2.2.1 is concerning. It indicates that adequate processes and controls are not currently in place to ensure that all women considering termination of pregnancy are able to, and do, give fully informed consent.

Proper informed consent must be -

“voluntarily given, and free from manipulation by, or undue influence from, family, medical staff or other social coercive influences.”

Consent can be obtained only after sufficient dialogue between the patient and health practitioner and time given to allow the patient to consider and clarify information. There must be two-way communication in discussions that is transparent and well balanced. Questions asked by the patient must be answered appropriately. Adequate information must be provided in a form and language that is demonstrably understood by the patient, covering all relevant factors including the nature of the procedure, other options and possible outcomes, risks and benefits for the patient and others.

At the summit, a number of women shared their stories of the counselling and ‘consent’ process (or rather lack of) that they went through prior to a termination procedure at abortion clinics:

“Blankly they booked me in, took my money, gave me a five minute counselling session where basically they twisted everything to suggest abortion was my obvious best path.. and I use the word ‘counselling’ very loosely because someone asking, “Do you want to go ahead with this and you say ‘Um, yes’, is not counselling. Not one person warned me of the dangers, emotionally, physically, or spiritually... Not once, not once did they suggest perhaps I might need other support options or put me in touch with an independent counsellor.” - Emma

[After leaving an abortion clinic] - “A few days later I looked at the receipt and to my surprise I noticed that there was actually a counselling fee included in the price but I never received counselling.” - ‘Hannah’

Jaya Taki shared her story publicly in 2017 about being coerced into an abortion by her then partner, an NRL player:

[On speaking with a “counsellor” at a Sydney abortion clinic]... “I remember thinking that you have a counselling session beforehand and that’s when they decide if you can have an abortion or not. The first question she said was, ‘How long have you been together?’ I said, ‘Oh, four months.’ She said, ‘Oh yeah, I can see why you’d want an abortion.’ And I remember thinking, ‘Please ask me more questions. Please ask me if this was my

30 Name changed for privacy reasons
choice.’ And she said, ‘Yeah, I get it, you don’t want a baby that early in your relationship.’
No-one supported me and I thought that that was my final chance. I was hoping that she would sign off and say, ‘This woman cannot have an abortion.’ Instead she gave me an envelope and said, ‘Make sure you put your money in there.’” - Jaya Taki

Of particular note, the Medicare Rebate for Independent Non-Directive Counselling cannot be claimed for counselling services provided at an abortion clinic.

Whilst this has obviously been mandated to ensure non-directive counselling is independent, it also means there is little incentive for clinics to provide any significant counselling for women as this must be paid for by the clinic or the cost passed on to the woman. Furthermore, there is no law in Australia requiring someone providing a counselling service to have qualifications and there is no assurance that those providing this service at clinics are qualified counsellors.

**Prenatal Testing**

In addition to the issue that women report that they were not given the opportunity for proper informed consent at abortion clinics, this problem was also raised in other practice settings. Of particular concern is the lack of information and support given to women around prenatal screening. There are no national guidelines for prenatal screening. Some women report they were not offered the opportunity to give proper informed consent to the initial screening itself, for further screening or to a termination in the event of a challenging diagnosis.

At the summit, Joelle Kelly, T21 Mum Advocate shared some statements from women on what was said to them during a screening process and after a prenatal diagnosis:

“In spite of me making it clear that under no circumstances I would have an amnio they still booked me in for one. When I turned up for what I thought was a routine ultrasound, we headed down the corridor to a different room and I was told I was having an amnio. They put a lot of pressure on me to go ahead, including saying that I was wasting their time if I refused.”

“In the grieving room, I was told the statistics for termination for Down Syndrome [95%] and told I had two weeks to make a decision and I could have a normal baby after this one.”

32 As shared by Joelle Kelly, T21 Mum Advocate, in her presentation at the Australian Summit on Abortion Law Reform 2018. https://youtu.be/kK5kZVd7nKM
33 Ibid.
“After the ultrasound, the doctor asked to speak to me and said, “Things do not look good.” He then rattled off statistics about how having a baby with Down Syndrome would affect my other child and my marriage. He gave me handouts and said, “You know the word ‘mongoloid’ is sometimes used to describe Down Syndrome babies.”

“At 21 weeks, I was asked, ‘When do you want to arrange a termination?’ I said, ‘No, I don’t want to’, to which he replied, ‘Why would you want to keep this one when you can try again for a normal baby?’”

Rather than being offered an equal opportunity, up-to-date information and support to continue a pregnancy to term, women are being pressured to abort with little to no information or support offered to them if they decide to continue the pregnancy.

The issues raised around informed consent and termination of pregnancy was workshopped extensively at the summit. The following recommendations were made that would improve the information and care pathways offered women to enable them to give informed consent.

Recommendations for government in summary

Commonwealth government

The Commonwealth Department of Health should review health policies around termination of pregnancy to ensure that all Australian women have the opportunity to offer fully informed consent.

This review should cover whether women:
- Have access to adequate independent counselling;
- Have access to adequate pregnancy support services and be provided with information about them;
- Are provided with adequate information on the physical and mental health risks associated with termination of pregnancy;
- Are screened for all factors that place them at an increased risk of mental health problems after a termination and be informed of any increased risk;
- Know they can seek a second opinion; and
- Have adequate time in which to make a decision (a ‘cooling off period’).

As part of provisions to ensure women give fully informed consent and have explored all their options, the Commonwealth Government should consider the implementation of an online

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34 As shared by Joelle Kelly, T21 Mum Advocate, in her presentation at the Australian Summit on Abortion Law Reform 2018. https://youtu.be/kK5kZVd7nKM

35 Ibid.

36 In particular, whether women have access to adequate counselling at abortion clinics. The Medicare rebate for non-directive counselling cannot be claimed by clinics, hence there is little incentive to provide it. Clinics should be required to offer and refer (uncounselled) women for independent non-directive counselling. See section 3.3.2 of this paper.
‘Decision Making Tree’ on national government funded websites, such as ‘Pregnancy, Birth, Baby’, http://www.pregnancybirthbaby.org.au/.

This would be with neutral language and with no bias - e.g. “For this week of pregnancy - you may wish to consider…” A ‘decision-making tree’ could also be created as a basis for new guidelines that GPs, counsellors and social workers can use to help a woman walk through her options with an unexpected or problematic pregnancy.

The pathways could open up new options and recommendations for diagnoses in pregnancy and available options, information and support - e.g. if a woman is given a medical reason to consider abortion for amniotic fluid leakage, the decision-making tree would suggest she seek a second opinion from a specialist in amniotic fluid leakage (using information on specialists provided). There she can discuss protocols with the specialist and revisit options.

**State and territory governments**

State and territory governments should ensure their health departments and other places that perform terminations in their jurisdiction immediately review guidelines and regulations around termination of pregnancy to ensure that all women have the opportunity to offer fully informed consent.

State and territory governments should collaborate with the Commonwealth Government on developing national guidelines around informed consent for termination of pregnancy. Health workers should be appropriately trained and national guidelines implemented in all places where women are counselled in pregnancy or give consent to termination of pregnancy.

Detailed policy recommendations are found in sections 3.3 and 3.4.
2.2.4 Post Abortion Care

As shared by women who spoke at the summit and universally acknowledged, some women are psychologically affected after abortion.

“When I left the clinic, I did feel relief; no more arguing, no more stress, no more being afraid but it later turned into regret … I struggled, I had anxiety, insomnia, I often had suicidal thoughts, but my depression felt mild. So I continued on, until after a year I started to get really bad. I was having panic attacks, I was grieving, I was suffering from memory loss: everything suddenly became very overwhelming. I could no longer do grocery shopping, I didn’t want to drive to work, I was missing my deadlines and it was taking me an unusual amount of time to finish a job ... I took a holiday ... I slept a little better, I felt refreshed. So I returned to work, only four days later to have a complete breakdown. My boss sent me straight to the doctor where I was put on medication. I never returned to work.” - ‘Hannah’

Research has been clear for a long time that abortion is a risk factor for mental health problems for women across the globe and this is acknowledged by those on both sides of the abortion debate.

In 1995, an entire issue of the Journal of Social Issues was dedicated to research on the psychological effects of abortion:

“There is virtually no disagreement amongst researchers that some women experience negative psychological reactions post abortion.” - Editor, Dr Gregory Wilmoth.

The 1995 Beijing Declaration and Platform for Action (UN), signed by 189 governments, including Australia, states that wherever abortion is available:

“Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions...37

In Australia, research is limited in this area and further research is needed. In 2008, a study by Dingle et al.38, of 1223 young Australian women whose ages ranged from 18 to 23 years, found that:

“Women with a history of abortion or miscarriage were twice as likely to meet criteria for alcohol, cannabis, other illicit drug use, depressive or anxiety disorder compared with those who were never pregnant or who had given birth.”

To date, this study undertaken a decade ago, was the last and only comprehensive study to assess the impact of termination of pregnancy on the mental health of Australian women and it was limited to young women. There have been no studies to assess the mental health of the

37 UN Fourth World Conference on Women.1995. Section 106 (k). 

general population of women in Australia after pregnancy and look into any increased odds of disorders after abortion.

However, as noted in section 2.2.1, emerging client data from Children by Choice reveals a concerning finding about the effect of reproductive coercion\(^{19}\) (which includes abortion coercion) on women’s mental health:

> “Contacts reporting reproductive coercion were more than three times more likely to experience suicidality as the general contact base and almost twice as likely to experience mental health problems [emphasis added].”\(^{39}\)

The adverse mental health outcomes that women may experience after abortion include: persistent negative emotions, anxiety, depression, substance abuse, PTSD and suicidal ideation/behaviours.

It is acknowledged by abortion providers that abortion is a risk factor for psychological problems and that pre-abortion conditions identify women at risk. However there is concerning evidence that women in Australia are not adequately screened and informed of increased risk prior to the procedure, due to lack of counselling at clinics and lack of adequate guidelines around informed consent in relation to termination of pregnancy. The pre-abortion conditions identified by international research which indicate a higher risk of mental health problems include women who:

- Have had mental health problems or a mental illness prior to the abortion;\(^{40}\)
- Are ambivalent (have mixed feelings) about the abortion decision or difficulty or distress in making a decision;\(^{41}\)
- Experience coercion or pressure to have the abortion;\(^{42}\)
- Are committed to the pregnancy;\(^{41}\)
- Have personality factors such as low self-esteem, low perceived control over life and use avoidance/denial strategies to cope;\(^{41}\)
- Are terminating a pregnancy that is wanted or meaningful;\(^{43}\)
- Are under 21 years old;\(^{44}\)
- Have had one or more abortions already;\(^{45}\)
- Have had past childhood sexual abuse;\(^{46}\) and
- Receive poor quality abortion care or inadequate counselling.\(^{47}\)

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\(^{42}\) AMRC, 2011. Induced Abortion and Mental Health. 8. Findings of the steering group. ‘There were some additional factors associated with an increased risk of mental health problems specifically related to abortion, such as pressure from a partner to have an abortion.’


\(^{47}\) AMRC, 2011. Induced Abortion and Mental Health. p. 79.
A textbook for abortion providers, “Management of Unintended and Abnormal Pregnancy Comprehensive Abortion Care” lists most of the above risk factors for ‘negative emotional sequelae’ and additional ones including:

- Lack of emotional support and receiving criticism from significant people in their lives;
- Fetal abnormality or other medical indications for the abortion;
- Advanced stage in pregnancy;
- Belief that abortion is the same as killing a newborn infant; and
- Expecting depression, severe grief or guilt, and regret after the abortion.

It advises that providers assess the patient accordingly, pre-termination and states:

“Patients with risk factors may require more time to reconsider options or make a plan for coping strategies.”

Scientific studies from around the globe identify abortion as a risk factor in:

1. Substance abuse - at least 15 studies;
2. Anxiety - at least 18 studies;
3. Depression - at least 17 studies; and
4. Suicidal behaviour - at least 8 studies.

These studies are listed, described and fully referenced in the paper, ‘Does Abortion Cause Mental Health Problems?’, which is available online.

They include large scale linkage studies by Reardon et al. of 172,279 women in the United states and by Gissler et al. of 156,789 Finnish women. The Reardon study reported a 154% increased risk of suicide associated with abortion. The Gissler study which linked data to death certificates and to a termination of pregnancy registry found an alarming 650% increased risk of suicide associated with abortion (a six times higher risk than for women who gave birth).

Fergusson et al. in New Zealand conducted birth cohort studies of 500 women in 2006 and in 2008. In both years, they found significantly higher mental health disorders associated with abortion. In 2008, the data from women at age 30 showed the following increased risks associated with abortion: suicidal ideation: 61%; alcohol dependence: 188%; illicit drug dependence: 185%; major depression: 31%; and anxiety disorder: 113%.

In 2007 Pedersen et al. conducted a longitudinal, nationally representative study in Norway and found the following increased risks of substance use/abuse associated with abortion:

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nicotine dependence: 400%; alcohol problems: 180%; marijuana use: 360%; other illegal drugs: 670%. All the studies cited above included ‘no abortion’ and birth of unplanned pregnancy control groups.

Studies across cultures hence show an increased risk of mental health problems associated with abortion and the need for post abortion counselling to be available to women. However this is not adequately provided as part of standard practice in Australia. It may be offered by clinics but in most, if not all cases, this is only for counselling over the phone, not face-to-face, which is necessary for proper treatment. Clinical experience from psychologists has found that women who are traumatised don’t want to go near the clinic where they had the abortion and even avoid driving past it. Independent, face-to-face counselling, offsite to abortion facilities is rarely offered to Australian women.

Many counsellors, psychologists, psychiatrists and even state/territory health departments do not acknowledge that abortion is a risk factor for mental health problems. When it is not acknowledged that abortion may be a contributing reason for a mental health problem, a patient cannot be treated for this.

The studies that have been conducted in Australia show that there are increased risks associated with abortion for young women and for women who experience abortion coercion. Longitudinal studies (ideally prospective) are urgently needed to assess how Australian women in general fare after abortion and what care provisions are needed. Contextual information related to circumstances of pregnancy loss should be collected, so that research can account for factors associated with mental health problems, such as reasons to abort, support received and gestational age.  

Recommendations for government in summary

**Commonwealth government:** That research is commissioned into mental health outcomes of abortion for women and their male partners, that is representative of the general population. Ideally prospective longitudinal studies should commence promptly to assess the impact of abortion on the mental health of Australian women and service provisions that are needed. The Commonwealth Department of Health should review and develop guidelines on termination of pregnancy that include post abortion care models and policies.

**State and territory governments:** State and territory governments should ensure that where abortions are provided, women know about and have access to free, independent, face-to-face post abortion counselling and in a different location to where abortions are provided. Allied health professionals and counsellors working in the area of women’s health should be trained to identify if an abortion is a contributing factor in mental health problems for a woman and trained in appropriate treatment.

Detailed policy recommendations on post-abortion counselling protocols are in section 3.5.

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54 Application for funding could be made to the National Health and Medical Research Council of Australia (NHMRC), as part of further and more comprehensive research in Australia on termination of pregnancy.
2.2.5 Data Collection and Availability

Adequate data on elective termination of pregnancy and women’s experiences of it, is not available in Australia. Data collected and reported by one state is inadequate to calculate a national abortion rate.

There is no consistency of data collection between states and territories of Australia. When data is collected, it is largely inaccessible to Parliamentarians and the public. It is hence not possible to assess the benefits/risks of termination of pregnancy for women in Australia. This includes whether terminations are resulting in better health outcomes for women, which is the basis for legal abortion in most states and territories.

The problem of lack of adequate data being available in Queensland, particularly to Members of Parliament, was discussed. Information is currently available only to one public servant - the Chief Medical Officer.

How can Members of Parliament recommend or decide on any change in law and be assured it will be in the best interests of women and other members of the community, when they have very limited access to data on current practices and to assess the possible impact of any change?

For example, in one of the few Australian studies documented on pregnancy loss and mental health problems for women, Dingle and colleagues noted that their study was limited due to data being unavailable. This study found an increased risk of psychiatric disorders in young women who had had abortions, yet the research was limited in scope and hence in capacity to speak to policy/service providers:

“We could not account for associated factors such as reasons to abort, support received and gestational age at the time of the pregnancy loss... [Due to lack of access to data we could not investigate...] “...whether specific circumstances surrounding the termination, the timing of the termination or other pregnancy related events would confound associations between pregnancy loss and psychiatric disorders.”

Parliaments should not legislate to change any law on termination of pregnancy when Parliamentarians have inadequate data on which to base their decisions.

Recommendations for government in summary

Commonwealth government: The Commonwealth Department of Health should commission research into women’s experiences around termination of pregnancy and publish the findings.

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**State and territory governments:** State and territory governments should require accurate reporting of data on termination of pregnancy that resolve current flaws in reporting. Women’s experiences and reasons for abortions should also be collected in each jurisdiction.

**Queensland:**
The Queensland government should make an amendment to current law that limits access to data on termination of pregnancy to the Chief Medical Officer only to make it accessible to the Health Committee and Members of Parliament. The Queensland government should consider allowing the public access to information on termination of pregnancy collected by government departments, as currently is provided for in some other Australian jurisdictions.

**Other states and territories:**
Similarly if state or territory legislation in jurisdictions other than Queensland prevent Parliamentarians from directly accessing adequate data on termination of pregnancy, there should be amendments to the law to allow such access.

Regular audits or surveys should be requested where data collection is already occurring - e.g. through the Pregnancy Advisory Service in Victoria. Results of these audits should be published through health departments. These audits should be designed to provide comprehensive information to legislators, health workers and the public on termination of pregnancy in each jurisdiction of Australia, including the number of terminations, the gestational period, the reasons for terminations, the number of terminations each woman has and demographic information.

Detailed policy recommendations are found in section 3.6.
The five key issues raised in Chapter 2 and others were discussed in detail in round table discussions at the summit. There were ten round tables and each table had its own topic. As a result of these discussions, policy recommendations for consideration by governments emerged from each of the ten areas. These include detailed policy recommendations for the five top issues already raised in Chapter 2.

The full policy recommendations for immediate consideration by Commonwealth, State and Territory governments arising from the ten areas of discussion at the summit are:

### 3.1 Abortion Coercion and Domestic Violence

**Context:** From the research currently available, the association between domestic violence (otherwise known as Intimate Partner Violence or IPV) and abortion is high for Australian women. As cited earlier in this paper, a study by Taft and Watson in 2007 found that the odds of termination of pregnancy (TOP) for women who experienced recent partner violence (17%) were more than four times higher than of non-abused women (4%). Likewise, a 12 month audit in 2009 into the records of over 3,000 women who contacted PAS in Victoria found that almost 1 in 5 women (16%) seeking terminations disclosed experience of violence. Children by Choice client data from 2015 also shows that about 74% of clients who report reproductive coercion (abortion coercion or other forms of reproductive coercion), also report domestic violence. CBC client data on abortion coercion alone is not presently accessible.

It is unknown what percentage of these numbers of abused women sought terminations freely or due to abortion coercion, either emotional or physical. In 2014 an extensive systematic review was published by Hall and colleagues, looked at IPV and termination of pregnancy (TOP) across six continents (including Australia). It found high rates of physical, sexual and emotional IPV among women seeking terminations, yet many women were not asked about IPV at the time of the termination, even when screening occurred\(^\text{56}\). This was despite women desiring intervention when they did report IPV. This review of literature from across the globe found:

“Although it was not always determined whether experiencing IPV was a determining factor in the decision to end, rather than continue, a pregnancy, the findings support the concept that violence can sometimes lead to an initial pregnancy (via coercion, rape, sexual assault, or contraceptive sabotage) and to subsequent TOP (via coercion).”

According to the meta-analysis, IPV was associated with the partner not knowing about the TOP, however IPV was not associated with lack of partner support for a TOP. Hence, according to this, violent partners are not saying, “No, you can’t have a termination”; however women are more likely to conceal a termination from a violent partner. Women cited IPV as a reason for wanting a termination.

Likewise Marie Stopes Australia reports in a new 2017 study that the most frequent type of reproductive coercion disclosed to health practitioners by Australian women was concealing a pregnancy and subsequent abortion due to fear of their male partner.

Current screening processes and intervention protocols/services around terminations in Australia are not adequate to ensure forced terminations in situations of domestic violence are not occurring.

### 3.1.1. Research on Abortion Coercion

That research is commissioned by the Commonwealth government and also by relevant government agencies. This research as a minimum should include: a definition of abortion coercion; explanation of forms of abortion coercion; comprehensive audits into women’s experiences around abortion, particularly when they also experience domestic violence. Research should clearly examine whether these women felt pressured to have a termination and whether they were otherwise offered support to continue their pregnancy to keep their child if they wished. For insights into the problem, qualitative studies are also needed where the stories of women who have experienced abortion coercion are compiled. Research into abortion coercion in Australia should be made widely available and Parliamentarians given time to consider it before any legislative change to abortion laws is considered.

### 3.1.2. Regulations on Abortion Coercion

The Commonwealth government should provide national policies and guidelines on how to protect women from abortion coercion. Policies and regulations should be considered and implemented by all state and territory governments to assist women who may be vulnerable to abortion coercion. These could include, education of allied health professionals...

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and abortion providers on abortion coercion and screening before a termination, particularly in antenatal settings, to ensure women are not being coerced. Policies should also include how to better care for women facing challenging pregnancies, as part of usual care pathways.

With regard to domestic violence, whilst research is currently insufficient to determine whether Australian women are being forced into abortion by their male partners or seek this freely; research nevertheless clearly shows an association between domestic violence (or IPV) and termination of pregnancy (TOP):

“Given the clear associations, termination services provide an appropriate setting in which to assess screening for, or give information about, IPV, whether pre- or post- TOP, and for offering an intervention that women desire, such as a “one stop” offer of referral to specialist IPV services, especially in view of low return to clinics for follow-up.”

“Good practice obligates that termination services should have robust policies for ensuring women’s safety and confidentiality, providing information and referral pathways for those who disclose IPV, and exemplar guidance exists.”

Research indicates that clinical factors associated with a higher chance of domestic violence are: previous/multiple terminations, lack of contraception, initially planned pregnancy, ultrasound redating and the partner not being told about the TOP or not funding it.

Screening for abortion coercion should be considered alongside domestic violence screening and particularly where abortions are provided. Audits and reviews of abortion provider procedures and the workplace culture of health workers in all care pathways for women facing challenging pregnancies should take place to determine if these facilitate abortion coercion. Screening protocols should also be developed and implemented nationally.

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58 See footnote 56, p. 21.
60 Where universal screening is not possible, the emerging trends in our data indicate targeted screening for reproductive screening should include:
   - CALD [culturally and linguistically diverse] & ATSI [Aboriginal and Torres Strait Islander] women;
   - Women between the ages of 20 and 30 presenting for abortion care; and
   - Women presenting for assistance with pregnancies of a higher gestation.
60 Marie Stopes Australia has recently committed to address the issue of reproductive coercion and is working with a number of organisations to do so. It has committed to undertaking internal audits of patient ‘touch-points’ to determine if practices are inadvertently facilitating partner coercion. It has also committed to develop and pilot a national screening trial for reproductive coercion. See p. 45 of draft white paper at https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/
3.1.3. Statistics on Abortion available to State and Territory Governments

Accurate and complete statistics on abortion needs to be collected from all providers of abortion in each state/territory and provided to government. This information should include the age of women at the time of the abortion, the number of abortions each women has had, gestation of pregnancy, reasons given for obtaining an abortion (including an option that says partner wants me to) and whether the woman was offered counselling or alternatives, etc. This information would be crucial in determining the numbers of women being coerced to abort.

3.1.4. Requirement for Screening for Abortion Coercion before Medicare Rebate

It is recommended that Medicare rebates for abortion are linked to whether a woman has been adequately screened for abortion coercion. For example, a doctor or abortion provider could be required to sign off this on a checked list or refer to a trained independent counsellor who can provide it.

3.1.5. Domestic Violence Laws to Include Abortion Coercion

Laws on domestic violence should be amended to recognise that a woman who consents to an abortion under duress due to coercion from her partner is not providing valid consent and that this is a form of domestic violence.

3.2 Pre-decision Support Service Protocols

**Context:** One-stop support services that offer women the option to continue an unexpected or problematic pregnancy are very limited in Australia. These holistic and integrated care models, where the service stays with the woman for as long as she needs it, even well after the pregnancy outcome, offer a unique and needed service to women. Existing services are very limited and not available to most Australian women in this situation because many are not currently government funded, promoted or included in usual care pathways.

Fair and appropriate resource allocation by government for pregnancy services must include funding of services that assist women in continuing challenging pregnancies, not just funding of services that allow them to terminate:
“More specifically, if funding is not equally distributed through the Medical Benefits Scheme to both abortion providers and acquirers and to the agencies who assist women to offer them a live birth, there is not a true choice.” - Dr Alexandra Doig61

3.2.1. Standards of Practice for Support Services in Challenging Pregnancies

That core principles of good practice for services dealing with unexpected or challenging pregnancies are standardised and regulated by a peak body. These should be highly publicised, so that women and their partners understand the nature of good quality support and their entitlement to it.

3.2.2. Government Accreditation and Audits of Pregnancy Support Services

That the Commonwealth government review and accredit holistic support services for women in challenging pregnancies and fund these services. Funding would mean government audits of these pregnancy support services which would help ensure best practice and their expansion to women in need in Australia.

3.2.3. Standard and Accessibility of Pregnancy Support Workers

That all counsellors and pregnancy support workers are trained according to best practice standards and that, in particular, holistic pregnancy support services are available to any woman requesting support.

3.2.4. Guidelines on Pregnancy Counselling and Support in Care Pathways

That guidelines around pregnancy counselling and care pathways ensure that all potential referrers have full information on and are required to disclose to women, the pregnancy support services and other specialist services available to support them in pregnancy.

3.2.5. Training and Guidances for Health Care Workers to Respond to Ambivalence and Coercion in a Pregnancy Decision

Best practice standards should ensure that all those working with women with unexpected or problematic pregnancies within care pathways, are

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61 Presentation by Dr Alexandra Doig MBBS at the Australian Summit on Abortion Reform 2018.
able to identify when women are feeling ambivalent about making a decision or are experiencing coercion.

3.2.6. New Medicare Rebate for Pregnancy Support Services

That pregnancy support services which follow an ongoing case care approach have a new Medicare rebate.

3.3 Informed Consent

Context: Empirical evidence indicates that a significant number of Australian women considering termination of pregnancy or not afforded the opportunity or are able to give fully informed consent, due to abortion coercion and lack of support or information. This is despite the professional and legal obligations of medical professionals to act in a patient’s best interests. Stories from women who felt they did not give fully informed consent to a termination indicate that they were not afforded enough time, information or appropriate support to continue their pregnancies, as an alternative to termination.

Emma, who has had multiple abortions, felt the counselling she received at abortion clinics ‘isn’t really counselling’:

“Counselling to me is quite objective... it’s supportive and sort of putting it all on the table for you to make a decision. Whereas what I found when I went in, it was quite leading questions, [such as] ‘So obviously, you’re very upset at the moment. How can we help you? If you weren’t pregnant anymore would that relieve you of the situation that you are in?’ [Replies] ‘Absolutely.’
‘Great, well it’s very easy. All we do is it’s very gentle, you won’t feel a thing and then you will be able to go on and move on with your life.”’ – Emma

Emma also says she felt, at the clinics, ‘they could not have cared less about me as a person’. She says:

“Really they just want to book you in and get you out the door – That’s how it appeared to me in hindsight looking back because there was really no support in providing options or actually getting to the depth of what’s going on with me in that time. I would have absolutely have made different choices if I had been supported in my pregnancies. All I faced was opposition – there was not one person in the all of the pregnancies that I faced, not one person who said ‘You can do this’ or ‘Let’s just talk about it’. Not one." - Emma

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62 Emma’s ‘The Rest of the Story’ – (Part 2) Youtube: https://youtu.be/badtXoQJaF8
63 Ibid.
3.3.1. Review of Guidelines on Informed Consent in Relation to Termination of Pregnancy and Controls over Best Practice

That the Commonwealth Department of Health commission a review into policies and guidelines on informed consent. The aims of this review would be to:

1. Improve processes and controls over termination of pregnancy; and
2. Ensure women have full opportunity to give informed consent to the procedure.

This review should include qualitative research into the experiences of women who felt they did not give informed consent to a termination, in a broad range of instances, including through government health services, private clinics and in cases of a challenging prenatal diagnoses. Prospective, longitudinal studies should commence with this review to access the current situation around women’s experiences in consenting to an abortion and the impact of any change in guidelines and standards at a national or state/territory level, as recommended in this paper.

Policies and improved guidelines from the Department of Health should be made available to and implemented by all state and territory health departments and in the private sector, as part of best practice in termination of pregnancy.

3.3.2. Review of Counselling Requirements at Abortion Clinics and Medicare Items

Medicare item numbers for non-directive counselling (4001, 81000, 81005 and 81010) exclude ‘GPs, psychologists, social workers and mental health nurses who have a direct pecuniary interest in a health service that has as its primary purpose the provision of pregnancy termination services.’

Women such as Emma and ‘Hannah’ who spoke at the summit and others across Australia, including Jaya Taki, claim they did not receive adequate counselling at abortion clinics. It would appear, that because health workers cannot receive Medicare rebates for non-directive counselling (that requires a minimum of 20 counselling) at abortion clinics, adequate counselling is not being provided at abortion clinics. This is an added cost to clinics, or a cost passed on to the woman. Due to the pecuniary interest of abortion clinics in providing

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65 Jaya shares her abortion coercion story: [https://youtu.be/gaBuyQ2ieeY](https://youtu.be/gaBuyQ2ieeY)
termination services, there is little incentive to provide any lengthy counselling that would provide a woman with the time and support needed for her to consider continuing a challenging pregnancy.

Furthermore, there is no law in Australia that requires someone providing a counselling service to have either qualifications or experience. This means that abortion clinics may not be using qualified counsellors. At the very least women should be informed and advised to seek independent counselling before going directly to a clinic.

A review is needed into what counselling requirements, if any, are required and mandated for abortion clinics. It is essential that pre-termination counselling meeting minimum requirements and information on support services is offered to women who directly present at clinics, without having had the opportunity for prior counselling. Inadequate counselling prior to a procedure is a risk factor for negative mental health effects after an abortion. It should be mandated that women are offered and can receive adequate non-directive counselling through referral to an independent counsellor. Time to make a considered decision prior to a termination procedure should be provided for.

3.3.3. Research on Possible Correlation Between Multiple Abortions and Sexual Abuse and other forms of Domestic Violence

Investigation is needed into claims by some counsellors that there is a correlation between multiple abortions, sexual abuse and other forms of domestic violence. This is a possible red flag that should be included in guidelines for doctors to follow-up and suggest intervention when women return for repeat abortions.

3.3.4. Screening and Informing Women of any Increased Risk of Mental Health Problems Prior to Termination of Pregnancy

Research consistently shows that the greatest predictor for mental health problems after an abortion is a prior history of mental health problems.

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67 AMRC, 2011. Induced Abortion and Mental Health. p. 79.
There are a range of other conditions pre-termination that are known to place women at greater risk of adverse psychological outcomes. A list of what these conditions are outlined in section 2.2.4. Informed consent for termination of pregnancy must include screening for women who have risk factors that make them more susceptible to mental health problems after abortion. These women must be fully informed of their increased risk of having mental health problems if they go ahead with the procedure and encouraged to consider other options rather than abortion.

3.4 Medical Support Options

**Medical Support Options: Informed Consent**

**Context:** Medical professionals, particularly GPs and those who have the first contact with women who present with an unexpected or problematic pregnancy are often not well equipped to assist women in these circumstances. This is due to consultation time pressures, inadequate training in options counselling, inadequate guidelines to assist women through the decision-making process and lack of information on the option to continue a challenging pregnancy including available pregnancy support services.

3.4.1. Government facilitated Pregnancy Options

‘Decision Making Tree’

Provision of an online ‘Decision Making Tree’ on government websites and in publications, as a tool for women to find a pathway toward being fully informed. This would be with neutral language and no bias - e.g. “For this week of pregnancy - what you need to consider...” This tree could be extended to incorporate prenatal diagnostics, antenatal diagnostics and have a list of resources/organisations to assist women when they arrive at whatever decision they are contemplating. This could be printed and distributed in abbreviated form to GPs.

3.4.2. Information and Support for Pregnant Women to Get a Second Opinion

Governments should ensure that women with an unexpected or problematic pregnancy are informed that they are entitled to access a second opinion and how to go about this. This could be achieved through the production of a leaflet distributed in health facilities and through other advertising. For example, how to obtain a second opinion in the case of amniotic fluid loss in pregnancy or a prenatal diagnosis.

“However, the most consistently identified factor, and that with the largest impact on post-abortion mental health outcomes was previous mental health problems”. AMRC. 2011. Induced Abortion and Mental Health. p.13.
3.4.3. GP Training in Non-Directive Counselling and Support Pathways

Clinical practice models for GPs should be improved. An Australian survey in 2006 commissioned by Marie Stopes International, indicated that more women facing an unplanned pregnancy turn to their local GP (17%), than those who wanted to speak to a pregnancy counsellor over the phone (12%) or in person (7%)\(^70\). This is consistent with results from the audit of PAS records in Victoria in 2009 that found, “In the absence of a coordinated pathway of pregnancy referral, GPs are often the first point of contact for women with unplanned pregnancy in Victoria, and provide a large proportion of referrals to PAS”\(^71\).

GPs should be trained in pregnancy options counselling. It is recommended the government request that the professional colleges of GPs, RACGP and the ACRRM encourage and support GPs to do the PD Module and be credentialed in non-directive pregnancy counselling. GPs should be encouraged to use the Medicare number assigned to this counselling. This is MBS item number 4001 - GPs (at least 20 min, non-directive counselling) as best practice and for data tracking. GPs should be trained not only in non-directive counselling but in identifying abortion coercion and intervention options.

GPs who are not trained should be required to refer women for non-directive counselling, before a referral to an abortion provider (as providers cannot be relied upon to provide adequate counselling - see section 3.3.2).

If GPs are providing the initial consultation for a woman in a challenging pregnancy, they should be required to provide adequate information about abortion procedures and disclose that pregnancy support services are also available, as the alternative to termination services (without requiring they refer).

Medical Support Options: Guidelines for Termination of Pregnancy (TOP)

Context: Various statements and guidelines for termination services are provided by RANZCOG\(^72\) and state and territory health departments. However, guidelines are insufficient in some cases and inconsistent between jurisdictions and practices. This means inconsistency of guidelines and practice across Australia for termination of pregnancy.

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\(^{70}\) Marie Stopes International. What Women Want When Faced With an Unplanned Pregnancy. 2006. Conducted by Websurvey. This was a survey of 1022 women in Australia of their experiences of unplanned pregnancy.


The latest clinical guidelines on TOP produced by the Northern Territory government in 2017 do not include a pathway for information or referral to pregnancy support and services. The guidelines illustrate only one pathway after information is provided on pregnancy options - ‘Request for termination’. There is an absence of a care pathway for the other option which should be available at this point - a request for support services or information that may assist with continuing a challenging pregnancy. The other option that should also be included at this point is a request for a second opinion.

When termination is considered, it is important a pregnancy support pathway and the option to seek a second opinion is acknowledged and provided by practitioners, to ensure a woman is properly informed of help available to her if she wants to consider continuing the pregnancy. With this information, she may need more time to consider her options and to know she will have the support of specialised services if she decides to continue a challenging pregnancy.73

There is a need for policy makers in health to move away from the current ideological divide. There should be a considered and honest review of all sound research, to provide women with complete, unbiased information on the procedure and risks, as part of guidelines on termination of pregnancy.

What is apparent from the experiences shared at the summit is that there are serious inadequacies or inconsistencies in procedures around termination of pregnancy and deficiencies in guidelines.

3.4.4. Review of Guidelines for Termination of Pregnancy

That the Commonwealth government reviews guidelines for termination of pregnancy. Appropriate experts should work to identify all deficiencies in current guidelines and ensure these guidelines are developed to include all important areas of care.74

An Expert Working Group or Committee should be formed to look at deficiencies in guidelines in all jurisdictions and make recommendations.


74As the government has done in other areas of health. In 2017, ‘COPE’, the Centre of Perinatal Excellence, published new National Perinatal Mental Health Guidelines, that it had been commissioned by the Commonwealth government to review and update. http://cope.org.au/about/review-of-new-perinatal-mental-health-guidelines/.

Best practice guidelines in health have also been developed by working groups that include representatives from private practice, health funds, medical practitioners, the Office of the Private Health Insurance Ombudsman, consumer representative organisations and Department of Health. http://www.ombudsman.gov.au/__data/assets/pdf_file/0014/30353/pea-bestpracticeguidelinesforhospitals.pdf
Some of the matters that may need to be incorporated into guidelines as suggested in discussions at the summit are:

1. Pre-intervention history including screening for coercion and higher risk of mental health problems and counselling. If the pregnancy is not life-threatening, a second visit for the procedure should be mandated after counselling to allow due consideration of the planned intervention. This is especially important in cases where first presentation of the patient is at a provider of terminations, where sufficient non-directive counselling is not provided. As part of discussions with patient, information is provided on the procedure including risks (physical and mental), the pregnancy including risks, human development appropriate to gestational age and also information on available pregnancy support services;

2. Pregnancy testing to confirm and document the pregnancy status;

3. Ultrasound to confirm intrauterine location of the pregnancy;

4. Blood group testing and provision of anti-D if required;

5. Follow up HCG testing for very early pregnancies where the ultrasound was not definitive;

6. A protocol for a second opinion from an obstetrician and/or medical obstetric physician, in cases where a healthcare professional, such as a GP or disease specific specialist, advises a termination of pregnancy for a medical reason;

7. Post-intervention care provided to 6 weeks post procedure. This should be covered by an MBS number and remuneration appropriate for the provision of services such as phone and face to face follow-up, counselling advice and support, with appropriate referral if required. Consideration should be given to the delayed lodgement of the MBS claim, or stepwise lodgement based on provision of these aftercare services;

8. Written post-procedure instructions and clear referral pathways for complications or mental health issues. There should be audit tools for complications, including a mental health screening tool, with collection of 6 week and 6 month data, for improvement of best practice.

*Medical Support Options: Post Abortion Care*

**Context:** Although it is universally acknowledged that abortion is a risk factor for mental health problems for some women, the availability of suitable post abortion counselling to women in Australia is inadequate.
3.4.5. Post Abortion Care Models and Best Practice

Post abortion follow up care models and best practice is needed for application in private and government sectors, to ensure that all women who need counselling after abortion receive it. In the area of post abortion counselling, training of health professionals should be developed in consultation with experts who specialise in the area of post abortion grief.

3.5 Post Abortion Counselling Protocols

Context: There are inadequate guidelines around post abortion counselling in Australia to ensure all women who suffer adverse psychological effects after abortion receive the care they need.

3.5.1. Free, Independent and Available Post Abortion Care

Free and independent post abortion counselling should be made available to any woman who requests it and off-site to where the abortion took place. Women need to be advised that post abortion care is available before the procedure takes place.

3.5.2. Acknowledgement by State Health Departments of Negative Mental Health Effects of Abortion for Some Women

That there is a directive in all state and territory health departments that acknowledges the negative mental health effects of termination of pregnancy for some women. Details should be included as to what these mental health effects are, as well as guidelines for the standard of care for a woman presenting with emotional or psychological effects post termination. Ideally these guidelines and information should be developed by Commonwealth Department of Health for standardised policies on post abortion care in state and territory health departments.

3.5.3. National Guidelines on Post Abortion Counselling

The Commonwealth government Department of Health should ensure national, standardised post abortion care policies and models. These should be included in guidelines and care pathways for termination of pregnancy in all state and territory health services and recommended by governments and peak medical bodies for adoption also in private practices.
3.5.4. Education on Post Abortion Trauma and Treatment
Psychologists, psychiatrists and GPs need to be educated on the realities of post abortion trauma that exists for some women after abortion. They should be provided with appropriate training, developed in collaboration with specialists in this area, to treat women presenting with mental health problems, for which abortion may be a contributing factor.

3.5.5. Research on the Mental Health Effects of Abortion on Women
The government should urgently commission research into the mental health effects of abortion on Australian women that is representative of the general population.

3.6 Data Collection and Clinical Practice Auditing

Data Collection

Context: There are three problems with data collection on termination of pregnancy in Australia:

1. Data collection is inadequate - reliable statistics on abortion are unavailable. When it is reported there are flaws in reporting requirements. Reporting does not distinguish between the same procedures performed for induced abortions\(^{75}\), spontaneous abortions (miscarriages) or pregnancies ended before viability for medical reasons\(^{76}\). For example, currently all public, private and community providers of dilation and curette procedures are not required to specifically report induced abortions. (This procedure is also performed for miscarriage). Medical abortion procedures are also not required to be reported retrospectively to ensure the patient completed the procedure. Furthermore, details of women’s experiences of abortion are rarely collected and are insufficient in detail to confidently speak to policy making.

2. Data on termination of pregnancy is inconsistent between states and territories. In some jurisdictions it is not available at all and the inconsistencies do not allow comparison. It is not possible to compare the impact of different laws or policies surrounding abortion in different jurisdictions and how these may speak to service provision.

3. Data that is collected is largely inaccessible. In some states such as Queensland, information on termination of pregnancy is not available to Members of Parliament or the public.

\(^{75}\) Also medically referred to as ‘elective’ abortions. See footnote 2 for a definition.

\(^{76}\)Terminations before viability that are not considered ‘elective’ or induced abortions. E.g. therapeutic abortions or terminations for a medical necessity where the aim of the procedure is not the death of the embryo or fetus although this may be inevitable. (The latter may be referred to as indirect abortions).
3.6.1. Change of Queensland Laws on Access to Data concerning Termination of Pregnancy

There should be a change in the Queensland law to allow Members of Parliament access to data on termination of pregnancy, that currently can only be accessed by the Chief Medical Officer. This change in law should also consider granting the Health Committee and Members of Parliament access to the same information. Parliaments should not be expected to change laws around termination of pregnancy when they do not have reasonable access to adequate data.

3.6.2. State and Territory Government Audits and Requirements for Adequacy of Data Collection on Termination of Pregnancy and Reporting

Investigation into best practice around data collection on termination of pregnancy and reporting in every Australian jurisdiction is needed. Data collection or reporting that is available publicly across all states and territories of Australia is inadequate because it does not include reliable estimates of abortion rates. Consistent and reliable methods of reporting abortions need to be developed and implemented.\(^77\)

Collection or reporting of information on women’s experiences of abortion is virtually nonexistent. Audits should be regularly conducted in every state and territory on abortion rates and other details relating to termination of pregnancy which include demographic and social characteristics, counselling or pregnancy support services availed, referrals, circumstances of pregnancy, domestic violence, special needs, reasons for considering abortion and post termination complications or psychological difficulties.

**Clinical Practice Audit**

**Context:** There are large organisations registered as charities in Australia that provide abortions and receive large sums of money through government grants and funding arrangements (such as Marie Stopes International\(^78\)). Government audits, such as by the Health Insurance Commission, are routinely and randomly performed on the financial practices of abortion providers. However, performance audits over abortion practices appear to be limited to compliance with NSQHS standards, through the Australian Commission on Safety and Quality in Healthcare. As they relate to abortion providers, the NSQHS standards (ten standards) apply to day procedures and clinical


practice in general. Accreditation through an authorising agency (which ensures compliance to NSQHS standards), such as the Australian Council on Healthcare Standards (ACHS) accreditation of Marie Stopes Australia - NSW for ‘Day Procedure Service’ is not an assurance of adequacy in provision of termination of pregnancy services specifically.

3.6.3. Regular Audits on All Practices in Relation to Termination of Pregnancy

Government performance audits should be conducted regularly, in relation to all practices around termination of pregnancy specifically, whether performed through government health departments or in private practice. These should include an assessment against best practice guidelines and standards of care. In particular, controls should be examined around pre-termination counselling at practices with a pecuniary interest in providing terminations. These controls should ensure independent counselling can be obtained by all women pre and post-termination and that this meets minimum time and quality requirements. State and Territory Health Ministers in each jurisdiction should work with independent NGOs concerned with this area of women’s health to review all practice in relation to termination of pregnancy.

3.6.4. New Medicare Items for Pregnancy Support

Services that provide Case-based Ongoing Care for Women encountering Problems in Pregnancy

That new MBS (Medicare) items be introduced for options with unexpected or problematic pregnancies, other than abortion, i.e. one-stop support services in pregnancy.

3.6.5. Review of Training of Abortion Providers to ensure Best Practice particularly in Pre-Decision Protocols and Post Abortion Follow-up

State and territory governments should review the education of abortion providers (in training programs across medical colleges and in undergraduate and graduate degree curriculum) and abortion service practice models, particularly pre-decision protocols. Models should include identification and guides on ambivalence in decision-making, coercion and the process to enable informed consent - e.g. the adequacy of information provided to women on human development within the

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womb and on the risks of termination of pregnancy (including mental health risks). Consistent, national guidelines are needed for all clinical practices and regulation by an independent body to ensure best practice.

3.7 Abnormal Screenings/Prenatal Testing

Prenatal Testing: Informed Consent

**Context:** Currently Australia has no guidelines around the prenatal screening process. There is no consistency between practices, even in the same geographical location, regarding what information is provided to women; in the referral process to specialists; in the terminology used to deliver a potential diagnosis; in the ongoing support provided; or in how women are connected to appropriate services. Lack of information and support does not allow informed consent.

As Joelle Kelly, T21 Disability Advocate, said at the summit:

“For, without information to choose from, their “choice” simply becomes an influenced decision, usually from within the medical field.”

In the case of a challenging prenatal diagnosis, the prevailing attitude among many medical professionals appears to be that termination is in the best interests of the woman. This is leaving women with little to no information or support to carry their pregnancies to term.

3.7.1. Best Practice Guidelines on Informed Consent before and after Prenatal Screening

That the Commonwealth Department of Health commission the development of best practice guidelines on informed consent to ensure this is obtained for prenatal screening and for termination of pregnancy in situations of a challenging prenatal diagnosis. These would include information on prenatal screening and possible outcomes and the option not to proceed with screening. After a challenging prenatal diagnosis and where termination of pregnancy is given as an option, guidelines should be developed in line with the proposed review of guidelines on termination of pregnancy to incorporate informed consent. These guidelines should also include information and pregnancy support options, as detailed in sections 3.3.1 and 3.4.4 of this paper. Screening for an abortion should properly assess the patient for all factors that place her at an increased risk of mental health problems after the abortion, as an abortion for fetal abnormality is already a risk factor. A full

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80 As shared by Joelle Kelly, T21 Mum Advocate, in her presentation at the Australian Summit on Abortion Law Reform 2018. [https://youtu.be/kK5kZVd7nKM](https://youtu.be/kK5kZVd7nKM)
assessment may result in advice that she consider carrying to term or is given a plan for coping strategies. See section 2.2.4 of this paper.

3.7.2. Consistent National Guidelines on Prenatal Screening

The Commonwealth government should develop national guidelines around prenatal screening, for implementation throughout all state and territory practices where prenatal screening takes place. These guidelines should ensure that women receive unbiased, up-to-date and consistent information at two critical points in a pregnancy:

1. Before the commencement of any prenatal screening; and
2. After screening results in a high chance of a challenging prenatal diagnoses.

3.7.3. Guidelines for Care of Women who receive a challenging Prenatal Diagnosis

Protocols for women who receive a challenging medical diagnosis for their unborn child: they must be given the opportunity for adequate and relevant counselling before proceeding further and the right to a second opinion and information on how to obtain that second opinion. Doctors need to provide information on all options available, including carrying to natural term, adoption and late term diagnostic testing.

3.7.4. Cooling off period in the event of a challenging Prenatal Diagnosis

In the event of a medically challenging diagnosis, a cooling off period should be included as part of the national guidelines. During this time the mother is to be given access to up-to-date information and specific services relating to the diagnosis.

3.8 Maternal Support vs Isolation

**Context:** The Commonwealth government, through various incentives such as the Child Care Subsidy and Parental Leave is aiming to retain women in the workforce after they have had a child. However, the government is not proportionally supporting parents who wish to home care their children and not return to the workforce. These parents are not afforded comparable financial, moral or practical support through government initiatives, to home care their children.

Maternal isolation is a significant social and welfare issue in western countries. Action for Children’s recent poll of over 2000 parents found that more than half
had experienced a problem with loneliness, with a fifth feeling lonely in the last week.\textsuperscript{81}

In addition, findings from a 2017 Mumsnet survey found that more than half of parents said problems with low self confidence was a cause of loneliness, with well over half feeling lonely at the school gate (57\%) or at playgroups (59\%). Parents with a child under one, those not in full time work and single parents are among those more likely to have a problem with loneliness.\textsuperscript{82}

A survey this year by the Young Women’s Trust found that over half of young mothers said they had become lonelier since becoming a mother, with a quarter leaving the house once a week or less. Two thirds said they had fewer friends since becoming a mother and that the nature of these friendships had changed.\textsuperscript{83}

With tens of billions of dollars being spent on Child Care subsidies there appears to be disproportionate government support for institutionalised child care. However, research indicates that institutionalised day care has significant adverse effects for some children. Yet, parents are also struggling with finances, isolation and lack of support in the home. Families deserve real choices when they have their family, including being able to home care their young children.

\subsection*{3.8.1. Child Care Subsidy}

That the government reforms child care payments so:

\begin{enumerate}
\item All child care payments are rolled into one means tested payment to all parents.
\item Income tax policies consider how many dependents rely on that income.
\item Parents are paid directly and fees are not subsidised for commercial child care.
\end{enumerate}

The Commonwealth government should monitor the impact of the new Child Care Subsidy, particularly on children, through ongoing research on the effect of formal child care on Australian children. It should adopt Recommendation 1 of the 2009 Senate Committee which said, “The Committee recommends that further research be carried out regarding the possible adverse effects of commencing formal childcare at very young ages and for long duration, possibly in conjunction with bodies such as the Centre for Community Child Health.”\textsuperscript{84}

\begin{footnotes}
\item Mumsnet Survey 2017: Survey was open to all UK Mumsnetters who are parents from 6/9/17 to 20/9/17 and gained 1,166 responses.
\item Young Women’s Trust. What Matters to Young Mums. 2017.
\end{footnotes}
3.8.2. Research into Maternal/Paternal isolation, loneliness and parental desires in care of their children

That the Commonwealth Government undertakes research into the welfare of mothers and parents in Australia to determine the extent of maternal/paternal isolation and the support needs of parents, particularly stay-at-home parents. Research should also be undertaken to reveal how parents in Australia wish to care for their children - at home or through formal care, according to the age of children, the number of children and the desire of either or both parents to return to part-time or full-time work.

3.8.3. Grants for High-Quality Mothers’ and Fathers’ Groups

That the government consider providing grants and incentives for local communities and church groups to develop more high-quality mothers’ and fathers’ groups. Such grants would need to be attached to a requirement that those organising have good training and follow guidelines to ensure that the experience of a parent at these groups is a positive and helpful one.

3.8.4. Education campaigns on existing services to raise awareness of support available to mothers and fathers

State and territory governments should run education campaigns to inform parents of existing support groups and services available in their area and/or ensure hospitals assign new mothers to a local mothers’ support group.

3.9 Paternal Rights and Responsibilities

**Context:** In the case of a woman deciding between terminating or continuing an unexpected or challenging pregnancy, the biological father has no legal rights over the decision made. The male partner has however, significant influence over whether a woman feels she can continue a pregnancy in difficult circumstances. Many women state how it was the support or lack of support from the father that played a big part in her decision to terminate or keep the baby.
3.9.1. Educational Programs Against Abortion Coercion

Culture shifting programs and campaigns should be developed and implemented in high schools and university to eradicate abortion coercion by male partners and fathers.

3.9.2. Mentorship Programs for Young Men/Boys

That state and territory governments should consider educational mentorship programs for young men/boys, to act responsibly, appeal to their desire to leave a good legacy and give them good role models.

3.9.3. Research on the Mental Health Effects of Abortion on Male Partners

The Commonwealth government should immediately commission research into the mental health effects of abortion on male partners, particularly when they pressured their partner into having an abortion.

3.10 Safe Access Zones

Context: People offering pregnancy support to women outside clinics in a manner that is not harassing or intimidating, are being caught within new safe access zones laws in some jurisdictions. These laws prohibit any communication outside clinics about abortion that may be perceived to be opposed to it and so include the presence of those offering information about pregnancy support. Criminal penalties apply.

3.10.1. Inclusion Zones

If exclusion zones are enforced around abortion clinics effectively prohibiting all offers of pregnancy support within these zones, then ‘inclusion zones’ or areas of exemption within these zones, should also be mandated. Inclusion zones meaning ‘inclusion of choice’ are needed to ensure all women considering an abortion have a choice right up until the time of the procedure, particularly for women who go directly to a clinic without having the opportunity to see an independent options counsellor. Inclusion zones or ‘exemptions’ would be safe places for women to access independent counselling and available pregnancy support services. For example, this could be at or around a pregnancy support centre within an exclusion zone.
3.10.2. Repeal or Amendment of Laws that Criminalise People offering Information in Safe Access Zones

Laws in some Australian jurisdictions that make it illegal for people to offer information on support available to women (whilst not physically or emotionally harassing in any way) in zones that cover broad geographical areas around abortion clinics should be repealed or amended. It should not be a crime for otherwise law-abiding citizens to offer information to people if it is done in a polite and respectful manner. Women and couples who are supported after contact with volunteers near clinics, say this was the only time they were offered a real option to continue their pregnancy.85

85 Aashika and Surya were grateful for the help that was offered to them near an abortion clinic in New South Wales. As a result, they received ongoing assistance both during and beyond the pregnancy. View their story here: https://youtu.be/JL5ChlnapYQ
4.1 Identifying Current Limitations and Gaps in Service Provision

As highlighted by the summit and identified elsewhere by researchers, healthcare providers, educators, advocacy groups and consumers, there are serious limitations and gaps in service relating to unplanned or challenging pregnancies in Australia. These include as described earlier, serious gaps in available national data on pregnancy outcomes and women’s experiences, little or no research on serious issues relating to termination of pregnancy, including abortion coercion, the association between abortion and domestic violence and the health outcomes for women and their partners after abortion.

Also falling through the gaps in service provision are women who are not afforded adequate, independent pre-termination counselling (when they expected or needed it) and women who are not afforded options other than a termination.

These options should include information or access to pregnancy support services or where to get a second opinion and information and support in the event of a challenging prenatal diagnoses. For these reasons and more, women claim that they feel they were not offered a real choice in their decision to terminate a pregnancy and that they were not afforded the opportunity to give fully informed consent. There is evidence that this is adversely affecting women’s mental health in Australia.
4.2 Action Proposal to 2028: Improving Women’s Health Services in Australia

Over the next ten years, a collective of experts, medical and legal professionals, advocacy groups, organisations and community members - including those who attended the summit along with others - will seek to work together with governments and government agencies to drive change that will improve women’s reproductive health services in Australia.

The organisation, Women and Babies Support (WOMBS) International, commits to facilitating this ongoing collaborative effort of such a collective, insofar as our resources enable our capacity. This may be through future conferences, forums, interviews, inviting stakeholders to make submissions on areas requiring action, as well as publishing papers to facilitate the work of this collective effort. The grassroots community involvement which has been at the core of the ‘Abortion Rethink’ project will continue to be an integral part of the collective moving forward, particularly the voices of women who have experienced a challenging pregnancy or abortion and are calling for change.

The 2018 action items in this chapter are based on the top five issues and recommendations arising from the summit, as outlined in the overview in Chapter 2 and in full in Chapter 3. The action proposal table detailed in this chapter endeavours to incorporate all the recommendations in Chapter 2 and Chapter 3. Most policy recommendations from Chapter 3 were relevant to the top five issues in some way so have been incorporated into these five areas. Additional items based on recommendations that did not fit under the top five areas have been included in the table as other matters of importance.

The purpose of this action proposal is to identify a starting point that can be progressed by the collective of stakeholders already formed through the summit. It will be worked upon and expanded or altered periodically after ongoing consultation with all interested parties and in line with progress on each action item. We invite other stakeholders, individuals and organisations, with appropriate knowledge or interest in these areas of women’s health to join this collective effort. We welcome scrutiny and feedback on these proposals from all interested stakeholders.
### Collective Action: Proposals from 2018

Numbers next to each target action item refer to relevant policy recommendations in Chapter 3.

<table>
<thead>
<tr>
<th>Action Items 2018</th>
<th>Target Year: By 2028</th>
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| 1. **Abortion Coercion and association between Domestic Violence and Termination of Pregnancy** | 1. Research into abortion coercion, including audits commissioned by governments and abortion providers of women’s experiences and the association between abortion and domestic violence. 3.1.1, 3.3.3  
2. Review and improvement of education and procedures of allied health professionals and abortion providers to improve controls over identifying and preventing ambivalence in a pregnancy decision, abortion coercion (e.g. through screening) and domestic violence with new guidelines that include intervention protocols. 3.2.5, 3.6.5  
3. Screening programs for abortion coercion and intervention protocols developed and implemented in all care pathways. Protocols may include requirement for screening for Medicare rebate. 3.1.1, 3.1.4  
4. Internal and external audit of clinical and non-clinical practice in termination of pregnancy for controls over identifying abortion coercion and intervention protocols. 3.1.1, 3.1.2  
5. Guidelines in every jurisdiction on termination of pregnancy and state/territory regulations protect women from abortion coercion. 3.1.1  
6. Educational programs and campaigns on abortion coercion. 3.9.1, 3.9.2  
7. Domestic violence laws on abortion coercion. 3.1.5 |
| 2. **Pre-decision Support** | 1. Government facilitated ‘decision-making tree’ for women with unexpected or challenging pregnancies. 3.4.1  
2. Mandates for abortion providers to offer and refer (uncounseled) women for independent non-directive counselling. For those women who can’t show they have received non-directive counselling, providers must offer and provide referral for it. 3.3.2  
3. Campaigns and/or updated guidelines to ensure women are informed of the need to seek independent counselling prior to going to an abortion clinic and aware of pregnancy support services. 3.2.1  
4. Development of national best practice standards for pregnancy support services and training, that may be regulated by a peak body. 3.2.1, 3.2.3 |
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</table>
| **2. Pre-decision Support Cont’d** | 5. **Promotion of the existence and need for pregnancy support services beyond counselling.** Guidelines around pregnancy counselling and care pathways require disclosure of pregnancy support services. 3.2.4  
6. **Accreditation and funding of one-stop pregnancy support services** by the Commonwealth, state and territory governments. Government audits of these services. 3.2.2.  
7. **New MBS item for pregnancy support services.** 3.2.6, 3.6.4  
8. **GPs trained in non-directive counselling** for challenging pregnancies. 3.4.3 |
| **3. Informed Consent** | 1. **Review by the Commonwealth government** of policies around termination of pregnancy and informed consent. 3.3.1  
2. **Review of current counselling requirements** at abortion clinics and other places of practice of termination of pregnancy. 3.3.2  
3. **Improved guidelines, mandates and training on informed consent for health workers providing care for women with challenging pregnancies and abortion providers in relation to termination of pregnancy.** Best practice includes counselling requirements, adequate information provided, pre-termination screening and that a second opinion is available to the patient. Screening includes that for coercion and for any increased risk of mental health problems after a termination. 3.1.1, 3.3.4, 3.4.2, 3.6.5  
4. **Review of guidelines around termination of pregnancy** for deficiencies and to include important matters currently missing. 3.4.4  
5. **National guidelines on prenatal testing protocols.** These guidelines should ensure proper informed consent, information, counselling, time, a second option and resources for all options are provided to women facing a challenging prenatal diagnoses. 3.7.1, 3.7.2, 3.7.3, 3.7.4  
6. **Routine and random government performance audits** on all government funded abortion practices. 3.6.3 |
<p>| <strong>4. Pregnancy loss and post-abortion counselling services</strong> | 1. <strong>Education of medical professionals and health workers, particularly those providing abortions</strong> of the negative mental health effects of abortion for some women. Training of professionals and health workers in the appropriate disciplines for treatment of post abortion grief and mental problems for which abortion has been a contributing factor. Education may be provided through training programs in medicine, psychology, social work and public health. 3.5.2, 3.6.5 |</p>
<table>
<thead>
<tr>
<th>Action Items 2018</th>
<th>Target Year: By 2028</th>
</tr>
</thead>
</table>
| 4. Pregnancy loss and post-abortion counselling services Cont’d | 2. National guidelines and models for post-abortion care and counselling. 3.4.5, 3.5.1, 3.5.3  
3. Education of allied health workers on post-abortion trauma and treatment. 3.5.4  
4. Free, independent, face-to-face post-abortion counselling being offered and made available to any woman who needs it. Post abortion counselling provided at a different location to where the termination took place. 3.5.1  
5. Research into the mental health effects of abortion on women and male partners. 3.5.5, 3.9.3 |
| 5. Data Collection and Research | 1. Routinely collected national data that gives accurate figures for elective abortions in Australia, reasons for abortions and women’s experiences of service provision. 3.1.3, 3.6.2  
2. Commonwealth government commissioned research into women’s experiences around termination of pregnancy. 3.6.2  
3. 5 -10 year prospective longitudinal study on pregnancy loss and mental health outcomes for women and their partners, To commence in 2019. 3.9.3  
4. Change of state or territory laws to allow public access to data on termination of pregnancy. 3.6.1 |
| 6. Other matters of importance:  
- Maternal/paternal support initiatives | 1. Reform of child care payments to give stay-at-home parents comparable financial support to home care their children, as the government currently finances working parents for formal child care. 3.8.1  
2. Research into maternal/paternal isolation and parent needs. 3.8.2  
3. Provision of more quality mothers’ and fathers’ groups and education to ensure all new parents are aware of and have access to these groups. 3.8.3  
4. Awareness of support available to mothers and fathers. 3.8.4  
5. Mentorship programs for young men on responsibilities to support women during and after pregnancy. 3.9.1, 3.9.2 |
4.3 How Do We Get There?

Progress will be made if a broad section of the collective working in women’s health agree to work together on common issues around termination of pregnancy, regardless of varying political ideologies.

Our existing collective of experts in health care, law, government and in advocacy will start with the most pressing issues, assess progress after a year and revisit these and more at the next conference.

We propose the establishment of a committee or working groups for the purpose of driving change and improvement in the area of reproductive health in Australia.

We hope to welcome others to this collective effort and see further development and expansion of action items.

We look forward to seeing the results of policy recommendations taken up by governments, Parliamentarians, policy makers and those in education and health services in Australia.

To monitor yearly progress in these areas, we will produce a report on action taken in response to these policy recommendations. This outcomes report will be similarly distributed to interested stakeholders and Parliamentarians within 12 months of publication of this White Paper.

We ask all those participating in the distribution and response to this paper, to contact us regarding any of the areas raised in this document and let us know what action is taken.

We invite all interested external stakeholders to participate in further developments.

Please contact:

Tiana Legge, CEO, Women and Babies Support (WOMBS) International.

Email: tlegge@wombs.org.au

Catherine Toomey, Convenor, the ‘Abortion Rethink’ project.
Email: abortionrethink@gmail.com
Conclusion

State and territory governments should not consider changing abortion laws when legislators have inadequate access to data and information on termination of pregnancy. Reliable estimates of Australia’s abortion rates across Australian jurisdictions are unavailable.

Data collection and/or availability on terminations also varies greatly across states. It is also grossly inadequate for use in good policy making or comparison between states, particularly with regard to the impact of different abortion laws. As a priority, state and territory governments should regulate to ensure the commencement of adequate and ongoing data collection and reporting of women’s experiences around termination of pregnancy.

For the health and welfare of women in Australia, state and territory governments should immediately commission research into the reasons women have abortions and into abortion coercion. This research should be made widely available to Parliamentarians and the general public.

Performance audits should be conducted in private and publicly run facilities to ensure decision making pathways, procedures and guidelines allow women to give fully informed consent to termination of pregnancy. In the pre-decision phase, women need to be made aware of and have adequate access to pregnancy support services.

Governments should act on research and audit findings to ensure that adequate safeguards and regulations are in place so that all women facing unexpected or problematic pregnancies in their jurisdiction can make informed decisions free from abortion coercion. Governments that are genuine about supporting a woman’s choice in pregnancy need not feel content that Australian women currently have the option to legally terminate a pregnancy. Australian governments need to improve services for women who currently feel unsupported in pregnancy and coerced into an abortion, to give them an option to continue and to have a real choice.

Commonwealth, state and territory governments should commit to ensuring that not only options counselling but appropriate holistic pregnancy support services are available to any woman who needs it. It is important that women are informed of these services through usual health care pathways. Protocols and education of all health workers to protect women from abortion coercion will require a reform of policies and directives in health and social services.

Finally, post abortion care in Australia is inadequate. State and territory governments should address the important issue of women’s mental health after abortion. Most professionals working in the area of mental health do not acknowledge the evidence that abortion is a risk factor for mental health problems and hence are not trained to treat a woman suffering negative mental health effects after an abortion. Education and training in this area needs to be urgently addressed.

State and territory governments also need to ensure adequate controls are in place to ensure women are properly screened for an increased risk of mental health problems prior to the
procedure. All women who choose to have an abortion should have prompt access to free, independent post abortion counselling, at a different location to where the abortion took place.

There is a need for a major social and cultural shift to ensure that all women facing pregnancy in difficult situations have a real choice between abortion and continuing a pregnancy. Progressive and forward thinking governments should balance and lead this shift.

We live in an era where Australian women have adequate access to legal abortion. Hand-in-hand with this access should be the offer of real, quality and independent support in pregnancy if needed. A woman’s choice should indeed be a choice, not a one way street toward a currently well supported and well funded option of abortion.

The collective effort of stakeholders and community members formed through the summit are concerned with the issues affecting women’s health that are raised in this paper. The immediate consideration of policy recommendations by Australian governments and all those involved in providing related services for women is encouraged. Clear, ongoing action and co-operation is needed by stakeholders working in areas related to women’s health before and after a challenging pregnancy, to improve care for women in Australia. This White Paper proposes action items for the collective effort from now until 2028, to be used as a starting point for change.
### Appendix 1: Recommended Pregnancy and Post Decision Support Services in Australia

<table>
<thead>
<tr>
<th>STATE</th>
<th>NAME</th>
<th>LOCATION</th>
<th>SERVICE</th>
<th>CONTACT DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Diamond Pregnancy</td>
<td>Bella Vista &amp; Gosford</td>
<td>- Free pregnancy tests;                                                                       Jennifer Gurry, Director (02) 8814 7488 or 0413 408 815</td>
<td>Unit 13, 24 Watt St, Gosford NSW <a href="mailto:jenny@diamondwomenssupport.com">jenny@diamondwomenssupport.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Non-directive counselling (ph. and/or face to face);                                        Suite 4.02, 29-31 Lexington Dr, Bella Vista NSW</td>
<td><a href="http://www.diamondwomenssupport.com">www.diamondwomenssupport.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Material assistance;                                                                        Preethy Abraham, Office Manager (02) 9699 8190</td>
<td><a href="mailto:SARASPLACE.NSW@GMAIL.COM">SARASPLACE.NSW@GMAIL.COM</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Information and referrals;                                                                  <a href="mailto:sarasplace.nsw@gmail.com">sarasplace.nsw@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Mentor programs - with emotional support; and                                                <a href="http://sarasplace.org.au/">http://sarasplace.org.au/</a></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Post abortion counselling.</td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>Sara’s Place</td>
<td>Sydney CBD</td>
<td>- Pregnancy Testing;                                                                          Stacy Allan, Director 0402 744 055 or 1300 793 575</td>
<td>Suite 3, Unit 4 276 Macquarie Rd, Warner’s Bay NSW 2281 <a href="mailto:director@zoesplace.org.au">director@zoesplace.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Non-directive counselling;                                                                  <a href="http://www.zoesplace.org.au">www.zoesplace.org.au</a></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Mentoring;</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- Material/ pragmatic assistance; and</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- Post abortion support.</td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>Zoe’s Place</td>
<td>Warners Bay</td>
<td>- Pregnancy testing;                                                                          Ms Jeanette Reid, Manager (02) 8843 2580 or (02) 8822 2266</td>
<td><a href="mailto:Penrith@ccss.org.au">Penrith@ccss.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Non-directive counselling;                                                                  <a href="mailto:Penrith@ccss.org.au">Penrith@ccss.org.au</a></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Mentoring;</td>
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<td></td>
<td></td>
<td></td>
<td>- Post abortion support.</td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>Project Elizabeth</td>
<td>Penrith, Blacktown,</td>
<td>- Counselling and support in relation to current and past pregnancy including miscarriage and abortion;</td>
<td>Ms Jeanette Reid, Manager (02) 8843 2580 or (02) 8822 2266</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Western Sydney and Blue</td>
<td>- Delivery of service can be at home, hospital, centre based or over the phone;              <a href="mailto:Penrith@ccss.org.au">Penrith@ccss.org.au</a></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>Karinya House</td>
<td>Canberra and</td>
<td>- Parenting programs; and</td>
<td><a href="mailto:Penrith@ccss.org.au">Penrith@ccss.org.au</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>surrounding region</td>
<td>- Assistance to those considering fostering or adoption.</td>
<td><a href="mailto:Penrith@ccss.org.au">Penrith@ccss.org.au</a></td>
</tr>
</tbody>
</table>
| QLD | Priceless House | Brisbane | An integrated practice model of care incl.;  
Free pregnancy tests;  
Non-directive counselling (ph. and/or face to face);  
Material assistance;  
Information and referrals with affiliate professionals & programs;  
Ante & post natal support;  
Birth partnering;  
Mentor programs - with emotional support;  
Case work management  
Adoption and alternative permanency support programs;  
Parenting support;  
Post Abortion counselling & programs  
Education program/s. |
|---|---|---|---|
| QLD | Cathryn Marshall, Office Manager  
(07) 3217 4114  
1800 090 777  
0413 888 613  
34 Wellington Rd  
Woolloongabba Qld |
| | info@pricelesslifecentre.org.au  
www.pricelesshouse.org.au |
| QLD | Chloe’s Place  
(previously Cairn’s Pregnancy Help) | Cairns | Emotional and practical support with options counselling; and  
Links with community support networks. |
| | Cristy Mock, Managing Director  
13000 848 080  
117 Anderson St,  
Manunda Qld 4870 |
| | cairnspregnancyhelp@gmail.com  
| QLD | Eva’s Place | Toowoomba | An integrated practice model of care;  
Free pregnancy tests;  
Non-directive counselling (ph. and/or face to face);  
Material Assistance;  
Information and Referrals with affiliate professionals & programs;  
Ante & Post Natal Support;  
Mentor Programs - with Emotional support; and  
Case work management  
Alternative permanency |
| | Juliet Ballinger, Director  
(07) 4642 1910  
0497 646 635  
Level 1, 5 Bell St  
Toowoomba City  
Qld 4350 |
| | info@evasplace.org.au  
www.evasplace.org.au |
<table>
<thead>
<tr>
<th>State</th>
<th>Organisation</th>
<th>Location</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAS</td>
<td>Esther’s House</td>
<td>Networked/Mobile</td>
<td>Mobile counselling &amp; mentoring services; Parenting support; Post Abortion counselling; Mentoring - one on one with a mum who has had similar experience; Advocacy - we help our clients to get what they need, including accompany them to appointments or just to talk with someone they are struggling to communicate with; Information - Early pregnancy options, Community Support Services, Disability Services, Housing services, Child care, Respite and In-Home Care Services; and Education - Pregnancy education and information.</td>
</tr>
<tr>
<td>WA</td>
<td>Pregnancy Problem House</td>
<td>5 Centre Locations</td>
<td>Integrated care practice model; 5 different centres (from city to regional); Help lines; Practical assistance; Using IP of internationally recognised/ quality tested programs; Considerable community affiliate network; Multilevel support; and Remuneration of management staff.</td>
</tr>
<tr>
<td>SA</td>
<td>Genesis</td>
<td>Cowandilla</td>
<td>Counselling; Face to face mentoring; Practical assistance (baby goods ‘store’); Schools program for</td>
</tr>
</tbody>
</table>
| VIC | Caroline Chisholm House | Various (Caroline Springs) | Education around issue; and  
- 100% Volunteer run.  
- Non-directive, non-judgemental, independent pregnancy counselling;  
- Support workers are skilled in helping on issues such as: pregnancy options, ante/ postnatal support and adjustment to early parenting, financial management, grief counselling, housing or legal issues, parenting, child protection;  
- Well linked with other excellent services through the [www.caroline.org.au](http://www.caroline.org.au) whole organisation. | Helen Cooney, CEO  
0409 668 721  
cooney@caroline.org.au  
info@caroline.org.au |
| VIC | Open Doors | Ringwood | Non-directive, client centred counselling, psychotherapy and support for -  
*pregnancy decisions - pregnancy loss (incl. miscarriage & post abortion grief)  
*postnatal depression and anxiety - grief and loss - relationships;  
- Post abortion retreats;  
- Baby and Me Support Group; and  
- Offers a Primary & Secondary School values based Education Program. | Alison Campbell Rate, Executive Director (Hon.)  
(03) 9870 7044  
Outside Melbourne: 1800 647 995  
P O Box 610 Ringwood 3134 VIC  
5 Greenwood Ave Ringwood 3134 VIC |
WOMBS International and our Abortion Rethink project aim to promote healthy dialogue around the issue of pregnancy options in Australia.

Please do not hesitate to contact us with any queries or comments.

Every voice matters.