The Abortion Rights Debate

Edited by Justin Healey

ISSUES IN SOCIETY

Edited by Justin Healey

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# CONTENTS

## CHAPTER 1  ABORTION AND THE LAW
- Abortion policies and reproductive health around the world  
  1
- International and regional standards on the right to life  
  3
- The world’s abortion laws 2014  
  6
- Explainer: is abortion legal in Australia?  
  8
- A beginner’s guide to abortion law in Australia  
  10
- Unplanned pregnancy in Australia  
  12
- Medical versus surgical termination  
  15
- Abortion – emotional issues and counselling  
  16

## CHAPTER 2  VIEWS IN THE ABORTION RIGHTS DEBATE
- Making a ‘choice’ based on all the facts  
  18
- No right to health without a right to abortion  
  22
- Abortion – what is it?  
  24
- Reproductive rights, abortion and Zoe’s law: why freedom of choice is still feminism’s biggest fight  
  26
- Does an unborn child feel pain during an abortion?  
  29
- Hands off our hard-fought abortion rights  
  31
- Abortion risks: a position statement  
  33
- Doctors’ moral objections don’t justify denying abortion access  
  35
- Freedom of conscience: why the right to conscientious objection must be restored  
  37
- What ‘miracle babies’ mean for abortion rights  
  40
- Real choices: abortion advocates’ message  
  42
- The anti-abortion fallacy  
  44
- Eugenics and abortion  
  45
- Access to abortion: a human rights issue for Australian women  
  47
- What if the child will have a disability?  
  49
- What should we do about sex-selective abortion?  
  51

**Exploring issues – worksheets and activities**  
  53
**Fast facts**  
  57
**Glossary**  
  58
**Web links**  
  59
**Index**  
  60
The Abortion Rights Debate is Volume 402 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
Abortion rights address the circumstances under which a woman may obtain a legal abortion in a specific jurisdiction. It is a divisive issue as the rights debate frequently raises ethical and practical discussions in relation to the law, morality, science, medicine, sexuality, autonomy, religion and politics.
This book considers the options that are presented with an unplanned pregnancy, and how these options relate to a number of ethical concerns and legal safeguards internationally, and more specifically, in Australia.
What are the various ‘pro-life’ and ‘pro-choice’ arguments in response to the availability and timing of surgical and non-surgical abortion, the health and circumstances of the expectant mother, fetal abnormalities, the status of the fetus, and the conscientious objections of medical practitioners? Whose rights should prevail?

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.
The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.
The content comes from a wide variety of sources and includes:
- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.
It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
ABORTION POLICIES AND REPRODUCTIVE HEALTH AROUND THE WORLD

HIGHLIGHTS FROM A KEY REPORT PRODUCED BY THE UNITED NATIONS

• Between 1996 and 2013, the percentage of Governments permitting abortion increased gradually for all legal grounds, except to save a woman’s life which remained at 97 per cent. Despite overall expansion in the legal grounds for abortion, policies remain restrictive in many countries.
• In about two thirds of countries in 2013, abortion was permitted when the physical or mental health of the mother was endangered, and only in half of the countries when the pregnancy resulted from rape or incest or in cases of foetal impairment. Only about one third of countries permitted abortion for economic or social reasons or on request.
• Since 1996, legal grounds for abortion have expanded in a growing number of countries in both developing and developed regions, but abortion policies remain much more restrictive in countries of the developing regions.
• Governments in developing regions were more than four times as likely to have restrictive abortion policies as those in developed regions. In 2013, 82 per cent of Governments in developed regions permitted abortion for economic or social reasons and 71 per cent allowed abortion on request. In contrast, only 20 per cent of Governments in developing regions permitted abortion for economic or social reasons and only 16 per cent allowed it on request.
• In recent years, many Governments have implemented measures to improve access to safe abortion services to the extent of the law. Out of 145 countries with available data in 2012, Governments of 87 countries (60 per cent) had implemented concrete measures to improve access to safe abortion services in the past five years.
• With ever-declining fertility levels, a growing number of Governments have adopted policies to raise fertility. The percentage of Governments with policies to raise fertility has almost doubled from 14 per cent in 1996 to 27 per cent in 2013, whereas
The percentage of Governments with policies to lower fertility has remained virtually unchanged from 42 per cent in 1996 to 43 per cent in 2013.

- A growing number of Governments have expressed concern about high rates of adolescent fertility. The percentage of Governments identifying adolescent fertility as a major concern has risen steadily, from 46 per cent in 1996 to 67 per cent in 2013.
- Governments have increasingly adopted policies to reduce adolescent birth rates. Of the 195 countries with information available in 2013, 90 per cent of Governments had adopted policies and programmes to reduce adolescent fertility, up from 60 per cent in 1996.
- Out of 172 countries with available data in 2012, Governments of 152 countries (88 per cent) had implemented concrete measures to increase women’s access to comprehensive sexual and reproductive health services in the past five years, regardless of marital status and age.
- In 2013, among 195 countries with available data, all but 10 Governments (95 per cent) had adopted some legal measures or policies to prevent domestic violence, including 78 per cent having legal measures, 90 per cent having policies and 73 per cent having both legal measures and policies.

- Maternal mortality has been declining, but Governments of most countries in developing regions continue to view their levels as unacceptable. In 2013, three out of four Governments in developing regions considered their level of maternal mortality as unacceptable, compared with less than one out of four Governments in developed regions.
- Fertility rates are significantly higher in countries with restrictive abortion policies. The average adolescent birth rate in countries with restrictive abortion policies in 2013 was about three times greater (69 births per 1,000 women aged 15 to 19 years) than in countries with liberal abortion policies (24 births per 1,000 women aged 15 to 19 years). The average total fertility rate in countries with restrictive abortion policies in 2013 was also significantly higher (3.22 children per woman) than in countries with liberal abortion policies (1.97 children per woman).
- Countries with restrictive abortion policies have much higher unsafe abortion rates. The average unsafe abortion rate was more than four times greater in countries with restrictive abortion policies in 2011 (26.7 unsafe abortions per 1,000 women aged 15 to 44 years) than in countries with liberal abortion policies (6.1 unsafe abortions per 1,000 women aged 15 to 44 years).
- Countries with restrictive abortion policies have much higher levels of maternal mortality. The average maternal mortality ratio was three times greater in countries with restrictive abortion policies in 2013 (223 maternal deaths per 100,000 live births) than in countries with liberal abortion policies (77 maternal deaths per 100,000 live births).

IMPACT OF UNSAFE ABORTION

- 22 million unsafe abortions are performed each year.
- Approximately 47,000 deaths and 5 million injuries each year are a result of complications from unsafe abortion.
- 98% of all unsafe abortions occur in developing countries, most of which have restrictive abortion laws.
- The WHO has estimated that nearly all of the deaths and disabilities resulting from unsafe abortion “could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion.”

NOTES


International and regional human rights treaties protect a right to life without defining when life begins. Authoritative sources for interpretation — including the history of negotiations and the jurisprudence of the bodies charged with interpreting and monitoring compliance with human rights treaties — clarify that these protections do not apply before birth and recognise that to protect an absolute right to life before birth could contradict human rights protections for women.

The histories of negotiations over the terms of human rights treaties (travaux préparatoires), which provide a source for interpretation where the language of a treaty is ambiguous, indicate that right to life provisions are not intended to protect a prenatal right to life. Additionally, treaty monitoring bodies, through general comments, concluding observations, and decisions in individual cases, consistently emphasise the importance of protecting women’s rights, and assert that to guarantee women’s fundamental rights to life and health, among others, States must remove barriers to the full enjoyment of those rights, such as the denial of safe and legal abortions.

**INTERNATIONAL HUMAN RIGHTS STANDARDS**

**Universal Declaration of Human Rights**

Article 1 of the Universal Declaration of Human Rights states that “[a]ll human beings are born free and equal in dignity and rights.” Significantly, the history of negotiations indicates that the word “born” was used intentionally to exclude a prenatal application of the rights protected in the Declaration. The drafters of the Declaration rejected a proposal to delete “born,” and the resulting text of the Declaration conveys intentionally that the rights of the Declaration are “inherent from the moment of birth.”

**International Covenant on Civil and Political Rights**

The International Covenant on Civil and Political Rights (ICCPR) rejects the proposition that the right to life, protected in Article 6(1), extends to prenatal life. The drafters of the ICCPR specifically rejected a proposal to amend this article to provide that “the right to life is inherent in the human person from the moment of conception, this right shall be protected by law.” The Human Rights Committee, which interprets and monitors state compliance with the ICCPR, has further clarified that the ICCPR’s right to life protections may be violated when women are exposed to a risk of death from unsafe abortion as a result of restrictive abortion laws. In the case of K.L. v. Peru, the Committee established that the denial of a therapeutic abortion, where continued pregnancy posed a significant risk to the life and mental health of the pregnant woman, violated the woman’s right to be free from cruel, inhuman, or degrading treatment. The Human Rights Committee reaffirmed this decision in the case of L.M.R. v. Argentina, when it held that the denial of a legal abortion for a rape victim inflicted physical and mental suffering, violating the woman’s right to be free from torture or cruel, inhuman, or degrading treatment, and her right to privacy.

**Convention on the Rights of the Child**

Although the Preamble of the Convention on the Rights of the Child (CRC) provides that “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,” the history of negotiations makes clear that this language is not intended to extend Convention protections, including right to life protections, prenataily. To the contrary, the negotiations explicitly note that this language is not “intend[ed] to prejudice the interpretation of Article 1 or any other provision of the Convention,” where Article 1 defines “a child” for the purposes of the Convention as “every human being below the age of 18 years.” Proponents of the amendment calling for safeguards before birth further clarified that “the purpose of the amendment was not to preclude the possibility of abortion.”

The Committee on the Rights of the Child, which interprets and monitors state compliance with the CRC, supports the understanding that the CRC does not protect a prenatal right to life. The Committee has not issued any comments suggesting that there is a right to

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life before birth; instead the Committee has expressed concern about maternal mortality in adolescent girls stemming from unsafe abortion— a violation of their right to life—and urged states to reform punitive abortion legislation and ensure access to safe abortion services, irrespective of the legality of abortion.15

**Convention on the Elimination of All Forms of Discrimination against Women**

The jurisprudence of the Committee on the Elimination of Discrimination against Women (CEDAW Committee), which interprets and monitors state compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), makes clear that the fundamental principles of non-discrimination and equality require that the rights of a pregnant woman be given priority over an interest in prenatal life.

In the case of *L.C. v. Peru*, the CEDAW Committee found that the government had violated a pregnant girl’s rights by prioritising the fetus over her health by postponing an essential surgery until the girl was no longer pregnant. The girl’s continued pregnancy posed a substantial risk to her physical and mental health, and the CEDAW Committee held that the denial of a therapeutic abortion and the delay in providing the surgery constituted gender-based discrimination and violated her rights to health and freedom from discrimination.16 The CEDAW Committee has further expressed concern that women’s rights to life and health may be violated by restrictive abortion laws.16

**REGIONAL HUMAN RIGHTS STANDARDS**

**American Declaration on the Rights and Duties of Man and American Convention on Human Rights**

Article 1 of the American Declaration on the Rights and Duties of Man provides that "[e]very human being has the right to life, liberty, and the security of his person."27 Drafters of the American Declaration specifically rejected a proposal to adopt the following language: "Every person has the right to life. This right extends to the right to life from the moment of conception."28 They reasoned that such a provision would have conflicted with existing abortion laws in the majority of the member states.19

While Article 4 of the American Convention on Human Rights states: "Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception,"29 both the Inter-American Court of Human Rights and the Inter-American Commission on Human Rights, the two adjudicatory bodies that interpret and monitor compliance with the Inter-American system’s human rights conventions, have clarified that this protection is not absolute.21

In the case of *Artavia Murillo et al. (“in vitro fertilisation”) v. Costa Rica*, the Inter-American Court refuted the proposition that other international human rights conventions and declarations protect the right to life prior to birth, finding that such documents, including the Universal Declaration of Human Rights, the ICCPR, and the CRC, did not provide any evidence to substantiate the notion that that the embryo could be considered “a person.”30 Finally, in addressing the issue of when life begins, the Court reasoned that since there is not an agreed definition of when life begins, adopting one such definition “would imply imposing specific types of beliefs on others who do not share them.”31

The determination that the American Convention does not protect an absolute right to life before birth has also been affirmed through provisional and precautionary measures issued to states with restrictive abortion laws. Following the denial of necessary cancer treatment to a pregnant Nicaraguan woman on the grounds that such treatment could cause an abortion, the Inter-American Commission issued precautionary measures to Nicaragua, finding that the State could not deny her life- and health-saving care and calling on the State to provide the necessary medical treatment.32 Additionally, the Inter-American Court issued provisional measures ordering El Salvador to take all necessary steps to preserve the life of a woman whose pregnancy placed her life in grave danger,33 which under these circumstances required termination of the pregnancy.34 Implicit in these determinations is the notion that the State cannot prioritise the health or wellbeing of the fetus over the pregnant woman’s rights.

**European Convention on Human Rights**

Article 2(1) of the European Convention on Human Rights provides: “Everyone’s right to life shall be protected by law.”35 The European Commission on Human Rights, in *Paton v. United Kingdom*, held that the Convention
language “tend[s] to support the view that [Article 2] does not include the unborn,” and acknowledged that recognition of an absolute right to life before birth would “be contrary to the object and purpose of the Convention.”

In *Vo v. France*, the European Court of Human Rights, which interprets and monitors compliance with the European Convention, affirmed that “the unborn child is not regarded as a ‘person’ directly protected by Article 2 of the Convention and that if the unborn do have a ‘right’ to ‘life,’ it is implicitly limited by the mother’s rights and interests,” including her rights to life, health, and privacy. The Court reiterated this holding in *A, B and C v. Ireland*, and noted that “[a] prohibition of abortion to protect unborn life is not...automatically justified under the Convention on the basis of unqualified deference to the protection of pre-natal life or on the basis that the expectant mother’s right to respect for her private life is of a lesser stature,” such that restrictions on abortion must be consistent with women’s fundamental rights.

**African Charter on Human and Peoples’ Rights**

*Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa*

Article 4 of the African Charter on Human and Peoples’ Rights states that “[h]uman beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person.” Drafters of the African Charter specifically rejected language protecting a right to life from the moment of conception.

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) does not address when life begins, but it implicitly reinforces the understanding that the right to life accrues at birth, providing that States must take measures to “protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus.”

### NOTES


17. Id. p. 259.

18. Id. p. 263.

The world’s abortion laws 2014

Currently, more than 60% of the world’s people live in countries where induced abortion is permitted either for a wide range of reasons or without restriction as to reason. In contrast, more than 25% of all people reside in countries where abortion is generally prohibited, while nearly 14% live in countries where abortion is permitted to preserve the woman’s health. The table below illustrates the varying degrees to which countries worldwide permit access to abortion. Laws are categorized according to provisions in national statutes, regulations and court decisions. The categorization of each law does not necessarily reflect the law’s actual implementation in that country.

Depending on such factors as public support for abortion rights, the views of government officials and providers, and individual circumstances, laws in each category may be interpreted more broadly or restrictively than indicated by their classifications below. Countries in Category I have the most restrictive laws. Those in each subsequent category recognize the grounds specified in the preceding category as well as additional grounds.
CATEGORIES OF ABORTION LAWS FROM MOST TO LEAST RESTRICTED

<table>
<thead>
<tr>
<th>Category</th>
<th>Countries</th>
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A NOTE ON TERMINOLOGY

“Countries” listed on the table include independent states and, where populations exceed one million, semi-autonomous regions, territories and jurisdictions of special status. The table therefore includes Hong Kong, Northern Ireland, Puerto Rico, Taiwan, and the West Bank and Gaza Strip. Other entities, where visible on the map, appear in colours corresponding to laws in force, but they are not listed on the table.

Laws that make no explicit exception to save a woman’s life are normally interpreted to permit life-saving abortions on grounds of the general criminal law defense of “necessity.” In this situation, although laws do not expressly permit abortion, the procedure could be performed on the rationale that it is necessary to preserve the life of the woman.

According to the World Health Organization, “health” is “a state of complete physical, **mental and social well-being and not merely the absence of disease or infirmity.” Laws in this category that do not make an explicit exception to protect a woman’s mental health should be interpreted to allow abortion on such grounds.

GESTATIONAL LIMITS KEY

All countries in Category IV have gestational limits of 12 weeks unless otherwise indicated. Gestational limits are calculated from the first day of the last menstrual period, which is considered to occur two weeks prior to conception. Where laws specify that gestational age limits are calculated from the date of conception, these limits have been extended by two weeks.

<table>
<thead>
<tr>
<th>Gestational limit of 8 weeks</th>
<th>Gestational limit of 14 weeks</th>
<th>Law does not indicate gestational limit;</th>
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<tr>
<td>Gestational limit of 10 weeks</td>
<td>Law does not limit pre-viability abortion;</td>
<td></td>
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<tr>
<td>Gestational limit of 18 weeks</td>
<td>Gestational limit of 90 days</td>
<td>Gestational limit of 24 weeks regulatory mechanisms vary</td>
</tr>
<tr>
<td>** Gestational limit of 3 months</td>
<td>** Gestational limit of 3 months</td>
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The Center for Reproductive Rights is a nonprofit legal advocacy organization dedicated to promoting and defending women’s reproductive rights worldwide. 120 Wall Street, New York, New York 10005, United States. www.reproductiverights.org © July 2014, Center for Reproductive Rights.
Abortion is a safe medical procedure, yet half of Australian women may have difficulty accessing a termination because they live in states and territories that designate it a crime.

From the 19th century onward, abortion was regarded as a crime in Australia. Abortion law was included in criminal legislation and was based on the 1861 English Offences Against the Person Act.

Since then, some states and territories have reformed or decriminalised abortion, while others continue to restrict women’s access to abortion in a way entirely inappropriate for the 21st century.

Abortion laws in Australia are all state or territory laws. The Commonwealth is only responsible for the oversight of drugs for medical abortion through the Therapeutic Goods Administration.

Queensland
Queensland law remains little changed from the 1899 Criminal Code which contains the same wording as the 1861 English Act. Any person who carries out, or assists with, an abortion may be liable to criminal prosecution, including the woman herself.

Any defence hinges on the interpretation of the “surgical operations and medical treatment” defence in section 282 of the Code.

In the 1986 case R v Bayliss, which interprets sections 282 of the criminal code, Justice McGuire found that “in exceptional cases” an abortion would not be unlawful where it was carried out in good faith to avoid “serious danger to the mother’s life or her physical or mental health (not merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail”.

In 2009-10, a Cairns couple was charged under the Queensland legislation. Although they were acquitted after a jury trial, they were subject to 18 months of glaring negative publicity.

New South Wales
Abortion has been a criminal offence in NSW since 1900, under the state’s Crimes Act.

NSW case law has established that in certain circumstances, similar to those in Queensland, an abortion would not be unlawful. It also allows for broader considerations of economic and social factors to determine whether continuing the pregnancy poses a serious danger to the woman’s mental health.

Western Australia
Until 1998, the position in Western Australia under the Criminal Code Act 1902 was similar to current Queensland law: unlawful abortion was a criminal offence. Although, there was no case law in WA to determine when abortion was lawful.

Following legislative reform (but not complete decriminalisation) in 1998, abortion is now lawful up to 20 weeks if the woman gives her consent*, or, where she is unable to consent herself, she will suffer “serious danger to her physical or mental health or serious personal, family or social consequences if the abortion is not performed”.

After 20 weeks, abortions can only be performed if two medical practitioners from a statutory panel of six agree that the woman or her foetus has a “severe medical condition” that justifies the procedure.

In practice, the panel only accepts very severe fetal abnormalities, driving women towards abortion ‘tourism’ in Victoria and elsewhere.

South Australia
Under the Criminal Law Consolidation Act 1935, and 1969 amendments, abortion is lawful in SA in certain circumstances prescribed by legislation. So, similarly to WA, there has not been complete decriminalisation.

All Australian women should be able to access abortions, no matter where they live.
Abortion must be carried out in a hospital or prescribed facility, which has limited availability of early medical abortion in the state.

The woman must have resided in SA for a minimum of two months for the abortion to be lawful unless the grounds are fetal abnormality or immediate threat to the life or health of the woman.

Under SA law, the woman herself can still be charged with procuring an ‘unlawful’ abortion.

**Northern Territory**

Abortion remains in the NT Criminal Code but has been modified by the Medical Services Act 1974, which makes abortion lawful up to 14 weeks. Two medical practitioners must agree that there is a risk to the mother in continuing the pregnancy or there is substantial risk that the child would be born with a serious ‘handicap’.

Abortion is also lawful up to 23 weeks gestation where the medical practitioner is of the opinion that terminating the pregnancy is immediately necessary to prevent serious harm to the woman’s life, physical or mental health.

However requirements that early medical abortions must be performed in hospitals, and not clinics, limit the availability, as there are so few hospitals in the NT.

**Tasmania**

In Tasmania until 2013, under the Criminal Code Act 1924, the “unlawful termination” of a pregnancy was prohibited. The Reproductive Health (Access to Terminations) Act 2013 has essentially decriminalised abortion and moved it into the health regulations.

Abortion can be performed by a medical practitioner with the woman’s consent, up to 16 weeks’ gestation. After 16 weeks, it can be performed if two medical practitioners (one of whom must be an specialist gynaecologist) reasonably believe the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.

The woman herself cannot be charged.

This Tasmanian legislation also includes restrictions on the harassment of women seeking abortion services by mandating exclusion zones around clinics, the only legislation so far to do so.

**Victoria**

The Victorian Abortion Law Reform Act 2008 decriminalised abortion by removing it from the 1958 Crimes Act and placing it in the health regulations.

A pregnant woman who requests an abortion is entitled to the procedure when the pregnancy does not exceed 24 weeks. After 24 weeks, abortion is available where a medical practitioner reasonably believes that the abortion is appropriate and has the agreement of a second practitioner.

Where a doctor conscientiously objects to abortion, he or she is obliged to make a referral to a provider who is known not to conscientiously object.

Ideally, all states and territories would have consistent laws based on Victorian legislation, with the addition of Tasmania’s prohibition on the harassment of women as they enter abortion clinics.

**Australian Capital Territory**

Abortion was decriminalised in 2002 with the introduction of the ACT Medical Practitioners (Maternal Health) Amendment Act. A woman seeking or receiving an abortion faces no legal sanction; nor does the service provider.

All Australian women should be able to access abortions, no matter where they live. Ideally, all states and territories would have consistent laws based on Victorian legislation, with the addition of Tasmania’s prohibition on the harassment of women as they enter abortion clinics.

* This article has been updated to better reflect the legal position in Western Australia, where the woman consents to abortion and the foetus is 20 weeks or less gestation.

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A BEGINNER’S GUIDE TO
ABORTION LAW IN AUSTRALIA

Progress in relation to abortion laws still need to be made in some states in
Australia, according to this Right Now article by David Donaldson

Abortion law in Australia is up to the states; accordingly, state laws vary. Victoria and
the ACT have the most liberal legislation on this issue, Queensland the strictest. Thankfully, the issue
is not as polarising in Australia as the United States, where ‘pro-life’
activists, having failed to outlaw the procedure, are trying to regulate clinics out of existence. But
although the anti-abortion sentiments of our Opposition leader are well known, Australians are
generally supportive of women’s right to choose.

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issue, Queensland the strictest. Thankfully, the issue is not as polarising in Australia as the United States, where ‘pro-life’
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The 2009 prosecution in Queensland of Tegan Leach, 19 years old at
the time, for using the abortifacient drug RU486 demonstrated that
women in Australia continue to be short-changed by the law when
it comes to what is essentially a personal decision. Although she
was found not guilty and such trials are rare, restrictive laws and the
accompanying worry and shame around the issue mean that in some
states the law continues to interfere with a woman’s right to choose.

And in a long running and often bitter struggle by pro-lifers
to swim against the tide, women also continue to be harassed out-
side fertility control clinics. The picket outside the clinic in East
Melbourne, which has been running since the organisation opened
in 1972, continues to be ignored by Melbourne City Council, even
after a gunman killed one of the building’s security guards in 2001.

Victoria and the ACT’s abortion laws are among the best in the
world, but progress needs to be made in other states, especially
Queensland. Since 2008, women in Melbourne are permitted to
receive a termination upon request up to 24 weeks, and must receive
the agreement of two doctors past that time.

Those in Brisbane, however, legally must show that without the
procedure, their own life, health or mental health would be under
significant threat. Certainly, such categories can be interpreted
widely, and often are. Keeping such laws on board however, even
when rarely practiced, increases the uncertainty and anxiety for all
those involved with the practice – partners, doctors, and of course the
women themselves.

A perfect example of this is the
fact that, following the charging
of Tegan Leach for the use of RU486, several Queensland hospitals stopped offering terminations. Fearing legal repercussions for carrying out a routine procedure, some hospitals began referring women to doctors in New South Wales. The legal uncertainty surrounding Queensland’s out-of-date law, even when fitfully enforced, made life more difficult for women and health professionals.

It is also worth noting that sending women across the border mirrors the well known practice of women from Ireland – where abortion is illegal unless the life of the woman is in danger – flying to the UK to receive abortions. And in 2011, there were even 102 Emirati women recorded as having travelled to the UK for the procedure.

Restricting women’s right to choose does not stop abortions from taking place, but drives women to nearby jurisdictions. It also forces the practice into homes and hotels, presenting far greater – and completely unnecessary – health risks for the patient.

It is unfortunate that the question of who has the right to decide what happens with a woman’s body is something that still needs to be discussed. But while the threat of prosecution and social denigration hangs over women for exercising their right to decide, something still needs to be done.

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It is estimated that almost half of all pregnancies in Australia are unplanned. Unplanned pregnancies occur for a wide variety of individual, social and political reasons.

Some of these include:
• Misinformation such as ‘you can’t get pregnant the first time you have sex’ or ‘you can’t get pregnant during your period’
• Embarrassment of buying contraception
• Self-esteem issues
• Having sex while using drugs or alcohol (reduced judgement and capacity to make safe decisions)
• Parents not talking to their children about contraception
• Lack of communication or support within the relationship
• Sexual or intimate partner violence
• Lack of government funding to increase education and access to contraception, and
• Lack of access to contraception due to insufficient sexual and reproductive health education, high cost, unsupportive doctors, religious beliefs and limited and inaccurate explanations around contraception.

It is also important to remember that no contraception method is 100% effective. While some methods may technically be 98-99% effective, the effectiveness of any method is reduced when allowing for human error. Even when used correctly and consistently, contraceptive methods can fail: the World Health Organisation estimates that even if every couple used contraception perfectly every single time they had sex, there would still be six million unplanned pregnancies each year worldwide. Abstinence is usually not a realistic contraception option for most people across their entire reproductive lifespan.

To ensure that women cope effectively with an unplanned pregnancy, it is important that women have access to correct information and non-directive support about their three options – parenting, abortion and adoption.

Women’s experience of unexpected pregnancy

Women respond in a number of ways to an unplanned pregnancy. For many women it is a shock, as more often than not, they were using some form of contraception and did not expect to fall pregnant: studies of Australian and New Zealand women considering abortion have shown that up to 80 per cent had been using contraception at the time they became pregnant. While not every unplanned pregnancy is unwanted, many women will be faced with a decision about what the best option is for them and their family in this situation.

Some women experiencing unplanned pregnancy contact agencies such as Children by Choice and Family Planning to find out more information about their options. Most women talk to their partner or the man involved in the pregnancy, or confide in a good friend or close relative – three quarters of women told a national survey about unplanned pregnancy options that they felt no need to speak to a counsellor in order to make their decision.

When trying to make a decision about an unplanned pregnancy, women usually try to identify which option they will cope with best. This usually ensures that women will cope with whichever option they choose. In order to identify which option is best it is important that women have accurate information on all their options.
Abortion

“Given the complex and compelling nature of human sexuality, it is inevitable that unplanned and unwanted pregnancies will continue to occur. And despite the availability of contraceptive agents, a percentage of Australian women will continue to seek safe, legal abortion.”


Almost half of all unplanned pregnancies in Australia end in a termination of pregnancy (abortion), and, using what little data is available on abortion rates in Australia, it is estimated that almost one in three Australian women will choose abortion in their lifetime. Medicare claims for abortive procedures in the years 1995-2004 averaged about 75,700 annually, with numbers decreasing over this period; however it should be noted that the same Medicare item numbers are used to denote procedures which are not terminations, including miscarriage, foetal death, or other gynaecological conditions.

The suction curettage method is the most widely used in Australian clinics. When performed in registered clinics, this method of pregnancy termination is a very safe procedure, with an estimated complication rate of less than 2% in Australia. Medication termination is available in some locations, but providers are still limited.

All Australian states have some abortion services however the availability varies, with some states allowing abortion up to 24 weeks gestation. Western Australia and South Australia are the only two states routinely collect data on pregnancy termination, and they both report that over 90% of pregnancy terminations in Australia occur in the first 14 weeks.

In most states, services are provided in private clinics only, so patients will pay some out-of-pocket expenses. In Queensland, the cost of a termination has risen steeply in the last few years, and increasing numbers of women are struggling to pay for a procedure. Some clinics may offer a reduced cost for health care cardholders and pensioners. Costs are higher in clinics based in regional and northern areas of Queensland, and women from rural and remote town and communities often face additional costs and barriers due to travel and accommodation – only three clinics operate north of the Sunshine Coast.

Following a court case in 1986, abortion is legal in Queensland when there is serious risk to the woman’s physical and mental health if the pregnancy continues. Abortion remains the only medical procedure included within the Queensland Criminal Code.

Adoption

The number of adoptions in Australia has declined steeply since the 1970s due to a rise in the acceptance of, and government financial support for, single and unmarried parents, and improved access to contraceptives and abortion services. The 1970s also saw the beginning of the end of the forced adoption practices that created long-lasting harm for pregnant unmarried women and their children.

Now, between 8 to 12 local adoptions of infants occur in Queensland every year. In Queensland, the Adoption Services Queensland unit, within the Department of Communities, arranges all legal adoptions. The unit will not consider an application for adoption until after the baby is born. However, if adoption is being considered during the pregnancy, there are a number of organisations that can provide information, support and counselling.

Birth parents can sign an adoption consent form from 30 days after the birth. The Department will make every effort to obtain the consent of both parents, however, the birth father’s consent is not required in cases where there is a risk of violence to the woman or child, he cannot be identified, or incest is involved. After providing consent, either birth parent has 30 days to revoke this consent (like a cooling off period). Following the revocation period, the adoption is legal and the child will be placed with adoptive parents.

Once the adoption order has been made, the birth parents are unable to regain the right to parent the child. Since February 1, 2010, the adopted child and the birth parents have the right to access identifying information once the adopted child turns 18 for all previous adoptions.

Parenting

Parenting is the option chosen in around half, or just over half, of all unplanned pregnancies. Australia's
overall fertility rate steadily declined for 40 years after the baby boom of 1961, to a low of 1.73 babies per woman in 2001. The last ten years have seen a rise in the fertility rate, and it is now close to 2.0%. The rise in fertility has mostly been seen in women older than 30, with an increasing age at first birth amongst Australian women.

The teenage pregnancy rate is relatively high in Australia compared to other developed countries: 17.3 of every 1,000 women in 2003. As with women of any age, young women who experience higher socio-economic disadvantage also experience a higher birth rate. (See the Australian Bureau of Statistics website for more information at www.abs.gov.au). Young pregnant or parenting women can also face further disadvantage in trying to continue their education.

A woman’s decision to become a parent is often embedded in a range of cultural and society constructs; however, the face of parenting and of families has changed significantly in Australia over recent decades and there is now a diversity of arrangements that people choose to embark on in order to raise their children, including single parenting. This is partly due to the rise in acceptance of single parenting and diverse family arrangements.

Whether in a ‘traditional’ family unit or not, some women will face many challenges in raising their children. It is important that women and their children are supported through these challenges; Children by Choice can provide referrals to many pregnancy and parenting support groups for women and their children.

An unplanned pregnancy presents a woman or couple with three options: abortion, adoption or parenting. There are no definitive rules for how to reach a decision regarding a pregnancy. However it is essential for the pregnant woman to own the decision, whether it is to parent, have an abortion, or to place the child for adoption. It is therefore important that the options are carefully considered before following through with the decision. Having accurate and current information on all of these options and being able to access unbiased, non-judgemental support during decision-making, contributes to making a well-informed decision.

REFERENCES


### REASONS TO CHOOSE A MEDICAL ABORTION
- It can be used in the earliest weeks of pregnancy.
- It requires no surgery.
- It requires no anesthesia.
- It has the potential for greater privacy.
- Some women feel it gives them greater control over their bodies.
- It may feel more “natural” for some women.

### REASONS TO CHOOSE A SUCTION CURETTAGE (SURGICAL) ABORTION
- It requires fewer office visits.
- The procedure takes a short amount of time.
- It is more effective than medical abortion (less risk of an incomplete procedure).
- Women usually do not have heavy bleeding at home.

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### COMPARISON OF METHODS FOR FIRST-TRIMESTER ABORTION

<table>
<thead>
<tr>
<th>SUCTION CURETTAGE ABORTION</th>
<th>MEDICAL ABORTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>A doctor uses suction to empty your uterus.</td>
</tr>
<tr>
<td><strong>How does it work?</strong></td>
<td>During a visit to the clinic, a doctor places a speculum into your vagina. The doctor numbs the cervix and then gradually widens, or dilates, your cervix. Then, a tube is placed into your uterus. Suction, created by an electric machine or by a hand-held syringe, is applied on the other end of the tube and empties your uterus.</td>
</tr>
<tr>
<td><strong>How effective is the method?</strong></td>
<td>98 per cent of suction curettage abortions are successful; only about 2 per cent of women need a repeat procedure or other intervention.</td>
</tr>
<tr>
<td><strong>How far along in my pregnancy can I use this method?</strong></td>
<td>Six to 14 weeks since the first day of your last menstrual period. Women are often asked to wait until six weeks of pregnancy to decrease the possibility of leaving all or part of the pregnancy behind after the surgical procedure. If performed earlier than six weeks, the procedure may be less effective.</td>
</tr>
<tr>
<td><strong>How many clinic visits are required?</strong></td>
<td>Usually requires one visit – for health education, exam and procedure. You may return to the clinic if you need follow-up care.</td>
</tr>
<tr>
<td><strong>How long is each appointment?</strong></td>
<td>If you are between six and 12 weeks pregnant, the appointment will take approximately three hours. Later abortions usually require longer or multiple visits.</td>
</tr>
<tr>
<td><strong>Is it painful?</strong></td>
<td>Most women experience some cramping during or after the short procedure.</td>
</tr>
<tr>
<td><strong>What kind of anesthesia (pain relief) will I receive?</strong></td>
<td>The doctor will apply numbing medication (local anesthesia) to your cervix. Oral medications, including Valium, Vicodin and/or Ibuprofen, also are used to relax you and to control your discomfort.</td>
</tr>
<tr>
<td><strong>How much will I bleed?</strong></td>
<td>Women usually have light bleeding at home after the procedure for up to two weeks.</td>
</tr>
<tr>
<td><strong>May I bring a support person with me?</strong></td>
<td>Yes, one friend, partner or family member may accompany you during the health education, explanation of the procedure and the procedure itself.</td>
</tr>
<tr>
<td><strong>Must I have somebody with me?</strong></td>
<td>No, but you must have a ride home if you opt to take Vicodin or Valium. It is preferable that you have a friend pick you up. Please bring extra money if you need to take a taxi home.</td>
</tr>
</tbody>
</table>

Reviewed by health care specialists at UCSF Medical Center (USA).

This information is for educational purposes only and is not intended to replace the advice of your doctor or health care provider. We encourage you to discuss with your doctor any questions or concerns you may have. www.ucsfhealth.org/education/medical_versus_surgical_abortion/

This e-book is subject to the terms and conditions of a non-exclusive and non-transferable LICENCE AGREEMENT between THE SPINNEY PRESS and: Forrest Library, Wembley Downs, library.admin@hale.wa.edu.au.
Many international studies show that women who have had an abortion are no more likely to experience long-term psychological or emotional problems than women who have not had an abortion. While many women undergoing abortion experience negative emotions, including guilt, the majority feel abortion was the right decision.

Most women reach a decision about an abortion without professional support. However, for some women, professional counselling offers a valuable and much-needed resource.

**Deciding whether to have an abortion**
Most women deciding whether to have an abortion consider many of the same factors as women contemplating motherhood, including:
- Their relationship with their partner
- The wellbeing of the foetus
- Their readiness to take on a parenting role
- The needs of children they may already have
- Their career and financial situation
- Their mental and physical health
- The level of support they are likely to receive from their extended family
- Their moral, emotional and religious beliefs about pregnancy, abortion and motherhood.

Australian women who have had an abortion have reported that their emotional reactions were affected by a range of factors, including:
- Being able to make the final decision to have the abortion
- Having access to supportive, confidential and non-judgemental services
- Having access to unbiased counselling when needed
- The reporting of the true experiences of women who have had an abortion.

**Emotional issues around abortion**
Although most Australians support safe and legal abortion, there is still social stigma surrounding the procedure and an under-reporting of women’s experiences.

Research shows most women who have had an abortion feel they made the right decision. In most cases, emotional distress peaks before the procedure and resolves soon after. After having the procedure, most women experience relief and the return of a feeling of control.

A small proportion of women experience ongoing guilt and regret after having an abortion.

Factors that can contribute to this include:
- Having low self-esteem
- Feeling unable to cope
- Belonging to a culture or group that views abortion negatively
- Feeling there is little support
- Feeling stigmatised or unable to tell others
- Having originally committed to the pregnancy
- Seeing the foetus as having human characteristics.

**Abortion and planned pregnancy**
During pregnancy, a woman may be told there are problems with her health or the health of the foetus. When this happens, she may be faced with the decision of whether to have an abortion.

Although having an abortion in this circumstance is likely to cause a great deal of emotional distress, studies show most women feel they made the right decision. Genetic and pregnancy counselling is available to support the woman in making her decision.

In other circumstances, a woman may reconsider her plans and terminate (end) a pregnancy that she had originally wanted because of a relationship ending, financial problems, medical conditions or family issues.

**Emotional difficulties after denial of abortion**
Women who are denied abortion and keep their child are likely to experience more emotional distress than those who have the procedure. In one study, more...
than half of the women who were denied an abortion reported long periods of mental disturbance and emotional strain after the birth of the child.

**Abortion counselling**

While many women have made their decision to have an abortion before attending a clinic, some will need more information to help in making their decision. This may include information about alternatives (such as adoption and foster care), including support services that are available if she wishes to continue with the pregnancy.

All women should be given information about the procedure itself, anaesthesia options for surgical termination and pre- and post-abortion care. Part of the decision-making process includes being fully informed of the risks involved.

Most women reach a decision about an abortion without professional support. However, for some women, professional counselling offers a valuable and much-needed resource.

Some women may need counselling from a trained professional. Medicare-rebated pregnancy support counselling services are provided by some doctors, social workers, mental health nurses and psychologists. For a woman who is considering abortion and is having difficulties making a decision, counselling can offer an unbiased, non-judgemental and non-directional opportunity to work through her feelings and thoughts. In some cases, the woman’s partner or parent also requests access to counselling.

**Follow-up counselling after abortion**

After the abortion, some women want to talk about their experiences with a doctor, nurse or professional counsellor. Issues such as physical and emotional recovery, and contraceptive options are usually discussed.

**Counselling to reduce harm**

For a very small number of women, the experience of an unplanned pregnancy and subsequent abortion is highly traumatic. Feelings of grief, guilt, shame, depression and anxiety need to be handled by a highly trained and skilled counsellor. Appropriate counselling can minimise the risk of long-term psychological harm.

If your experience of abortion is affecting your health, you should speak with a health professional.

**Not all abortion counselling is unbiased**

Some organisations that claim to offer family planning services do not discuss all options with women. They tend to have a particular point of view, which is all they offer to women. It is helpful to ask the organisation you are contacting what their position is regarding abortions.

**Where to get help**

- Your doctor
- Family Planning Victoria Tel. (03) 9257 0100 or freecall 1800 013 952
- Family Planning Victoria’s Action Centre (for people aged under 25) Tel. (03) 9660 4700 or freecall 1800 013 952
- The Royal Women’s Hospital Pregnancy Advisory Service Tel (03) 8345 3061
- Women’s health centre

**Things to remember**

- Most women who have had an abortion are no more likely to experience long-term psychological or emotional problems.
- Not all women who have an abortion experience guilt, grief or shame as a result of the procedure.
- Studies show most women who have an abortion feel they made the right decision.
- Counselling ideally offers a woman a non-judgemental opportunity to work through her feelings about her pregnancy. It includes advice, information, support, education and therapy.

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People who support abortion are called Pro-Choice. But what woman ever wants to ‘choose’ abortion in her life? All too often, that choice is made without all the information. Or that ‘choice’ really isn’t a choice at all – that a woman felt pressured by family, circumstances, or even a doctor to go through with an abortion.

Finally, that ‘choice’ often leads to years of side effects which range from emotional, to psychological and even physiological. The biggest complaint by women is that they weren’t offered access to all the information and/or felt pressured at the time of making their decision.

Right to Life NSW offers a perspective on abortion that considers the rights of all persons involved in the issue – the children, the man (or Father,) the baby, the extended families, even those of healthcare professionals – but most importantly, the woman (or Mother.) We believe that when armed with all the information, a woman can avoid making that choice, that in the end she never intended or wanted to ever make in her life.

THE FIGURES

1. There are an estimated 80,000-90,000 abortions every year in Australia¹
2. This equates to approximately 250 abortions per day²
3. This equates to 1 abortion for every 2.8 live births³
4. 1 in 3 Australian women will have an abortion in their lifetime⁴

5. In NSW, there are approximately 25,000-30,000 abortions every year.⁵

THE LAW

There is no national law regarding abortion in Australia. Rather, it’s handled at a state level, with the grounds on which abortion is permitted varying from state to state. In every state, abortion is legal ONLY to “protect the life and health of the woman,” although each state has a different definition.

In reality, though, the phrase “protect the life and health of the woman” has come to mean “on request of the woman” so that abortion is currently available “on demand” throughout the Commonwealth of Australia.

Additionally, there is no law anywhere in Australia that requires the notification or consent of a woman’s partner. There is no enforced waiting period for an abortion, and except in Western Australia, a minor does not require parental consent or notification for an abortion.

We believe that when armed with all the information, a woman can avoid making that choice, that in the end she never intended or wanted to ever make in her life.

In New South Wales, abortion law is primarily based upon a 1971 ruling by Judge Aaron Levine which declared abortion to be legal if a doctor found ‘any economic, social or medical ground or reason’ that an abortion was required to avoid a ‘serious danger to the pregnant woman’s life or to her physical or mental health’ at any point during pregnancy.

This was expanded by the Kirby ruling of 1994, which extended the period during which health concerns might be considered from the duration of pregnancy to any period during the woman’s life.

In practice, this has been taken as a licence for abortion-on-demand. The consequences to the woman’s health of having an abortion do not seem to have weighed into the equation.

Even so, abortion-rights advocates want to take it even further, and completely decriminalise abortion in New South Wales.

In addition, legislative efforts to recognise the unborn have stalled in the NSW Parliament. A law...
that would recognise a 20-week-old foetus as a ‘person’ passed the NSW lower house in November 2013. But that bill has stalled in the upper house, where it has yet to be introduced. It’s called ‘Zoe’s Law,’ and is named after Brodie Donegan’s unborn daughter, Zoe, who was killed when a drug-affected driver hit Brodie’s car in 2009. She was eight months pregnant with Zoe. The bill would recognise a crime of grievous bodily harm against an unborn child for the first time.

There is a growing body of international research as well as an enormous amount of anecdotal evidence that suggest abortion has a long-lasting negative effect on women.

THE SCIENCE

When does life begin?

The question of when human life begins is an important one in determining when (if ever) abortion is an ethical ‘choice’.

While some belief systems and individuals maintain that meaningful human life truly begins after birth, it is widely accepted among the medical and scientific community that:

a. Biologically, human life begins at conception, and
b. A foetus beyond 24 to 26 weeks is sentient (self-aware). For this reason, in most places, legal abortions following 24 weeks of gestation are only performed in case of medical emergency.

WHAT’S THE IMPACT OF ABORTION ON WOMEN?

1. Abortion is linked to increased rates of depression, drug and alcohol abuse

   a. An Australian study which followed over 1,200 women from ages 14 to 21 found:
      a. Among women with no pre-existing depression or substance abuse, those who had abortions had more than double the rate of alcohol abuse and 3.6 times the rate of illicit drug use compared to those who gave birth.
      b. Women who show signs of distress at the time of their abortion are at significantly more risk of long-term depression.8

2. A New Zealand study which followed over 500 women from ages 15 to 30 found

   i. Women who had abortions had a 30% increased rate of mental disorders including depression, anxiety and substance abuse. In most cases, these women had no problems before their abortion.

3. Abortion increases the risk of premature births with future pregnancies

   i. A German study which examined over 2.2 million pregnancies found:
      a. Women who had 1 abortion had a 30% increased rate of very premature birth (before 32 weeks)
      b. Women who had 2 or more abortions had a 90% increased rate of very premature birth.

4. Abortion clinics often fail to assess whether a patient is being pressured by others or to allow enough time for the woman to make up her own mind.

   i. A study of American women found:
      a. 64% felt pressured to have the abortion
      b. 80% did not receive adequate counselling
      c. More than half felt rushed or uncertain when agreeing to the abortion procedure.

THE FACTS FOR WOMEN

There is a growing body of international research as well as an enormous amount of anecdotal evidence that suggest abortion has a long-lasting negative effect on women.
1. Emotional risks associated with abortion

1. Abortion results in short-term relief for most women, usually accompanied by negative emotions. Such relief tends to be fleeting.
2. 10 to 20 per cent of women suffer from severe, negative psychological complications after abortion, despite the frequent presence of relief soon after the abortion.
3. Many more women experience emotional distress immediately after the abortion and in the months following. Negative emotions include sadness, loneliness, shame, guilt, grief, doubt and regret.
4. Depression and anxiety are experienced by substantial numbers of women after abortion.
5. For a small proportion of women, abortion triggers post-traumatic stress disorder.
6. After abortion, women have an increased risk of psychiatric problems including bipolar disorder, neurotic depression, depressive psychosis and schizophrenia.
7. Increased risk of substance abuse and self-harm. This is particularly true during a subsequent pregnancy.

2. Physical risks associated with abortion

1. Research has established that abortion is associated with a variety of significant physical risks, including premature delivery, infection (which may lead to infertility, particularly in the presence of genital infection), uterine perforation, and miscarriage and low birth weight in future pregnancies.
2. There appear to be more deaths from all causes, including suicide and homicide, after abortion compared with childbirth.
3. A first pregnancy carried to full term provides a degree of protection against breast cancer. Many studies have identified an increased risk of breast cancer associated with the early abortion of a first pregnancy. Other studies have shown no risk.

3. What you’re NOT being told

1. Many women cite their abortion provider did not present them with the range of physical and emotional risks associated with abortion.
2. Many women say their abortion provider was unprepared to provide support or counselling regarding concerns post-abortion.
3. Many women say they weren’t told how developed their unborn baby was, and had they been able to understand that the foetus they were carrying was, in fact, a baby (for example, via ultrasound) they might have made an alternative decision to abortion.

THE FACTS FOR MEN, FAMILIES AND DOCTORS

• FOR MEN: While less common and usually less intense as a woman, some men can feel a sense of guilt and sadness at the decision to abort, even though they might have been supportive at the time – and especially if they wanted their child
to be born. Many men regret the opportunity of fatherhood lost. Later in life, they find themselves wondering about the child that might have been, had there been a different choice. Many feel significantly disempowered in the process.

While less common and usually less intense as a woman, some men can feel a sense of guilt and sadness at the decision to abort, even though they might have been supportive at the time – and especially if they wanted their child to be born. Many men regret the opportunity of fatherhood lost.

- **FOR FAMILIES:** Family relationships and stability can be compromised as a result of an abortion. Family secrets can often break families up (both immediate and extended) even if they go unmentioned.

- **FOR CHILDREN:** Children who are born of mothers who have aborted their siblings may experience the effects of her displaced grief. If they’re born after another child has been aborted, they might be treated (unwittingly by their mother) as a ‘replacement child’.

- **FOR THE UNBORN BABIES:** They are the most vulnerable of all in this entire equation, with no voice in their own survival. While society debates when life actually begins, science has shown from the moment of conception that the unborn baby’s identity is established – whether it’s a boy or a girl, the colour of the eyes and hair, the dimples of the cheeks and the cleft of the chin. The information about who that unborn baby will become is already in place.

- **FOR DOCTORS:** Every doctor would prefer to save a life than to take one. However, further to that, the situation in certain states has become even more serious as doctors face deregistration if they refuse to refer for abortion.

**REFERENCES**

2. Department of Health and Ageing, answer to Senate Question Number 325 asked on notice on 31 January 2005 by Senator Boswell.

A few months ago the United Nations Office of the Commissioner for Human Rights recognised Dr Willie Parker as a human rights defender. Dr Parker is a US-based abortion provider who provides abortion care in several states, including to the only abortion service in the state of Mississippi, and is one of a dwindling number of doctors providing abortion care services in the USA due to the hostile and constantly changing legal environment, daily protests outside clinics, and threats to their lives from anti-choice activists.

Access to safe, legal abortion as a health issue is recognised as part of the right to health. In 2011 the United Nations Special Rapporteur on the right to health recommended that all nation states “decriminalise abortion, including related laws, such as those concerning abetment of abortion”.

Despite this recognition and its status as a key component of reducing maternal morbidity and mortality, abortion remains criminalised to some degree in many parts of the world.

In Australia there are currently only three out of eight jurisdictions in which abortion is legally the woman’s decision and completely decriminalised (with some exceptions such as unqualified practitioners or a lack of consent from the patient).

Two jurisdictions rely on nineteenth century criminal law and judicial precedent, and three have a perplexing mix of criminal and other laws which put the legal responsibility of decision-making in the hands of doctors (who usually need to certify a range of criteria are met), not women.

Many people would be surprised to learn that criminal charges for abortion in Australia are not a relic of the “bad old days”. The last trial in Australia in which a woman was charged with the offence of procuring her own miscarriage was less than five years ago (Queensland in 2010) and the last doctor prosecuted for the crime of providing an abortion was less than ten years ago (NSW in 2006).

With abortifacient drugs mifepristone and misoprostol approved by the Therapeutic Goods Administration in 2012 and reports of women obtaining it over the
internet, thus bypassing medico-legal requirements, it is only a matter of time before another woman falls foul of restrictive and outdated state or territory laws. These antiquated laws are adapted from the United Kingdom’s Offences Against the Person Act 1861 enacted at a time when there were no pregnancy tests, doctors did not know to wash their hands in between treating patients, and women did not have the right to vote, let alone contribute to the development of the laws that governed their pregnancies.

‘Personhood’ laws

Much more recently we are facing a new legal anti-choice tactic. So called ‘personhood’ laws seek to redefine fertilised eggs, zygotes, embryos and foetuses as ‘persons’ with full legal rights equal to the woman carrying them.

Such laws are designed to protect the supposed rights of the foetus, but in reality they are being used to erode the rights to life, liberty and autonomy for pregnant women. Ironically, it seems to be women with planned, wanted pregnancies who have been worst affected.

The USA provides myriad examples. In 2004 in Pennsylvania, Amber Marlow wanted a natural delivery for her seventh baby when doctors insisted on a caesarean. Instead of negotiating with their patient, they successfully obtained a court order giving them custody of the foetus and with it, the right to force surgical intervention on Ms Marlow against her will. Ms Marlow discharged herself before they were able to do so and went on to have an uneventful natural birth in a different hospital.

In Utah, Melissa Rowland was charged with murder after one of her twins was stillborn, while in Indiana in 2011 Bei Bei Shuai, who attempted suicide (not a crime in that state) was charged with murder and attempted foeticide when her neonate died shortly after birth.

In 1983 the (predominantly Catholic) Republic of Ireland amended its constitution to give the foetus equal human rights to that of the pregnant woman. Now, thousands of Irish women travel abroad for abortions each year.

But there have been far more dire consequences of this amendment for pregnant women. In 2012, Savita Halappanavar was 17 weeks pregnant when she began to miscarry. Medically, she needed intervention to complete the miscarriage, but because the foetus still had a faint heartbeat, medical professionals were prevented by law from intervening. Ms Halappanavar became increasingly unwell, suffered septicemia and died, leaving her two existing children without their mother.

Another Irish woman, 15 weeks pregnant, suffered a traumatic head injury. Emergency interventions failed to save her and she was declared clinically dead on 3 December 2014, but because there was a heartbeat detectable in the unviable foetus, doctors were prohibited from turning off life support. The woman’s husband and children had to endure more than three weeks watching her body deteriorate while lawyers fought for her right to a dignified death and burial. A court ruling on 26 December granted permission for her life support to be switched off, but only because the judge deemed there was no chance the foetus would survive long enough to reach viability.

Australia: the next battleground?

Australia has had two ‘personhood’-style bills proposed: the so-called ‘Zoe’s Law’ in 2014 in New South Wales, and a similar bill called ‘Jayden’s Law’ in South Australia in the previous year.

Neither succeeded in becoming law in their respective jurisdictions. But opponents of these American-style ‘personhood’ laws fear that Australia might be the next battleground for the kinds of extreme human rights abuses inflicted upon pregnant women that have been occurring overseas.

It is imperative that all women, regardless of their intentions for current or future pregnancy, remain vigilant against attempts to erode their human rights. No matter what her views on abortion, this trend is something every Australian woman should be alarmed about and something every supporter of human rights must fight.

Jenny Ejlak is a long-term reproductive rights advocate who has been part of successful abortion decriminalisation legal reforms in two jurisdictions. She has worked in counselling, public health and women’s health, is a member of the Public Health Association of Australia and is a founding member and current President of Reproductive Choice Australia.


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Issues in Society | Volume 402

The Abortion Rights Debate
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ABORTION – WHAT IS IT?

Abortion is the killing of a human being, writes the Right to Life Association of SA

The belief that every human life is of equal worth and is worthy of protection and loving care has come under increasing attack. The sanctity of life ethic is being replaced by a quality of life ethic. Advocates of this new ethic maintain that some persons should be terminated because they are unwanted, unplanned, imperfect or are not properly productive.

Wherever and whenever the respect for human life is cheapened and diminished, there is an educational effect upon that culture and society. This has happened in Australia. In around 30 years the rate of abortion has escalated to the point where there is now one abortion for every three live births.

Abortion is the killing of a human being. It is the termination of a unique life in which individuality is inherent and real in the genetic programming from the time of fertilisation. Unique adult characteristics are already determined.

The unborn does have and must have rights. This is recognised by legislation in some states and other parts of the world, in that the unborn has rights in cases of assault or accident to the mother.

The consequences of terminating a pregnancy have been minimised by abortion proponents.

The medical risk to the woman is probably low, but includes haemorrhage and infection that may be fatal.

There are numerous studies showing a long-term association with breast cancer that cannot be dismissed.

There are consequences to the mental wellbeing of the mother. Agony can be felt decades into the future. It is not always possible to continue to deny the reality that a child has been killed.

There are consequences in relationships with the current partner and future partners of those involved in an abortion.

There are consequences to our spirit, unless we are totally successful in denying the spiritual component of our being.

The vast majority of women who make a decision to go through with an unwanted pregnancy have no doubt that they have made the right choice for themselves as well as the baby.

Abortion is seen as a solution to many social problems such as child abuse. Instead, child abuse has increased dramatically – estimates range between 40% and 300%. According to researchers, an estimated 4 out of every 10 children are either emotionally or physically abused, even though we have prevented the birth of about 2½ million unwanted children in Australia since 1970. On average, one unborn Australian child dies by abortion every 6 minutes.

An estimated 80,000 abortions are performed annually in Australia: 4% for medical reasons, the remainder for socio-economic reasons, including ‘convenience’, ‘cost of bringing up the child’, and ‘career or studies.’ The government finances around 80,000 abortions through direct Medicare payments of over $6 million.
Abortion is the killing of a human being. It is the termination of a unique life in which individuality is inherent and real in the genetic programming from the time of fertilisation. Unique adult characteristics are already determined.

Western civilisation has firmly held to life-supportive principles as promoted by Hippocrates from 450 BC until the early 1900’s when certain groups and individuals began promoting death as a solution to social problems.

What wars and sickness have failed to do, society and the medical profession are managing to achieve.

Abortion makes the greatest impact of all on the demographic structure of a country. The birth rates in all Western countries are at the lowest levels on record. We are reaching zero population growth. This is a biological impossibility because of the inexorable ageing of the population. It is merely a moment in the country’s history when the falling curve of the birth rate crosses the rising death rate line on a graph. A corollary of this is zero economic growth. It makes a dying country.

Rhetoric paints the preborn as a parasite, a lump, a ‘glob of tissue’. In fact, it is the woman’s child, as much like her as any child she will ever have, sharing her appearance, talents and family tree. In abortion, she offers her own child as a sacrifice for the right to avoid change in her life, and it is a sacrifice that will haunt her. She can lose her health.

In addition to the women who experience a punctured womb or are killed on abortion tables, there are more subtly damaging effects. The cervix is designed to open gradually over several days at the end of pregnancy. In many abortions the cervix is wrenched open in a matter of minutes. The delicate muscle fibres can be damaged – a damage that may go unnoticed until she is far into a later, wanted pregnancy, and then they give way in a miscarriage. By some estimates, the aborted woman’s chance of later miscarriages doubles.

The last loss is of her peace of mind. Planned Parenthood have conceded that as many as 90% of aborted women may experience trauma after abortion.

If we were to imagine a society that truly supported and respected women, we would have to begin with preventing unplanned pregnancies. Contraceptives fail and half of all aborting women admit they weren’t using them at the time. Preventing unplanned pregnancies will involve a return to sexual responsibility, using commonsense to enable us to think situations through and make appropriate decisions to protect ourselves and plan for our children’s lives.

Reproductive rights, abortion and Zoe’s law: WHY FREEDOM OF CHOICE IS STILL FEMINISM’S BIGGEST FIGHT

Women’s reproductive rights are still a subject of debate in Australia, and indeed across the world, particularly in light of a series of significant legal reforms, observes pro-choice commentator for Women’s Agenda, Lucia Osborne-Crowley.

Recently in Australia, Victoria and Tasmania have joined the states and nations across the world that entirely decriminalised abortion, endowing women with both the legal and practical right to choose whether or not to continue a pregnancy.

But reproductive rights reform has not always been – indeed still isn’t – a linear trajectory towards greater self-determination for women.

In the United States, many states have recently enacted foeticide laws, allowing courts to convict women for harm to their own foetus during pregnancy. Most recently, an Indiana woman named Purvi Patel was sentenced to twenty years in prison when she went into early labour and subsequently lost her child.

Reproductive rights may not be wholly moving forward in Australia, either. The state parliament in NSW has, for two years, been attempting to pass a bill that would fundamentally change the state’s reproductive rights law. The bill, called Zoe’s Law, creates legal personhood for an unborn child at or over 20 weeks gestation. If this bill were passed, it may leave open the possibility of a mother being punished for her treatment of her own foetus, given the woman and the unborn child would legally be considered two separate entities.

The bill has been introduced to NSW parliament twice and has not yet been passed. It is expected that the bill may be reintroduced in the upcoming parliamentary session.

In light of this proposed reform and the questions raised by Patel’s sentencing in Indiana, we thought we would ask some questions about reproductive rights. Why are they so important? Are they being eroded? Is it possible that a sentence like Patel’s could ever be handed to an Australian woman?

To answer these questions, Women’s Agenda consulted three experts – health and reproductive rights lawyer Julie Hamblin, legal and political scholar Dr Kate Gleeson, and principal solicitor and CEO of Women’s Legal Service Tasmania Susan Fahey.

What are reproductive rights and why are they important?

At their narrowest level, reproductive rights exist to protect a woman’s self-determination and autonomy over her body and her health when it comes to having children, starting a family or protecting herself against sexually transmitted disease. Broadly, the state of a society’s reproductive rights for women also affects their autonomy over their economic, social, family and professional lives. These rights are aimed to provide a woman complete control over the decisions she makes about her body, her health and her life. The most important reproductive rights – and the most contentious – are a woman’s right to an abortion and a woman’s right to birth control.

Historically, many societies have been slow to enact and uphold women’s reproductive rights. So slow, in some cases, that they still have not reached even basic levels of protection for these rights. The growth of reproductive rights for women, beginning with landmarks such as the invention of the contraceptive pill, necessitated a shift away from ideas about male control of family life and of women’s sexual lives. The right to end male control of these issues was hard-won.

The right to abortion – a woman’s right to choose whether or not to continue a pregnancy – remains the most important issue for reproductive rights, in Australia and around the world.

Women’s autonomy and self-determination has been fought for in many different arenas throughout history – the right to vote, the right to divorce, the right to be represented in parliament. In large part, many of the battles of a woman’s control of her life have been fought and won. Reproductive rights are among very few autonomy-related rights that are still in contention. In this way, the struggle for reproductive autonomy is hugely significant.

As Dr Kate Gleeson told Women’s Agenda, “the central question of reproductive rights is control. They are about women’s autonomy to choose what happens to their body and health”. As CEO and principal solicitor of Women’s Legal Tasmania Susan Fahey explained, “this is one of the only legal issues that is constantly, reliably under attack. The onslaught has never faltered”.

The right to abortion – a woman’s right to choose whether or not to continue a pregnancy – remains the most important issue for reproductive rights, in Australia and around the world. The right to an abortion protects women from being made to carry a child they cannot raise, for economic, social, psychological or health-related reasons. It also protects women who have fallen pregnant as a result of violence and abuse. It also simply protects the right of a woman to decide whether or not she is ready and willing to have a child.
So where are we at with reproductive rights in Australia?

In Australia, the states and territories have markedly different levels of protection when it comes to reproductive rights. Women's reproductive rights are best protected in Tasmania, following a recent campaign to overhaul abortion law. Tasmania has decriminalised abortion entirely and enacted 150 metre exclusion zones around abortion clinics, within which space it is unlawful to protest abortion or harass a woman using the clinic.

Victoria comes in at a close second, having also decriminalised abortion but having not enacted protections for women seeking abortions. NSW and Queensland are far behind – in both states, abortion, while accessible, is technically illegal and still written into each state's criminal code.

This is a source of confusion for many – women can technically access abortions in NSW, so how is it possible that it is illegal?

“NSW is one of only two states that has not amended its abortion law, which dates back 100 years or more. In NSW, abortion is still a crime – both for the woman undergoing it and for the doctor performing it. The Crimes Act does not specify in which circumstances an abortion is lawful or unlawful, so this must be determined by the courts,” Sydney health lawyer and reproductive rights specialist Julie Hamblin explained to Women's Agenda.

Whosoever, being a woman with child, unlawfully administers to herself any drug or noxious thing, or unlawfully uses any instrument or other means, with intent in any such case to procure her miscarriage, shall be liable to imprisonment for ten years.

These are the words currently governing abortion in the NSW Crimes Act. They state that unlawful abortion may result in imprisonment, but does not specify how the legality of an abortion is determined. This has thus been determined by the courts over the years and, in general, judges have set precedents allowing abortion to be lawful as long as the doctor has a reasonable belief that continuing the pregnancy allowing the pregnancy would have a negative physical or psychological impact on the mother.

The right to an abortion protects women from being made to carry a child they cannot raise, for economic, social, psychological or health-related reasons. It also protects women who have fallen pregnant as a result of violence and abuse. It also simply protects the right of a woman to decide whether or not she is ready and willing to have a child.

These precedents allow abortion to be accessible, at least in theory, in NSW. But the technical illegality still poses significant barriers.

“The legality of abortion must be determined by each individual judge in each individual case – there is no certainty for any woman in NSW that she will not be prosecuted for having an abortion,” Hamblin explained.

“Worse still, judges must determine the legality of an abortion based on the reasonable belief of the doctor that doing so is in the best interests of the woman – legally, the woman’s beliefs about her body and health are
irrelevant. This is a deeply unsatisfactory legal position when it comes to women’s reproductive rights.”

Many legal and medical academics believe abortion should be decriminalised in NSW and its lawfulness explicitly protected by the Crimes Act to eliminate this uncertainty.

While this may seem like a technicality, and that in practice women do have access to abortions even under laws like this, legal experts say this is not always the case.

“We’ve seen so many women who sought medical advice when they fell pregnant and were told by pro-life doctors that abortion is illegal. These doctors did not specify that there are circumstances in which a judge can determine it is legal, so the women assumed their only choices were to have the child or face going to gaol,” Fahey told Women’s Agenda.

“Practically, yes, some women have access to abortion in NSW. But only if they have enough disposable income and access to a clinic – this excludes many, many women of lower socio economic states and women living in rural NSW,” Hamblin said.

Because of abortion’s place in NSW’s criminal code, it is not performed in public hospitals. For this reason and many others, Hamblin says abortion will never be free of stigma until it is entirely decriminalised.

“The taint of criminality is a significant problem for the autonomy and self-determination of NSW women,” she said.

So will NSW decriminalise abortion? It’s hard to tell, but all three lawyers that Women’s Agenda consulted for this article believed it is inevitable that abortion will be decriminalised at some stage in the future.

“We know that in NSW most people agree that a woman should have safe, affordable access to abortion when she needs it. So we have a law that is out of step with the majority public opinion, and we have a very vocal minority winning out when it comes to abortion law. As in any pluralist society, eventually our law and policy will reform to favour the majority opinion rather than the minority,” Hamblin said.

If lawyers and doctors are pushing for decriminalisation, where does Zoe’s Law fit in?

Zoe’s Law does not directly refer to or influence abortion law – it merely allows courts to prosecute harm done to a foetus by creating legal personhood for that foetus.

However, as Hamblin explains, “if a foetus becomes a legal entity, that is very powerful evidence for judges to consider when making a decision about the lawfulness of an abortion.”

“Supporters of Zoe’s Law say the bill will not affect abortion, but enacting legal personhood for a foetus in the context of our vague legislation about the legality of abortion is dangerous.”

Hamblin and Fahey agreed that in this context, Zoe’s Law could have numerous damaging consequences – intended or otherwise – for women’s reproductive autonomy in NSW.

The passing of Zoe’s Law would also place a powerful – perhaps definitive – roadblock in the path towards decriminalisation. As Hamblin explains, if NSW enacted Zoe’s Law and created legal personhood for a foetus and then subsequently decriminalised abortion, this would amount to legislating murder.

Fahey says it is crucial that NSW law moves in the direction of progress, as Tasmania’s has, rather than regress towards greater external control of women’s bodies.

“Tasmania’s new abortion laws doesn’t make abortion compulsory, we are not forcing it on anyone, we have simply legislated the right to choose and the right to the freedom of that choice,” she explained.

“If a foetus becomes a legal entity, that is very powerful evidence for judges to consider when making a decision about the lawfulness of an abortion.”

She and Hamblin both agreed that decriminalisation would not only protect individual women from potential prosecution, but it would lead to great strides in terms of ending the stigma around abortion. Zoe’s Law, on the other hand, may do the opposite on both counts.

Foetal personhood is the legal principle that underpins the United States foeticide laws – the ones which led to women like Purvi Patel being sentenced to twenty years in prison for her foetus’s death. Could Zoe’s Law open NSW up to this possibility? All three lawyers consulted by Women’s Agenda said it is unlikely – they agreed it is too difficult to compare the American and Australian legal systems, and that the moral, religious and political values informing abortion law in the US are too strong to be comparable to ours.

However, even if Zoe’s Law is unlikely to result in such an extreme legal situation, the lawyers agreed, it is certainly a step in the wrong direction when it comes to women’s reproductive rights.

DOES AN UNBORN CHILD FEEL PAIN DURING AN ABORTION?

ABORTION IS BOTH PAINFUL AND LETHAL, OBSERVES BILL MUEHLENBERG IN THIS ‘NEWS WEEKLY’ OPINION PIECE

Those who seek to justify the killing of unborn babies resort to all sorts of myths and falsehoods to make their case and assuage their conscience. They in fact have to live in a world of lies and misinformation in order to defend their willingness to destroy the unborn, and make that defence seem palatable.

Denying the humanity and personhood of the unborn child is of course one main way in which they proceed. And that is always the case with those who seek to oppress others: they seek to dehumanise the victims. Thus, slave-owners dehumanised blacks, just as baby-killers dehumanise the unborn.

It is customary to hear that the unborn baby is just a blob of cells. As such, an abortion supposedly does not hurt it or cause it any pain. After all, “How can a clump of cells experience pain?”, as the pro-abortionists argue. This rhetoric is just that: rhetoric. It is really about dehumanising the victim and ignoring the evidence.

Science has shown us quite clearly that unborn babies do indeed feel pain. For example, American surgeon Robert Shearin has argued that unborn babies can experience pain at quite an early age: “As early as eight to ten weeks after conception, and definitely by thirteen-and-a-half weeks, the unborn experiences organic pain… [At this point she] responds to pain at all levels of her nervous system in an integrated response which cannot be deemed a mere reflex. She can now experience pain.”

Another study said: “Physiologic responses to painful stimuli have been well documented in neonates of various gestational ages and are reflected in hormonal, metabolic, and cardio-respiratory changes similar to but greater than those observed in adult subjects. Other responses in newborn infants are suggestive of integrated emotional and behavioural responses to pain and are retained in memory long enough to modify subsequent behaviour patterns.”

It concluded with this caution that “humane considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations.”

More recently, a British review of the latest research has found that an unborn baby is definitely aware of pain by 24 weeks, and possibly aware as early as 20 weeks.

Other research points to the fact that pain is being felt even before 20 weeks. As one doctor explains: “At twenty weeks, the child has all the parts in place – the pain receptors, spinal cord, nerve tracts, and thalamus – needed for transmitting and feeling pain. The unborn child responds to touch as early as week six, and by week eighteen, pain receptors have appeared throughout the child’s body.”

And professor of neurobiology and anatomy Maureen L. Condic recently presented scientific evidence concerning the ability of unborn children to experience pain at a US House subcommittee. I offer here a few excerpts from her written testimony.

She said: “To experience pain, a noxious stimulus must be detected. The neural structures necessary to detect noxious stimuli are in place by 8-10 weeks of human development. There is universal agreement that pain is detected by the foetus in the first trimester.

“The debate concerns how pain is experienced, i.e., whether a foetus has the same pain experience a newborn or an adult would have. While every individual’s experience of pain is personal, a number of scientific observations address what brain structures are necessary for a mental or psychological experience of pain.

“First, it is clear that children born without higher brain structures (‘decorticate’ patients) are capable of experiencing pain and also other conscious behaviours... This indicates that the long-range connections that develop in the cortex only after 22 weeks (and are absent in these patients) are not obligatory for a psychological perception of pain...

“[W]hat we directly observe about foetal pain is very clear and unambiguous. Foetuses at 20 weeks post sperm-egg fusion have an increase in stress hormones in response to painful experiences that can be eliminated by appropriate anaesthesia. Multiple studies clearly indicate ‘the human foetus from 18-20 weeks elaborates pituitary-adrenal, sympatho-adrenal, and circulatory stress responses to physical insults’. All of these responses reflect a mature, body-wide response to pain.”

But the pain of death is of course...
the biggest concern of all here. Even if the abortion procedure involved no pain at all, it still results in a dead baby. That should be all the reason we need to say no to abortion. Abortion does not solve the ‘problem’ of pregnancy – it simply gives us a dead baby.

But abortion is both painful and lethal. It involves great pain and agony while it is being undertaken, and it gives us a dead child at the end.

We rightly show pictures of young seals being clubbed to death, because we want to persuade civilised people to have this awful practice put to an end. Perhaps it is time we did the same with the awful practice of abortion. Indeed, isn’t it telling that those who most support abortion are those who get the most upset when we show them the product of their ‘choice’?

Bill Muehlenberg is a commentator on contemporary issues, and lectures on ethics and philosophy. His website CultureWatch is at www.billmuehlenberg.com

Hands off our hard-fought abortion rights

Yet another male politician is trying to wind back the clock on abortion laws. All these pieces of legislation are designed to do is oppress and control women, writes Clementine Ford

This week, Victorian independent parliament representative Geoff Shaw revealed plans for a bill that would radically change the state’s abortion laws.

Shaw’s bill aims not only to pave the way once again for the criminalisation of abortion in Victoria, but also to set a precedent for other Australian states to follow suit. As a political representative, he is dangerous, out of touch and – most importantly – completely hostile to women and the female reproductive rights that have been so valiantly fought for.

Shaw follows in a long and nefarious line of American parliamentarians who have sought to chip away at abortion rights by going through the back door (if you’ll pardon the pun).

Unlike a predominantly non-secular America, the vast majority of Australians are in favour of women’s reproductive rights, including the right to access safe and legal terminations. Attempting to ban outright the procedure here has so far proved impossible.

As a result, in recent years we’ve seen men (and it is always, always men) propose legislation that pretends to protect the theoretical right to terminate a pregnancy while placing the legal right itself in a stranglehold.

In 2008, former senator Guy Barnett introduced a bill to Federal Parliament that would scrap Medicare funding for late-term abortions. At the time, Barnett was fond of quoting a “$1.7 million” figure that had paid for “10,000 late term abortions”.

However, a Medicare Australia spokesperson clarified that funding was only provided for services deemed “clinically relevant” by a doctor. In facts that Barnett and his ilk fail to mention, this translates as pregnancies in which the foetuses are no longer medically viable due to birth defects or even death. The bill failed.

Early last year, Democratic Labour Party Senator John Madigan introduced a private member’s bill that aimed to remove Medicare funding for abortions “procured on the basis of gender selection”. Madigan, like Shaw, argued that this was a feminist issue – the aim was to protect female life.

Unlike a predominantly non-secular America, the vast majority of Australians are in favour of women’s reproductive rights, including the right to access safe and legal terminations. Attempting to ban outright the procedure here has so far proved impossible.

But this is a furphy too, a dog whistle to all those folks who just want to see women’s reproductive rights shackled once again.

Madigan and Shaw don’t care about girls or women. How can they, when their agenda is driven by the desire to see women forced to give birth to foetuses they do not want and often cannot provide for?

Then, as remains the case now, it was shown that the ‘problem’ of sex selective abortion in Australia is a myth peddled by anti-choicers – if such a thing were occurring in numbers that threatened the lives of female
foetuses, we would see it reflected in the widening gap of girls and boys being born. So far, a gap has failed to present itself.

As any reproductive rights activist could tell you, if they really cared about the lives of girls and women, they would be advocating for GREATER access to birth control (including terminations) in all parts of the world, not hiding behind a veneer of concern in order to shuffle through their conservative agenda.

They would certainly be pushing for increased reproductive aid programs to countries like China and India, where sex selective abortions (or ‘gendercide’) are widespread problems. As it is, they’re merely happy to co-opt the traumas of women in foreign countries to justify their oppression of women in their own.

More recently, women in individual states in Australia have been threatened by the proposed introduction of ‘fetal personhood’ legislation.

After NSW grappled with the threat of the sympathetically titled ‘Zoe’s Law’, similar bills were introduced in both South Australia and Western Australia. The law would seek to confer personhood rights on a foetus, making its rights equal (and often greater) to the woman carrying it.

To many people, such a law sounds reasonable. After all, if a third party harms or even kills a woman’s unborn foetus, shouldn’t they be held to account?

The problem is that the law is left open to interpretation in a way that has fundamentally horrifying consequences for the women carrying said foetus. Consider America, where currently 38 states out of 50 have introduced some form or another of foetal personhood laws.

In tandem, a number of women have been imprisoned on murder charges relating to ‘foeticide’. South Carolina is one such state – the National Advocates for Pregnant Women found that while only one external person has been charged for assault under the terms of foetal personhood legislation (and their conviction was eventually overturned), up to 300 women have been arrested for actions undertaken during pregnancy.

The decriminalisation of abortion in Victoria was a cause for celebration. It recognised the fundamental rights of women to determine when, how and if they deliver a foetus into the world.

A foetus with the possibility of life is not equal to a woman with a life already established. To pretend otherwise is to gravely undermine the contribution that women bring to the world and the value that they have. Women need to stop arguing about who belongs to each other to end pregnancies that they did not want. And until relatively recently, this has meant that a lot of women have died. Who of these abortion warriors thinks to care about them?

The problem is that the law is left open to interpretation in a way that has fundamentally horrifying consequences for the women carrying said foetus. Consider America, where currently 38 states out of 50 have introduced some form or another of foetal personhood laws.

All of these pieces of legislation – the ones past and the ones yet to come – are designed to oppress and control women. A foetus with the possibility of life is not equal to a woman with a life already established.

To pretend otherwise is to gravely undermine the contribution that women bring to the world and the value that they have. Women need to stop arguing as if our reproductive actions need to be justified. They don’t.

We are not glorified incubators whose sole purpose is to churn out children for men to govern. Our aspirations and achievements are not limited to providing sex and offspring. And no one – no one – should be afforded the privilege of dictating the use of our bodies without our consent.

To put it in terms that Shaw and his conservative brethren might understand: WE will decide who comes to this country and the circumstances in which they come. Get ready, Shaw. Because the fight is coming to you.

Clementine Ford is a freelance writer, broadcaster and public speaker based in Melbourne.

Abortion risks: a position statement

Women’s Forum Australia maintains a strong commitment to life-affirming cultural change for women’s wellbeing and freedom. Our vision is for women to be given real choice – no woman should have to choose between her own welfare and that of her unborn child...

Women’s Forum challenges the rhetoric of ‘choice’ promoted by an abortion industry that has a vested interest in promoting abortion as a procedure without repercussion. Abortion and women’s experiences of abortion should not be trivialised and treated as though they are a simple medical procedure...

Women’s Forum believes women should have complete and accurate information and counselling about the abortion decision which includes the physical and psychological risks of abortion.

**QUICK FACTS**¹

- Only 22% of Australians think they are well informed on the topic of abortion.
- 1 in 4 pregnancies not naturally miscarried end in abortion.
- 94% of Australians think a woman should consider all the alternatives before deciding to have an abortion.
- 71% of Australians support greater public discussion about the topic of abortion.
- 76% of Australians believe men have an equal right to public comment.
- 37% of Australians are supportive of abortion on demand. 63% of Australians either oppose or are not strongly supportive of abortion on demand.
- 64% to 73% of Australians think that the abortion rate is too high.
- 87% of Australians believe that it would be a good thing if the number of abortions in Australia were reduced.
- 7 out of 10 Australians agree with arguments for legal access to abortion based upon women’s rights and the idea that abortion is ‘a necessary evil’, while 75% agree with the argument that it gives women control over their own lives.

W
omen’s Forum Australia (Women’s Forum) maintains a strong commitment to life-affirming cultural change for women’s wellbeing and freedom. Our vision is for women to be given real choice – no woman should have to choose between her own welfare and that of her unborn child.

Conservative estimates indicate 25% of pregnancies in Australia end in abortion.¹ Women’s Forum notes 75% of Australians believe this rate is too high and 87% are in favour of policy action that could enable a reduction in the rate.² Of the Australian community, 96% want women to have access to alternatives to abortion.³

Currently, across the various states and territories, abortion is either legal or extensively practised. However, legislation that criminalises abortion (such as in Victoria) fails women by ignoring basic safeguards including informed consent and voluntary, independent counselling. Moreover, 78% of Australians support a process in which women contemplating abortion are given counselling⁴ with 86% believing that this counselling should be independent of abortion providers.⁵

Women’s Forum challenges the rhetoric of ‘choice’ promoted by an abortion industry that has a vested interest in promoting abortion as a procedure without repercussion. Abortion and women’s experiences of abortion should not be trivialised and treated as though they are a simple medical procedure. A woman knows that abortion is much more than that because it involves a decision about her unborn child.

Women’s Forum believes women should have complete and accurate information and counselling about the abortion decision which includes the physical and psychological risks of abortion.

“A growing body of Australian and international research strongly suggests that abortion can have serious and broad ranging impacts on women’s health and wellbeing.”

There is relative consensus among post-abortion psychology researchers that at least 10-20% of women who have had an abortion suffer from severe negative psychological complications.⁶ Moreover, risks of physical harm associated with abortion include infection, placenta previa, and possibly miscarriage, premature delivery and low birth weight in future pregnancies.⁷ In addition, there appear to be more deaths from all causes, after abortion, compared with childbirth.⁸

The vast majority of abortions are performed on healthy mothers and babies over the age of 18.⁹

Specified medical conditions, foetal abnormality and rape are ‘hard cases’ that motivate relatively few abortions.¹⁰ An Australian research project found that 5% of women presenting at abortion clinics gave the reason ‘result of forced sex’ for desiring an abortion. Again, 5% stated the reason ‘worried about health of pregnancy’ for desiring an abortion.¹¹

Notwithstanding the difficulties and challenges involved in all of these situations, the vast majority of abortions are performed on healthy women over the age of 18 who have healthy babies.¹² The South Australian Department of Health reported in 2007 that 26.1% of terminations were performed on women aged 30-39. This underscores the need for social policy initiatives which address the underlying reasons women seek abortion.

Women’s Forum points out the decision to abort is marked by a high degree of ambivalence and the reasons women give for seeking an abortion are more
complex than simply not intending to become pregnant. Research has exposed the social and economic pressures that prompt women to seek an abortion: financial concerns, uncaring or violent relationships, unsupported work places, schools and universities.xiii

An important question that should unite all Australians is:

What can our families, our communities; our governments and our culture do so that women can freely complete their pregnancies?

The negative impacts of abortion on significant numbers of women underscores the need for public policy, and structural and cultural changes to enable women to have real choice without undue pressures.

Women’s Forum believes initiatives that offer pregnant women life affirming alternatives to abortion and support their freedom to be mothers include:

- Improving the provision of accurate and complete information regarding abortion, providing independent counselling for women seeking an abortion, and promoting alternatives to abortion including adoption and pregnancy support services.
- Reducing financial pressure on women and families through measures such as the Baby Bonus, Family Tax Benefit, Paid Parental Leave, income splitting for tax purposes and tax deductibility of childcare.
- Offering support and flexibility for mothers so they are able to continue with paid work and study, for example through Paid Parental Leave, part-time, work-from-home, and online learning options.
- Improving the provision of information and support for women with pregnancies where foetal abnormality is suspected.
- Educating men and boys about fatherhood and their role in providing support to their partners.
- Increasing the provision of healthy relationships programs in high schools.

- Developing and implementing effective community strategies to address domestic violence and sexual assault; and
- Undertaking national research to understand better the pressures influencing women to have an abortion, and how those pressures can be addressed and ameliorated.

Women’s Forum seeks an evidence-based approach to the abortion debate that results in positive cultural change, for women’s wellbeing and freedom.

NOTES

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Doctors’ moral objections don’t justify denying abortion access

Conscientious objection must not be used to justify the withholding of referral, writes Eleanor Milligan in this article first published in The Conversation

Abortion in Australia is governed by varied state-based laws. Despite the clear requirement for doctors with conscientious objection not to block access to abortion, this aspect of some state laws has recently been challenged.

The Bill at the heart of the tussle is the 2008 Victorian Abortion Law Reform Act, which was recently mirrored in Tasmania’s abortion law reform. Victoria’s abortion law is widely seen as legally and socially successful.

In the firing line

In both the Tasmanian and Victorian legislation, doctors with a conscientious objection to abortion are legally required to provide women with a list of practitioners offering a “full range of pregnancy options”, including termination.

But this clause in particular is under fire in Victoria, where a doctor with a conscientious objection to abortion is being investigated by the medical standards body for not following the requirements of the state’s abortion legislation.

And Victorian Premier Denis Napthine indicated on Monday that he would consider “on merit” any move to wind back the state’s abortion law.

Both laws have sought to position abortion as a clinical, rather than criminal issue (as it previously was), and ensure women have access to legally permissible termination.

But the clauses requiring doctors to refer women to others when they have a conscientious objection have been criticised by some as impinging on the autonomy and human rights of practitioners who hold a moral objection.

The Australian Medical Association, for instance, argues the clauses undermine doctors’ moral judgement or religious beliefs.

Understanding the debate

Abortion is a complex issue, and individual health practitioners, like other people in the communities they serve, hold a broad range of personal beliefs about its ethical acceptability.

Abortion is a complex issue, and individual health practitioners, like other people in the communities they serve, hold a broad range of personal beliefs about its ethical acceptability.

Most individuals hold these beliefs privately. But a problem arises when doctors use personal beliefs to justify withholding access to clinical care that falls within accepted professional standards and legal obligations.

Doctors who invoke their conscientious objection to obstruct access to a legally permissible, clinically acceptable intervention are accused of abusing their position to undermine legitimate patient care.

This situation is typically cast as an intractable ethical problem – the “pro-life vs pro-choice” dilemma. Or as an equally intractable moral impasse in which the autonomy and rights of patients stand against the autonomy and rights of doctors.

But it’s unhelpful to consider this situation in these terms. In actual fact, the inability to provide a treatment is not a novel or particularly complex situation in medicine.

Legal and professional expectations

There are a multitude of reasons and limitations resulting in an
individual doctor being unable to provide a particular treatment. It may be because a treatment is outside her scope of practice, or that the facility does not have appropriate equipment, or, the primary caregiver may lack the specialist knowledge required to treat.

There are a number of legal foundations that determine how doctors must fulfil their duty of care. According to these legal precedents, which are embedded in the professional guidelines, doctors must recognise the limitations on their scope of practice, appropriately refer when they lack the required skill or ability, “make the care of patients their first concern”, and ensure their personal views do not adversely affect patient care.

And there are well-established professional expectations outlined in the Medical Board of Australia’s Good Medical Practice Guide.

With respect to conscientious objection, the code warns doctors against “using your objection to impede access to treatments that are legal”, and

Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

Bearing this in mind, it’s clear that the existing professional standard of care that doctors are required to meet in order to maintain professional registration is no different, and no more onerous, than what the Victorian and Tasmanian laws require.

Most individuals hold these beliefs privately. But a problem arises when doctors use personal beliefs to justify withholding access to clinical care that falls within accepted professional standards and legal obligations.

**Everyday practice**

These laws don’t coerce doctors to perform procedures they have a conscientious objection to, but they do require appropriate referral for legitimate treatment of patients they cannot or do not want to treat.

In a 2009 article about the state of conscientious objection in the United States, law researcher Julie Cantor writes:

Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it ... They need all legal choices presented to them in a way that is true to the evidence, not the randomness of individual morality.

Conscientious objection must not be used to justify the withholding of referral. It should not be considered differently, or given greater weight than any other “limitation” an individual doctor may have in being unable to personally provide care.

It’s certainly not such a special case that collective professional standards should be lowered, legal precedents dismissed, and special exemptions given to accommodate individual practitioners’ moral values at the expense of upholding common standards of patient care. Inevitably some will find such laws uncomfortable, however, they strike an appropriate balance.

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Eleanor Milligan is affiliated with Griffith University School of Medicine, AMAQ – Ethics and Medico-Legal Committee, Queensland Medical Interim Notifications Group, NHMRC-Australian Health Ethics Committee.

**THE CONVERSATION**

Freedom of conscience: why the right to conscientious objection must be restored

An abridged version of an address given to the Life Dinner by Dr David van Gend, a Toowoomba GP and Queensland secretary of the World Federation of Doctors who Respect Human Life.

I feel a little out of place coming from Queensland to speak about the wretched situation in Victoria – coming from a state where it is always sunny, where the people are always nice, and where we don’t have oppressive laws that try to compel the conscience of free citizens.

But we are all in this together: an assault on fundamental freedoms in one state will become a precedent for similar abuses in other states.

It was a Melbourne man, Julian Savulescu, now an ethics professor at Oxford, who declared that doctors who will not provide abortion should be “punished through removal of licence to practise”.

In 2006, he wrote: “A doctor’s conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law ... If people are not prepared to offer legally permitted, efficient and beneficial care to a patient because it conflicts with their values, they should not be doctors.” Crucial to his argument is his assertion that, “when society has already decided that a service is legal”, it is not for doctors to “compromise the delivery of services”.

When Dr Savulescu’s article was discussed in 2006 in the medical newspaper Australian Doctor, I was given as an example of the sort of doctor who, in his view, “should either get out of the speciality or the profession altogether”.

I gave a different angle to Australian Doctor: that abortion as commonly practised is not a medical service; it is a “medical abuse”, which doctors are bound by their Hippocratic principles and humane conscience not to commit.

And no law, no professional board, has the authority to compel any doctor to violate the principles of their vocation or mutilate their own conscience by collaborating in intentional killing. Yet in Victoria, under section 8 of the Abortion Law Reform Act 2008, that compulsion by the authorities is exactly what doctors and nurses face.

Not long ago, society was a little more civil and did not contemplate using the force of law to compel the conscience of fellow citizens.

Jennifer Jackson, in a textbook she wrote, Ethics in Medicine: Virtue, Vice and Medicine (Cambridge, UK: Polity Press, 2006), says that it is “a hallmark of civilised society that we exercise tolerance towards people with whom we disagree deeply on moral or religious matters ... that we find ways to avoid forcing people to disobey the dictates of their conscience”.

Laws to disallow a doctor’s conscientious objection are likely to deter the most conscientious young people from becoming doctors. Is that in the public interest?

And what if the principle of section 8 is extended to other matters such as euthanasia – as happened only last week in the Canadian province of Quebec, which, as I understand, now requires doctors with a conscientious objection to euthanasia to refer their patient to another doctor who will do the job?

And what if the principle of non-objection to abortion is extended to compulsory participation in abortion for all doctors in training?

Of course, that is exactly what many hard-headed strategists would like to see: an ethical purge of sensitive, often religious, consciences from the medical profession, either through Savulescu’s proposed “removal of licence to practise” or by deterring them at the outset.

The passage of Victoria’s Abortion Law Reform Act 2008 marked a victory, of sorts, in a 40-year cultural battle, and to seal this victory the victors enacted section 8 to intimidate dissenters. Section 8 is a sinister and bullying measure designed to silence free speech as well as free conscience.
Free speech and free conscience

And, of course, these two fundamental freedoms are linked, because free speech – or free argument – is just the expression of free thought, and the thoughts that matter most to individuals are those formed out of deep conscientious conviction. So free speech is the expression of free conscience; they stand or fall together.

As the great poet John Milton declared 370 years ago at the end of an impassioned speech to the British Parliament, “Give me the liberty to know, to utter, and to argue freely according to conscience, above all liberties.”

But doctors in the state of Victoria have lost the liberty to argue freely according to conscience, let alone to practise freely according to conscience.

Medical ethicist Professor Nicholas Tonti-Filippini observed last November that section 8 has the power even to silence discussion about conscientious objection. He wrote: “A doctor who merely discussed with other doctors on Facebook his intention not to refer has been brought before a panel of the Australian Health Practitioners Regulation Authority (AHPRA) and he was cautioned about unprofessional conduct …

“It is extraordinary that the law should compel a doctor to act against most codes of medical ethics … But it is even more extraordinary to be pursued by the regulator for what one says about this situation.”

The leading medical campaigner on this issue in Victoria, Dr Eamonn Mathieson, puts it best, saying section 8 exists “to put fear into the hearts of doctors who practise medicine with a conscience and a morality different [from that of] the authors of this law”.

And so, on April 28, 2013, we read in a Melbourne daily newspaper: “A Melbourne doctor who refused to refer a couple for an abortion because they wanted only a boy has admitted he could face tough sanctions …”

“[T]he couple had asked Dr [Mark] Hobart to refer them to an abortion clinic after discovering at 19 weeks they were having a girl when they wanted a boy. By refusing to provide a referral for a patient on moral grounds or refer the matter to another doctor, Dr Hobart admits he has broken the law and could face suspension, conditions on his ability to practise or even be deregistered.”

He said: “I’ve got a conscientious objection to abortion, I’ve refused to refer in this case a woman for abortion and it appears that I have broken the rules.”

This talk tonight is dedicated to that 19-week-old baby girl who was put to death for the crime of being a girl, with the full blessing of Victoria’s evil laws.

It is dedicated to Victorian doctors like Mark Hobart who are being harassed by the authorities because they refuse to collaborate with an oppressive law – a law which, in the judgement of Frank Brennan SJ AO, former head of Australia’s Human Rights Consultation Committee, “carries the hallmarks of totalitarianism”.9

How has it come to this, that a quarter century after the fall of Soviet communism and nearly 70 years after the Nuremberg trials, a Victorian statute is described in terms usually reserved for dictatorships?

Lawyer and university vice-chancellor Professor Greg Craven felt justified in labelling section 8 “genuinely fascist”.10 Professor Tonti-Filippini agreed that “expecting a doctor to act against his conscience is totalitarian”,11 and the mild-mannered father of general practice in this country, Emeritus Professor John Murtagh, was moved to call section 8 “Stalinesque”.12

Do Victorian politicians know no shame, to have provoked such condemnation by such thoughtful men, and to be tolerating the sort of tyrannical law that was more characteristic of our culture’s mortal enemies through a world war and a cold war?

Fundamental injustice

But now the soulless collectivism that so brutalised medical conscience three generations ago is brutalising it again. That collectivism is embodied in section 8, as an exercise in state power crushing individual conscience. In your campaign against section 8 may I suggest that you be unrelenting in highlighting its totalitarian quality.

And you might highlight a central quote from the UK House of Lords’ select committee on medical ethics in 1994, which declared: “the prohibition of intentional killing is the cornerstone of law and social relationships”.

By framing section 8 in terms of violating the very cornerstone of law and social relationships, we will counter our opponents who try to dismiss our conscientious concerns as being merely ‘religious’ and therefore faintly irrational.

Opposition to intentional killing is not some pedantic scruple of religious minds, which a secular society may indulge or dismiss depending on how tolerant
it feels. No: it is the foundation of human justice in all civilisations. There can be no more foundational ground for conscientious objection than an objection to intentional killing – yet section 8 has the extreme arrogance to deny even that ground for objection.

Being arrogant wouldn’t matter if section 8 was toothless and unenforceable; but this is a clause with teeth.

Faced with Dr Mark Hobart’s refusal to refer for a sex-selection abortion, 1 would have expected the Australian Health Practitioners’ Registration Authority (AHPRA) to say, “We have a conflict here between an outrageous law and the time-honoured professional principle of conscientious liberty, and we will not raise a finger to trouble such a doctor unless compelled to do so by government. And if we are compelled to do so by government, we will resign.”

Now that would have been a board worthy of the medical profession and of a free society. But instead, AHPRA chose to interrogate Dr Hobart for refusing to send a 19-week baby girl to her death!

The Australian Medical Association in Victoria has made its opposition to section 8 admirably clear, especially since the case of Dr Hobart, and the president of the AMA federally, Steve Hambleton, said last year: “The Victorian legislation is incongruous with the medical profession’s code of practice and appears to fail to recognise that doctors have rights too.”

Victorian Premier Denis Napthine was initially impressed with this medical opposition to section 8, saying some years ago, “Health professionals of the highest calibre, with the highest levels of experience, are saying to us that clause 8 is fundamentally wrong ... And clause 8 is fundamentally wrong.”

Dr Napthine voted against the Abortion Law Reform Act in 2008. So how can he preside over such a law as Premier, and do nothing?

Perhaps the Premier can take courage from another conservative politician who died 10 years ago last week.

Ronald Reagan rejected the cowardly stance of détente with the Soviet Union and condemned the evil empire for what it was.

Along with two other courageous figures, British Prime Minister Mrs Margaret Thatcher and Pope John Paul II, he dared to confront this monstrous system and bring it down.

He famously and unflinchingly demanded, in front of that section of the Iron Curtain that divided Berlin, “Mr Gorbachev, tear down this wall!”

If the Premier of Victoria were to abandon the cowardly stance of détente towards the monstrous evil of the Abortion Law Reform Act, he could start with section 8.

Respectfully I say: “Dr Napthine, tear up this law, and start to heal the conscience of your parliament and your state.”

ENDNOTES


2. John Kron, ‘Do doctors have a right to refuse to provide treatments on moral grounds?’, Australian Doctor, May 9, 2006. URL: www.australiandoctor.com.au/articles/a10033f1a1.asp


13. AMA quotes, ibid.

This is an abridged version of an address given to the Life Dinner in Melbourne on 14 June 2014 by Dr David van Gend.
WHAT ‘MIRACLE BABIES’ MEAN FOR ABORTION RIGHTS

Premature babies may now have a greater chance at life, but we shouldn’t let this welcome development be co-opted by anti-abortion legislators, writes Leslie Cannold

What do medical breakthroughs slated to improve the health of premature infants have to do with abortion rights?

More than 20 years ago, I pursued this question in a master’s thesis for my bioethics degree. I was reacting to the claim by renowned philosopher Professor Peter Singer – made in his book The Reproduction Revolution – that technological breakthroughs that lowered the age of foetal viability would end the conflict over abortion.

Part of my research involved getting across state-of-the-art medical technology for nurturing human life outside a woman’s womb, including the problems that had to be solved to improve the prognosis for extremely premature infants.

‘Miracle baby’ stories abound in the news, but survival rates and long-term medical outcomes for extremely premature infants – those born between 22 and 26 weeks gestation – are grim. Just 1 per cent of those who are alive when labour begins at 22 weeks survive. Of those who survive birth and make it to the neo-natal intensive care unit, just 16 per cent will ever go home and only 5 per cent will be unencumbered by life-long health concerns.

Impairment associated with ‘micro-preemies’ include cerebral palsy (1 in 5); learning difficulties (2 in 3); behavioural problems including autism-like symptoms (1 in 4); and a high incidence of respiratory problems, reflective of the incapacity of the extremely immature lungs of a premature infant to go on to develop properly.

Two decades ago, it was this latter problem that was seen as a natural brake on a continuation of what had been a steady decline in the age of foetal viability. I still remember the doctor who told me that 22 weeks was the lower limit for foetal survival outside the womb because of insurmountable problems with immature lungs: “There’s just no way we can get them to breathe any earlier.”

He may have been mistaken. In a world first, Melbourne’s Monash Medical Institute announced last week that animal experiments suggest the administration of placental stem cells to micro-preemies may radically improve lung function and even reduce brain damage. The treatments will be trialled on 10 premature babies in Malaysian hospitals. If things go well, more trials are planned in Australia at Monash Children’s Hospital and overseas.

This is fantastic news for premature infants and the parents who desperately want them not just to survive, but to thrive. But the sting in the tail is one I and other feminist researchers identified decades ago – the risk that ever-lowering ages of foetal viability can serve as an excuse for anti-choice legislators to narrow the window in which women can legally choose abortion.

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The Abortion Rights Debate

Issues in Society | Volume 402
women could evacuate unwanted foetuses as young as technology would allow – 6 weeks gestation, 12 weeks perhaps – into high-tech humidicribs where they could be matured, then adopted out.

The women whose voices can be heard in my book *The Abortion Myth* were appalled by this prospect, no matter which side of the abortion conflict they were on. For them, abortion was a solution to unwanted motherhood. Most saw themselves as obligated to gestate their own foetuses and, should they continue the pregnancy, to raise the resulting child. For them, the debate was about whether a pregnant woman still had time to reject these responsibilities by choosing termination, or whether once conception had taken place, it was already too late.

The prospect of mass incubation of extremely immature unwanted foetuses in humidicribs was reviled as unacceptably *Brave New World* and entirely irrelevant to how women on both sides of the debate defined the central moral conundrum posed by problem pregnancy.

But sadly, feminist pleading – including my own – for women’s moral perspective on abortion to ground public debate about reproductive law and policy has been ignored. In both the scholarly literature and public contest about reproduction, the obsessive focus on “when life begins” and its correlative focus on the biological attributes of fetuses that do – or don’t – grant them a “right to life” roll on.

Women’s experience of pregnancy, and the moral considerations in play for them when they make choices to have children or avoid them by means of contraception and abortion, as well as their evolving conception of what makes a good mother, fails to get a look-in.

This disregard of women’s moral perspective makes it virtually certain that every technological advance that results in the survival of ever-younger premature infants will give oxygen to those pushing fetal-centred reasons for further limiting the time period in which women can exercise what the international community has long agreed is the basic human right to control one’s family size.

So what should be done? One approach for activists keen to remove abortion from the criminal code in Queensland, NSW, SA and Tasmania is to take a leaf from the ACT and Victorian statute books. In both these states, lawmakers listened to activists who flagged the problem and responded by either dispensing with gestational limits on women’s reproductive freedom all together (ACT) or – where gestational limits were insisted on – ensured they weren’t pegged to foetal viability (VIC).

The public can also insist that public debates about abortion are grounded in women-centered ethics, not those focused solely on the foetus. Of course, contests over who is a good mother and when maternal obligations can responsibly be rejected are likely to be as contentious as current questions about “where life begins”. Indeed, socio-logical research consistently shows that contests over motherhood, and the related question of their proper role in society, are what are truly at issue for those who feel most passionately about the abortion issue on both sides of the debate.

However, making the friction over maternal obligations and the proper role of a ‘good woman’ in modern society more explicit will increase the relevance of the contest to those who must negotiate the moral minefield of abortion ethics, politics and law because they are the ones who experience problem pregnancies – women.

Dr Leslie Cannold is an author, researcher and medical ethicist with an adjunct position at Monash University.
Real choices: abortion advocates’ message

Young women are not given a choice to continue their education, or get their promotion if they also choose to parent. That is not equality, and it is far from choice, asserts Debbie Garratt on behalf of Real Choices Australia.

According to Reproductive Choice Australia, the ‘take home’ message from their President Leslie Cannold at the recent Network of Women Students Conference was simple:

“Abortion is a nexus point of gender inequality – workplace participation, domestic labour, gender roles, sexuality and consent etc. So long as gender inequality persists, abortion is an issue and it needs our action.”

This is the ideological lie that so many young women and men have bought: in order to participate equally in social, educational, professional and relational worlds, women must have access to abortion ... the implicit message of course being that pregnancy and motherhood are incompatible with, or unworthy of equal rights.

In her book New Woman, feminist author Gloria Conde writes:

“Feminism fooled women into thinking that motherhood was an obstacle for their fulfillment. The consequence was to make her feel inferior if she was a mother or wanted to have children. A woman has to excuse herself before men, before society, and before other women, for becoming pregnant, or for needing (or wanting) time to educate and bring up her children.”

The ideological message of abortion rights has so strongly permeated our society, that few dare to question it, and young women take up chanting ranks of protest to defend it without any understanding of what they are actually advocating.

As I spoke at a recent conference in Sydney against a backdrop of a small but noisy group of young women protesting against the right of a group of people to be educated about abortion and euthanasia, I wondered why they were so disinterested in engaging in discussion. They refused invitations to hear the speakers. They were determined to try to disrupt the paying attendees from hearing the speakers. Before they left, they wrote foul language on the pavement for passing children to read. They were so very angry, yet I’m not sure they even fully understand what they are defending.

As I was telling my audience about a 22-year-old woman who was coerced into having an abortion because her boyfriend ‘wasn’t ready to be a father’ and her university did not provide enough supportive services for her to continue her studies effectively with a small baby, they were yelling about ‘equal rights’. The young woman whose story I shared had also bought the lie. She believed that abortion was the ‘right’ thing to do in order not to ‘trap’ her boyfriend into unwanted fatherhood. Besides, they were going to get married in a couple of years and they would have children then, when they both chose to.

So of course, she exercised her ‘right’ to have an abortion. After all, without it she would not have been equal enough to continue her degree. Without it she would not have been equal enough to get the better jobs her peers might achieve. Without abortion she would not have been equal enough to say to her boyfriend that she wanted to ‘choose’ parenthood even if he didn’t.

Six weeks later her boyfriend had dumped her; he says because she wouldn’t just ‘get over’ the abortion and stop crying about it. Three weeks after that she left university and went home to her parents saying, “I did everything I should have done, I did the right thing, why is everyone else just getting on with it ... why can’t I ... what
happened to me?"

Abortion advocates argue that women only suffer after abortion because of the stigma attached to the procedure by ‘anti-choicers’. They argue that women should be allowed to make their own decisions, free from the pressures of those who withhold ‘choice’ from them. They deny and even ridicule the experiences of the thousands of women who every year are pressured by their circumstances and the people who are supposed to care about them, to have abortions they don’t really want.

They deny that a woman would actually grieve the loss of a child to abortion, that she may have even a tenuous maternal link to her unborn child and that the breaking of that link can be devastating.

Whilst so many loud and ignorant protesters jump up and down about women’s equality, they haven’t even taken a moment to consider what they are advocating. They throw around words about choice, and lies about backyard abortion deaths; they deny the evidence of harm from abortion; they ridicule other women who are silently devastated or not so silently standing up to say “this is not okay”. They are contributing to women’s lack of equality.

To abortion advocates women can only be equal if they choose one or the other ... to have children OR participate in social and educational worlds. Whilst they rant about lack of access to the surgical and medical means of ridding women of unwanted pregnancies, they do not want to see what is truly going on; that young women are not given a choice to continue their education, or get their promotion if they also choose to parent. That is not equality. It is far from choice.

Until we address the actual inequalities, inflexible workplaces, lack of quality childcare, not enough support and encouragement for full-time parents, young women will continue to believe their only hope of a future lies in denying their reproductive right to bear children.

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THE ANTI-ABORTION FALLACY

If it comes to a clash between the supposed interests of potentially rational but not yet even conscious beings and the vital interests of actually rational women, we should give preference to the women every time. Bioethicist Peter Singer explains

In the Dominican Republic last month, a pregnant teenager suffering from leukemia had her chemotherapy delayed, because doctors feared that the treatment could terminate her pregnancy and therefore violate the nation's strict anti-abortion law. After consultations between doctors, lawyers and the girl's family, chemotherapy eventually was begun, but not before attention had again been focused on the rigidity of many developing countries' abortion laws.

Abortion receives extensive media coverage in developed countries, especially in the United States, where Republicans have used opposition to it to rally voters. Recently, President Barack Obama's re-election campaign counter-attacked, releasing a television advertisement in which a woman says that it is "a scary time to be a woman," because Mitt Romney has said that he supports outlawing abortion.

But much less attention is given to the 86% of all abortions that occur in the developing world. Although a majority of countries in Africa and Latin America have laws prohibiting abortion in most circumstances, official bans do not prevent high abortion rates.

In Africa, there are 29 abortions per 1,000 women, and 32 per 1,000 in Latin America. The comparable figure for Western Europe, where abortion is generally permitted in most circumstances, is 12. According to a recent report by the World Health Organization (WHO), unsafe abortions lead to the death of 47,000 women every year, with almost all of these deaths occurring in developing countries. A further five million women are injured each year, sometimes permanently.

Almost all of these deaths and injuries could be prevented, the WHO says, by meeting the need for sex education and information about family planning and contraception, and by providing safe, legal induced abortion, as well as follow-up care to prevent or treat medical complications. An estimated 220 million women in the developing world say that they want to prevent pregnancy, but lack either knowledge of, or access to, effective contraception.

That is a huge tragedy for individuals and for the future of our already very heavily populated planet. Last month, the London Summit on Family Planning, hosted by the British government's Department for International Development and the Gates Foundation, announced commitments to reach 120 million of these women by 2020.

The Vatican newspaper responded by criticising Melinda Gates, whose efforts in organising and partly funding this initiative will, it is estimated, lead to nearly three million fewer babies dying in their first year of life, and to 50 million fewer abortions. One would have thought that Roman Catholics would see these outcomes as desirable. (Gates is herself a practising Catholic who has seen what happens when women cannot feed their children, or are maimed by unsafe abortions.)

Restricting access to legal abortion leads many poor women to seek abortion from unsafe providers. The legalisation of abortion on request in South Africa in 1998 saw abortion-related deaths drop by 91%. And the development of the drugs misoprostol and mifepristone, which can be provided by pharmacists, makes relatively safe and inexpensive abortion possible in developing countries.

Opponents will respond that abortion is, by its very nature, unsafe – for the fetus. They point out that abortion kills a unique, living human individual. That claim is difficult to deny, at least if by 'human' we mean "member of the species Homo sapiens."

It is also true that we cannot simply invoke a woman's "right to choose" in order to avoid the ethical issue of the moral status of the fetus. If the fetus really did have the moral status of any other human being, it would be difficult to argue that a pregnant woman's right to choose includes the right to bring about the death of the fetus, except perhaps when the woman's life is at stake.

The fallacy in the anti-abortion argument lies in the shift from the scientifically accurate claim that the fetus is a living individual of the species Homo sapiens to the ethical claim that the fetus therefore has the same right to life as any other human being. Membership of the species Homo sapiens is not enough to confer a right to life on a being. Nor can something like self-awareness or rationality warrant greater protection for the fetus than for, say, a cow, because the fetus has mental capacities that are inferior to those of cows. Yet 'pro-life' groups that picket abortion clinics are rarely seen picketing slaughterhouses.

We can plausibly argue that we ought not to kill, against their will, self-aware beings who want to continue to live. We can see this as a violation of their autonomy, or a thwarting of their preferences. But why should a being's potential to become rationally self-aware make it wrong to end its life before it actually has the capacity for rationality or self-awareness?

We have no obligation to allow every being with the potential to become a rational being to realise that potential. If it comes to a clash between the supposed interests of potentially rational but not yet even conscious beings and the vital interests of actually rational women, we should give preference to the women every time.

Peter Singer is Professor of bioethics at Princeton University and Laureate Professor at the University of Melbourne. His books include Practical Ethics, Rethinking Life and Death and The Life You Can Save.

EUGENICS AND ABORTION

... the belief and practice of improving the genetic quality of the human population, by encouraging the reproduction of people with ‘good’ genes and discouraging those with ‘bad’ genes.

Right to Life NSW believes it is wrong in any way to put to put less value on someone because of race, or on the grounds of a physical, mental or social condition. That includes the life of an unborn baby.

**IVF and abortion – specific areas of RTL NSW interest**

In the case of abortion, prenatal testing of an unborn baby will sometimes lead to the destruction of a foetus. In other words, abortion is used ‘eugenically’ to take the life of an unborn baby who testing shows may be disabled or mentally challenged. The same can be said for destroying an unused embryo in the IVF process, where test results may show a risk of a child having a genetic condition.

**RTL NSW stance**

Right to Life NSW believes it is wrong in any way to put less value on someone because of race, or on the grounds of a physical, mental or social condition. That includes the life of an unborn baby.

**DOWN SYNDROME**

*Down syndrome – a real-life case of the eugenics debate*

What if we could eliminate Down syndrome (DS)? There are many people who believe this is within our grasp as a society. On the surface, it may sound good. But is it? ABSOLUTELY NOT.

What that would require is eliminating an entire group of people just because of their physical and mental disabilities. In other words, the perception that they are of less value than someone living a normal life.

Secondly, there is no cure for DS. To eliminate DS, you would have to abort every baby with DS before he or she is born.

That may sound drastic and unthinkable. But thanks to new, less-invasive prenatal testing, parents have a lot more information on their unborn baby. That includes, whether he or she has DS. While governments don’t keep numbers on how many DS babies are aborted, it’s clear from all the information out there that, when given the knowledge of their baby having DS, more parents than not will abort that baby.

So is this eugenics? Many will argue it isn’t, because governments aren’t forcing parents to make the decision on whether to keep or abort their DS baby. They also argue using the term consent. They say the parents of the unborn baby consented to the abortion because they believed it was best for them and/or the baby. However, the unborn baby has no choice. He or she hasn’t given their consent.

Also, ask yourself this: if more parents than not choose to abort a baby because he or she has DS, doesn’t it sound like society has decided that someone with Down syndrome isn’t worth as much?

**Quick facts supporting our position**

Termination rate in the United States for pregnancies where there was a definitive prenatal diagnosis of Down syndrome. 24 studies were accepted:

- 67% for 7 population-based studies
- 85% for 9 hospital-based studies
- 50% for 8 anomaly-based studies

**QUALITY OF LIFE**

*‘Quality of life’ vs ‘Sanctity of life’*

Parents who are expecting a baby now have access to more information than ever before. In addition to being able to just find out the sex of their unborn baby, they can also find out if he or she has a genetic disorder. For many parents, hearing the news that their baby has a disorder like Down syndrome is too much. They worry about the life that child will live. They worry about the life they’ll live raising that child. In other words, they worry about the “quality of life”.

**HISTORY**

*What is eugenics?*

The term ‘eugenics’ came into being in the 19th century, and exploded in the first half of the 20th century. The goal, to make societies better by weeding out the ‘bad’ genes. Countries all over the world had eugenics policies, including Australia. At its worst, we saw the genocide carried out by Nazi Germany. Since then, many countries abandoned those social policies.

**PREVALENCE**

*This isn’t still going on, is it?*

Despite the absence of state-sponsored eugenics programs, you might say the movement is still very much alive and well. At issue are two questions:

- Who gets to live?
- Who gets to give life?
By ‘who gets to live’, are the beliefs by many people around the world that if their unborn baby has a genetic disorder, they should be aborted. While this is a very personal decision for the parents, the reality is that a majority of parents, when faced with that decision, will do just that. They are being influenced by others who believe that that baby has less value than a healthy baby. They are being influenced by societal beliefs that it’s wrong to bring such a baby into the world.

By ‘who gets to give life’, are the beliefs that disabled people, or people with a certain genetic or mental disposition, should not be allowed to have children. There are places where there are even the forced sterilisations of disabled or mentally challenged mothers, so they won’t have any babies.

And it all comes back to this: the ‘quality of life’. Namely, the quality of life for a baby, his or her parents, the families, and society. While that may sound like a noble cause or phrase, it fails to take into account one major thing: the ‘sanctity of life’.

Through the manipulation of human reproduction, eugenic beliefs deprive millions of babies who might be born with a disability a chance at life. These are babies who grow up to live happy and productive lives. These babies have parents who grow stronger through their adversity and the love they have for those children.

**FUTURE**

**What’s next?**

Already, we’re seeing cases where a couple will abort a foetus because the baby isn’t the desired sex they were hoping for. Or there are concerns over some physical deformity. As parents are given more and more information about a baby that hasn’t even been born yet, they will have more and more reasons not to keep that baby. In other words, the Sanctity of Life is given less value when it comes to the life of that unborn baby.

**IMPACT**

**What eugenics means ...**

- **For the unborn** – Eugenic beliefs place a value on life, that some are worth more than others. If prenatal screening shows an unborn baby has a genetic disorder, he or she faces a real possibility of not having a chance to live – that he or she is of less value than a healthy baby, and therefore should be aborted.

- **For the physically or mentally challenged** – Eugenic beliefs paint a picture that certain people shouldn’t be allowed to have children. At its worst, eugenics leads to the forced sterilisations of women in some countries, although most countries have turned away from the practice.

- **For society** – The belief that some unborn babies should be allowed to live while others aren’t, leads to a dangerous, slippery slope. Practices like in vitro fertilisation where unused embryos are discarded because of genetic testing, or the abortions of foetuses who test positive for a genetic disorder, are already ‘weeding out’ millions of lives because of the belief they are of less value.

**NOTES**


2. UN Human Rights Council, *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development: Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Manfred Nowak, 15 January 2008, A/HRC/7/3, [paras 38, 39].

Sexual and reproductive health rights encompass many areas of basic human rights. The right to health and healthcare, the right to information, the right to life, the right to live free from discrimination and the right to privacy are all inherent in comprehensive access to sexual and reproductive health rights. Of course there are many aspects to this broad area of health rights, including access to good maternity care, sexual health services, contraception and sexuality education. It also includes access to safe and legal abortion – arguably the most contested of sexual and reproductive health rights.

In Australia women’s right to lawful abortion is determined by which state or territory she lives in. Abortion is covered by state-based criminal law or health regulations, and ranges between full lawful access and archaic-sounding legal restrictions accompanied by labyrinthine pathways to negotiate in order to have an abortion performed. It’s a situation too complex to summarise for this blog, but more information is available at www.childrenbychoice.org.au. Suffice to say, wildly differing laws from state to state create confusion for doctors and problems for women.

In some states, women may request and be granted an abortion in a public hospital without having to satisfy any grounds other than to give their informed consent for the procedure. In other states a woman who is pregnant following a sexual assault, or who has been diagnosed with a fatal or severe fetal anomaly and wishes to terminate that pregnancy, has only two options: pay hundreds (sometimes thousands) of dollars for a procedure in a private facility or tell her story to upwards of four medical professionals that advise the state hospital’s ethics board. The board will then decide whether or not she qualifies for a public procedure.

In recent months, I have heard from doctors, social workers and women themselves about cases where women have been denied abortion in horrific circumstances. One woman diagnosed at 20 weeks gestation with a fatal fetal anomaly – that is, her pregnancy had no chance in resulting in a live birth – was not only refused abortion at her public hospital, but also refused referral to a private specialist and then sent to ante-natal care. She carried the pregnancy for a further 17 weeks before labour followed by stillbirth. In another case, a woman with a severe medical condition, pregnant after being raped by a carer, was refused an abortion in a public hospital, despite her sight being at risk if the pregnancy continued. She had to find hundreds of dollars herself to have an abortion in a private clinic. Another woman receiving ante-natal care at a Catholic hospital presented for a scan at 16 weeks only to be told there was no amniotic fluid present, nor a heartbeat. Her fetus had died in utero. Instead of providing her with medical care, the hospital sent her home to wait for certain miscarriage, not wanting to speed the process as they believed it to be tantamount to abortion.

Such stories are scarily not as uncommon as we would like to think. For some women, the denial of their basic rights to health care results in having to continue with an unwanted or unviable pregnancy. It’s a postcode lottery. The inequity is staggering. In a first world country with what is generally considered a first class health system, this is unconscionable and a clear breach of human rights.

Wildly differing laws from state to state create confusion for doctors and problems for women.

Around the world, human rights acts, charters and instruments have done much to advance people’s enjoyment of optimal sexual health and reproductive health and rights, including the right to abortion. South Africa’s Bill of Rights has enshrined the ‘right to bodily and psychological integrity, which includes the right ... to make decisions concerning reproduction’, which has
protected abortion access from anti-choice attacks. In the United States, the decision in 1973’s Roe v Wade Supreme Court case overrode state laws to legalise abortion up until viability to protect women’s constitutionally-protected right to privacy.

Human rights groups around the world continue to advocate for the removal of laws criminalising abortion: Amnesty International has urged all countries still holding these laws to repeal them; Human Rights Watch continues to document the result of criminalised abortion and lack of abortion access. The Parliamentary Assembly of the Council of Europe has also called upon member states which have not already done so to decriminalise abortion, to ‘guarantee women’s effective exercise of their right to abortion and lift restrictions which hinder, de jure or de facto, access to safe abortion’.

The introduction of a National Human Rights Action Plan provides a unique opportunity to level the playing field in Australia. Naturally this debate cannot take place solely in a rights-based framework, but it is a great place to start. Essential components and areas to target include access to quality, safe, legal and affordable abortion services; national standards for quality sexuality education; and honest discussions about the rights of faith-based or anti-abortion health workers or facilities to withhold abortion care or information versus the rights of pregnant women. Conversations on these and other related issues are already taking place in different jurisdictions around Australia. However, to expand those discussions as part of a national approach to consistent rights for all would be infinitely preferable, if we are to avoid a repeat of the current confusion caused by different rules for different states. A national action plan should underpin the provision of these services and increase the accountability and transparency of provision, as well as providing national consistency and clarity.

For some women, the denial of their basic rights to health care results in having to continue with an unwanted or unviable pregnancy. It’s a postcode lottery. The inequity is staggering. In a first world country with what is generally considered a first class health system, this is unconscionable and a clear breach of human rights.

If, as many hope, the National Human Rights Action Plan is a stepping stone on the way to a national charter of rights, it is vital that we include sexual and reproductive health rights, particularly in relation to abortion, from the beginning.

Kate Marsh is the Public Liaison Officer for Children by Choice, a pro-choice counselling, information and advocacy service for women facing unplanned pregnancy. Kate’s work involves policy and political advocacy around unplanned pregnancy issues at both a state and a federal level, and she has been very active in the campaign to decriminalise abortion in Queensland. Kate is the founder and coordinator of Pro Choice QLD, a coalition of organisations and individuals who campaign collectively to reform abortion law. She is also a member of the Young Women’s Advisory Group to the Equality Rights Alliance, Australia’s largest organisational network of women’s advocates.

What if the child will have a disability?

Many people think abortion is best for an unborn baby diagnosed with a disability. Disability is relative as no one is perfect, argues the Right to Life Association of SA

Much can now be done for a child with a disability: surgery, artificial limbs, special education, support schemes, etc. Congenital defects caused by rubella, for example, may be correctable, and the great potential for happiness and satisfaction with life of people born with Down syndrome is well established.

People with a disability are not of necessity unhappy because of their disability: rather it is often the lack of support and the condescending attitudes of those who say “He’d be better off if he hadn’t been born.” Is physical or mental perfection a prerequisite for human rights? Who are we to say that someone would be “better off dead”?

Many children with a disability can, with proper care and education, become independent and self-fulfilling, and most others can become semi-independent. They can often be taught to read, write and behave in a socially acceptable manner. However, even those who are not able to achieve this are not necessarily less happy.

Despite their limitations, with love and support, people with disabilities have as much potential to be happy as anyone else. But even if they might not be as happy few would argue that all unhappy or potentially unhappy people should be killed.

The child with a disability often brings out the best in his or her family, leading them by determined example and often bringing great affection and warmth to the family.

Abortion of the disabled child is a violent form of discrimination. Nobody suggests that older children who are disabled after road accidents should be killed to relieve the burden on the family. The effect of selective abortion to eliminate a disabled child on the mother and, through her, the family, can be severe. The incidence of depression following abortion for genetic foetal defect may be as high as 92% among women studied.

Resources available
Disability definitely puts strains on a family and the community is only now beginning to fulfil its responsibility to help. Some parents may believe that abortion would be best if their child were potentially very severely disabled because they feel inadequate to properly care for him or her. These parents often do not know about the organisations and groups available and in despair seek abortion.

These organisations can assist in selecting and arranging the best way to help a child. They can assist in organising supplementary care for parents who are able to look after their child at home but need some extra help, or who simply need reliable and competent respite and support from time to time.

For families that really cannot cope, there are many support services available or they may decide that adoption is better for all concerned. Although it may take
Abortion of the disabled child is a violent form of discrimination. Nobody suggests that older children who are disabled after road accidents should be killed to relieve the burden on the family.

The following letter once appeared in the *Daily Telegraph*:

“Sir, We were disabled from causes other than thalidomide, the first of us having two useless arms and hands, the second two useless legs, and the third have use of neither arms nor legs. We are fortunate only, it may seem, in having been allowed to live, and we want to say with strong conviction how thankful we are that no one took it upon themselves to destroy us as useless cripples. We have found worthwhile and happy lives and we face our future with confidence. Despite our disabilities life still has much to offer, and we are more than anxious, if only metaphorically, to reach out towards the future.”

All people with a disability ask is that they are recognised for their warmth and their desire to contribute to society at their maximum ability. As people, it is their wish to enjoy the benefits and activities of our society.

WHAT SHOULD WE DO ABOUT SEX-SELECTIVE ABORTION?

Aborting a foetus just because of its sex seems repugnant to most of us, writes Wendy Rogers for The Conversation

A Melbourne doctor is being investigated by the medical professional standards body for refusing to refer a woman to another GP after she sought an abortion.

The case raises important questions about doctors’ duties of care, particularly when they have a conscientious objection to a requested procedure, as well as about abortion itself.

Abortion is legal in Victoria. The 2008 Victorian Abortion Law Reform Act repealed provisions on the procedure in the 1958 Crimes Act, and abolished common law offences related to it.

The Act is very precise on the responsibilities of practitioners who object to abortion, saying they’re obliged to inform the woman of their position and refer her to another practitioner who is known to not share their views.

Dr Mark Hobart is being investigated for the alleged offence of failing to refer after he went public with his story; the couple involved have not made a complaint against him.

THE IMPORTANCE OF CHOICE

Access to safe and legal abortion is a critical element of women’s health; involuntary continuation of unplanned pregnancies causes harm.

There are many different reasons why women may feel unable to take on the responsibilities of giving birth to and caring for children. And lack of access to safe and legal abortion hampers gender equity as women do the bulk of caring for children, which can diminish their educational, employment, and other opportunities.

Legislation such as the Victorian Abortion Law Reform Act promotes gender equity by offering women the choice of whether or not to continue a pregnancy. And this is one reason why the Hobart case is troubling – the woman allegedly requested an abortion on the grounds that the 19-week foetus was female but she and her husband wanted a son.

A law enacted to promote gender equity and protect women’s rights appears to have become the vehicle for sex-selective abortion because the female foetus was unwanted.

Aborting a foetus just because of its sex seems repugnant to most of us because it’s based on the notion that sex or gender is so important that it should determine whether a pregnancy is continued. Linking the worth of the future child to gender reflects deeply held stereotypes about what a girl or boy will be like.

Even ‘family balancing’ – selecting a child of the opposite sex from an existing child or children – is based on stereotypical beliefs about the nature and importance of differences between the sexes.

But should abortion based on foetal sex be banned? This is a complex and difficult issue with no quick or easy solution.

MAKE IT ILLEGAL?

Criminalising sex-selective abortion sends a strong message that society doesn’t condone this kind of discrimination. Laws against sex selection have been passed in various countries where it is widely practised against female foetuses. But laws alone have not proven to be effective due to limited cooperation from women, their families, and practitioners.

In Australia, where abortion is legally available, it would be extremely difficult to enforce a law against sex
It would be virtually impossible to prove that a request for abortion was based upon foetal sex rather than any other reason.

Such a law would undermine women’s access to abortion and curtail their right to make choices about childbearing. It would potentially lead to discrimination against some women based on cultural stereotyping, although as noted above, desires for sex selection are not limited to a culturally-based son preference.

Rather than seek a legal solution, we should challenge stereotyping and discrimination based on sex.

We should reject the view that chromosomal sex is the most important feature of a child, and that sex chromosomes predict how a child will turn out or what kind of a person they will be – that boys will be boisterous and difficult; girls empathic and caring.

Rather than seek a legal solution, we should challenge stereotyping and discrimination based on sex.

In the meantime, GPs and other doctors should provide care for women within the legal framework for abortion. Those like Hobart who do not, fail their patients and expose themselves to disciplinary action.

Wendy Rogers is a professor in Clinical Ethics (CoRE) at Macquarie University.

In Australia, where abortion is legally available, it would be extremely difficult to enforce a law against sex selection. It would be virtually impossible to prove that a request for abortion was based upon foetal sex rather than any other reason.

Penalising individual patients and doctors will not achieve this. We need to chip away at sex discrimination, support gender equity through frank and fearless public debate, relevant policy, and fair representation of women in government, the media, and other parts of society.

This case challenges our views about reproductive freedom. We should abhor sex-selective abortion and work to eliminate it, but legislation is not the best way to achieve this.

WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

CONTENTS

BRAINSTORM 54
DISCUSSION ACTIVITIES 55
MULTIPLE CHOICE 56
Brainstorm, individually or as a group, to find out what you know about the abortion rights debate.

1. What is abortion, and who maintains its legal status in Australia?

2. Explain the difference between the terms ‘pro-life’ and ‘pro-choice’, when used in relation to abortion rights?

3. What does the term ‘eugenics’ mean, and how is it related to the abortion debate?
Complete the following activity on a separate sheet of paper if more space is required.

“Abortion is a complex issue, and individual health practitioners, like other people in the communities they serve, hold a broad range of personal beliefs about its ethical acceptability.”

Eleanor Milligan

Consider the statement above. Are you for or against the legalisation of abortion in Australia? Form into two or more groups in your class and compile a list of points with which to discuss the pros and cons of legalising abortion in Australia. Share your thoughts, arguments and ideas with the other groups, and take a final vote to reflect the overall views of the class.

PROS

CONS
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the page.

1. In 2010, a woman was criminally charged with “procuring her own miscarriage” following an abortion. In which state of Australia did this occur?
   a. ACT
   b. NSW
   c. QLD
   d. SA
   e. TAS
   f. VIC
   g. WA

2. The term ‘eugenics’ came into being in which century?
   a. 17th century
   b. 18th century
   c. 19th century
   d. 20th century
   e. 21st century

3. Abortion laws in Australia are all state or territory laws. Match the state/territory with its corresponding legislation:
   1. ACT
   2. NSW
   3. QLD
   4. SA
   5. TAS
   6. VIC
   7. WA
   a. Any person who carries out, or assists with, an abortion may be liable to criminal prosecution, including the woman herself.
   b. Lawful up to 20 weeks if the woman gives her consent, or, where she is unable to consent herself, she will suffer “serious danger to her physical or mental health or serious personal, family or social consequences if the abortion is not performed”. After 20 weeks, it can only be performed if two medical practitioners from a statutory panel of six agree that the woman or her foetus has a “severe medical condition” that justifies the procedure.
   c. A pregnant woman who requests an abortion is entitled to the procedure when the pregnancy does not exceed 24 weeks. After 24 weeks, abortion is available where a medical practitioner reasonably believes that it is appropriate and has the agreement of a second practitioner.
   d. It has been a criminal offence since 1900. However, in certain circumstances an abortion would not be unlawful. Legislation allows for broader considerations of economic and social factors to determine whether continuing the pregnancy poses a serious danger to the woman’s mental health.
   e. An abortion can be performed by a medical practitioner with the woman’s consent, up to 16 weeks’ gestation. After 16 weeks, it can be performed if two medical practitioners (one of whom must be a specialist gynaecologist) reasonably believe the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated. The woman herself cannot be charged.
   f. Decriminalised in 2002; a woman seeking or receiving an abortion faces no legal sanction; nor does the service provider.
   g. Lawful in certain circumstances; the abortion must be carried out in a hospital or prescribed facility. The woman must have resided in the state for a minimum of 2 months for it to be lawful unless the grounds are foetal abnormality or immediate threat to the life or health of the woman. The woman herself can still be charged with procuring an ‘unlawful’ abortion.

MULTIPLE CHOICE ANSWERS
1 = c ; 2 = c ; 3 – 1 = f, 2 = d, 3 = a, 4 = g, 5 = e, 6 = c, 7 = b.

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Between 1996 and 2013, the percentage of Governments permitting abortion increased gradually for all legal grounds, except to save a woman's life which remained at 97 percent. Despite overall expansion in the legal grounds for abortion, policies remain restrictive in many countries (United Nations Department of Economic and Social Affairs, Population Division (2014). Abortion Policies and Reproductive Health around the World – Highlights). (p.1)

In about two thirds of countries in 2013, abortion was permitted when the physical or mental health of the mother was endangered, and only in half of the countries when the pregnancy resulted from rape or incest or in cases of foetal impairment. Only about one third of countries permitted abortion for economic or social reasons or on request (ibid). (p.1)

Since 1996, legal grounds for abortion have expanded in a growing number of countries in both developing and developed regions, but abortion policies remain much more restrictive in countries of the developing regions (ibid). (p.1)

22 million unsafe abortions are performed each year (Center for Reproductive Rights 2014, Briefing Paper: Abortion Worldwide: 20 years of reform). (p.2)

Approximately 47,000 deaths and 5 million injuries each year are a result of complications from unsafe abortion (ibid). (p.2)

98% of all unsafe abortions occur in developing countries, most of which have restrictive abortion laws (ibid). (p.2)

The WHO has estimated that nearly all of the deaths and disabilities resulting from unsafe abortion "could have been prevented through sexuality education, family planning, and the provision of safe, legal induced abortion and care for complications of abortion." (ibid). (p.2)

From the 19th century onward, abortion was regarded as a crime in Australia. Abortion law was included in criminal legislation and was based on the 1861 English Offences Against the Person Act. Since then, some states and territories have reformed or decriminalised abortion, while others continue to restrict women's access to abortion in a way entirely inappropriate for the 21st century (de Costa, C and Douglas, H, Explainer: is abortion legal in Australia?). (p.8)

Abortion laws in Australia are all state or territory laws. The Commonwealth is only responsible for the oversight of drugs for medical abortion through the Therapeutic Goods Administration (ibid). (p.8)

It is estimated that almost half of all pregnancies in Australia are unplanned. Unplanned pregnancies occur for a wide variety of individual, social and political reasons (Children By Choice, Unplanned pregnancy in Australia). (p.12)

Almost half of all unplanned pregnancies in Australia end in a termination of pregnancy (abortion), and, using what little data is available on abortion rates in Australia, it is estimated that almost one in three Australian women will choose abortion in their lifetime (ibid). (p.13)

Medicare claims for abortive procedures in the years 1995-2004 averaged about 75,700 annually, with numbers decreasing over this period; however it should be noted that the same Medicare item numbers are used to denote procedures which are not terminations, including miscarriage, foetal death, or other gynaecological conditions (ibid). (p.13)

Many international studies show that women who have had an abortion are no more likely to experience long-term psychological or emotional problems than women who have not had an abortion (Better Health Channel, Abortion – emotional issues and counselling). (p.16)

While many women undergoing abortion experience negative emotions, including guilt, the majority feel abortion was the right decision (ibid). (p.16)

Most women reach a decision about an abortion without professional support. However, for some women, professional counselling offers a valuable and much-needed resource (ibid). (p.16)

There is relative consensus among post-abortion psychology researchers that at least 10-20% of women who have had an abortion suffer from severe negative psychological complications (Women's Forum Australia, Abortion). (p.33)

Specified medical conditions, foetal abnormality and rape are 'hard cases' that motivate relatively few abortions. An Australian research project found that 5% of women presenting at abortion clinics gave the reason 'result of forced sex' for desiring an abortion. Again, 5% stated the reason 'worried about health of pregnancy' for desiring an abortion (ibid). (p.33)

The vast majority of abortions are performed on healthy women over the age of 18 who have healthy babies (ibid). (p.33)

In both the Tasmanian and Victorian legislation, doctors with a conscientious objection to abortion are legally required to provide women with a list of practitioners offering a “full range of pregnancy options”, including termination (Milligan, E, Doctors' moral objections don’t justify denying abortion access). (p.35)

In Australia, where abortion is legally available, it would be extremely difficult to enforce a law against sex selection. It would be virtually impossible to prove that a request for abortion was based upon foetal sex rather than any other reason (Rogers, W, What should we do about sex-selective abortion?) (pp. 51-52)
**Abortion**

Abortion is the termination (end) of a pregnancy. A low-risk surgical procedure called suction aspiration or suction curette is generally used for first trimester abortions. Non-surgical abortions using medication such as mifepristone (RU486) are available in some clinics. Most abortions are performed during the first trimester of pregnancy (up to 12 weeks), but some may be performed in the second trimester (12 to 24 weeks) or, in rare circumstances, in the third trimester (24 to 36 weeks).

**Abortion laws**

Laws relating to abortion vary between Australian states and territories. Most of the variation concerns the reason for abortion and the stage of pregnancy. Early abortion (up to 14 weeks) is available Australia-wide and later abortion is available in most states and territories.

**Abortion rates**

The exact number of abortions performed in Australia each year is not known – only South Australia, Western Australia and the Northern Territory collect abortion statistics, and only South Australia releases the data. Furthermore Medicare conceals the statistics by grouping Tasmania with Victoria. However it is estimated that the number of abortions performed in Australia annually is between 70,000 to 80,000 which amounts to about 20 per 1,000 pregnancies being aborted. International rates range from about 7 abortions per 1,000 women aged 15 to 44 per year in Germany to 90 in Eastern Europe, with a world average of 35. These rates tend to reflect the attitude of each country to comprehensive sexuality education and effective contraception rather than the sexual behaviour of the people who live there.

**Abortion rights**

Abortion rights supporters themselves are in some instances divided as to the types of abortion services that should be available and to the circumstances, for example different periods in the pregnancy such as late-term abortions, in which access may be restricted.

**Emergency contraception**

Emergency contraception is the prevention of pregnancy after unprotected vaginal intercourse, mostly by using drugs related to the female hormones estrogen and progesterone. The ‘morning-after pill’ is similar to birth control pills but generally contains higher hormone doses. Another form of emergency contraception uses an intrauterine device (IUD) inserted by a physician within 5 days after intercourse.

**Abortion rights advocates argue for legal access to induced abortion services. The issue of induced abortion remains divisive in public life, as evidenced by recurring arguments to liberalise or to restrict access to legal abortion services.**

Abortion is the termination (end) of a pregnancy. An estimated 92% of abortions performed worldwide are safe. However, many women die or are injured as a result of unsafe or illegal abortion. In developing countries, more than half (55%) of abortions are unsafe, compared to nearly all (92%) in developed countries. The number of abortions performed in Australia annually is not known precisely, but it is estimated that there are between 70,000 to 80,000, which amounts to about 20 per 1,000 pregnancies being aborted. International rates range from about 7 abortions per 1,000 women aged 15 to 44 per year in Germany to 90 in Eastern Europe, with a world average of 35. These rates reflect the attitude of each country to comprehensive sexuality education and effective contraception rather than the sexual behaviour of the people who live there. Abortion rights supporters themselves are in some instances divided as to the types of abortion services that should be available and to the circumstances, for example different periods in the pregnancy such as late-term abortions, in which access may be restricted.
**Websites with further information on the topic**

Abortion Grief Australia Inc  [www.abortiongrief.asn.au](http://www.abortiongrief.asn.au)
Adelaide Centre for Bioethics and Culture  [www.bioethics.org.au](http://www.bioethics.org.au)
Australian Reproductive Health Alliance  [www.arha.org.au](http://www.arha.org.au)
Cherish Life Queensland  [www.cherishlife.org.au](http://www.cherishlife.org.au)
Children By Choice Association Inc  [www.childrenbychoice.org.au](http://www.childrenbychoice.org.au)
Dr Marie (Marie Stopes International)  [www.drmarie.org.au](http://www.drmarie.org.au)
Family Planning Alliance Australia  [http://familyplanningallianceaustralia.org.au](http://familyplanningallianceaustralia.org.au)
Family Planning NSW  [www.fpnsw.org.au](http://www.fpnsw.org.au)
Pro-Life Victoria  [www.prolife.org.au](http://www.prolife.org.au)
Reproductive Choice Australia  [www.reproductivechoiceaustralia.org.au](http://www.reproductivechoiceaustralia.org.au)
Right to Life Association of South Australia  [www.lifes.net](http://www.lifes.net)

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**THANK YOU**
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INDEX

A
abortion
access to 44, 47-48
advocates 42-43
alternatives to 34
debate 18-52
pro-choice arguments 22-23, 26-28, 31-32, 35-36, 40-41, 44, 47-48, 51-52
pro-life arguments 18-21, 24-25, 29-30, 33-34, 37-39, 42-43, 45-46, 49
counselling 16-17, 33, 34
coercion to have 42-43
grounds for
socioeconomic 6-7
to preserve health 6-7
to save the woman’s life 6-7
without restriction as to reason 6-7
methods 15
medical (medication-based) 15
suction curettage (surgical) 13, 15
negative impacts of 33-34
policies, international 1-2
restrictions 2, 6-7, 10-11
right to 22-23, 26-28, 31-32, 35-36, 40-41, 44, 47-48, 51-52
risks
emotional 20
physical 20, 33
psychological 33
sex-selective 51-52
statistics
Australian 13, 18
global 1-2
surgical see abortion methods, suction curettage
survey, attitudes 33
unsafe 2, 44
adoption 13, 49

C
choice, right to 18-21, 42-43, 44, 51
conscientious objection, doctors’ 35-36, 37-39, 51-52

D
developing regions 1-2, 44
disability 45-46, 49-50
doctors see conscientious objection
Down syndrome 45, 49

E
emotional issues 16-17, 20
eugenics 45-46

F
fertility rates
international 1-2
teenagers, Australian 14
foetal
abnormality 34, 45-46
anomaly, fatal 47
genetic disorder 45-46, 49
impairment 1
pain 29-30
personhood
legislation 28, 31-32
viability 40-41
foetus, moral status of 44

G
gestational limits 7

H
human rights standards 22-23, 47-48
international 3-4
regional 4-5

L
laws
Australia, states and territories 8-9, 18-19, 27-28
Australian Capital Territory 9, 10
New South Wales 8, 11, 18-19, 22, 27
Northern Territory 9
Queensland 8, 10, 11, 13, 22, 27
South Australia 8, 13
Tasmania 9, 27, 28, 35, 36
Victoria 9, 10, 27, 31-32, 35, 36, 51
Western Australia 8, 13
criminal charges 22, 31-32
decriminalisation 22, 28, 48
developing countries 1, 44
international 1-2, 3-5, 6-7
countries, laws in each 6-7
grounds for 6-7
restrictions 6-7
J ayden’s Law 23
legal grounds for abortion 1, 3-5, 6-7, 8-9, 10-11
personhood 23, 26
prenatal protections 3-7
prosecutions 10-11, 22-23
Zoe’s Law 19, 23, 26-28, 32
Leach, Tegan 10, 11
life, when it begins 19, 41

M
medical abortion 15
‘micro-preemies’ 40-41
mifepristone 22, 44

P
parenting 13-14
personhood 23, 26
pregnancy
planned 16
unplanned 12-14
causes 12
options 12-14, 16-17
prevention 25

Q
quality of life 45

R
reproductive health, global 1-2
reproductive rights 26-28, 31-32 see also abortion debate, pro-choice arguments
to bear children 42-43
right to life see abortion debate, pro-life arguments
RU486 11

S
sanctity of life 24, 45
sex selection
laws against 51-52
suction curettage 13, 15

W
women
experience of unexpected pregnancy 12
impact of abortion on 19-20
rights of 3-7