Submission on the Religious Freedom Bills – Second Exposure Drafts

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1. About Women's Health Grampians

Established in 1991, WHG is one of nine regional and three state-wide women's health services funded by the Victorian Department of Health and Human Services. We are a not-for-profit organisation that leads work to improve gender equality and women's health outcomes in the Grampians region of Victoria . We tackle complex issues that impact the lives of women across our region, including gender inequality, the prevention of violence against women and access to sexual and reproductive health services.

Through our programs and partnerships, we aim to end the disadvantage, discrimination and violence experienced by women in our region and beyond. By addressing gender inequality, we can create stronger families and communities for everyone.

We work closely with all levels of government, community and business partners to achieve better public policy and services for women, and to address the barriers to achieving gender equality.

2. About the Central Highlands Integrated Family Violence Committee

CHIFVC is an integrated family violence committee, one of fourteen across the state, designed to lead and advocate for a strong family violence system, and improved responses to family violence.

CHIFVC is a committee made up of more than 20 agencies based in the Central Highlands, brought together by the Guiding Statement that 'We believe that no one should live with violence and that all people should be safe, respected and valued.'

CHIFVC provides strategic leadership, advocacy and governance to the family violence sector, and work together for a joined-up, coordinated approach that helps keeps women and children safe, and perpetrators accountable.

3. Our region

Our region has a population of approximately 250,000 people and spans more than 48,000 square kilometres and 11 Local Government Areas. The region is made up of three sub-regions of Central Highlands, Grampians Pyrenees and the Wimmera, with a diverse range of communities from major growth urban centres to rural and remote towns. The largest city in the region, Ballarat, has a population of 101,000 people.

4. Submission overview

Women's Health Grampians wishes to raise our concerns about the proposed Religious Discrimination Bill and the threat that it poses to our right to live, work and learn free from prejudice and discrimination, regardless of sexuality, marital status, gender identity or faith. In particular, we wish to highlight the impact that this Bill poses to fair, inclusive and non-discriminatory workplaces, schools and healthcare, and women's access to sexual and reproductive healthcare in rural areas in particular, which are discussed in more detail below.

4.1 Restrictions on current discrimination laws

Australia has a comprehensive suite of anti-discrimination laws in place that reflect how we see ourselves as a nation – fair, equal, respectful. These laws are buttressed by our commitment to international human rights treaties and human rights legislation in states such as Victoria. It is a complex legislative foundation that allows for religious freedom while protecting women, LGBTIQ+ people, people with disability and others from discriminatory statements in education, employment and healthcare settings. These laws aim to protect everyone, equally.

The proposed Religious Discrimination Bill, however, threatens that by giving primacy and protection to individuals who discriminate in the public sphere on the basis of their religious beliefs. It protects teachers, employers or workers – including those that work in our secular public system – who, for example:

- Make sexist statements based on their religious beliefs (i.e. that women should submit to their husbands) that can be particularly damaging within a family violence context; or
- Erroneously and offensively suggest that same-sex attracted women or trans women require spiritual correction or healing.

Workplaces that have worked hard to enshrine policies that create inclusive, supportive and respectful environments for their staff are now being compromised as this Bill prioritises those with religious views over all others. This includes members of Women's Health Grampians' Communities of Respect and Equality (CoRE) Alliance – a network of over 120 workplaces and organisations in the Grampians region that share a vision for a safe, respectful and equal society.[1]

4.2 Women's access to healthcare

Patient care must always come first in our healthcare system. The religious beliefs of a healthcare provider must not impact on the right of a patient to receive appropriate treatment. The draft Religious Discrimination Bill is of particular concern as it relates to sexual and reproductive healthcare. All women are entitled to obtain accurate information about sexual and reproductive health services such as contraception, IVF or abortion; make their own decision, free from coercion or pressure; and access safe, legal and affordable services, including medical and surgical abortion.

In Victoria, under Section 8 of the Abortion Law Reform Act 2008, doctors are allowed to exercise a conscientious objection. They do not need to provide an abortion or even a referral to an abortion provider, but are required to refer to another doctor who does not have a conscientious objection, and who will be able to support the woman with her request. This is an excellent example of the balancing of an individual's right to religious freedom, and another individual's right to receive timely, appropriate healthcare.

This Bill, however, makes it harder for health sector employers to ensure their staff do not refuse treatment to people on religious grounds, and clause 42 of the second exposure draft is one such example. This clause protects statements of belief that are made in good faith from the operation of

[1] For more information on the CoRE Alliance and its members, visit: https://whg.org.au/priorities-programs/core.

certain provisions of Commonwealth, state and territory anti-discrimination law. Undoubtedly, 'protecting the freedom to express religious beliefs civilly and as part of public discourse is an essential part of maintaining a healthy and functioning democracy.' However in a healthcare context, this is troubling. The example provided in the Explanatory Notes is below:

> *A statement by a doctor to a transgender patient of their religious belief that God made men and women in his image and that gender is therefore binary may be a statement of belief, provided it is made in good faith. However, a refusal by that doctor to provide medical services to a transgender person because of their religious belief that gender was binary would not constitute a statement of belief as the refusal to provide services constitutes an action beyond simply stating a belief, and therefore may constitute discrimination on the basis of gender identity.*

The distinction between a statement, and the provision of services, in the context of a medical consultation, is minimal. It does not reflect the power imbalance between doctor and patient, nor the potential history of uninvited, derogatory comments that the patient may have endured, regardless of whether these comments were made in 'good faith' or not. This is of deep concern to us, and it extends to a wide range of services delivered to a wide range of people. Women go to their doctors to seek information, advice and help – they are visiting them as trusted health professionals, not to receive unwarranted religious commentary.

Our 2017 research into the views of rural GPs on unintended pregnancy show that rates of conscientious objection among GPs in the Wimmera region of Victoria is 38% - the estimated state average is 15%.[2] This suggests that the Religious Discrimination Bill could have a deeper impact in rural and regional areas of Australia than in metropolitan areas. Women in rural and remote areas already experience poorer health outcomes due to a lack of access to services and infrastructure, and inequality that is entrenched by distance, isolation and disadvantage. This draft Bill has the potential to deepen that divide by placing the practitioner, not the patient, at the centre of a consultation, thereby restricting the number of healthcare providers offering supportive and non-judgmental services.

4.3 Responses to family violence

The recent Victorian Royal Commission into Family Violence made a range of recommendations designed to expand the services responsible for responding to family violence, and to provide guidance as to the kinds of responses that keep victim survivors safe, that hold perpetrators accountable, and that maximise recovery rates for those who experience family violence. These changes, made via the Multi Agency Risk Assessment and Management Framework[3], have meant that by the end of 2020, a variety of staff in universal services, including health professionals, educators and teachers, will be legally required to recognise the signs of family violence, respond respectfully and sensitively to the victim survivor, keep them safe, and connect them to the expertise they need (e.g. specialist family violence services).

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[2] Keogh, Croy, Newton, Hendron, Hill (2017). *Research report: Rural GPs and unintended pregnancy in the Grampians, Pyrenees and Wimmera regions*. Women's Health Grampians and University of Melbourne. Available at: https://whg.org.au/wp-content/uploads/2013/09/Unintended-Pregnancy-Grampians_2017_-Final-version.pdf.

[3]

These legally mandated responsibilities are likely to be undermined by the proposed Religious Discrimination Bill, to the extent that a religious belief is in conflict with those responsibilities and the evidence base that informs them. The evidence base is clear that responses to family violence that excuse or downplay the violence, which situate the violence as the responsibility of the victim survivor and/or which normalise violence as part of relationships can exacerbate trauma and make recovery much more extended. Additionally, the response to the first disclosure of family violence has a disproportionate impact, and in many cases will be made to a universal rather than a specialist service provider, and so adhering to the MARAM requirements is essential.

For example, if a woman experiencing family violence from her partner discloses this fact to a health professional or a teacher, MARAM requires that they respond 'respectfully, sensitively and safely,' in a way that minimises retraumatisation. If that doctor or teacher is instead protected in their expression of a religious belief that, for example, men are entitled to discipline their wives, or that violence is not a legitimate reason to leave a marriage, or that men must 'lead the household,' the aim of MARAM is undermined, and the long term outcomes for the victim survivor (as well as any children victim survivors and indeed, potentially even for the perpetrator) are likely to be significantly poorer.

4.4 Recommendations

Given the concerns outlined above, our recommendation would be that, on balance, the Religious Discrimination Bill is likely to have far more detrimental impacts than its intent, and its positive impacts are unclear and potentially unnecessary. The Bill should not proceed to law.

However, if it does proceed, the issues outlined above, which are likely to exacerbate gender inequality (and thus increase family violence), undermine the practical implementation of women's rights to choose, and significantly undercut many and varied efforts to ensure consistent and effective responses to family violence, mean that the Bill would require significant redrafting.