Abortion, pregnancy loss, grief and palliative care

Human Rights (Children Born Alive Protection) Bill submission

MSI AUSTRALIA

Acknowledgement

MSI Australia acknowledges the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

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Further information

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Contents

Executive Summary

After two decades of legislative and policy reform, and a Senate Inquiry into universal access to reproductive healthcare, backlash is predictable.

These challenges to sexual and reproductive health rights are timely. They help to identify the next steps we need to take to embed quality and safety of abortion care throughout health systems and services in Australia.

Our recommendations are:

1. Dismiss the Human Rights (Children Born Alive Protection) Bill
2. Develop national clinical guidelines for abortion care in Australia
3. Strategise for human rights and health rights
4. Provide universal access to pregnancy loss and grief care
5. Resource services that assist with pregnancy choices support and mental health care
6. Prevent reproductive coercion with research, training and evolving models of care

Explanation of these recommendations are provided below.

We look forward to working with the Australian Government and other key stakeholders to reshape sexual and reproductive health access and enable bodily autonomy for all.

Background

On 9 February 2023 the Senate referred the "Human Rights (Children Born Alive Protection) Bill 2022" to the Community Affairs Legislation Committee for inquiry and report by 1 July 2023.[1]

There is a current consultation on the inquiry. We appreciate the opportunity to provide a submission.

We support submissions made by partner organisations and alliances that provide all options sexual and reproductive healthcare. We highlight the importance of submissions made by the Human Rights Law Centre, SPHERE and the Australian Women's Health Network.

We consent to this submission being published on the inquiry website and shared publicly online. We would welcome an opportunity to speak at a public hearing.

MSI Australia

As an independent, non-profit organisation, MSI Australia (formerly Marie Stopes Australia) is Australia's only national accredited provider of abortion, contraception and vasectomy services, and the country's longest running provider of teleabortion.

For individuals looking to control their sexual and reproductive health and choices safely, we are the fiercely pro-choice, non-judgemental, holistic health provider. Our clinical expertise supported client journey, and values-led approach combine to deliver safer clinical outcomes and client wellbeing.

We published a white paper on reproductive coercion in 2018 called 'Hidden Forces: Reproductive Coercion in contexts of domestic violence'. [2] This was reviewed with recommendations updated in a Second Edition published in 2020.

We work alongside MS Health, a non-profit pharmaceutical provider of medical abortion medication that sits within the MSI Reproductive Choices International umbrella.

Our services

At MSI Australia we provide the following services:

- Contraceptive options counselling, including vasectomy counselling
- Pregnancy options counselling, including abortion, adoption, care, kinship care and parenting

[1] Parliament of Australia (2023), https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ChildrenBornAlive2022

[2] MSI Australia (2023), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, both editions available at https://www.msiaustralia.org.au/reproductive-coercion/

- Various aspects of nurse care including blood tests, ultrasounds and safety planning
- STI tests and cervical screening
- Contraceptive care, including Long Acting Reversible Contraception (LARC)
- Vasectomy care
- Tubal ligation care
- Medical abortion care (in person in clinic)
- Teleabortion, or medical abortion via telehealth (at our virtual clinic)
- Surgical abortion care up to 24 weeks and 6 days gestation
- Aftercare, including low-sensitivity urine pregnancy tests where relevant
- Australian Choice Fund bursaries, philanthropic bursaries to subsidise part of or all of contraception or abortion funding gaps[3]

Some of these services are face to face, others are online and some are a hybrid depending on the needs of clients and availability of clinical staff. Information on sexual and reproductive health access, equity and agency in Australia is available in the resources section of our website.[4] This submission is made from the perspective of being a service provider of these particular services.

[3] MSI Australia (2023), Australian Choice Fund at https://www.msiaustralia.org.au/donate//
[4] MSI Australia (2023), Policy Brief section of Resource Library at https://www.msiaustralia.org.au/resources/document-library/

Consultation Response

This Bill proposes mandatory resuscitation of a fetus which shows signs of life when outside of the uterus. It claims to protect the woman or pregnant person from penalty, yet penalties could apply to others surrounding the situation.

In this section we provide clarity to some of the myths and misconceptions perpetuated through the title, framing and content of the Bill. In doing so we attempted to use accessible language integrated with medical concepts, starting from the language of birth outcomes, moving through to palliative care and adverse events.

Pregnancy outcomes

There are five pregnancy outcomes:

1. Abortion
2. Preterm birth
3. Term birth
4. Miscarriage
5. Stillbirth

The language of reproductive choice does not reflect the nuanced circumstances either medical and/or psychosocial, in which people find themselves. For example some people will only have one pregnancy outcome while others may have two or more to consider.

People need access to abortion care for a range of complex, personal and health related reasons. Abortion care at later pregnancy gestations is rare, and usually involves complex psychosocial trauma, accident or emergency care.

Fetal anomaly

Ultrasound and genomic scans during a pregnancy can show that a fetus has an anomaly. Fetal anomalies exist within spectrums of risk; risks which usually relate to how the health system responds to the fetal anomaly. The risk is not linked to the fetus itself, the risk relates to the various systems in place, or not in place, surrounding the family including medical, social and legal supports.

The pregnancy scan may indicate that the fetus is unlikely to survive beyond birth, or that it has a disability, or that it has another form of anomaly and is likely to be a term birth. Rating the risk will depend on the situation of the pregnancy, the medical facilities and workforce at hand, disability support available, the parent/carers personal or health situation, and other environmental factors.

It is up to the woman or pregnant person, in consultation with their health professionals to determine the risk associated with the pregnancy. It is the woman or pregnant person’s choice as to how to proceed.

Some women and pregnant people with fetal anomalies choose to continue with the pregnancy, some parent, some consider kinship care, others access abortion care. Their various reasons are personal and complex.

Associated clinical guidelines are informed by extensive evidence and clinical knowledge on genomic health, fetal anomalies and associated medium risk pregnancies.

Reproductive coercion during pregnancy screening

If a woman or pregnant person is coerced towards a pregnancy outcome, that is reproductive coercion.[5] Using ableist language during pregnancy scans, can be seen as reproductive violence. This involves a power differential within the professional-patient relationship, in which a person in authority implies that a disabled fetus may be of a different worth or value to any other fetus.

Fetal anomalies that are 'not compatible with life'

In some pregnancy scans, health professionals may use the term 'not compatible with life'. In these cases the pregnancy may also be at higher risk of preterm birth with complications, or a stillbirth. Related complications may create significant health risks for the woman or pregnant person if she/they proceed with the pregnancy.

Many, but not all, women and pregnant people with fetal anomalies that are 'not compatible with life' choose to access abortion care. Their various reasons to have an abortion include to expedite an inevitable outcome or to prevent maternal health risks.

Associated clinical guidelines are informed by extensive evidence and clinical knowledge on genomic health, fetal anomalies and associated high risk pregnancies.

Injections to 'cause fetal demise'

Injections to assist with abortion care, otherwise known as 'injections to cause fetal demise' are clinically known as feticide. These injections are generally recommended for abortion procedures at or above 22 weeks' gestation. There are, however, no clinical guidelines that provide guidance to their use.

The injection occurs during the hours or day prior to an abortion procedure. This means that a fetus does not have a heartbeat at the point of the abortion, which would occur using dilatation and evacuation (D&E) techniques.

At our clinics, some clinicians choose to use the injection at 16 weeks gestation onwards. At our clinics the injection is recommended for all abortion procedures above 22 weeks gestation.

Whether or not a clinician uses feticide is their decision in consultation with their medical director, health or hospital board, or other clinical governance structure. If

[5] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

there were national clinical guidelines for abortion care, they could provide guidance to procedures which involve feticide.

Situations where there are 'signs of life'

In rare cases, a woman or pregnant person seeking abortion care may have their pregnancy induced later in pregnancy. These procedures occur in hospital settings with complex care teams. They involve a medical induction, or later term medical abortion. In these cases, if a feticide has not been used, a fetus may show 'signs of life'.

Signs of life are involuntary movements. Signs of life do not equate to life.

Clinically, we follow biological explanations for signs of life. Signs of life can occur with a fetus at any gestation or person of any age. It is a part of a natural process post blood and oxygen circulation. For people who work in palliative care, it is a familiar occurrence.

Outside of medical lenses, people of faith or other areas of spirituality can have values and beliefs which interpret signs of life in various ways. As clinicians, we need to understand, respond to and cater for the diverse values and beliefs of patients.

In the rare circumstance that there are 'signs of life', after medical induction the fetus will move straight to palliative care.

The fetus will stop showing signs of life within minutes or hours of the induction.

The importance of palliative care

Palliative care is a critical part of pregnancy loss and grief. In these extremely rare situations where there may be risk of signs of life following the procedure, clinicians will have discussed this with the patient in advance.

In the moment, clinical staff respond by following the palliative care plan. They use the language that the woman or pregnant person has chosen to refer to the fetus/baby.

In emergency situations where a palliative care plan has not been prepared in advance, palliative care begins as with any other accident or emergency event.

If this Bill were successful, it would mean that palliative care is not provided post birth. Instead of being able to hold the fetus/baby, or undertake other grief and loss rituals, the woman, pregnant person and other family members present would need to wait while the fetus/baby is taken away.

This Bill would mandate clinicians to undertake steps to 'resuscitate' which would override any attempt at compassionate care, including palliative care plans.

Clinical guidelines

It is clearly stated in clinical guidelines and is widely known as standard practice that in these circumstances, all health and hospital services should provide compassionate and palliative care.

An example of language used in clinical guidelines, from the Queensland Health Termination of Pregnancy guidelines (table 23, section 5.4.3) [6]

- *"Provide individualised and holistic care to women according to circumstances*
- *If appropriate to clinical circumstances, discuss with the woman before the procedure, the potential for live birth including:*
    - *Preferences for awareness of live birth (e.g. informed immediately at time of birth or information delayed)*
    - *Desire for engagement in any subsequent care*
    - *Expected fetal appearance and/or clinical course relevant to circumstances*
    - *Legal requirements for birth registration and management of fetal remains*
    - *Refer to Definition of terms and Section 5.4.1 Birth registration*
- *Establish local procedures for the management of live birth*
- *Offer counselling and support services to women, partners and healthcare professionals involved with care of a live born fetus*
- *If a live birth occurs:*
    - *Support the woman's wishes and preferences*
    - *Handle baby gently and carefully and wrap to provide warmth*
    - *Offer opportunities to engage in care provision (e.g. cuddling/holding) as desired*
    - *Do not provide life sustaining treatment (e.g. gastric tubes, IV lines, oxygen therapy)*
    - *Provide sensitive emotional support and reassurance to parents throughout the process and afterwards*
    - *Document date and time end of life occurs"*

When health services operate outside of clinical guidelines and not in the interests of the patient, that is not safe or quality care. Difficult experiences, health discrimination and adverse events should be reported through feedback mechanisms to the health service, and can also be reported to the Health Department, Health Practitioner Ombudsman, and various state and territory ombudsmen.

[6] Queensland Health (2019) Queensland Clinical Guideline: Termination of Pregnancy at https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

Adverse events in clinical settings

In this document we have provided an overview of our organisational approaches to abortion care, reproductive choice, and palliative care. Our National Medical Advisory Committee (NMAC) monitors, reviews and evaluates cases that occur outside of our clinical policies, procedures and guidelines. Subsequently adverse events can lead to complex investigations of clinical procedures, outcomes, staffing and facilities.

We publish our adverse event rates publicly online, and in our impact reports, every year.[7] It is an important part of safety and quality, consumer information and health sector leadership. It is also essential to successful NSQHS Standards Accreditation including compliance requirements to ensure quality and safety in care.[8]

Without national guidelines for abortion care, it is up to each abortion provider to develop and monitor their own abortion related policies, procedures and guidelines. It is also up to health consumers to research clinical providers and to enquire about adverse event rates prior to having a procedure. The lack of guidelines on abortion care, and the lack of consumer information on how and where to research adverse event rates, is indicative of abortion care only recently shifting into health law.

[7] MSI Australia (2023), 'Our standards' at https://www.msiaustralia.org.au/about-us/our-standards/ and 'Impact reports' at https://www.msiaustralia.org.au/about-us/our-impact/.
[8] National Commission on Safety and Quality in Healthcare (2023), National Safety and Quality Health Service Standards at https://www.safetyandquality.gov.au/standards/nsqhs-standards/assessment-nsqhs-standards.

Recommendations

The National Women's Health Strategy (2020-2030) considers sexual and reproductive health equity to be an indicator of success.[9]

Recommendation 1: Dismiss the Human Rights (Children Born Alive Protection) Bill

This Bill perpetuates myths and misconceptions about abortion care, further reinforcing abortion stigma. It singles out one aspect of pregnancy without looking at the broader psychosocial and systems context, highlighting the need for national clinical guidelines on abortion care.

Recommendation 2: Develop national clinical guidelines for abortion care

A crucial part of sexual and reproductive health is quality care. Moving abortion from criminal law into healthcare, requires complex conversations about clinical guidelines and practice, including monitoring for safety and risk.

Any health service which had adverse impacts, including whether it did not enable autonomy or choice, or did not involve palliative care, must be responded to by clinical governance mechanisms. Governance mechanisms, which differ in each health region, are guided by clinical guidelines.

The Department of Health must resource a national abortion taskforce which can oversee the development of national clinical guidelines for abortion care including psychosocial care. The taskforce should enable clinical leadership and encourage participation from all states and territories.

Recommendation 3: Strategise for human rights and health rights

The Universal Declaration of Human Rights needs to be recognised by Australia in Convention. The Australian Government should strategise for *an Australian Convention on Human Rights*, which can link to our national health strategies.

The *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)* need to be adequately resourced, implemented and monitored to ensure key measures of success are achieved, including equitable access to sexual and reproductive healthcare.

All states and territories should design and resource sexual and reproductive health strategies that link to the *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)*. State and Territory strategies should

[9] Australian Government Department of Health, National Women's Health Strategy (2020-2030), at https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030

address the domains identified in the 2014 Melbourne Proclamation that honours Australia's commitment to the Sustainable Development Goals.[10]

Recommendation 4: Provide universal access to pregnancy loss and grief care

Provide flexible funding to support engagement in rituals related to pregnancy loss and grief, including specific cultural rites, cremation and other related costs. These should be applicable to any pregnancy loss including abortion, miscarriage and stillbirth. Flexible Funds should enable self-determination such as being contracted via Aboriginal Community Controlled Health Organisations, disability organisations and migrant and refugee women's health services. This should be a short or medium term approach until a long-term solution that recognises cultural wellbeing as a health indicator is embedded within health finance and care coordination systems.

Recommendation 5: Resource services that assist with pregnancy choices support and mental health care

Resource a national nurse triage, information, referral and advice organisation (such as existing contractor Healthdirect Australia and their National Health Service Directory) to provide streamlined pathways to sexual and reproductive health providers including all options providers of pregnancy and contraceptive choices counselling, ultrasound care, abortion care and contraceptive care.[11] Included in this information, should be safety and quality of various abortion providers.

Resource a national organisation with mental health, trauma informed service expertise (such as existing contractors 1800RESPECT and Headspace) to provide all options and non-judgemental pregnancy and contraceptive choices counselling, including screening, safety planning and ongoing support in response to cases of reproductive coercion and abuse, family violence and sexual assault.

Recommendation 6: Prevent reproductive coercion with research, training and evolving models of care

Support programs, initiatives and services that can expand models of sexual and reproductive healthcare on Country, including pregnancy screening and pregnancy loss intersections of abortion care, miscarriage and stillbirth, alongside other pregnancy outcomes such as kinship care and parenting.[12]

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[10] Sexual Health Victoria (2022), 2014 Melbourne Proclamation at https://shvic.org.au/assets/resources/150501Melbourne-Proclamation-2014-FINAL.pdf

[11] Healthdirect (2022), Health Service Finder, which includes sexual health services but does not yet have a category for abortion or contraception providers: https://www.healthdirect.gov.au/australian-health-services

[12] Brenna Bernardino (2022), The Road to Abortion Equity speech at https://msi-australia.medium.com/speech-by-brenna-bernardino-the-road-to-abortion-equity-101a7341959a?source=friends_link&sk=06e63b899af6b1be33ccb2b0a38c2e46

Resource academic research partnerships to increase evidence and understanding of reproductive coercion prevention and response mechanisms. Build on these partnerships to develop communities of practice throughout Australia.[13]

Embed pre-service and in-service healthcare professionals' training and education on the prevention of reproductive coercion in all primary care, including radiography, genomic, allied and mental health professional degrees.[14]

Relevant readings

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Women with Disabilities Australia (2016), Position Statement 4: Sexual and Reproductive Health Rights at https://wwda.org.au/wp-content/uploads/2016/10/Position_Statement_4_-_Sexual_and_Reproductive_Rights_FINAL_WEB.pdf.

[13] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/
[14] MSI Australia (2020), Hidden forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.msiaustralia.org.au/reproductive-coercion/

Further information and feedback

If you would like to know more about the work that we do at MSI Australia (formerly Marie Stopes Australia), you can follow us on social media or get in touch via the following channels.

Twitter: @MSI_Australia

Facebook: @AustraliaMSI

Instagram: MSIAustralia_

Website: msiaustralia.org.au

You can also support access to sexual and reproductive healthcare by making a tax deductible donation @ https://www.msiaustralia.org.au/donate/