SPHERE
NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

Women's Sexual and Reproductive Health Coalition

Response to Human Rights (Children Born Alive Protection) Bill 2022

The national Women's Sexual and Reproductive Health Coalition, chaired by SPHERE (the SPHERE Coalition), welcomes the opportunity to make this submission in response to the Human Rights (Children Born Alive Protection) Bill 2022.

SPHERE is the National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care – a collaborative research centre comprising national and international experts in sexual and reproductive health.

The SPHERE Coalition is a cross-sectoral, multidisciplinary alliance comprising over 150 clinician experts and consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers with a shared vision for improving women's sexual and reproductive health.

We welcome the opportunity to provide feedback on the *Human Rights (Children Born Alive Protection) Bill 2022*. Access to pregnancy termination services is a reproductive and legal right in Australia and is a key priority of the National Women's Health Strategy 2020-2030. We have significant concerns regarding the proposed *Human Rights (Children Born Alive Protection) Bill 2022* as it:

- demonstrates a poor and inaccurate understanding of second trimester abortion care and the complexities of foetal viability,
- is an infringement on the reproductive rights of pregnant women and may be detrimental to their health and wellbeing, and
- interferes with the responsibility and obligations of medical providers to offer patient-centred care and their ability to meet established medical and professional ethics standards in delivery of clinical services.

As such, we strongly recommend that this Bill not be passed nor supported.

Foetal viability

The proposed bill calls for the provision of "*medical care or treatment to children born alive as a result of terminations*". Although abortion is fully decriminalised in all Australian states and territories, most jurisdictions have gestational age limits (ranging from 14 to 24 weeks gestation) for abortions on request. Beyond these gestational limits, most jurisdictions require the approval of two doctors (Children by Choice 2021).

Foetal viability (i.e. the potential to be able to survive outside the womb) is complicated and lacks uniformly applicable legal, medical and gestational age criteria on the basis of which it can be defined and applied (Bates 1983). Advances in neonatal intensive care have shifted foetal viability to lower gestational ages, however, reported survival rates between 22-24 weeks gestation vary across countries. For example, a study conducted in the USA collecting data on 4,987 infants born before 27 weeks of gestation without congenital anomalies found that only 5.1% born at 22 weeks gestational age survived and 3.4% survived without severe impairment (Rysavy et al 2015). A systematic review reported 22-week survival rates that ranged from 0% to 34% (Guillén et al 2015). There is broad

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agreement in the medical community that this period of gestation is a 'grey zone', where a small proportion of foetuses have survived only through major medical intervention and most with ongoing disability (South Australian Law Reform Institute 2019).

Life-sustaining interventions are generally only recommended for infants born from 23-24 weeks in Australia (see, for example, Queensland Clinical Guidelines 2020), and come with major risks of serious health problems (affecting quality of life and ability to thrive) and early mortality due to insufficiently developed heart, lungs and brain (Askola 2018).

Legislative approaches that mandate "life-saving" treatment for extremely premature neonates ignore the low and variable survival rates that are highly dependent on the availability of advanced neonatal medical care and expertise that cannot be feasibly financed or standardised across and within Australian jurisdictions.

Later gestation abortion

Later gestation abortions (i.e. after 14 weeks) are very uncommon. Data from South Australia, the only Australian jurisdiction that publicly releases abortion data, indicate that in 2018, 91% of terminations were provided at or before 14 weeks' gestation, with the remaining 9% provided beyond this gestational age. Among later gestation abortions, only 2% were performed at or beyond 20 weeks' gestation (South Australian Law Reform Institute 2019).

Abortions occurring later in the second trimester are especially likely to involve complex medical circumstances, including serious or fatal fetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the fetus is one of a multiple pregnancy; or complex personal circumstances, including late recognition of pregnancy, delayed access to services, social and geographic isolation, domestic or family violence, rape or incest, socio-economic disadvantage, drug addiction or mental health issues (Queensland Law Reform Commission 2018). An example provided by the South Australian Law Reform Institute was that of a minor with an intellectual disability who became pregnant as a result of sexual abuse by a family member. Given her intellectual disability, she was unable to appreciate or understand her pregnancy until she was at a late gestational stage.

Importantly, pregnancy terminations later in the second trimester are only undertaken after careful consideration and discussion amongst all relevant parties and in the most compelling of circumstances, for example where continuing the pregnancy poses a risk to the woman's health or a major foetal abnormality is identified late in gestation (South Australian Law Reform Institute 2019).

Infants 'born alive' following abortion

As Dr Vijay Roach, Immediate Past President of the Royal Australian and New Zealand College of Obstetrics and Gynaecology, explains "a child 'born alive' during a late term abortion procedure is extremely rare, if not non-existent, and this situation is already fully covered by existing clinical practice". Furthermore "the claim of children 'left to die' is unfounded and offensive to the health practitioners involved and the parents. Any legislative provision …. seeking to regulate what happens is simply unnecessary and unhelpful as this situation, if it ever arises, is preferably left to clinical practice as to what is appropriate in the circumstances and to reflect the choice of the parties involved in careful consultation with their medical practitioners" (South Australian Law Reform Institute 2019). Dr Catriona Melville, Deputy Medical Director of Marie Stopes Australia, further explains that "as late-term abortions are most commonly required due to lethal foetal anomalies, doctors "wouldn't be providing life sustaining treatment" and the foetus would not be viable (Karp 2021).

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The examples provided in Senator Canavan's speech on 30th November, 2022, the *Human Rights (Children Born Alive Protection) Bill 2022* of the 33 babies born alive in Victoria, and 204 in QLD, as a result of abortion are misleading and medically inaccurate. These procedures were performed if the foetus had lethal or significant abnormalities or if a birth posed a risk to the mother and the foetus had zero chance of survival. In these situations, women are offered medication to euthanise the foetus in the womb prior to delivery, or in some cases the baby is delivered alive for medical or personal reasons and then given palliative care (e.g. if a woman wants the opportunity to hold the baby as it dies).

Interference with Medical and Professional Ethics Standards

Providers of abortion care, like all other medical providers in Australia, are bound by clear medical protocols that are in line with current evidence-based standards for abortion-related clinical care. As such, legally mandating "heroic" measures for foetuses that have medical issues which are incompatible with life or with the mother's health is in contravention of current standards of medical and ethical care.

A key objective of clinical practice is to provide care that is patient-centred. Patient-centred care includes the provision of medical care that is compatible with patients' personal goals, wishes and preferences related to the care provided. The proposed measures in the *Human Rights (Children Born Alive Protection) Bill 2022* reflect a poor understanding of the realities of clinical decision-making and are essentially irreconcilable with patient autonomy and patient-centred care.

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