AUSTRALIAN WOMEN'S HEALTH NETWORK

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Sent via email to community.affairs.sen@aph.gov.au

17 March 2023

Dear Committee Secretary,

RE: Submission to the Senate Standing Committees on Community Affairs, in response to the "Human Rights (Child Born Alive Protection) Bill 2022"

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. Please find attached a submission to the Senate Standing Committees on Community Affairs.

The Australian Women's Health Network (AWHN) is a national voice for women's health. AWHN acts as a vehicle for women's health organisations, consumers and advocates to connect and collaborate through our membership base. In our work we develop, advance, and respond to public policy and practice as it impacts on women's health.

Thank you for hosting this consultation. Should you have any questions about this submission, you are welcome to contact me at

Sincerely,

Bonney Corbin

Chair

Australian Women's Health Network
www.awhn.org.au

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Submission to the Senate Standing Committees on Community Affairs, in response to the "Human Rights (Child Born Alive Protection) Bill 2022"

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]

We appreciate the opportunity to provide a submission. We consent to this submission being published on the inquiry website and shared publicly online.

The Australian Women's Health Network

The Australian Women's Health Network (AWHN) is a national voice for women's health. AWHN acts as a vehicle for women's health organisations, consumers and advocates to connect and collaborate through our membership base. In our work we develop, advance, and respond to public policy and practice as it impacts on women's health.

We provide independent advice from a broad evidence-base to promote a gendered approach to health equity.[1] Our work is funded by a combination of philanthropic donations, member fees and the Department of Health, Health Peak and Advisory Bodies program.

Consultation response

The Bill perpetuates myths and misconceptions in its title, framing and content. Here we explain why the Bill should be dismissed.

Women's rights are human rights

Reproductive choices are essential to the realisation of women's human rights, and the fulfilment of Australia's commitments under the Convention on the Elimination of Discrimination against Women (CEDAW).[2] At present, sexual and reproductive health and rights in Australia are neither equitable nor universal. While we have a sound national policy model in the National Women's Health Strategy and National Preventive Health Strategy, there is a significant implementation gap and a need to translate evidence into action.

[1] AWHN's position papers, including papers on sexual and reproductive health are available online at https://awhn.org.au/position-papers/
[2] AWHN (2022), Policy Brief: Abortion, at https://awhn.org.au/position-papers/

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.[3]

It is up to a woman or pregnant person, in consultation with their health professionals to determine the risk associated with the pregnancy.[4] 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.

If a woman or pregnant person is coerced towards a pregnancy outcome, that is reproductive coercion and abuse.[5] This includes using ableist language during pregnancy scans, when a health worker implies that a disabled fetus may be of a different worth or value to any other fetus.

The need for clinical guidelines

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.

If there were national clinical guidelines for abortion care, they could provide guidance to procedures which involve feticide. There are no clinical guidelines that provide guidance to feticide use. 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.[6]

In rare cases, a woman or pregnant person seeking abortion care may have their pregnancy induced later in pregnancy.[7] 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 what is clinically called 'signs of life'. Signs of life are involuntary movements, they do not equate to life.

In the rare circumstance that there are 'signs of life', health workers follow clinical guidelines. An example of language used in clinical guidelines, from the Queensland Health Termination of Pregnancy guidelines (table 23, section 5.4.3)[8]

When abortion services operate outside of clinical guidelines and not in the interests of the patient, that is not care, is unsafe and can involve gender-based health discrimination. Health discrimination and

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[3] Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2019), Late Abortion position statement at https://ranzcog.edu.au/wp-content/uploads/2022/05/Late-Abortion.pdf.
Cheng, H. C., Black, K., Woods, C., & de Costa, C. (2020). Views and practices of induced abortion among Australian Fellows and trainees of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists: A second study. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *60*(2), 290-295.
[4] 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.
[5] Sheeran, N., Vallury, K., Sharman, L.S., Corbin, B., Douglas, H., Bernardino, B., Hach, M., Coombe, L., Keramidopoulos, S., Torres-Quiazon, R. and Tarzia, L., 2022. Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), pp.1-10.
[6] Guilbaud, L., Maurice, P., Dhombres, F., Maisonneuve, É., Rigouzzo, A., Darras, A. M., & Jouannic, J. M. (2020). Feticide procedures in second and third trimesters terminations of pregnancy. *Gynecologie, obstetrique, fertilite & senologie*.
[7] Springer, S., Gorczyca, M. E., Arzt, J., Pils, S., Bettelheim, D., & Ott, J. (2018). Fetal survival in second-trimester termination of pregnancy without feticide. *Obstetrics & Gynecology*, *131*(3), 575-579.
[8] 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

other problematic experiences within health services 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.

Access to palliative care is essential

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 an abortion, health workers will have discussed this with the patient in advance.

In the moment, health workers 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 any other family members present would need to wait while the fetus/baby is taken away.

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

Recommendations

The *National Women's Health Strategy (2020-2030)* has bi-partisan support. The Strategy considers sexual and reproductive health equity to be an indicator of success.

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

This Bill perpetuates myths and misconceptions about abortion, reinforcing gender-based discrimination in health alongside abortion stigma. It does not consider pregnancy within a broader psychosocial and systems context.

2. Strategise for health and human 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 'Priority Area 1: Maternal, sexual and reproductive health'.

3. Publish national guidelines for abortion care

Australia has focused efforts moving abortion from criminal law into healthcare. Now that legal changes have occurred, Departments of Health in each State and Territory need to have clinical conversations about guidelines and practice, including monitoring for safety and risk.

At the national level, the Department of Health should resource a taskforce to oversee the development of national clinical guidelines for abortion care including mental and social support and care. The

taskforce should and encourage participation from all states and territories to ensure that the guidelines can be translated across health regions.

4. Resource an independent national triage, referral and advice service

Resource an independent national triage, referral and advice organisation to provide streamlined pathways to sexual and reproductive health providers including all options providers of choices counselling, ultrasound care, abortion care and contraceptive care.[11] Included in this should be information about the safety and quality of various sexual and reproductive health providers.

5. Encourage employers to provide reproductive health leave

Provide incentives for public and private employers to implement reproductive health leave that can support access to health and healing.[9] This leave must apply to 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.

6. Prevent reproductive coercion

Resource academic research partnerships to increase evidence and understanding of reproductive coercion prevention and response mechanisms. Support community-controlled 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 kinship care and parenting. Embed reproductive coercion prevention in all health worker training and education.

[9] AWHN (2022), Policy Brief: Reproductive health leave, at https://awhn.org.au/position-papers/