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South Australian
Abortion Action Coalition
Better abortion access

Committee Secretary
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Dear Committee Secretary

Response to Human Rights (Children Born Alive Protection) Bill 2021

The South Australian Abortion Action Coalition (SAAAC) welcomes the opportunity to provide feedback on the *Human Rights (Children Born Alive Protection) Bill 2021*.

SAAAC is a coalition of health professionals, academics, lawyers, feminists, unionists, students and interested members of the public and is supported by more than 40 influential state and national organisations. SAAAC takes a reproductive justice approach to our work. Our website is https://saabortionactioncoalition.com/.

SAAAC's vision has always been broader than decriminalisation, with attention to federal and state barriers to the accessibility, acceptability, and quality of abortion care.

If you have any questions about this submission, you are welcome to contact us at SA Abortion Action Coalition saabortionctioncoalition@gmail.com

Sincerely

Dr Erica Millar, Senior Research Fellow, La Trobe University and member of SAAAC

Margie Ripper, retired Associate Professor from the University of Adelaide and member of SAAAC

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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 2021* because it:

- Seeks to regulate an extremely rare, if non-existent, procedure and disregards, or misunderstands, current practice, which already offers the best, and most appropriate, care to all extremely premature newborns. Consequently, the intention of this bill is to further stigmatise abortion, the people who have them, and the people who provide them.
- Fails to understand the circumstances and practices of abortion care at later gestations;
- Misrepresents (or misunderstands) the complexities of foetal viability;
- Infringes the professional responsibility and obligations of medical providers to offer patient-centred care and ignores existing medical and professional ethics standards in the delivery of clinical services, and
- Contravenes the reproductive rights of pregnant people and may be detrimental to their health and wellbeing.

Abortion care at later gestation
Pregnancies terminated after 20 weeks' gestation are uncommon (they constitute about 2 % of all abortions, according to South Australian data, see South Australian Abortion Reporting Committee 2020). Later gestation abortions are often performed because of foetal abnormality but invariably such abortions involve complex medical or personal circumstances. Medical reasons include serious or fatal foetal abnormalities where the diagnosis is delayed, the prognosis is uncertain, or the foetus is one of a multiple pregnancy. Medical indications for the pregnant person include life-threatening illness or injury which is incompatible with the continuation of the pregnancy. Complex personal circumstances that lead to abortion in the second gestation include: late recognition of pregnancy, social and geographic isolation, domestic or family violence, rape or incest, poverty and/or homelessness, drug addiction or mental health issues (Queensland Law Reform Commission 2018).

People can require abortions later in pregnancy than they otherwise would because of 'system delays', including the lack of local and affordable access to an abortion, misdiagnosis of pregnancy by health professionals, and/or delays in tests or in the reporting of tests (South Australian Law Reform Institute 2019).

We note that, although common, the distinction between foetal and psychosocial reasons is an unhelpful one and can be interpreted as a divide between deserving and undeserving abortions. In fact, patients across both categories decide to seek an abortion for 'psychosocial' reasons, i.e. because of their own circumstances and beliefs, their social and cultural environment, and the context in which they are making a decision.

The possibility of a child 'born alive' during a second or third trimester abortion procedure is, according to the former President of the Royal Australian and New Zealand College of Obstetrics and Gynaecology, *"extremely rare, if not non-existent"*. He goes on to point out that *"this situation is already fully covered by existing clinical practice"* and that "*Any legislative*

provision seeking to regulate what happens is simply unnecessary and unhelpful as this situation" (Dr Vijay Roach, quoted in SALRI 2019: 163).

During the standard method of abortion after 21+ 6 (the earliest measure of foetal viability) the pregnant person is offered a feticidal injection that is inserted trans-abdominally into the uterus. According to a ten-year review at the Royal Brisbane and Women's Hospital (2010-2020), this is standard practice for all abortions post 22 weeks, and the vast majority of feticides are performed after a diagnosis of neurological abnormalities (36 %), aneuploidy or genetic syndromes (22 %), or cardiac malformations (19%) (Rosser et al. 2022).

The decision to not include feticide as part of abortion care is the exception rather than the rule and might be made, for example, if a pregnant person wants the opportunity to hold the baby as it dies. Such newborns are given palliative care as is proscribed by professional codes of medical and nursing practice.

The professional and ethical codes of practice which guide medical and nursing practice apply equally to the respectful care of all preterm neonates, however they are delivered, and in palliative care more generally.

Foetal viability and 'life-saving' interventions

Any definition of foetal viability (i.e. the potential to be able to survive, in a biological sense, outside the womb) is complicated by the lack of uniformly applicable legal, medical and gestational age criteria by which it can be defined and applied. Although the gestational age of foetal viability is reducing, survival rates of these extremely premature babies are extremely low and vary according to the level of neonatal intensive care available in different countries and regions. A systematic review reported survival rates of neonates born at 22 weeks' gestation ranging from 0% to 34% (Guillén et al 2015). In such cases, survival beyond birth requires intensive medical intervention and, even so, those who live do so with ongoing disability (South Australian Law Reform Institute 2019).

In Australia it is standard medical practice to only recommend life-sustaining interventions for neonates born from 23-24 weeks (see, for example, Queensland Clinical Guidelines 2020), and even these babies risk serious health problems (affecting quality of life and ability to thrive) and early mortality due to an insufficiently developed heart, lungs and brain (Askola 2018).

Legislative approaches that mandate 'life-saving' treatment for extremely premature neonates (whether in the context of abortion or not) 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 as standard care across and within Australian jurisdictions.

The decision to terminate a pregnancy after 20 weeks' gestation is often difficult, not least because it is typically a multiday procedure. It can be particularly difficult when an initially wanted pregnancy is terminated as the result of foetal, maternal or social complexities that propel the decision. It is both cruel and disrespectful of pregnant people and health care providers to legally mandate 'life-saving emergency treatment' in cases where, by definition, the intention is to end foetal life. Such interventions would, at most, delay the inevitable demise of the newborn but importantly traumatise and distress the person who had the abortion and the health

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professionals involved (Rosser et al. 2022). To suggest such intervention is both uninformed and inhumane.

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. A core objective of clinical practice is to provide care that is patient-centred and which affirms the patients' personal goals, wishes and preferences regarding care. Legally mandating life-saving measures for foetuses that have medical issues which are incompatible with life or with the pregnant person's health contravenes current standards of medical and ethical care.

The proposed measures in the *Human Rights (Children Born Alive Protection) Bill 2021* reflect a poor understanding of the realities of clinical decision-making and are completely incompatible with patient autonomy and patient-centred care. As with restrictions on later abortion care more generally, the burden of this bill, if effected, would fall disproportionately on the most vulnerable and disadvantaged in the community (Megaw 2018).

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