Submission No 13

INQUIRY INTO REPRODUCTIVE HEALTH CARE REFORM BILL 2019

Organisation: Right to Life NSW

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SUBMISSION

Right to Life NSW

Reproductive Health Care Reform Bill 2019 (as amended and passed by the Legislative Assembly) to the Social Issues Committee, Legislative Council, Parliament of New South Wales

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If not opposed as per Recommendation 1, the Bill ought to be amended to explicitly require that any child born alive after an attempted abortion is given the same life-saving medical treatment as would be given to any other child born alive at that stage of gestation.

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If not opposed as per Recommendation 1, Clause 6 of the Bill, which would authorise the abortion of children capable of feeling pain, should be opposed.

Recommendation 6:

If not opposed as per Recommendation 1, Clause 9 should be replaced by a provision simply affirming that any registered health practitioner may refuse to perform a termination, assist in the performance of a termination or otherwise facilitate the performance of a termination if a health practitioner has a conscientious or professional objection to the performance of the termination.

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If not opposed as per Recommendation 1, the Bill should be amended to provide that an abortion performed solely for the purpose of sex selection is unlawful.

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If not opposed as per Recommendation 1, the Bill should be amended to provide for an offence of coercing, or attempting to coerce, a woman to undergo an abortion.

Introduction

Every pregnancy involves a mother and her unborn child (or children) in an intimate, bodily relationship.

Pregnancy is the state of a woman having a child developing in her uterus. No pregnancy lasts for ever. All pregnancies **terminate -** naturally by miscarriage, stillbirth or the birth of a living child; or with medical assistance through induced labour or Caesarian section.

Abortion, properly understood, is not the **termination of pregnancy** but the **intentional termination of the life of the unborn child.**

When an attempted abortion results in the birth of a live born child it is described as **a failed abortion** – precisely because the end in view was the death of the unborn child, not simply **terminating the pregnancy**.

This distinction is relevant to the ***Reproductive Health Care Reform Bill 2019*** which defines ***termination*** in a circular manner as:

> *an intentional termination of a pregnancy in any way, including, for example, by—*
> *(a) administering a drug, or*
> *(b) using an instrument or other thing*

This definition, given in the Dictionary in Schedule 1 of the Bill, is flawed as, by seeking to make the unborn child and his or her intended death, invisible or hidden, it could, as written cover administering drugs to induce labour in a woman whose pregnancy has gone past her due date or using forceps in a delivery – in both cases with no intention of terminating the life of the unborn child, and, in fact, with the intention of delivering a live born child.

Right to Life NSW believes, on the basis of common sense confirmed by modern scientific findings, that each unborn child, from the first moment of fertilisation onwards, is an individual member of the species *homo sapiens*, and therefore quite simply, "one of us", a fellow human being.

Any proposal, such as that which is at the heart of this Bill, to give the **formal approval of the State to the intentional termination of the life of an unborn child** by a medical practitioner, is **at odds with the fundamental human right to life** which all other human rights presuppose.

Right to Life NSW values the irreplaceable role of women as mothers. We, along with other prolife organisations and individuals in New South Wales, seek to stand in solidarity with every pregnant woman, especially those for whom pregnancy, for whatever reason, is experienced as a crisis or as a problem to be solved. We believe that, whatever the medical, physical, psychological and social circumstances of a woman who is carrying an unborn child, there is a life-affirming solution that will respect the rights and needs of both the mother and her unborn child.

Who is the unborn child whose life is to be terminated by abortion?

The science of fetology has dramatically improved our understanding of unborn human life. It is no longer possible in the age of 4-D ultrasound and in utero fetal surgery to hold that the fetus is just a bunch of cells or anything other than a living human being.

These are just some facts about the unborn child revealed by recent scientific developments:

- "*Cardiac motion can be visualized using ultrasonography from as early as 26–32 days after conception, and certain aspects of embryonic heart function have been studied using Doppler ultrasonography from 6 weeks of gestation*."[1] At 6 weeks the mean heart rate is 117 beats per minute. At 10 weeks the mean heart rate is 171 beats per minute.[2]
- A motor response can first be seen as a whole body movement away from a stimulus and observed on ultrasound from as early as 7.5 weeks' gestational age. The area around the mouth is the first part of the body to respond to touch at approximately 8 weeks, but by 14 weeks most of the body is responsive to touch.[3]
- By 15 weeks gestation the human fetus has fully developed and functioning taste buds.[4]
- "*Starting from the 14th week of gestation twin foetuses plan and execute movements specifically aimed at the co-twin. These findings force us to predate the emergence of social behaviour: when the context enables it, as in the case of twin foetuses, other-directed actions are not only possible but predominant over self-directed*".[5]

[1] A. Wloch et al. "Atrial dominance in the human embryonic heart: a study of cardiac function at 6–10 weeks of gestation", Ultrasound in obstetrics & gynecology, 2015; 46: 553–557, http://onlinelibrary.wiley.com/doi/10.1002/uog.14749/pdf

[2] A. Wloch et al., "Doppler study of the embryonic heart in normal pregnant women", *Journal of maternal-fetal and neonatal medicine*, 2007, 20:533-9, http://www.tandfonline.com/doi/abs/10.1080/14767050701434747?journalCode=ijmf20

[3] LB Myers et al. "Fetal endoscopic surgery: indications and anaesthetic management", *Best Practice & Research Clinical Anaesthesiology*, 2004, 18:231-258, https://www.sciencedirect.com/science/article/pii/S1521689604000023?via%3Dihub

[4] M. Witt and K. Reutter, "Embryonic and early fetal development of human taste buds: a transmission electron microscopical study", *The Anatomical Record*, 1996, 246:507-23, http://onlinelibrary.wiley.com/doi/10.1002/(SICI)1097-0185(199612)246:4%3C507::AID-AR10%3E3.0.CO;2-S/epdf

[5] U. Castiello et al., "Wired to Be Social: The Ontogeny of Human Interaction", *PLoS One*, 2010; 5, Published online, http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013199

Is abortion ever in a woman's best interest?

If the current test for the lawfulness of an abortion was properly applied in the light of the best available medical evidence, then it would be virtually impossible for a medical practitioner to come to an honest and reasonable belief that the abortion was "necessary to prevent a serious danger to the pregnant woman's life or to her physical or mental health and that the danger of the abortion to the woman is the danger of the operation is not out of proportion to the danger intended to be averted".

A summary of the best available medical evidence shows that **abortion is associated with adverse, rather than beneficial, outcomes for women's mental health**; **that it increases rather than prevents maternal mortality** and that, at least in countries with a modern health system, abortion, properly understood, **is never required for the preservation of the mother's life.**

Abortion is associated with adverse outcomes for women's mental health

There is a substantial body of research indicating an increased risk of mental health problems following an abortion. Not all the specific risk factors have been identified but some of the research has controlled for factors including pre-existing mental health problems and the unwantedness of the pregnancy and found that **abortion is an independent risk factor for increased mental health problems.**

Longitudinal studies in New Zealand have found a general association of abortion with subsequent mental health problems. In 2006 David Fergusson and colleagues using data from the longitudinal Christchurch Health and Development Study reported that women who had an abortion before age 25 had 1.49-1.72 times the risk of experiencing mental health problems than women who had not got pregnant or who had become pregnant and not had an abortion. Those having an abortion had elevated rates of depression, anxiety, suicidal behaviours and substance use disorders[6]

In 2008 Fergusson and colleagues reported that exposure to abortion was associated by age 30 with a 1.3 relative risk of mental health problems **while carrying an unwanted pregnancy to term was not a risk factor for mental health problems.** This study effectively ruled out earlier suggestions that the adverse mental health risks seen in women who had abortion were associated with unwanted pregnancy itself rather than with the abortion.[7]

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[6] D Fergusson, L Horwood and E Ridder, "Abortion in young women and subsequent mental health", *Journal of Child Psychology & Psychiatry*, 2006; 47(1): 16-24, http://dx.doi.org/10.1111/j.1469-7610.2005.01538.x

[7] D Fergusson. L Horwood and J Boden, "Abortion and mental health disorders: evidence from a 30-year longitudinal study", *British Journal of Psychiatry* 2008; 193: 444–51, http://bjp.rcpsych.org/content/bjprcpsych/193/6/444.full.pdf

In 2009 Fergusson and colleagues reported that over 85% of women who had an abortion reported at least one negative reaction to the abortion (sorrow, sadness, guilt, grief/loss, regret, disappointment) with 34.6% of women who had an abortion reporting five or six of these negative reactions. For those women with moderate negative reactions (1-3) to abortion this was associated with a 1.43 relative risk of subsequent mental health problems compared to women who did not have an abortion. For those with stronger negative reactions (4-6) the relative risk of subsequent mental health problems was 1.64-1.81. Fergusson concludes that for this population (women under 30) abortion is responsible for approximately 5% of all mental health problems.[8]

A 2016 US study using data from the National Longitudinal Study of Adolescent to Adult Health confirmed previous findings from Norway and New Zealand that, unlike other pregnancy outcomes, abortion is consistently associated with a moderate increase in risk (45%) of mental health disorders during late adolescence and early adulthood.[9]

This study was particularly significant in providing "*some of the strongest evidence to date that the association of* ***abortion with subsequent mental distress is not merely contingent but is indeed causal*****".**

Abortion increases maternal mortality

Abortion has been found in population wide studies in Finland, California and Denmark to be associated with an increased risk of mortality, in particular **a dramatically increased risk of suicide** - up to 6.6 times six times higher than that of women who had given birth in the prior year.[10]

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[8] D Fergusson. L Horwood and J Boden, "Reactions to abortion and subsequent mental health", *British Journal of Psychiatry* 2009; 195: 420–26, http://bjp.rcpsych.org/content/bjprcpsych/195/5/420.full.pdf

[9] DP Sullins, "Abortion, substance abuse and mental health in early adulthood: Thirteen-year longitudinal evidence from the United States*", SAGE Open Medicine* 2016: 4:1–11, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5066584/pdf/10.1177_2050312116665997.pdf

[10] See:
M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000", *European Journal of Public Health*, 2005, 15:459-63, https://academic.oup.com/eurpub/article/15/5/459/526248
M. Gissler et. al., "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000", *European Journal of Public Health*, 2005, 15:459-63, https://academic.oup.com/eurpub/article/15/5/459/526248
E Karalis et al., "Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012", http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.14484/abstract

Registry based studies such as the two Danish studies and the early studies from Finland and California are important in gaining **an accurate picture of comparative maternal mortality** following induced abortion and childbirth.

The claim that abortion is safer for women than childbirth is usually based on limited data with many deaths following abortions not identified as such. This claim cannot be sustained in light of the **registry studies which consistently demonstrate that induced abortion, and even more so late induced abortions or repeat abortions, significantly increase the risk of maternal death.**

Abortion, properly understood, is never required for the preservation of the mother's life

Cancer treatment to preserve a mother's life even if that treatment may pose a risk to the health, or even the life, of her unborn child is not abortion.

Nor is the early induction of labour for conditions such as severe eclampsia provided (i) there is no direct assault on the unborn child intended to kill it and (ii) on delivery the child be given the same treatment, including resuscitation, as would be given to any child delivered at the same gestational age.

Neither of these scenarios is accurately defined as abortion, which always includes an intention to end the life of the unborn child, or at least recklessness about causing his/her death.

The Dublin Declaration on Maternal Healthcare signed by over 100 medical professionals, including 245 obstetricians and gynaecologists expresses this approach succinctly:

> *As experienced practitioners and researchers in obstetrics and gynaecology, we affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman.*
> *We uphold that there is **a fundamental difference between abortion, and necessary medical treatments** that are carried out to save the life of the mother, even if such treatment results in the loss of life of her unborn child.*

DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women", *Southern Medical Journal*, 2002, 95:834-41, https://sma.org/southern-medical-journal/article/deaths-associated-with-pregnancy-outcome-a-record-linkage-study-of-low-income-women/
DC Reardon & PK Coleman, "Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980–2004", *Medical Science Monitor,* 2012, 18: PH71-76, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3560645/
PK Coleman, DC Reardon and BC Calhoun, "Reproductive history patterns and long-term mortality rates: a Danish, population-based record linkage study", *European Journal of Public Health*, Volume 23, Issue 4, 1 August 2013, Pages 569–574, https://academic.oup.com/eurpub/article/23/4/569/427991

We confirm that the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women.[11]

Recommendation 1:

The Bill should be opposed.

Clause 5 – A medical practitioner's unfettered right to abort any pregnancy to 22 weeks

Clause 5, **which is a key clause of the Bill**, simply provides, subject to informed consent (which can be waived in the case of emergency), that:

> *A person who is a medical practitioner may perform a termination on a person who is not more than 22 weeks pregnant.*

The current law only permits a medical practitioner to perform an abortion if he or she has a an honest and reasonable belief that the abortion is necessary to prevent a serious danger to the pregnant woman's life or to her physical or mental health and that the danger of the abortion to the woman is the danger of the operation and is not out of proportion to the danger intended to be averted.

The Bill would therefore do much more than merely remove abortion by a medical practitioner from the *Crimes Act 1900*. It would **positively authorise a medical practitioner to perform an abortion**, with the informed consent of the woman, **for any reason whatsoever**.

While purporting to treat abortion as a matter of healthcare, this provision, by removing any duty of the medical practitioner to give any consideration whatsoever to either the health of the woman or her unborn child, really **treats abortion simply as a purely social decision**, albeit involving the purely technical skills of a medical practitioner to perform.

The social reasons for abortion could include sex selection abortion due to cultural son preference (see discussion below under Clauses 14 and 15) as well as abortions for even suspected minor disabilities.

[11] See: https://www.dublindeclaration.com/

Recommendation 2:

If not opposed as per Recommendation 1, the Bill ought to be amended to exclude abortion for social reasons and restrict it to 'abortion as necessary' as per current law.

Clause 6 – Abortion of the viable unborn child from after 22 weeks up to full term: ineffective additional requirements

Clause 6 authorises any specialist medical practitioner, who after considering certain matters and obtaining the agreement of any other specialist medical practitioner, decides that an abortion "*should be performed*" to perform an abortion on a pregnant woman or girl at any time from 22 weeks of pregnancy right up until full term.

Such abortions must, except in an emergency, be performed in a hospital or in any other facility approved for the purpose by the Secretary of the Minister for Health.

These additional requirements for an abortion from 22 weeks to full term are effectively meaningless.

The range of circumstances to be considered is so broad that it is hard to imagine a scenario where a doctor who personally believed in abortion for any reason or none up to full term could be faulted if he or she claims to have considered "that, in all the circumstances, the termination should" have been performed.

Finding a second doctor to agree would not be difficult, especially given that **there is no requirement that the second doctor be independent of the first.**

Abortion of the viable unborn child at any time up to birth: the Victorian experience

Under Victoria's "reformed" abortion law, from 2009 to 2017 there have been 3103 abortions performed at 20 weeks or later.

In **more than 10% of cases late term abortion resulted in the delivery of a live born baby**. In Victoria from 2009 to 2017 some 332 babies were **born alive after a late term abortion** and **simply left to die**.[12]

[12] Data derived from *Victoria's Mothers, Babies and Children*, 2009-2017, an annual report produced by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, https://www.bettersafercare.vic.gov.au/about-us/about-scv/councils/ccopmm/reports#goto-victorias-mothers,-babies-and-children-reports

Abortion of the viable unborn child at any time up to birth: New developments in viability

In November 2017 the journal *Pediatrics* published a case report on "*a female infant resuscitated after delivery at 21 weeks' 4 days' gestation and 410 g birth weight*" possibly the most premature known survivor to date.[13]

According to the case report this little baby girl "had multiple risk factors for adverse outcome, including prolonged mechanical ventilation, bronchopulmonary dysplasia, and threshold retinopathy of prematurity." However, she "achieved discharge from the hospital on low-flow oxygen at 39 weeks' 4 days' gestation and 2519g." By "24 months' and 8 days' chronological age, she achieved cognitive, motor, and language Bayley III scores of 90, 89, and 88, equivalent to 105, 100, and 103 at 20 months 2 days corrected age."

The authors conclude "It is known that active intervention policies at 22 weeks' gestation improves the outcome for those infants and it may be reasonable to infer that these benefits would extend, if to a lesser degree, into the 21st week. Ultimately, such limited data exist at this gestational age that **the time may have arrived for obstetrical centers to begin systematically reporting fetal outcomes in the 21st week**."

A 2015 study in the New England Journal of Medicine found that with active treatment babies born prematurely at 22 weeks have close to a one in four chance of survival, mostly without any severe impairment. This increases to a one in three chance of survival at 23 weeks; a nearly six out of ten chance at 24 weeks; a nearly three out of four chance at 25 weeks and over four out of five chance at 26 weeks.[14]

The decreasing age of viability is relevant insofar as Clause 6 would permit the abortion of an unborn child who could be delivered alive and still survive.

It is difficult to see any rational basis for a doctor to perform a deadly assault on a viable unborn child while continuing to treat as murder any deadly assault on a child of the same gestational age who has already been delivered alive.

Clause 6 would permit the abortion of any child from 22 weeks through to full term –ending the life of a child who could potentially be safely delivered, and if given appropriate medical care, survive and flourish.

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[13] KA Ahmad, "Two-Year Neurodevelopmental Outcome of an Infant Born at 21 Weeks' 4 Days' Gestation', *Pediatrics*, Nov 2017, http://pediatrics.aappublications.org/content/early/2017/10/31/peds.2017-0103

[14] M.A. Rysavy et al., "Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants", *NEJM: New England Journal of Medicine*, 2015;372:1801-11, Table 2, p. 1807, https://pdfs.semanticscholar.org/d525/b327ed2f9019fd9ac6b56664413119917499.pdf

The current New South Wales Ministry of Health policy directive requires that where there is a likelihood that treatment will be of benefit, there is an obligation to render life-saving medical treatment to a child born alive as a result of an attempted abortion. [15]

If the Bill is passed it should be amended to include a specific requirement that any child born alive after an attempted abortion is given the same life-saving medical treatment as would be given to any other child born alive at that stage of gestation.

Recommendation 3:

If not opposed as per Recommendation 1, Clause 6 of the Bill, which would authorise the abortion of unborn children who would be viable outside the womb, event for a short time, should be opposed.

Recommendation 4:

If not opposed as per Recommendation 1, or if Clause 6 is not opposed as per Recommendation 3, the Bill ought to be amended to explicitly require that any child born alive after an attempted abortion is given the same life-saving medical treatment as would be given to any other child born alive at that stage of gestation.

Clause 6 – Abortion of the viable unborn child at any time up to birth: Abortion of a child capable of feeling pain

Recent scientific findings have established the developing capacity of the unborn child to feel pain well before birth and certainly by 22 weeks of pregnancy.

> *(1) Pain receptors (nociceptors) are present throughout the unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks after fertilization.*
>
> *(2) By 8 weeks after fertilization, the unborn child reacts to touch.* ***After 20 weeks, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling.***
>
> *(3) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.*
>
> *(4) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life.*

[15] NSW Ministry of Health, *Pregnancy - Framework for Terminations in New South Wales Public Health Organisations*, 2 July 2014, https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_022.pdf

(5) For the purposes of surgery on unborn children, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli are applied without such anesthesia.

(6) The position, asserted by some physicians, that the unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and analysis provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

(7) The position, asserted by some commentators, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from engaging in vigorous movement in reaction to invasive surgery.[16]

Consequently, there is **substantial medical evidence that an unborn child is capable of experiencing pain** at least by 22 weeks of pregnancy.

Recommendation 5:

If not opposed as per Recommendation 1, Clause 6 of the Bill, which would authorise the abortion of unborn children capable of feeling pain, should be opposed.

Clause 9 – Conscripting all health practitioners for unlimited abortion

Clause 9 would require a health practitioner with a conscientious objection to abortion to "give information to" a woman requesting an abortion "on how to locate or contact a medical practitioner who, in the first practitioner's reasonable belief, does not have a conscientious objection to the performance of the termination" or to transfer the woman's care to such a medical practitioner or a health care provider believed to have such a practitioner.

This provision is **neither necessary nor reasonable**.

It is not necessary because no referral is needed for an abortion and any woman who is told by a health practitioner that he or she has a conscientious objection to performing an abortion can very readily seek another practitioner by simply searching 'abortion clinics New South Wales' on any internet browser.

[16] *Pain-Capable Unborn Child Protection Act 2017 (US),* https://www.congress.gov/115/bills/hr36/BILLS-115hr36rfs.pdf

It is unreasonable to expect a health practitioner who has a conscientious objection to abortion **to choose which abortionist or abortion facility to direct a woman to** for the purpose of obtaining an abortion. Normally a health practitioner refers a patient in order for the patient to obtain specialist professional care to improve the patient's health.

In the case of abortion, a health practitioner with a conscientious objection to abortion is likely to genuinely believe that he or she has two patients to which a duty of care is owed - the pregnant woman or girl and her unborn child. The only outcome of abortion for the second patient – the unborn child – is death. And, assuming the health practitioner is familiar with the medical literature on abortion and its adverse impacts on women's mental health and on maternal mortality, the outcome for the woman may also be poor, or even deadly.

Why should the law impose a duty on a health practitioner to refer his two patients to a health practitioner who would bring about an outcome detrimental to the life and health of those patients?

Recommendation 6:

If not opposed as per Recommendation 1, Clause 9 should be replaced by a provision simply affirming that any registered health practitioner may refuse to perform a termination, assist in the performance of a termination or otherwise facilitate the performance of a termination if the health practitioner has a conscientious or professional objection to the performance of the termination.

Clauses 14 and 15 –Abortions for sex selection: opposed but facilitated rather than prohibited

The current legal test for abortion in New South Wales, if rightly applied, could not fairly be said to legally justify an abortion performed solely for the purpose of sex selection whether pursuant to a cultural preference for sons over daughters or, a likely less prevalent desire for so-called "family balancing". A female child in the womb cannot reasonably be concluded to pose a serious danger to a woman's physical or mental health simply by being female rather than male.

However**, if this Bill is passed as it stands, abortions for sex selection could then be lawfully performed in New South Wales** – as they are in Victoria under its *Abortion Law Reform Act 2008*.

As discussed above Clause 5 of the Bill would allow an unfettered right to abort an unborn child up to 22 weeks of pregnancy for any reason whatsoever. By definition this includes aborting an unborn girl child simply because she is a girl.

Clause 6 of the Bill is so broad in its terms that, while requiring various matters to be considered, could still allow an abortion to be performed after 22 weeks and up to full term solely due to the unborn child being a girl rather than a culturally preferred boy.

These provisions would in no way be limited or hampered by Clauses 14 and 15 of the Bill.

Clause 14 of the Bill would require the Secretary of the Ministry of Health to conduct a review into whether abortions are being performed for the purposes of gender selection notwithstanding **we have had solid evidence that gender selection abortions are occurring** throughout Australia – and in New South Wales specifically - since the SBS radio investigation reported in May 2015 on research conducted by four prestigious demographers using customised data from the Australian Bureau of Statistics.

The findings of this 2015 SBS investigation were further confirmed for Victoria by researchers at La Trobe University[17] who found that under Victoria's "reformed" abortion law, in the five year period from 2011 to 2015, there were on average 37 girls each year missing from Indian-born mothers and 24 girls each year missing from Chinese-born mothers due to sex selection abortions.

On 30 May 2015 SBS journalist Pallavi Jain presented a SBS radio investigation into skewed birth ratios evident in Australian Bureau of Statistics date for babies born to Indian and Chinese parents between 2003 and 2013.[18]

Four demographers were consulted by SBS: Dr. Christophe Guilmoto, Demographer at the French Research Institute for Development; Dr. Nick Parr, Macquarie University's Associate Professor in Demography; Dr. Gour Dasvarma, Flinders University's Associate Professor in Population Studies; and Dr. Peter McDonald, Professor of Demography, Crawford School of Public Policy, College of Asia-Pacific, ANU.

These demographers concurred that the figures show the number of boys born compared to girls is unnaturally high for some overseas born parents in Australia: 109.5 boys for every 100 girls for Chinese-born Australians and 108.2 boys for every 100 girls for Indian-born Australians compared to the ratio for all Australian births of 105.7 males for every 100 females.

[17] Kristina Edvardsson et al, "Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999–2015" *International Journal of Epidemiology*, https://pdfs.semanticscholar.org/c17e/c473b213a61e62076f8cf687f0720c0e094c.pdf

[18] https://www.sbs.com.au/radio/fragment/new-abs-data-suggests-gender-selection-happening-australia

Dr. Christophe Guilmoto stated that “Australia registered 1,395 missing female births during 2003-2013 among Chinese and Indian communities in Australia”.[19]

Dr Nick Parr said that "There has to be some form of pre-natal sex selection taking place. In my opinion the most plausible explanation is that there is sex-selective abortion occurring.”

Dr Christophe Guilmoto agreed that sex-selective abortions seem to be occurring in Australia. “I think there is no other explanation. Once we have run statistical test on this data and they show that the gap between the sex ratio at birth among these two communities and the rest of the population is not random, then we know there is something. There are very few ways to influence the sex of your child so the most common is to resort to sex selective abortion”.[20]

The customised table of births provided by ABS to SBS for this investigation includes a breakdown by States. This data shows that in New South Wales just for children born to parents both of whom were born in China there is a skewed birth ration of 108.3 boys for every 100 girls and consequently 279 girls missing in New South Wales in that community alone from 2003 to 2013, an average of more than 25 missing girls each year.[21]

Clause 15 of the Bill would note that “this House opposes terminations for the sole purpose of gender selection”. This clause was inserted into the Bill by an unopposed amendment in the Legislative Assembly.

Presumably this opposition to abortion for the sole purpose of sex selection is shared without exception by the members of the Committee and of the Legislative Council as a whole.

If so the Committee ought to recommend that abortion solely for the purpose of sex selection should be unlawful.

Recommendation 7:

If not opposed as per Recommendation 1, the Bill should be amended to provide that an abortion performed solely for the purpose of sex selection is unlawful.

[19] https://www.sbs.com.au/radio/storystream/news-its-girl-still-unwelcome-some-cultures-australia
[20] https://www.sbs.com.au/news/could-gender-selective-abortions-be-happening-in-australia
[21] https://www.sbs.com.au/radio/fragment/new-abs-data-suggests-gender-selection-happening-australia

Abortions for suspected or confirmed congenital abnormality are eugenic and discriminatory

Clauses 5 and 6o f the Bill taken together would permit abortion for eugenic reasons right up to full term in contravention of the rights of persons with disabilities to be treated with equal respect both before and after birth.

The United Nations Committee on the Rights of Persons with Disabilities has stated that:

> *Laws which allow for abortion on grounds of impairment violate the Convention on the Rights of Persons with Disabilities (Art,. 4,5,8). Even if the condition is considered fatal, there is still a decision made on the basis of impairment. Often it cannot be said if an impairment is fatal. Experience shows that assessments on impairment conditions are often false. Even if it is not false, the assessment perpetuates notions of stereotyping disability as incompatible with a good life*."[22]

Attempts to deny the eugenic nature of laws permitting abortion for disability are without any plausible foundation. **We will never treat people with disability with the equal respect which is their due if we were to endorse this law which allows for them to be excluded from a chance at life after birth** – even if that may be a very short life.

Under Victoria's "reformed" abortion law, from 2009 to 2017 there have been 3103 abortions performed at 20 weeks or later. Of these 1686 abortions were performed on children with a confirmed *or suspected* "congenital abnormality", that is eugenic abortions based on a fear of raising child with a disability, a fear often based on inaccurate and discriminatory information about disability.[23] Given **a known false-positive rate** in the second and third trimester diagnosis of disability of around 8.8% this means perhaps **150 perfectly healthy babies were aborted** in this period **out of a mistaken fear that they had a disability**.

Is this what we want for New South Wales?

In the case of a prenatal diagnosis of an untreatable condition that is likely to lead to the death of the child before, at or shortly after birth, perinatal hospice, sometimes called **hospice in the womb, provides affirmation and support to parents in the face of devastating grief and loss.** [24]

[22] http://www.ohchr.org/Documents/HRBodies/CCPR/GCArticle6/CRPD.docx

[23] Data derived from *Victoria's Mothers, Babies and Children*, 2009-2017, an annual report produced by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, https://www.bettersafercare.vic.gov.au/about-us/about-scv/councils/ccopmm/reports#goto-victorias-mothers,-babies-and-children-reports

[24] Palliative Care Australia, Paediatric Addendum, Dec 2018, https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/12/PalliativeCare-Paediatricaddendum-2018_web.pdf ;

Recommendation 8:

If not opposed as per Recommendation 1, the Bill should be amended to provide that an abortion performed due to suspected or confirmed congenital abnormality in the unborn child is unlawful.

Coerced abortion

Right to Life NSW does not believe that women should be criminally responsible for an abortion performed on them by a medical practitioner (or any other person).

Studies show that up to 64% of pregnant women feel pressured by others to have an abortion[25].

Those coercing women to undergo an abortion include abusive partners, scandalised parents and pimps of trafficked women.

The Bill should be amended to make it an offence to coerce, or attempt to coerce, a woman to undergo an abortion.

Recommendation 9:

If not opposed as per Recommendation 1, the Bill should be amended to provide for an offence of coercing, or attempting to coerce, a woman to undergo an abortion.

Conclusion

Right to Life NSW unashamedly opposes abortion because:

- In every case it is intended to cause the death of one of us – an unborn human child;
- Strong evidence points to the real harms to women and girls from abortion.

The Bill creates a complete immunity for any doctor to perform any abortion regardless of how viable the unborn child is, it fails to prevent coerced abortions, abortions for sex selection to eliminate the girl child or abortions for eugenic reasons which are clearly discriminatory towards children with suspected or confirmed disability.

[25] Rue. V.M. et al., "Induced abortion and traumatic stress", *Medical Science Monitor*, 2004, Volume 10, Number 10, Special Report, at: https://pdfs.semanticscholar.org/cb7a/f9bd586cb8e7f8614dd7b429c4d3ea640c8e.pdf, p. SR9