AUSTRALIAN FEDERATION OF ISLAMIC COUNCILS

Abortion Legislation – Proposal for reform in Western Australia

A SUBMISSION TO THE GOVERNMENT OF WESTERN AUSTRALIA

DEPARTMENT OF HEALTH

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1. Introduction

On 18 November 2022 the Western Australian Government issued a Discussion Paper[1] entitled "Abortion Legislation – Proposal for reform in Western Australia". This paper outlined a series of legislative reforms being considered by the Government relating to the regulation of Abortions in Western Australia. These reforms are purported to be necessary to bring the legislation in line with other jurisdictions and to provide better pathways to healthcare for women who seek abortions in the State.

The proposed reforms relate to the following specific areas:

1. Decriminalisation of Abortion
2. The requirements for counselling in obtaining consent
3. The requirements for consultation with multiple medical practitioners
4. The regime relating to Conscientious Objection
5. The regulations applicable to 'Late' term abortions
6. The approval of medical facilities for 'Late' term abortions

AFIC responds to each of these proposes in this Submission. Prior to proceeding to the substantive part of this Submission, however, we wish to address a threshold issue. AFIC notes that the Introduction to the Discussion Paper states:

> *"The Department of Health is aware many people hold strong views on this subject. It is not part of this consultation to consider if abortion should be precluded or prevented. Abortion is legally available in WA. Rather, this Discussion Paper focuses on the legislation that could be in place around these medical procedures."*[2]

While we respect this position and do not intend to make submissions on the threshold issue, we do not believe that some of the proposed reforms can be properly considered in the absence of understanding the context of the position in relation to abortions generally, particularly those relating to 'Late' term abortions and the involvement of medical practitioners. To that end we wish to put on the record some key points that we respectfully submit are relevant from the Islamic faith position and which we will refer to in the substantive submission.

[1] https://consultation.health.wa.gov.au/pahd-ocho-alr/abortion-laws/user_uploads/abortion-legisation----proposal-for-reform-in-western-australia---november-2022-1.pdf
[2] Ibid. p.6

2. The Islamic Position Regarding Abortions

All human life is sacred in Islam and the taking of any life, even that of an unborn foetus, is prohibited. The different rulings come about from how it is determined that a foetus is no longer just a growing organism inside the womb but has become a separate sentient being. In Islam there are 2 parts to this – firstly, the general position is that Allah, Most High, places the eternal soul into the foetus at the 120th day and that is why abortion is generally prohibited after this day.

In the first 40 days the foetus is still not fully formed in terms of the body as a whole and is considered to not be an independent being from its mother and so abortion is generally allowed in this time.

Between 40-120 days is when the foetus becomes fully formed and is clearly identifiable as a human being even though it has no soul yet. But it could be ensouled if Allah, Most High, chose. That is why abortion is only permitted during this time if there is a genuine and pressing need.

In summary, therefore, the period of pregnancy is generally divided into 3 stages when considering abortion from an Islamic perspective.

- First 40 days – it is generally accepted that during the first 40 days a foetus may be aborted with agreement of both parents.
- Between 40-120 days – there is a difference of opinion within the religion, but the majority view is that abortion is permitted where there is a pressing need such as it was a result of rape or there are signs of a major deformity that is not compatible with life.
- After 120 days – the unanimous position in the religion is that abortion is not permitted.

The only exception to all the above is where the continued pregnancy is a danger to the mother's life. Where that is the case then abortion is permitted no matter how far along it is, even beyond the 120 days.

There is general agreement on the position during the first 40 days and beyond the 120 days. There are differences of opinion on the period in between. Some scholars take the view that abortion during this time is the same as after the 120-day mark, but the majority take the view described above.

Given that the 20-week period referred to in the Discussion Paper is already beyond the 120 days mark any consideration of how Abortions are regulated beyond this becomes of vital importance to Muslims as in reality from about the 17-18 week mark (approximately 120 days) abortions for any reason, other than posing a danger to the health of the mother, would be completely impermissible.

3. Decriminalisation

We note that the decriminalisation of Abortion is a process that is already underway with the 1998 reforms that removed abortion as a crime if certain requirements are met. With those requirements being adequately covered in the health laws and regulations the continued presence of these in the Criminal Code seems to add little utility.

It is our submission that there should always be a regulatory framework to govern abortions whether those provisions reside within a criminal code or a suite of health laws and regulations. This is based on the position within Islam that aborting a pregnancy is not an unfettered right but subject to various criteria depending on the gestation period and the reasons for the termination. Accordingly, there will always remain the risk of unauthorised abortions occurring outside of those parameters and this needs to be regulated.

Recommendation

On the basis that the overall legislative regime adequately identifies the circumstances of what would be deemed an unauthorised abortion, with the appropriate penalties for such actions, AFIC supports the proposed reforms to remove abortion from the Criminal Code.

4. Informed Consent, Mandatory Counselling & two Medical Practitioners

The Discussion Paper treats an abortion like any other medical procedure and as such concludes with a recommendation that obtaining consent, and the requirement for counselling prior or as part of that process, should not be treated any differently to the general requirements for obtaining consent for medical procedures. While that is a truism at the cursory level this ignores the circumstances of an abortion specifically that it involves another human, or potentially human, life. Regardless of what position one takes in relation to when an unborn foetus takes on the status of a human life worthy of its own protections and rights there is no denying the significant impact an abortion can take on the mental health of a woman.

In a 2018 Literature Review, *"The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities"*[3], the author notes:

"Collectively, they [the studies of the mental health impacts of abortion] *reveal the following:*

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207970/

(a) There are no findings of mental health benefits associated with abortion. (These would be signified by the entire 95% confidence line being below 1.0.)
(b) The association between abortion and higher rates of anxiety, depression, substance use, traumatic symptoms, sleep disorders, and other negative outcomes is statistically significant in most analyses.
(c) The minority of analyses that do not show statistically significant higher rates of negative outcomes do not contradict those that do. (Shown by the upper bound of the 95% confidence overlapping the lower 95% CI of the statistically significant studies.)"

To further highlight the traumatic nature of this procedure the author in the above study goes on to note the following:

"Similarly, Julius Fogel, who as both a psychiatrist and OB-GYN and as a pioneer of abortion rights performed tens of thousands of abortion, testified that while abortion may be necessary and generally beneficial, it always exacts a psychological price:

Every woman—whatever her age, background or sexuality—has a trauma at destroying a pregnancy. A level of humanness is touched. This is a part of her own life. When she destroys a pregnancy, she is destroying herself. There is no way it can be innocuous. One is dealing with the life force. It is totally beside the point whether or not you think a life is there. You cannot deny that something is being created and that this creation is physically happening …

Often the trauma may sink into the unconscious and never surface in the woman's lifetime. But it is not as harmless and casual an event as many in the pro-abortion crowd insist. A psychological price is paid. It may be alienation; it may be a pushing away from human warmth, perhaps a hardening of the maternal instinct. Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist."

A 2011 study published in the British Journal of Psychology noted the following:[4]

"Results
***Women who had undergone an abortion experienced an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion**. The strongest subgroup estimates of increased risk occurred when abortion was compared with term pregnancy and when the outcomes pertained to substance use and suicidal behaviour.*

Conclusions
*This review offers the largest quantitative estimate of mental health risks associated with abortion available in the world literature. Calling into question the conclusions from traditional reviews, **the results revealed a moderate to highly increased risk of mental health problems after abortion. Consistent with the tenets of evidence-based medicine, this information should inform the delivery of abortion services**."*

[4] https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/abortion-and-mental-health-quantitative-synthesis-and-analysis-of-research-published-19952009/E8D556AAE1C1D2F0F8B060B28BEE6C3D

It is important to note at this point that we are not considering the impact on mental health of abortions being available or not but of the actual procedure itself. We respectfully submit that the mental health considerations of abortion are not the same as other medical procedures and as such need to be considered in a different way. Even proponents of the view that abortion *does not* lead to any identifiable increase in mental health issues concede that the procedure itself still involves experiencing levels of "grief, regret, sadness..."[5]

It is this added level of potential trauma that distinguishes abortions from other procedures and which we believe warrants a level of consideration over and above what is the general requirement for informed consent. Accordingly, AFIC respectfully submits that the proposed reform in the Discussion Paper be rejected.

The requirement for two medical practitioners to be involved in this process is linked to the general proposal relating to consent outlined above and specifically relates to the need for a second medical practitioner, not involved in the treatment of the woman, to also obtain consent. The Discussion Paper notes that:

> *"This legal requirement has several disadvantages such as:*
>
> • *The requirement for additional consultations may delay the abortion. Delays to accessing medical intervention can increase the risk of complications and recovery time for the patient.*
>
> • *The requirement can be a barrier for some people, particularly those living in rural and remote areas with fewer medical practitioners.*
>
> • *Seeing multiple practitioners can result in extra cost for the patient."*

While we do not discount the concerns raised above, we do not feel that they are so insurmountable as to overcome the potential adverse impacts of the procedure if it is undertaken without the appropriate level of counselling and discussion that has been highlighted in this section.

These are problems of logistics and costs which are well within the scope of government to address. Issues of availability and accessibility of health services are general and apply across many areas and can be addressed through the reprioritisation of health resources if these issues are genuine barriers.

[5] https://www.sydney.edu.au/news-opinion/news/2018/05/02/no-evidence-of-serious-mental-health-issues-for-women-after-abor.html

Recommendation:

There be no change. Retain the existing provisions requiring mandatory counselling in order to obtain informed consent for abortion, as per the Act.

There be no change: Retain the existing provisions requiring two medical practitioners to be involved before a woman can have an abortion.

5. Conscientious Objection

Given the moral and ethical considerations relating to abortions and their potential to have a direct and significant impact on medical practitioners who hold contrary personal views the ability to refuse to perform such a procedure based on conscientious objection is vital and needs to be accommodated.

The concept of conscientious objection is neither new nor novel and applies in other areas of medical practice. As the Discussion Paper itself notes:

> *The Australian Medical Association Code of Ethics[4] states, in section 2.1.3:*
>
> *"If you refuse to provide or participate in some form of diagnosis or treatment based on a conscientious objection, inform the patient so that they may seek care elsewhere. Do not use your conscientious objection to impede patients' access to medical treatments including in an emergency situation."*

We note that the above makes no reference to the practitioner referring the patient to another practitioner who is willing to perform the procedure. For many individuals who would oppose performing such a procedure themselves, the act of referring to another practitioner, would be enabling something they are morally opposed to and may be considered no different to performing the procedure themselves.

The requirement to refer appears to be linked to ensuring the impacted patient has access to information on available practitioners in a timely and effective manner. We would submit that this is better responded to in ways other than requiring practitioners to make these referrals themselves. This could be done through:

- Public Hospitals where the information can be made available generally and does not require any individual to do so.
- Telephone support services through the Department of Health where individuals can obtain the information more readily having regard to problems with general access to medical practitioners.
- Online or web-based information where patients can access directories of available practitioners without the need to 'shop' around as it were.

All the above would provide quicker and more current information on which medical practitioners are willing to perform these procedures.

Recommendation:

Retain current provision allowing a person, hospital, health institution or other institution to conscientiously object to providing abortion care, without any requirement to refer the patient to a practitioner who is willing and able to provide abortion care.

6. Late Abortions

We respectfully do not accept that the Discussion Paper provides any substantially cogent reason for changes in relation to late term abortions. The paper itself notes that these are an extremely small number of all abortions, accounting for only 0.9% of abortions carried out in 2021 in Western Australia.

This leads to the question, what challenge precisely is the proposal seeking to address?

The Discussion Paper goes on to note:

> *"Increasing the gestational age at which additional requirements apply would:*
>
> - *enable more time for the woman and their family to consider options and choices during a highly emotive and distressing period in their lives, before additional approval and other requirements need to be met.*
> - *align the WA legislation with other Australian jurisdictions; and*
> - *provide women with certainty that care can be accessed in WA and reduce the necessity to travel interstate"*

We will address the above points in reverse order.

Firstly, the need to travel interstate would only arise in circumstances where a late term abortion was not available in Western Australia. We note that the discussion paper highlights several times that the overwhelming majority of late term abortions are 'unwanted' abortions that relate to 'significant foetal abnormality'. These procedures are already available in the State. So, what precisely is there uncertainty about?

If diagnostic testing reveals significant foetal abnormality post the current 20-week gestational period mandated then access to an abortion is available, subject to a medical panel approval, in Western Australia. There is no need for a woman to travel interstate for this unless she is either seeking a late term abortion in circumstances where there is no diagnosis of foetal abnormality or where the medical panel does not believe the evidence finds the abnormality, whatever it may be, as warranting the termination of the pregnancy – which by this stage is a human life capable of independent existence based on most medical research.

In neither of the above cases, we submit would the reforms be justifiable.

Secondly, the proposition that this reform would bring the legislation into alignment with other jurisdictions. This should never be a substantive reason to reform legislation of an issue which has moral and ethical considerations – just because other jurisdictions have made certain moral choices is not a reason for all to follow suit. But more importantly the proposal would not in fact achieve such an outcome any way. Nationally, we note that the gestation period for late term abortions varies from 16 weeks (Tas) right through to 24 weeks (Vic & NT). So, it is not correct to assert that the proposal will align the Western Australian legislation at all.

The only reasonable conclusion, we believe, that can be drawn from the proposed reforms, and the positions put forward, is that an ethical preference has been made to allow women to abort pregnancies up to the 24-week mark without the need to base this on the requirements currently in place for late term abortions. A position that we would completely oppose and one which gives context to the first point asserted in the discussion paper as being sought to be redressed.

To "*enable more time for the woman and their family to consider options and choices during a highly emotive and distressing period in their lives, before additional approval and other requirements need to be met"* is only relevant in cases that would not otherwise be approved for late term abortions. If there is a diagnosis of foetal abnormality at any time after the current 20 weeks, then this is not an issue. The woman, and family, will have the time to consider all the information available and the options open to them because there is no upper time limit on accessing the late term abortion.

However, where there is no diagnostic evidence of such an abnormality then the 20-week mark does signify a watershed time which may put the woman under pressure to decide as to whether she wants to keep the pregnancy or not. This brings us to the position we began this submission with.

We fundamentally believe that once a foetus reaches the 120-day gestation mark that it has now been ensouled and is a human being with all the rights that any human being attains. The termination of such a life should not be done except in the most extreme of circumstances. The 120-day period equates to 17-18 weeks gestation – a timeframe that is already exceeded by the 20-week gestation period currently in place. Not only is there no justifiable reason for extending this to any period beyond the current we submit that the gestation period for what would be considered a 'Late Term' abortion be reduced to 18 weeks.

We have outlined above and at the beginning of this submission the Islamic position in relation to the ensoulment of a foetus and it is incumbent upon us to maintain that once this has occurred (18 weeks) then the foetus should not be aborted except in the extreme circumstances outlined above. Given that there is a process in place to allow late term abortions, we submit that the negative impact of such a change would be minimal. If diagnostic testing post 18 weeks still identified significant foetal abnormalities or a risk to the health of the mother, then approval for a late-term abortion can be sought as it currently is. We note that 18 weeks would still be within the range of 16-24 weeks currently legislated across the various jurisdictions in Australia.

The positive impact of such a change would be to honour the sanctity of a human life.

Recommendation:

Change the gestational period for late-term abortions to 18 weeks and retain the current requirements for approval of late-term abortions.

7. Requirement for Medical Panel Approval

The proposal here is to remove the requirement for later term abortions to be approved by a medical panel and instead replace it with the treating medical practitioner plus one other forming a view that it is appropriate. For all the same reasons outlined in Section 6 above, we do not support such a change.

The only abortions that take place after the 18-week gestation mark should be ones in extreme circumstances and the reasons for the proposed reforms do not, in our view, justify such action. The only substantive justification provided is that no other jurisdiction has a similar requirement. This is not a valid reason to change the laws.

Recommendation:

No change. Retain the requirement for members of a Ministerial Panel to approve abortions beyond the gestational age limit (i.e., late abortions).

8. Ministerial Approval for Facilities performing Late Abortions

Given the stated circumstances that exist to justify late term abortions it is imperative that facilities that undertake these have the appropriate level of expertise and care. With due respect, while the discussion paper notes that there are currently only 2 facilities in WA that have been approved to perform this procedure there is no detail concerning why this is the case.

Why has the Minister only approved 2 facilities? If other facilities have the requisite level of expertise and health care, why haven't they been approved?

Again. it appears that rather than deal with the underlying issue of what is preventing the appropriate level of access to health care services it is proposed to simply remove the regulatory requirement. The resolution to this issue is a simple one – where a facility has the right level of expertise then the Minister should have no reason not to approve it. Where it doesn't then it should not be performing these procedures.

Recommendation:

No change. Retain the requirement for Ministerial approval for a health service to be able to perform abortions

9. Conclusion

After careful consideration of the material in the Discussion Paper and the proposed reforms outlined therein:

- AFIC supports the first proposed reform to treat abortion as a health issue and as such to deal with unauthorised abortions under the health legislation rather than the criminal code.

- AFIC does not support any of the remaining reform proposals. The justification provided for the proposals does not support the changes and would change the balance between the rights of the woman and the rights of the unborn child that is found in the current legislative regime beyond what is appropriate or morally acceptable.

- AFIC submits that the gestational period for the classification of late-term abortions should be reduced to 18 weeks from the current 20 weeks. Such a change is consistent with other jurisdictions, the Islamic position on the ensoulment of the foetus and still allows for late-term terminations under the existing criteria.

Yours faithfully

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president