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Abortion Law Reform
Law Commission
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Kia ora koutou

Thank you for the opportunity to make a submission to the Law Commission review of abortion law. We understand that the Commission has been tasked with exploring options for treating abortion as a health issue in legislation. Family Planning is well-placed to offer comment. Family Planning is the largest provider of sexual and reproductive health services in New Zealand, an abortion provider in Tauranga since 2013, and the single-largest abortion referral agency in the country.

Introduction

Family Planning supports the Government's intention to treat abortion as a health issue in legislation. Abortion legislation under the Crimes Act 1961 and the Contraception, Sterilisation and Abortion Act 1977 is no longer fit for purpose from both a health care and human rights perspective. Women's[1] lives and status in society have changed since the 1970s. There is now broad international recognition that the ability to decide if and when to have a child is integral to gender equality and human rights. There have been significant changes in the way health care is delivered over the past four decades, including new methods and approaches to abortion provision. There is no evidence that a change in legal status would increase abortion rates; this has not happened in other countries and states where laws have been updated. A modern legal framework which treats abortion as a health issue will allow services to be focused on the health needs of women and provision to be aligned with best practice standards.

[1] Family Planning acknowledges that people who identify as women and transgender have abortions.

Family Planning supports the following approach to abortion:

- Abortion should be removed from the Crimes Act. There should not be statutory grounds for abortion.

- Abortion should be provided with a woman's informed consent. There should not be a certification process. Abortion should be a health care issue between a woman and a qualified health practitioner.

- As a health issue, abortion should be overseen, regulated and funded through the Ministry of Health. Oversight, funding and administration of abortion provision should no longer be the responsibility of the Ministry of Justice.

- Abortion services should be safe, accessible and meet the needs of communities. Abortion should be regulated in a way which allows health practitioners to follow international best practice in abortion care.

- Abortions should be provided by suitably qualified health professionals. Regulations, professional standards and guidelines - and disciplinary processes – are already in place for overseeing how health professionals practice.

- For abortions at a late gestational age, there should be consideration for all the relevant medical circumstances, as well as the woman's current and future physical, psychological and social circumstances.

- If new legislation maintains that a health practitioner can object to providing abortion services and information because of moral beliefs, there must be a requirement that the health practitioner make a direct referral to a provider who can help.

- Law should not require abortions to be provided in hospitals or specially licensed facilities. Most abortions can be provided through community health care clinics, and medical abortion pills can be safely taken at home once women have been provided the information and support they need.

- A statutory requirement for mandatory counselling for abortion should not be introduced, and counselling should remain optional. Free pre and post-abortion counselling services should be accessible and available as an option to all women considering abortion.

- No other statutory requirements that restrict and delay access to abortion services (eg. waiting periods or parental notification) should be introduced through new legislation.

Abortion as a health issue

Today abortion is recognised globally by professional health bodies, organisations and communities as an important reproductive health issue for women.

> *"Over the past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly"*. – World Health Organization[2]

Decriminalising abortion and removing the statutory grounds for lawful abortion in New Zealand will reflect this shift in thinking and recognise abortion as a legitimate reproductive health issue for women.

The current statutory grounds for lawful abortion, and the certification process in place to comply with the grounds, impact the abortion care that women receive. The certification process is a significant cause of unnecessary delays for women seeking an abortion. These delays can result in abortions being performed at a later gestational age, which is contrary to best practice standards and can also cause considerable stress to women.

For example:

- Only 57% of abortions are done before 10 weeks gestation in New Zealand compared to 81%[3] in the United Kingdom; 73% of abortions occur before 9 weeks in Western Australia.[4]
- In the United States, two-thirds (66%) of abortions occur at 8 weeks of pregnancy or earlier[5], as compared to New Zealand where only 19% of abortions in 2016 occurred under 8 weeks gestation.[6]

> *"Abortion is safer the sooner it is done. Services should be able to meet the local demand for abortion so that women can have their abortion at the earliest possible gestation and as close to home as possible"* – The Royal [UK] College of Obstetricians and Gynaecologists

Delays affect women in a disproportionate manner and limit equity, access and choice for abortion care. Women who have to travel long distances to providers, women with few

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2 WHO World Health Organisation (2012) *Safe abortion: technical and policy guidance for health systems*: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1

3 file:///C:/Users/amyb/Downloads/AbortionStatisticsYeDec16HOTP%20(1).pdf

4 http://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports%20and%20publications/Abortion/PDF/Abortion_Report_2010-12.pdf

5 Guttmacher Institute (2018) *Induced Abortion in the United States*. Retrieved from: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

6 Abortion Supervisory Committee (2018) Annual Report 2017.

resources and women who experience other barriers to health care are impacted more significantly. For example, for women who must travel long distances, access to transportation can be a barrier where they do not have a car and/or someone to drive them to and from the abortion service for multiple visits. Women in rural communities who must travel to a main centre for an abortion are sometimes removed from their support networks. Where there are delays, a woman may miss an opportunity to use early medical abortion, which is generally only an option up to 9 weeks gestation. Allowing abortion to be provided by a qualified health practitioner, with a woman's informed consent, will support more timely and equitable access to abortion services.

As a health issue, abortion should be regulated, funded and overseen by the Ministry of Health, like other health services. While Family Planning acknowledges the significant effort and contribution of the Abortion Supervisory Committee (ASC), we believe that under the Ministry of Health, abortion can be better integrated into comprehensive sexual and reproductive health services.

There is no evidence globally that treating abortion as a health issue will result in an increase in the number of abortions in New Zealand. There is significant evidence that the legal status of abortion in a country does not correlate with the abortion rate.[7] For example, Victoria decriminalised abortion in 2008 but has not experienced an increase in the abortion rate. Despite many countries modernising their abortion laws over the past few decades, abortion rates have declined significantly in developed countries over this time period. In developing countries, there has not been a significant change in abortion rates.

> *"Since 2000, 28 countries changed their abortion law—all but one expanding legal grounds to allow abortions to protect a woman's health, for socioeconomic reasons or without restriction as to reason."*[8]

Modernised laws, as well as increased availability of medical abortion has contributed to more safe abortions and a lower global maternal mortality rate.[9]

Where abortion is provided

International evidence shows that most early gestation medical and surgical abortions can be safely provided in community clinics and medical offices. While Family Planning acknowledges that there are different medical requirements for abortion at later gestations (e.g. post 14 weeks), for most abortions, there is no need for specialised facilities. There is no

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7 Singh S et al. (2018) Abortion Worldwide 2017: Uneven Progress and Unequal Access, New York: Guttmacher Institute. https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf
8 Ibid.
9 Ibid.

reason for a more stringent licensing process for facilities performing abortions than for facilities performing other comparable procedures.

Abortion is common and safe. For example, abortion is considered significantly safer than childbirth.[10] Documents published by the WHO[11], The Royal College of Obstetricians and Gynaecologists[12] and the National Academies of Science, Engineering and Medicine[13] in the United States all state that abortions can be carried out in community/primary care clinics.

> *"As the equipment and space required for a safe abortion service are similar to those needed for routine women's healthcare and family planning services, efforts should be made to provide safe abortion services in a wide range of health facilities and in an integrated manner."* - The Royal College of Obstetricians and Gynaecologists

Early medical abortion does not need to be performed in a health facility. Early medical abortion is considered most effective with the use of two pills – mifepristone and misoprostol. It has been clearly established that women can safely take the second medication at home. In fact, it is preferable that they take the second medication when they are ready, so they can manage bleeding and cramping when they are in a suitable location.

> *"Indeed, most women in the United States return home after taking mifepristone and take the misoprostol 28 to 48 hours later."* - The National Academies of Sciences, Engineering, and Medicine

If abortion could be integrated into sexual and reproductive health services without special licensing requirements, there would be potential for Family Planning to further develop abortion services to meet the needs of communities.

Who provides abortions

Evidence shows that a range of health practitioners can provide surgical and medical abortions. This is supported by international guidelines. For example, some guidelines have

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10 Raymond, E.G., and Grimes, DA (2012) The Comparative Safety of Legal Induced Abortion and Childbirth in the United States. *Obstetrics & Gynecology*: February Volume 119 - Issue 2 - p 215–219. https://journals.lww.com/greenjournal/fulltext/2012/02000/The_Comparative_Safety_of_Legal_Induced_Abortion.3.aspx

11 WHO World Health Organisation (2012) Safe abortion: technical and policy guidance for health systems: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1

12 Royal College of Obstetricians and Gynaecologists: Best Practice in Comprehensive Abortion Care (2015) https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf

13 The National Academies of Sciences, Engineering, and Medicine - The Safety and Quality of Abortion Care in the United States (2018) https://www.nap.edu/read/24950/chapter/1 Or: http://nationalacademies.org/hmd/reports/2018/the-safety-and-quality-of-abortion-care-in-the-united-states.aspx

indicated that the skills needed for IUD insertion mirror those needed for surgical abortion.[14] A broader range of health practitioners, across jurisdictions, are safely providing early medical abortions.

In New Zealand, registration authorities such as the Medical, Nursing and Midwifery Councils adequately regulate and monitor the practice of health practitioners. Health practitioners are required to practice within their scope and there are good professional processes in place to ensure competent, professional practice. This system is as applicable to abortion provision as it is for any other medical procedure or medicine prescribing.

It is essential that health practitioners are specifically trained to provide both surgical and medical abortion. PHARMAC's introduction of funded HIV prophylaxis known as PrEP includes a statement that health practitioners prescribing this medication have been specifically trained.[15]. A similar expectation could be associated with the prescription of medications used for abortion.

Counselling

Under current New Zealand law, there is no statutory requirement for mandatory counselling when having an abortion. Family Planning believes it is important that mandatory counselling not be introduced in new legislation.

There is significant misinformation about women's need for counselling when making a decision around abortion. Likely because of the stigma and moral considerations surrounding abortion, some people believe abortion is a traumatic experience for women, and they need to be counselled to manage emotions and decision-making. While this can be true for some women, the majority of women do not request, want or need counselling.

Family Planning offers counselling to all women having an abortion at our Tauranga clinic. Very few have taken up this option. A proportion of women already have a counsellor and these women take advantage of the opportunity of discussing their current situation with that person.

Counselling - both before and after an abortion - should be available to women, at no cost, but should not be mandatory.

Research has established that the mental health of women prior to an abortion is the greatest predictor of the mental health of a woman following an abortion. The rates of

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[14] WHO World Health Organisation (2012) Safe abortion: technical and policy guidance for health systems: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1

[15] https://www.pharmac.govt.nz/medicines/my-medicine-has-changed/prep-for-hiv/

mental health problems for a woman with an unwanted pregnancy are the same whether she has an abortion or gives birth.[16]

While there is limited research on abortion decision-making, several international studies have concluded that women are generally as sure or more sure of their abortion decisions as compared to other health decisions.[17'18]

Other restrictions including abortion for young people

There have been attempts in other jurisdictions to introduce restrictions to abortion such as through mandatory waiting periods, compulsory ultrasounds or parental notification. These legal restrictions are not based on medical best practice. They cause delays in accessing services and contribute to health inequity. Family Planning believes restrictions to abortion should not be introduced in a new law.

There have been previous attempts in New Zealand to restrict abortion access for young people by requiring parental notifcation of a pregnancy. In 2004, there was an amendment proposed to require parental notification for abortion under the Care of Children Act 2004. The amendment failed. The Care of Children Act 2004 (section 38) expressly provides females, regardless of age, the right to consent to an abortion or to refuse an abortion. We are not aware that this right has been abused or has caused harm since it was enacted.

The Hillary Kieft Petition was the most recent attempt to restrict access to abortion for young people. The Justice and Electoral Committee considered the issue and reported in 2016.[19] After robust Parliamentary review and process, the petition did not progress. The Hillary Kieft report states:

> *"The evidence presented by the relevant organisations overwhelmingly demonstrated that, although it is best practice for a young person to tell her parents that she is pregnant, this should not be mandatory. Young people should be encouraged and supported to tell their family, but in some*

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16 National Collaborating Centre for Mental Health (2011*) Induced Abortion and Mental Health: A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors*. December.

17 Ralph, LJ. et al (2017) Measuring decisional certainty among women seeking abortion. Contraception. March 2017. Volume 95, Issue 3, Pages 269–278. http://www.contraceptionjournal.org/article/S0010-7824(16)30410-3/abstract

18Goenee, M.S. (2014) Decision-making concerning unwanted pregnancy in general practice. *Family Practice* Vol 00, No 00, 1-7.

19 Petition 2014/11 of Hillary Kieft and 6 others Report of the Justice and Electoral Committee. https://www.parliament.nz/resource/en-NZ/51DBSCH_SCR69571_1/ee578f2ba3c744ab5a21d4d5196b68a26c5e542d

situations this would put them at risk of harm." – Justice and Electoral Committee

Where a young person is under 16 years of age, the Health and Disability Commission states: *"the general view, then, is that a child may consent themselves if and when the child achieves sufficient understanding and maturity to understand fully what is proposed*."[20]

As evidenced in the review of the Hillary Kieft petition, medical associations in New Zealand oppose laws that mandate young people to notify parents before accessing sexual and reproductive health care services, acknowledging that in the majority of cases, it would not improve, or could be a risk to, the health and well-being of the young person.[21]

Late abortion

Family Planning acknowledges that late abortions are a difficult and complex issue for women, their families and health practitioners. Family Planning does not provide late abortion. We are supportive of our colleagues who do this challenging and important work. Late abortion can be a divisive issue among the public.

Late abortions are rare. In New Zealand less than 1% (76 in total in the 2016 calendar year) of abortions are performed after 20 weeks. Women seek a late abortion because of a significant problem with the pregnancy or difficult life circumstances. While morally more challenging for many people, it is especially important for abortion to be accessible to women in these highly complex circumstances.

In New Zealand the law recognises life beginning at birth. Family Planning believes that late abortion should be managed in a way that allows health professionals to consider all the relevant medical circumstances, and the woman's current and future physical, psychological and social circumstances in determining whether a late abortion is appropriate.

This could be achieved through legislation - as it is in many jurisdictions including Victoria in Australia, the United States states and many European countries -where there are gestational limits for abortion included in law. In Victoria, women can have an abortion upon request up to 24 weeks. In Sweden it is up to 18 weeks, and in Washington State in the United States it is legal until foetal viability, which is generally accepted by the State to be about 26 weeks. In these jurisdictions, after the gestational limit, abortion is legal only in certain circumstances.

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[20] Health and Disability Commissioner (2014). Fact Sheet 3: The Age of Consent and Informed Consent for Children. Retrieved from: http://www.hdc.org.nz/media/266086/fact%20sheet%203%20–%20the%20age%20of%20consent%20and%20informed%20consent%20for%20children.pdf.

[21] This includes the the New Zealand Medical Association and the Royal New Zealand College of General Practitioners. International organisations including the World Health Organization, the American Academy of Pediatrics, and the American Medical Association also oppose parental notification.

In Canada, while there are no laws around abortion at all - including gestational limits - medical guidelines, and health care policies and practices still impose limits to when women can have an abortion. "Although access to abortion is not limited by law, hospitals and clinics may establish their own policies and practices that limit when they will provide abortion services. Most abortions are performed within the first 12 weeks of pregnancy. In some cases, physicians may perform abortions up to the 20th week, but rarely beyond 20 weeks unless the woman's health is at risk."[22]

Conscientious objection

Both the Health Practitioners Competence Assurance Act 2003[23] and the Contraception, Sterilisation and Abortion Act 1977[24] contain sections which allow health practitioners to object to providing abortion services and contraception.

The Contraception, Sterilisation and Abortion Act states that: "If, after considering the case, the woman's own doctor considers that it may be one to which any of paragraphs (a) to (d) of subsection (1), or (as the case may require) subsection (3), of section 187A of the Crimes Act 1961 applies, he shall comply with whichever of the following provisions is applicable, namely: (a) where he does not propose to perform the abortion himself, he shall refer the case to another medical practitioner..." Medical practitioners with a conscientous objection may interpret this section of the law to mean that if they personally do not believe that any of the grounds apply, they do not have to refer.

The New Zealand Medical Council was taken to court in 2011 over new guidelines which would have required doctors opposed to abortion and contraception to refer a patient to another doctor who could help. In his decision, Justice Alan MacKenzie said the obligation to refer would have "exceeded doctors' statutory obligations."[25]

Current Medical Council guidelines state:

> *"Your personal beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell*

22 http://www.legalline.ca/legal-answers/abortion-access-and-rights/
23 Health Practitioners Competence Assurance Act 2003. Section 174. http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM205007.html?search=sw_096be8ed8166e49d_objection_25_se&p=1&sr=2
24 Contraception, Sterilisation and Abortion Act 1977. Section 46. http://www.legislation.govt.nz/act/public/1977/0112/latest/DLM18538.html
25 New Zealand Herald (2011) NZ anti-abortion doctors case dropped. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10767558

them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right."

Ideally, all health practitioners caring for women of reproductive age would be able to provide abortion services or information about abortion. It is a common procedure, with about 1 out of 4 women having an abortion in her lifetime. Where providers object to providing abortion services or information, Family Planning believes it must be a requirement that they actively refer women to a provider who can help them. Based on the 2011 court decision, the law would have to change to allow for a referral requirement.

Conclusion

Family Planning acknowledges that a modern legal framework is only one step, albeit a vital one, toward improving access to abortion services. Treating abortion as a health issue in legislation will provide an enabling environment for key conditions to be met: embedding national guidelines and best practice standards for abortion care; training and maintaining competence of health practitioners; and allocating adequate funding for abortion provision so it meets community need. Abortion is a legitimate health care and human rights issue for women, and this status should be reflected in our legal and regulatory frameworks.

We are happy to discuss any of the issues raised in this submission.
Thank for your work on abortion law reform.

Ngā mihi nui

Jackie Edmond
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