National Office
Level 7
203 - 209 Willis Street
PO Box 11-515
WELLINGTON 6142

T: (04) 384 4349
F: (04) 382 8356
familyplanning.org.nz

Charities # CC11104

13 September 2019

Committee Secretariat
Abortion Legislation Committee
Parliament Buildings
Wellington

Tēnā koe

Thank you for the opportunity to make a submission on the Abortion Legislation Bill. In our view, the passage of this legislation would be an historic change for the women of New Zealand, and one which is long overdue. Family Planning is the largest provider of sexual and reproductive health services in the country, an abortion provider in Tauranga since 2013, and the largest abortion referral agency in the country.

Introduction

We remind the Committee of the robust and wide-ranging review undertaken by the Law Commission in 2018. We believe the review provides a foundation of evidence for the Committee as the Abortion Legislation Bill is considered. The Commission has already consulted with the public extensively and through its work has reviewed a number of the issues that were raised as concerns during the first reading of the Bill. Family Planning made a submission to the Law Commission during its consultation, and we include our submission as an appendix, Appendix A.

Family Planning urges the Committee to give sufficient weight to the views and expertise of health professionals providing sexual and reproductive health services. We acknowledge that

people have different values and beliefs around whether abortion is morally acceptable. However, abortions happen now, and this law will not change that reality. Law change will enable abortion to be provided based on medical best practice and will support more equitable access to abortion. In nearly every other area of health care delivery, we trust health professionals to deliver care based on professional guidelines that are evidence-based because they have the knowledge and expertise to do so. Abortion should be no different.

This Bill is also about giving women dignity. New Zealand prides itself on being a society of inclusiveness and tolerance. We know that one out of four women in New Zealand will have an abortion.[1] We should ensure women seeking abortion are treated with respect and compassion, not judged harshly. Most New Zealanders (67.5%) support abortion being legal regardless of the reason, which shows respect for pregnant people's ability to make the decision for themselves based on their own life circumstances and values.[2]

Overall Family Planning strongly supports the Government's intention to treat abortion as a health issue in legislation. In this submission, we comment on specific aspects of the Bill, and address issues raised as concerns during the first reading of the legislation. Family Planning, alongside other health experts, agree that the Law Commission's model A, where a women and her health practitioner make the decision about the pregnancy, is the most appropriate framework for the provision of abortion services. However, Family Planning is pleased that the proposed Bill will remove abortion from the Crimes Act and allow 99% of women seeking an abortion to make their own decision in consultation with a health provider, which aligns with international best practice.[3]

[1] Law Commission (2018) *Alternative Approaches to Abortion Law: Ministerial Briefing Paper*. Retrieved from: https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf, pg 31.
[2] New Zealand Attitudes and Values Study 2017/2018 data. https://www.psych.auckland.ac.nz/en/about/our-research/research-groups/new-zealand-attitudes-and-values-study.html
[3] 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

In summary, Family Planning:

- supports removing abortion from the Crimes Act and treating abortion as a health issue in legislation
- supports removing any statutory test on the health practitioner for a person who is not more than 20 weeks pregnant
- supports the requirement that the Minister of Health must ensure that counselling services are available for women seeking abortion who want counselling
- supports women being able to self-refer to an abortion provider
- supports the provision to prohibit protestors from interfering, intimidating or obstructing a person accessing or providing abortion services and allowing services to request that a safe zone is established around a premises
- supports the Ministry of Health overseeing the collection and analysis of abortion statistics, noting that privacy of individuals must be paramount
- supports the requirement that health practitioners who conscientiously object to reproductive health care services must ensure that their patients have contact information for another health practitioner or, in the case of abortion, can access a list of providers offering the services
- supports an approach where employers must accommodate conscientious objection unless it would unreasonably disrupt the employer's activities
- does not support a statutory test for abortion for a pregnancy over 20 weeks
- **recommends** making the Bill inclusive by removing the definition of woman and using the words people or a person who is pregnant throughout the Bill, noting in the explanatory note that the majority of people who have abortions are women
- **recommends** removing the redundant definition of a qualified health practitioner
- **recommends** considering whether a Ministry of Health list of abortion providers is the most effective and practical approach

A. Strengths of the proposed legislation

Removing abortion from the Crimes Act

1. Personal, cultural and religious beliefs about abortion should not dominate discussions or determine the shape of the legislation. People from all cultures, communities and religious groups have abortions. It is important to maintain the focus of the legislation on abortion as a health issue. The debate should be about how a modern legal framework can promote equitable access to quality abortion services. The 13,000 plus who seek abortion each year deserve legislation that enables them to get the best quality health care. Maintaining the current legal framework will not allow that to happen.

2. 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.[4] The World Health Organisation writes: "the legal status of abortion has no effect on a woman's need for an abortion, but it dramatically affects her access to safe abortion."[5]

3. Today abortion is recognised globally by professional health bodies, organisations and communities as an important reproductive health issue for women – as well as a human rights and privacy issue.[6] Most developed countries already allow abortion for any reason or on broad social grounds.[7,8] "…[B]roadly liberal laws are found in nearly all countries in Europe and Northern America, as well as in several countries in Asia."[9] New Zealand is not taking a new or radical approach to this issue through the proposed Bill. New Zealand has actually been completely out of step on this issue and is one of the few developed countries where abortion is still in criminal law. Where countries have liberalised abortion laws during the past few decades, overwhelmingly they have expanded grounds to access abortion or removed grounds altogether. Countries that have recently liberalised abortion laws include Ireland[10], Iceland[11] and Queensland, Australia[12]. There is no evidence from countries that have liberalised laws, or countries where abortion is allowed for any reason, that there is harm caused by this legal approach.

---

[4] 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
[5] 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
[6] Privacy Commissioner (2018) Submission to the Law Commission review of abortion laws.
[7] The World's Abortion Laws, Center For Reproductive Rights, https:// reproductiverights.org/worldabortionlaws
[8] 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
[9] Singh S et al. (2018)
[10] https://www.theguardian.com/world/live/2018/may/26/irish-abortion-referendum-result-count-begins-live
[11] https://www.icelandreview.com/news/abortion-bill-passed-in-icelandic-parliament/
[12] https://www.theguardian.com/australia-news/2018/oct/17/queensland-parliament-votes-to-legalise-abortion

Removing a statutory test for abortions under 20 weeks

4. We strongly support the Bill's proposal to remove any statutory test on the health practitioner for a woman who is not more than 20 weeks pregnant. There is no evidence to suggest that there is a need for, or any benefit from, a statutory test for abortion, but ample evidence that statutory tests both stigmatise and delay access to abortion.

5. 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, compared to other countries, recent research shows abortions are performed later during a pregnancy in New Zealand. For example, only 43% of abortions are performed before 9 weeks in New Zealand[13] compared to 84% in Sweden and 83% in Iceland.[14]

   > *"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[15]"* – The Royal [UK] College of Obstetricians and Gynaecologists

6. 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 resources and women who experience other barriers to health care are impacted more significantly. 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.

   "In the majority of countries, medication abortion accounts for at least half of all abortions, with the highest proportions found in the Nordic countries of Finland (97%), Sweden

[13] Statistics New Zealand (2019) *Abortion statistics: Year ended December 2018*. Retrieved from: https://www.stats.govt.nz/information-releases/abortion-statistics-year-ended-december-2018
[14] Popinchalk A, Sedgh G. (2019) *Trends in the method and gestational age of abortion in high-income Countries.* BMJ Sexual and Reproductive Health. 45:95–103. Retrieved from: https://srh.bmj.com/content/familyplanning/45/2/95.full.pdf
[15] 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

(93%) and Norway (88%)."[16] In New Zealand, medication abortions account for only about 21% of all abortions[17].

7. Allowing abortion to be provided by a qualified health practitioner, with a woman's informed consent, based on best practice guidelines, will support more timely and equitable access to abortion services.

Counselling

8. Family Planning supports the requirement that the Minister of Health must ensure that counselling services are available for women seeking abortion who want counselling. However, we recommend that the Bill should read that the Minister of Health must ensure that "timely access" to counselling services is available throughout New Zealand. Counselling services must not only be available, but access must be equitable and timely. Abortions are safest when performed as early as possible. If a woman wants counselling before making a decision about abortion, it could significantly impact access to abortion services if she needs to wait several weeks for an appointment. Additionally, counsellors must meet standards for abortion counsellors such as those outlined in the *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand*.[18]

9. Leading mental health organisations[19] agree that abortion is not the cause of mental health problems. A woman's mental health before an abortion is the strongest predictor of her mental health following an abortion. Years after, most women (90%) agree that their abortion was the right decision.[20] Each woman experiences abortion differently, with some women struggling with the decision and feeling shame and stigma, and others feeling great relief. It is essential that counselling is offered to women who need and want it, but it should not be mandatory.

10. We do ask the Committee to consider whether there is any other area of health care where a health practitioner has a legal requirement to discuss a particular aspect of care, as any such requirement would nearly always be addressed through clinical standards and protocols, guided by the process of informed consent and discussions between a health practitioner and a patient.

---

[16] Popinchalk A, Sedgh G. (2019) *Trends in the method and gestational age of abortion in high-income Countries.* BMJ Sexual and Reproductive Health. 45:95–103. Retrieved from: https://srh.bmj.com/content/familyplanning/45/2/95.full.pdf

[17] Abortion Supervisory Committee (2018) *Annual Report.*

[18] Ministry of Justice (2018) *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* https://www.justice.govt.nz/tribunals/abortion-supervisory-committee/standards-of-care/

[19] Such as the Academy of Medical Royal Colleges, American Psychological Association, the Psychological Society of Ireland.

[20] Fergusson, D.M, Horwood, LJ and Boden, J.M. (2009) Reactions to abortion and subsequent mental health. *The British Journal of Psychiatry.* 195, 420–426.

Self-referral

11. Family Planning strongly supports women being able to self-refer to an abortion provider. This will reduce delays for women seeking abortion services and will also help reduce some of the stigma and shame that women may experience when seeking abortion care. Under the system where women need a referral, women have an extra step to take before they can access an abortion provider. There is a chance that they will encounter a health practitioner who conscientiously objects to abortion, which results in delays as they seek an alternative referrer, and also shame and stigma associated with being judged. It will be important that women know where to find information about abortion and abortion providers, however, it seems overly prescriptive to address this issue in legislation.

Protest activity and safe zones

12. Family Planning supports the provision to prohibit protestors from interfering, intimidating or obstructing a person accessing or providing abortion services. We also support services being able to request that a safe zone is established around a premises. We feel that this is a reasonable approach given that many abortion providers do not currently experience problematic protest activity while others do[21]. The approach is flexible enough to manage any increases in protest activity in future.

Duties of the Director General

13. Family Planning supports the Ministry of Health overseeing the collection and analysis of abortion statistics. This is currently a function of the Abortion Supervisory Committee. Abortion is one of the few areas of sexual and reproductive health where there is comprehensive annual national data about service provision. The privacy of individuals is paramount when managing this data. Information about abortion service provision should not be included in any database where data could be linked to an individual. Abortion data should continue to be shared publicly, alongside other annually reported health statistics, and should inform service provision.

Conscientious Objection

14. Ideally, all health practitioners caring for women of reproductive age would be able to provide reproductive health services and information including contraception and abortion. However, we acknowledge that some health practitioners object to providing these services because of their personal beliefs. Current law supports this position and

[21] Law Commission (2018) *Alternative Approaches to Abortion Law: Ministerial Briefing Paper*. Retrieved from: https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf

does not require health practitioners to provide any information except to tell a patient that they can get these services elsewhere.

15. Family Planning supports the more balanced approach in the proposed Bill. We support the requirement that health practitioners who conscientiously object to reproductive health care services must ensure that their patients have contact information for another health practitioner or, in the case of abortion, can access a list of providers offering the services. Typically this issue would be addressed through professional standards, rather than in legislation.[22] However, a 2011 legal decision[23] against the Medical Council found that current legislation does not allow for a professional standard which requires doctors to refer patients to another service. Therefore, it is necessary to have professional responsibilities clarified in law when there is conscientious objection in order to avoid future uncertainty and further cases going to court.

16. Family Planning questions why conscientious objection is defined only in relation to contraception, sterilisation and abortion? While we understand that the definition is written in the context of this Act, a broader definition would still make clear what conscientious objection means in the context of reproductive health service provision. The Law Commission defines conscientious objection as: "a health practitioner's refusal to provide, or be involved in, a lawful treatment or procedure on the basis that it goes against their conscience or beliefs."[24]

17. It is worth considering whether the issue of conscientious objection could be addressed solely in the HPCA Act – and applied to all health services – rather than also being addressed narrowly in the Contraception, Sterilisation and Abortion Act. The current approach singles out reproductive health care, including contraception and abortion, as somehow more ethically challenging or contentious than other health care and may encourage some people to refuse to provide contraception and/or abortion services. This issue was raised by health practitioners and professional bodies during the Law Commission consultation.[25]

Employers providing certain services

18. Family Planning appreciates the intent of the legislation to balance the interests of employees with the activities and interests of the employer. Family Planning supports the

---

[22] Medical Council (2016) Good Medical Practice. Retrieved from: https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf
[23] New Zealand Herald (2011) NZ anti-abortion doctors case dropped. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10767558
[24] Ibid, pg 155.
[25] Law Commission (2018) Alternative Approaches to Abortion Law: Ministerial Briefing Paper. Retrieved from: https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf, pg 161.

right of individuals to hold beliefs about reproductive health care. However, if accommodating these beliefs would unreasonably disrupt an employer's ability to conduct business – including providing reproductive health care - it is unreasonable that an employer should be required to accommodate them. This approach appears to be consistent with the approach taken in the Human Rights Act 1993.[26] We note that organisations will need to clarify their expectations of employees, and their ability to accommodate objections.

B) Concerns about the proposed legislation

Statutory test for abortions over 20 weeks gestation

19. For a woman who is more than 20 weeks pregnant, the Bill requires the heath practitioner to reasonably believe the abortion is appropriate with regard to the pregnant woman's physical and mental health, and well-being.

20. Treating abortions up to 20 weeks gestation and after 20 weeks gestation differently in the law is not based on health reasons. Twenty weeks gestation is an arbitrary point during a pregnancy, not tied to any medical or physiological point which would require abortion to be treated differently at this stage.[27]

21. Family Planning has been clear, along with a number of other health providers and professional bodies that the Law Commission consulted with, that we support the Law Commission's model A, where there are no statutory tests for abortion, and abortions are provided based on the needs of the person and their families, professional clinical standards and informed consent. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) writes: "No specific clinical circumstance should qualify or not qualify a woman for termination of pregnancy. The impact of any particular condition is highly individual and often complex. No list can be complete and becomes highly restrictive in the most complex of circumstances."[28]

22. Only health practitioners who are highly trained are able to provide this service, as it requires more advanced training and skills as well as a suitable health facility. There are always complicated circumstances surrounding abortions later in pregnancy, which doctors must consider.

---

[26] Employment New Zealand. Reasonable accommodation (measures). Retrieved from: https://www.employment.govt.nz/workplace-policies/employment-for-disabled-people/reasonable-accommodation-measures/

[27] Submission to the Law Commission by Professor Peter Stone, Professor Maternal Fetal Medicine The University of Auckland

[28] RANZCOG (2018) Submission to the Law Commission

> *"As noted above in respect of Model B, the risks or complexities of a specific medical procedure are not usually addressed through legislation. Instead, matters such as the risks to the patient and supporting patients to make difficult decisions are typically managed through standards of care and the law that applies to health procedures generally."*
>
> - Law Commission, pg. 92

23. Late gestation abortions are rare. Abortions post 20 weeks comprise less than 1% of all abortions[29]. The Law Commission found that abortions following 20 weeks gestation only take place because of serious risks to the baby or mother.

24. During first reading, several MPs expressed a desire to look more closely at the issue of late gestation abortions and some said that the public must be reassured that these abortions are adequately regulated. We agree that the Committee should review this issue closely by speaking to the people who currently provide this health service to women. These medical providers are the experts and can provide factual information about the circumstances under which these abortions are provided. Unfortunately, the conversations about late gestation abortion are often based on misinformation and scare tactics, including the incorrect assertion that under the proposed Bill, abortion will happen up to birth.

25. If a statutory test for abortions over 20 weeks does remain in the final version of the legislation, Family Planning supports the proposed grounds in the Bill – physical health, mental health and wellbeing – given that there are a range of reasons and circumstances which grounds would need to encompass.

Definition of woman

26. The Bill defines woman as a person of any age who is capable of becoming pregnant. This definition is problematic given that some people who are capable of becoming pregnant do not identify as a woman. The definition, therefore, excludes people who are gender diverse or transgender. It would be preferable to refer to people or a person who is pregnant, throughout the Bill, while still noting in the explanatory note that the majority of people who have abortions are women.

Definition of health practitioner and qualified health practitioner

27. The proposed definition of a qualified health practitioner is redundant. Every health practitioner is required by law to act in accordance with the Health Practitioners Competence Assurance (HPCA) Act. A health practitioner is defined in the HPCA Act as

[29] Abortion Supervisory Committee (2018) *Annual Report*

someone who is registered with an authority as a practitioner. A person would not be registered as a health practitioner unless they are suitably qualified to act in the capacity of a health practitioner. Furthermore, all health practitioners are required to work within their scope of practice. This applies to all health practitioners working in any aspect of health care, and therefore applies to abortion as well. As with any health service provision, regulatory authorities will need to determine what training and qualifications are needed to work within a scope of practice. The Ministry of Health writes[30]:

> *The HPCA Act also specifies registered health practitioners registered with a particular authority must not perform activities that fall outside the* ***scope of practice*** *for which they are registered.*

Additionally, there are professional codes of conduct and ethics which guide health practitioner practice.

There is no reason for the Bill to specifically state that only a qualified health practitioner can provide abortions. Only qualified health practitioners can legally provide any health service.

MOH list of abortion providers

28. The law states the Ministry of Health will make and maintain a list of abortion providers in New Zealand. While it would be useful for people to have an easily accessible list of providers, we question how this would work in practice, particularly how the list will be kept up to date? For example, if a general practitioner becomes trained to provide abortion services, how will the Ministry of Health be made aware and who is responsible for providing the information to the Ministry of Health? Would this be an issue better addressed in regulation or would it be best to address the issue like any other health service where services are advertised by the provider and referrals managed by health practitioners?

C) <u>Common misconceptions about law change</u>

Sex selection

29. During the first reading of the Bill, some Members of Parliament questioned whether people would use abortions for sex selection if there are no legal grounds for accessing legal abortion. The Law Commission has reviewed this issue in some detail and found no evidence of sex selection in New Zealand. The Commission also found that there would be limited mechanisms for addressing the issue in law as "many health practitioners explained

[30] Retrieved from: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act

that in practice they would never be faced with the issue because it was highly unlikely a woman would disclose she was seeking an abortion because of the sex of the fetus."[31] There is no evidence to suggest that removing statutory grounds for abortion would result in people using abortion for sex selection any more than would currently be the case. The World Health Organisation, in a statement with other agencies including UNICEF and UNFPA, argues that States have a responsibility to prevent sex selection, but also have an obligation to address the issue without denying women access to needed services such as safe abortion and further violating their rights.[32]

Foetal impairment

30. There has been some comment about abortions and foetal impairment, with some people concerned that law change would result in increased numbers of abortions of foetuses that would be born with a disability. Making a decision about a wanted pregnancy following a prenatal diagnosis of an impairment is highly complex and personal.[33] People should be supported by health practitioners to make the decision that is best for them and their family, based on their own circumstances and beliefs. We should ensure that the legal framework for abortion enables women and families faced with these decisions to be treated with compassion.

> *"The decision-making process for women and their partners after the diagnosis of fetal abnormality is a difficult one. They must try to absorb the medical information they have been given, while in a state of emotional shock and distress, and work out a way forward that they can best live with."*[34]

31. Legal criteria are blunt and ineffective instruments to manage these complexities and also remove the right of women and families to make the decision that is best for them. Health practitioners are best placed to support women and their families through this decision making process.

---

[31] Law Commission (2018) *Alternative Approaches to Abortion Law: Ministerial Briefing Paper*. Retrieved from: https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/Law%20Commission%20-%20ALR%20Ministerial%20Briefing%20Paper%20-%20FINAL.pdf pg 178-179.

[32] WHO, '*Preventing gender-biased sex selection: An interagency statement OHCHR, UNFPA, UNICEF, UN Women and WHO*' (2011). Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/44577/9789241501460_eng.pdf;jsessionid=65F227F2BBE1C752514B43C401C7FC38?sequence=1

[33] Antenatal Results and Choices (UK) retrieved from: https://www.arc-uk.org/for-parents/ending-a-pregnancy/parents-story

[34] Royal College of Obstetricians and Gynaecologists (2010*) Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales*. Retrieved from: https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf

D) Implementation

32. A new legal framework for abortion is an essential first step toward improving access to abortion services and enabling best practice care. The second necessary step relates to implementation of a new law. Family Planning understands that the Ministry of Health is already preparing for potential law change. If there is law change, it will be important for the Ministry to consult widely on how abortion services are provided, with the recognition that abortion service provision can be, and should be, offered through primary care. Currently DHBs, overseen by the Abortion Supervisory Committee, determine where and by whom abortion services are provided, however, evidence shows that early gestation abortion services can be delivered effectively through primary care. Engaging primary care in the provision of abortion, so services can be provided locally, will support more equitable access to abortion and will align with best practice standards.

Summary

33. Family Planning supports treating abortion as a health issue in legislation. A legal framework based on a health approach to abortion will provide an enabling environment for more equitable and timely access to abortion services in New Zealand. A new law for abortion will not change the number of women who seek abortion, but will allow health practitioners to provide evidence-based care. It will allow pregnant people to provide informed consent for abortion, in consultation with their health practitioner, aligning abortion law and practice in New Zealand with modern understanding of bodily autonomy, privacy and human rights.

We would like to make an oral submission to the Committee to discuss the issues raised in this submission. Thank for your work on abortion law reform.

Ngā mihi nui

Chief Executive
Jackie Edmond

Appendix A: Family Planning Submission to the Law Commission

11 May 2018

Abortion Law Reform
Law Commission
PO Box 2590
Wellington 6140
DX SP 23534

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[35] 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.

[35] 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[36]

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%[37] in the United Kingdom; 73% of abortions occur before 9 weeks in Western Australia.[38]
- In the United States, two-thirds (66%) of abortions occur at 8 weeks of pregnancy or earlier[39], as compared to New Zealand where only 19% of abortions in 2016 occurred under 8 weeks gestation.[40]

> *"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 resources and women who experience other barriers to health care are impacted more

---

[36] 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
[37] file:///C:/Users/amyb/Downloads/AbortionStatisticsYeDec16HOTP%20(1).pdf
[38] http://ww2.health.wa.gov.au/~/media/Files/Corporate/Reports%20and%20publications/Abortion/PDF/Abortion_Report_2010-12.pdf
[39] Guttmacher Institute (2018) *Induced Abortion in the United States*. Retrieved from: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states
[40] Abortion Supervisory Committee (2018) Annual Report 2017.

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.[41] 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."*[42]

Modernised laws, as well as increased availability of medical abortion has contributed to more safe abortions and a lower global maternal mortality rate.[43]

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

---

[41] 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
[42] Ibid.
[43] Ibid.

Abortion is common and safe. For example, abortion is considered significantly safer than childbirth.[44] Documents published by the WHO[45], The Royal College of Obstetricians and Gynaecologists[46] and the National Academies of Science, Engineering and Medicine[47] 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 indicated that the skills needed for IUD insertion mirror those needed for surgical abortion.[48]

---

[44] 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

[45] 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

[46] 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

[47] 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

[48] 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

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.[49]. 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 mental health

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

problems for a woman with an unwanted pregnancy are the same whether she has an abortion or gives birth.[50]

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.[51,52]

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

---

[50] 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.
[51] 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
[52]Goenee, M.S. (2014) Decision-making concerning unwanted pregnancy in general practice. *Family Practice* Vol 00, No 00, 1-7.
[53] 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

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*."[54]

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.[55]

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. 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

[54] 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.

[55] 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.

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."[56]

Conscientious objection

Both the Health Practitioners Competence Assurance Act 2003[57] and the Contraception, Sterilisation and Abortion Act 1977[58] 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."[59]

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 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

---

[56] http://www.legalline.ca/legal-answers/abortion-access-and-rights/
[57] 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
[58] Contraception, Sterilisation and Abortion Act 1977. Section 46. http://www.legislation.govt.nz/act/public/1977/0112/latest/DLM18538.html
[59] New Zealand Herald (2011) NZ anti-abortion doctors case dropped. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10767558

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
Chief Executive