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The fragility of de facto abortion on demand in New Zealand Aotearoa

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Abstract
On the whole, women in New Zealand have good access to safe and affordable means to terminate unwanted pregnancies. Although seemingly ideal, the current situation is a fragile one. Under current legislation, abortion is criminalised and legal access to it relies on gaining the approval of two certifying consultant physicians. In this report, we provide an historical overview of the social and political influences shaping New Zealand's current approach to abortion, considering the consequences of having abortion governed by criminal law. The situation in New Zealand is used to support a proposal that a pragmatic liberal feminist approach to abortion is best for women where it is a medical matter rather than a legal or moral one.

Keywords
abortion, New Zealand, feminist, human rights, discourse, pro choice

A complex array of legal, moral and medical positions shape views on abortion. In this paper, we propose that a pragmatic liberal feminist approach is best. Treating unwanted pregnancies practically, as a medical rather than a legal or moral matter, promotes women's sexual and reproductive health. A liberal attitude endorses women's basic human right to act autonomously. We support our proposal with reference to the situation regarding abortion in New Zealand.

In the middle of the 19th century, New Zealand had one of the highest rates of mortality from abortion in the world (Sparrow, 2014). In contrast to that dismal past, the current situation is a dramatic improvement where no woman need risk

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her life to terminate an unwanted pregnancy. Paradoxically, however, abortion is criminalised. The inconsistency between abortion legislation and its practice is problematic. Not least of all is the problem that New Zealand's criminalised abortion laws make the current good access to abortion vulnerable to change for the worse for women. We highlight the very real and immediate threat that exists to women's current good access to abortion in New Zealand.

From a liberal feminist perspective, New Zealand abortion legislation is fundamentally flawed. It breaches women's basic human rights, and the procedures required to access abortion effectively pathologise women. While positive changes can be achieved within the current system, we suggest that the best way forward is to treat abortion as a medical issue and not a moral or legal one. Robust public health services must underpin a decriminalised legal framework to support safe and timely access to abortion. Our work strongly supports feminist campaigns to decriminalise abortion.

New Zealand abortion laws

Access to abortion in Aotearoa New Zealand is governed by criminal law. The key pieces of legislation are: (i) The Crimes Act 1961 and its amendments, which provide the legal grounds for abortion; (ii) the Contraception, Sterilisation and Abortion Act 1977, covering procedure and administration. Two other statutes are also relevant: the Health Practitioners Competence Assurance Act 2003, allowing for conscientious objection by healthcare professionals; and the Care of Children Act 2004, protecting the privacy and access to abortion of girls under 16. The penalty for providing illegal abortions is a prison term of up to 14 years.

The Crimes Act allows abortion when: (i) the risk "that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl"; (ii) "that there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped";[1] (iii) that the pregnancy is the result of incest or sex with a guardian; and finally (iv) that "the woman or girl is severely subnormal". After 20 weeks' pregnancy, the only ground is "to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health". It is noteworthy that rape, extremes of age and socio-economic factors are not grounds for a legal abortion in New Zealand.

Under the Contraception, Sterilisation and Abortion Act, a woman who seeks an abortion in New Zealand must gain the approval of two certifying consultant physicians. Without such an approval, a woman cannot have a legal abortion. To become certifying consultants, physicians must be approved by the statutory, government appointed, Abortion Supervisory Committee. That committee is also responsible for overseeing the work of the certified consultants.

Fortunately, the certified physicians appointed by the Abortion Supervisory Committee are overwhelmingly supportive of what women want. Around 99% of abortions requested are authorised (Right to Life New Zealand Inc. v The Abortion Supervisory Committee, 2008). The statistic shows the situation in

New Zealand to be de facto abortion on demand because women's requests are almost always granted.

Statistics also show around 98% of abortion requests are granted under the mental health ground provision in the Crimes Act – a proportion that has remained steady over recent decades (Abortion Supervisory Committee, 2014). To avoid being criminalised for terminating a pregnancy, women are instead pathologised. They are cast as needing abortion because of their psychological vulnerability. Leask (2013) provides a detailed genealogical analysis of abortion discourses in New Zealand that position women as bad and mad. The following historical overview provides a necessarily brief description of the social forces shaping current abortion access.

Historical overview

New Zealand's current approach to abortion can be traced back to the 19th century when the restrictive laws of England and associated societal views were adopted. Eugenic thinking and pronatalist values were pervasive at the time. The long-term success of British colonisation of New Zealand was considered threatened by the superior fertility of Māori (Smyth, 2000). A colonial woman's primary role and responsibility was successful human reproduction within marriage. As one early publication described it, "in the womb of British womanhood lies the Empire's progress and strength" (cited in Smyth, 2000, p. 11).[2] The low birth rates among colonial women, rather than women's reproductive health per se, was the early primary motivation for the state provision of family planning services.

The immorality and illegality of abortion in colonial times largely stemmed from eugenic and pronatalist thinking (Leask, 2013). It was treated as a serious crime in colonial society and resulted in harsh penalties including extended periods of incarceration (Smyth, 2000; Sparrow, 2010). Additional barriers faced by colonial women were the stigma of illegitimate children and the extreme poverty resulting from having a lot of children.[3] The desperate personal circumstances in which colonial women could find themselves created a demand for methods to terminate unwanted pregnancies. So, despite the law of the time, chemists, herbalists and other suppliers of patent medicines advertised wares that the public understood as abortifacients (Sparrow, 2014). Some medically trained doctors offered clandestine abortion services. Those illegal services were delivered relatively safely in the knowledge that the procedure was unlikely to be detected and proved in a court of law. Unsurprisingly, women who sought surgical terminations rarely testified against abortionists.

The stigma of having children outside marriage, the harsh economic reality of large families, the absence of reliable contraception and a lack of legal, safe surgical terminations was a lethal mix for women in 19th century New Zealand. Tragically, the country led the world at that time in women's deaths from botched abortions (Sparrow, 2014). Even abortions conducted by skilled practitioners at that time regularly resulted in life-threatening infections or haemorrhage. The evidence of the grim reproductive reality for the early, British colonial women of New Zealand can

be gleaned from the sobering coroners' reports of women who died and court reports of grisly deaths and desperate crimes (Sparrow, 2014).

The legacy of 19th century English law that made abortion illegal in New Zealand cast a long shadow. New Zealand's abortion laws were unchanged until 1977.[4] Smyth (2000) characterised the 1970s as a time of the *abortion wars*, not least because of the well-supported public and vocal protests on all sides of the issues. It was during this time that the anti-abortion Catholic lobby group, Society for the Protection of the Unborn Child (SPUC), was established, which formalised the influence of religious-based morality on debates (Leask, 2013; McCulloch, 2013).

The pro-choice movement involved two separate but related women's organisations – the Abortion Law Reform Association of New Zealand (ALRANZ), which took a moderate approach, seeking legal reform primarily for health and safety reasons, and Women's National Abortion Action Campaign (WONAAC), which took a feminist right to choose position and called for a repeal of all abortion laws (McCulloch, 2013). It is only ALRANZ that continues as an active pro-choice lobby group today. "Mind your own uterus" is an example of one of their slogans aimed at anti-abortion groups that emphasises their pro-choice position.

Another organisation that has played an important, albeit at times reluctant and ambivalent, role on abortion matters is New Zealand's Family Planning Association (NZFPA). Women originally formed it in the 1930s as part of a campaign for education on birth control and the provision of scientifically validated contraception for married people – that was unofficially extended to unmarried individuals during the 1970s. The first NZFPA birth control clinic was opened in 1953, and by the 1970s it had a nationwide network of branches and clinics (Smyth, 2000). It provides a necessary infrastructure supporting New Zealand's de facto abortion on demand.

The opening of New Zealand's first abortion clinic in 1974 ignited widespread public debate and protests. As a result, a Royal Commission of Inquiry into Contraception, Sterilisation and Abortion was established. The New Zealand Royal Commission's report (1977) was conservative in its assumptions and recommendations, and not just regarding abortion. It was unsympathetic to expressions of sexuality outside a traditional Western and Christian nuclear family structure, lamenting a decline in (Christian) church attendance. The language and tone of the report indicated the Commission was more influenced by conservative moral arguments than by those based around human rights or medical facts. And it was this report on which the Contraception Sterilisation and Abortion Act (1977) was based.

Consequences of criminalised abortion

On the back of the pro-choice movement and a fortunate outcome of their support of the work of the New Zealand Family Planning Association, abortion law is interpreted more liberally than the 1976–1977 Parliament intended. The

conservative legal framework, however, makes abortion access highly vulnerable to both legislative and political challenges. In a recent example, the Roman Catholic anti-abortion organisation Right to Life Inc. took a case through the courts from 2005 until 2012 that challenged, among other things, the practice of the Abortion Supervisory Committee in how it oversees the doctors who authorise abortions (Right to Life New Zealand Inc. v Abortion Supervisory Committee, 2008). Arguing that Parliament did not envisage the current de facto abortion on demand practice when it passed the laws, Right to Life sought to have the Abortion Supervisory Committee impose a more restrictive regime of abortion approvals. Although it ultimately lost this case in a narrow 3-2 ruling in the Supreme Court, Right to Life made gains along the way that have set dangerous precedents. In one judgement, for example, in the High Court in 2008, Justice Forrest Miller stated that:

> There is reason to doubt the lawfulness of many abortions authorised by certifying consultants. Indeed, the Committee itself has stated that the law is being used more liberally than Parliament intended. (Right to Life New Zealand Inc. v Abortion Supervisory Committee, 2008, p. 56)

Other attacks on access through the courts have included a successful effort by a group of anti-abortion health care professionals to expand the scope of conscientious objection. Most recently, in June 2015, Right to Life unsuccessfully challenged the granting of a licence to a Family Planning clinic in a small regional city to perform early medication abortions – the first such service in the country. This challenge highlights another of the implications of the criminalisation of abortion, which is the extent to which it hinders best practice, contributing to delays in abortion access and limiting the use of newer abortion methods. There has been little research into New Zealand women's overall experience of the abortion process but Silva, McNeill and Ashton (2011a, 2011b) found women waited an average of nearly four weeks between the first visit with the referring doctor and the date of their abortion, which women felt was too long. One cause of the long average time lag is the distances that must be travelled by some rural women to access certifying consultants and abortion clinics. However, the delays are also caused by the approval process itself. New Zealand has longer delays than in countries where no such approval is necessary (British Department of Health, 2014; Statistics New Zealand, 2015).

A further consequence of the current legislative framework is that it was passed into law when early medical abortions were not available – or even envisioned – leaving the language around abortion provision unable to take into account anything other than surgical abortions. Early medical abortion involves taking an antiprogestin followed around 2 days later by a prostaglandin. According to New Zealand law, all abortions must be performed in a licensed institution, which does not make sense for a medical abortion which can be done safely at home. So, the law has limited medical abortion as an option for many women who cannot spend 2 days at a medical facility.

An additional problem caused by the inconsistencies in the law and its practice is that it places individual women and doctors at risk of prosecution. While this has not occurred in New Zealand, the Australian state of Queensland, which has a similar abortion law, saw the prosecution in 2009–2010 of a 21-year-old woman and her boyfriend accused of unlawful abortion after they obtained, and she took, abortion medication sent from overseas by a relative (Children by Choice, 2015). While both were eventually acquitted, the case showed that relatively liberal practices offer little or no protection when built on conservative law.

New Zealand law treats abortion as a criminal, not a medical or health issue, which reinforces abortion stigma. Anti-abortion activists have made this clear in arguing explicitly against decriminalisation because "people often equate the lack of criminal sanction with acceptable behaviour" (Right to Life, 2010). In addition, a law that enshrines specific allowable grounds, or reasons, for abortion reinforces a discourse that makes it an exceptional choice rather than a matter based on individual human rights (Leask, 2015).

New Zealand abortion law and human rights

New Zealand law undermines women's status as competent human beings. The point was made by the United Nations Convention on the Elimination of all forms of Discrimination Against Women Committee in its observations on New Zealand's Seventh Periodic Report (UN CEDAW, 2012, p. 8), which noted "with concern . . . the convoluted abortion laws which require women to get certificates from two certified consultants before an abortion can be performed, thus making women dependent on the benevolent interpretation of a rule which nullifies their autonomy". The committee went on to recommend that New Zealand "review the abortion law and practice with a view to simplifying it and to ensure women's autonomy to choose" (p9). There was no response from the government of the day to this recommendation, and no action has been taken, or is planned (UN CEDAW, 2014). Indeed, the government explicitly stated that it did not intend to address these concerns because of the socially and culturally divisive nature of the abortion issue (United Nations Human Rights Council, 2014). Furthermore, the government's current human rights action plan makes no reference to abortion law reform or reproductive rights (Human Rights Commission, 2015).

Future directions

Making abortion a medical issue rather than a criminal one would not only address New Zealand's current violations of the human rights of women and girls, it would also help reduce abortion stigma and allow abortion to be more properly embedded within the health care system as part of a spectrum of reproductive health care. This in turn would allow practitioners room to improve the range and availability of abortion services, most notably medical abortions. It would also offer women and doctors protection from criminal sanction and aid in efforts to reduce abortion stigma. We suggest that efforts to provide reproductive health

services according to Māori customs, such as cultural practices around what should be done with human tissue, would also be best served by removing the threat of criminal sanction from abortion.

The vulnerability of good access to abortion caused by its criminalisation continues to make a positive future for women uncertain. It should be noted, however, that a lot can still be done within the current legal framework to improve services, such as greater access to early medication abortion and speedier referral. The recent opening of a telephone referral service is one example of a positive initiative taking place within the law (Johnston, 2015). However, the fact that this initiative was taken at the practitioner level, rather than the government level, together with the lack of response by government to United Nations recommendations, shows there is no political will in New Zealand to improve the situation. It seems clear to us that without another widespread mobilisation of support for women's reproductive rights the current situation is unlikely to change.

In conclusion, there is good access to abortion in New Zealand but the situation is far from ideal. New Zealand women do not have a basic human right to reproductive control because the state has ultimate decision-making power over the legal termination of unwanted pregnancies. Almost all legal abortions are granted on mental health grounds, which effectively pathologises women by casting them as psychologically fragile. Abortion's association with illegality supports and perpetuates its social stigmatisation.

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Notes

1. The issue of what might constitute "a substantial risk" that a child be "seriously handicapped" is itself a dilemma around selection and non-discrimination that can arise on the basis of obstetric ultrasounds (see Stephenson, Mills, & McLeod, 2017).
2. Māori society had its own stock of knowledge and range of practices for dealing with reproductive life, which largely operated successfully and separately from the colonial system (Le Grice, 2014; Sparrow, 2014).
3. Illegitimacy was not an issue in traditional Māori culture (Le Grice, 2014; Sparrow, 2014).
4. England liberalised its laws in 1967 by expanding the grounds for abortion but abortion activists there are still lobbying for decriminalisation.

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