ALRANZ
Abortion Rights Aotearoa

Introduction

The Abortion Law Reform Association of the New Zealand (ALRANZ) is the oldest reproductive rights organisation in New Zealand. Its founding in 1970 pre-dates the work of the Royal Commission.

ALRANZ has spent the last 48 years fighting for abortion law reform. We believe women are people, with the intrinsic human right to decide what happens to their own bodies. We believe the state has no business coercing anyone to become a parent without that person's consent. We believe New Zealand law must be changed to reflect these principles.

ALRANZ is a not-for-profit incorporated society. Our goals are:

- to change the law to reflect that abortion care is health care
- to root out gender discrimination from reproductive health care in New Zealand
- to make abortion care accessible to all who need it
- to root out abortion stigma and other forms of slut-shaming from New Zealand culture
- to ensure reproductive health care is patient-centred

To achieve these goals, ALRANZ believes the best way to reform New Zealand's legal framework around abortion is to dismantle it without replacing it. Canada affords an instructive example of a country that has treated abortion as health care since 1988.[1] Its abortion rate is comparable to New Zealand's.[2]

Accordingly, our submission emphasises the sections of the law that must be repealed, with few preservations.

We note the Minister of Justice, in his letter of reference, specifically asked the Law Commission to "seek some input from appropriate health professionals". While ALRANZ supports their involvement, we note the one group with the greatest stake in law reform - people who make use of abortion services - has been overlooked. In this submission, we attempt to give them voice. Our work over the years places us in a good position to do so.

Summary

1. Any reformed legal framework around abortion must cease the discrimination that permeates our current laws.
    a. The statutory grounds for abortion in s 187A of the Crimes Act 1961, and the establishment of the certifying consultant role in s 30 of the Contraception, Sterilisation, and Abortion Act 1977, must both be repealed.
    b. Health care providers must no longer be permitted to refuse to provide reproductive health care without warning and with impunity.
    c. The Health Practitioners Competence Assurance Act 2003 s 174 must be repealed.
2. Any reformed legal framework must not allow limitations to the delivery of abortion care for non-medical or non-scientific reasons.

[1] For a view of legislative changes to implement Canadian-style law reform, see http://alranz.org/change-the-law/sample-legislations/.
[2] William Robert Johnston "Abortion Rates by Country" 25 Feb 2017 Johnston's Archive < www.johnstonsarchive.net >.

a. Abortion care must be administered by the Ministry of Health, rather than the Ministry of Justice.
b. People who need abortion care must be able to self-refer to an abortion service, without intermediaries.
c. Requirements on facilities, and licensing of premises and providers, must reflect the safety and routine character of the procedure.
d. Access to abortion must not be subject to gestational limits.
e. The Care of Children Act 2004 s 38 must be preserved.

3. Any reformed legal framework must allow abortion care to evolve and improve over time as medicine advances without needing to be changed.

Our position

1. Any reformed legal framework around abortion must cease the discrimination that permeates our current laws.

New Zealand's current statutory framework around abortion discriminates against pregnant people, specifically those who do not wish to be pregnant, by requiring different and demonstrably worse treatment in the provision of health care to them. No other New Zealanders are required

- to submit their health care decisions to the approval of certifying consultants;
- to have their reasons judged against a list of 'acceptable' grounds;
- to lie about their mental health status to satisfy those grounds;
- to be subject to the unpredictable and arbitrary withholding of health care.

These limitations on the rights of pregnant people cannot be justified in a free and democratic society.

a. The statutory grounds for abortion in s 187A of the Crimes Act 1961, and the establishment of the certifying consultant role in s 30 of the Contraception, Sterilisation, and Abortion Act 1977, must both be repealed.

These two sections constitute the main drivers of delay, coercion, and discrimination in this system. These pernicious elements of our current legal regime must go. The statutory grounds for abortion in s 187A of the Crimes Act 1961 must be repealed. The certifying consultant role, established in s 30 of the Contraception, Sterilisation, and Abortion Act 1977, must be abolished.

b. Health care providers must no longer be permitted to refuse to provide reproductive health care without warning and with impunity.

Section 46 of the Contraception, Sterilisation, and Abortion Act 1977 fosters discrimination. Abortion and contraception are forms of health care routinely sought by women. In no other context and to no other class of person does the law permit health care providers to refuse services that their role and training direct them to provide, simply because they do not wish to provide them. Health care providers must no longer be permitted to refuse to provide health care without warning and with impunity.

c. The Health Practitioners Competence Assurance Act 2003 s 174 must be repealed.

The Health Practitioners Competence Assurance Act 2003 s 174 must be repealed. This section is similar to section 46, above, but broader in scope. 'Reproductive health services' can include pregnancy and childbirth. Under the current section, if a doctor received a call at 2 am, requesting they return to the hospital to perform an emergency caesarean section, they may be able to refuse on the ground of conscience, without sanction.

It is difficult to see why New Zealand needs one such section, let alone two.

2. Any reformed legal framework must not allow limitation to the delivery of abortion care for non-medical or non-scientific reasons.

New Zealand abortion care providers are currently prevented from providing early medical abortions according to international best practice standards. This is because our law was written before the primary drug was invented, and so, cannot take its existence into account.

Some jurisdictions in the United States have implemented targeted regulations against abortion providers (TRAP laws) that the Supreme Court of the United States found to be an undue burden on the constitutional right to an abortion because they had no logical or scientific basis.[3] We must take care not to introduce such spurious limitations here.

a. Abortion care must be administered by the Ministry of Health, rather than the Ministry of Justice.

Abortion care must be administered by the Ministry of Health, rather than the Ministry of Justice. All health matters should logically fall under the same ministry.

b. People who need abortion care must be able to self-refer to an abortion service, without intermediaries.

People who need abortion care must have the right and the opportunity to self-refer to an abortion service, without intermediaries as required by the process described in s 32 of the Contraception, Sterilisation, and Abortion Act 1977. Abortion care is both safe and time-sensitive. Requiring a referral, as the law currently does, causes delay and wastes time. Any reformed legal framework must make provision for this.

c. Requirements on facilities, and licensing of premises and providers, must reflect the safety and routine character of the procedure.

Requirements on facilities, and licensing of premises and providers, must reflect the safety and routine character of the procedure. Abortion care is extremely safe. Less than 0.23% of cases result in complications requiring hospitalisation.[4] Abortion care is routine. Roughly one in four people with a uterus will have an abortion in their lifetime.[5]

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[3] *Whole Women's Health v Hellerstedt* 579 US ___ (2016).
[4] Ushma D Upadhyay PhD MPH and others "Incidence of Emergency Department Visits and Complications After Abortion" *Obstetrics & Gynecology* January 2015 at 175 <https://journals.lww.com/greenjournal>.
[5] Smitha Mundesad "Abortion study: 25% of pregnancies terminated, estimates suggest" 12 May 2016 BBC < www.bbc.com>.

The law must not prevent early surgical abortion from occurring in settings like doctors' surgeries or Family Planning clinics, nor prevent early medical abortions from occurring in the patient's home. The law must allow health care professionals with proper training, including nurses, doctors, and midwives, to provide abortion care.[6]

d. Access to abortion must not be subject to gestational limits.

Access to abortion care must not be subject to gestational limits. Pregnancies that continue into the late second and early third trimesters are typically wanted pregnancies. Those who must access abortion care at that stage are frequently in crisis. There is no benefit to society from forcing people in crisis to pursue a gatekeeping legal process to access health care.

e. The Care of Children Act 2004 s 38 must be preserved.

The Care of Children Act 2004 s 38 must be preserved. Anecdotal evidence suggests the vast majority of teens seek their parents' support when they fall pregnant. Those who don't wish to tell their parents often fear abuse, for good reason.[7] Teens who lack supportive parents should not be penalised by forcing them to seek judicial bypass.

3. Any reformed legal framework must allow abortion care to evolve and improve over time as medicine advances without needing to be changed.

One of the faults of current law is its overly prescriptive nature, which makes it difficult for the abortion bureaucracy to take advantage of medical advances. Any reformed legal framework must leave the provision of abortion in the hands of the Ministry of Health, without establishing legal limitations.

Conclusion

Reconceptualising abortion as health care, rather than a criminal matter, will require a fundamental shift in thinking. To treat abortion as health care, the legal system must lay down its former concerns about slippery slopes and moral hazards. People receive health care because they need it; there are no other criteria.

Abortion care from qualified providers must be available on the same basis as other medical care: available upon request from a qualified provider. Unwanted pregnancy, a treatable medical condition like any other, must no longer be stigmatised and treated differently.

ALRANZ would welcome the opportunity to expand on our submission in person.

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[6] TA Weitz and others "Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver." *American Journal of Public Health* March 2013 at 454.
[7] "Laws Restricting Teenagers' Access to Abortion" ACLU < www.aclu.org >.