**Brief Submission on Revision of the Abortion Law**

Dr Hera Cook and co-signatories (listed below)  
Department of Public Health  
University of Otago, Wellington

**18 May 2018**

**Introduction**

The Law Commission has been asked by the Minister of Justice to consider the criminal aspects of abortion law, the statutory grounds for abortion and the process for receiving services. This submission comes from a group of Health research workers with varied expertise. Our collective expertise spans public health, reproductive health and child health. Some of us have published on ethical issues of public health and on abortion and contraception. Our names are listed at the end of this submission.

**Summary of Submission**

Abortion is a safe routine medical procedure that should be administered by the Ministry of Health and District Health Boards. Women have the right to bodily autonomy and access to safe legal abortion is part of ensuring this. Doctors who carry out abortions are required to do so in accordance with their professional ethics. No other legal framework is required to maintain limits upon abortion. Some aspects of the current law should be maintained, namely the data collection and reporting role of the Abortion Supervisory Committee and the provision of counselling. Abortion procedures should be supportive of women’s cultural needs, including Maori.

**Legal Framework**

1. Forty years of provision of legal abortion have shown that abortion is a normal, safe medical procedure that does not require regulation by the state, other than those regulations required for ensuring the safety of similar medical procedures. We support the removal of abortion from the Criminal Law and the removal of the sections of the Contraception, Sterilization and Abortion Act that compel legislative overview of abortion.
2. We support the Canadian legal approach since 1988, according to which abortion is legal at any stage of a woman’s pregnancy. There need be no statutory grounds applicable to abortion.
3. Abortion care is part of routine health care, and as with any other medical procedure we believe it should be administered solely by the Ministry of Health and District Health Boards.

**Consent and Limits**

1. We support women’s right to the control over their bodies, including their fertility. This is consistent with women’s human rights and with international treaties including the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).

Only the woman concerned has the right to make her decision about continuing with, or ending, her pregnancy. Parliamentarians voting on their consciences and doctors refusing to provide reproductive health care based on their personal beliefs are not able to give or withhold informed consent as described in the Code of Health and Disability Services Consumers’ Rights. We do not agree with the Abortion Supervisory Committee that there is merit in having a “robust pathway … which requires certifying consultants to assess and certify patients.” There is no place in today’s world for the assessment and certifying of women who seek an abortion, any more there is a place for such activity when people require other medical procedures.

1. There are ethical and practical limits to abortion and term limits are an ineffective and clumsy means of managing situations in which these limits arise. The customary presentation of an opposition between women’s right to bodily autonomy and control over their fertility and doctors’ right to a conscientious objection against any involvement in abortion is not relevant to these limits. In practice, since 1977 doctors who carry out abortions have been engaged in the exercise of conscience about the existence and quality of life; making decisions as to when in pregnancy the boundary is crossed and a foetus becomes a child so that abortion is no longer possible; as to when there is a danger to the mother’s life that overrides the potential life of the foetus; and that a foetus is nonviable, or the emerging human being’s quality of life will be unacceptably poor. When these are the choices, doctors, who support women’s right to choose by carrying out routine abortions, may then refuse to carry out a particular abortion for specific reasons. In these instances, there may be a genuine opposition between the rights of the woman and those of the foetus or emergent human being she carries. Only a tiny percentage of abortions are in this category and legally mandated term limits are not an appropriate means of managing the dilemmas that arise. Rather the proposed legal approach leaves the decisions where they already lie: with the woman deciding whether she wants an abortion in her circumstances and with the doctors deciding if they are or are not willing to carry out her abortion.
2. The Canadian example demonstrates that there is no need to legislate abortion term limits. Late term abortions are carried out rarely (0.59% in 2016) and on the basis of urgent medical needs or fetal abnormality. As stated in paragraph 5, we recommend that the decision to carry out a late term abortion should be that of the pregnant woman following upon advice from her medical attendants as to whether they are willing to proceed.

**Comments on other aspects of abortion**

1. Counselling can and should be offered outside the current framework of certification. Decisions about fertility, in this instance whether or not to continue a pregnancy, are of major importance in the lives of women. Despite the intentions of those who forced the inclusion of provision for counselling in the 1977 legislation, the provision of counselling has been very highly valued by many women. We strongly advocate maintaining provision for counselling where it is desired by the woman. Throughout the process all women should be treated with dignity and respect and they should not be stigmatized or labelled by the system.
2. Maori believe in te tapu o te tangata/the sacredness of life, and that tamariki are a gift mai ngā Atua (from the spiritual realm/from the Gods).  The role of whānau, hapū and iwi is to support the upbringing of tamariki and mokopuna. There are situations of abuse and incapacity in which wāhine may choose abortion. However, there needs to be support and access to loving, non-judgmental support systems, counselling and services inclusive of Māori processes and practices before such a decision is taken.
3. A legal duty to ensure that women who request information about abortions are given accurate and prompt advice about alternative medical providers, not just the information that such providers exist, must be laid upon medical staff who wish to exercise their right to conscientious objections. Doctors and other medical staff have a right to conscientiously object to abortion, as set out in existing legislation. But they do not have the right to obstruct or impede a woman from obtaining an abortion.
4. Removal of abortion from the purview of legislation would enable procedures for the carrying out of abortions, including medical abortions (e.g. use of mifepristone and misoprostol) or any other method that is developed, to be updated and improved as research evidence and new technologies become available, just as for any other medical procedures. The current legislative framework surrounding abortion access in New Zealand means that legal limitations restrict how medical advances can be incorporated into abortion care.
5. The Abortion Supervisory Committee (ASC) should continue to exist for the purpose of maintaining knowledge of abortion and commissioning further research where necessary. This is because:
   1. Parliament should ensure a factual record is available. The ASC can then assess and report on claims about the impact of new legislation that may be made, in particular, by those opposed to abortion.
   2. There is inequity in the provision of abortion services, with considerable geographical variation in the availability of abortion and in the timeliness of the abortions. The ASC has an important role to play in the improvement of abortion services (eg, service provision in all DHBs).
   3. Accurate knowledge of use of fertility control methods is necessary for provision of services, including contraceptive services and for monitoring the reproductive health of New Zealanders. In this context, data collection by the ASC should be expanded to include hormonal contraceptive prescriptions as well as abortions.
6. We regret that abortion may be used for the purpose of sex selection, which we strongly oppose. There are, however, currently no practical means of preventing this, given the widespread use of technology that enables early identification of fetal sex. We believe the most effective solution to this use of sex selection will be the valuing of women and men equally in society. In the short term, we urge consideration be given to a) making it illegal to advertise sex selective abortions; and b) tasking the Abortion Supervisory Committee with attempting to monitor any patterns in the use of abortion that may relate to sex selection.
7. We would like to express our appreciation of the efforts made by many of those currently involved in the provision of abortion to provide a non-judgemental, supportive service.

**Contact:**

Dr Hera Cook  
[hera.cook@otago.ac.nz](mailto:hera.cook@otago.ac.nz)  
Department of Public Health  
University of Otago, Wellington  
PO Box 7343  
Wellington South 6242  
New Zealand  
Tel: +64 4 918 6724  
Mob: 021 028 72236

**Signatories:**

**Clare Aspinall, PhD student, DPH UOW**

**Michael Baker, Professor, DPH UOW**

**Judith Ball, PhD student, Research Fellow, DPH UOW**

**Naomi Brewer, PhD, Research Fellow, DPH UOW**

**Cristina Cleghorn, Senior Research Fellow, DPH UOW**

**Hera Cook, PhD, Historian and Senior Lecturer, DPH UOW**

**Ruth Cunningham, PhD, Senior Research Fellow and Public Health Physician, DPH, UOW**

**Sarah Donovan, Research Fellow, DPH, UOW**

**Amanda D’Souza,** Public Health Physician, **DPH, UOW**

**Richard Edwards, Professor, DPH, UOW**

**Brodie Fraser, PhD student, DPH UOW**

**Ryan Gage, Assistant Research Fellow, DPH, UOW**

**Janet Hoek, Professor Public Health and Marketing, DPH UOW**

**Philippa Howden-Chapman, Professor, DPH UOW**

**Kerry Hurley, DPH, UOW**

**Amanda Kvalsvig, Epidemiologist, Public Health Physician, DPH UOW**

**Giorgi Kvizhinadze, Research Fellow, DPH UOW**

Keri Lawson-Te Aho, Lecturer, DPH UOW

Mary E. McIntyre, PhD, Research Fellow in Public Health (Ecology & Health), DPH UOW

**Jenny Ombler, Research Fellow, DPH UOW**

**Beck O'Shaughnessy, DPH, UOW**

**Kimberley O'Sullivan, PhD,** Research Fellow, **DPH, UOW**

Nevil Pierse, Research Associate Professor, **DPH, UOW**

Gordon Purdie, Biostatistician, DPH UOW

Ed Randall, Research Fellow, PhD student, DPH UOW

Lara Rangiwhetu, PhD student, DPH UOW.

Johanna Reidy, PhD, Lecturer/Research Fellow, DPH UOW

Marie Russell, PhD, Research Fellow, DPH UOW

Diana Sarfati, Professor, Public Health Physician, DPH UOW

Caroline Shaw, PhD, Senior Lecturer and Public Health Physician, DPH UOW

Louise Signal, Professor, DPH UOW

James Stanley, PhD, Senior Research Fellow, Biostatistician, DPH UOW

Romona Tiatia, PhD, Pacific Research Fellow, DPH UOW

Louise Thornley, Research Fellow, DPH UOW

Helen Viggers, Research Fellow, DPH UOW

Maddie White, Assistant Research Fellow, DPH UOW

Catherine Whitely, Masters Student.

Nick Wilson, Professor, DPH UOW

Wei Zhang, Research Assistant and PhD Student, DPH UOW

References:

*Statistics - Abortion in Canada* Updated April 5, 2017, using data compiled from Canadian Institute for Health Information (CIHI) annual statistics. [*www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf*](http://www.arcc-cdac.ca/backrounders/statistics-abortion-in-canada.pdf)

C.E. Whitely, Improved access to long-acting reversible contraception (LARC) and the declining abortion rate, Masters Thesis, University of Otago, 2017

Abortion Supervisory Committee Report 2017