ALRANZ Submission on Abortion Legislation Bill 2019

ALRANZ Abortion Rights Aotearoa supports the passage of this bill.

We would like to make an oral submission.

Introduction

ALRANZ Abortion Rights Aotearoa ('ALRANZ') has been fighting to reform New Zealand's abortion laws for over 40 years. We believe that women are people, inherently equal to men and possessing the intrinsic human right to decide what happens to our own bodies. We believe the state has no business coercing people to remain pregnant through force of law.

The Abortion Legislation Bill ('the Bill') is not perfect. In this submission we make note of parts we support, parts that could be improved, and pitfalls its drafters thankfully avoided, which the Select Committee and the Committee of the Whole House must not take up should they be proposed.

The status quo with respect to abortion in New Zealand is discriminatory. It treats pregnant people as uniquely incompetent to make medical decisions for themselves. It violates the human rights of women and pregnant people. This toxic system must be reformed.

We believe it is long past time for the New Zealand government to trust people to decide for themselves whether and when to become parents.

Summary

ALRANZ supports the passage of the Bill. We particularly commend:

- enabling people to self-refer into the abortion care system
- allowing qualified health practitioners who are not doctors to provide care
- allowing health legislation to govern the settings where abortion care may be provided
- making counselling optional, and offering unbiased, professional counselling after abortion care

We recommend the following improvements:

- amending clause 7 ss 10 - 11 to enact the Law Commission's Model A, or, failing that, moving the statutory test to 24 – 28 weeks gestation
- requiring the Ministry of Health to maintain a list of providers who obstruct access to reproductive health care
- applying harassment regulations to all abortion services from assent
- replacing 'woman' with 'pregnant person' in the body of the legislation.

We recommend the Select Committee and the Committee of the Whole House continue to reject the following:

- changing the Care of Children Act 2004 s 38 to require parental notification or consent
- medically unnecessary and patronising waiting periods
- restricting certain abortions based on the purported reasons for them
- formulating scripts to dissuade people from receiving abortion care, and forcing doctors to read them out

Contents

1. What is laudable

Much of the Bill is excellent. ALRANZ believes the following elements of the Bill are particularly important for addressing the problems with current system, and should be included in the resulting statute.

a. Self-referral, clause 7 s 14

Abortion is a time-sensitive medical procedure. Under the status quo, GPs serve as pointless gatekeepers who waste their patients' time without adding anything to their care. Allowing people to refer themselves into the system will save patients time, money, and aggravation.

b. Qualified health practitioners, clause 5

Research from the USA has demonstrated nurse practitioners, physicians' assistants, and midwives are able to provide early medical and early surgical abortions safely.[1] Allowing qualified non-doctors to provide abortion care will likely increase the availability of care.

[1] 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.

c. Only health-related restrictions on clinics, Explanatory Note

Currently, most abortions are provided in hospital settings. This places a burden on the health care system because early medical and early surgical abortion care can be provided safely in settings like properly equipped doctors' surgeries. It also burdens people in rural areas, who must travel to urban centres to access care that should be available locally.

d. Counselling optional, clause 7 s 13

As the Law Commission's report noted, counselling should not be mandatory. Some patients welcome the opportunity to discuss their decision with an unbiased, professional counsellor, but others find it intrusive and unnecessary. We are glad the Bill also supports the availability of unbiased, professional counselling for patients post abortion, which may be a comfort to some.

2. What can be improved

Some elements of the bill can be improved upon. We recommend the following enhancements to the Select Committee.

a. Model A still better, clause 7 s 10 - 11

Model A is the only option that treats abortion care like every other kind of health care. Imposing arbitrary limits on a pregnant person's bodily autonomy, as the current bill does, demonstrates an unjustified lack of trust in their ability to exercise their own judgment.

It is long past time for Parliament to stop catering to paternalistic myths about abortions at later gestations, and women's intellectual and moral inferiority.

b. 20 weeks too short, clause 7 s 11

The statutory test reads:

> *The health practitioner reasonably believes that the abortion is appropriate in the circumstances ... [having] regard to the woman's - physical health; and, mental health; and, well-being.*

The test as it now stands cannot be improved upon except by eliminating it entirely.

The Bill imposes the statutory test at 20 weeks, purportedly because the Births, Deaths, Marriages, and Relationships Registration Act 1995 requires stillbirths to be registered if they occur after 20 weeks gestation. This arbitrary time frame is early compared to others used internationally. The World Health Organisation, for instance, recommends the definition of stillbirth as occurring after 28 weeks gestation.[2]

The 20-week limit in s 11 presents difficulties for families in cases of foetal anomaly or surprise pregnancy. Families that need more time to consider a negative test result or how they might accommodate a child with a disability should have the time they need, without a looming deadline that will take the decision out of their hands. Moving the statutory test to 24 - 28 weeks would give people more time.

[2] "Maternal, newborn, child, and adolescent health" World Health Organisation <who.int>.

If the Births, Deaths, Marriages, and Relationships Registration Act 1995 prevents families from taking the time to consider their options, then it should be amended to require registration of stillbirths later.

c. Conscientious objection still unbalanced, clause 7 s 19(2)

Requiring the Ministry of Health to maintain a list of abortion care providers is positive, but will not help patients avoid providers who obstruct access to reproductive health care. Conscientious objectors' need for privacy is still being privileged over patients' need to avoid them. This is unfair and discriminatory.

Maintaining a list of doctors, nurses, and pharmacists who obstruct access to care would go far towards allowing people who need reproductive health care to avoid those who refuse to provide it, and spare some vulnerable people the contempt of unsympathetic health providers.

d. Harassment regulations automatic, clause 7 s 17, Explanatory Note

Renewed focus on abortion laws may lead to an increase in attempts to intimidate and harass those seeking abortion care by those who consider the reformed law too liberal. We are glad the Bill gives more consideration to the problem than the Law Commission report did. But the Bill should establish safe areas around all abortion services and clinics from its assent. We already know pregnant people and providers experience harassment outside abortion services. They should have the protection of the law.

e. Definition of woman, clause 5

While it is nice that the definition of 'woman' in clause 5 acknowledges that anyone with a uterus can need abortion care, use of the term 'woman' throughout the Bill linguistically disappears non-cisgender people. The term 'pregnant person' would include everyone, and should be preferred.

3. Bad ideas the bill avoided

By following Law Commission's lead, the government has avoided many unsupportable, unscientific fallacies. The Select Committee and the Committee of the Whole House must continue to reject them.

a. Changing the Care of Children Act 2004 s 38

There have been calls in the past for legislation requiring minors to notify or seek the permission of parents to receive abortion care. Teens who do not wish to tell their parents frequently fear abuse, for good reason.[3] Repealing this section would place these teens in danger.

Even if a judicial bypass were put in place, only the most savvy and confident teens would be able to access it. Teens who are less able would end up as teen parents.

Data collected by the Abortion Supervisory Committee suggest the vast majority of teens inform their parents. Of the remainder, many will have sought the support of a trusted adult who was not a parent or guardian.

[3] "Laws Restricting Teenagers' Access to Abortion" ACLU < www.aclu.org >.

We must continue to ensure the safety and well-being of all teens, not just the most motivated or the ones from good families. Section 38 must not change.

b. Waiting periods

Ireland and some US states have enacted medically unnecessary stand-down periods between counselling and the abortion procedure. These waiting periods add to the cost and difficulty of obtaining care, and further stigmatise abortion care and those who receive it.[4]

Pregnant people are capable of making medical decisions on their own timetables. It is patronising for the government to force them to slow down, as though their own judgment was suspect.

One of the advantages the Bill seeks to secure is decreasing the current lag time of 25 days on average between referral and procedure.[5] Waiting periods would be counterproductive as well as patronising and medically unnecessary. They should be rejected.

c. Reason shopping

Some jurisdictions attempt to prohibit abortion for certain reasons, like sex selection or disability. These restrictions ask health practitioners to read their patients' minds at best, and racially profile them at worst.

If it passes, the Bill will end the status quo in which patients must lie about their mental health to receive care. The last thing New Zealand needs is to encourage more lying around abortion.

Parliament would do better to address the underlying causes of such attitudes: sexism; and, lack of support for families whose children have disabilities.

d. Biased scripts

Several US state legislatures have composed scripts for dissuading people from receiving abortion care, and passed laws requiring doctors to read them out. The scripts sometimes contain well-known myths and lies about abortion, such as abortion leading to breast cancer, infertility, or depression.

It should not be the role of Parliament to compel doctors to lie to their patients.

It should not be the role of Parliament, or of health practitioners, to insert themselves into the medical decisions of New Zealanders. It is discriminatory to treat pregnant people seeking abortion care differently from others who make medical decisions for themselves, and to treat the decision to receive abortion care as different from other medical decisions.

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[4] "Waiting Periods For Abortion" Guttmacher Institute <www.guttmacher.org>.

[5] "Ladies in waiting: the timeliness of first trimester services in New Zealand" NCBI <ncbi.nlm.nih.gov>.