Abortion Law Reform

Submission to the Law Commission

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About the New Zealand Nurses Organisation Tōpūtanga Tapuhi Kaitiaki o Aotearoa

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 49,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

INTRODUCTION

1. The Women's Health College (WHC), New Zealand Nurses Organisation *Tōpūtanga Tapuhi Kaitiaki o Aotearoa* (NZNO) welcomes the opportunity to confirm professional nursing positon on abortion law reform we outlined at the meeting with the Law Commission last month.

2. This submission has been prepared by the WHC, which represents over 550 nurses and midwives practising in Women's Health in Aotearoa. it is informed by consultation with NZNO's membership and staff including members of Te Rūnanga o Aotearoa, the Board, College of Primary Care Nurses, College of Child and Youth Nurses , nurses working in family planning, sexual health and secondary schools, and professional nursing, policy, legal, and research advisers.

3. We have also consulted with other nursing, medical, women's health, and human rights agencies, including for example, Family Planning New Zealand (FPNZ), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), and the National Council of Women.

4. WHC and NZNO has read and **supports** FPNZ's submission.

5. Currently, access to abortion services is inappropriately controlled by the justice system, and service provision is variable, inefficient, and expensive. Delayed and inequitable access increase risks to women's

health, and often lead to higher costs. Eg medical abortion is a lot safer and cheaper than surgical abortion. (Pregnancy and childbirth carry greater risks than safe, legal abortion.)

6. Barriers to abortion undermine internationally accepted women's rights to make decisions, freely and responsibly, about parenthood and control over what happens to their bodies and are embedded in various United Nations Conventions, and the Sustainable Development Goals (SDGs).

7. Attitudes to abortion have changed as advances in medical science have allowed interventions in the whole fertility/reproductive continuum. While most interventions have been welcomed and accommodated in the health system, abortion remains legally isolated by virtue of its inclusion in the Crimes Act (1961).

8. The central tenets of WHC,NZNO's position with regard to abortion are that:

    - Abortion has no place sitting in the Crimes Act.
    - Abortion is a health issue.
    - Abortion is an issue between a pregnant woman and her registered health practitioner.

9. Accordingly, we **support** abortion being removed from the Crimes Act and **recommend** that:

    - the Ministry of Health be responsible for the oversight, and funding, and administration of abortion services (this need not preclude independent review of abortion services, currently the responsibility for of the Abortion Supervisory Committee);
    - the Contraception Sterilisation and Abortion Act (1977) (the CS & A Act) is updated to reflect current attitudes to women's rights and parenthood, and to ensure consistency with other health service and health practitioner regulation – ie the safe, equitable provision of abortion services, including information and counselling, provided by appropriately qualified and registered health practitioners; and

10. NZNO and the WHC are confident that removing abortion from the Crimes Act will not lead to the de-regulation of abortion care. Apart from the CA & A Act, there are sufficient safeguards provided by Health and Disability Commissioner Act (1994), The Code of Health & Disability Services Consumers Rights (1996), the Health Practitioners Competence Assurance Act (2003) (HPCA Act), along with the Health and Disability Service Standards, Service Specifications, Standing orders and other regulatory levers.

DISCUSSION

11. While recognising the tensions that have historically surrounded abortion, it is clear that social paradigms around fertility, reproduction, parenthood, women's rights, and 'responsible' behaviour have changed enormously.

12. M.J. Johnstone review of abortion ethics in relation to nursing [1] includes the following (paraphrasing Margaret Little[2]), that reasonably reflects the modern context in which abortion services are sought and provided.

> "… were abortion viewed in more contextual terms of 'stewardship' rather than 'dominion' it could properly be situated as a 'sober matter, an occasion, often for moral emotion, such as grief and regret', not as an act of vice. And where there is grief and regret this should be taken as a signal 'not that the action was indecent, but that decent actions sometimes involve loss'."
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> Chapter 9 *Abortion ethics and the nursing profession. P234.*

13. Regardless of individual conscience or moral disagreement, it is accepted that the public health system has accepted responsibility for providing safe abortion services, in the same way that it provides for contraception, and the reverse, a range of assisted reproduction services, including in vitro fertilisation (IVF), egg and sperm donation, etc.

14. Similarly, both before and throughout gestation, the health system provides a numerous interventions to inform both clinical and personal decisions relating to the pregnancy, including the decision to terminate, or to refuse treatment. There is no rationale for singling out one pathway to abortion/intervention over another, though the associated risks and costs are significantly affected by such decisions.

15. The HPCA Act allows health practitioners grounds for conscientious objection (as does the CS & A Act). Justice McKenzie's ruling in 2011 on the New Zealand Medical Council's requirement for doctors who had a conscientious objection to abortion to refer patients to appropriate services, allows considerably more latitude

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[1] Johnstone, M.J. (2009) *Bioethics: a nursing perspective*. Chatswood. NSW: Elsevier. p. 234

[2] Chpt 23. Margaret Olivia Little *Abortion*. (2007) Eds R.G. Frey, Christopher Health Wellman. Wiley Online Library . https://onlinelibrary.wiley.com/doi/abs/10.1002/9780470996621.ch23

16. We agree with FPNZ that “Ideally, all health practitioners caring for women of reproductive age would be able to provide abortion services or information about abortion” and note their point that, based on the above ruling, there would need to be a law change to ensure this.

17. Under the Crimes Act the reasons for termination a pregnancy are:

    - Serious danger to physical health
    - Serious danger to mental health
    - Incest or sexual relations with a guardian
    - Risk that the child, if born, would be seriously physically or mentally disabled
    - Woman or girl is severely subnormal
    - Other factors which are not grounds in themselves, but which may be taken into account e.g., extremes of age and rape.

18. The language of the early 1960's is clearly not in keeping with modern attitudes or current health practice.

19. Pregnancy testing is widely available and accurate at very early stages of gestation and safe effective medical abortion has replaced surgical abortion as the preferred option for women presenting early in pregnancy.

20. Advances in health practice and regulation also render obsolete the rationale for setting legal, rather than health parameters around abortion, including certification and service provision. Essentially, with abortion in the Crimes Act, a judicial ruling controls what is clearly a woman's health prerogative.

21. Moreover judicial decisions have also controlled how services are provided – eg that the pill taken for medical abortion must be given at a clinic – regardless of safe, clinical practice by registered health practitioners.

Certification and fees

22. The structures and function and powers of the Abortion Supervisory Committee (ASC) are identified under the CS&A Act which:

    - sets guidelines for termination of pregnancy (TOP) counselling;
    - places restrictions on locations of Abortion Clinics;
    - outlines licensing condition; and

- describes the procedures that must be followed.

23. The CS&A Act says that: “a woman seeking abortion must first gain approval from two certifying medical consultants, one of whom must have experience in obstetrics. An operating surgeon must be willing to perform the procedure and a certificate must be issued for the operation. Self-abortion is an offence”'.

24. The need for certification is the single biggest barrier to timely access to abortion; dual certification doubles the barrier and hence the risk. It is entirely unnecessary for a woman’s decision about reproduction to be mediated by two physicians with whom she has no therapeutic relationship or history.

25. It is also a shocking and unnecessary use of public funds, and necessitates a labyrinthine and inappropriate process for a core health service. The ASC reports yearly to the Minister for Justice, not the Minister for Health. The not inconsiderable funding attached to the payment to certifying consultants comes from the Justice Vote, where it is clearly out of place.

26. In some areas of Aotearoa New Zealand, medical practitioners are paid to provide abortion services using the certification process. Adjusting for this loss of income is something that health authorities may need to consider post abortion law reform, though many nurses consider the financial incentive of the certification process an unnecessary and inappropriate incentive for keeping medical practitioners in the 'business' of abortion services.

27. As with other health interventions, the only requirement for abortion should be informed consent, not certification.

Funding anomalies

28. An anomaly with current legislation and service provision is that the role of nurses in abortion care is not recognised or specifically funded. As early medical abortion services increase, the role of the medical practitioner is decreasing in a woman's care and the nurses' role is increasing. However, nurses do not get any 'extra' money for working in any aspect of abortion care.

29. There are similar funding anomalies with late second trimester terminations where again the medical practitioner is paid to sign the certificate and prescribe medication, but the actual care to the woman is provided by nurses and midwives employed by the DHBs.

30. There are few medical practitioners who perform second trimester surgical dilatation and evacuation procedures. These procedures are only carried out in Auckland, Wellington and Dunedin. Again, the

nurses in theatre and post-op recovery have no extra incentive to work in this care.

31. It is not acceptable that abortion health care is attached to money provided by the taxpayer out of the Justice Department. If extra payment is to be made for this work then it should be available without prejudice to all practitioners regulated under the HPCA Act who are trained and qualified to provide them.

32. Abortion is a core health service, and should be assessed and funded within the Health Vote.

Counselling

33. There is strong evidence to support the provision of pre-decision abortion counselling. Targeted counselling around a women's decision has been shown to help her through the process and increase her confidence in her decision, with less risk of subsequent stress. As with any medical procedure, people who have been counselled appropriately, have made an informed decision and know what to expect can generally get on with their lives. We would strongly support the continuation of free, targeted abortion counselling.

Health practitioners

34. Nurses provide care in early and late medical abortions, internationally are providing surgical care up to 12 weeks gestation and could do so in Aotearoa. This will require changes to both the Crimes Act and the C S & A Act – replacing reference to “medical practitioner” to health practitioner as defined by the HPCA Act - but will not require changes to the Registered Nurse scope of practice which already provides for expanded practice.

35. The WHC has already implemented guidelines for the training of nurse colposcopists and would welcome the development of education and training for RNs to allow them to perform surgical abortions up to 12 weeks.

36. We note that RANZCOG is considering introducing a training module for doctors specialising in obstetrics and gynaecology that incorporates abortion care. The WHC and NZNO would welcome this initiative to ‘future proof’ the service offered to women.

37. Abortion numbers around the country are falling. There is no evidence that would support a sudden increase, because the decision would be left between the woman and her health practitioner.

Licensing

38. With advances in medicine, a safe abortion up to 12 weeks of pregnancy can be performed in any well set up Medical Centre.

There is no need for special licensing as stipulated under the CS&A Act.

39. As previously indicated, there is legislation and a suite of regulatory controls and levers that the Ministry of Health uses to ensure the patient safety and the quality of health services, including abortion.

40. Early medical abortion and care should be available to all women and could be provided in medical centres and Family Planning clinics throughout Aotearoa, once restrictions on premises for abortion are removed.

CONCLUSION

41. The women of Aotearoa New Zealand deserve a non-judgemental, safe, timely, accessible abortion service

42. Removing abortion from the Crimes Act and incorporating it into health system regulation is the first necessary step to ensure better access to timely, safe care.

43. Other regulatory changes should include:

    - the Ministry of Health having responsibility for the funding and management of abortion services;
    - replacing statutory references to medical practitioners to health practitioners regulated by the HPCA Act to enable abortion services to be carried out by appropriately trained and qualified health practitioners;
    - removing restrictions on the premises where abortions, including medical abortions, can take place; and
    - requiring registered health practitioners to refer patients to abortion services, regardless of conscientious objection.

44. Nurses are likely to have an increased role in the provision of abortion services and have the skills and regulatory support to do so.

45. WHC and NZNO look forward to the Law Commission's Report in due course.

Nāku noa, nā

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