SUBMISSIONS TO THE ROYAL COMMISSION ON CONTRACEPTION STERILISATION AND ABORTION

by the
New Zealand Psychological Society, 17 September 1975

I. INTRODUCTION

The New Zealand Psychological Society wishes to present the enclosed submissions to the Royal Commission on Contraception, Sterilisation and Abortion. The Society believes that the laws and social policies relating to contraception, sterilisation and abortion affect both the psychological well-being of individuals in New Zealand and the degree of social pathology in New Zealand communities.

The recommendations contained in these submissions suggest changes in the existing laws and social policies, which, being in accord with current psychological knowledge, will help reduce both psychological pathology and social pathology presently existing in New Zealand communities.

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II. CONTRACEPTION AND STERILISATION

(a) Recommendations:

1. The New Zealand Psychological Society requests the repeal of Section 2 of the Police Offences Act, 1954. (Paragraph 1)

2. The Society recommends as social policy, the encouragement of open advertisement of contraceptive devices and materials and urges the Commission to recommend that suitable guidelines be formulated and adopted. (Paragraph 2)

3. The Society recommends that contraceptive information be freely available to everyone regardless of age, gender, intelligence or any other social category. (Paragraph 3)

4. To this end we recommend that a curriculum of instruction be prepared and offered universally, with suitable protection of the rights of conscience. (Paragraphs 3.1.1 to 3.1.3)

5. We consider that it is the duty of the state to provide and maintain free and open access to contraceptive advice for every individual throughout reproductive life. (Paragraph 3.2)

6. We urge an open policy in contraceptive supply, limited only by choice and medical considerations, not by cost. Sterilisation should be freely available as part of this policy. (Paragraphs 3.3 and 3.4)

7. Steps should be taken to make treatment of venereal diseases more

openly and freely available as part of a national programme to eradicate the two major diseases. (Paragraph 3.5)

(b) Contraception and sterilisation:

Preamble:

Unplanned pregnancies are not all unwanted. However, the rates of ex-nuptial births and abortions give some measure of them. We can only add that in the only available New Zealand study one live birth in five within marriage was unplanned and unwanted at the time of conception. We have reason to believe this figure is rather lower than the actual rate.

We consider this to be a poor start for the child concerned and though most parents adjust to the fact of the pregnancy we do not know at what psychological cost or how successfully they do so.

We have clinical evidence, not quantified as to frequency, but nevertheless strong, that the level of contraceptive information, especially amongst young people, is low, its quality poor, that contraceptive anxiety is widespread. We also believe that absence of good contraceptive information and irrational attitudes towards its practice force many young people into abstinence or a prolonged reliance on masturbation leading to poor sexual adjustment and stunted sexual development.

1. *Earlier submission*

The Society wishes to have stand as part of the record of these proceedings its earlier submission to the Statutes Revision Committee for the repeal of the Police Offences Amendment Act, 1954, s. 2.

2. *Public Information*

Partly as a result of the existence of this section of the Act, but also for wider reasons of supposed public attitudes towards contraception New Zealand has little open advertising about contraception.

We believe that there should be no obstruction or restriction in public policy or in practice to such advertising.

2.1 While it may not be possible to legislate for this in every aspect of the media we do feel that general bodies such as the Broadcasting Council, private radio and the Press Council should encourage advertising of contraceptives and contraceptive information as being in the general public good.

2.2 We urge that this Commission lay down guidelines to this end and recommend their adoption.

3. *Responsible contraception*

Sexual responsibility requires good information, access to contraceptive advice, and supplies.

3.1. *Information*

Sound information, including the dangers of some and the limitations of all methods, mechanical, chemical, rhythm or abstinence, temporary or permanent, should be available to all, regardless of age, gender or intelligence.

3.1.1. The only general way for this information to be distributed to all is by the design and implementation of a full curriculum for all children at or about the age of puberty and amplified and extended as part of the family life education programme at the high school level.

3.1.2. While, on grounds of conscience or as a matter of parental right, such a curriculum should include special ways for this information to be presented and discussed so that parental rights are not violated, there is no general right by which children should be deprived of receiving full information on contraceptive technique. There is no religious or other defence of ignorance: innocence may be a virtue, ignorance can never be. Any attempt to protect the virtue of innocence by committing the sin of perpetuating ignorance is morally, theologically, intellectually, socially and psychologically indefensible.

3.1.3. Full training of teachers should be undertaken to achieve a high level of access to skilled instruction in contraception.

3.2. *Access to advice*

We consider that free and open access to contraceptive advice should be continuously available and that it is the duty of the State to ensure this condition.

3.2.1. Because of their experience in this field, their existing organisation and their community support, the Family Planning Association is a suitable means to achieve this end.

3.2.2. The coverage of Family Planning Clinics through the country is inadequate. Government should fund the Association so that, in conjunction with the Health Department, full and adequate national coverage is attained.

3.2.3. On grounds of conscience some employees of the State in Health, Social Welfare, or other services may not wish to give contraceptive advice. However, no person employed by the State should be, by virtue of that fact, prevented from giving contraceptive information to any person. Conversely should any State employee feel that he cannot, in conscience, give such advice, he should be required to pass the case on to someone who can.

3.2.4. Training programmes to achieve these ends need to be initiated.

3.2.5. We regard with some concern the growing evidence of adverse effects from the use of steroid chemicals ("the pill") as contraceptives and against I.U.D.s. The convenience of these methods has caused many, and particularly younger people, to adopt one of these techniques in preference to older, safer methods, such as caps and condoms.

3.2.6. In advice programmes it should be emphasised that no one method of contraception need apply throughout reproductive life. Young sexually active females may require the pill until they are able and mature enough to be fitted with a cap. Similarly, the step from temporary to permanent contraception (sterilisation) should be con-

templated at the appropriate time, that is, when a mature decision to terminate reproducive capacity has been reached. It follows, therefore, that in both giving initial instruction and continuing advice there needs to be different emphases and priorities for persons of different age, marital status and gender.

3.3. *Supply*

No barriers should be imposed on the choice of a method by inhibiting supply.

3.3.1. The contraceptive efficiency of all supplies where known should be indicated on those supplies and this should be required by law.

3.3.2. The side effects and dangers in using any method should be indicated on the relevant supplies. This should be required by law.

3.3.4. Full information on proper application and use of contraceptives should be supplied with the products. This should be required by law.

3.3.5. Unless there are clear medical reasons to the contrary the contraceptive of choice should be freely available to the user.

3.3.6. We are particularly concerned that sterilisation should be available on demand. While this form of contraceptive, because it is final and permanent, should always be screened by adequate counselling, it should not be withheld because of the personal views of particular members of the medical profession.

3.4. *Costs*

No person should be deprived of adequate contraceptive means on grounds of cost.

3.4.1. The pill and I.U.D.s should be provided free of charge on medical prescription.

3.4.2. Caps, condoms, foam and spermicidal jellies and creams should be provided free by Family Planning Clinics, student health services, and many similar outlets. Ideally such supplies should be free over the counter at chemists shops, but more limited access may at first be all that can be attained. At very least the immediate removal of sales tax would be in the public interest.

3.4.3. Sterilisation should be available on a regular clinical basis at all public hospitals.

3.5. *Venereal disease*

An open contraception policy in a country requires the eradication of the major venereal diseases.

3.5.1. A venereal disease clearance should be required of all those entering the country including seamen, aircrew and servicemen.

3.5.2. An eradication campaign should be instigated and carried through with saturation publicity and freely available clinical access until control of syphilis and gonorrhoea is achieved.

3.5.3. Personnel in Venereal Disease clinics should be properly trained in prevention, detection and counselling roles and adequate safeguards regarding privacy and confidentiality maintained.

III. ABORTION

(a) Recommendations

1. The New Zealand Psychological Society strongly recommends that Sections 182 to 187 of the Crimes Act 1961 be repealed.
2. The Society recommends that any laws relating to the life of the unborn child apply only to a child that is capable of living outside the womb.

The Society recommends that clauses containing the following principles be incorporated in the law relating to medical services.

3. Termination of pregnancy shall only be carried out by a registered medical practitioner, or by a specially trained person under the direct supervision of a medical practitioner.
4. A woman requesting termination of pregnancy shall be required to have a minimum of one hour of counselling prior to termination and such counselling shall make known the alternatives to an abortion.
5. Termination of pregnancy before the twelfth week of pregnancy shall only be performed in a licensed hospital or clinic.
6. Termination of pregnancy after the twelfth week shall only be performed in a licensed public or private hospital.
7. Information and advice concerning contraception shall be made available at any clinic or hospital carrying out abortions.
8. Any medical practitioner or other person working in a medical clinic or hospital who does not wish to be involved in abortions shall be exempted from such involvement by personal choice.
9. Penalties for illegal abortions should be the same as those existing in the law for other illegal medical operations.

(b) Abortion

1. *Moral and Legal Issues*

The Society believes that every person should have the right to choose the medical treatment they desire, where such a choice is consistent with general physical and psychological health and does not infringe on the rights of other individuals.

1.1. Some people regard the foetus as a human being and as having rights consistent with this status. However, other people do not regard the foetus as a human being and see it as attaining the rights of other human beings when the mother gives birth to the child or when the foetus reaches the stage of growth where it is capable of living outside the mother's womb.

Both of these views are common in New Zealand and they lead to opposite positions with regard to whether abortion is a morally appropriate choice in the situation where a woman does not desire to continue with a pregnancy. In such a situation, few people would disagree with the view that even if a woman has reasons for not continuing with a pregnancy, she has the right to so continue if she feels that abortion is morally wrong. However, where a woman does not desire to continue with a pregnancy and does not think abortion

is morally wrong, abortion is an ethically appropriate choice. Restricting such a woman's right to choose to have an abortion amounts to compulsory pregnancy and is morally equivalent to forcing a woman, who wishes to continue her pregnancy, to have an abortion.

1.2. The existing law relating to abortion in New Zealand, Sections 182 to 187 of the Crimes Act 1961, are inherently ambiguous and do not make clear what is meant by an "illegal abortion", "unlawfully procuring a miscarriage" or when a foetus attains the status of an "unborn child". This ambiguity has given rise to the necessity of complex interpretation through case law as to whether "mental health" grounds, for example, are a legitimate reason for performing an abortion. The Society considers the law relating to abortion to be totally inadequate and in need of immediate change.

1.3. A woman who desires to have an abortion and who does not consider the foetus as having the right of a human being is open to conviction under the present law for a "victimless crime" where there is no person who is harmed or injured by the abortion. Such a law is, in fact, legislating morality and as such the law is open to increasing disrespect from those who do not agree with the "morality" contained in the law. The Society considers such law to be bad law, as it tends to lead to disrespect for the law in general. Also, the enforcement of such laws can have negative social effects in leading to disrespect for, and antagonism towards the police and judicial system responsible for executing the law. In this regard it is important to note that the majority of people in New Zealand do not favour the current restrictive law on abortion. (See paragraph 2.6)

1.4. In view of the points mentioned in Paragraphs 1.1, 1.2, and 1.3, the Society strongly recommends that Sections 182 to 187 of the Crimes Act 1961 be repealed.

1.5. As no person should be compelled to be involved in abortions if he feels abortion is morally wrong, the Society recommends that any medical practitioner or other person working in a medical clinic or hospital who does not wish to be involved in abortions should be exempted from such involvement by personal choice.

1.6. The Society believes that the penalties for illegal abortions should be the same as those existing in the law for other illegal medical operations.

1.7. While recognizing that abortion during the third trimester of pregnancy is extremely undesirable on medical grounds, the Society recommends that any laws relating to the life of the unborn child apply only to a child that is capable of living outside the womb.

2. Psychological and Society Effects arising from Abortion and Compulsory Pregnancy.

Women who are forced to carry a pregnancy to full term against their will and women who choose to terminate their pregnancies through abortion are both in situations which lead to several possible

outcomes in relation to mental health, physical health, and the overall social cost to the community.

2.1. Although some studies have attempted to show that abortion sometimes leads to psychiatric complications (e.g., Simon and Senturia, 1966), most recent research shows that psychiatric complications among women who choose to have an abortion, and who subsequently have an abortion, are considerably less than among women who have been refused abortion and who are forced to carry their pregnancy to full term (e.g., Osofsky and Osofsky, 1972; Pare and Raven, 1970; Walter, 1970). Also, psychiatric complications among women having an abortion may be less than complications among unselected mothers immediately after giving birth to a child (Fleck, 1970).

2.2. Very few studies have attempted to assess the social pathology rate among the children of women who have been refused abortions and who have been forced to carry their pregnancy to full term, compared with the children of unselected mothers. However, one study which did attempt to assess the social pathology rate in two groups in Sweden found that women who were refused abortions had children who:

1. had histories of more psychiatric care
2. were more likely to become delinquent
3. used alcohol more
4. were more likely to be rejected by the army (if male)

and 5. become mothers at a younger age (if female),

compared with children of mothers who had not sought abortion (Forssman and Thuwe, 1966). Assuming that the same results would occur in New Zealand, this means that the restriction of abortion is likely to lead to a higher incidence of social pathology in New Zealand communities.

2.3. Many studies carried out in the United States have shown a marked decrease in illegitimate births where abortion has been legalised (Sklar and Berkov, 1974). There is no doubt that allowing more freely available legal abortions in New Zealand would substantially lower the high illegitimacy rate in this country.

2.4. Several studies have shown that any increase in the availability of legal abortions leads to an accompanying decrease in the rate of illegal abortion (Sklar and Berkov, 1974) and a subsequent decrease in the rate of septic complications and death resulting from illegal abortions (Tietze, 1969). Also, the evidence is now clear that the maternal mortality rates for legal abortions, carried out with adequate medical facilities in the first trimester of pregnancy, are lower than the maternal mortality rates for births (Sarvis and Rodman, 1974, p. 124).

Current estimates suggest that between 15,000 and 18,000 illegal abortions are performed on New Zealand women each year (O'Neill, 1975), compared with the 919 abortions performed in public hospitals in New Zealand in 1973 (Facer, 1974).

2.5. The current restrictive New Zealand law relating to abortion discriminates against women of low socioeconomic status, as a considerable number of New Zealand women (one estimate suggests about 4,000 per annum; Rogers and Lenthall, 1975) who can afford the cost, obtain abortions in Australia. On the other hand many women with poor financial resources, who can least afford to have an unwanted child and who have less material resources for child rearing, are unable to obtain an abortion in New Zealand.

2.6. Recent surveys have shown that the majority of New Zealanders (62 percent in 1974) agree with the view that abortion should be legally allowed "where a woman and her doctor decide that it would be advisable not to continue the pregnancy" (Kirkwood and Facer, 1975). Thus any liberalization of the present abortion laws in this direction would be in accordance with the views of the majority of New Zealanders.

2.7. Some people who oppose abortion argue that the liberalization of the law on abortion will lead to a decrease in respect for human life. The evidence suggests the contrary, however, as those countries which are concerned about the quality of life tend to have liberal abortion laws (e.g., Denmark and Sweden) while those countries which have shown a high incidence of violence and a lack of respect for human life tend to have had the most restrictive abortion laws (e.g., Nazi Germany).

The Society believes that the quality of life of a pregnant adult woman, with existing social relationships in the community, who is faced with the possibility of an unwanted child, should take precedence over the survival of a foetus which is not capable of living outside the womb, and which has no existing social relationship in the community.

2.8. The Society therefore considers that abortion should be an option available to any woman who, in consultation with her medical practitioner, feels she cannot continue with her pregnancy.

2.9. The Society also feels that abortion is not an operation to be undertaken lightly and that frequent abortions are undesirable, socially and medically. It, therefore, recommends that a woman requesting termination of pregnancy shall be required to have a minimum of one hour of counselling prior to termination and such counselling shall make known to the woman the alternatives to abortion.

3. *Conditions of Abortion*

Research has shown that abortion is most safely and effectively carried out during the first twelve weeks of pregnancy using the vacuum aspiration method, and that such abortions can be performed on an outpatient basis (Beric and Kupresanin, 1971).

3.1. The Society, therefore, recommends that termination of pregnancy at or before the twelfth week of pregnancy shall only be performed in a licensed hospital or clinic.

3.2. Where abortions are carried out after the twelfth week risk of medical complications increases, making it advisable to have full hospital facilities available. The Society recommends that termination of pregnancy after the twelfth week shall only be performed in a licensed public or private hospital.

3.3. As many abortions become necessary through the lack of use or misuse of contraceptives, the provision of adequate contraceptive counselling, concerning the range of contraceptives available and the way in which each type of contraceptive is used, is necessary to reduce the need for abortion.

3.4. The Society recommends that information and advice concerning contraception shall be made available at any clinic or hospital carrying out abortions.

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