



Registering foetuses on the National Identity System

Implications for reproductive rights

We recommend:

That the Ministry of Health

1 Does not enable the registration of foetuses/unborn babies on the new health identity system as is currently proposed

2 Ensures that all information systems solutions, policies and programmes relating to sexual and reproductive health services recognise and preserve the distinction between foetuses and born children

3 Undertakes Gender Impact Assessment and reproductive rights analysis in the development of policy and infrastructure in all areas of women's health

4 Uses neutral language in technical Ministry of Health documentation related to sexual and reproductive health by referring to "foetus" rather than either "unborn baby" or "baby" when describing the foetus in utero.

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Introduction

THE Health IT Board is currently progressing with the Health Identity Programme which will deliver a single integrated system to lay the foundation for a secure and transferable electronic shared care record. It will replace the existing technology platforms supporting the National Health Index. The National Health Index number (NHI number) is a unique identifier that is assigned to every person who uses health and disability support services in New Zealand from birth or from first access. A person's NHI number is stored on the National Health Index (NHI) along with that person's demographic details. NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across New Zealand.

As part of the upgrade of the NHI there has been a proposal from foetal medicine specialists to formalise a process for assigning NHI numbers to foetuses whose mothers are under specialist foetal medicine care. There is already an informal practice of registering foetuses locally in DHBs using pre-allocated NHI numbers however this proposal formalises this process and would allow foetuses to be registered as "unborn babies" as part of the national system. The rationale behind this is for clinical safety reasons and to minimise the incidence of multiple registrations when more than one DHB provides services to the pregnant women in respect of the foetus. A set of clinical triggers that would warrant the registration of an "unborn baby" are yet to be agreed on.

This paper outlines concerns with this proposal from a reproductive rights perspective. It has been developed in response to the apparent lack of gender impact assessment and reproductive rights analysis undertaken on the proposal to date. Furthermore, to date, the relevance of reproductive rights considerations to this proposal has not been recognised by either the clinicians who have made the proposal or IT planners. As a result this paper is intended to clearly set out these concerns. It concludes with a set of recommendations to ensure that health IT solutions with regards to foetal medicine do not compromise women's reproductive rights, by inadvertently aiding efforts to establish legal status for foetuses in New Zealand law.

Abortion and reproductive rights

WOMEN'S right to comprehensive sexual and reproductive health services, including abortion, is rooted in international human rights standards guaranteeing the rights to life, health, privacy, and non-discrimination¹. However despite this, access to safe and legal abortion remains unsecured in many countries and abortion services are vulnerable to on-going legal challenge by those who oppose abortion in countries that have secured them². There is a high incidence of both morbidity and mortality that results from women seeking unsafe and illegal abortions, making safe and legal access to abortion services a key women's health and human rights issue³.

¹ Center for Reproductive Rights, Briefing paper. *Abortion and human rights: government duties to ease restrictions and ensure access to safe services*, October 2008

² Guttmacher Institute/World Health Organisation, *Facts on induced abortion worldwide*, February 2011, http://www.guttmacher.org/pubs/fb_lAW.html

³ Ibid.

In New Zealand most women can currently access safe and legal abortions however abortion is yet to be decriminalised, resulting in legal restrictions. The grounds for abortion in Aotearoa New Zealand remain in the Crimes Act. Under the Contraception, Sterilization and Abortion (CS&A) Act passed in 1977, abortion is legal so long as it is performed only in licensed premises and providing women obtain approval from two certifying consultants that they meet the grounds for abortion under the Crimes Act 1961. In 1977 and 1978 the Government amended the Crimes Act to provide a definition of the grounds for legal abortion.

Under sections 182 – 187A of the Act, an abortion is permitted during the first 20 weeks of pregnancy on the grounds that: (a) continuance of the pregnancy would result in serious danger (not that normally attendant upon childbirth) to the life or to the physical or mental health of the women; (b) if there is a substantial risk that the child, if born, would be so seriously abnormal as to be handicapped mentally or physically; (c) if the pregnancy is the result of incest or of sexual intercourse with a girl under care or protection; or (d) if the pregnant woman is severely mentally “subnormal”. Women must establish that they meet these grounds for abortion as laid out in the Act in order to legally access an abortion. As of the year ending December 2009, ninety eight percent of abortions in New Zealand are authorised on the grounds that proceeding with the pregnancy would pose serious threat to the women’s mental health⁴. The status of abortion in New Zealand law is considered a contributing factor to on-going issues with abortion services, namely the timeliness of access to services, access for women in rural areas, and the choice of abortion method⁵⁶⁷⁸.

One of the key strategies of abortion opponents has been attempts to establish, both legally and socially, the notion that the foetus is an “unborn child”

Establishing foetal personhood in law as anti-abortion strategy

INTERNATIONALLY, reproductive and sexual rights are being progressively realised⁹¹⁰. However despite this, the right to access safe and legal abortion services, in those countries that have secured them, face constant challenges from opponents of abortion.

One of the key strategies of abortion opponents has been attempts to establish, both legally and socially, the notion that the foetus is an “unborn child” and therefore that the termination of a pregnancy constitutes

⁴ *Abortion Supervisory Committee Report*, 2010, http://www.parliament.nz/en-NZ/PB/Presented/Papers/e/f/2/49DBHOH_PAP21018_1-Abortion-Supervisory-Committee-Report-for-the-year.htm

⁵ Silva, M. McNeill, R. Ashton, T. 2010 Ladies in waiting: the timeliness of first trimester pregnancy termination services in New Zealand, *Reproductive Health*, Vol 7, No 19.

⁶ The risk of complications from abortions increases with the gestation of pregnancy.

⁷ Silva, M. McNeill, R. Geographical access to termination of pregnancy services in New Zealand, *Australian and New Zealand Journal of Public Health*, 2008, Vol 32, No 6, pp. 519 – 521.

⁸ Abortion Supervisory Committee, 2009

⁹ United Nations General Assembly. 2011. *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*.

¹⁰ Guttmacher Institute/World Health Organisation, *Facts on induced abortion worldwide*, February 2011, http://www.guttmacher.org/pubs/fb_IAW.html

murder¹¹¹². Abortion restrictions can then be justified on this basis. Technological changes during the past three decades – foetal photography, ultrasound, advances in care for preterm infants, and foetal surgery- have provided the anti-abortion movement with an important resource for progressing their goal¹³¹⁴¹⁵. The imagery of foetuses produced by such technology has facilitated the personification of the foetus and challenged previous constructions of boundaries between foetus and infant¹⁶¹⁷. The problem with foetal imagery is that it erases pregnant women from view, decontextualising the foetus and overstating its independence from the woman who carries it and the social circumstances of her life. Anti-abortion groups have used foetal imagery to progress sympathies for the “unborn child” in opposition to the pregnant woman who is “out of view”.

In recent decades this has had a significant impact on western cultural understandings of what constitutes a pregnancy, and thus a termination of pregnancy¹⁸. Pregnant women and foetuses are increasingly seen as separate individuals, the rights of “unborn babies” needing to be defended against the selfish actions of their mothers¹⁹. This rationale has been used to justify the violent and intimidating practices of some abortion opponents against women seeking abortion, and against providers of abortion services.

As well as influencing western cultural views about pregnancy, anti-abortion groups are engaged in on-going attempts to establish the personhood of foetuses as rights bearing subjects in law. In New Zealand anti-abortion groups have made repeated attempts to establish a legal

standing and statutory legal rights for the foetus. Most recently anti-abortion group Right to Life (RTL) has had a long running case against the Abortion Supervisory Committee in the High Court. One of the aims of the case was to establish the rights of the foetus. Justice Miller ruled against Right to Life in 2008 on this matter. RTL went

on to argue for recognition of the rights of the foetus in the Appeal Court. The matter was again rejected again by the Appeal Court and subsequently the Supreme Court has not allowed it to be argued in a forthcoming case on other matters relating to abortion brought by RTL. The ‘born alive’ rule continues to govern the legal status of personhood in New Zealand law.

However there are currently inconsistencies in New Zealand law with

11 Norris, A. Basset, D. Steinberg, J. Kavanaugh, M. De Zordo, S. Becker, D. 2011. Abortion Stigma: a reconceptualisation of constituents, causes, and consequences, *Women's Health Issues*, Vol 21-3S, S49-S54.

12 Duden, B. 1993. *Disembodiment women: perspectives on pregnancy and the unborn*. Cambridge: Harvard University Press.

13 Norris et al.

14 Mitchell, L. (2001). *Baby's first picture: ultrasound and the politics of fetal subjects*. Toronto: University of Toronto Press.

15 Taylor, J. (2004). A fetish is born: sonographers and the making of the public fetus. In J. Taylor, L. Layne, D. Wozniak (Eds.), *Consuming motherhood* (pp. 187-210). New Brunswick: Rutgers University Press.

16 Hartouni, V. (1998). Fetal exposures: abortion politics and optics of allusion. In P. Treichler, L. Cartwright & C. Penley (Eds.), *The visible woman: imaging technologies, gender and science* (pp. 198-216). New York: New York University Press.

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18 Stabile, C. (1998). Shooting the mother: fetal photography and the politics of disappearance. In P. Treichler, L. Cartwright & C. Penley (Eds.), *The visible woman: imaging technologies, gender and science* (pp. 171-197). New York: New York University Press.

19 Petchesky, R. P. (2000). Foetal images: the power of visual culture in the politics of reproduction. In L. Janes, K. Woodward & F. Hovenden (Eds.), *The gendered cyborg* (pp. 171-192). London: Routledge.

regards to the legal status of the foetus. Peart notes several examples of cases in which New Zealand courts have effectively granted personhood to “protect” foetuses²⁰. In the high profile Nikki’s Case from 2002 “The High Court made an unborn child a ward of the Court to protect it against its mother’s decision to allow the birth to be filmed as part of a pornographic film”²¹. Likewise in the Baby P case from 1995 the court decided it had jurisdiction over a foetus that needed care and protection because it considered the mother unreliable and because she was in a violent relationship with the father²².

Both Canada and the United States have introduced legislation that recognises some legal status for foetuses. The United States’ Unborn Victims of Violence Act 2004 recognises a “child in utero” as a legal victim, if he or she is killed during the commission of any of over 60 listed federal crimes of violence. While the legislation was likely well intended and explicitly excludes abortion, reproductive rights groups and many legal observers have condemned it as a step toward granting legal personhood to human foetuses. The prosecution of pregnant women for foetal harm is also on the rise in the US²³.

Although no state in the US has enacted a law that specifically criminalises conduct during pregnancy, prosecutors have used statutes prohibiting abuse or neglect of children to charge women for actions that potentially harm the foetus²⁴. Estimates based on court documents, news accounts, and data collected by attorneys representing pregnant and parenting women indicate that at least 200 women in more than thirty US states have been arrested and criminally charged for their alleged drug use or other actions during pregnancy^{25,26}. The United Nations Special Rapporteur on the right to health has recently condemned the criminalisation of pregnant women’s behaviour.

In New Zealand anti-abortion groups have made repeated attempts to establish a legal standing and statutory legal rights for the foetus

The emergence of the foetal patient

AS A RESULT of developments in science and technology in foetal medicine the foetus is increasingly being assigned patienthood separate to the pregnant woman within whom the foetus is located. The emergence of two “patients” in foetal medicine raises concerns from a reproductive rights perspective. This is particularly the case in the context of the rise of the “unborn child” in the popular imagination and the attempts to establish its legal rights. In her research within foetal medicine departments social scientist Monica Casper^{27,28} noted that through an array of practices, the

20 Peart, N. The legal status of life before birth. In Skegg, P.D.G. & Paterson, R. Eds. *Medical Law in New Zealand*. Wellington: Thompson/Brookers, 2006. Pp. 461.

21 Ibid.

22 Ibid.

23 Center for Reproductive Rights. 2000. *Punishing women for their behaviour during pregnancy: an approach that undermines women’s health and children’s interests*. Briefing paper. www.reproductiverights.org

24 Ibid.

25 Ibid.

26 United Nations General Assembly. 2011. *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*.

27 Casper, M. 1994. At the margins of humanity: fetal positions in science and medicine, *Science, Technology, & Human Values*, Vol 19, No 3, pp. 307-323.

28 Casper, M. 1999. Operation to the rescue: feminist encounters with fetal surgery. In L. Morgan & M. Michaels (Eds.), *Fetal subjects, feminist positions* (pp. 101-112). Philadelphia: University of Pennsylvania Press.

foetus is positioned as a (potential) person with human attributes and as the primary patient. A consequence of this was that the pregnant women's personhood was reduced, the pregnant women becoming the secondary patient, an incubator at best or an obstacle at worst. Casper states,

In fetal surgery, then, practitioners have organised their work activities around a living fetal entity defined as the primary work object and constructed as a patient, person, and agent - in short, as "human". These fetal positions are consequential both for surgeons' work practices and for pregnant women. As with Liley's representations of active fetal agency, contemporary treatment practices erase maternal agency and position pregnant women as technologies, or as something other than persons.²⁹

This is not to say that pregnant women are not active agents in pursuing the potential benefits of foetal medical interventions for improving the outcomes of wanted pregnancies or that these interventions are necessarily bad for women. Both claims are likely to be grossly unrepresentative of most women's engagement with the technologies of foetal medicine.

Women's human rights and reproductive autonomy depend on both society and the legal system accepting that the foetus does not have any legally enforceable rights and is not legally recognised as a person until it is born alive

The challenge at the policy and service development level is however to ensure that the systems and practices developing within a foetal medicine context are sensitive to the broader reproductive rights context. This is a context in which women's procreative freedoms in relation to unwanted pregnancies must be actively preserved as a result of on-going attempts to undermine them. The needs and requirements of women with wanted pregnancies must not, and need not, be pitted against those women whose pregnancies are not wanted. This requires reproductive and maternal health services and systems that are informed by a broader understanding of reproductive politics and a commitment to placing the pregnant women, rather than the foetus, as the central consideration.

Registering “unborn babies” on the National Identity System as a reproductive rights issue

AS A RESULT of developments in foetal medicine there is now clearly a clinical safety requirement to ensure that the tests and treatment records of foetuses are distinguishable from pregnant women within clinical records. However the proposed solution of enabling the registration of foetuses within the National Identity system raises concerns from a reproductive rights perspective.

From a reproductive rights perspective this indicates the erosion in New Zealand health care and its information systems of the important distinction legally, and in practice, between foetuses and born babies. As demonstrated above, it is this distinction upon which women's human rights relating to reproduction and the right to terminate a pregnancy depend. In other words, women's human rights and reproductive autonomy depend on both society and the legal system accepting that the foetus does not have any legally enforceable rights and is not legally recognised as a person

until it is born alive. From a reproductive rights perspective the proposal to simply extend NHI eligibility to “unborn babies” undermines this important distinction and sets a concerning precedent, especially considering the presence of some ambiguities in New Zealand case law regarding foetal rights.

Women’s Health Action accepts that there may be no immediate legal implications in terms of inferring legal rights upon the foetus resulting from this proposal. We note that this is consistent with the legal opinion sought from Health Legal within the Ministry of Health. However we contend that the Ministry of Health has a special obligation to protect women’s reproductive rights³⁰. This means ensuring that all information systems, policies and programmes relating to sexual and reproductive health recognise and preserve the distinction between foetuses and born children. We are concerned that the Ministry of Health summary paper for HIP scope consideration titled ‘Registering Unborn Babies on the National Identity System’ included neither a consideration of potential gender impact nor a reproductive rights assessment³¹. We consider that this should be standard practice in the development of policy in all areas of women’s health. We also consider it more appropriate in technical Ministry of Health documentation related to sexual and reproductive health to refer to “foetus” rather than either “unborn baby” or “baby” when describing the foetus in utero.

Women’s Health Action supports information system solutions that ensure foetal treatment records are distinguishable from those of pregnant women to fulfil clinical safety requirements. However we also assert that these solutions must also be careful to preserve the distinction between foetuses and born children in system and practice. We urge the Ministry of Health to lead the development of solutions that satisfy both requirements.

The Ministry of Health has a special obligation to protect women’s reproductive rights

30 United Nations General Assembly. 2011. *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

31 Gender Impact Assessment tool http://www.odi.org.uk/rapid/tools/toolkits/EBP/Gender_impact.html

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