

# **Abortion Legislation Bill**

Government Bill

As reported from the Abortion Legislation Committee

## **Commentary**

### **Recommendation**

The Abortion Legislation Committee has examined the Abortion Legislation Bill and recommends by majority that it be passed with the amendments shown.

### **Our approach to considering this bill**

The Abortion Legislation Bill seeks to have abortion services provided like other health services. We recognise that abortion is a sensitive and contentious topic about which people hold a range of strong views. These deeply held views are also reflected amongst Members of Parliament.

We are grateful to those submitters who shared their views and stories, including their deeply personal, and at times difficult, experiences of abortion.

The Speaker of the House has determined that voting on the bill will be treated as a conscience issue for members. Accordingly, each member of the committee approached the consideration of the bill with their own views and did not represent any party position.

Our report also reflects that our views are based on our consciences. When expressing our opinions, we have used “we” for matters on which we unanimously agree. On matters where we were unable to reach consensus, we have used the term “most of us”, unless otherwise specified. This phrase refers to those members who supported the bill at first reading. They are:

- Hon Amy Adams (New Zealand National Party)
- Hon Ruth Dyson (New Zealand Labour Party)
- Jan Logie (Green Party of Aotearoa New Zealand)
- Hon Tracey Martin (New Zealand First)

- David Seymour (ACT New Zealand).

We have used the term “some of us” to refer to those members who opposed the bill at first reading. They are Anahila Kanongata’a-Suisuiki (New Zealand Labour Party) and Agnes Loheni (New Zealand National Party).

## **Reducing the need for abortions in New Zealand**

All members of the committee are of the view that we would like New Zealand to be a country where no pregnancies are unwanted and the number of abortions is low. Several factors—admittedly, outside our remit—would help to achieve these goals. They include improving access to contraception, addressing rates of sexual violence, and ensuring that support is available for mothers who want to continue with their pregnancies following an unplanned pregnancy.

In October 2019, Pharmac announced that it was extending access to long-acting reversible contraceptives. The full cost of Mirena and Jaydess (a new option) will be funded for anyone seeking long-term contraception. We were pleased to hear about this initiative and recognise the importance of contraception access for ensuring that people have control over their childbearing choices.

We heard from several submitters, particularly young women, who believed they might not have chosen abortion if they had received more support during pregnancy. We believe there should be no reason for teenagers to have to leave school during pregnancy or after having a baby. We encourage better access to, and support for, teen-parent units. However, we acknowledge that teenagers should be well supported to remain at their existing schools should they wish to do so.

## **About the structure of this commentary**

This commentary covers:

- descriptions of the current process for obtaining an abortion and the main changes that the bill proposes
- a brief explanation of our process for written submissions and oral hearings
- our proposed amendments and other matters that we discussed
- minority views.

## **Current process for obtaining an abortion**

### **Two certifying consultants must authorise an abortion**

The Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) requires two certifying consultants to authorise an abortion. They must be doctors, and at least one of them must be a practising obstetrician or gynaecologist. The Abortion Supervisory Committee appoints these certifying consultants after consulting the New Zealand Medical Association.

**Situations when abortions are permitted**

In New Zealand, a doctor can only perform an abortion in the first 20 weeks of pregnancy if two certifying consultants believe any of the following:

- continuing the pregnancy would result in serious danger to the woman's life, or to the woman's physical or mental health
- there is a substantial risk that the child, if born, would be "so physically or mentally abnormal as to be seriously handicapped"
- the pregnancy is the result of incest or sexual intercourse with a dependent family member
- the woman is "severely subnormal".

A doctor can only perform an abortion after 20 weeks gestation if two certifying consultants believe that it is necessary to save the woman's life or prevent serious permanent injury to her physical or mental health.

The CSA Act sets out a number of processes that must be followed before an abortion can be performed.

**Legal framework**

In New Zealand, performing an unlawful abortion and supplying the method for obtaining an abortion are criminal offences under sections 183 and 186 of the Crimes Act 1961. An abortion is considered unlawful unless certain legal grounds are met. These grounds, which are explained later, are set out in section 187A of the Crimes Act.

Under section 183(2) of the Crimes Act, the offence of obtaining an abortion does not apply to the woman seeking an abortion. However, section 44 of the CSA Act makes it an offence for a woman to unlawfully procure her own miscarriage or obtain an unlawful abortion. The penalty for the offence is a fine of no more than \$200.

The CSA Act sets out the regulatory framework and process for a woman seeking an abortion. It establishes the Abortion Supervisory Committee, which consists of three members, two of whom must be medical practitioners. The committee has a range of functions and powers, which are described in more detail below.

**Abortions must be performed in licensed institutions**

An abortion must be performed in a hospital, clinic, or other institution that the Abortion Supervisory Committee has granted a licence.

In New Zealand, two methods of abortion (surgical and medical) are used. The method used depends on the stage of the pregnancy, and other factors including the woman's preference for procedure, medical history, operator skill, and whether services are available locally.

A surgical abortion is most commonly performed using surgical techniques to remove the contents of the uterus through the cervix.

Medical abortion involves a woman taking drugs that cause a miscarriage. An early medical abortion most commonly involves a woman taking two medicines at specified intervals (mifepristone and misoprostol) that cause a miscarriage. An early medical abortion is a medical abortion that is performed in the first nine weeks of pregnancy.<sup>1</sup>

The CSA Act requires a woman to take both doses of medicine at a licensed institution. Generally, this means that a woman must attend an abortion clinic to take the first dose of medicine, and return to the clinic 24 to 48 hours later to take the second dose.<sup>2</sup> Having to make two visits can mean the woman has to potentially take more time off work or school, and incur additional travel and costs for things such as accommodation and childcare.

### *Licensing of facilities*

The Abortion Supervisory Committee considers, and grants or refuses, applications for limited or full licences. A limited licence authorises abortions to be performed only during the first 12 weeks of the pregnancy. A full licence authorises abortions to be performed at any gestation.

The committee must be satisfied that the institution has adequate facilities and counselling services, employs competent staff, and that the licence holder is a fit and proper person.<sup>3</sup>

Before granting a full licence, the committee must also be satisfied that the institution has adequate facilities for accommodating patients overnight.

The committee sets standards for the facilities that should be provided in licensed institutions. It must also take appropriate steps to ensure that they maintain adequate facilities and employ competent staff.

### **Role of the doctor when a woman requests an abortion**

Under section 46 of the CSA Act, no person is obliged to provide abortion services if they have a conscientious objection.

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<sup>1</sup> For early medical abortions, the Abortion Supervisory Committee recommends that a woman takes 200 milligrams of mifepristone, followed 24 to 48 hours later by 800 micrograms of misoprostol. For pregnancies between 9 weeks and 13 weeks and 6 days, the ASC recommends the above dose, followed by 400 micrograms of misoprostol every three hours until the pregnancy is aborted.

<sup>2</sup> For accessibility and convenience, some abortion service providers administer both drugs at the same time. However, we were told that this has a lower success rate.

<sup>3</sup> The licence holder will be the person in charge of the hospital or other institution.

When a woman or girl<sup>4</sup> visits her doctor and requests an abortion, the doctor must—unless they have a conscientious objection—refer the woman to a certifying consultant. The original doctor could be the first certifying consultant, and/or the person performing the abortion.

The certifying consultant must determine whether any of the legal grounds listed in section 187A of the Crimes Act apply. In a pregnancy of up to 20 weeks gestation, they are that:

- continuing the pregnancy would result in serious danger to the life, or to the physical or mental health, of the woman
- there is a substantial risk that the child would be “so physically or mentally abnormal as to be seriously handicapped”
- the pregnancy is as a result of incest or sexual intercourse with a dependent family member
- the woman is “severely subnormal”.

For a pregnancy of more than 20 weeks gestation, the abortion must be considered necessary to save the woman’s life or to prevent serious permanent injury to her physical or mental health.

If the certifying consultant determines that any of the grounds apply, the process varies depending on whether they plan to perform the abortion themselves. If they do, they must refer the case to one other certifying consultant to determine whether the grounds are met.

A certifying consultant who does not plan to perform the abortion themselves must refer the case to another doctor who may be willing to perform the abortion. This doctor is known as the operating surgeon.<sup>5</sup> If they are satisfied that any of the legal grounds applies, and are willing to perform the abortion, the operating surgeon must refer the case to one other certifying consultant.

### **Role of the certifying consultants**

The certifying consultants must consider the case as soon as practicable after it has been referred to them.<sup>6</sup> They can interview the patient, but are not required to unless the patient requests it. With the patient’s consent, the certifying consultant can also consult any other person that they consider necessary.

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<sup>4</sup> Section 38 of the Care of Children Act 2004 provides that a female of any age can consent to, or refuse, an abortion. This means that a young person does not require the consent of a parent or guardian to have, or refuse, an abortion.

<sup>5</sup> This applies for both surgical and medical abortions.

<sup>6</sup> If any of the certifying consultants has not reached a decision within 14 days, they must advise the Abortion Supervisory Committee in writing of the reasons for the delay.

If the certifying consultants agree that any of the legal grounds applies, they must issue a certificate authorising the abortion. If they do not believe that any of the legal grounds applies, they must refuse to authorise the abortion.

If the certifying consultants' opinions differ, they must refer the case to another certifying consultant for a third opinion.

The abortion can be performed at a licensed institution by a doctor when the certifying consultants have issued the certificate authorising the abortion.

### **Barriers caused by the current process**

We heard that the current authorisation process can cause lengthy delays. In some cases, a person may have to see as many as six practitioners before having an abortion.

We were advised that data is not routinely collected on the period of time it takes for women to access abortion services. However, a 2010 study assessed the timeliness of first-trimester services in New Zealand. It found an average wait of 25 days between the first appointment with the referring doctor and having the procedure.

We were told that some of the delays resulted in women having to have surgical abortions because they had passed the threshold for a medical abortion. Medical abortions are generally considered less invasive.

In its "Standards of Care for Women Requesting Abortion in Aotearoa New Zealand", the Abortion Supervisory Committee noted that the earlier in a pregnancy an abortion is performed, the safer and less painful it is. When performed earlier in the pregnancy, the procedure also takes less time, is less stressful for patients and clinicians, and is cheaper. The committee noted that early abortions also provide a woman with more choice about how and when her abortion is done.

We also heard that access to abortion services throughout New Zealand is inequitable, resulting in some women having to travel significant distances for services. Several district health boards (DHBs) do not provide abortion services within their region. In DHB regions that do provide services, some women must still undertake long journeys or travel to areas that are difficult to reach. Further, some DHBs do not provide first-trimester services locally and others only provide second-trimester services when a fetal abnormality is present. The inequitable access disadvantages women in certain areas, particularly rural areas, and women who may be unable to afford the costs associated with travel.

### **Abortion Supervisory Committee's other functions**

In addition to the roles described above, the other functions of the Abortion Supervisory Committee include:

- continually reviewing the abortion legislation and its operation and effect in practice
- taking appropriate steps to ensure that counselling facilities for women who seek abortions are adequate and sufficient

- collecting, analysing, and sharing information about abortions, and reporting annually to Parliament on how the legislation is operating.

### **Law Commission report on alternative approaches to abortion law**

In February 2018, the Minister of Justice requested advice from the Law Commission on alternative approaches to abortion law that would align with treating abortion as a health issue. In October 2018, the Law Commission published its briefing paper, “Alternative approaches to abortion law”.<sup>7</sup>

The commission reported on three models:

- **Model A:** There would be no statutory test that must be satisfied before an abortion could be performed. A woman would decide whether to have an abortion, in consultation with her health practitioner.
- **Model B:** A statutory test would need to be met before an abortion could be performed. However, this test would be in health legislation rather than the Crimes Act. The health practitioner who intends to perform the abortion would need to reasonably believe that the abortion is appropriate in the circumstances, having regard to the woman’s physical and mental health and wellbeing.
- **Model C:** There would be no statutory test for pregnancies of not more than 22 weeks gestation. For pregnancies of more than 22 weeks gestation, the same statutory test as in Model B would apply.

The options and discussion in the commission’s briefing paper informed the development of the bill. The bill as introduced is based on Model C, but with the statutory test applying after 20 weeks instead of 22 weeks, reflecting the current stage at which a different legal test applies.

### **Main changes that the bill as introduced proposes**

#### **Bill aims to treat abortion like other health services**

The bill seeks to have abortion services provided like other health services. It would do this by removing abortion from the Crimes Act and better aligning the regulation of abortion with other health services.

The bill would also modernise the legislation related to abortion. Medical abortions were not an established procedure when the CSA Act was passed. Further, the legislation contains deeply offensive language in relation to disabled people.

The bill would apply together with the existing regulatory controls for health services that are established in health legislation and the wider health system. In New Zealand, a range of legislation regulates the quality and safety of health services. It includes:

- the right for health consumers to receive an appropriate standard of care, access information, be fully informed, give informed consent, and make complaints

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<sup>7</sup> The report is available here.

about their care (Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights)<sup>8</sup>

- the requirement for health practitioners to be suitably qualified, competent, and fit to practise their professions (Health Practitioners Competence Assurance Act 2003)
- restrictions on who can supply or administer prescription medicine, in accordance with a prescription given by an authorised health practitioner (Medicines Act 1981)
- the requirement for hospitals to be certified and obligations for smaller service providers to ensure the safety of health facilities (Health and Disability Services (Safety) Act 2001 and the Health and Safety at Work Act 2015).

### **Removal of certain criminal offences from the Crimes Act**

Clause 12 of the bill as introduced would replace sections 182A to 187A of the Crimes Act. It would remove the existing criminal offences related to abortion, as well as the legal grounds for abortion. Instead, the circumstances when an abortion could be provided would be contained in the CSA Act.

The bill would insert a new criminal offence as section 183 of the Crimes Act. The offence would be for a person who is not a health practitioner performing an abortion or attempting to perform one, or procuring an abortion, or attempting to procure one. A woman on whom the abortion is performed, or attempted to be performed, would be excluded from the offence.

The Green Party member of the committee would prefer all abortion-related offences to be removed from the Crimes Act, in keeping with treating this procedure as a health issue. The member considers this would also recognise that the regulatory framework for health services is equipped to deal with risks from untrained providers.

### **Offence of killing an unborn child**

Section 182 of the Crimes Act contains an offence of killing an unborn child, and provides for a prison term of up to 14 years. The offence applies if a person causes the death of any fetus in such a way that they would be guilty of murder if it had become human.<sup>9</sup> Clause 11 of the bill as introduced would amend section 182(2) to make it clear that the offence does not relate to abortions performed in accordance with the CSA Act.

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<sup>8</sup> Clause 16 of the bill would amend section 2(1) of the Health and Disability Commissioner Act to clarify that abortion services are covered by the Health and Disability Services Consumers' Code of Rights.

<sup>9</sup> Section 159 of the Crimes Act provides that a child becomes a human being within the meaning of the Act when it has completely proceeded in a living state from its mother.



The Green Party representative wishes to clarify that this offence would apply when a pregnant person is assaulted. This distinguishes it from a situation where a pregnant person deliberately seeks an abortion outside the legal framework in this bill, which should never be considered a criminal offence.

### **New process for obtaining an abortion**

Clause 7 of the bill as introduced would replace sections 10 to 46 of the CSA Act with new sections 10 to 21.

New section 10 specifies that a qualified health practitioner could provide abortion services to a woman who is not more than 20 weeks pregnant. The decision would be between a woman and her doctor and no criteria would need to be satisfied before the abortion could be performed.

New section 11 as introduced sets out when a qualified health practitioner could provide abortion services to a woman who is more than 20 weeks pregnant. They would have to reasonably believe that the abortion was appropriate in the circumstances, having regard to the woman's physical and mental health, and well-being.

Under new section 14, a woman could self-refer to an abortion service provider. This means that she would no longer need to visit a GP for a referral before seeking abortion services from a qualified health practitioner.

As a result of these changes, certifying consultants would no longer be required.

### **Counselling**

Under section 35 of the CSA Act, a certifying consultant must advise a woman of her right to seek counselling when they make a decision about a case. Although counselling is not mandatory, the Act does not explicitly state this.

Under the bill, new section 13 provides that a health practitioner must advise a woman that counselling services are available if she is considering, or has had, an abortion. However, the bill makes it clear that counselling is not mandatory, as is also the case under the existing legislation.

The Minister of Health would be responsible for taking appropriate steps to ensure that counselling services are available throughout New Zealand.

### **Establishment of safe areas**

New section 17 contains a regulation-making power to create safe areas—of up to 150 metres—around specified facilities where abortion services are provided. The purpose of the safe areas is to protect the safety and well-being, and respect the privacy and dignity, of people accessing or providing abortion services.

New section 15 defines the behaviour that would be prohibited in a safe area. It includes intimidating or obstructing a person while intending to prevent them from accessing or providing abortion services. It also includes communicating with or visually recording a person who is accessing or providing abortion services.

**Conscientious objection**

Section 46 of the CSA Act provides that anyone can conscientiously object to performing, or helping to perform, abortion, sterilisation, or contraception services. Under the current legal framework, when a person requests these services, the person with the conscientious objection is not obliged to provide the services.

Section 174 of the Health Practitioners Competence Assurance Act 2003 sets out the conscientious objection provisions for health practitioners. A health practitioner who objected to providing contraception, sterilisation, or other reproductive health services would have to inform the person requesting services that they can obtain the services elsewhere.

The bill aims to facilitate access and avoid delays for women seeking abortions. Therefore, new section 19 would amend the process for a person who has a conscientious objection. That person would need to inform the person requesting the service about their conscientious objection at the earliest opportunity. For contraception or sterilisation services, the person would also need to tell the person how to access either the contact details of a provider; for abortion services, the person would need to tell the person how to access the list of abortion service providers. The Director-General of Health would be required to make and maintain a list of abortion service providers under clause 7, new section 18(1)(c).

Under section 46 of the CSA Act, it is illegal for an employer to deny anyone employment, give less favourable terms, or make any type of benefit conditional on a person providing abortion services.

New section 20 of the bill specifies that an employer that provides contraception, sterilisation, or abortion services would need to accommodate employees with a conscientious objection. However, this requirement would not apply if the employer considered that the conscientious objection would unreasonably disrupt the provision of services.

If the applicant or employee alleged discrimination based on conscientious objection, they could use the existing provisions in the Human Rights Act 1993 or the Employment Relations Act 2000.

Clause 14 of the bill as introduced would amend section 174(1)(a) of the Health Practitioners Competence Assurance Act to specifically include abortion. It would also replace section 174(2) to align that Act with the changes made to conscientious objection in the CSA Act.

**Monitoring and oversight of abortion services**

The bill would disestablish the Abortion Supervisory Committee. The Ministry of Health would assume the monitoring and oversight of abortion services as part of its existing role within the health sector.

New section 18 would require the Director-General of Health to collect, collate, analyse, and publish information about the provision of, and counselling services related

to, abortion services. They would also need to develop and publish standards for these services.

The bill would also remove the requirements for abortions to be performed in a specifically licensed facility. Instead, the safety of facilities would be governed by general health law, as is the case for other health services.

### **Our process for written submissions and oral hearings**

We received 25,776 written submissions from interested groups and individuals.<sup>10</sup> These submissions were all read and analysed, and the matters they raised informed our consideration of the bill.

About 91.6 percent of the written submissions oppose the bill and about 7 percent support the bill. About 1.4 percent of submissions did not have a discernible view. This analysis is based on the 25,718 written submissions that were received within the submissions period.<sup>11</sup>

We invited 160 submitters to oral hearings in Auckland, Christchurch, and Wellington.<sup>12</sup> We heard 30 hours of evidence. Inviting specific submitters allowed us to sit as a full committee and ensured that submitters had a longer than average hearing time.

Agnes Loheni believed that all submitters who wished to make an oral submission should have the opportunity to do so and she moved a motion to this effect. The motion was not agreed to.

We heard from individuals and organisations, including legal experts, medical professionals, faith-based organisations, and national bodies, focusing on:

- individuals with personal stories and experiences of abortion
- medical professionals who described how the bill may affect their role
- submitters who made specific recommendations for improving the bill
- submitters who discussed experiences of barriers to accessing abortion services.

### **Proposed amendments**

This commentary covers the main amendments we recommend to the bill as introduced. We do not discuss minor or technical amendments.

In addition to the amendments, we also discuss other matters that have not resulted in changes to the bill. We have grouped these matters under the relevant topics, rather than noting them separately after the proposed amendments.

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<sup>10</sup> This included 20,739 unique submissions, and 5,037 form submissions which replicated the content of another submitter.

<sup>11</sup> The 58 supplementary submissions that were received after submissions closed are not included in this figure.

<sup>12</sup> We subsequently heard from 139 submitters.

## **Abortions for the purpose of sex selection**

We were concerned to learn that the United Nations Population Fund estimates that 126 million women are “missing” around the world due to gender-biased sex selection. This figure includes abortion, as well as deaths of females after birth from infanticide and child neglect.

All of us oppose abortion solely on the basis of a preference for a particular sex, and we want to ensure that nothing in this bill could be seen as condoning it. However, we consider that it is important to acknowledge that there is no evidence of this happening in New Zealand and our concerns are based on reaffirming a strong position of New Zealand on this issue.

We considered possible options for addressing our concerns, including amending the bill to restrict abortion for the purpose of sex selection.

### **Non-legislative responses**

Non-legislative responses internationally include commitments by governments to address gender discrimination and bias, which are the underlying causes for sex-selective abortion practices.

One such example that New Zealand is a signatory to is the United Nations Population Fund’s Programme of Action of the International Conference on Population and Development. This initiative includes an objective to eliminate all forms of discrimination against girls and the root causes of a preference for sons. This discrimination can result in harmful and unethical practices regarding pre-natal sex selection and female infanticide.

### **Legislative responses**

We were advised that a range of methods have been used in countries that have, or have had, high rates of gender-biased sex selection.<sup>13</sup> They include legislation that prohibits determining the sex of a fetus, abortion for sex selection, and advertising about sex selection. Other approaches include setting conditions for a woman’s eligibility for certain pre-natal procedures, and regulating the sale of ultrasound machines.

However, we took note of the World Health Organization’s interagency statement on preventing gender-biased sex selection. It reported that restricting technology or prohibiting sex detection can limit safe access to abortion.

We were advised that legislation restricting the use of abortion for the purpose of sex selection is rare in jurisdictions comparable to New Zealand.

We oppose the performance of abortions solely on the basis of a preference for a particular sex, but most of us do not consider that including a restriction in legislation is necessary. This is because we believe that it could result in ethnic profiling, people not disclosing that the abortion is due to sex selection, or people seeking unlawful

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<sup>13</sup> The countries include India, Nepal, and South Korea.

abortions. However, one of us believes that preventing a woman from having to lie about the reason for an abortion is not a good enough reason for excluding the restriction from the legislation.

We recommend inserting a provision in clause 7 as new section 20F. It would be similar to one contained in the recent legislation in New South Wales, Australia.<sup>14</sup>

Our provision would emphasise that Parliament opposes the performance of abortions solely on the basis of a preference for a particular sex. It would also require the Director-General of Health to review whether abortions were being sought solely because of a preference for the fetus to be a particular sex. The review would need to occur at least every five years and the outcome reported to the Minister of Health. If there was evidence of abortions for the purpose of sex selection, the report would need to contain recommendations for how to prevent them.

We also recommend inserting a requirement as new section 20G for the Minister of Health to present a copy of the report to the House. It would need to be as soon as practicable after receiving the report. This requirement would also apply to the Director-General's review of the availability of certain services, which we discuss in the next section.

## **Availability of services**

### **Services that district health boards must provide**

The Minister of Health sets the national minimum requirements for the range and types of services that DHBs must fund. Abortion services and related counselling services are included in the range of services.

There are regional variations in the provision of abortion services across New Zealand. DHBs are required to provide, or arrange to provide, services to their populations that meet the minimum range and level of access set by the Ministry of Health. To achieve this, DHBs will often contract organisations, or make agreements with them, to provide the services required to meet the needs of the DHB's population. This may involve a DHB arranging for services to be provided by another DHB.

### **Concerns about barriers to accessing abortion services**

Most of us were extremely concerned to hear about the inequity of access to abortion services throughout New Zealand and the barriers that some submitters faced. The barriers included people in non-remote areas having to travel long distances for medical abortions, and lengthy delays to access services.

Most of us were also concerned to learn that the inequity also extends to the costs incurred in accessing abortion services. For example, we heard that while some DHBs reimburse the cost of travel and accommodation, others do not. This is a particular

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<sup>14</sup> The Abortion Law Reform Act 2019 was assented on 2 October 2019.

concern for women seeking medical abortions who may generally need to return to an abortion clinic 24 to 48 hours after their first visit.

The National Travel Assistance Scheme (NTA) can provide reimbursement towards the cost of travel and accommodation.<sup>15</sup> It provides financial assistance to people who need to travel long distances or very frequently to attend specialist hospital treatment. The person must be referred by their specialist to see another specialist. Both specialists must be part of a health and disability service that is government funded.

To be eligible, a person must be travelling 80 kilometres or more one way (as a child under 18) or 350 kilometres or more (as an adult). For holders of a Community Services Card, the distance is 25 kilometres or more one way (as a child) or 80 kilometres or more one way (as an adult).<sup>16</sup> While guidance is provided on what the scheme should cover at a minimum, it is the responsibility of DHBs to determine eligibility for the scheme and for cases outside the minimum described in the guidance. The scheme allows DHBs to have regional variation in the situations they will cover under the NTA. A review of the scheme,<sup>17</sup> which was published in 2019, found that the administration of the scheme was inconsistent across DHBs, and that there was a general lack of awareness about the scheme.

We acknowledge that if the bill is enacted, the ability for women to refer themselves to abortion services, and making medical abortion prescriptions accessible in more places, could result in some of these barriers being removed. Services could also be provided in more settings, including rural locations, if abortions no longer need to be performed in specifically licensed institutions.

However, most of us consider that these changes alone will not address some people having to travel long distances for abortion services. This is because the national minimum requirements do not stipulate that services must be provided within a certain distance of a person's residence.

Most of us believe that contraception (including emergency contraception) and early medical abortions should be provided within a reasonable distance from a person's domicile. We realise that people have to travel long distances for other health services. However, most of us consider that contraception and abortion services are different. This is because no other service requires a person to travel for hours to merely be prescribed a pill. Further, the ability for a person to conscientiously object may mean that certain services, some of which are ordinarily provided in a pharmacy, are not available in some areas.

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<sup>15</sup> The scheme is intended to be a contribution to a person's costs to attend appointments. It is not intended to cover the full costs.

<sup>16</sup> The other eligibility criteria relate to people who need to travel very frequently.

<sup>17</sup> Ministry of Health (2019), *The National Travel Assistance Scheme: Policy Recommendations Report*, September 2018.

The time-sensitive nature of abortion means barriers to early access can be distressing for women and lead to more complicated medical interventions being required to terminate a pregnancy after the first trimester. Most of us agree that improving access to abortion services early in a pregnancy is in the best interests of the patient.

To assess whether the legislation results in the barriers to accessing abortion services being removed, most of us recommend amending clause 7 to insert new section 20B. Our proposed new section would require the Director-General to undertake periodic reviews of certain matters.

The Director-General would be required to report to the Minister of Health at least every five years about whether access to certain services is timely and equitable. The services are contraception, sterilisation, and abortion services, and information and advisory services about whether to continue or terminate a pregnancy.

The review and report would also need to consider the costs throughout New Zealand for women accessing the services, including travel and accommodation costs.

### **Conscientious objection**

All of us want to ensure that the rights of a person to exercise religious freedom and a person's ability to access services are balanced.

The bill would require a person to disclose their conscientious objection at the earliest opportunity. We spent some time considering what "earliest opportunity" would mean in practice.

We discussed ways in which a conscientious objection could be communicated to a person, balancing their right to be informed against not stigmatising someone who has a conscientious objection. The methods we discussed include being notified when a person first registers with a medical practice, receiving information from a practice's website or at reception, and calling a Ministry of Health telephone line.

We recognise that, for some people, conscientious objection operates on a continuum, making it more difficult to clearly disclose. For example, some doctors may be willing to perform abortions only up to a certain gestation or depending on their patient's individual circumstances.

Most of us consider that it is unreasonable for a person to only discover that a person has a conscientious objection when attending a consultation or pharmacy. All of us believe that it would be inappropriate for a woman to be charged for a consultation where she is simply informed of a conscientious objection. We also believe that maintaining relationships by minimising the potential for confrontational conversations is in the best interests of patients and medical professionals. Therefore, we strongly urge medical practices to find the best way to communicate conscientious objections for the sake of both patients and medical practitioners.

**Ensuring the consistency of conscientious objection provisions**

Clause 7, new section 19, would apply to a person who objects to providing contraception, sterilisation, or abortion services, or information or advisory services about whether to continue or terminate a pregnancy.

It would cover any person who is asked to provide, or help to provide, these services, and could include doctors, nurses, midwives, administrative staff, counsellors, and pharmacists.

A person would have to disclose their conscientious objection at the earliest opportunity, with the obligations differing depending on the service requested. For contraception and sterilisation services, the conscientious objector would have to tell the person how to access the contact details of another provider of the service (new section 19(2)(a)).

For abortion services, or advisory services about abortion, the conscientious objector would have to tell the person how to access the list of abortion service providers (new section 19(2)(b)).

We understand that the aim of requiring a conscientious objector to tell a person how they could find another provider is to facilitate access to that service. Most of us believe that the requirement in clause 7 as introduced, new section 19(2)(b), would not facilitate access to abortion services. This is because the list of abortion service providers would only contain qualified health practitioners.<sup>18</sup> If a person was requesting services from a conscientious objector who is not an abortion service provider, such as a receptionist, they would still be referred to the list. This could cause delays, for example if all the person needed was to make an appointment.

Most of us recommend amending new section 19(2) to make the conscientious objection provisions consistent across contraception, sterilisation, and abortion services. Someone with an objection would have to tell the person how to access the contact details of the specific service they wanted.

For consistency, we recommend similarly amending clause 14, to amend section 174(2) of the Health Practitioners Competence Assurance Act. This section relates to conscientious objection for health practitioners regarding reproductive health services.

*Supplying contraceptives to sexual violation complainants*

Section 5 of the CSA Act relates to supplying contraceptives to avoid the risk of pregnancy when a person makes a complaint of sexual violence. It requires a constable to refer the complainant to a medical practitioner. The section also applies when a patient complains of sexual violation to any medical practitioner.

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<sup>18</sup> The bill defines a qualified health practitioner, in relation to the provision of abortion services, as a health practitioner who is acting in accordance with the Health Practitioners Competence Assurance Act.



If the medical practitioner has a conscientious objection, they must advise the person of their right to obtain services from another medical practitioner or a family planning clinic.

For consistency with our proposed amendments above, we recommend inserting clause 6A to amend section 5. A person with a conscientious objection would need to declare their conscientious objection and tell a woman how to access the contact details of another person who is a provider of contraceptive services.

### **Conscientious objection would not apply in a medical emergency**

The CSA Act does not specify whether a person may exercise a conscientious objection during a medical emergency. We believe that the obligations for a person who has a conscientious objection should be explicit.

Therefore, we recommend amending clause 7 to insert section 19(3). This would make it clear that a health practitioner has a professional and legal duty to provide medical assistance in a medical emergency and that a conscientious objection does not override this duty.

### **Conscientious objection only to apply when considering whether to continue or terminate a pregnancy**

Clause 7, new section 19(1)(d) as introduced, would apply to information or advisory services about continuing or terminating a pregnancy. Most of us recommend replacing the words “continuing or terminating” with “whether to continue or terminate”. This would make it clear that the section is not intended to apply to a person seeking advice about continuing a pregnancy that they wanted.

### **Conscientious objection and employment**

Clause 7, new section 20, would allow employers, when making decisions about employment, to consider how an employee with a conscientious objection would affect their provision of services. An employer would have to accommodate a person with a conscientious objection, unless they considered it would unreasonably disrupt the employer’s activities.

The assessment of whether the disruption is unreasonable is subjective—that is, the employer must make the decision. We understand that the assessment was intended to be similar to the one in the Human Rights Act, which is objective. Most of us recommend that the assessment should be objective.

Therefore, most of us recommend amending proposed new section 20(2) to provide that if accommodating the applicant’s or employee’s objection would unreasonably disrupt the employer’s provision of health services, the employer may take any of the actions described in subsection (1).

For consistency with the Human Rights Act, most of us recommend amending clause 7 to insert section 20(2A). This amendment would make it clear that an employer must consider adjusting an employee’s activities so that another employee performs the duties to which the applicant or employee objects.

*Definition of employer*

The Employment Relations Act defines an employer as “a person employing any employee or employees; and includes a person engaging or employing a home-worker”. It does not include volunteers. Contractors are not covered by most employment-related laws and do not have the right to take personal grievances.

Accordingly, the Human Rights Act contains an expanded definition of employer. It includes people who would not otherwise be covered by the Employment Relations Act. This ensures that they are protected against discrimination in employment and can make a complaint under the Human Rights Act.

The bill as introduced does not contain a definition of an employer. We were advised that, as drafted, the bill appears to apply only to those in a traditional employer and employee relationship. This would mean that where people in non-traditional employment relationships have a conscientious objection, the obligations and rights of both parties are unclear. Examples of non-traditional employment relationships to which the bill could apply include volunteers and contractors, such as locums or temporary staff employed through a recruitment agency.

We believe that volunteers and contractors should also have the right to conscientiously object to providing certain services. Therefore, we recommend amending clause 7 to insert section 20(5). This would specify the definition of an employer, which would be similar to the definition in section 2 of the Human Rights Act. An employer would be defined as including:

- the person for whom work is being done by an independent contractor
- the person for whom work is being done by contract workers under a contract between that person and the person who supplies the contract workers
- the person for whom work is being done by an unpaid worker.

We emphasise that this would only apply to conscientious objection, and that other employment relations obligations should not be imposed on those described above.

**Conscientious objection for contraception, sterilisation, and abortion services**

We had mixed views about whether conscientious objection should apply to all aspects of the CSA Act. Several of us have reservations about pharmacists being able to conscientiously object, particularly in areas where they are the sole provider of services.

We were advised that in areas where the only pharmacist has a conscientious objection, alternative options may be available. For example, in some situations a doctor who prescribes abortion medication can also supply the medication. In all cases, DHBs are obliged to ensure that services are available for their population and to be the provider of last resort. DHBs would need to ensure that they have appropriate processes to enable access.

We do not want to impinge on the right of an individual to exercise a conscientious objection. When a person has a conscientious objection, most of us consider that the overarching obligation remains with the Minister of Health, through the DHBs, to

ensure that timely access is not degraded. This applies not only to abortion services, but also for contraception services.

We recommend inserting new section 20A in clause 7 to require the Minister of Health to ensure that certain services are available. Under proposed new section 20A(a)(i), the Minister of Health would be required to take reasonable steps to ensure that the services specified in section 19(1) were available throughout New Zealand. Those services relate to contraception, sterilisation, and abortion services, and information and advisory services about whether to continue or terminate a pregnancy.<sup>19</sup>

The Minister of Health would also need to ensure that the abortion services were provided in accordance with the standards published by the Director-General under our proposed new section 20D(1)(b).

### **Charging for services when a person has a conscientious objection**

We discussed whether a person should be charged for a service that has not been provided because of a conscientious objection.

Generally, there are no patient charges for a woman in the first trimester seeking pregnancy-related care if she is eligible for maternity care in New Zealand.<sup>20</sup> The Primary Maternity Services Notice (pursuant to section 88 of the New Zealand Public Health and Disability Act 2000) covers GPs who provide pregnancy care for a woman in the first trimester. This includes referral to abortion services. However, where GPs have not applied for an authorisation to claim from the Notice, they will instead charge a patient fee for any pregnancy care provided.

We note that a GP with a conscientious objection may still provide services for a woman who attends a consultation after discovering or suspecting that she is pregnant. This may include confirming the pregnancy, taking first-trimester swabs and blood tests, discussing possible options, or referring the patient to another service. Given the level of variation in services provided, we agree that not charging for a consultation with a GP with a conscientious objection may be difficult to administer.

As previously mentioned, all of us agree that a person should not be charged for a consultation for non-maternity services, such as contraception, where only a conscientious objection is disclosed and no further services are provided.

### **Safe areas**

The bill would create a regulation-making power to allow safe areas—of up to 150 metres—to be established around specific abortion facilities, on a case-by-case basis. The purpose is to protect the safety and well-being of people accessing abortion facil-

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<sup>19</sup> The other services that need to be made available relate to counselling. We discuss those changes in our section on counselling.

<sup>20</sup> Costs for maternity care vary after the first trimester.

ities, including practitioners providing and assisting with abortion services, and to respect their privacy and dignity.

A person who engaged in certain prohibited behaviour would commit an offence and be liable on conviction to a fine of up to \$1,000.

We discussed whether the intended purpose of safe areas justified limiting a person's right to freedom of religion and freedom of expression. We also considered whether safe areas should be automatic or established after an application from an abortion provider.

We note that safe areas operate in four Australian states and two territories. Of these jurisdictions, all but the Australian Capital Territory prohibit protests within 150 metres of an abortion service.<sup>21</sup> We heard evidence that some people would not provide abortion services in Victoria, Australia without safe zones.

Agnes Loheni and David Seymour do not believe that safe areas are needed in the New Zealand context. Further, the impairment of freedom of expression would not be justified even in the case of any foreseeable protest activity in New Zealand. They noted that the Law Commission did not recommend this provision in its report.

The rest of us support safe areas being established upon application.<sup>22</sup> We note that abortions are already performed at some hospitals and could be provided in more settings, such as medical practices. We consider it unnecessary for safe areas to automatically apply to all abortion facilities.

### **Prohibited behaviour in safe areas**

Clause 7 of the bill as introduced, new section 15(3), defines the prohibited behaviour in a safe area.

Section 15(3)(a) would prohibit a person from intimidating, interfering with, or obstructing a person with the intention of preventing them from accessing or providing abortion services, or advice or information about abortion services, or being reckless as to whether they are prevented.

Section 15(3)(b) would prohibit a person from communicating with or visually recording a person who is accessing or providing abortion services, or advice or information about abortion services. The behaviour would have to be in a way that:

- is intended to cause the person emotional distress (section 15(3)(b)(i)); and
- would cause emotional distress to an ordinary reasonable person in the position of the person (section 15(3)(b)(ii)).

The majority of us consider that the threshold for the offences in section 15(3)(b) is too high. In particular, it would be difficult to prove what effect the offender intended their behaviour to cause. We also believe that proving the recklessness of a person's

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<sup>21</sup> Exclusion zones of no less than 50 metres are set at the discretion of the ACT Health Minister.

<sup>22</sup> In this section, we use the term "the majority of us" to refer to members who support safe areas.

behaviour under section 15(3)(a) could be difficult. Therefore, most of us consider that the tests in section 15(3)(a) and (b) should be objective—that is, an ordinary reasonable person would know that the behaviour would cause emotional distress to a person accessing or providing abortion services.

The majority of us recommend amending the definition of prohibited behaviour by replacing section 15(3) in clause 7. Our proposed amendment would define a protected person. They would have to be in a safe area to access, provide, or assist with the provision of abortion services or advice or information about abortion services.

Prohibited behaviour would be defined as intimidating, interfering with, or obstructing a protected person:

- with the intention of frustrating the purpose for which they are in the safe area; or
- in a way that an ordinary reasonable person would know would cause emotional distress to a protected person.

It would also include communicating with, or visually recording, a person in a manner that an ordinary reasonable person would know would cause emotional distress to a protected person.

### **Renewal of safe areas**

The majority of us believe that it is reasonable for safe areas to be periodically reviewed to ensure that the limitation on people's rights is balanced and justified. We recognise that a safe area that has been operating may not have had any incidents within it. This makes it hard to justify why it is needed. If a review resulted in a safe area being revoked, most of us do not believe that the process for reapplying would be too onerous.

The majority of us recommend amending clause 7, inserting section 17(3). Our amendment would require the Ministry of Health, in consultation with the Ministry of Justice, to have completed a review of the safe area within five years of the area's establishment. The Director-General would need to report to the Ministers of Health and Justice on whether the regulations should be continued, amended, or revoked.

### **Penalty for prohibited behaviour**

A person who engages in prohibited behaviour would commit an offence and be liable for a fine of up to \$1,000. We discussed whether the maximum penalty for the offence was appropriate.

We received advice that the penalty is consistent with similar offences in the Summary Offences Act 1981 and the Trespass Act 1980. A person could also be charged with more serious offences, such as criminal harassment under the Harassment Act 1997 or assault offences under the Crimes Act.

**Posting visual recordings online of people accessing abortion services**

We are interested in the penalties for a person who visually records a person accessing abortion services and posts them online. The Harmful Digital Communications Act 2015 contains several ways that a person can make a complaint, with the penalties varying according to the level of harm caused.

A person can complain to NetSafe, which was established to resolve complaints about harm caused to individuals by digital communications. This can involve a settlement with the person who posted the digital communication.

A person can also apply to the District Court for an order in cases of serious or repeated breaches. The penalty for breaching the order is up to 6 months imprisonment or a maximum fine of \$5,000.

Section 22 of the Harmful Digital Communications Act also contains an offence of causing harm by posting a digital communication. This is punishable by up to 2 years imprisonment or a fine of \$50,000 for individuals or \$200,000 for organisations.

**Collecting and publishing information about abortion services****Duties of the Director-General of Health**

Clause 7, new section 18, specifies the duties of the Director-General of Health.

New section 18(a) would require the Director-General to collect, collate, analyse, and publish information about the provision of abortion services and related counselling services. They would also have to develop and publish standards for these services under new section 18(b). New section 18(c) would require the Director-General to make and maintain a list of abortion providers.

We recommend splitting these duties into separate sections. Consequently, we recommend deleting new section 18.

We recommend that the requirements from section 18(a) and (b) be inserted as new section 20D. We recommend inserting the requirement to make and maintain a list of abortion service providers as new section 20C.

**Transitional provisions for data collection**

Under the CSA Act, all providers of abortion services are required to report abortion data to the Abortion Supervisory Committee.

New section 21(a) would allow the Governor-General to make regulations. These would enable the Director-General of Health to collect the information needed to perform the duties specified in section 18 of the bill as introduced.

We recommend inserting transitional provisions as clause 7, new section 20E. This would require abortion service providers to continue collecting data related to abortion services, which would be provided to the Ministry of Health. The information to be collected would be specified in new Schedule 2.

We recommend that the transitional provisions should expire 18 months from the date that the bill comes into force.

Our proposed amendments would give time for the Ministry of Health to make operational arrangements, or for regulations to be made. This would ensure continuity between the data collected by the Abortion Supervisory Committee and the ministry.

### **Privacy of health information**

The bill would remove sections 36 and 45 of the CSA Act. Sections 36(2) and 45(2) provide that the reports submitted to the committee by certifying consultants and doctors must not contain the name or address of any patient.

The bill as introduced does not contain specific provisions regarding the anonymity of the data collected and published by the Director-General of Health.

A range of rules protects the privacy of health information for individuals. They include confidentiality obligations in professional and ethical standards, and the Privacy Act 1993. Under that Act, codes of practice may be developed for sectors. The Health Information Privacy Code 1994 controls how personal health information for an individual is collected, used, disclosed, stored, disposed of, and accessed.

We expect that any regulations resulting from this bill would align with legislation that protects the privacy of individuals. However, for clarity, we recommend amending clause 7 to insert section 20D(2) specifying that the information published according to this section must be anonymised.

### **Data to be collected by the Ministry of Health**

#### *Data that the Abortion Supervisory Committee collects*

The Abortion Supervisory Committee currently collects data via its ASC Form No. 4, which operating doctors must complete when an abortion is performed. The information is forwarded to Statistics New Zealand to collate and publish.

The data collected is: facility name; date of birth; Health Domicile Code; residency status; ethnicity; number of previous live births and previous induced abortions; estimated gestation; grounds for performing the abortion; abortion procedure; contraception provided at the time of the procedure; complications; and method of contraception at conception.<sup>23</sup>

We believe that the data that is collected should be consistent so that it is comparable. Therefore, we agree that, at a minimum, the Ministry of Health should be expected to continue to collect the data contained in the ASC Form No. 4. The exception to this is the legal grounds for an abortion, given that they would no longer apply.

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<sup>23</sup> The Abortion Supervisory Committee also collects information from holders of licensed institutions and certifying consultants. These roles will no longer exist if the bill is passed.

*Additional data that we would like to see collected*

To reduce the rate of abortions, we believe, it is important to collect data that would help determine why women seek to end pregnancies. This would allow future governments to identify areas where there are gaps in services.

We would also like to ensure that women who have abortions are well supported throughout the process. Therefore, we believe that data should be collected about the support that they received before the abortion, as well as information such as time-frames for the process of obtaining an abortion.

We asked the Abortion Supervisory Committee whether it would like to see any other data collected that is not currently collected. It told us that the following information could be beneficial:

- data about the provision and uptake of counselling services—both during the decision-making process and after an abortion—including the name of the provider to allow counselling care to be adequately monitored
- information on family violence and screening
- the length of time between a patient's first contact with a service and obtaining the abortion procedure
- information on the type of health practitioner who has performed the abortion or administered or prescribed abortion medication
- the use of interpreters
- general information about health practitioners, such as their location, gestational limits they are willing to perform up to, and the types of procedures they carry out.

We agree with the Abortion Supervisory Committee that it would be beneficial to collect this data and encourage the Ministry of Health to include this in its work programme.

**List of abortion service providers**

We considered how a person could identify providers of abortion services. This is particularly important given that a person could self-refer if the bill is passed.

Clause 7, new section 18(1)(c), would require the Director-General of Health to make and maintain a list of abortion service providers. This list would not need to be published. In our previous section, we recommended moving these provisions to new section 20C.

We discussed whether the list should be made publicly available, with providers able to choose whether their details were published. However, we noted that publishing a list could put practitioners' safety and privacy at risk.

Therefore, most of us recommend inserting new section 20C(3), which provides that the list be made available on request. Most of us also recommend amending clause 7 to insert section 20C(2). This amendment would specify that a provider could opt out of having their details made available on request.



All but one of us also recommend amending clause 2 to insert a definition of “abortion service provider”. An abortion service provider would be defined as “an entity that provides abortion services”. Consequently, all but one of us also recommend inserting a definition for “entity”.

### **Informed consent**

Some submitters who have had abortions told us that they do not believe they had given fully informed consent. All of us consider that it is imperative that women are appropriately and comprehensively informed when deciding whether or not to have an abortion.

This is particularly true for minors. Particular care needs to be taken to ensure that minors are told about the consequences of whatever decision they make in a way that they will understand. Young people may be making decisions alone, although abortion service providers have told us that they work hard to ensure that young people are supported by an appropriate adult wherever possible.

### **Obligations for informed consent under the code**

The Code of Health and Disability Services Consumers’ Rights is a regulation made under the Health and Disability Commissioner Act. It applies to all health and disability services in New Zealand. The code describes the rights of all health and disability consumers and the obligations for service providers.

Informed consent is an important part of the code. Health practitioners providing abortion services would continue to be subject to all responsibilities in the code.

The components of the consent process are: effective communication, full information, and competent consent that is given freely. These are covered by Rights 5, 6, and 7 of the code (the right to effective communication, the right to be fully informed, and the right to make an informed choice and give informed consent).

Right 7(1) explicitly states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent.<sup>24</sup> The code does not specify any age limit or make special provision for children—it applies to all consumers. Right 7(2) of the code presumes that every consumer of health services is competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that they are not competent.

Under section 36 of the Care of Children Act, a child aged between 16 and 18 years may give consent to medical procedures, including contraceptive treatment and advice, and surgical procedures.

In New Zealand, a person under the age of 16 will be considered competent and able to choose whether to accept treatment if they are mature enough to fully understand

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<sup>24</sup> The exceptions to this are where any enactment, the common law, or any other provision of the code provides otherwise.

the treatment offered.<sup>25</sup> This includes the purpose, risks, and benefits of the treatment. The health practitioner must judge whether a person is competent to give informed consent to a procedure. This view is based on the risk involved in the procedure, and the person's understanding and maturity.

We would like to highlight that the consent process is not limited to being informed about medical procedures. It also includes ensuring that women are provided with all options and choices, such as adoption. We heard a suggestion that women should be provided with the contact details for disability organisations. This would apply when a woman sought information about whether to continue or terminate a pregnancy after screening had suggested that an impairment may be present.

For minors, we emphasise the importance of extra consideration being given due to their age, and ensuring that the process is well explained and understood. The "Standards of Care for Women Requesting Abortion in Aotearoa New Zealand" state that young women should be provided with accurate, age-appropriate education, information, and support related to their chosen pregnancy option (standard 8.3.5). They also emphasise that abortion services should suggest or support a young person to involve a parent or another adult (standard 8.3.8).

## Counselling

Under the CSA Act, the Abortion Supervisory Committee must take appropriate steps to ensure that sufficient and adequate facilities are available for counselling women who seek advice about abortion. This bill would transfer this responsibility to the Ministry of Health.

Counselling is not mandatory under the CSA Act. However, after making a decision about a case, a certifying consultant must advise a woman that she has the right to seek counselling.

Clause 7 of the bill as introduced, new section 13, would require a health practitioner to advise a woman that counselling services are available. This would apply where a woman seeks advice about whether to continue or terminate a pregnancy, wishes to terminate a pregnancy, or has had an abortion. The health practitioner could not require a woman to attend counselling as a condition of receiving abortion services.

We considered whether young people under the age of 18 should be obliged to have mandatory counselling. However, we received evidence that it would be a breach of consent, breach the right to autonomy and self-determination, and potentially expose them to physical, mental, or cultural harm.

We agree that counselling needs to be available but not mandatory. It should be culturally appropriate, suited to the person's age or vulnerabilities, and available when they need it. We believe it is particularly important for counselling to remain avail-

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<sup>25</sup> Section 38 of the Care of Children Act specifically states that a child of any age can consent, or refuse to consent, to an abortion.

able at any stage after an abortion or when a woman continues with a pregnancy. We heard from several submitters who said that counselling might have helped when they later completed a pregnancy, often years after their abortion.

### **Ensuring the availability of counselling services**

We recommend deleting section 12 in clause 7, which requires the Minister of Health to ensure availability of counselling services for abortion. We recommend moving this provision to our new section 20A (Minister of Health to ensure availability of services). We previously discussed this amendment in our section on availability of services.

Our proposed new section 20A(a) would require the Minister of Health to take reasonable steps to ensure that counselling related to abortion services was available throughout New Zealand. The counselling services would have to be provided according to the standards published by the Director-General under our proposed new section 20D(1)(b).

### **Director-General to review access to counselling services**

We believe that it is important to assess whether women are receiving appropriate support that is equitable across New Zealand. We also consider that the costs of counselling services should be assessed, including whether they are equitable or a barrier for some people.

We recommend inserting a requirement in our proposed new section 20B for the Director-General to undertake periodic reviews of certain matters. At least every five years, the Director-General would have to consider whether access to counselling services was timely and equitable. The Director-General would be required to report to the Minister of Health the outcomes of the review, including any recommendations for improving access to services.

The review and report would also need to consider the costs for women to access counselling services.

### **Abortions after 20 weeks gestation**

We were advised that performing abortions from around 19 weeks gestation involves more complex circumstances, settings, and procedures than those performed earlier. In New Zealand, about seven specialists perform these procedures, all in hospital settings. In such cases, multiple practitioners are involved in the clinical care, which can include a specialist obstetrician, maternal–fetal medicine specialist, midwife, nurse, and a social worker.

The CSA Act already differentiates between abortions before and after 20 weeks gestation. The bill as introduced would not change the threshold at which different considerations apply. Rather, it would change the legal test that was applied.

Clause 7, new section 11, sets out the statutory test for abortion services for a woman who is more than 20 weeks pregnant. A qualified health practitioner must reasonably

believe that an abortion is appropriate. They would have to have regard to the woman's physical and mental health, and well-being.

A number of submitters oppose the statutory test. Submitters who oppose the bill consider that the test is vague and unclear and will be open to interpretation by health practitioners. They believe that the test will result in abortions being performed after 20 weeks without an appropriate framework for medical and clinical oversight. Some submitters maintain that the bill would allow anyone who requests an abortion after 20 weeks to obtain one, even if there is no threat to their physical or mental health, or well-being.

Conversely, many submitters who support the bill believe that there should be no statutory test, supporting the Law Commission's Model A. They consider that women and their doctors are best placed to make decisions at later gestations. Also, they note that very few abortions occur after 20 weeks.<sup>26</sup> These are generally terminating wanted pregnancies in complex and distressing situations, where there are severe fetal anomalies or the abortion is necessary to save the woman's life.

We acknowledge these concerns from submitters. However, most of us were persuaded by submissions from several abortion providers. They told us that abortions after 20 weeks are only performed when there is a compelling clinical need, after extensive consultation between a woman and her health practitioners. The majority of these abortions are for fetal anomalies, which may not be identified until the routine 18 to 20 week ultrasound.

### **Differentiating between the Law Commission's models**

Model C of the Law Commission's alternative approaches to abortion law clearly differentiates between abortions before and after 22 weeks gestation. A statutory test would only need to be satisfied for abortions after 22 weeks gestation. For pregnancies of not more than 22 weeks, the decision to have an abortion would be between a woman and her doctor.

When the Abortion Legislation Bill was introduced, the Minister of Justice made it clear that Model C was being adopted, but that the legal test would apply after 20 weeks, rather than 22 weeks. All but one of us believe that the distinction between Model A (no statutory test) and Model C needs to be strengthened.<sup>27</sup> Our proposed change to this effect is discussed later in this section.

### **Legal and ethical obligations for doctors**

The decision to perform an abortion—at both pre- and post-20 weeks gestation—ultimately remains with the qualified health practitioner, rather than the woman. Nothing in the bill would compel a doctor to perform an abortion if a woman requests

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<sup>26</sup> In 2017, only 1.7 percent of abortions occurred between 17 and 20 weeks and 0.5 percent after 20 weeks.

<sup>27</sup> The Green Party representative's view is set out later in this section.

ted one. Rather, new sections 10 and 11 only state that a health practitioner may provide abortion services to a woman. Further, doctors are bound by a range of legal and ethical duties to their patients, which are set out below.

Under common law, a doctor is required to perform their professional duties to the standard of reasonable care and skill. This is reinforced in right 4(1) of the Code of Health and Disability Consumers' Rights. Right 4(2) of the code specifies that providers must comply with legal, professional, ethical, and other relevant standards when providing services. Any patient can make a complaint to the Health and Disability Commissioner or the relevant regulatory authority about a service.

The Medical Council of New Zealand sets standards of clinical and cultural competence, and ethical conduct for doctors. "Good Medical Practice", which the council has developed as the foundation document for these standards, sets out what constitutes good clinical care.

Doctors are expected to make decisions, in partnership with the patient, about providing care that is clinically appropriate. "Good Medical Practice" states that doctors and patients should assess the patient's needs and priorities. The doctor's care or treatment should be based on this assessment and their clinical judgement about how effective treatment options are likely to be.

The principles of medical ethics—autonomy, beneficence, nonmaleficence (doing no harm), and justice—are used to guide decisions about cases or questions that are morally difficult. Patients have a legal right to services that meet ethical standards. The Medical Council of New Zealand recognises the Code of Ethics of the New Zealand Medical Association as the primary source of advice on ethics for the medical profession.

We have confidence that doctors base their decisions on these legal and ethical guidelines. However, we note that the bill does not explicitly state the legal and ethical frameworks a doctor would use.

We also understand that doctors would always consult colleagues before performing abortions after 20 weeks gestation, and they would only be performed if the doctor deemed them medically appropriate. Given that this would not change if the bill is enacted, we consider that the consultation, and any other steps the doctor follows, should be confirmed by the legislation.

Therefore, we recommend amending new section 11. Our proposed amendment to section 11(1) would make it clear that the health practitioner would need to reasonably believe that the abortion was clinically appropriate in the circumstances.

Under our amended section 11(2), the qualified health practitioner would need to consult at least one other qualified health practitioner when considering whether the abortion was clinically appropriate. They would need to have regard to all relevant legal, professional, and ethical standards to which they are subject, and the gestational age of the fetus.

The health practitioner would still need to have regard to the woman's physical and mental health, and well-being. However, we recommend that the term "well-being"

be extended to “overall well-being”. This would reflect that well-being can encompass more than just physical and mental health.

We also recommend inserting new section 11(3). This would make it clear that the requirements under subsection 11(2) would not apply in a medical emergency.

The Green Party representative recommends amending the bill to implement Model A of the Law Commission’s three models, by removing the statutory test for abortions after 20 weeks gestation. Such abortions only occur in exceptional circumstances, and medical professionals are invariably involved in supporting pregnant people to make their decisions. An additional test is therefore unnecessary and creates a potential barrier to service provision. The Green Party member notes that under this model, the current approach to conscientious objection would remain; and that health professionals would never be required to perform an abortion if they considered it to be clinically inappropriate.

Model A was preferred by the majority of the health sector, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the New Zealand Nurses Organisation, and the Abortion Providers Group Aotearoa New Zealand.

The Green Party representative considers that this model is most consistent with a health-based approach to abortion care, recognises the importance of the pregnant person’s bodily autonomy, and will minimise delays to abortion provision. Minimising delay is particularly important for abortions later in pregnancy due to the higher risk of complications as pregnancy progresses.

### **Definition of “woman”**

The bill defines a woman as “a person of any age who is capable of becoming pregnant”. We had differing views about this definition.

Several of us believe that this definition is offensive because women who are post-menopausal or infertile would not be considered women.

Others of us note that the definition could exclude transgender men, non-binary people, and other gender minorities from accessing abortion services. Problematically, the definition would include underage girls. A 13 year old girl who is pregnant as a result of rape should not be considered a “woman” under the law. Those of us with this view suggest that the definition be amended from “woman” to “pregnant person”.

We recommend amending clause 5 to delete the definition of “woman”. As a consequential change, we recommend amending clause 12 to delete the definition of “woman” contained in amended section 183 of the Crimes Act.

### **Privacy of information on medical records**

We note that some women may be uncomfortable with their GP knowing they have had an abortion. We asked whether it is possible for this information on an individual’s health record to be inaccessible to their GP.

We were advised that, generally, a person would have to give consent for anyone else to have access to their health record. Also, the information systems used in hospitals and primary care are not currently integrated, so information from a hospital would not be available to a GP.

We suggest that, for abortion services, the default process for giving consent to access records should be an opt-in one. That is, a person would need to give consent to the record of their abortion being accessible to their GP.<sup>28</sup>

### **Fetal pain**

Some of us expressed concern about a fetus experiencing pain during an abortion. We were told that a review, published in the *Journal of the American Medical Association*, concluded that conscious pain perception is unlikely to occur before the third trimester.<sup>29</sup>

We received advice that there appears to be no authoritative research that conclusively proves or disproves the perception of fetal pain during the third trimester of pregnancy.

### **Sterilisation**

Section 8 of the CSA Act requires a medical practitioner who performs a sterilisation to forward a report to the Director-General of Health. However, we were told that the Ministry of Health does not use the data from the report.

We recognise that our consideration of this bill covers sterilisation only as it relates to conscientious objection. However, we consider that the requirement to collect sterilisation data is redundant since it is not being used.

The ministry told us that it needs to collect data about sterilisation, but the information that it currently collects is not as useful as it could be. Instead, it needs to collect additional data about non-consensual sterilisations. We agree that sterilisation without consent is an important issue and we urge Parliament to act to ensure that this data can be collected.

### **Agnes Loheni minority view**

#### **Introduction**

National Party member Agnes Loheni opposes the select committee recommending passage of the Government's Abortion Legislation Bill.

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<sup>28</sup> The information may be disclosed if the purpose for which the information is used is directly related to the purpose for which the information was obtained (rule 11 of the Health Information Privacy Code). The information would be available if the GP had made the initial referral to the abortion service.

<sup>29</sup> Lee, S. J. et al. (2005), Fetal pain: A systematic multidisciplinary view of the evidence. *Journal of the American Medical Association*, 294(8), 954.

## Process

Some 25,718 submissions were received by the Abortion Legislation Select Committee. Of these approximately 91.6 percent opposed the bill. Approximately 2,800 submitters requested to make an oral submission of which the committee chose to hear from approximately 160. I disagreed with the committee's decision and criteria used to deliberately and intentionally restrict the number of oral submissions on such an important matter, particularly one which comes with heartfelt and well-considered opinions. This includes the voices of abortion survivors, those conceived in rape, and other important stories directly relevant to the matter.

The committee has been asked by the Government to consider this bill in the absence of sufficiently addressing important questions. This includes whether there is a need for changes to New Zealand's current abortion legislation so that it aligns with a health approach, and if so, why?

The Ministerial Briefing Paper from the Law Commission—which heavily influenced the drafting of the Abortion Legislation Bill—“provid[ed] advice on alternative legal frameworks that could be adopted to align with a health approach to abortion”. The Commission did not (and was not instructed to) determine whether there was a legitimate need to alter current abortion legislation. Instead, the Government appears to have pre-determined its outcome, notably that the legislation should be changed so that abortion is treated like any other health service. A more appropriate process in responding to requests to alter abortion legislation in New Zealand would be to conduct a proper investigation, with the process held by a Royal Commission of Inquiry.

In the Minister of Justice's speech at the first reading of this bill, it was suggested that legislative change is necessary because women are criminalised by our current abortion laws. No woman has ever been charged with having an unlawful abortion. This sentiment misrepresents the reality and intention of our current abortion legislation under the Crimes Act 1961. To protect women from unlawful abortions, the Crimes Act criminalises people who perform abortions in contravention of the Act. Under section 44 of the Contraception, Sterilisation, and Abortion Act 1977, it is an offence for a woman to have an unlawful abortion, punishable by a maximum penalty of a \$200 fine.

Again, it must be strongly noted, that no woman has ever been charged with having an unlawful abortion in New Zealand. To ensure no woman is ever criminalised section 44 would need to be repealed. The committee report, however, does not address this misrepresentation of the Crimes Act.

## Specific and substantive matters

### Removal of certain criminal offences from the Crimes Act

This bill, if enacted, will severely breach and irreparably damage the “sanctity of life” principle which has been a cornerstone of New Zealand's common law. Our current abortion law seeks to balance the rights and autonomy of the expectant mother against the interests of unborn human life. As a result, the Crimes Act includes



offences for killing an unborn child because the prohibited conduct involves the intentional taking of human life. In contrast, the Abortion Legislation Bill disproportionately shifts the balance to favour the rights and autonomy of the mother—in fact, it removes the human rights of the unborn child completely.

### **Post 20 week abortions**

The criteria outlined in the bill (“physical health”, “mental health”, and “well-being”) are undefined and as a result are incredibly broad. Put simply, under the current proposed wording it would be possible for an abortion of a baby—from 20 weeks to moments before birth—to be terminated almost at whim as the wording is so undefined to be disingenuous.

Moreover, the legislation proposes that the current requirement that two health practitioners assess the suitability of an abortion for a woman will now be reduced to one health practitioner and only apply for abortions post 20 weeks. This introduces much broader criteria to determine which pregnancies can be terminated post 20 weeks gestation than is outlined in the current legislation.

### *Concerns raised*

At first reading of this bill, Justice Minister Hon Andrew Little said he did not intend to liberalise abortion right up to birth. In fact, there appears to be little appetite amongst the New Zealand public for a post-20-week “on-demand” equivalent abortion regime. Despite this, a number of submitters expressed concern at the lack of an upper limit for abortions. They were concerned that abortions can, with one doctor’s agreement, be performed right up to birth. One submitter explained that under this legislation “Abortions will be lawfully permitted, and easily accessed, until full-term in the proposed bill. This is the only logical interpretation of the Bill”. And yet, there has been little discussion to sufficiently explain the need for altering the current statutory test for post-20-week abortions.

Submitters have expressed concern over the vague terminology and noted that the terms “physical health”, “mental health”, and (most crucially) “well-being” are not defined in the bill. As a result, the terms are incredibly broad and open to individual interpretations that may have an adverse impact on both mother and definitively on the unborn child. Many submitters expressed concern that the ability to obtain abortions post 20 weeks gestation will become easier and the rate of such procedures will increase should the bill be enacted.

Some submitters were concerned that there was no upper limit for abortions suggesting that there could be a cap on abortions at 30 or 35 weeks gestation. Some submitters claimed that abortions post 20 weeks were almost always because of abnormalities with the unborn child and therefore suggested that it would be logical to cap the limit at no more than 10 weeks post the 20-week scan when abnormalities would ordinarily be picked up.

Some submitters pointed out that scans at 20 weeks (and post 20 weeks) gestation were not always reliable and that sometimes the unborn child may be terminated as a

consequence of incorrect information. Medical submitters told us that removing the requirement for two medical opinions would also remove a safeguard against that occurring.

Submissions from professional organisations recommended the need for stronger safeguards and limitations in abortions with later gestations. For example, one group recommended criteria for the statutory test could be staggered to include tighter regulations as the pregnancy progressed. Another organisation suggested an upper gestational limit to abortions, while others recommended having two health practitioners sign off on abortions for pregnancies post 20 weeks gestation.

### **Fetal abnormality**

It can be a traumatic experience for the parents to discover the unborn child has fetal abnormalities, especially if the viability of the unborn child is seriously compromised. Currently the law enables a mother to abort their unborn child in these circumstances. This section addresses concerns that vague definitions of physical health and mental health can be grounds for terminating an unborn child that is otherwise completely viable and indeed may be able to live a full adult life.

#### *Concerns raised*

Submitters expressed concern that changes to the grounds for abortions, with the addition of undefined legislative terms, will lead to more abortions on the grounds of fetal abnormality.

The experience of comparable international jurisdictions provide evidence of termination of pregnancies with moderate to severe fetal abnormalities. For example, submitters brought to our attention the example of Denmark, where over 98 percent of babies diagnosed with Down Syndrome are aborted, while in Iceland no children have been born with Down Syndrome for the last five years. We were also told by submitters that in the United Kingdom there are increasing numbers of late-term abortions for conditions such as cleft lip and palate or club foot. These are not outcomes to be celebrated and in fact, should be condemned as highly discriminatory.

Submitters, particularly disability advocates, expressed concern that freeing up abortion laws would likely lead to further stigmatisation and discrimination of New Zealanders with disabilities. Submitters told us that, “The absence of any but very vague criteria such as ‘physical health’, ‘mental health’, and ‘wellbeing’, together with the social stigma already alluded to, opens not simply the possibility, but the likelihood that disabled fetuses will be denied proper protection because of bad information, prejudice, and stigma. We have already seen how even tight criteria in the old law can be circumvented”.

We were also told that in Crown Law’s assessment of the bill’s provisions and its likelihood of resulting in indirect disability discrimination, “it concluded that because the Bill does not make express reference to disability, ‘the Bill is less likely than the present legislative regime to lead to indirect discrimination on the basis of disability.’ With respect, we disagree. Remaining silent on a discriminatory practice does not

make it less likely to happen. In fact, quite the opposite. The Bill's removal of current restrictions significantly widens the ability for a woman to have an abortion on the grounds of disability."

Laws that explicitly allow abortion on the grounds of fetal impairment violate articles 4, 5, and 8 of the Convention on the Rights of Persons with Disabilities (CRPD). In fact, New Zealand's Independent Monitoring System on the CRPD noted the bill's failure to protect against disability-selective antenatal selection. As one disability advocacy organisation told us, "Selective screening for Down Syndrome, especially as it is currently practiced, does not appear to be compatible with disability rights' principles, and brings into question whether current practices uphold the intent of the UNCRPD. Screening practices that reduce birth prevalence can result in further marginalisation of that sector of the population".

### **Conscientious objection and employment**

Under current legislation a health practitioner is not obliged to provide abortion services if they have a conscientious objection. Nor is a health professional obligated to redirect a woman seeking an abortion to another abortion provider. Moreover, that professional cannot be discriminated against in any way by an employer for being a conscientious objector. These protections would be removed under the Abortion Legislation Bill.

Establishing what grounds constitute conscientious objection should not be subject to the whims of elected representatives and their public sector agents. Nor should a conscientious objector be compelled to engage in an activity, or recommend where such an activity can be engaged in, if they are personally compelled or driven for any reason not to. If, on matters of life and death, health practitioners are forced to act against their conscience or because the state decrees it, we reduce them to mere automatons and not moral agents. To force those health practitioners who have firm positions against participation is a direct attack on fundamental human rights.

### *Concerns raised*

The proposed legislation states that if a conscientious objector would cause unreasonable disruption to activities an employer can:

- refuse to employ the applicant
- afford the applicant or employee less favourable terms of employment
- terminate the employment
- subject the employee to any detriment, or
- retire the employee.

Worryingly "unreasonable disruption to activities" is not defined in the proposed legislation. A legal organisation told us that this phrase is "too subjective, and doesn't require an employer to prove that the objection would disrupt their business or consider whether other staff could carry out the objector's duties". Another professional body told us that "allowing employers to dismiss conscientious objectors on the

grounds that their moral/ethical stance would ‘unreasonably disrupt the employer’s activities’, was vague, and in practice would negate the protections outlined in section 20(1) of the Bill”.

Most submitters who commented on this section were opposed to the provision. An organisational submission stated that “the person’s entire employment relationship can be adversely affected on the basis of a personal belief that they sincerely hold. Such an extensive limitation on fundamental rights requires far greater justification than this”. Some submitters were concerned that this section may cause conscientious objectors to be pressured or coerced into assisting or performing abortions against their conscience. They further comment that employees may be subject to coercion rather than risk having their employment terminated, and that more safeguards on employee harassment are needed.

As one submitter noted, this clause is in direct contrast to the End of Life Choice Act 2019 section 8(3) which states:

An employer must not—

- (a) deny to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit merely because the employee objects on the grounds of conscience to providing any assistance referred to in subsection (1); or
- (b) provide or grant to an employee any employment, accommodation, goods, service, right, title, privilege, or benefit conditional upon the employee providing or agreeing to provide any assistance referred to in subsection (1).

While section 20 was designed to balance the right to conscientious objection with the duty to provide health services, I find that the balance must sway in the favour of freedom of conscience and religion.

### **Safe zones**

The right to engage in lawful protest is a mainstay of New Zealand’s democracy and a core part of freedom of expression. The legislation currently proposes the creation of safe zones where overt or even covert protest (which could include silent prayer) is illiberal and contrary to the importance of freedom of expression that has been well recognised by the New Zealand courts. The right to protest is often celebrated in New Zealand including by government and the media. That this life and death issue is singled out as an activity in which any protest is banned is both worrying and telling.

### *Concerns raised*

In its briefing paper, the Law Commission does not support the large-scale proposal to make all abortion clinics subject to safe zones. Its concern is that a blanket introduction of safe zones would limit rights further than required to achieve the objective of the legislation, particularly given the importance of these civil rights in a democratic society. The Commission is clearly of the view that the proposed safe zones are an over-reach and “may not be rationally connected to this objective (creating safe zones), nor proportionate”. It notes that “There are existing legal protections against

intimidating behaviour around abortion facilities. Under the Summary Offences Act 1981, some forms of intimidating and anti-social behaviour are prohibited including: offensive behaviour or language (section 4(1)(a), (b), and (c)); intimidation (section 21(1)(d) and (e)); and obstructing a public way (and section 22). The Trespass Act 1980 also prohibits trespass after warning to leave (section 3)".

At no point has an issue or example of the issue the legislation is being asked to address ever been detailed. The only justification appeared to be a general concern that women should not be subject to prayer on their way to get an abortion. How often, or how obstructive, people seeking abortions have been exposed to examples of this nature was not defined. As one organisational submission explained, "The Summary Offences Act 1981 prohibits disorderly or offensive behaviour against public order, intimidation (which includes stopping, confronting, or accosting someone in a public place), and obstructing a public way. As a result, the safety and well-being of women and abortion providers are already protected from inappropriate protest actions. The implementation of safe areas is thus an unnecessary restriction on the rights of New Zealanders to freedom of expression." Therefore, the introduction of safe zones is an unproportionate response, and is likely to have significant consequences on the future of New Zealand's democracy.

### **Sex selection**

While the Law Commission stated in its briefing paper that it "has not seen any evidence of sex-selective abortion in New Zealand", it did note that "there is some, albeit limited, evidence to suggest that they occur in countries New Zealand often compares itself to". Sex selective abortions are recognised as being difficult to measure. However, the proposed legislation will allow this to happen on a much greater scale.

#### *Concerns raised*

A few submitters raised concerns that changes to the current criteria for abortions would eliminate any barriers to sex selective abortions, allowing for discrimination on the basis of gender. As one organisation submitted, "In a system where abortions are lawful on social grounds, there is no protection against antenatal sex discrimination and amongst son-preference cultures residing in New Zealand, it is baby girls who will suffer the most discrimination".

Another submitter suggested that sex selective abortions could also be the result of a desire for family balancing, as "sex selection affirms gender-stereotyping children, and some commentators have argued that it may increase the 'risk that resulting children would be treated as vehicles of parental satisfaction, rather than as ends in themselves'".

### **Conclusion**

The process that led to the Abortion Legislation Bill has bypassed proper investigation into whether current abortion legislation should be altered, and if so how. I believe this lack of due process has resulted in a bill with significant flaws. It appears

the Government's desire to progress their government bill at speed has led to a lack of due process, which is most concerning when dealing with an issue of death and life.

Having heard and read submissions as a member of the Abortion Legislation Select Committee these flaws were outlined in the many submissions that oppose the bill.

In fact, I believe this report echoes the concerns of many submitters regarding the criteria for abortions post 20 weeks gestation, the impact of that broad criteria on allowing abortions for fetal abnormality, changes to conscientious objection and employment discrimination practices, the introduction of safe zones, and the lack of safeguards against abortion on the basis of sex selection.

Regardless of whether Members of Parliament agree with the intent of this bill, I believe all Members should be determined to ensure that the result of this process is the best possible legislation.

### **ACT Party minority view**

As the ACT Party leader and representative, I would like to record my support for the way that the committee has conducted itself, particularly the leadership provided by the Chair and Deputy Chair. While I would have preferred to support the Law Commission's Model A over the chosen Model C, this legislation represents a significant improvement upon New Zealand's current laws.

However, I dissent against the majority's report in relation to the safe zones. We all want to be safe but the danger to be addressed, in my view, has not been established. I contend that the proponents of safe zones have imported foreign experiences where those accessing abortion services really are harassed and obstructed. In New Zealand, the equivalent protests tend to be benign, even pitiable.

Safe zones, as proposed, impair the right to free speech. They do it in a limited area, and on a temporary but renewable basis. Nevertheless, they restrict the expression of honestly held opinion for an ad hoc purpose. In so doing they set a precedent so loosely circumscribed that it could be used to justify almost any future imaginable impairment.

I note that the Law Commission did not recommend safe zones in the report that led to this legislation. I agree with its approach and have urged colleagues on the committee to contemplate that they are out of step with the Commission, alongside the arguments above. I have also urged them to consider that impairing freedom of expression will increase the political opposition to this otherwise noble legislation.

It would be better lawmaking, and better politics, to exclude the safe zone provision from this legislation. Having failed to persuade this committee, I intend to move amendments at the Committee of the whole House stage and try my luck at persuading a wider group.

## **Appendix**

### **Committee process**

The Abortion Legislation Bill was referred to the committee on 8 August 2019. The closing date for submissions was 19 September 2019. We received and considered 25,776 submissions from interested groups and individuals. We heard oral evidence from 139 submitters at hearings in Auckland, Christchurch, and Wellington.

We received advice from the Ministry of Justice and the Ministry of Health. The Parliamentary Counsel Office provided legal drafting services.

### **Committee membership**

Hon Ruth Dyson (Chairperson)

Hon Amy Adams

Anahila Kanongata'a-Suisuiki

Jan Logie

Agnes Loheni

Hon Tracey Martin

David Seymour





**Key to symbols used in reprinted bill**

**As reported from a select committee**

text inserted by a majority

~~text deleted by a majority~~



*Hon Andrew Little*

## **Abortion Legislation Bill**

Government Bill

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**The Parliament of New Zealand enacts as follows:**

- 1 Title**  
This Act is the Abortion Legislation Act **2019**.
- 2 Commencement**  
This Act comes into force on the day after the date of Royal assent. 5

**Part 1**

**Amendments to Contraception, Sterilisation, and Abortion Act 1977**

- 3 Principal Act**  
This Part amends the Contraception, Sterilisation, and Abortion Act 1977 (the **principal Act**). 10
  - 4 Long Title repealed**  
Repeal the Long Title.
  - 5 Section 2 replaced (Interpretation)**  
Replace section 2 with:
- 2 Interpretation** 15  
In this Act, unless the context otherwise requires,—  
**abortion—**
    - (a) means intentionally causing the termination of a woman’s pregnancy by any means, including—
      - (i) by using a drug or combination of drugs; or 20
      - (ii) by using an instrument; but
    - (b) does not include—
      - (i) any procedure intended to induce the birth of a live fetus believed to be viable; or
      - (ii) any procedure to remove a dead fetus; or 25

(iii) any contraceptive

**abortion service provider** means an entity that provides abortion services

**abortion services** means services provided by a qualified health practitioner to facilitate an abortion

**conscientious objection** means an objection on the ground of conscience to the provision of contraception, sterilisation, or abortion services 5

**contraceptive** means a substance, device, or technique intended to prevent conception or implantation

**Director-General** means the Director-General of Health

**employer** includes any person acting or purporting to act on behalf of an employer 10

**entity** means—

(a) a body corporate:

(b) a corporation sole:

(c) an unincorporated body: 15

(d) a sole trader

**health practitioner** has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003

**hospital** means a hospital care institution within the meaning of section 58(4) of the Health and Disability Services (Safety) Act 2001 20

**medical emergency** includes a surgical emergency

**medical practitioner** means a health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine 25

**qualified health practitioner**, in relation to the provision of abortion services, means a health practitioner who is acting in accordance with the Health Practitioners Competence Assurance Act 2003

**safe area** means any premises at which abortion services are provided, and any area around those premises, prescribed in regulations made under **section 17(1)** as a safe area. 30

~~**woman** means a person of any age who is capable of becoming pregnant.~~

## 6 New sections 2A and 2B inserted

After section 2, insert:

### 2A Transitional, savings, and related provisions 35

The transitional, savings, and related provisions set out in ~~the Schedule 1~~ have effect according to their terms.

**2B Act binds the Crown**

This Act binds the Crown.

**6A Section 5 amended (Supply of contraceptives to sexual violation complainants)**

(1) In section 5(1)(b), replace “another medical practitioner or a family planning clinic” with “an alternative person who is a provider of contraceptive services and how to access the contact details of such a person”.

(2) After section 5(3), insert:

(3A) If a medical practitioner referred to in subsection (1) or (2) has a conscientious objection to supplying or authorising the supply to the complainant of any contraceptive, the medical practitioner must tell the complainant—

(a) of their conscientious objection at the earliest opportunity; and

(b) how to access the contact details of another person who is a provider of contraceptive services.

**7 Sections 10 to 46 replaced**

Replace sections 10 to 46 with:

**10 Provision of abortion services to women not more than 20 weeks pregnant**

A qualified health practitioner may provide abortion services to a woman who is not more than 20 weeks pregnant.

**11 Provision of abortion services to women more than 20 weeks pregnant**

(1) A qualified health practitioner may only provide abortion services to a woman who is more than 20 weeks pregnant ~~only~~ if the health practitioner reasonably believes that the abortion is clinically appropriate in the circumstances.

(2) In considering whether the abortion is clinically appropriate in the circumstances, the qualified health practitioner must ~~have regard to the woman’s~~—

(a) ~~physical health; and~~ consult at least 1 other qualified health practitioner; and

(b) ~~mental health; and~~ have regard to—

(i) all relevant legal, professional, and ethical standards to which the qualified health practitioner is subject; and

(ii) the woman’s—

(A) physical health; and

(B) mental health; and

(C) overall well-being; and

(iii) the gestational age of the fetus.

(e) ~~well-being.~~

(3)	<b>Subsection (2)</b> does not apply in a medical emergency.	
<b>12</b>	<del><b>Minister of Health to ensure availability of counselling services for abortion</b></del>	
	<del>The Minister of Health must take reasonable and practicable steps to ensure that counselling services are available throughout New Zealand in relation to the provision of abortion services when entering into Crown funding agreements under the New Zealand Public Health and Disability Act 2000.</del>	5
<b>13</b>	<b>Counselling</b>	
(1)	A health practitioner must advise a woman of the availability of counselling services if the woman—	10
	(a) seeks advice or information about whether to continue or terminate a pregnancy; or	
	(b) advises the health practitioner of the wish to terminate a pregnancy; or	
	(c) has terminated a pregnancy.	
(2)	A qualified health practitioner may not, as a condition of providing abortion services to a woman, require the woman to attend counselling before or after the provision of those services.	15
<b>14</b>	<b>Self-referral to abortion services</b>	
	A qualified health practitioner may not, as a condition of providing abortion services to a woman, require the woman to be referred from a health practitioner.	20
<b>15</b>	<b>Certain behaviour prohibited in safe areas</b>	
(1)	A person must not engage in any prohibited behaviour in a safe area.	
(2)	A person who contravenes this section commits an offence and is liable on conviction to a fine not exceeding \$1,000.	25
(3)	<del>In this section, <b>prohibited behaviour</b> means any of the following:</del>	
	<del>(a) intimidating, interfering with, or obstructing a person with the intention of preventing the person, or being reckless as to whether the person is prevented, from—</del>	
	<del>(i) accessing abortion services;</del>	30
	<del>(ii) providing, or assisting with providing, abortion services;</del>	
	<del>(iii) seeking advice or information about abortion services;</del>	
	<del>(iv) providing, or assisting with providing, advice or information about abortion services;</del>	
	<del>(b) communicating with, or visually recording, a person who is doing any of the things described in <b>paragraph (a)(i) to (iv)</b> in a manner that—</del>	35
	<del>(i) is intended to cause the person emotional distress; and</del>	



	(ii) <del>would cause emotional distress to an ordinary reasonable person in the position of the person.</del>	
(3)	<u>In this section,—</u> <b><u>prohibited behaviour</u></b> means—	
	(a) <u>intimidating, interfering with, or obstructing a protected person—</u>	5
	(i) <u>with the intention of frustrating the purpose for which the protected person is in the safe area; or</u>	
	(ii) <u>in a manner that an ordinary reasonable person would know would cause emotional distress to a protected person;</u>	
	(b) <u>communicating with, or visually recording, a person in a manner that an ordinary reasonable person would know would cause emotional distress to a protected person</u>	10
	<b><u>protected person</u></b> means a person who is in a safe area for the purpose of—	
	(a) <u>accessing abortion services; or</u>	
	(b) <u>providing, or assisting with providing, abortion services; or</u>	15
	(c) <u>seeking advice or information about abortion services; or</u>	
	(d) <u>providing, or assisting with providing, advice or information about abortion services.</u>	
16	<b>Power of constable to arrest without warrant</b>	
	If a constable reasonably believes that a person is engaging in prohibited behaviour in a safe area, the constable may—	20
	(a) require the person to stop engaging in the prohibited behaviour; and	
	(b) if the person fails to stop engaging in the prohibited behaviour, arrest the person and take the person into custody without a warrant.	
17	<b>Regulations: safe areas</b>	25
(1)	The Governor-General may, by Order in Council made on the recommendation of the Minister of Health after consultation with the Minister of Justice, make regulations for the purposes of <b>section 15</b> prescribing as a safe area—	
	(a) any specified premises at which abortion services are provided; and	
	(b) an area around those premises that is an area having a boundary of not more than 150 metres from any part of the premises.	30
(2)	The Minister <u>of Health</u> may recommend the making of regulations under <b>subsection (1)</b> if the Minister is satisfied that prescribing a safe area—	
	(a) is necessary to protect the safety and well-being, and respect the privacy and dignity, of persons—	35
	(i) accessing abortion services:	
	(ii) providing, or assisting with providing, abortion services:	

	(iii) seeking advice or information about abortion services:	
	(iv) providing, or assisting with providing, advice or information about abortion services; and	
	(b) can be demonstrably justified in a free and democratic society as a reasonable limitation on people's rights and freedoms.	5
(3)	<u>Not later than 5 years after making any regulations under <b>subsection (1)</b> prescribing a particular safe area, and then at subsequent intervals of not more than 5 years, the Director-General, in consultation with the Secretary for Justice, must—</u>	
	<u>(a) review the regulations (if they are still in force) to determine whether that prescribed safe area is still—</u>	10
	<u>(i) necessary for the purpose specified in <b>subsection (2)(a)</b>; and</u>	
	<u>(ii) demonstrably justified as specified in <b>subsection (2)(b)</b>; and</u>	
	<u>(b) report to the Minister of Health and the Minister of Justice on whether the regulations should be—</u>	15
	<u>(i) continued without amendment; or</u>	
	<u>(ii) continued with amendment; or</u>	
	<u>(iii) revoked.</u>	
<b>18</b>	<b><del>Duties of Director-General of Health</del></b>	
	<del>The Director-General of Health must—</del>	20
	<del>(a) collect, collate, analyse, and publish information about the provision of—</del>	
	<del>(i) abortion services in New Zealand; and</del>	
	<del>(ii) counselling services in relation to, or in connection with, the provision of abortion services; and</del>	25
	<del>(b) develop and publish standards for the services described in <b>paragraph (a)</b>; and</del>	
	<del>(c) make and maintain a list of abortion service providers.</del>	
	<i>Miscellaneous provisions</i>	
<b>19</b>	<b>Conscientious objection</b>	30
(1)	This section applies to a person (A) who is requested by another person (B) to provide, or assist with providing, any of the following services:	
	(a) contraception services:	
	(b) sterilisation services:	
	(c) abortion services:	35

- (d) information or advisory services about ~~continuing or terminating~~ whether to continue or terminate a pregnancy.
- (2) If A has a conscientious objection to providing, or to assisting with providing, to B the service requested, A must tell B ~~of their conscientious objection at the earliest opportunity and, at the earliest opportunity—~~ 5
- (a) ~~if the service requested is a service described in **subsection (1)(a) or (b)**, tell B how to access the contact details of another person who is a provider of the service requested; and~~
- (b) ~~if the service requested is a service described in **subsection (1)(c) or (d)**, tell B how to access the list of abortion service providers referred to in **section 18(c)**.~~ 10
- (a) of their conscientious objection; and
- (b) how to access the contact details of another person who is a provider of the service requested.
- (3) This section does not override a health practitioner’s professional and legal duty to provide prompt and appropriate medical assistance to any person in a medical emergency. 15
- 20 Employer providing certain services must accommodate conscientious objection of applicant or employee unless it would cause unreasonable disruption to activities** 20
- (1) An employer that provides any of the services specified in **section 19(1)** may not take any of the following actions on the basis that an applicant for employment, or an employee, who is qualified for work in connection with the provision of those services, has a conscientious objection:
- (a) refuse or omit to employ the applicant for work that is available; or 25
- (b) offer or afford the applicant or the employee less favourable terms of employment, conditions of work, superannuation or other fringe benefits, and opportunities for training, promotion, and transfer than are made available to applicants or employees of the same or substantially similar capabilities employed in the same or substantially similar work; 30
- or
- (c) terminate the employment of the employee in circumstances in which the employment of other employees employed in the same or substantially similar work would not be terminated; or
- (d) subject the employee to any detriment in circumstances in which other employees employed in the same or substantially similar work would not be subjected to such detriment; or 35
- (e) retire the employee, or to require or cause the employee to retire or resign.

- (2) However, if ~~an employer considers that~~ accommodating ~~the~~ an applicant's or employee's conscientious objection would unreasonably disrupt the employer's ~~activities, provision of health services,~~ the employer may take any of the actions described in **subsection (1)**.
- (2A) Accommodating an applicant's or employee's conscientious objection may include arranging for the duties in respect of which the applicant or employee has an objection to be carried out by an existing employee. 5
- (3) An applicant or employee who alleges that an employer has contravened this section may make a complaint under the Human Rights Act 1993 as if the complaint were a complaint of unlawful discrimination under section 22 of that Act. 10
- (4) If an applicant or employee who alleges that an employer has contravened this section is entitled to pursue a personal grievance under the Employment Relations Act 2000, the applicant or employee may take either, but not both, of the following steps: 15
- (a) apply to the Employment Relations Authority for the resolution of the grievance under that Act; or
  - (b) make a complaint under the Human Rights Act 1993.
- (5) In this section, **employer** has the meaning given in **section 2** and also includes— 20
- (a) the person for whom work is done by an independent contractor; and
  - (b) the person for whom work is done by contract workers under a contract between that person and the person who supplies the contract workers; and
  - (c) the person for whom work is done by an unpaid worker. 25
- 20A Minister of Health to ensure availability of certain services**
- The Minister of Health must, when entering into Crown funding agreements under the New Zealand Public Health and Disability Act 2000, take reasonable steps to ensure that—
- (a) the following services are available throughout New Zealand: 30
    - (i) the services specified in **section 19(1)**; and
    - (ii) counselling services in relation to, or in connection with, the provision of abortion services; and
  - (b) the following services are provided in accordance with the standards published by the Director-General under **section 20D(1)(b)**: 35
    - (i) abortion services;
    - (ii) counselling services in relation to, or in connection with, the provision of abortion services.

**20B Duty of Director-General to undertake periodic reviews of certain matters**

(1) Not later than 5 years after the commencement of this section, and then at subsequent intervals of not more than 5 years, the Director-General must—

(a) review whether there is timely and equitable access to—

(i) the services specified in **section 19(1)**; and

(ii) counselling services in relation to, or in connection with, the provision of abortion services; and

(b) report to the Minister of Health on—

(i) the outcomes of the review; and

(ii) the recommendations that the Director-General considers appropriate (if any) for improving the timely and equitable access to those services.

(2) The review and report under **subsection (1)** must include consideration of the relative costs throughout New Zealand for women accessing those services.

**20C Duty of Director-General to compile, maintain, and make available list of abortion service providers**

(1) The Director-General must compile and maintain a list of the names and contact details of abortion service providers in New Zealand.

(2) The Director-General may not include in the list the name and contact details of any abortion service provider who advises the Director-General that they do not want their name and contact details included in the list.

(3) The Director-General must ensure that the list, or the information on the list, is accessible to any person on request.

**20D Duty of Director-General to collect, collate, analyse, and publish information**

(1) The Director-General must—

(a) collect, collate, analyse, and publish information about the provision of—

(i) abortion services in New Zealand; and

(ii) counselling services in relation to, or in connection with, the provision of abortion services; and

(b) develop and publish standards for the services described in **paragraph (a)**.

(2) However, the Director-General must not publish, under **subsection (1)(a)**, any information in a form that could reasonably be expected to identify a woman who has been, or is being, provided with abortion services or counselling services.

**20E Abortion service provider to notify Director-General about abortion services provided**

**(1) An abortion service provider must notify the Director-General after the following services are provided by or through the provider:**

- (a) a surgical abortion; or**
- (b) a medicine is prescribed or administered for the purpose of inducing an abortion.**

**(2) A notification must include, in relation to the provision of the services referred to in **subsection (1)**,—**

- (a) the information specified in **Schedule 2**; and**
- (b) such other information the Director-General may require.**

**(3) However, in no case may the information provided under this section include the name of the woman to whom the abortion service was provided.**

**(4) A notification must be given—**

- (a) not later than 1 month after the provision of the abortion service; and**
- (b) in the form or manner required by the Director-General.**

**(5) This section is repealed on the expiry of 18 months after the date on which it comes into force.**

**20F Abortion for sole purpose of sex selection**

**(1) This Parliament opposes the performance of abortions being sought solely because of a preference for the fetus to be of a particular sex.**

**(2) Not later than 5 years after the commencement of this section, and then at subsequent intervals of not more than 5 years, the Director-General must—**

- (a) review whether there is any evidence of abortions being sought solely because of a preference for the fetus to be of a particular sex; and**
- (b) report to the Minister of Health on—**
  - (i) the outcome of the review; and**
  - (ii) if there is such evidence, any recommendations that the Director-General considers appropriate for preventing abortions being sought solely because of a preference for the fetus to be of a particular sex.**

Compare: Abortion Law Reform Act 2019 s 16 (NSW)

**20G Reports to be presented to House of Representatives**

**As soon as practicable after receiving a report under **section 20B(1) or 20F(2)**, the Minister of Health must present a copy of the report to the House of Representatives.**

- 21 General regulation-making power**
- The Governor-General may, by Order in Council, make regulations for all or any of the following purposes:
- (a) enabling the Director-General of Health to collect information that may be required to enable the Director-General to discharge the Director-General's duties specified in ~~section 48~~ **section 20B, 20C, 20D, or 20F**:
  - (b) providing for any other matters contemplated by this Act, necessary for its administration, or necessary for giving it full effect.

- 8 New-Schedule Schedules 1 and 2 inserted**
- After **section 21** (as inserted by this Act), insert the ~~Schedule~~ **Schedules 1 and 2** set out in **Schedule 1** of this Act.

## Part 2

### Amendments to other enactments

#### Subpart 1—Amendments to Crimes Act 1961

- 9 Amendments to Crimes Act 1961**
- This subpart amends the Crimes Act 1961.
- 10 Cross-heading above section 182 replaced**
- Replace the cross-heading above section 182 with:
- Killing unborn child*
- 11 Section 182 amended (Killing unborn child)**
- Replace section 182(2) with:
- (2) Nothing in subsection (1) applies to any person who before or during the birth of any child causes its death by—
    - (a) a means employed in good faith to preserve the life of the child's mother; or
    - (b) providing abortion services in accordance with **section 10 or 11** of the Contraception, Sterilisation, and Abortion Act 1977.
- 12 Sections 182A to 187A replaced**
- Replace sections 182A to 187A with:

*Abortion services***183 Abortion procured by person other than health practitioner**

(1) A person commits an offence and is liable on conviction to a term of imprisonment not exceeding 5 years if the person is not a health practitioner and—

- (a) procures, or attempts to procure, an abortion for a woman; or
- (b) performs, or attempts to perform, an abortion on a woman.

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(2) The woman is not guilty of an offence under this section.

(3) In this section,—

**abortion** has the meaning given to it by **section 2** of the Contraception, Sterilisation, and Abortion Act 1977

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**health practitioner** has the meaning given to it by section 5(1) of the Health Practitioners Competence Assurance Act 2003.

~~**woman** has the meaning given to it by **section 2** of the Contraception, Sterilisation, and Abortion Act 1977.~~

## Subpart 2—Amendments to Health Practitioners Competence Assurance Act 2003

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**13 Amendments to Health Practitioners Competence Assurance Act 2003**

This subpart amends the Health Practitioners Competence Assurance Act 2003.

**14 Section 174 amended (Duty of health practitioners in respect of reproductive health services)**

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(1) In section 174(1)(a), after “sterilisation,”, insert “abortion,”.

(2) Replace section 174(1)(b) with:

(b) the health practitioner has an objection on the ground of conscience to providing the service (a **conscientious objection**).

(3) Replace section 174(2) with:

25

(2) When this section applies, the health practitioner must tell the person requesting the service ~~of their conscientious objection at the earliest opportunity and, at the earliest opportunity—~~

~~(a) if the person is requesting abortion services, tell the person how to access the list of abortion service providers referred to in **section 18(c)** of the Contraception, Sterilisation, and Abortion Act 1977; or~~

30

~~(a) of their conscientious objection; and~~

~~(b) if the person is requesting any other service, tell the person how to access the contact details of another person who is a provider of the service requested.~~

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## Subpart 3—Amendment to Health and Disability Commissioner Act 1994

### 15 Amendment to Health and Disability Commissioner Act 1994

This subpart amends the Health and Disability Commissioner Act 1994.

### 16 Section 2 amended (Interpretation)

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In section 2(1), definition of **health services**, replace paragraph (b)(ii) to (iv) with:

- (ii) reproductive health services, including—
  - (A) contraception services and advice:
  - (B) fertility services:
  - (C) sterilisation services:
  - (D) abortion services

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## Subpart 4—Consequential amendments and revocation

### 17 Consequential amendments and revocation

- (1) The Act specified in **Part 1 of Schedule 2** is consequentially amended as indicated in that schedule. 15
- (2) The legislative instrument specified in **Part 2 of Schedule 2** is consequentially amended as indicated in that schedule.
- (3) The legislative instrument specified in **Part 3 of Schedule 2** is revoked.

**Schedule 1**  
**New ~~Schedule~~ Schedules 1 and 2 inserted into Contraception,**  
**Sterilisation, and Abortion Act 1977**

s 8

**Schedule 1**  
**Transitional, savings, and related provisions**

5

s 2A

**Part 1**  
**Provisions relating to Abortion Legislation Act 2019**

- |          |  |              |
|----------|--|--------------|
| <b>1</b> | <b>Interpretation</b><br>In this Part,—<br><b>Act</b> means the <b>Abortion Legislation Act 2019</b><br><b>commencement date</b> means the date on which the Act comes into force<br><b>Ministry</b> means the Ministry of Health.   | 10           |
| <b>2</b> | <b>Abortion Supervisory Committee disestablished</b><br>(1) On the commencement date, the Abortion Supervisory Committee is disestablished and the term of office of every member of the committee ends.<br>(2) No member of the committee is entitled to any compensation in respect of the termination of the member's office.   | 15           |
| <b>3</b> | <b>Advisory, technical, and other committees dissolved</b><br>(1) On the commencement date, all advisory, technical, and other committees appointed by the Abortion Supervisory Committee are dissolved and the term of office of every member of a committee ends.<br>(2) No member of a committee is entitled to any compensation in respect of the termination of the member's office.                                      | 20<br><br>25 |
| <b>4</b> | <b>Assets, liabilities, and information of Abortion Supervisory Committee</b><br>(1) On the commencement date, all assets and liabilities of the Abortion Supervisory Committee in existence immediately before the commencement date are vested in the Crown as assets and liabilities of the Ministry.<br>(2) All information held by the Committee immediately before the commencement date is transferred to the Ministry. | 30           |

<b>5</b>	<b>Final report of Abortion Supervisory Committee</b>	
(1)	As soon as is reasonably practicable after the commencement date, the Abortion Supervisory Committee must arrange for the final annual report of the Committee to be submitted to Parliament.	
(2)	The final annual report must be in respect of the Committee's activities for the period—	5
(a)	commencing on <b>1 July</b> immediately preceding the commencement date; and	
(b)	ending with the close of the day immediately preceding the commencement date.	10
(3)	Despite <b>clause 2</b> , the Abortion Supervisory Committee continues in existence for the purpose only of submitting a report to Parliament in accordance with this clause.	
<b>6</b>	<b>Certifying consultants to submit reports to Director-General of Health</b>	
(1)	This clause applies to a person who immediately before the commencement date was a certifying consultant.	15
(2)	A person to whom this clause applies must, as soon as is reasonably practicable after the commencement date, send to the Director-General of Health any information that the Director-General of Health may require relating to—	
(a)	the cases considered by the person during the pre-commencement reporting period; and	20
(b)	the performance of the person's functions in relation to those cases during the pre-commencement reporting period.	
(3)	In this clause, <b>pre-commencement reporting period</b> means the period—	
(a)	commencing on the day after the date on which the person last submitted a report to the Abortion Supervisory Committee under section 36 of the Contraception, Sterilisation, and Abortion Act 1977 (as it read immediately before its repeal by <b>section 7</b> of the Act); and	25
(b)	ending with the close of the day immediately preceding the commencement date.	30

**Schedule 2**  
**Information to be included in notification of provision of abortion service**

s 20E

<u>1</u>	<u>The address of the abortion service provider.</u>	5
<u>2</u>	<u>The following details in respect of the woman to whom abortion services were provided:</u>	
	<u>(a) the woman's date of birth; and</u>	
	<u>(b) the woman's ethnicity; and</u>	
	<u>(c) whether the woman is a New Zealand resident; and</u>	10
	<u>(d) the number of previous pregnancies the woman has had; and</u>	
	<u>(e) the estimated duration of the woman's pregnancy; and</u>	
	<u>(f) the woman's residential area (represented by the domicile code for that area).</u>	
<u>3</u>	<u>The type of contraception used (if any) at the time of conception.</u>	15
<u>4</u>	<u>The type of abortion procedure used.</u>	
<u>5</u>	<u>Detail of any complications occurring before discharge.</u>	
<u>6</u>	<u>The type of contraception provided at the time of the abortion.</u>	
<u>7</u>	<u>The date that—</u>	
	<u>(a) the surgical abortion was performed; or</u>	20
	<u>(b) the medicine was prescribed or administered for purpose of inducing the abortion.</u>	

## Schedule 2

### Consequential amendments and revocation

s 17

#### Part 1

#### Consequential amendment to Act

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##### Official Information Act 1982 (1982 No 156)

In Schedule 1, repeal the item relating to the Abortion Supervisory Committee.

#### Part 2

#### Consequential amendment to legislative instrument

##### Medicines Regulations 1984 (SR 1984/143)

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After regulation 58B, insert:

##### **58C Substances used to terminate pregnancy are medicines**

Substances used to terminate a pregnancy are medicines for the purposes of the Act.

#### Part 3

#### Revocation of legislative instrument

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##### Abortion Regulations 1978 (SR 1978/50)

##### Legislative history

5 August 2019  
8 August 2019

Introduction (Bill 164–1)  
First reading and referral to Abortion Legislation Committee