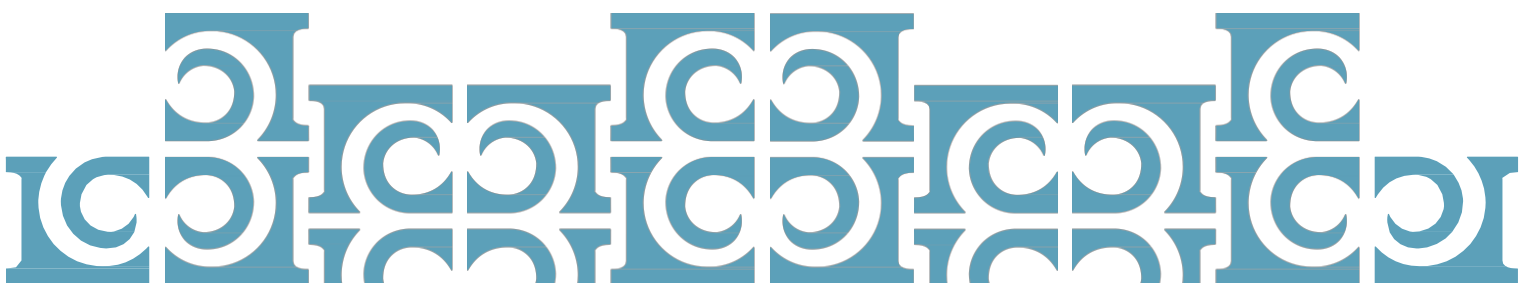


Alternative approaches to abortion law

Ministerial briefing paper



ALTERNATIVE APPROACHES TO ABORTION LAW

MINISTERIAL BRIEFING PAPER

ADDENDUM

The Commission notes that the Termination of Pregnancy Bill 2018 (Qld) was passed by the Queensland Parliament on 17 October 2018, shortly after this ministerial briefing paper was finalised for printing.

The Law Commission | Te Aka Matua o te Ture is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the people of New Zealand.

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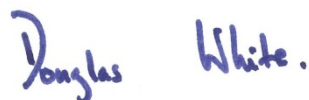
Foreword

This ministerial briefing paper has been prepared as a matter of priority under section 7(3) of the Law Commission Act 1985, at the request of Hon Andrew Little, the Minister of Justice. It provides advice on what alternative approaches could be taken in New Zealand's legal framework if the Government decides to propose a policy shift to treat abortion as a health issue.

The Commission has not conducted a full review of all aspects of abortion law and does not express a view on the appropriate policy approach.

The Commission received input from the health sector and submissions from members of the public in developing its advice. I would like to express our gratitude to all who shared their expertise and views. I would also like to acknowledge in particular the advice and assistance provided by the Ministry of Health in facilitating the Commission's consultation with health sector representatives.

This briefing paper has been prepared by Belinda Clark and a team of the Commission's legal and policy advisors. I thank them for their hard work.

A handwritten signature in blue ink that reads "Douglas White." The signature is written in a cursive, slightly informal style.

The Hon Sir Douglas White
President

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Abbreviations and terms

ABBREVIATIONS

APGANZ	Abortion Providers Group Aotearoa New Zealand
ASC	Abortion Supervisory Committee
DHBs	District health boards
CSA Act	Contraception, Sterilisation, and Abortion Act 1977
EMA	Early medical abortion
GP	General practitioner
HDC Act	Health and Disability Commissioner Act 1994
HDSS Act	Health and Disability Services (Safety) Act 2001
HPCA Act	Health Practitioners Competence Assurance Act 2003
NZBORA	New Zealand Bill of Rights Act 1990
NZMA	New Zealand Medical Association
NZNO	New Zealand Nurses Organisation
RANZCOG	Royal College of Australian New Zealand Obstetricians and Gynaecologists
WHO	World Health Organization

KEY TERMS

A full glossary of terms used in this ministerial briefing paper is contained in Appendix 2.

Abortion

Abortion refers to the intentional termination of an established pregnancy. The Law Commission uses the term “abortion” rather than “termination of pregnancy” in this briefing paper because it is widely understood by the public and in common use internationally. Most health practitioners who provided input to the Commission supported the use of “abortion” in law and standards since people are familiar with it.

Woman

This briefing paper refers to the “woman” seeking an abortion and uses the pronouns she/her. In doing so, the Commission intends to include any person who is capable of becoming pregnant. The Commission acknowledges that not every person seeking an abortion is a woman; trans men, takatāpui (a term encompassing diverse Māori gender and sexual identities) and other gender diverse people may also become pregnant and seek an abortion.

Fetus

This briefing paper uses the term “fetus” to refer to a fertilised human ovum at any stage of gestation (including an embryo). The term “unborn child” is only used when referring to existing legislative provisions that include it, as it is not a scientific term and does not have a commonly accepted definition.

In technical literature “fetus” or “foetus” refers to a fertilised human ovum more than eight weeks after conception. Between two and eight weeks after conception the term “embryo” is used. A fertilised ovum that has not yet developed into an embryo is called a “zygote”.

Gestation

“Gestation” refers to the stage of the pregnancy and development of the fetus, usually measured in weeks from the date of the pregnant woman’s last menstrual period.

The length of gestation in a healthy pregnancy varies but is commonly estimated to be around 40 weeks. This is divided into three periods called trimesters. The first trimester is from 0 weeks to week 12. The second trimester is from week 13 to week 27. The third trimester is from week 28 to birth.

Legislative terms

The current legislation contains terms that are outdated. For example, one of the provisions in the Crimes Act 1961 refers to the woman being “severely subnormal”. In some instances the Commission has needed to use these terms to explain or analyse the current law. Their use has, however, been avoided where possible.

Introduction

1. Performing an unlawful abortion is a criminal offence in New Zealand.¹ An abortion is unlawful unless certain legal grounds are met.² Two specially appointed doctors, called certifying consultants, must be satisfied that one of the grounds applies before an abortion can occur.³ It is also an offence, punishable by fine, for a woman to unlawfully procure her own miscarriage or obtain an unlawful abortion.⁴
2. The Minister of Justice has signalled an intention to propose a policy shift to treat abortion as a health issue.⁵ This ministerial briefing paper provides advice on alternative legal frameworks that could be adopted to align with a health approach to abortion.

THE MINISTER OF JUSTICE'S REQUEST FOR ADVICE

3. On 27 February 2018 the Minister of Justice, Hon Andrew Little, asked the Law Commission to provide to him a briefing paper advising what alternative approaches could be taken in New Zealand's legal framework to align with a health approach to abortion.
4. The Minister's letter (Appendix 1) set out the scope of the advice sought in the following terms:

“Specifically, I expect the scope of the Law Commission's advice to include reviewing the criminal aspects of abortion law, and the statutory grounds for an abortion and process for receiving services, which are contained in both the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.

A draft bill is not required, however, you may wish to provide drafting to illustrate the options the Law Commission identifies. I do not expect you to review the offence of killing an unborn child in the Crimes Act 1961, but you may wish to highlight any adjustments to that provision that would be needed because of the options discussed.”
5. The advice was sought under section 7(3) of the Law Commission Act 1985, which requires the Commission to give appropriate priority to the examination of any aspect of the law of New Zealand that the Minister requests.⁶ The Minister asked the Commission to report back to him within an eight-month timeframe.

¹ Crimes Act 1961, s 183.

² Crimes Act, s 187A.

³ Contraception, Sterilisation, and Abortion Act 1977 (CSA Act), s 29.

⁴ CSA Act, s 44.

⁵ Letter from the Minister of Justice to the President of the Law Commission (27 February 2018) (Appendix 1).

⁶ Law Commission references generally involve identifying issues and creating terms of reference; publishing issues papers for public comment; then preparing a final report with recommendations for reform of the law. They are noted for being comprehensive and typically take at least one year to complete, and sometimes significantly longer.

Ministerial briefing papers provided under section 7(3) are more restricted in scope, usually responding to a specific question or examining a particular issue. The Law Commission has previously provided ministerial briefing papers on the

THE COMMISSION'S APPROACH

6. In this briefing paper the Law Commission sets out three alternative models for New Zealand's abortion laws. The Commission assesses the extent to which each model is likely to align with the Minister's proposed policy of treating abortion as a health issue, but does not recommend a particular model. The Government—and ultimately Parliament as the elected representatives of the New Zealand public—will decide what, if any, changes should be made to the law. In line with this approach, the Commission has not included a draft Bill.
7. To understand what a health approach to abortion might look like, the Commission examined how the law deals with other health services.⁷ The general laws and professional standards relating to health services aim to:
- prioritise the health and wellbeing of the individual patient and their autonomy to make an informed decision;⁸
 - ensure effective, timely and equitable access to health services;⁹ and
 - enable continuous improvement of the quality of services.¹⁰

The Commission has referred to these principles in assessing what changes to the law might be required to treat abortion as a health issue.

8. The Commission's advice has also been informed by the approaches taken in jurisdictions New Zealand often compares itself to, particularly those where abortion laws have recently been reformed or where reform is currently under consideration. A summary of the law in other jurisdictions and recent reform initiatives is included in Appendix 6.

INPUT FROM HEALTH PROFESSIONALS AND THE PUBLIC

9. The Minister requested that the Commission seek input from appropriate health professionals and provide an opportunity to receive the public's views.
10. The Commission met with representatives from a range of health professional bodies, health regulatory bodies and abortion service providers during the early stages of its review to gain an understanding of the issues. Many subsequently made formal submissions.

adequacy of sanctions and remedies for harmful digital communications (Law Commission *Harmful Digital Communications: The adequacy of the current sanctions and remedies* (NZLC MB3, 2012)); information sharing (Law Commission *Information Sharing: Review of Privacy* (NZLC MB2, 2011)); and the monitoring of the Evidence Act 2006 (Law Commission *Monitoring of the Evidence Act 2006* (NZLC MB1, 2010)).

⁷ The general regulatory framework that applies to health services is summarised in Chapter 3.

⁸ See, for example, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, rights 4, 6 and 7; New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 2 and 4 (principles 1–2, 6, and 8).

⁹ New Zealand Public Health and Disability Act 2000, s 3(1); New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 4 (principles 10–11); Minister of Health *New Zealand Health Strategy: Future Direction* (Ministry of Health, 2016) at 19 and 25–28 (the strategy is issued under the New Zealand Public Health and Disability Act 2000, s 8).

¹⁰ Health and Disability Services (Safety) Act 2001, s 3(1)(d); New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 4 (principles 6–7).

11. In addition, with the assistance of the Ministry of Health, the Commission held a meeting with representatives of health professional bodies and abortion service providers (including district health boards) while developing its advice. This allowed the Commission to test the likely workability of the options for reform it had identified.
 12. The Commission also provided an opportunity for members of the public to give their views. The Commission published a website setting out the existing law and invited the public to make submissions. In addition to views shared through the website, the Commission received submissions by email and post. The period for public submissions ran from 4 April to 18 May 2018. In total, the Commission received 3,419 submissions.
 13. The consultation and public submission process the Commission undertook is described in greater detail in Appendix 4. A summary of submitters' views is set out in Appendix 5.
 14. The Commission is grateful to everyone who took the time to share their expertise, experiences and views. It also thanks Ministry of Health officials for their assistance and advice in engaging with health professionals.
-

Executive summary

INTRODUCTION

- i. In this ministerial briefing paper, the Law Commission examines alternative legal frameworks that could be adopted to align with a health approach to abortion.
- ii. The briefing paper first sets out the law applying to abortion in New Zealand and how abortion services are provided in practice. It also examines core aspects of the wider legal context: namely, the general health regulatory framework, human rights law and the Treaty of Waitangi.
- iii. The Commission's advice is then divided into two parts:
 - **Part One** sets out three alternative legal models that could be adopted if abortion is to be treated as a health issue. These are referred to as Models A, B and C. Each model takes a different approach to when abortion would be lawful. **The three models are set out in Chapter 4.**
 - **Part Two** considers various other aspects of abortion law that may require amendment, irrespective of which of the models set out in Part One may be preferred. Specific areas of the law examined include the criminal aspects of abortion law; access to and oversight of abortion services; informed consent and counselling; conscientious objection; and issues concerning the related offence of killing an unborn child. Part Two also briefly notes other areas that may warrant further consideration by the Government if abortion law reform is progressed.

PART ONE: ALTERNATIVE LEGAL MODELS FOR TREATING ABORTION AS A HEALTH ISSUE

- iv. The Minister of Justice's request for advice indicated an intention to propose a policy shift to treat abortion as a health issue. If that approach is taken, it calls into question the need for any specific abortion legislation, since the existing health regulatory framework already applies to all health services. Most health services are not subject to their own legislative regime and are instead governed by this general health regulatory framework (described in Chapter 3). The Commission was, however, asked to provide advice on a range of alternative approaches.
- v. The first legal model the Commission outlines (Model A) contemplates no specific abortion legislation and would therefore involve repealing the abortion provisions in the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977. The two other models presented (Models B and C) would retain a specific statutory regime for abortion, although both would be significantly simpler than the current regime. All three models would give greater priority to the health and wellbeing of the woman seeking an abortion than the current law. The three models (described in Chapter 4) are outlined below.

ALTERNATIVE LEGAL MODELS FOR WHEN ABORTION WOULD BE LAWFUL	
Model A	<ul style="list-style-type: none"> • There would be no statutory test that must be satisfied before an abortion could be performed. • The decision whether to have an abortion would be made by a woman in consultation with her health practitioner.
Model B	<ul style="list-style-type: none"> • A statutory test would need to be satisfied before an abortion could be performed, but the test would be in health legislation rather than the Crimes Act. • <i>The statutory test:</i> the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.
Model C (combines aspects of Models A and B)	<p><i>For pregnancies of not more than 22 weeks gestation—same as Model A</i></p> <ul style="list-style-type: none"> • There would be no statutory test that must be satisfied before an abortion could be performed. • The decision whether to have an abortion would be made by a woman in consultation with her health practitioner. <p><i>For pregnancies of more than 22 weeks gestation—same as Model B</i></p> <ul style="list-style-type: none"> • The same statutory test as in Model B would need to be satisfied before an abortion could be performed. The test would be in health legislation rather than the Crimes Act. • <i>The statutory test:</i> the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.

- vi. Chapter 5 proposes **two changes to the law that would be required under all of the three models:**
- the current grounds for abortion in the Crimes Act would be repealed; and
 - the requirement for abortions to be authorised by two certifying consultants would be repealed.

PART TWO: OTHER ASPECTS OF ABORTION LAW

- vii. Part Two of this briefing paper considers what changes might be required to other aspects of the legal framework for abortion to align it with a health approach. Except where expressly stated, the options and proposals set out in Part Two could apply under any of the three models set out in Part One.

Criminal aspects of abortion law

- viii. The Commission proposes either repealing the criminal offences for abortion or amending them so that they only apply to unqualified people who perform abortions. Health practitioners who perform abortions and women who self-induce miscarriages would not commit a crime. The safety of women is already protected by other existing offences in the Crimes Act and health legislation, as well as the disciplinary regime that applies to health practitioners.
- ix. If Model B or C is adopted, a regulatory offence under health legislation could be considered to ensure that people who perform abortions comply with the law.

Access to abortion services

- x. Aspects of the current law can cause delay and present other barriers for women seeking abortion services. The Commission suggests a number of reforms that could be considered to improve access. Women could be permitted to self-refer to abortion services, rather than requiring a referral from a doctor. The current legal restrictions on where and by whom abortions can be performed could be repealed. This would allow abortions to be performed, or abortion medication administered, by any appropriately qualified health practitioner and at a wider range of health care facilities (for example, Family Planning clinics and medical centres), particularly in early pregnancy. General health regulation would ensure abortions are performed safely.

Oversight of abortion services

- xi. Abortion services are currently overseen by the Abortion Supervisory Committee (ASC), which is administered by the Ministry of Justice. The ASC could be abolished and its oversight functions shifted to the Ministry of Health. The Ministry of Health is responsible for the oversight of other health services and is best placed to ensure that abortion services are adequately funded and accessible.
- xii. The Ministry of Health could also take over the ASC's function of issuing best practice guidance for health practitioners involved in abortion care, with input from appropriate experts (including input from Māori, consistent with the principle of partnership under the Treaty of Waitangi).

Informed consent and counselling

- xiii. Many submitters raised concerns around informed consent and whether women are adequately supported to make informed decisions about abortion. The Commission has examined the current law and guidance surrounding informed consent to health procedures generally and considers it is already sufficient. In particular, health practitioners are required to ensure that women are sufficiently informed of the options available to them, and have the time and support they need to make an informed

choice. The Commission also suggests counselling should not be mandatory for women seeking abortion, although it should remain available to all who want it.

Conscientious objection

- xiv. The current law gives health practitioners the right to refuse to provide services in relation to abortion if they object on the grounds of conscience. The Commission does not suggest that right should be removed. However, the Government could consider changing the law to ensure that conscientious objection does not unduly delay women's access to abortion services. Health practitioners with an objection could be required to refer a woman seeking an abortion to someone who can provide the service as soon as reasonably practicable.

The offence of killing an unborn child

- xv. The Crimes Act contains a provision that makes it an offence to kill an unborn child. This offence is not aimed at abortion, but rather at the killing of children during birth or through assaults on pregnant women. However, the wording of the offence is wide enough to cover abortions performed at later gestations. The Government may wish to consider amending the provision to ensure it is consistent with the Government's preferred policy approach to abortion.

Areas for further consideration

- xvi. Lastly, the Commission considers two issues that are not reflected in the proposals for reform presented in this briefing paper but that may warrant further consideration by the Government. The first is the possible introduction of "safe access zones" around abortion clinics, to protect women accessing abortion services from potentially intimidating or distressing behaviour by protesters. The Commission found insufficient evidence to conclude that reform is necessary to protect against such behaviour. This issue could, however, be considered further if problems were to arise.
 - xvii. The second was a concern raised by some submitters and health practitioners that if abortion becomes more easily accessible, it might be used inappropriately based on the sex of the fetus or fetal impairment. These issues are closely tied to laws and policies around prenatal screening and fertility treatment, as well as questions of broader societal concern. They may warrant further consideration by the Government.
-

CHAPTER 1

Abortion law in New Zealand

OVERVIEW

- 1.1 New Zealand's abortion laws are primarily set out in two statutes: the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act). The CSA Act was enacted, and the Crimes Act provisions on abortion were amended, following a Royal Commission of Inquiry in 1977.¹ Aside from some minor changes in 1978, those provisions have not been substantively amended since then.²
- 1.2 Under the Crimes Act it is an offence to procure³ or supply the means to procure⁴ an abortion. These offences are subject to certain exceptions.⁵ The offence of procuring an abortion in the Crimes Act does not apply to the woman seeking an abortion.⁶ There is, however, an offence in the CSA Act (punishable by a fine) that applies to women who seek to unlawfully procure their own miscarriage or obtain an unlawful abortion.⁷
- 1.3 The CSA Act also sets out a regulatory framework for the provision of abortion services and creates the Abortion Supervisory Committee (ASC), the regulatory body responsible for general oversight of abortion law.⁸ Under the CSA Act regime, abortions can only be carried out if they have been approved by two “certifying consultants” (doctors appointed by the ASC)⁹ and occur in an institution licensed by the ASC.¹⁰ A person who

¹ Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand; Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26.

² Minor clarifications were made to the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) in 1978, primarily in respect of the process for considering abortions under s 32 of the Act: Contraception, Sterilisation, and Abortion Amendment Act 1978. Section 187A of the Crimes Act 1961 was also amended in 1978 to add a further ground on which abortion could be performed—namely, that “there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped”: Crimes Amendment Act 1978, s 2.

³ Crimes Act, s 183.

⁴ Crimes Act, s 186.

⁵ Crimes Act, s 187A.

⁶ Crimes Act, s 183(2).

⁷ CSA Act, s 44.

⁸ CSA Act, s 30.

⁹ CSA Act, s 29.

¹⁰ CSA Act, s 18.

performs an abortion without complying with these requirements commits a regulatory offence.¹¹

- 1.4 There are also two key provisions in other statutes that apply to abortion. The Care of Children Act 2004 provides that women and girls of any age can consent (or refuse to consent) to an abortion.¹² The Health Practitioners Competence Assurance Act 2003 sets out the obligations of health practitioners who conscientiously object to providing reproductive health services, including abortion.¹³
- 1.5 Key aspects of New Zealand's current abortion laws are explained in greater detail below. Also relevant to abortion are the general laws and professional standards that apply to the provision of all health services, which are discussed in Chapter 3.

PERFORMING AN ABORTION IS A CRIME EXCEPT IN CERTAIN CIRCUMSTANCES

- 1.6 Under section 183 of the Crimes Act it is an offence, punishable by up to 14 years' imprisonment, to unlawfully administer a drug, or to use an instrument or any other means, with intent to procure the miscarriage of any woman or girl.¹⁴ "Miscarriage" means the destruction, death, or premature expulsion or removal of an embryo or fetus.¹⁵ The woman cannot be charged as a party to this offence.¹⁶
- 1.7 There is a further offence in section 186 of the Crimes Act, punishable by up to 7 years' imprisonment, of supplying the means of procuring an abortion (whether a drug, instrument or other thing).¹⁷ The person must believe the drug, instrument or thing is intended to be unlawfully used to procure a miscarriage.
- 1.8 An offence may be committed under section 183 or 186 even if the means used or supplied were not in fact capable of procuring a miscarriage.¹⁸
- 1.9 The offences in sections 183 and 186 only apply if the relevant act is done "unlawfully". This will be the case unless one of the exceptions in section 187A applies.¹⁹

¹¹ CSA Act, s 37. Regulatory offences, sometimes referred to as "quasi-criminal" offences, form part of a regulatory regime and are designed to incentivise compliance with standards of conduct set out in legislation. They are discussed in more detail in Chapter 6.

¹² Care of Children Act 2004, s 38. Consent to abortion is discussed in Chapter 9.

¹³ Health Practitioners Competence Assurance Act 2003, s 174. Conscientious objection is discussed in Chapter 10.

¹⁴ Crimes Act, s 183(1).

¹⁵ Crimes Act, s 182A. There is an exception if the expulsion or removal is for the purpose of inducing the birth of a fetus believed to be viable or removing a dead fetus.

¹⁶ Crimes Act, s 183(2).

¹⁷ Crimes Act, s 186.

¹⁸ Crimes Act, s 187.

¹⁹ Crimes Act, s 187A(1) and (3).

When procuring an abortion is not an offence

- 1.10 Section 187A sets out the circumstances in which procuring an abortion or supplying the means to do so is **not** an offence under section 183 or 186.²⁰ These are often called the grounds for abortion. Section 187A was inserted into the Crimes Act in 1977 when the CSA Act was passed. Prior to that, “unlawfully” was not defined.
- 1.11 Section 187A distinguishes between pregnancies of up to 20 weeks gestation²¹ and those of more than 20 weeks gestation. In the case of a pregnancy of up to 20 weeks gestation, a person will not commit an offence by procuring an abortion or supplying the means to do so if they believe that:²²
- continuing the pregnancy would result in serious danger to the life, or to the physical or mental health, of the woman (not being danger normally attendant upon childbirth);
 - 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 incest²³ or sexual intercourse with a dependent family member; or
 - the woman is “severely subnormal”.²⁴
- 1.12 In assessing whether continuing the pregnancy would result in serious danger to the woman’s life or physical or mental health, it is permissible to take into account (where relevant) that the woman is near the beginning or end of usual child-bearing years; or that there are reasonable grounds to believe the pregnancy is the result of sexual violation.²⁵ However, these factors are not themselves grounds for performing an abortion.
- 1.13 In the case of a pregnancy of more than 20 weeks gestation, an abortion can only be performed in more limited circumstances. A person who procures or supplies the means to procure an abortion will commit an offence unless they believe the abortion is necessary to save the woman’s life or prevent serious permanent injury to her physical or mental health.²⁶

²⁰ This does not necessarily mean the abortion will be lawful. For example, if an abortion is performed without obtaining the approval of two certifying consultants then it will breach the CSA Act.

²¹ “Gestation” means the stage of the pregnancy and development of the fetus, usually measured in weeks from the date of the pregnant woman’s last menstrual period.

²² Crimes Act, s 187A(1).

²³ That is, sexual intercourse between a parent and child, brother and sister or grandparent or grandchild: s 187A(1)(b).

²⁴ “Severely subnormal” is defined by reference to s 138(2). However, as a result of an amendment to that section effected by the Crimes Amendment Act 2005, it no longer uses or defines the term (instead referring to a “significant impairment”). The failure to amend s 187A appears to be an oversight. Prior to amendment, s 138(2) defined “severely subnormal” as “incapable of living an independent life or of guarding herself against serious exploitation or common physical dangers.” Under the amended section, “significant impairment” is defined as an intellectual, mental or physical condition that significantly impairs a person’s capacity to understand the nature of sexual conduct; to understand the nature of or foresee the consequences of decisions about sexual conduct; or to communicate decisions about sexual conduct: s 138(6).

²⁵ Crimes Act, s 187A(2).

²⁶ Crimes Act, s 187A(3).

Most convictions under the Crimes Act abortion offences relate to assaults

- 1.14 The Ministry of Justice provided the Commission with records of the number of charges under sections 183 and 186 from 1980 to 2016. During that time there were:
- 40 charges under section 183 (procuring abortion), of which 12 resulted in conviction; and
 - one charge under section 186 (supplying means of procuring abortion), which resulted in conviction.
- 1.15 An additional three convictions were recorded for “other abortion” offences. The data does not show which specific section each of those convictions was made under, only that they related to sections 182–187 of the Crimes Act.
- 1.16 All of the convictions under section 183 for which the Commission was able to locate court decisions related to assaults on women that caused (or were intended to cause) a miscarriage.²⁷ The Commission is unaware of any case in which a person has been convicted under section 183 for performing an abortion.
- 1.17 The single conviction under section 186 did, however, relate to the unlawful supply of pills that could cause an abortion.²⁸

IT IS AN OFFENCE FOR A WOMAN TO PROCURE HER OWN MISCARRIAGE

- 1.18 Under the CSA Act it is an offence for a woman to unlawfully take a drug or poison, or use (or permit to be used on her) any instrument or other means with intent to procure a miscarriage.²⁹ In determining whether an action is unlawful for the purposes of the offence, the grounds in section 187A of the Crimes Act (discussed above) apply.³⁰ A woman may commit this offence even if she was not actually pregnant at the time³¹ or if the method used was not capable of procuring a miscarriage.³²
- 1.19 According to data received from the Ministry of Justice, there have been no convictions for this offence. There was one unsuccessful prosecution for a breach of the CSA Act in 2003/4, but the data does not show which CSA Act offence the prosecution related to. As discussed below, there are other offences in the CSA Act that apply to people who perform abortions without meeting certain regulatory requirements.

²⁷ *R v Mosen* [2013] NZHC 2540; *R v Fonoti* HC Auckland CRI-2006-092-13045, 28 November 2008; *R v C* HC Auckland T 991919, 23 December 1999; *R v Keen* HC Wellington T 58-93, 19 November 1993. See also *R v Richardson* [2012] NZHC 1465 (where the defendant was discharged on the s 183 count). As is discussed in Chapter 11, other provisions in the Crimes Act also apply to people who assault pregnant women causing the death of the fetus.

²⁸ *Zhu v Ministry of Health* HC Auckland CRI 2006-404-00286, 14 November 2006.

²⁹ CSA Act, s 44(1). “Miscarriage” is defined in s 44(2) in the same way as s 182A of the Crimes Act. It means the destruction, death, or premature expulsion or removal of an embryo or fetus, other than for the purpose of inducing the birth of a fetus believed to be viable or removing a fetus that has died.

³⁰ CSA Act, s 44(3). As explained above at [1.11]–[1.13], the grounds that apply to pregnancies of up to 20 weeks gestation are: a) serious danger to the woman’s life or physical or mental health; b) substantial risk that the child would be seriously handicapped; c) pregnancy caused by incest or sexual intercourse with a dependent family member; d) woman is “severely subnormal”. After 20 weeks the abortion must be necessary to save the woman’s life or prevent serious permanent injury to her physical or mental health.

³¹ CSA Act, s 44(1).

³² CSA Act, s 44(4).

- 1.20 The penalty for the offence of a woman procuring her own miscarriage is low: the woman can be fined up to \$200.³³ Prior to the enactment of the CSA Act in 1977, the offence of a female procuring her own miscarriage was contained in section 185 of the Crimes Act (now repealed) and was punishable by imprisonment for up to seven years.
- 1.21 The Royal Commission of Inquiry that led to the enactment of the CSA Act considered abolishing the offence, but ultimately recommended it should be retained with a drastic reduction in penalty.³⁴ The reduction in penalty was intended to reflect what the Royal Commission referred to as the “desperate” situation of women who seek an unlawful abortion.³⁵ The retention of the offence was considered necessary to recognise the status of the fetus and to avoid the incongruity of imposing criminal liability on third parties (such as doctors) who “may be motivated by pity” to perform an unlawful abortion, but not on the woman herself.³⁶

IT IS AN OFFENCE TO PERFORM AN ABORTION WITHOUT CERTIFICATION OR OUTSIDE A LICENSED INSTITUTION

- 1.22 Section 37 of the CSA Act creates a regulatory offence that applies to any person who performs an abortion other than:
- in an institution (such as a hospital or clinic) licensed by the ASC; and
 - in pursuance of a certificate issued by two certifying consultants.

This offence is punishable by up to 6 months’ imprisonment or a fine of up to \$1,000. It is designed to ensure compliance with the licensing and certification requirements in the CSA Act, which are described at [1.32]–[1.52] below.

- 1.23 The Crown is not required to prove that the person performing the abortion was aware of the non-compliance. However, where the charge relates to the performance of an abortion other than in pursuance of a CSA Act certificate, it is a defence to show that the defendant believed a certificate had been issued.³⁷
- 1.24 A doctor does not commit an offence under section 37 if they believe the abortion is “immediately necessary to save the life of the patient or to prevent serious permanent injury to her physical or mental health.”³⁸ This allows abortions to be carried out quickly in emergency situations, without having to satisfy the certification requirements or transfer the patient to a licensed institution.

³³ CSA Act, s 44(1).

³⁴ Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand; Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 281.

³⁵ At 280.

³⁶ At 281.

³⁷ CSA Act, s 37(3). There is no equivalent defence for believing that an institution was licensed.

³⁸ CSA Act, 37(2). The section refers to a “medical practitioner”, which is defined as a health practitioner registered with the Medical Council of New Zealand as a practitioner of the profession of medicine (CSA Act, s 2 and Crimes Act, s 2). This briefing paper uses the more common term “doctor”.

1.25 According to data received from the Ministry of Justice, there have been no convictions under section 37.³⁹ A doctor with permanent name suppression, known only as “Dr N”, was disciplined by the Health Practitioners Disciplinary Tribunal in 2013 for prescribing misoprostol (a drug used to induce a miscarriage) without complying with the requirements in the CSA Act.⁴⁰ The doctor was suspended from practice for six months. In 2017 New Zealand Police sought to investigate the case following a complaint by Right to Life New Zealand. However, the investigation was closed after the High Court declined an application by Police to access the court file to obtain the name of Dr N.⁴¹

ABORTION SERVICES ARE REGULATED UNDER THE CONTRACEPTION, STERILISATION, AND ABORTION ACT

1.26 The CSA Act establishes a process that must be followed before an abortion can be performed. It also provides for the oversight and monitoring of abortion services. The Act:

- establishes the ASC;⁴²
- creates a regime for licensing institutions where abortions can be performed;⁴³
- sets out a process for authorising abortions, including a requirement for approval by two specially appointed doctors (called “certifying consultants”);⁴⁴
- provides for access to counselling services;⁴⁵ and
- allows any person to refuse to perform or assist in performing abortions on grounds of conscience.⁴⁶

The ASC oversees the operation of abortion law

1.27 The ASC consists of three members, two of whom must be doctors.⁴⁷ Members are appointed by the Governor-General on the recommendation of the House of Representatives.⁴⁸ The Act does not specify a process for selecting candidates. In practice, the Commission understands the Minister of Justice usually seeks nominations from ministerial and caucus colleagues, including the Minister of Health and Minister for Women, and sometimes from other political parties. The Minister then undertakes cross-

³⁹ As noted at [1.19] above, the Ministry of Justice data recorded one unsuccessful prosecution under the CSA Act in 2003/4, but it is unclear which offence that prosecution related to.

⁴⁰ *Dr N Health Practitioners Disciplinary Tribunal* 543/Med12/224P, 31 May 2013. The doctor prescribed the medication to three women without their abortions having been authorised by two certifying consultants. The medication also was not taken at a facility licensed to perform abortions. Dr N was granted permanent name suppression by the High Court in *N v Professional Conduct Committee of Medical Council of New Zealand* [2013] NZHC 3405, [2014] NZAR 350.

⁴¹ *N v Professional Conduct Committee of Medical Council of New Zealand (No 2)* [2017] NZHC 984, [2017] NZAR 818. Police advised the Commission that as a result of this decision it was unable to determine Dr N’s identity or that of her patients, so there was no way to proceed with the investigation.

⁴² CSA Act, ss 10(1) and 14.

⁴³ CSA Act, ss 14 and 18–25.

⁴⁴ CSA Act, s 32.

⁴⁵ CSA Act, s 31 and 35.

⁴⁶ CSA Act, ss 46.

⁴⁷ CSA Act, s 10(2).

⁴⁸ CSA Act, s 10(3). Section 12 provides for an alternative appointment process to fill a vacancy if an Abortion Supervisory Committee (ASC) member dies, resigns or is removed from office.

party consultation and selects candidates for consideration by the House of Representatives.

1.28 Appointments are for a three-year term, but reappointment is permitted.⁴⁹ Members of the ASC are protected from personal liability for any acts done or omissions made in good faith in pursuance of powers under the CSA Act.⁵⁰

1.29 The ASC has numerous statutory functions, which can be grouped into the following four categories:⁵¹

- **Review functions:** the ASC must keep under review—
 - the abortion law provisions in the Crimes Act and the CSA Act and their practical operation;⁵² and
 - the procedure set out in the CSA Act for determining whether an abortion is justified.
- **Licensing functions:** the ASC licenses institutions to perform abortions and prescribes standards for the facilities to be provided in licensed institutions.
- **Service assurance functions:** the ASC must take all reasonable and practical steps to ensure that—
 - licensed institutions maintain adequate facilities and employ competent staff;
 - sufficient and adequate counselling services are available nationwide for women seeking abortion-related advice; and
 - abortion law is administered consistently nationwide and the CSA Act operates effectively.

The ASC also has the ability to recommend maximum fees that may be charged for abortion services in licensed institutions, although it has never done so.⁵³

- **Monitoring and reporting functions:** the ASC is required to monitor and disseminate information about the performance of abortions in New Zealand, and to report annually to Parliament on the operation of abortion law.

⁴⁹ CSA Act, s 11(1).

⁵⁰ CSA Act, s 40.

⁵¹ CSA Act, s 14(1).

⁵² The ASC has, for example, raised concerns about some of the language used in the CSA Act: *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 3–4. As noted below at [12.4], the Law Commission recognises that some of the language in the current legislation is outdated, but does not give specific advice on that in this briefing paper since more significant changes to the legislation are likely to be required in any event. For example, in Chapter 5 the Commission suggests the repeal of the current grounds for abortion in s 187A of the Crimes Act, which contain some of the language the ASC has objected to (see [5.6] below).

⁵³ The current members of the ASC told the Commission they do ask for fee information when considering applications by institutions to renew licences, and have on occasion queried the fees charged as part of that renewal process.

- 1.30 To assist the ASC in performing its functions, it may appoint advisory and technical committees;⁵⁴ obtain expert advice;⁵⁵ receive assistance or services from the Crown;⁵⁶ and seek the opinion of the High Court on a matter of law.⁵⁷
- 1.31 Doctors are required to notify the ASC of each abortion they perform and the reasons for it (although they must not include the name or address of the woman).⁵⁸ The CSA Act does not permit the ASC to require full case records from certifying consultants or to review their decisions in individual cases. The Supreme Court has found that the ASC's review functions are of a more general, systemic nature, and it is not empowered to act as a quasi-inquisitorial or disciplinary body.⁵⁹

Abortions must be authorised by two certifying consultants

- 1.32 Under the CSA Act, an abortion cannot be performed unless it has been authorised by two certifying consultants.⁶⁰ Breaching this requirement is a regulatory offence.⁶¹
- 1.33 Certifying consultants are doctors appointed by the ASC in consultation with the New Zealand Medical Association.⁶² At least half of the certifying consultants appointed must be practising obstetricians or gynaecologists.⁶³ There must also be a sufficient number of certifying consultants practising in each area of New Zealand to ensure that any woman seeking an abortion can have her case considered without "considerable travelling or other inconvenience".⁶⁴

⁵⁴ CSA Act, s 15.

⁵⁵ CSA Act, 16.

⁵⁶ CSA Act, s 17.

⁵⁷ CSA Act, s 28. This power was exercised in *Re Abortion Supervisory Committee* [2003] 3 NZLR 87 (HC). The ASC brought a case seeking the High Court's opinion on whether a woman needed to remain on licensed premises after taking medical abortion pills until the fetus was expelled, given that s 18 of the CSA requires an abortion to be "performed" at a licensed institution. The Court concluded a woman is not required to remain on the premises until the expulsion of the fetus, but that the pills must be taken at the clinic (at [36] and [56]–[57]).

The power was also considered in *Right to Life New Zealand Inc v Rothwell* [2006] 1 NZLR 531 (HC), where it was argued that the ASC had a duty to state a case for the High Court under s 28 of the CSA Act where it was in doubt as to the law (at [73]). The Court rejected this, noting that s 28 "confers a power" and "does not impose a duty" (at [76]).

⁵⁸ CSA Act, s 45.

⁵⁹ *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2012] NZSC 68, [2012] 3 NZLR 762 at [44]–[46]. See also Royal Commission of Inquiry "Contraception, Sterilisation, and Abortion in New Zealand; Report of the Royal Commission of Inquiry" [1977] 11 AJHR E26 at 286 (recommending the establishment of a committee to have "general oversight of the administration of abortion law").

⁶⁰ CSA Act, s 29.

⁶¹ CSA Act, s 37(1)(b). The offence does not apply to the performance of an abortion by a medical practitioner who believes that abortion is immediately necessary to save the life of the patient or to prevent serious permanent injury to her physical or mental health: s 37(2).

⁶² CSA Act, s 30. The New Zealand Medical Association is a professional medical organisation representing the collective interests of doctors from all disciplines (including specialists, general practitioners, doctors-in-training and medical students).

⁶³ CSA Act, s 30(4)(a). Obstetrics and gynaecology are branches of medicine dealing with pregnancy, childbirth and the female reproductive system: see Tony Deveson and Graeme Kennedy (eds) *New Zealand Oxford Dictionary* (Oxford University Press, Melbourne, 2005), definitions of "obstetrics" and "gynaecology".

⁶⁴ CSA Act, s 30(4)(b).

1.34 When selecting certifying consultants, the ASC must “have regard to the desirability of appointing medical practitioners whose assessment of cases coming before them will not be coloured by views in relation to abortion generally that are incompatible with the tenor of this Act.”⁶⁵ The CSA Act states this includes both the view that abortion should not be performed in any circumstances and the view that abortion is entirely a matter for the woman and her doctor to decide.⁶⁶

There is a detailed statutory process for authorising an abortion

1.35 The CSA Act sets out a process that must be followed for an abortion to be authorised. This process is described in the diagram overleaf and the text that follows. The process set out here only includes the steps that are legally required under the CSA Act. This does not provide a complete picture of what occurs in practice. Chapter 2 describes how abortion services are provided in practice.

⁶⁵ CSA Act, s 30(5).

⁶⁶ CSA Act, s 30(5).

Process for authorising abortions under the Contraception, Sterilisation, and Abortion Act 1977

If a woman requests an abortion, a doctor must arrange for her case to be considered in accordance with the process outlined in ss 32 and 33 of the Contraception, Sterilisation, and Abortion Act 1977. *CSA Act, s 32(1)*

The doctor considers whether any of the grounds in s 187A of the Crimes Act 1961 may apply. *CSA Act, s 32(2)*

If the doctor considers a ground may apply, but is not performing the abortion, they must refer the case to another doctor who may be willing to perform the abortion (referred to as “the operating surgeon”). *CSA Act, s 32(2)(a)*

If the operating surgeon considers that any of the grounds in s 187A of the Crimes Act 1961 apply, the operating surgeon arranges for two certifying consultants to consider the case (or if the operating surgeon is a certifying consultant, one other certifying consultant). *CSA Act, s 32(3)*

The Act does not specify what happens if the operating surgeon considers that none of the grounds apply.

If the doctor considers a ground may apply, and is willing to perform the abortion, they need to refer the case to two certifying consultants (or if the doctor is a certifying consultant, one other certifying consultant). *CSA Act, s 32(2)(a)–(b)*

The Act does not specify what happens if the doctor considers that none of the grounds apply.

Grounds for abortion in section 187A of the Crimes Act

If abortion is in the **first 20 weeks of pregnancy**, the person performing the abortion must believe that:

- continuing the pregnancy would result in serious danger to the physical or mental health of the woman;
- 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; or
- the woman is “severely subnormal”.

When determining whether continuing the pregnancy would result in serious danger to the woman’s physical or mental health, the person performing the abortion may take into account:

- the age of the woman;
- whether the pregnancy is the result of sexual violation.

If the abortion is performed **after the first 20 weeks of pregnancy**, the person performing the abortion must believe the abortion is necessary:

- to save the life of the woman; or
- to prevent “serious permanent injury to her physical or mental health”.

No one is required to perform or assist with an abortion if they have a **conscientious objection**. *CSA Act, s 46*

A doctor can also refuse to arrange for the case to be considered in accordance with the process outlined in the CSA Act, but they must tell the woman that she can obtain a referral elsewhere. *Health Practitioners Competence Assurance Act 2003, s 174; Hallagan v Medical Council of New Zealand HC Wellington CIV-2010-485-222, 2 December 2010*

The two certifying consultants must then consider as soon as practicable whether any of the grounds in s 187A of the Crimes Act apply. *CSA Act, ss 32(5) and 33(1)*

At least one of the certifying consultants must be a practising obstetrician or gynaecologist. *CSA Act, ss 32(2)(b)(ii) and 32(3)(b)*

In considering the case, the certifying consultants:

- must interview the woman if she requests. The woman can be accompanied by her own doctor, if they agree. *CSA Act, s 32(5)*
- may receive information from the doctor or the operating surgeon (with the woman's consent). *CSA Act, s 32(6)*
- may consult with any other person to assist with their consideration (with the woman's consent). They may not disclose the woman's identity without her consent. *CSA Act, s32(7)*
- are not obliged to determine a case without first interviewing or examining the woman. *CSA Act, s 32(8)*

In a case where the woman "lacks the capacity to consent, by reason of any mental incapacity", the certifying consultants must consult with a "medical practitioner or other person believed by them to be qualified and experienced in the field and able to make an assessment of the patient's condition and the likely effect on it of the continuance of the pregnancy or an abortion". *CSA Act, s 34*

If both certifying consultants decide that one or more of the grounds in section 187A of the Crimes Act 1961 apply, they will issue a certificate authorising the abortion. *CSA Act, s33(1)*

If both certifying consultants decide that none of the grounds apply, they will refuse to authorise the abortion. *CSA Act, s 33(2)*

If the certifying consultants disagree about whether to authorise the abortion, they must refer the case to a third certifying consultant. *CSA Act, ss 33(3)*
If the third consultant determines that a ground applies, the abortion is authorised. *CSA Act, s 33(4)*

The certifying consultants forward the certificate to the licensed institution where the abortion is to be performed. *CSA Act, s 33(5)*

- Abortions must not be performed unless they have been authorised by two certifying consultants. *CSA Act, s 29*
- Abortions can be performed by any doctor—they do not have to be performed by the operating surgeon. *CSA Act, s 33A*
- Every doctor who performs an abortion must record it and forward records to the ASC (not including name or address of woman). *CSA Act, s 45*

Certifying consultants are appointed by the Abortion Supervisory Committee (the ASC). *CSA Act, s 30*

They must keep records and submit reports to the ASC (not including women's names or addresses). *CSA Act, s 36*

When the certifying consultants have made a decision (whether they authorise or refuse to authorise the abortion), they must **inform the woman of her right to seek counselling** from any appropriate person or agency. *CSA Act, s 35*

Every counselling service should be directed by an experienced and professionally trained social worker. Lay counsellors may be employed if there are insufficient professional social workers. *CSA Act, s 31(2)*

Every counsellor should:

- know about all relevant social services and agencies; and
- be able to advise women or refer them to appropriate agencies for "advice on alternatives to abortion, such as adoption and solo parenthood".

CSA Act, s 31(2)(c)

A female of any age can **consent** to an abortion or refuse to have one. *Care of Children Act 2004, s 38*

Abortions must be performed in **licensed institutions** (*CSA Act, s 18*). There are two types of licence:

- Institutions with limited licences can only perform abortions in the first 12 weeks of a pregnancy.
- Institutions with full licences can perform abortions at any gestation. *CSA Act, s 19*

The ASC is responsible for granting and renewing licences.

Woman sees a doctor and requests an abortion

1.36 The statutory process begins at the point where a woman approaches a doctor about abortion. The CSA Act requires doctors, when requested by a woman who wishes to have an abortion, to arrange for the case to be considered according to the procedure set out in the Act.⁶⁷ A doctor who receives such a request—for example, a general practitioner (GP) or a doctor at a Family Planning clinic—is referred to in the Act as “the woman’s own doctor”.

Doctor or operating surgeon considers grounds for abortion and refers case to certifying consultants

1.37 If the woman’s own doctor considers that one of the grounds for abortion in section 187A of the Crimes Act may apply, the doctor has two options. If the doctor intends to perform the abortion personally, they must refer the case to two certifying consultants (or one other certifying consultant, if the woman’s own doctor is a certifying consultant).⁶⁸ At least one of the certifying consultants considering a case must be a practising obstetrician or gynaecologist.⁶⁹

1.38 If the woman’s own doctor does not intend to perform the abortion, they must refer the case to another doctor (referred to as the “operating surgeon”) who may be willing to do so.⁷⁰ If the operating surgeon is satisfied that one of the grounds in section 187A of the Crimes Act applies, they must refer the case to two certifying consultants (or one other certifying consultant, if the operating surgeon is a certifying consultant).⁷¹

1.39 In theory, either the woman’s own doctor or (where relevant) the operating surgeon could decline to refer a woman’s case to the certifying consultants if they considered that none of the grounds in section 187A of the Crimes Act would apply.⁷² In practice, however, health practitioners told the Commission that doctors tend to err on the side of making the referral and allowing the certifying consultants to make that assessment.

Certifying consultants consider whether grounds for abortion apply

1.40 Once a case has been referred to the certifying consultants, they must consider whether one of the grounds for abortion in section 187A of the Crimes Act applies.⁷³ To inform that assessment, they are entitled to interview the woman seeking an abortion⁷⁴ and must do so if she requests it.⁷⁵

⁶⁷ CSA Act, s 32.

⁶⁸ CSA Act, s 32(2)(b).

⁶⁹ CSA Act, s 32(2)(b).

⁷⁰ CSA Act, s 32(2)(a).

⁷¹ CSA Act, s 32(3). The operating surgeon is given greater decision-making power than the woman’s own doctor. An operating surgeon need only refer a case to certifying consultants if they are positively satisfied that one of the grounds in s 187A of the Crimes Act applies. By contrast, the woman’s own doctor must refer the case if they *consider* that one of the grounds *may* apply.

⁷² CSA Act, s 32(2)–(3).

⁷³ CSA Act, s 33(1).

⁷⁴ CSA Act, s 32(8).

⁷⁵ CSA Act, s 32(5).

- 1.41 The woman's own doctor and/or the operating surgeon may, with the woman's consent, provide any information about the case to the certifying consultants.⁷⁶ Certifying consultants can also consult any other person to assist them in considering the case, if the woman consents.⁷⁷
- 1.42 The certifying consultants must consider a case "as soon as practicable" after it is referred to them.⁷⁸ If they have not reached a decision within 14 days they must advise the ASC in writing of the reasons for the delay.⁷⁹

If two certifying consultants agree that one of the grounds for abortion applies, the abortion is certified as lawful

- 1.43 If both certifying consultants agree that one of the grounds in the Crimes Act applies, they must issue a certificate authorising the performance of the abortion.⁸⁰ If they both consider that none of the grounds apply, they must refuse to authorise the abortion.⁸¹
- 1.44 If only one of the certifying consultants considers that one of the grounds applies, the case must be referred to a third certifying consultant who effectively acts as a tie-breaker.⁸² If the third certifying consultant considers the abortion should be authorised, the other certifying consultant who is of that opinion must issue a certificate authorising the abortion.⁸³
- 1.45 Certifying consultants are not required to give reasons for their conclusions, other than specifying which of the grounds in section 187A of the Crimes Act applies.⁸⁴

The abortion is performed by a doctor at a licensed institution

- 1.46 Once a certificate has been issued by the certifying consultants, the abortion can be performed. This must be done by a doctor⁸⁵ at an institution licensed to perform abortions.⁸⁶ Licensing is discussed further below.
- 1.47 When a certificate is issued under the CSA Act, this reverses the onus of proof for the offences in sections 183 and 186 of the Crimes Act. In the absence of a certificate, a person who performs an abortion is only protected from liability if they had a positive belief that one of the grounds for abortion in section 187A applied.⁸⁷ By contrast, where a doctor performs an abortion under a CSA Act certificate, they are presumed to have

⁷⁶ CSA Act, s 32(6).

⁷⁷ CSA Act, s 32(7).

⁷⁸ CSA Act, s 32(5).

⁷⁹ CSA Act, s 33(6).

⁸⁰ CSA Act, s 33(1).

⁸¹ CSA Act, s 33(2).

⁸² CSA Act, s 33(3). The Commission is unaware of any data showing how often this occurs.

⁸³ CSA Act, s 33(4). The CSA Act does not specify what happens if the third certifying consultant considers none of the grounds apply (for example, whether a fourth certifying consultant might then become involved). It is clear, however, that an abortion can only be certified if two certifying consultants agree that one or more of the grounds apply (section 33(5)).

⁸⁴ *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 739.

⁸⁵ CSA Act, s 33A and Crimes Act, s 187A(4).

⁸⁶ CSA Act, s 18.

⁸⁷ Crimes Act, s 187A(1) and (3).

acted lawfully. They can only be convicted of one of the Crimes Act offences if the Crown proves that they did not believe their actions to be lawful under section 187A.⁸⁸

Abortions can only be performed in licensed institutions

- 1.48 Abortions can only be performed at institutions that are licensed by the ASC.⁸⁹ Two types of licences are available: full licences and limited licences.⁹⁰ Full licences allow an institution to perform abortions at any gestation (provided the criteria in the Crimes Act are met).⁹¹ Limited licences allow an institution to perform abortions only during the first 12 weeks of pregnancy.⁹²
- 1.49 Before granting a licence, the ASC must be satisfied that the institution has adequate facilities, competent staff and counselling services.⁹³ The person who will hold the licence must also be a “fit and proper person” to do so, although no guidance is provided in the CSA Act on how that assessment is to be made.⁹⁴ Licences expire after one year,⁹⁵ but will be renewed on application unless the ASC is satisfied that:⁹⁶
- the institution no longer meets the criteria for granting a licence; and
 - the holder of the licence has not taken all reasonable and practicable steps to ensure that the institution complied with abortion law.
- 1.50 The ASC can also cancel a current licence if either of those circumstances applies.⁹⁷
- 1.51 Any person can appeal to the High Court if they consider the ASC’s decision to refuse to issue or renew a licence, or to cancel a licence, is wrong in law.⁹⁸ Further appeal to the Court of Appeal is also permitted.⁹⁹

⁸⁸ Crimes Act, s 187A(4). As far as the Commission is aware this has never occurred, although as noted at [1.15]–[1.16] above there is some ambiguity in the conviction data available.

⁸⁹ CSA Act, s 18(1).

⁹⁰ CSA Act, s 19.

⁹¹ CSA Act, s 19(2).

⁹² CSA Act, s 19(3).

⁹³ CSA Act, s 21(1) and (2).

⁹⁴ CSA Act, s 21(1)(d) and (2)(d).

⁹⁵ CSA Act, s 23.

⁹⁶ CSA Act, s 24(3).

⁹⁷ CSA Act, s 25(1). It is unclear why both grounds must be established before the ASC is entitled to decline an application for renewal of a licence, but only one of the grounds need apply for the ASC to cancel a licence.

⁹⁸ CSA Act, s 26. In *Re Brasted* [1979] 1 NZLR 400 (SC), a charitable trust, the Auckland Medical Aid Trust, had applied to the ASC seeking a full licence for abortions to be performed at an institution owned by the Trust. The ASC refused the application and the Trust appealed under s 26 of the CSA Act. The main reason for the ASC’s decision was a concern that the Trust’s medical staff would not be able to apply the law as required by the CSA Act (at 402–403). The Court concluded the only reasons that could be given for refusal were those contained in s 21 of the CSA Act (at 406). Therefore, it was not open to the ASC to refuse the application on the grounds it did. The Court referred the matter back to the ASC for further consideration in light of the Court’s decision (at 408).

The scope of ss 26 and 27 was considered in *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2015] NZHC 2393. In that case, Right to Life argued the ASC had wrongly granted a limited licence to the New Zealand Family Planning Association. The Court noted that Right to Life could not appeal the decision under ss 26 and 27, as these sections are clear that “[o]nly a person dissatisfied with a refusal to grant a licence [or a decision to cancel a licence] may appeal to the High Court and then only on a question of law” (at [18]). Therefore, “No party aggrieved by the grant of a licence (such as RTL) has any appeal right”.

⁹⁹ CSA Act, s 27.

- 1.52 The requirement that abortions be carried out at a licensed institution applies to all abortions. “Medical abortions”—which are carried out by a woman taking medication that causes a miscarriage, rather than by a surgical operation¹⁰⁰—were not available at the time the CSA Act was enacted in 1977. The most effective regimen for medical abortion is to take two medications (mifepristone and misoprostol) 24–48 hours apart.¹⁰¹ A court decision in 2003 found that, to comply with the requirements in the CSA Act for an abortion to be performed in a licensed institution, both doses of medication must be taken at a licensed institution.¹⁰²

Counselling

- 1.53 Certifying consultants must inform a woman of her right to seek counselling after they have made a decision about her case.¹⁰³ The law does not, however, make it compulsory for women to undertake counselling at any stage.
- 1.54 The ASC is required to appoint suitably qualified persons to provide counselling services for women considering having an abortion.¹⁰⁴ Under the CSA Act, counsellors must be able to advise patients (or refer them to appropriate agencies for advice) on alternatives to abortion, such as adoption and solo parenthood.¹⁰⁵
- 1.55 The practical operation of counselling services is discussed in Chapters 2 and 9.¹⁰⁶

Health practitioners are not required to assist in performing or arranging abortions

- 1.56 Section 46 of the CSA Act provides that no doctor, nurse or other person is under any obligation to perform or assist in performing an abortion if they object to doing so on grounds of conscience.¹⁰⁷
- 1.57 There is also further provision for conscientious objection under the Health Practitioners Competence Assurance Act 2003 (HPCA Act). Section 174 provides:

174 Duty of health practitioners in respect of reproductive health services

- (1) This section applies whenever—
- (a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and
 - (b) the health practitioner objects on the ground of conscience to providing the service.
- (2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.

¹⁰⁰ Medical and surgical methods of abortion are discussed in more detail at [2.68]–[2.77] below.

¹⁰¹ Standards Committee to the Abortion Supervisory Committee *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (January 2018) at 38.

¹⁰² *Re Abortion Supervisory Committee* [2003] 3 NZLR 87 (HC) at [36] and [56]–[57]. The practical impact of requiring medical abortion pills to be taken at a licensed institution is discussed at [2.72]–[2.73], [2.84] and [7.25]–[7.29] below.

¹⁰³ CSA Act, s 35.

¹⁰⁴ CSA Act, s 31.

¹⁰⁵ Section 31(2)(c).

¹⁰⁶ At [2.44] and [9.39]–[9.57].

¹⁰⁷ CSA Act, s 46.

1.58 The High Court has interpreted section 174 as allowing doctors with a conscientious objection to decline to consider a woman's case or to refer her to another doctor who will.¹⁰⁸ In such cases, the doctor only needs to inform the woman, in general terms, that she can seek referral for an abortion through another doctor or a Family Planning clinic.

¹⁰⁸ *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010.

CHAPTER 2

Abortion in practice

INTRODUCTION

2.1 This chapter places abortion law in its practical context. It examines when, how and at what rates abortions are performed in New Zealand; outlines the process that women go through in practice to get an abortion; and explains how abortions are performed and what complications can arise.

KEY STATISTICS

Abortion is common but rates are declining

- 2.2 Abortion is a common procedure. In a recent study of New Zealand women born in 1972 and 1973, one in four reported having had at least one abortion.¹ The Abortion Supervisory Committee (ASC) states that around 30 per cent of women in New Zealand have an abortion during their life time.² This is in line with international estimates, which generally range between one in three women and one in four women.³
- 2.3 The number and rate of abortions performed in New Zealand have, however, been declining over the past decade. In 2007, 18,382 abortions were recorded, which is a rate of 20.1 abortions per 1,000 women of childbearing age.⁴ By 2017, that number had reduced to 13,285, or a rate of 13.7 abortions per 1,000 women.⁵ The decrease has mainly occurred in the under 24 age group.⁶
- 2.4 While there are likely to be a number of factors contributing to New Zealand's decreasing abortion rate, the ASC has observed that the widespread uptake of long-acting contraceptive devices may be a factor.⁷ This aligns with international trends where

¹ Meredith Burgess "Abortion in a New Zealand cohort – Incidence, reasons, and emotional impact" (Master of Public Health Thesis, University of Otago, 2017) at 47.

² Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*) at 1.

³ See, for example, Rachel K Jones and Jenna Jerman "Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014" (2017) 107(12) *Am J Public Health* 1904; Annabelle Chan and Rosemary J Keane "Prevalence of Induced Abortion in a Reproductive Lifetime" (2004) 159(5) *Am J Epidemiol* 475.

⁴ Stats NZ "Abortion Statistics: Year ended December 2017" (19 June 2018) <www.stats.govt.nz> at Table 1. This rate is based on the mean estimated population of women aged between 15–44 years.

⁵ Stats NZ "Abortion Statistics: Year ended December 2017" (19 June 2018) <www.stats.govt.nz> at Table 1. The rate of abortion was slightly higher in 2017 than in 2016 (13.7 compared to 13.5), but there has been a general downward trend since 2007.

⁶ Stats NZ "Abortion Statistics: Year ended December 2017" (19 June 2018) <www.stats.govt.nz> at Table 3.

⁷ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 6.

increased availability and use of contraception has reduced the number of unintended pregnancies.⁸

- 2.5 The Commission notes that a significant number of submitters saw access to, and availability of, contraception and sexual and reproductive health education as an important factor in reducing the abortion rate. Others saw the declining abortion rate as a sign that the current law is working and/or that an increasing number of young people consider abortion to be morally wrong.

Abortion is safe when performed by qualified professionals

- 2.6 When performed in appropriate conditions by a trained health practitioner, abortion is a safe and usually straightforward procedure. It is significantly safer than carrying a pregnancy to term.⁹ In New Zealand, no deaths resulting from abortion have been reported since the law changed in 1977. Complication rates are low, occurring in only 0.4 per cent of cases.¹⁰

Legal restrictions can lead to unsafe abortions

- 2.7 By contrast, in countries with highly restrictive abortion laws, unsafe abortions (for example, those performed by unqualified people and/or using inappropriate methods) are common.¹¹ The World Health Organization has estimated that approximately 47,000 women globally die each year from unsafe abortions and a further five million suffer disability.¹² Around one in four women who have an unsafe abortion are likely to develop a temporary or lifelong disability requiring medical care.¹³
- 2.8 International evidence suggests that restrictive abortion laws do not reduce the number of abortions performed, but do increase the proportion of abortions that are unsafe.¹⁴
- 2.9 Many submitters made the point that if legal abortion is difficult to access, women will find another, less safe way of obtaining an abortion. Several submitters shared personal stories of obtaining an abortion in unsafe or traumatic circumstances while living in countries with more restrictive abortion laws.

⁸ World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) (WHO *Technical and Policy Guidance*) at 17.

⁹ WHO *Technical and Policy Guidance* at 21 (Figure 1.2) and 49; Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, 2017) at 32. The Guttmacher Institute is a not-for-profit organisation that aims to advance sexual and reproductive health in the United States and internationally through social science research, policy analysis and public education.

¹⁰ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 22.

¹¹ Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, 2017) at 10, 12 (Figure 2.4) and 28–33.

¹² World Health Organization *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008* (6th ed, 2011) at 27–28. See also Susheela Singh and others *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009) at 32–33, estimating that 70,000 women die each year from unsafe abortion.

¹³ WHO *Technical and Policy Guidance* at 20, citing Susheela Singh “Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries” (2006) 368(9550) *Lancet* 1887.

¹⁴ WHO *Technical and Policy Guidance* at 23; Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, 2017) at 33. The *Abortion Worldwide 2017* report refers to evidence from Romania and South Africa documenting significant reductions in deaths when restrictions on abortion were lifted.

Most abortions occur in the first trimester, but later than in some jurisdictions

- 2.10 Abortions are considerably safer when performed at earlier gestations.¹⁵ Earlier abortions are also generally quicker and cheaper to perform, and are likely to be less distressing for both the woman and the health practitioners involved.¹⁶
- 2.11 In New Zealand most abortions occur during the first trimester (the first 12 weeks) of pregnancy. This accounted for 89.4 per cent of abortions in 2017.¹⁷ A further 8.3 per cent of abortions occurred in weeks 13–16.¹⁸ Only 1.7 per cent occurred between 17–20 weeks and 0.5 per cent after 20 weeks.¹⁹
- 2.12 However, first trimester abortions are performed significantly later than in countries New Zealand often compares itself to. For example, in England and Wales in 2017, 77 per cent of abortions were carried out before 10 weeks.²⁰ By contrast, only 59 per cent of abortions in New Zealand were performed before 10 weeks.²¹ While the reasons for this are not conclusively known, many health practitioners the Commission spoke to considered the authorisation process required under the current law prevents abortions from being performed as early as would otherwise be possible.
- 2.13 Many submitters were concerned about the extent of the delay experienced by women seeking an abortion. Some women who had been through the process said they had to wait a number of weeks due to the legal authorisation process and/or a lack of doctors in their area who would perform abortions. For some, this delay meant they lost the opportunity to have an early medical abortion (EMA).²² Others experienced significant pregnancy symptoms or found the delay traumatic. Some submitters also considered that performing abortions as early as possible is more ethical, as the fetus is less developed.

Most abortions are performed on mental health grounds

- 2.14 The vast majority of abortions in New Zealand are authorised on the ground that continuing the pregnancy would result in serious danger to the woman's mental health. This accounted for 97 per cent of abortions performed in 2016.²³ The remaining 3 per cent were authorised on the following grounds:²⁴

¹⁵ Martha Silva, Rob McNeill and Toni Ashton "Factors affecting delays in first trimester pregnancy termination services in New Zealand" (2011) 35(2) *Aust N Z J Public Health* 140 at 140; WHO *Technical and Policy Guidance* at 21 (Figure 1.2) (referring to mortality data from the United States).

¹⁶ *ASC Standards of Care* at [6.4].

¹⁷ Stats NZ "Abortion Statistics: Year ended December 2017" (19 June 2018) <www.stats.govt.nz> at Table 6.

¹⁸ Stats NZ "Induced abortions by duration of pregnancy 2017" (26 June 2018, data requested by the Law Commission).

¹⁹ Stats NZ "Induced abortions by duration of pregnancy 2017" (26 June 2018, data requested by the Law Commission).

²⁰ Department of Health and Social Care (UK) "Abortion Statistics: data tables" (7 June 2018) <www.gov.uk> at Table 6.

²¹ Stats NZ "Abortion Statistics: Year ended December 2017" (19 June 2018) <www.stats.govt.nz> at Table 6.

²² A medical abortion involves taking medication that causes a miscarriage, rather than having a surgical operation. In some locations medical abortion is only available during the first nine weeks of pregnancy (when it is referred to as early medical abortion). The methods of abortion are discussed below at [2.68]. The services available in different areas of the country are summarised at [2.36].

²³ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 21. The more recent 2017 figures released by Stats NZ do not show the grounds on which abortions are performed.

²⁴ *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 21. In addition to those listed, the following grounds were relied on in less than 0.1 per cent of cases: danger to both life and physical health; danger to both life and

- Danger to mental health and “handicapped child”: 1 per cent
 - “Seriously handicapped child”: 0.7 per cent
 - Danger to both mental and physical health: 0.6 per cent
 - Danger to life: 0.3 per cent
 - Danger to physical health: 0.2 per cent
 - Danger to both physical and mental health and “handicapped child”: 0.1 per cent
- 2.15 These statistics cover all abortions performed, regardless of gestation.²⁵ As noted, the legal grounds for abortion are narrower after 20 weeks. After that time, an abortion can only be authorised if it is necessary to save the woman’s life or prevent serious permanent injury to her physical or mental health.²⁶
- 2.16 The ASC and health practitioners told the Commission that virtually all abortions performed after 20 weeks relate to wanted pregnancies and occur because a serious fetal abnormality is detected or there is a serious risk to the woman’s life or physical health.²⁷
- 2.17 The statistics published by the Perinatal and Maternal Mortality Review Committee support that conclusion.²⁸ The Committee records “terminations of pregnancy” after 20 weeks, which under the Committee’s definition includes abortion as well as other induced preterm births (whether stillborn or born alive).²⁹ Of the 107 terminations recorded from 20 weeks onward in 2015, 82.2 per cent were associated with congenital abnormalities.³⁰ The remainder related to infections, haemorrhages, maternal conditions, fetal growth restrictions or spontaneous preterm births.³¹ Only 14 terminations were recorded after 24 weeks, of which 11 were associated with congenital abnormalities and the other three were due to maternal conditions or fetal growth restrictions.

mental health; danger to life and handicapped child; danger to physical health and handicapped child; danger to mental health and pregnancy result of a criminal offence.

²⁵ Assuming they are reported to the Abortion Supervisory Committee (ASC), as required by s 45 of the CSA Act.

²⁶ Crimes Act 1961, s 187A(3).

²⁷ Fetal abnormality is not in itself a ground for abortion after 20 weeks, so it is likely that the legal ground relied on in those cases would be to prevent serious permanent injury to the woman’s mental health.

²⁸ The Perinatal and Maternal Mortality Review Committee is appointed under s 59E of the New Zealand Public Health and Disability Act 2000 by the Health Quality and Safety Commission. The Committee’s main function is to review and report to the Health Quality and Safety Commission on perinatal and maternal deaths, with a view to reducing deaths and supporting continuous quality improvement through the promotion of on-going quality assurance programmes.

²⁹ Perinatal and Maternal Mortality Review Committee *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015* (June 2017) at 6 and 46. Termination of pregnancy is defined as including “any interrupted ongoing pregnancy from 20 weeks (whether the baby was stillborn or live born)”. This is likely to include, for example, an early induction necessitated by a fetal or maternal health condition with the hope and/or result that the child will be born alive.

³⁰ A congenital abnormality, also known as a birth defect, is a malformation of organs or body parts during development in utero. It can cause physical disability, intellectual and developmental disability and other health problems: PubMed Health “Congenital Abnormalities (Birth Defects)” (1 September 2017) <www.ncbi.nlm.nih.gov>.

³¹ Perinatal and Maternal Mortality Review Committee *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2015* (June 2017) at 65.

It is unclear how many women are refused abortions

- 2.18 In 2016 there were reportedly 252 cases in which a certifying consultant considered an abortion was not justified.³² This does not equate to 252 women being denied abortions, as a third certifying consultant may still have authorised the abortion.³³ There are no statistics available on the number of women who are ultimately refused an abortion, or the reasons for abortions being declined.
- 2.19 Two women spoke publicly about being denied an abortion in 2017.³⁴ In both cases the abortion was sought reasonably close to the 20 week threshold in the Crimes Act. It is unclear whether these cases were considered by certifying consultants or declined before referral.

STANDARDS OF CARE FOR WOMEN REQUESTING ABORTION

- 2.20 The ASC issues *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand (ASC Standards of Care)*, which provide guidance to health practitioners involved in the provision of abortion services.³⁵ The first standards document was developed in 2009. The standards were recently revised and a new version was issued earlier in 2018. The standards are developed by a standards committee appointed by the ASC, consisting of experts in abortion care.³⁶
- 2.21 The CSA Act does not require the ASC to issue standards of care³⁷ and the standards do not have any official legal status. However, the standards are consistent with the ASC's functions of taking all reasonable and practical steps to ensure that licensed institutions have adequate facilities and competent staff; that counselling services are available to women seeking abortion-related advice; and that abortion law is administered consistently and effectively.³⁸
- 2.22 The ASC has no ability to enforce the standards other than by declining applications by institutions for licences to perform abortions (which would reduce access to abortion services).

³² See Henry Cooke "Hundreds of Kiwi women told their abortions were 'not justified'" (13 March 2017) Stuff <www.stuff.co.nz>, referring to information released by the ASC under the Official Information Act 1982. This data is not published by the ASC.

³³ As discussed at [1.44] above.

³⁴ Susan Strongman "No Choice: when legal abortion is denied" *The New Zealand Herald* (online ed, Auckland, 19 September 2017) and Sarah Harris "Denied abortion: Woman discovers pregnancy at 4 months, 2 weeks" *The New Zealand Herald* (online ed, Auckland, 15 October 2017). Both women only discovered they were pregnant after 18 weeks and were reportedly denied an abortion on the basis that the pregnancy was too advanced (although they had not yet reached the 20 week threshold in s 187A of the Crimes Act). The same district health board (DHB) was involved in both cases.

³⁵ Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*).

³⁶ The standards committee for the most recent standards, issued in 2018, consisted of eight doctors, a nurse/midwife, a social worker, a Māori consultant and a consumer consultant (ASC *Standards of Care* at iv).

³⁷ Other than prescribing standards in respect of facilities to be provided in licensed institutions, which is required by s 14(1)(c) of the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act).

³⁸ CSA Act, s 14(1)(c), (d), (e) and (i).

2.23 The current ASC *Standards of Care* cover a wide variety of matters including:

- access to abortion services;³⁹
- information that should be provided to women considering abortion;⁴⁰
- clinical guidance for health practitioners involved in abortion care (from supporting women in making decisions through to post-abortion follow-up care);⁴¹
- provision of culturally appropriate services for Māori;⁴²
- the qualifications, knowledge and experience required of certifying consultants,⁴³ doctors,⁴⁴ counsellors,⁴⁵ nurses and midwives⁴⁶ involved in abortion care; and
- minimum theatre safety requirements for facilities that perform surgical abortions.⁴⁷

THE ABORTION PROCESS

2.24 The process a woman goes through to access abortion services varies depending on a number of factors, including where she lives, which health practitioner she first consults, what stage the pregnancy is at and what method of abortion she chooses (where a choice is available). There is also considerable variation around New Zealand as to how long it takes to get an abortion.

2.25 The Commission sets out below what it understands to be a common process, based primarily on the ASC *Standards of Care* and information provided by district health boards (DHBs) and health practitioners. The ASC *Standards of Care* include a care pathway that provides an overview of this process, which is reproduced in Appendix 3.

Referral to an abortion service provider

2.26 The process begins with a woman approaching a health practitioner, either after a positive home pregnancy test or when she thinks she may be pregnant. Usually at the first appointment the pregnancy will be confirmed. The health practitioner may also discuss the options available to the woman, such as continuing the pregnancy, adoption or referral to an abortion service provider.⁴⁸

2.27 If the woman expresses a wish to have, or to consider having, an abortion, several things then occur. First, the woman may need to make another appointment to see a general practitioner (GP) or Family Planning doctor. This may be the case where:

³⁹ Standards 6.2.1–6.2.10.

⁴⁰ Standards 7.1–7.5 and standard 8.1.1.

⁴¹ Standards 8.1–10.6.

⁴² Standard 6.3.

⁴³ Standard 8.5.1.

⁴⁴ Standard 9.2.1.

⁴⁵ Standard 8.2.5.

⁴⁶ Standard 8.6.6.

⁴⁷ Standard 6.6.1. These include requirements such as having adequate room to perform resuscitation if necessary; appropriate drugs to manage haemorrhage; and a clinical emergency response plan to manage potential clinical deterioration.

⁴⁸ Tony Fraser and Professor Murray Tilyard (eds) “Special Edition: Termination of Pregnancy in New Zealand” (2010) BPJ 1 at 4.

- the health practitioner first consulted is not a doctor. A woman may, for example, see a midwife (particularly if she already has children and has an existing relationship with a midwife) or a Family Planning nurse. If this happens, the woman will usually need to make another appointment to see a GP or Family Planning doctor, as only doctors can refer a woman's case to be considered by certifying consultants;⁴⁹
 - the doctor whom the woman first consults declines to refer her to an abortion service provider because the doctor has a conscientious objection.⁵⁰ Again, this will usually mean that the woman needs to see a different GP or Family Planning doctor to get a referral.
- 2.28 Health practitioners reported that in some areas it can take two to three weeks for a woman to get an appointment with a doctor who will refer her to an abortion service provider, particularly if she is not already enrolled with a GP or her GP has a conscientious objection.
- 2.29 Second, the referring doctor will usually carry out a routine blood test, genital swab (to test for sexually transmitted infections) and smear test (if required), and arrange an ultrasound scan to confirm gestational age. In some cases, some or all of these tests may be done by a different health practitioner (such as a midwife, nurse or ultrasound technician), either through a community health service or at the abortion clinic.
- 2.30 Third, the referring doctor may arrange for the woman to see a counsellor before she is referred to an abortion service provider. While counselling is available through abortion service providers, the Commission understands it is also offered at an earlier stage in some cases.
- 2.31 Fourth, the referring doctor may encourage the woman to take some time to think about her options and come back for a second appointment before she is referred to an abortion service provider. This appears to be reasonably common,⁵¹ although it is discouraged by the *ASC Standards of Care*.⁵²
- 2.32 Depending on the circumstances, a woman may therefore have anywhere from one to four or more appointments before she is referred to an abortion service provider. This process can take several weeks.

⁴⁹ CSA Act, s 32. It should be noted that in some locations abortion service providers will now accept referrals from health practitioners who are not doctors, or self-referrals by women. A doctor at the abortion service then makes the referral to the certifying consultants. However, the Commission understands this is not common practice around the country.

⁵⁰ See [1.56]–[1.58] above. Conscientious objection is discussed further in Chapter 10.

⁵¹ A survey of women conducted in 2009 found that 64.7 per cent saw the referring doctor for more than one consultation and the great majority of repeat consultations (over 80 per cent) were at the request of the doctor: Martha Silva and others "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7(19) *Reproductive Health* 1 at 5–6.

⁵² *ASC Standards of Care*, standard 6.4: "...as soon as it is evident that a woman is considering an abortion she should be offered referral to an abortion service for counselling and medical assessment so that she is given as much support and time as possible in making a decision. Simply sending the woman away to think about her decision can cause unnecessary delays in accessing abortion services."

Accessing abortion services

- 2.33 The ASC *Standards of Care* require DHBs to ensure that all women who are eligible for publicly-funded health care have access to abortion services.⁵³ This does not mean that abortion services are available in every DHB area. In addition, most services outside main centres only perform abortions up to 12 or 14 weeks gestation. Where no appropriate local services are available, women are referred to a service in another DHB area.⁵⁴
- 2.34 There are no services in the West Coast or Whanganui DHB areas, and in South Canterbury abortion is only available in cases of fetal abnormality. The entire Auckland region, including Waitematā and Counties-Manukau, is currently served by one publicly funded provider of first trimester abortion services, the Epsom Day Unit.
- 2.35 Depending on where a woman lives, the stage of the pregnancy and the reason an abortion is being sought, a woman may need to travel a significant distance to access an appropriate service.
- 2.36 The table below summarises the services available in each area, to the best of the Commission's knowledge.⁵⁵ It is based on information provided by each licensed institution to the ASC during the annual licence renewal process, as well as information the Commission received from DHBs.
- 2.37 For some abortion service providers, the reason an abortion is sought affects the gestation up to which it will be performed, even where this is not required by the legislation. Many providers impose a general gestational limit for their services (for example, 14 weeks). They may, however, agree to perform abortions at later gestations if a significant fetal abnormality is discovered or if there is a serious danger to the woman's physical health.
- 2.38 Some abortion service providers only offer medical abortion in the first nine weeks of pregnancy. The process for EMA is similar to a spontaneous miscarriage and women often go home to complete the abortion. Other providers only offer second trimester medical abortion, which is similar to induced labour and is completed in a hospital.⁵⁶

ABORTION SERVICES AVAILABLE BY DHB AREA

DHB area	Services provided
Northland	<ul style="list-style-type: none"> Whangārei Hospital: up to 13 weeks (surgical only), and up to 22 weeks (medical) for fetal abnormality only
Waitematā	<ul style="list-style-type: none"> Surgery on Shakespeare (Private Clinic): up to 9 weeks (medical) and up to 13 weeks (surgical) (limited licence) North Shore Hospital: after 18 weeks only (medical)

⁵³ Standard 6.2.1. All New Zealand citizens and permanent residents are eligible for publicly-funded health care, as well as some other people. The eligibility criteria are set out in the Health and Disability Services Eligibility Direction 2011 and explained on the Ministry of Health website: <www.health.govt.nz>.

⁵⁴ Standard 6.2.2.

⁵⁵ It is difficult to get a full picture of the services available through each provider. For example, the website Abortion Services in New Zealand <www.abortion.org.nz> contains slightly different information to the information provided to the ASC for licence renewal and the information provided to the Law Commission by DHBs.

⁵⁶ Abortion methods are described in more detail at [2.68] below.

Auckland	<ul style="list-style-type: none"> • Epsom Day Unit: up to 9 weeks (medical) and up to 13 weeks (surgical) • Auckland Hospital/National Women's Hospital: second trimester service only • Auckland Medical Aid Centre (private clinic): up to 9 weeks (medical) and up to 13 weeks (surgical) (limited licence)
Counties-Manukau	<ul style="list-style-type: none"> • Middlemore Hospital: after 18 weeks only
Waikato	<ul style="list-style-type: none"> • Waikato Hospital: first trimester (medical and surgical) and second trimester for fetal abnormality or severe mental illness only • Thames Hospital: up to 13 weeks (surgical only)
Lakes	<ul style="list-style-type: none"> • Rotorua Hospital: up to 9 weeks (medical) and up to 13 weeks (surgical), or up to 20 weeks for fetal abnormality only
Bay of Plenty	<ul style="list-style-type: none"> • Tauranga Family Planning Clinic: up to 9 weeks (medical only) (limited licence)
Tairāwhiti	<ul style="list-style-type: none"> • Hauora Tairāwhiti: up to 9 weeks (medical) and up to 14 weeks (surgical)
Hawke's Bay	<ul style="list-style-type: none"> • Hawke's Bay Hospital: up to 7 weeks (medical) and up to 14 weeks (surgical)
Taranaki	<ul style="list-style-type: none"> • Taranaki Base Hospital: up to 9 weeks (medical) and up to 16 weeks (surgical) • Taranaki Sexual Health Clinic: up to 9 weeks
Whanganui	<ul style="list-style-type: none"> • No services
Mid Central	<ul style="list-style-type: none"> • The Women's Clinic, Palmerston North: up to 9 weeks (medical) and up to 12 weeks (surgical) (limited licence) • Palmerston North Hospital: for fetal abnormalities only, up to 24 weeks
Wairarapa	<ul style="list-style-type: none"> • The Women's Clinic, Wairarapa Hospital: up to 9 weeks (medical) and up to 14 weeks (surgical)
Hutt Valley	<ul style="list-style-type: none"> • Hutt Hospital: for fetal abnormalities only, up to 22 weeks (medical)
Capital and Coast	<ul style="list-style-type: none"> • Te Mahoe Unit, Wellington Hospital: up to 9 weeks and between 13–20 weeks (medical), and up to 20 weeks (surgical). Later gestations on a case-by-case basis.

Nelson-Marlborough	<ul style="list-style-type: none"> • Wairau Hospital: up to 13 weeks (surgical only) • Nelson Hospital: up to 9 weeks (medical) and up to 13 weeks (surgical), or up to 22 weeks for fetal abnormality only
West Coast	<ul style="list-style-type: none"> • No services
Canterbury	<ul style="list-style-type: none"> • Christchurch Hospital/Christchurch Women's Hospital: up to 9 weeks and between 13–20 weeks (medical), and up to 13 weeks (surgical)
South Canterbury	<ul style="list-style-type: none"> • Timaru Hospital: for fetal abnormality only, up to 20 weeks
Southern	<ul style="list-style-type: none"> • Dunedin Hospital: up to 9 weeks (medical) and first and second trimester (surgical). Medical abortion is also available after 14 weeks for fetal abnormality or on significant maternal physical health grounds only • Southland Hospital: up to 9 weeks (medical) and up to 12 weeks (surgical)

2.39 The ASC has on occasion drawn attention to the lack of abortion services available in certain areas, such as Counties-Manukau, and encouraged health care providers to consider establishing services.⁵⁷ However, the ASC has no power to require the provision of services in a particular area or up to a certain gestation. Ultimately, the availability of abortion services depends on there being suitable facilities and practitioners willing to provide those services.

Pre-abortion care and assessment

2.40 At the abortion clinic, a health practitioner talks to the woman about the abortion process and gives her other information to help her make an informed decision.⁵⁸ The woman will usually be seen on her own first to allow open discussion and address any issues of potential coercion.⁵⁹ Family members or other support people may then be involved, and this is particularly encouraged for young women.⁶⁰

2.41 The ASC *Standards of Care* require abortion service providers to undertake an individualised psychosocial assessment of all women seeking an abortion.⁶¹ The assessment covers matters such as the woman's physical and mental health, family and financial situation, cultural background and whether she is at risk of family or sexual violence.⁶² It may be carried out by an appropriately trained social worker, counsellor, nurse or doctor.⁶³ The purpose of the assessment is to "better understand the client and

⁵⁷ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 5.

⁵⁸ *ASC Standards of Care*, standard 8.1.1. The information that must be provided is discussed in Chapter 9.

⁵⁹ *ASC Standards of Care*, standard 8.2.4. See also standard 8.3.7 in relation to young women. Health practitioners the Law Commission spoke to said they always ensure a woman is seen alone at least once.

⁶⁰ *ASC Standards of Care*, standards 8.37–8.38.

⁶¹ Standard 8.3.1.

⁶² Standards 8.3.2 and 8.3.14.

⁶³ Standard 8.3.1.

- any additional challenges she may be facing in order to provide individualised and appropriate care, and to arrange referral for additional support needs if required”.⁶⁴
- 2.42 If a woman is identified as requiring additional support, she will be actively encouraged to undertake counselling⁶⁵ and may also be referred to other support services specific to her needs.⁶⁶
- 2.43 The *ASC Standards of Care* recognise that some women in particular may require additional support, such as young women, women at risk of family violence, migrant and refugee women, women who have experienced sexual assault and women who have limited mental capacity.⁶⁷ Special guidance is given on how these cases should be addressed. For example, young women should be provided with age-appropriate information and support,⁶⁸ and encouraged to involve a family member (unless a risk from within the family is identified) or another adult such as a youth worker.⁶⁹
- 2.44 All women must be offered counselling when they are considering an abortion and after having an abortion.⁷⁰ Some abortion service providers require all women to see a counsellor before having an abortion, although this is not a legal requirement.⁷¹ Counselling must be free and easily accessible.⁷² Most abortion clinics have counselling available on-site, but where that is not the case, the woman may need to make an appointment to see a social worker or counsellor elsewhere and return to the clinic another day. Counselling is discussed in more detail in Chapter 9.
- 2.45 A pre-abortion medical assessment is also completed at the clinic.⁷³ Often the assessment is completed by one of the certifying consultants. Gestational age is confirmed through a physical examination or ultrasound scan;⁷⁴ the woman’s heart rate and blood pressure are taken;⁷⁵ she is offered screening for sexually transmitted infections;⁷⁶ and tests may be required to exclude ectopic pregnancy if certain risk factors are present.⁷⁷

⁶⁴ Standard 8.3.

⁶⁵ Standard 8.2.3.

⁶⁶ Standard 8.3.3.

⁶⁷ Standards 8.3.2, 8.3.3 and 8.3.5–8.3.25.

⁶⁸ Standard 8.3.5.

⁶⁹ Standards 8.3.7–8.3.9.

⁷⁰ Standards 8.2.1–8.2.2 and CSA Act, s 35 (the Act only requires a woman to be offered counselling before the abortion is performed, but the *ASC Standards of Care* include more extensive counselling requirements).

⁷¹ Martha Silva and others “Ladies in waiting: the timeliness of first trimester services in New Zealand” (2010) 7(19) *Reproductive Health* 1 at 4. Of the nine clinics that participated in the study, six required all patients to see a social worker or counsellor prior to seeing a certifying consultant.

⁷² *ASC Standards of Care*, standard 8.2.1. See also s 21(1)(e) and (2)(e) of the CSA Act, which require the ASC to be satisfied that an institution has adequate counselling services available before licensing it to perform abortions.

⁷³ In practice, aspects of this pre-abortion medical assessment are sometimes performed (or arranged, in the case of ultrasounds, which are often performed off-site by community providers) by a doctor, nurse or midwife at the woman’s primary health care provider before she is referred to the abortion service.

⁷⁴ *ASC Standards of Care*, standards 8.4.2–8.4.3. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends an ultrasound should always be performed before an abortion to confirm gestational age and exclude ectopic pregnancy: Royal Australian and New Zealand College of Obstetricians and Gynaecologists *The use of mifepristone for medical termination of pregnancy* (C-Gyn 21, February 2016) at [3.5].

⁷⁵ *ASC Standards of Care*, standard 8.4.14.

⁷⁶ Standards 8.4.8–8.4.10.

⁷⁷ Standard 8.4.15.

- 2.46 The woman will be offered a choice of different methods of abortion (medical or surgical) if they are available at the service, there are no medical contra-indications and the gestational age allows it.⁷⁸ Post-abortion contraceptive options are also discussed.⁷⁹

Consideration by two certifying consultants

- 2.47 The woman's case is then considered by two certifying consultants. Before an abortion can be performed, they must agree that one or more of the grounds in section 187A of the Crimes Act are met.
- 2.48 While the CSA Act does not require the certifying consultants to speak to the woman unless she requests it, the Commission understands that they almost invariably do.⁸⁰ One of the certifying consultants may have already spoken to the woman while undertaking the pre-abortion medical assessment. The second certifying consultant is often the doctor who performs the abortion. The certifying consultants review the woman's medical history and assess whether she meets one or more of the legal grounds for abortion.
- 2.49 If the certifying consultants are both satisfied that one or more of the grounds apply, they sign a certificate to that effect. As explained in Chapter 1, a third certifying consultant may become involved if the first two disagree.⁸¹ The abortion can only proceed once it has been authorised by two certifying consultants.

Informed consent

- 2.50 General health law requires health practitioners to ensure a person gives informed consent before providing health services to that person. The doctor who intends to perform the abortion must therefore be satisfied the woman has given her informed consent before carrying out the procedure.⁸²
- 2.51 The doctor ensures the woman is given information about the different methods of abortion and the risks and possible complications of the procedure, and confirms she understands this information.⁸³ If the woman appears unsure at this stage, the abortion will not be performed. She will be given further time to consider her options and access any additional counselling or support she requires.⁸⁴
- 2.52 Informed consent is discussed in more detail in Chapter 9.

⁷⁸ Standard 8.4.12. The difference between medical and surgical abortion is discussed at [2.68] below.

⁷⁹ Standard 9.12.1.

⁸⁰ In some locations one of the certifying consultants may only speak to the woman on the phone, but in most centres both consultants speak to the woman in person.

⁸¹ At [1.44].

⁸² *ASC Standards of Care*, standard 9.4.1.

⁸³ *ASC Standards of Care*, standards 9.4.1 and 7.4.

⁸⁴ See, for example, *General Practitioner/Clinical Director/Certifying Consultant/Counsellor/Hospital and Health Service – Case 98HDC12437* Health and Disability Commissioner 98HDC12437, 23 February 2000 at 8 and 15.

The abortion procedure

- 2.53 The *ASC Standards of Care* provide that women should not wait longer than two weeks from when they first request a referral to the time of the abortion procedure, unless they need longer to make a decision.⁸⁵ However, evidence suggests that in practice the process can take significantly longer. A study undertaken in 2009 found that on average it took 25 days from a woman's first appointment with a referring doctor to when the abortion was performed.⁸⁶ The average time may have reduced since 2009 as a result of services becoming available in several more locations. The Commission notes, however, that the percentage of abortions performed under 14 weeks gestation has not increased—and in fact, has slightly decreased—during that time.⁸⁷
- 2.54 Information provided to the Commission by DHBs suggests that from the time a woman is referred to an abortion service provider (which, as noted above, may be some time after a woman first requests referral) it commonly takes two to three weeks for an abortion to be performed. Additional data the Commission obtained through an Abortion Providers Group Aotearoa New Zealand (APGANZ) survey of abortion service providers suggests that wait times are highly variable, but for one abortion service provider the average wait was up to three weeks for a medical abortion and four weeks for a surgical abortion. Some abortion clinics had surgical abortion lists daily and others only fortnightly.
- 2.55 If the woman has chosen a surgical abortion, it is performed at the clinic and the woman can usually return home the same day. The procedure itself is generally completed in less than 10 minutes, although the woman will need to be at the clinic for several hours including preparation and monitoring time.
- 2.56 For medical abortions, the law requires the woman to take both medications at a licensed institution,⁸⁸ so the woman will usually leave the clinic after the first dose and return the next day to take the second dose.

Contraception

- 2.57 If the woman has requested contraception, this will usually be initiated on the same day as a surgical abortion or as soon as a medical abortion is complete. Long-acting reversible contraception⁸⁹ can be fitted at the same time as a surgical abortion or once a medical abortion is complete,⁹⁰ or contraceptive supplies can be provided or prescribed.⁹¹ In 2016 over 90 per cent of women who had an abortion were provided with some form of contraception at the time of the procedure.⁹² Almost half were fitted with long-acting reversible contraception.⁹³

⁸⁵ *ASC Standards of Care*, standard 6.4.1.

⁸⁶ Martha Silva and others "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7(19) *Reproductive Health* 1.

⁸⁷ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 19.

⁸⁸ *Re Abortion Supervisory Committee* [2003] 3 NZLR 87 (HC) at [36] and [56]–[57].

⁸⁹ Long-acting reversible contraception methods provide highly effective contraception for an extended period (up to 10 years) without requiring any action from the user (such as taking pills). Examples are an intrauterine device (IUD) or implant.

⁹⁰ *ASC Standards of Care*, standard 9.12.5.

⁹¹ *ASC Standards of Care*, standard 9.12.4.

⁹² *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 25.

⁹³ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 25.

Post-abortion care

- 2.58 At the abortion clinic, the woman will be given information about the symptoms they may experience following the procedure and when to seek medical care.⁹⁴ They will also be offered access to additional counselling and support free of charge.⁹⁵
- 2.59 A free post-abortion follow-up assessment should be offered by the health care provider that referred the woman to the abortion service provider.⁹⁶ This assessment includes discussion of contraceptive options if contraception has not already been provided. Where a woman has been identified as needing additional support (for example, because of her age or life situation), the health care provider should make three active attempts to contact her if she has not booked a follow-up appointment.⁹⁷

CULTURALLY APPROPRIATE SERVICES

- 2.60 The *ASC Standards of Care* include standards relating to culturally appropriate services, in particular in relation to care of Māori women and migrant and refugee women.
- 2.61 Social workers and others who provide counselling services to women considering abortion are required to have knowledge of:⁹⁸
- cultural norms and practices related to the care, touch and respect of the human body;
 - cultural practices concerning the disposal of human tissue; and
 - spiritual and religious beliefs and their influence on the ability to make, act on and integrate decisions made.
- 2.62 The *ASC Standards of Care* suggest that as part of having due regard to the Treaty of Waitangi, all staff at abortion service providers should undertake cultural competency training focusing on Māori health.⁹⁹ They should be familiar with the concepts of tapu and noa and how they can be respected in practice.¹⁰⁰ Abortion service providers are required to have an active plan to recruit Māori staff, with the aim of being able to offer Māori women the option to speak to a Māori counsellor.¹⁰¹
- 2.63 The *ASC Standards of Care* also include specific standards on how Māori cultural practices should be accommodated by service providers—for example, by respecting any taonga (valuables) worn with spiritual significance;¹⁰² having a place for women to

⁹⁴ *ASC Standards of Care*, standard 9.11.2.

⁹⁵ *ASC Standards of Care*, standards 9.11.4, 9.11.5 and 8.3.11.

⁹⁶ *ASC Standards of Care*, standards 10.1 and 10.5.

⁹⁷ *ASC Standards of Care*, standards 10.3–10.4.

⁹⁸ Counselling Advisory Committee to the Abortion Supervisory Committee *Standards of Practice for the Provision of Counselling* (April, 1998) at 8.

⁹⁹ *ASC Standards of Care*, standards 6.3.1 and 6.3.2.

¹⁰⁰ Standard 6.3.9. The *ASC Standards of Care* define “tapu” as “sacredness” and “noa” as “ordinariness” (at iii). Tapu and noa are also discussed at [3.47] below.

¹⁰¹ Standard 8.2.7.

¹⁰² Standard 6.3.11.

wash after the procedure;¹⁰³ and facilitating the return of pregnancy tissue to ancestral lands or providing a designated area of land for burial if desired by the woman.¹⁰⁴

- 2.64 The *ASC Standards of Care* also note that abortion service providers should be responsive to the cultural and linguistic needs of migrant and refugee women.¹⁰⁵ In order to give proper care to women with limited English language proficiency, abortion service providers are required to have access to suitably trained, competent interpreters.¹⁰⁶ The ASC recommends using independent interpreters rather than friends or family of the woman, to help ensure that the woman is in a position to give informed consent.¹⁰⁷

COST OF ABORTION SERVICES

- 2.65 The *ASC Standards of Care* provide that abortion services (including counselling and pre- and post-abortion care) should be free of charge for women eligible for publicly funded health care.¹⁰⁸ The fees charged by private providers and for women who are not eligible for public funding vary depending on the provider. Some providers also charge different fees depending on the abortion method and/or gestation. Fees for those not eligible for public funding can range from around \$700 (for EMA) to over \$2,400 (for surgical abortions).¹⁰⁹
- 2.66 The ASC can recommend a maximum fee¹¹⁰ but does not currently do so. However, the ASC has informed the Commission that it does require licensed institutions to provide it with information about the fees they charge and has queried those fees in the context of renewing licences.
- 2.67 Where an appropriate abortion service is not available in a woman's local area, she will need to travel to access one. The *ASC Standards of Care* suggest that in such cases the referring DHB should provide funding for transport and accommodation costs.¹¹¹ However, the Ministry of Health told the Commission that in practice travel assistance is only available where certain eligibility requirements are met.¹¹² Payment is also by way of reimbursement for costs already incurred, rather than being available in advance to cover travel costs.

¹⁰³ Standard 6.3.12.

¹⁰⁴ Standards 6.3.13–6.3.15. The practice of *whenua ki te whenua* is also discussed at [3.52] below.

¹⁰⁵ At 27.

¹⁰⁶ Standard 6.2.10.

¹⁰⁷ At 27 and standards 8.3.20 and 8.3.21.

¹⁰⁸ Standard 6.2.3.

¹⁰⁹ Based on information provided to the Commission by the ASC.

¹¹⁰ CSA Act, s 14(1)(f).

¹¹¹ *ASC Standards of Care*, standard 6.2.2.

¹¹² Funding is usually provided through the National Travel Assistance (NTA) scheme, although there is some variation in arrangements between DHBs. The NTA scheme is currently under review. This scheme applies to people who have been referred to one publicly funded specialist by another publicly funded specialist. Clients referred by GPs, other primary care providers or private specialists do not qualify for the scheme unless the DHB has granted the referrer delegated authority. For an adult over 18 without a community services card, the distance travelled must be 350km or greater each way. No overseas travel is funded. For more information see Ministry of Health "About the National Travel Assistance Scheme" (8 December 2017) <www.health.govt.nz>.

METHODS OF ABORTION

2.68 There are two methods of abortion practised in New Zealand: medical abortion and surgical abortion. The appropriate procedure for each method depends on the stage of the pregnancy.

Medical Abortion

- 2.69 Medical abortion requires a woman to take drugs that induce a miscarriage. The drugs used in New Zealand are mifepristone and misoprostol, which are taken in combination. Mifepristone was approved for use under the Medicines Act 2001 in August 2001.¹¹³ It is an anti-progestogen, meaning it inhibits the action of progesterone, a hormone that maintains the lining of the uterus and keeps the cervix closed. Misoprostol is a synthetic prostaglandin, a hormone that causes the uterus to contract. When mifepristone is taken, the cervix softens and opens slightly, allowing the misoprostol-induced contractions to expel the contents of the uterus.
- 2.70 The regimen of mifepristone and misoprostol depends on the duration of the pregnancy. Medical abortions performed up to nine weeks gestation are often called “early medical abortions” (EMA). For EMA, the ASC recommends that a woman takes 200 mg of mifepristone followed 24 to 48 hours later by 800 µg of misoprostol.¹¹⁴
- 2.71 If the pregnancy is between nine weeks and 13 weeks six days, the ASC recommends the woman takes 200 mg of mifepristone, followed 24 to 48 hours later by 800 µg of misoprostol, followed by an additional 400 µg of misoprostol every three hours until the pregnancy is aborted.¹¹⁵
- 2.72 The current law in New Zealand requires that a woman takes both the mifepristone and the misoprostol at a licensed institution. She may return home between doses. Some services administer both medications at the same time so the woman does not have to return to the clinic to receive the misoprostol, but most clinical guidelines recommend that the doses be taken between 24 and 48 hours apart.¹¹⁶
- 2.73 If the abortion is a first trimester medical abortion, the woman may return home after taking the misoprostol to complete the abortion.¹¹⁷ She will be provided with clear written advice about when to seek medical help and instructions on how to access advice or emergency treatment after hours.¹¹⁸ Usually the miscarriage will occur within six hours of taking the second dose of medication. It can take place as soon as 30 minutes after the

¹¹³ Technical Committee to the Abortion Supervisory Committee *Guidelines for the Use of Mifepristone for Medical Abortion in New Zealand* (2004) at 7.

¹¹⁴ *ASC Standards of Care* at 38. A milligram (mg) is one thousandth of a gram. The symbol “µg” denotes a microgram, or one millionth of a gram.

¹¹⁵ *ASC Standards of Care* at 38.

¹¹⁶ See for example *ASC Standards of Care* at 38; World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) (WHO *Technical and Policy Guidance*); Royal Australian and New Zealand College of Obstetricians and Gynaecologists *The use of Mifepristone for Medical Termination of Pregnancy* (C-Gyn 21, February 2016).

¹¹⁷ *ASC Standards of Care*, standard 9.8.4.

¹¹⁸ Technical Committee to the Abortion Supervisory Committee *Guidelines for the Use of Mifepristone for Medical Abortion in New Zealand* (2004) at [6.4.1]; *ASC Standards of Care*, standard 9.8.5; Royal Australian and New Zealand College of Obstetricians and Gynaecologists *The use of mifepristone for medical termination of pregnancy* (C-Gyn 21, February 2016) at 6.

second dose is taken, so women who leave the service are advised to have accommodation nearby. Second and third trimester medical abortions are completed at a hospital.

- 2.74 The completion of the medical abortion is determined by testing the woman's hormone levels by clinical means, such as a blood test, or by ultrasound.¹¹⁹

Surgical Abortion

- 2.75 Surgical abortion is usually performed by vacuum aspiration. Vacuum aspiration involves the evacuation of the contents of the uterus through a plastic or metal tube called a cannula attached to a vacuum.¹²⁰

- 2.76 Before the procedure, the woman's cervix is softened and dilated with a dose of 400 µg of misoprostol.¹²¹ The woman is also sedated and given local anaesthetic. In some cases general anaesthetic is appropriate,¹²² and some providers routinely use general anaesthetic. The vacuum aspiration itself takes from three to ten minutes.¹²³ World Health Organization (WHO) guidelines suggest the procedure can be performed on an outpatient basis.¹²⁴

- 2.77 Following the procedure, the doctor performing the abortion examines the aspirated tissue or performs an ultrasound to ensure that the pregnancy has been terminated.¹²⁵

Late Term Abortions

- 2.78 Abortion procedures are different for late term abortions.

- 2.79 Medical abortion can be performed through the second and third trimester. It requires increased doses of misoprostol.¹²⁶

- 2.80 Surgical abortion can be performed up to 16 weeks gestation by vacuum aspiration by using large bore cannula.¹²⁷ From 15 weeks gestation onwards surgical abortion can be performed by the dilation and evacuation method (D&E). This is a process to dilate and soften the cervix, followed by evacuation of the uterus using a large cannula and long forceps.¹²⁸ The availability of different methods of surgical abortion for late term abortions depends on the skills and experience of the doctors available to perform the abortion and on the policy of abortion provider.¹²⁹

- 2.81 The *ASC Standards of Care* follow the New Zealand Maternal Fetal Medicine Network instruction that, other than in exceptional circumstances, feticide (the act of causing the death of the fetus) should be part of the abortion process after 22 weeks gestation.

¹¹⁹ *ASC Standards of Care*, standard 9.8.7. In some jurisdictions surgical abortion is performed by curettage. The ASC advises that sharp curettage should not be used (*ASC Standards of Care*, standard 9.7.17).

¹²⁰ WHO *Technical and Policy Guidance* at 40.

¹²¹ *ASC Standards of Care*, standard 9.7.9.

¹²² *ASC Standards of Care*, standard 9.7.4.

¹²³ WHO *Technical and Policy Guidance* at 41.

¹²⁴ At 41.

¹²⁵ *ASC Standards of Care*, standard 9.7.19.

¹²⁶ *ASC Standards of Care* at 40.

¹²⁷ *ASC Standards of Care* at 41.

¹²⁸ WHO *Technical and Policy Guidance* at 41–42.

¹²⁹ *ASC Standards of Care* at [9.10].

Feticide involves a drug injection directly into the fetus' cardiac ventricle to stop the heart.¹³⁰ The ASC advises that if a woman does not consent to feticide, the abortion should not go ahead, because there is a possibility of neonatal survival.

Rates of medical and surgical abortions

- 2.82 Medical abortions account for a minority of the total abortions performed in New Zealand each year, although the number is increasing. In 2016, 15.4 per cent of abortions were medical abortions.¹³¹ This proportion was an increase from 2015 (13.4 per cent)¹³² and more than double the rate in 2012 (6.4 per cent).¹³³
- 2.83 Medical abortion is much more common in some other jurisdictions. In some European countries, like Sweden, Finland and France, medical abortion is more common than surgical abortion.¹³⁴ In England and Wales, 65.2 per cent of all abortions performed in 2017 were medical abortions.¹³⁵
- 2.84 The Ministry of Health and some health practitioners the Commission spoke to suggested the low uptake of medical abortion in New Zealand was due, in part, to the requirement to take the medication at a licensed institution. As noted above, this usually requires women to return to the abortion clinic on a separate occasion to take the second dose. Surgical abortions can be performed in one visit so may be more convenient, particularly for women who do not live near an abortion clinic. The licensing requirements also make it difficult for smaller service providers, such as GPs or Family Planning clinics, to offer medical abortion.
- 2.85 The length of time between when a woman first requests an abortion and when the abortion can be performed may also prevent some women from having medical abortions. As noted above, some providers only offer EMA (that is, up to nine weeks gestation). A small number of women who made submissions to the Commission said they missed out on the opportunity to use EMA as a result of delays.

Possible side effects and complications with abortion

- 2.86 Possible side effects after taking mifepristone include nausea and vomiting.¹³⁶ The main physical side effects of taking misoprostol include uterine cramping and prolonged and sometimes heavy bleeding.¹³⁷ Women may also suffer nausea, vomiting and diarrhoea from misoprostol.¹³⁸ Most women report some degree of pain.¹³⁹

¹³⁰ Royal College of Obstetricians and Gynaecologists *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales* (May 2010) at 31; Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion* (Evidence-based clinical guideline number 7, November 2011) at 57.

¹³¹ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 22 (Table 9.1).

¹³² *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 24 (Table 9.1).

¹³³ *Report of the Abortion Supervisory Committee* (Annual Report, 2013) at 23 (Table 9.1).

¹³⁴ Susheela Singh and others *Abortion Worldwide 2017: Uneven Progress and Unequal Access* (Guttmacher Institute, 2017) at 24 (Figure 4.2).

¹³⁵ Department of Health & Social Care (UK) "Abortion Statistics: data tables" (7 June 2018) <www.gov.uk> at Table 11B.

¹³⁶ Technical Committee to the Abortion Supervisory Committee *Guidelines for the Use of Mifepristone for Medical Abortion in New Zealand* (2004) at 20.

¹³⁷ WHO *Technical and Policy Guidance* at 43; Technical Committee to the Abortion Supervisory Committee *Guidelines for the Use of Mifepristone for Medical Abortions in New Zealand* (2004) at [5.6].

¹³⁸ WHO *Technical and Policy Guidance* at 43; Technical Committee to the Abortion Supervisory Committee *Guidelines for the Use of Mifepristone for Medical Abortions in New Zealand* (2004) at [5.6].

- 2.87 Complications are very rare for both procedures, but medical abortions have a slightly higher complication rate than surgical abortions.¹⁴⁰ Both procedures carry a low risk of incomplete abortion. Surgical abortion may also cause haemorrhage and uterine perforation in rare cases.¹⁴¹
- 2.88 The *ASC Standards of Care* advise that the earlier a woman has a medical abortion, the greater the chance of success without further medical intervention.¹⁴²
- 2.89 Late term abortions have more severe side effects and higher rates of complications,¹⁴³ although the overall risk profile is still low. Women undergoing second and third trimester medical abortion experience significantly more pain.¹⁴⁴ Incomplete abortion is more common.¹⁴⁵ Second and third trimester D&E methods of abortion present fewer complications than medical abortion, but uterine perforation and rupture is a risk, as is haemorrhage, cervical laceration and infection.¹⁴⁶
- 2.90 In 2016, 99.6 per cent of abortions performed in New Zealand did not lead to any complication.¹⁴⁷ The most common complications were retained placenta or products, and haemorrhage, each occurring in 0.1 per cent of cases.

Studies on the mental health impacts of abortion are inconclusive

- 2.91 The impact of abortion on mental health is difficult to accurately assess due to the presence of other factors. For example, a woman's mental health may be affected by an unwanted pregnancy whether an abortion is obtained or not.¹⁴⁸ Women may also have pre-existing mental health conditions, making it difficult to determine the effect of abortion itself on mental health.¹⁴⁹

¹³⁹ WHO *Technical and Policy Guidance* at 38–39.

¹⁴⁰ In a study of 233,805 medical abortions in the United States, “significant adverse events and outcomes” were reported in 0.65 per cent of cases. The majority of complications were incomplete abortions: K Cleland and others “Significant Adverse Events and Outcomes after Medical Abortion” (2013) 121(1) *Obstet Gynecol* 166.

¹⁴¹ WHO *Technical and Policy Guidance* at 47–48.

¹⁴² *ASC Standards of Care* at 37.

¹⁴³ Daniel Grossman, Kelly Blanchard and Paul Blumenthal “Complications after Second Trimester Surgical and Medical Abortion” (2008) 16(31Suppl) *Reprod Health Matters* 173.

¹⁴⁴ Daniel Grossman, Kelly Blanchard and Paul Blumenthal “Complications after Second Trimester Surgical and Medical Abortion” (2008) 16(31Suppl) *Reprod Health Matters* 173; T Kelly and others “Comparing medical versus surgical termination of pregnancy at 13–20 weeks of gestation a randomised controlled trial” (2010) 117(12) *BJOG* 1512.

¹⁴⁵ In one study from Scotland that reviewed 1,002 women who underwent abortion between 13 and 21 weeks gestation, 8 per cent of women failed to complete the medical abortion and required surgical completion: P Ashok, and others “Mid-trimester medical termination of pregnancy: A Review of 1002 Consecutive Cases” (2004) 69(1) *Contraception* 51. See too Amy Bryant and others “Second-Trimester Abortion for Fetal Anomalies or Fetal Death: Labour Induction Compared with Dilation and Evacuation” (2011) 117(4) *Obstet Gynecol* 788.

¹⁴⁶ Daniel Grossman, Kelly Blanchard and Paul Blumenthal “Complications after Second Trimester Surgical and Medical Abortion” (2008) 16(31Suppl) *Reprod Health Matters* 173.

¹⁴⁷ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 22 (Table 10.1).

¹⁴⁸ Academy of Medical Royal Colleges *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, including their Prevalence and Associated Factors* (London, December 2011) at 8 and 123.

¹⁴⁹ JR Steinberg, CE McCulloch and NE Adler “Abortion and mental health: findings from the national comorbidity survey-replication” (2014) 123(201) *Obstet Gynecol* 263; Academy of Medical Royal Colleges *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, including their Prevalence and Associated Factors* (London, December 2011) at 8 and 123.

2.92 A number of studies, including New Zealand research published in 2008, have indicated that abortion may be associated with a small increase in the risk of adverse mental health outcomes.¹⁵⁰ Several more recent studies have found that abortion does not significantly increase the risk of adverse mental health outcomes and may lead to better mental health outcomes than denial of abortion.¹⁵¹ These different findings may indicate that the impact abortion has on each woman is highly variable. The authors of the 2008 New Zealand research observed:¹⁵²

Specifically, the results do not support strong pro-life positions that claim that abortion has large and devastating effects on the mental health of women. Neither do the results support strong pro-choice positions that imply that abortion is without any mental health effects. In general, the results lead to a middle-of-the-road position that, for some women, abortion is likely to be a stressful and traumatic life event which places those exposed to it at modestly increased risk of a range of common mental health problems.

2.93 Submitters also expressed divided views on this issue. Some felt that abortion did negatively impact on the woman's mental health. Others disagreed, stating there was no evidence to support such a conclusion.

¹⁵⁰ DM Fergusson, LJ Horwood and JM Boden "Abortion and mental health disorders: evidence from a 30-year longitudinal study" (2008) 193(6) Br J Psychiatry 444. See also the meta-analysis in Prascilla K Coleman "Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009" (2011) 199(3) Br J Psychiatry 180.

¹⁵¹ M Antonia Biggs and others "Women's Mental Health and Well-being 5 years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study" (2017) 74(2) JAMA Psychiatry 169; DG Foster and others "A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one" (2015) 45(10) Psychol Med 2073; JR Steinberg, CE McCulloch and NE Adler "Abortion and mental health: findings from the national comorbidity survey-replication" (2014) 123(201) Obstet Gynecol 263.

¹⁵² DM Fergusson, LJ Horwood and JM Boden "Abortion and mental health disorders: evidence from a 30-year longitudinal study" (2008) 193(6) Br J Psychiatry 444 at 450.

CHAPTER 3

Wider legal context

INTRODUCTION

3.1 Any reform of abortion law will need to be considered in the context of human rights law, including the New Zealand Bill of Rights Act 1990 (NZBORA) and New Zealand's international obligations, and the Treaty of Waitangi. In the introduction to the Cabinet Manual, Sir Kenneth Keith emphasises the importance of ensuring government processes, including policy and legislative development, are consistent with the New Zealand constitution:¹

A balance has to be struck between majority power and minority right, between the sovereignty of the people exercised through Parliament and the rule of the law, and between the right of elected governments to have their policies enacted into law and the protection of fundamental social and constitutional values. The answer cannot always lie with simple majority decision-making. Indeed, those with the authority to make majority decisions often themselves recognise that their authority is limited by understandings of what is basic in our society, by convention, by the Treaty of Waitangi, by international obligations and by ideas of fairness and justice.

3.2 Abortion is also governed by the laws that apply to health care generally. These laws would continue to apply if the specific laws relating to abortion are amended or repealed. Their operation should therefore be taken into account when considering any changes to abortion laws.

3.3 This chapter provides an overview of key aspects of human rights laws and Treaty principles, as well as general health regulation.

HUMAN RIGHTS LAWS

3.4 Any proposed policy or legislation should be consistent with the rights and freedoms contained in the NZBORA and New Zealand's international obligations.² There are several human rights enshrined in both New Zealand's domestic law and in the international instruments New Zealand has ratified that are relevant to abortion.

¹ Cabinet Office *Cabinet Manual 2017* at 5.

² Cabinet Office *Cabinet Manual 2017* at [7.67]; Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 32 and 9.1. The Guidelines also require consultation with any department that has responsibility for a relevant treaty, to identify any international obligations and whether the proposed legislation will result in inconsistency with them. The Vienna Convention on the Law of Treaties (opened for signature 23 May 1969, entered into force on 27 January 1980), arts 26, 27 and 29, ratified by New Zealand in 1971, provides that treaty obligations are binding on a state and domestic law may not be used as a justification for failure to perform a treaty obligation.

Rights of women

There is no right to abortion under the NZBORA

- 3.5 The New Zealand courts have held that, unlike the law in some other jurisdictions,³ there is nothing in the NZBORA upon which a right to abortion might be based. In *Right to Life New Zealand Inc v The Abortion Supervisory Committee*, the High Court observed that the right to abortion in those jurisdictions is based on the proposition that if forced upon a woman, the physical and psychological effects of pregnancy, childbirth and child-rearing would violate her constitutional guarantees of liberty and security of person.⁴ The Court held that there is no equivalent right under the NZBORA.⁵
- 3.6 As described below, however, several other rights under the NZBORA and under international instruments may be affected by legal restrictions on abortion.

Right to life

- 3.7 Section 8 of the NZBORA provides that no one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice. Section 8 is similar to article 6 of the International Covenant on Civil and Political Rights (ICCPR), which provides that everyone has the right to life.⁶
- 3.8 The United Nations Human Rights Committee has stated that Article 6 of the ICCPR requires states parties to provide safe access to abortion to protect the life and health of the pregnant woman.⁷ In its recent Draft Comment No. 36 on the right to life under the ICCPR, the Committee has also said that states parties must provide safe access to abortion where carrying the pregnancy to term would cause the woman substantial pain or suffering, most notably where the pregnancy is the result of rape or incest, or when the fetus suffers from fatal impairment.⁸
- 3.9 The fetus and the right to life are discussed below at paragraphs [3.29] to [3.36].

³ For example: the Canadian Charter of Rights and Freedoms (Constitution Act 1982, being Schedule B to the Canada Act 1982 (UK), 1982, C 111), s 7, which provides the right to life, liberty and security of the person; 14th Amendment to the Constitution of the United States of America, which provides that the state shall not deprive any person of life, liberty, or property without due process of law. See too *R v Morgentaler* [1998] 1 SCR 30 (SCC) and *Roe v Wade* 410 US 113 (1973).

⁴ *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [98].

⁵ On appeal, the Court of Appeal did not address the issue, but said that the High Court's comments had much to commend them: *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [64].

⁶ International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), ratified by New Zealand 28 December 1978 (ICCPR).

⁷ United Nations Human Rights Committee *General Comment no. 28 on the Equality of Rights Between Men and Women (article 3)* CCPR/C/21/Rev. 1/Add (2000) at [10].

⁸ United Nations Human Rights Committee *Draft General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights – Right to Life* (2017) at [9].

Right to freedom from cruel or degrading treatment

- 3.10 Section 9 of the NZBORA affirms the right not to be subject to torture or to cruel, degrading, or disproportionately severe treatment. In *Right to Life New Zealand Inc v Abortion Supervisory Committee*, the High Court said that a right to abortion might be asserted under the NZBORA if continuance of the pregnancy were to imperil life or amount to cruel, degrading or disproportionate treatment.⁹ However, the Court did not decide the issue.
- 3.11 Article 7 of the ICCPR provides that no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. The United Nations Human Rights Committee's Draft Comment No. 36 notes that legal restrictions on abortion may subject women to physical or mental pain and suffering. The restrictions can therefore cause cruel, inhuman or degrading treatment and should be avoided.¹⁰

Right to privacy

- 3.12 In New Zealand, the Privacy Act 1993 provides protections for individual privacy and allows sectors to develop codes of practice. The Health Information Privacy Code 1994 governs the collection, use, disclosure, storage and disposal of, and access to, personal health information relevant to a particular individual. In particular, rule 11 prevents a health agency from disclosing health information concerning an individual except in limited circumstances.
- 3.13 In the Privacy Commissioner's submission to the Law Commission, the Commissioner explained that privacy relates to the ability to make important decisions about one's own life. The concept of privacy embodies the idea of individual and bodily autonomy; that an individual belongs to themselves and not to others or to society as a whole.
- 3.14 Article 17 of the ICCPR provides the right against arbitrary or unlawful interference with a person's privacy, family and home.
- 3.15 Courts in overseas jurisdictions have found that the right to privacy is particularly relevant to abortion. In *R v Morgentaler* the Canadian Supreme Court observed Canada's former laws that criminalised abortion placed the decision as to whether a woman could terminate a pregnancy in the hands of others. The Court held the law intruded on personal autonomy in decisions of an intimate and private nature and therefore deprived

⁹ *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [98]. On appeal, the Court of Appeal did not address the issue but said that the High Court's comments had much to commend them: *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [64].

¹⁰ United Nations Human Rights Committee *Draft General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights – Right to Life* (2017) at [9]. In *KL v Peru*, a 17 year old was pregnant. The fetus was diagnosed with a severe condition affecting the development of the brain and the skull. Peruvian law only permitted abortion when necessary to save the life of the pregnant woman or to avoid serious and permanent damage to her health. KL was denied an abortion. She continued the pregnancy and gave birth to an anencephalic girl. The baby survived four days. The Human Rights Committee, who heard the case under the Optional Protocol to the ICCPR, considered that KL had suffered cruel and inhuman treatment having been forced to continue the pregnancy and endure the stress of experiencing her daughter's deformities and death: *KL v Peru* United Nations Human Rights Commission Communication No. 1153/2003, CCPR/C/85/D/1153/2003 (2005).

women of the right to liberty.¹¹ The Court cited the United States Supreme Court decision in *Eisenstadt v Baird*, where that Court observed:¹²

If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

3.16 The right to privacy was central to the United States Supreme Court decision in *Roe v Wade*.¹³ The Court held that a person’s constitutional right to privacy “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy”.¹⁴

3.17 The Privacy Commissioner also submitted that the current law’s treatment of abortion as a criminal issue exposes sensitive reproductive health information to the criminal justice system in a way that is not the case for any other health care or medical decision. Personal and sensitive information could become public in the course of a criminal prosecution or a woman could suffer the disclosure of her health information to Police. The Commissioner stated:

The potential impact on privacy in relation to particularly sensitive health information means the existing law is inadequate to protect women seeking to exercise a choice relating to their own reproductive rights. It is inconsistent with the treatment of health information and the expectation of patient/doctor confidentiality.

Right to highest attainable standard of health

3.18 Article 12 of the International Covenant on Economic, Social and Cultural Rights provides that everyone has the right to enjoy the highest attainable standard of health.¹⁵ The United Nations Committee on Economic, Social and Cultural Rights has explained that the right to sexual and reproductive health is an integral part of the right to health.¹⁶ The Committee has commented that the right requires states to repeal, and refrain from enacting, laws and policies that create barriers to accessing abortion. This includes third party authorisation requirements, biased counselling, mandatory waiting periods and the exclusion of particular services from public funding.¹⁷ The Committee explained that states parties should be guided by contemporary human rights instruments and jurisprudence, as well as the most current international guidelines and protocols established by United Nations agencies—in particular, the World Health Organization and the United Nations Population Fund.¹⁸

¹¹ *R v Morgentaler* [1988] 1 SCR 30 (SCC).

¹² *Eisenstadt v Baird* 405 US 438 (1972) at 453.

¹³ *Roe v Wade* 410 US 113 (1973).

¹⁴ *Roe v Wade* 410 US 113 (1973) at 153. The Court held, however, that the right was not absolute and that at the point the fetus became viable the state had an overriding interest in the preservation of the fetus’ life.

¹⁵ International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976), ratified by New Zealand 28 December 1978.

¹⁶ United Nations Committee on Economic, Social and Cultural Rights, CESCR *General Comment No. 14: The right to the highest attainable standard of health (Art.12) E/C.12/2000/4* (2000) at [1].

¹⁷ United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/22* (2016) at [40]–[41].

¹⁸ United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/22* (2016) at [49].

3.19 The United Nations Special Rapporteur on the right to health has commented:¹⁹

Criminal laws penalising and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realisation of women's right to health and must be eliminated. These laws infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health. Moreover, such laws consistently generate poor physical health outcomes ... Creation or maintenance of criminal laws with respect to abortion may amount to violations of the obligations of States to respect, protect and fulfil the right to health.

Right to freedom from discrimination

- 3.20 Section 19 of the NZBORA provides that everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993, which among other things include sex and pregnancy.²⁰
- 3.21 Under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),²¹ states parties agree to take all appropriate measures to eliminate discrimination against women.
- 3.22 Article 12 of CEDAW requires states parties to eliminate discrimination against women specifically in the field of health care, including family planning.²² Article 16 provides that states parties must take appropriate measures to ensure that women have equal rights to decide freely and responsibly on the number and spacing of their children.
- 3.23 In General Recommendation No. 21, the United Nations Committee on the Elimination of Discrimination Against Women stated that responsibilities to bear and raise children affect other rights, including women's rights to access education and employment, and place an inequitable burden on women and their physical and mental health. A woman's decision to have children or not must not be limited by a spouse, parent, partner, or government.²³
- 3.24 In General Recommendation No. 24 on Article 12 of CEDAW, the Committee recommended that states amend legislation that criminalises abortion in order to

¹⁹ Special Rapporteur of the Human Rights Council *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/66/254* (2011) at [21].

²⁰ Human Rights Act 1993, s 21(1)(a). The Law Commission is unaware of any case in New Zealand dealing with abortion and the right to freedom from discrimination under the Human Rights Act. However, six women and the Abortion Law Reform Association of New Zealand have recently filed a complaint to the Human Rights Commission alleging abortion laws discriminate against women and pregnant people because women who seek abortion care receive demonstrably worse treatment than other people seeking health care: Sasha Borissenko "Abortion case headed for Human Rights Tribunal" (8 October 2018) Newsroom <www.newsroom.co.nz>.

²¹ Convention on the Elimination of Discrimination Against Women 1249 UNTS 13 (opened for signature 1 March 1980, entered into force 3 September 1981), ratified by New Zealand 10 January 1985 (CEDAW).

²² In *LC v Peru* a teenager was denied emergency surgery because she was pregnant. The hospital also denied the teenager an abortion. The Committee on the Elimination of Discrimination against Women heard a complaint brought by the teenager's mother under the Optional Protocol to CEDAW. The Committee considered that Peru had violated LC's right to access health care services under art 12 of CEDAW. The Committee considered Peru had also failed in its duties under art 2 to ensure legal protection of LC's rights and to take all measures to modify or abolish laws and practices that discriminated against her: *LC v Peru* Committee on the Elimination of Discrimination Against Women Communication No. 22/2009, CEDAW/C/50/D/22/2009 (2011).

²³ United Nations Committee on the Elimination of Discrimination Against Women *General Recommendation No.21: Equality in marriage and family relations A/49/38* (1994) at [21]–[22].

withdraw punitive measures imposed on women who undergo abortion.²⁴ In General Recommendation No. 35, the Committee stated that violation of sexual and reproductive health and rights, such as criminalisation of abortion or the denial or delay of safe abortion, is a form of gender-based violence.²⁵

3.25 In 2012, the Committee published its concluding observations in its seventh periodic review of New Zealand. It stated:²⁶

The Committee notes with concern, however, the convoluted abortion laws which require women to get certificates from two certified consultants before an abortion can be performed, thus making women dependent on the benevolent interpretation of a rule which nullifies their autonomy. The Committee is also concerned that abortion remains criminalized in the State party, which leads women to seek illegal abortions, which are often unsafe.

...

The Committee urges the State party:

(a) To review the abortion law and practice with a view to simplifying it and to ensure women's autonomy to choose;

(b) To prevent women from having to resort to unsafe abortions and remove punitive provisions imposed on women who undergo an abortion

3.26 In its recent concluding observations in its eighth periodic review of New Zealand, the Committee repeated its concerns and recommendations.²⁷

Rights under the NZBORA may be subject to limits

3.27 Section 5 of the NZBORA provides that rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.²⁸ The Supreme Court has held that in order to determine whether a restriction of rights is permissible under section 5, it is necessary to inquire:²⁹

(a) does the proposed limit on a right serve a purpose sufficiently important to justify limiting a right?

(b) if so:

(i) is the limiting provision rationally connected to its purpose?

(ii) does the proposed limit impair the right no more than is reasonably necessary for sufficient achievement of the purpose?

(iii) is the limit proportionate to the importance of the objective?

²⁴ United Nations Committee on the Elimination of Discrimination Against Women *General Recommendation No.24: Article 12 of the Convention (women and health)* A/54/38/Rev.1, chap. I, (1999) at [31(c)].

²⁵ United Nations Committee on the Elimination of Discrimination Against Women *General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19* CEDAW/C/GC/35 (2017) at [18].

²⁶ United Nations Committee on the Elimination of Discrimination Against Women *Concluding Observations of the Committee on the Elimination of Discrimination against Women: New Zealand* CEDAW/C/NZL/CO/7 (2012) at [33]–[34].

²⁷ United Nations Committee on the Elimination of Discrimination Against Women *Concluding Observations on the Eighth Periodic Report of New Zealand* CEDAW/C/NZL/CO/8 (2018) at [39]–[40].

²⁸ There is some suggestion, however, that some rights under the New Zealand Bill of Rights Act 1990 (NZBORA) should be considered absolute in the sense it is impossible to impose any justified limitation. See *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 (SC) at [65]; *Television New Zealand v Solicitor-General* [2008] NZCA 519, [2009] NZFLR 290 at [90].

²⁹ *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [104] per Tipping J.

- 3.28 The government is required to identify any inconsistencies with the NZBORA when developing legislation, including any reasons why the limit may be justified under section 5.³⁰ No case in New Zealand has considered the application of section 5 in the context of abortion.³¹

The fetus and human rights under New Zealand law

- 3.29 The long title to the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) states that the purpose of the Act's abortion provisions is:

...to provide for the circumstances and procedures under which abortions may be authorised after having full regard to the rights of the unborn child

- 3.30 Viewed on its own, this purpose statement may suggest that a fetus has certain legal rights that are recognised under the Act. However, the Court of Appeal in *Wall v Livingston* found that the provisions of the Act itself do not confer any enforceable rights on a fetus.³² Rather, as the Court observed, the Act sets out specific procedural requirements that protect the interests of the fetus to the extent Parliament considered appropriate when the Act was enacted. The Court of Appeal explained:³³

... nowhere in the Act but in the long title is there any mention of the phrase "the unborn child" or of its rights. Nor is anybody assigned a responsibility for protecting those rights in the form, for example, of an independent advocate (something rejected by the Royal Commission – see p 294 of the Report). The matter is handled indirectly. It is done by surrounding the lawful termination of a pregnancy with the precautionary process of prior medical authorisation by two certifying consultants which must be obtained (except in certain situations of emergency) if an offence is to be avoided.

... it is important not to lose sight of what must have been a deliberate Parliamentary decision: the avoidance of any attempt to spell out what were to be regarded as the legal rights in an unborn child; with the consequential absence of any statutory means by which rights (whatever their nature) could be enforced.

- 3.31 More recently the Court of Appeal in *The Abortion Supervisory Committee v Right to Life New Zealand Inc* held that "there is no basis either from the Long Title to the CSA Act or the abortion law to derive generally an express right to life in the unborn child."³⁴ In the absence of any statutory recognition of such a right, the common law "born alive" rule applies in New Zealand, under which a fetus has no legal rights prior to birth.³⁵ The

³⁰ Cabinet Office *Cabinet Manual 2017* at [7.67]; Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 32; NZBORA, s 7.

³¹ However, six women and the Abortion Law Reform Association of New Zealand have recently filed a complaint to the Human Rights Commission alleging abortion laws discriminate against women and pregnant people: Sasha Borissenko "Abortion case headed for Human Rights Tribunal" (8 October 2018) Newsroom <www.newsroom.co.nz>. Several cases in other jurisdictions have considered the extent to which reasonable limits can apply to the human rights arising in the respective jurisdictions in the context of abortion. See for example *R v Morgentaler* [1998] 1 SCR 30 (SCC); *In the Matter of an Application by the Northern Ireland Human Rights Commission for Judicial Review* [2018] UKSC 27, [2018] HRLR 14.

³² *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 737. In that case the Court of Appeal held that a doctor had no standing to seek judicial review of a decision by certifying consultants to authorise an abortion.

³³ *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 737.

³⁴ *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [54]. The Supreme Court declined leave to appeal on this point: *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2011] NZSC 97 at [1].

³⁵ *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [81]–[83] (affirmed on this point by the Court of Appeal in *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA

Supreme Court declined to hear an appeal on this issue, saying “it is plain that the [CSA Act] was based on the premise of the “born alive” rule”.³⁶

- 3.32 That conclusion is supported by the report of the Royal Commission of Inquiry that led to the CSA Act’s enactment. The Royal Commission considered that from the point of implantation a fetus has a status that entitles it to protection.³⁷ However, that protection should not be absolute and should yield to compelling competing interests. The Royal Commission found:³⁸

This status does not confer upon [the fetus] an absolute right to life. If it did, then human life with full conscious development would have to yield to it, and a greater value might be placed on fetal life with its potential still unformed than on human life with full conscious development.

- 3.33 Equally, however, the Royal Commission did not consider women should have an absolute right to an abortion.³⁹ The legislation recommended by the Royal Commission was intended to give an appropriate level of weight to the interests of both the woman and the fetus.⁴⁰
- 3.34 The preamble to the United Nations Convention on the Rights of the Child refers to the “appropriate legal protection, before as well as after birth”.⁴¹ In *Right to Life New Zealand Inc v The Abortion Supervisory Committee* the Court held that the preamble to the Convention “leaves each state to establish for itself the appropriate level of protections accorded to the unborn child”.⁴² No other relevant international instrument to which New Zealand is a party explicitly extends rights to the fetus.
- 3.35 The “born alive” rule is also relevant to health procedures other than abortion. In some overseas jurisdictions, the courts have held that a pregnant woman is entitled to refuse medical treatment that is needed to save the life of the fetus. The courts have reasoned that the fetus is not a separate legal person from its mother and therefore its rights do not prevail over the woman’s right to decline treatment.⁴³ The position is likely to be similar in New Zealand.⁴⁴

246, [2012] 1 NZLR 176 at [59]; leave to appeal to the Supreme Court declined: *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2011] NZSC 97] at [1]). See also *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) at [117] and *Right to Life New Zealand Inc v Rothwell* [2006] 1 NZLR 531 at [25].

³⁶ *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2011] NZSC 97] at [1].

³⁷ Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand; Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 192.

³⁸ At 192.

³⁹ At 194.

⁴⁰ At 269.

⁴¹ United Nations Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990), ratified by New Zealand 6 April 1993.

⁴² *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [103] (affirmed by the Court of Appeal in *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [67]).

⁴³ *St George’s Healthcare NHS Trust v S* [1999] Fam 26 (EWCA); *Winnipeg Child & Family Services (Northwest Area) v G* [1997] 3 SCR 925 (SCC).

⁴⁴ Professor Nicola Peart suggests that a woman would be able to refuse such treatment based on her right to refuse treatment under s 11 of the NZBORA: Nicola Peart “The Legal Status of Life Before Birth” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters) at 18.2.5. Professor Peart doubts the decision

- 3.36 In summary, the position in New Zealand is that a fetus is not treated as a legal person and does not have any legal rights unless and until it is born alive.⁴⁵

Rights of people with disabilities

- 3.37 Section 19 of the NZBORA provides that everyone has the right to freedom from discrimination on the prohibited grounds of discrimination set out in the Human Rights Act 1993, which include disability. New Zealand is also a party to the Convention on the Rights of Persons with Disabilities (CRPD).⁴⁶ Broadly, the CRPD requires states parties to ensure equal treatment of disabled people and to take measures to eliminate discrimination.
- 3.38 Under New Zealand's current abortion law, abortion is permitted up to 20 weeks gestation if there is a substantial risk that the child, if born, would be "so physically or mentally abnormal as to be seriously handicapped".⁴⁷
- 3.39 Some commentators suggest that legislative provisions that permit abortion because the child would be born with disabilities endorse, as a matter of public policy, the view that a life with disabilities is intrinsically less valuable than other lives.⁴⁸
- 3.40 The Committee on the Rights of Persons with Disabilities has stated that laws that explicitly allow abortion on the grounds of fetal impairment violate articles 4,⁴⁹ 5⁵⁰ and 8⁵¹ of the CRPD.⁵² The Committee expressed its concern that assessments of impairment

in *Police v Kahotea-Jones* DC Invercargill CRI-2006-025-3004, 28 November 2006, where the court ordered that a pregnant woman be detained and treated for her drug addiction in order to protect her unborn child. The courts have, however, made custody orders in respect of unborn children under the Children, Young Persons, and Their Families Act 1989 and the Guardianship Act 1968 (the predecessor to the Care of Children Act 2004) where the mother was engaged in conduct that would harm the unborn child: *Re Baby P (an unborn child)* [1995] NZFLR 577, (1995) 13 FRNZ 472 (FC) (where the mother was involved in a violent relationship); *Re an Unborn Child (Nikki's Case)* [2003] 1 NZLR 115, [2003] NZFLR 344 (HC) (where the birth of a child was to be filmed for use in a pornographic film).

⁴⁵ See *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [81]–[83] (affirmed on this point by the Court of Appeal in *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [59]; leave to appeal to the Supreme Court declined: *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2011] NZSC 97]). Note, however, that Butler and Butler argue the unborn child can enjoy rights under New Zealand law. They suggest that a fetus should enjoy the right to life under s 8 of the NZBORA from the point it becomes viable. See Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [9.4.17].

⁴⁶ Convention on the Rights of Persons with Disabilities A/RES/61/106, Annex I (opened for signature 30 March 2007, entered into force 3 May 2008), ratified by New Zealand 25 September 2008.

⁴⁷ Crimes Act 1961, s 187A(1)(aa).

⁴⁸ See Helen Pringle "Abortion and Disability: Reforming the Law in South Australia" (2006) 29(2) *Univ of NSWLJ* 207.

⁴⁹ The duty on states parties to ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities.

⁵⁰ The recognition that all persons are equal before and under the law, and the duty on states parties to prohibit all discrimination on the basis of disability.

⁵¹ The duty on states parties to raise awareness on respect for the rights and dignity of persons with disabilities, including combatting stereotypes, prejudices and harmful practices relating to persons with disabilities.

⁵² Committee on the Rights of Persons with Disabilities *Comments on the draft General Comment No.36 of the Human Rights Committee on article 6 of the International Covenant on Civil and Political Rights* (2017).

conditions are often false. Even if they are accurate, the assessment “perpetuates notions of stereotyping disability as incompatible with a good life.”⁵³

- 3.41 New Zealand’s Independent Monitoring Mechanism on the Convention on the Rights of Persons with Disabilities has expressed concern about antenatal screening and abortions in New Zealand.⁵⁴ It observed:⁵⁵

A disability-selective antenatal screening policy that has the purpose or effect of birth prevention of a protected minority group could be considered as raising issues of discrimination insofar as it impacts the social (and other rights) of the protected group. Practically, birth prevention of a specific group impacts on that group and the wider disability community in that it increases stigma in society, means there are fewer people with lived experience to advocate for protections and services, and adds to the notion that disability is a negative experience rather than a facet of human diversity.

- 3.42 These issues are further addressed later in this briefing paper. Chapters 4 and 5 discuss three alternative legal models for when abortion would be lawful. The Commission suggests the repeal of current grounds for abortion set out in section 187A of the Crimes Act, including the ground that the child, if born, would be “seriously handicapped”. Chapter 12 further discusses concerns around abortions sought because of fetal impairment.

THE TREATY OF WAITANGI AND TIKANGA MĀORI

The Treaty and its principles in the health context

- 3.43 The Treaty of Waitangi (the Treaty) is of vital constitutional significance⁵⁶ and has been described as “part of the fabric of New Zealand society”.⁵⁷ As with the NZBORA, all legislative proposals must be considered for consistency with the Treaty.⁵⁸ All policy and legislative development should comply with the principles of the Treaty both procedurally and substantively.⁵⁹

⁵³ Committee on the Rights of Persons with Disabilities *Comments on the draft General Comment No.36 of the Human Rights Committee on article 6 of the International Covenant on Civil and Political Rights* (2017). See too the comments and recommendations of the Committee on the Rights of Persons with Disabilities in its concluding observations on Spain, Hungary and Austria. The Committee recommended that the states parties abolish the distinctions made in law that allowed abortion based solely on disability: Committee on the Rights of Persons with Disabilities *Consideration of reports submitted by States parties under article 35 of the Convention: concluding observations of the Committee on the Rights of Persons with Disabilities: Spain* CRPD/C/ESP/CO/1 (2011) [17]–[18]; Committee on the Rights of Persons with Disabilities *Concluding observations on the initial periodic report of Hungary, adopted by the Committee at its eighth session (17–28 September 2012)* CRPD/C/HUN/CO/1 (2012) [17]–[18]; Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of Austria / adopted by the Committee [on the Rights of Persons with Disabilities] at its 10th session, 2–13 September 2013* CRPD/C/AUT/CO/1 (2013) [14]–[15].

⁵⁴ New Zealand’s Independent Monitoring Mechanism is made up of the Human Rights Commission, the Office of the Ombudsman and the Disabled People’s Organisations Coalition. It is constituted to meet New Zealand’s commitment under art 33.2 of the United Nations Convention of the Rights of Persons with Disabilities to promote, protect and monitor implementation of the Convention.

⁵⁵ New Zealand Independent Monitoring Mechanism *Submission from New Zealand’s Independent Monitoring Mechanism to Inform the Development of the List of Issues Prior to Reporting for New Zealand’s 2nd Periodic Review under the Convention on the Rights of Persons with Disabilities* (November 2017) at 10.

⁵⁶ Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 23.

⁵⁷ *Huakina Development Trust v Waikato Valley Authority* [1987] 2 NZLR 188 (HC) at 210.

⁵⁸ Cabinet Office *Cabinet Manual 2017* at [7.65(a)].

⁵⁹ Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 27. See also the introduction to the Cabinet Manual (Cabinet Office *Cabinet Manual 2017* at 5).

3.44 The principles of the Treaty require the Crown and Māori to act towards each other reasonably and in good faith.⁶⁰ In *He Korowai Oranga* (the Māori health strategy), the Ministry of Health articulates the principles of the Treaty in the health context as follows:⁶¹

- **Partnership:** involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation:** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection:** the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

3.45 Recognition of the Treaty is not reliant on having specific reference to the Treaty in relevant legislation.⁶² However, a number of statutes do expressly refer to the Treaty. The New Zealand Public Health and Disability Act 2000, which forms a central part of the statutory framework governing the health sector, includes a Treaty provision. Section 4 states that in recognition of the principles of the Treaty and with a view to improving health outcomes for Māori, the Act provides mechanisms to enable Māori contribution to decision-making on, and participation in, the delivery of health and disability services.⁶³ Specific measures in the Act include minimum Māori membership on district health boards (DHBs), and a requirement for DHBs to maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement.⁶⁴ One of the stated purposes of the Act is to reduce health disparities by improving the health outcomes of Māori and other populations.⁶⁵

3.46 In addition, the Commission notes that Stage One of the Waitangi Tribunal's current inquiry into health services and outcomes will look at the legislative and policy framework of the primary health care system, with a significant focus on the New Zealand Public Health and Disability Act, health strategies and funding.⁶⁶

⁶⁰ *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 (CA) (the "Lands case"); *Te Rūnanga o Wharekauri Rekohu Inc v Attorney-General* [1993] 2 NZLR 301 (CA).

⁶¹ Ministry of Health "Treaty of Waitangi Principles" (6 June 2014) <www.health.govt.nz>.

⁶² See for example *Huakina Development Trust v Waikato Valley Authority* [1987] 2 NZLR 188 (HC) where the Court held that the Treaty was part of the context in which the legislation was to be interpreted in relation to granting water rights, and *Barton-Prescott v Director-General of Social Welfare* [1997] 3 NZLR 179 (HC) where the Court held that all Acts dealing with the status, future, and control of children are to be interpreted as coloured by the principles of the Treaty of Waitangi.

⁶³ New Zealand Public Health and Disability Act 2000, s 4.

⁶⁴ Sections 22–23.

⁶⁵ Section 3.

⁶⁶ See *Memorandum-Directions of Judge S R Clark confirming approach to be taken to stage one of the Waitangi Tribunal Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, #2.5.25, 29 March 2018).

Mātauranga Māori in the health context

- 3.47 The ASC *Standards of Care* note that Eurocentric models of health care have developed as a result of the devaluing, invalidation and marginalisation of mātauranga Māori⁶⁷ through the process of colonisation; and that as part of working with Māori in good faith, as required by the Treaty, the government is required to “safeguard Māori Health concepts and mātauranga Māori in health care provision and medical practice”.⁶⁸ Ensuring compliance with the Treaty requires an understanding of key tikanga concepts, such as rangatiratanga,⁶⁹ whanaungatanga,⁷⁰ manaakitanga,⁷¹ tapu⁷² and noa.⁷³
- 3.48 There are a number of models describing Māori approaches to health.⁷⁴ Many health professional bodies also have strategies and guidelines for incorporating mātauranga Māori and Treaty principles into their practice,⁷⁵ including in the provision of abortion services.⁷⁶ As noted, the *ASC Standards of Care* include standards specifically

⁶⁷ Mātauranga Māori is defined as “the body of knowledge originating from Māori ancestors, including Māori world view and perspectives, Māori creativity and cultural practices”: John C Moorfield *Te Aka: Māori-English, English-Māori Dictionary and Index* (Pearson, Auckland, 2011). “All tikanga Māori are firmly embedded in mātauranga Māori, which might be seen as Māori philosophy as well as Māori knowledge”: Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 8.

⁶⁸ Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (*ASC Standards of Care*) at 11. The Standards Committee is a group of experts appointed by the ASC to develop its *Standards of Care*.

⁶⁹ Rangatiratanga: authority and the ability to act authoritatively. Often translated as chiefly autonomy, self-management and sovereignty; having the attributes or characteristics of a rangatira, a chief or person in authority. See Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 331; John C Moorfield *Te Aka: Māori-English, English-Māori Dictionary and Index* (Pearson, Auckland, 2011).

⁷⁰ Whanaungatanga is linked to whakapapa and refers to the rights and responsibilities associated with being a relative. Originally it referred to blood relationships but now it is used more widely to refer to other kin-like relationships as well. It denotes the fact that in te ao Māori relationships are everything and all individuals owe certain responsibilities to the collective. See Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 32; Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 524; Law Commission *Māori Custom and Values in New Zealand Law* (NZLC SP9) at [130].

⁷¹ Manaakitanga describes the process of showing and receiving care, respect, kindness and hospitality. It is expected for all people, regardless of whether (or especially when) there is no pre-existing relationship. Thus whanaungatanga may start with manaakitanga. This duty to nurture relationships, look after people, and be very careful about how others are treated underpins all tikanga. See Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 205; Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 33.

⁷² Tapu denotes the intersection between the human and the divine. It indicates states of restriction and prohibition, which, if breached, result in serious consequences. It is sometimes expressed as inviolability: see Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 404.

⁷³ Noa is the reciprocal of tapu, indicating freedom of restriction and neutrality: see Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 266; Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 16 and 35–36.

⁷⁴ Including Te Whare Tapa Whā, developed by Mason Durie; Te Wheke, developed by Rose Pere; and Te Pae Mahutonga, developed by Mason Durie: Ministry of Health “Māori health models” (9 November 2015) <www.health.govt.nz>.

⁷⁵ See, for example, Royal New Zealand College of General Practitioners *He Ihu Waka, He Ihu Whenua, He Ihu Tangata* (2017); Nursing Council of New Zealand *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice* (2011); Midwifery Council of New Zealand *Statement on cultural competence for midwives* (2011).

⁷⁶ *ASC Standards of Care*, standard 6.3.

addressing incorporation of mātauranga Māori and Treaty principles into provision of care to Māori women and their whānau.⁷⁷

Te ao Māori and abortion

- 3.49 There is a range of views about abortion within te ao Māori. Some submitters stated that abortion is not a Māori practice and goes against Māori values. Others acknowledge that view but point to evidence of induced abortion being practised prior to the arrival of Pākehā, and refer to traditional mātauranga and tikanga Māori around these practices.⁷⁸ Some accounts of traditional practice describe how a loss of conception could be caused through a breach of tapu, and/or through physical or medicinal intervention.⁷⁹ The *ASC Standards of Care* state that the diverse contemporary understandings and perceptions of abortion are influenced by mātauranga Māori, western knowledge systems and global influences.⁸⁰ Many people who made submissions to the Commission did not directly address the issue of Māori attitudes towards abortion but stressed the need for (and the currently limited access to) culturally appropriate services for Māori.
- 3.50 Very little research has been done on Māori attitudes towards abortion or relevant tikanga and mātauranga Māori.⁸¹
- 3.51 Te Whāriki Takapou, a Māori public health organisation involved in sexual and reproductive health promotion and research, submitted that the language used around abortion emerges from a western cultural tradition, and the Māori terms for abortion suggest different understandings. For example, there is no distinction in te reo Māori between a spontaneous miscarriage and an induced abortion.⁸² *Tahe* and *materoto* mean both “abortion” and “miscarriage”, and *whakatahe* means both “to cause to abort” and “to have a miscarriage”.⁸³
- 3.52 Some health practitioners highlighted that pregnancy may be viewed as part of whakapapa and noted that some abortion service providers have developed practices to take this into account. For example, in the case of surgical abortions, some providers give women the option of retaining the products of conception after the procedure so

⁷⁷ Standard 6.3.

⁷⁸ See Jade Sophia Le Grice “Māori and reproduction, sexuality education, maternity, and abortion” (Doctoral thesis for the degree of Doctor of Philosophy in Psychology, University of Auckland, 2014) at 36: “Some accounts of traditional practice suggest that there were known and accepted methods for causing loss of conception”, and at 44. Similar comments were made to the Commission by submitters, including Te Whāriki Takapou, a Māori public health organisation involved in sexual and reproductive health promotion and research.

⁷⁹ See, for example, the descriptions in Elsdon Best “The Lore of the Whare-kohanga” (1906) *The Journal of the Polynesian Society* Vol XV at 12–13; Ernest Dieffenbach *Travels in New Zealand; With Contributions to the Geography, Geology, Botany, and Natural History of that Country—Vol II* (John Murray, London, 1843) at 26. This is also discussed in Jade Sophia Le Grice “Māori and reproduction, sexuality education, maternity, and abortion” (Doctoral thesis for the degree of Doctor of Philosophy in Psychology, University of Auckland, 2014) at 35–36 and 44.

⁸⁰ *ASC Standards of Care* at 13.

⁸¹ For example, Jade Le Grice notes in her thesis: “Abortion is a very controversial topic for contemporary Māori and the present research will be the first empirical study on Māori perspectives, experiences and engagements with health services in this area”: Jade Sophia Le Grice “Māori and reproduction, sexuality education, maternity, and abortion” (Doctoral thesis for the degree of Doctor of Philosophy in Psychology, University of Auckland, 2014) at 2.

⁸² This is discussed in the *ASC Standards of Care* at 13; and in Jade Sophia Le Grice “Māori and reproduction, sexuality education, maternity, and abortion” (Doctoral thesis for the degree of Doctor of Philosophy in Psychology, University of Auckland, 2014) at 35. This point was also made by submitters.

⁸³ John C Moorfield *Te Aka: Māori-English, English-Māori Dictionary and Index* (Pearson, Auckland, 2011).

that those women who wish to do so can return them to the whenua.⁸⁴ Some clinics offer women an ipu⁸⁵ or other special receptacle for this purpose. However, this is not the case throughout the country. Submitters and health practitioners raised the point that barriers to access have a disproportionate impact on Māori. This is discussed in more detail in Chapter 7.

- 3.53 Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand (ALRANZ) and Family Planning New Zealand submitted a report to the 70th Committee for the Elimination of Discrimination Against Women in October 2017. The report states that the higher pregnancy, sexually transmitted infection and abortion statistics for Māori indicate timely access to culturally responsive contraceptive and reproductive health care at low or no cost is lacking.⁸⁶ It also states that the current abortion framework undermines the autonomy of women, including tino rangatiratanga over reproductive health as guaranteed by the Treaty of Waitangi; and creates an inequitable system with significant barriers to access for women, which disproportionately impact Māori.⁸⁷ This report was supported by a number of other organisations, including the Abortion Providers Group Aotearoa New Zealand (APGANZ). Similar points were made by a number of health bodies and practitioners who provided input to the Commission.

GENERAL HEALTH REGULATION

- 3.54 New Zealand has a robust and comprehensive regulatory framework for health and disability services. The framework already applies to the provision of abortion services, alongside the specific abortion regime in the CSA Act. This section sets out the regulatory framework in detail to illustrate the general health regulation that would continue to apply even if some or all aspects of the current abortion laws are repealed.
- 3.55 The New Zealand Public Health and Disability Act provides the legislative framework for the provision of public health care in New Zealand. The objectives of the public health system are to:⁸⁸
- improve, promote and protect the health of New Zealanders;
 - reduce health disparities by improving health outcomes for Māori and other population groups;
 - provide a community voice in matters relating to personal health services, public health services and disability support services; and
 - facilitate access to appropriate, effective and timely health services, and the provision of information to deliver these services.

⁸⁴ Whenua means land and also pregnancy tissue/placenta/afterbirth. Whenua ki te whenua is the practice of returning and burying the pregnancy tissue/placenta/afterbirth, often in land with an ancestral connection. See Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 320.

⁸⁵ “Container, bowl, vessel, calabash, urn, vase, mug—vessel for holding anything, but especially liquids” (John C Moorfield *Te Aka: Māori-English, English-Māori Dictionary and Index* (Pearson, Auckland, 2011).

⁸⁶ Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand (ALRANZ), and Family Planning New Zealand *Alternate Report to the 70th CEDAW Pre-sessional working group* (October 2017) at [6].

⁸⁷ At [12].

⁸⁸ New Zealand Public Health and Disability Act, s 3(1).

- 3.56 In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, the New Zealand Public Health and Disability Act provides mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health services. For example, the Act sets minimum Māori membership for DHBs and requires DHBs to maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement.⁸⁹
- 3.57 The health regulatory framework includes a range of mechanisms for ensuring adequate standards of practice and safety are maintained. Of particular relevance to the provision of abortion services, there are:
- legally enforceable rights for people accessing health services;
 - mechanisms to ensure that health practitioners are competent and fit to practise (including provision of oversight);
 - standards to ensure the adequacy and safety of health service provider facilities;
 - laws restricting the distribution and use of medicines and controlled drugs; and
 - strategies and policies to improve services, to ensure consistency of access to and provision of services, and to monitor the effectiveness of services.

Rights of people accessing health services

- 3.58 The Code of Health and Disability Services Consumers' Rights (the Code of Rights) establishes rights for people accessing health services and duties on people providing those services to ensure the rights are respected. The Code of Rights includes the right to be treated with respect, taking into account the needs, values and beliefs of different cultural, religious, social and ethnic groups (with specific reference to Māori).⁹⁰ The Code of Rights also includes the rights to receive services of an appropriate standard; to receive effective communication; to be fully informed; and to make an informed choice and give informed consent.⁹¹ Informed consent is discussed in more detail in Chapter 9.
- 3.59 The right to receive care of an appropriate standard requires health practitioners to comply with legal, professional, ethical and other relevant standards.⁹² As a result such standards may be legally enforceable through the Code of Rights.⁹³

⁸⁹ Section 4 and Part 3.

⁹⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, (Code of Rights) right 1(3).

⁹¹ Code of Rights, rights 4, 5, 6, and 7.

⁹² Code of Rights, right 4(2).

⁹³ These standards include legal standards such as service standards issued under the Health and Disability Services (Safety) Act; professional standards set by professional bodies such as colleges; ethical standards set by professional regulatory authorities; and other relevant standards, like contractual obligations and policies concerning quality of care. See the discussion in Ron Paterson "The Code of Patients' Rights" in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters) at [2.6.3].

Health and Disability Commissioner

- 3.60 The Health and Disability Commissioner promotes and protects the rights of health consumers set out in the Code of Rights.⁹⁴ The Commissioner can investigate complaints about breaches of the Code of Rights and make findings.⁹⁵ The Commissioner can also refer complaints to the Director of Proceedings (an independent person appointed by the Commissioner) to decide whether disciplinary or other proceedings or action should be taken in respect of a complaint about a health practitioner.⁹⁶
- 3.61 If the Commissioner has reason to believe that the practice of a health practitioner may pose a risk of harm to the public, or constitutes misconduct or breach of duty, the Commissioner must promptly inform the appropriate health regulatory body.⁹⁷ If the Commissioner believes that failures or inadequacies are harming, or are likely to harm, the public the Commissioner must inform the Director-General of Health.⁹⁸

Ensuring health practitioners are competent and fit to practise

- 3.62 The Health Practitioners Competence Assurance Act 2003 (HPCA Act) establishes mechanisms to ensure that health practitioners are competent and fit to practise. Health practitioners must be appropriately qualified and certified under the HPCA Act if they practise a profession where there is risk of public harm.⁹⁹ This includes doctors, nurses, midwives, psychologists, pharmacists and a number of other professions.¹⁰⁰ Only appropriately qualified and registered health practitioners are able to use these titles.¹⁰¹
- 3.63 As described below, health practitioners must work within a “scope of practice”. Scopes of practice set out the health services that a practitioner is authorised to perform.¹⁰² Certain procedures can only be performed by particular registered health practitioners permitted to do so by their scope of practice.¹⁰³ The HPCA Act also establishes the Health Practitioners Disciplinary Tribunal to hear and determine disciplinary proceedings brought against health practitioners.¹⁰⁴

⁹⁴ Health and Disability Commissioner Act 1994 (HDC Act), s 14.

⁹⁵ HDC Act, s 14.

⁹⁶ HDC Act, s 14.

⁹⁷ HDC Act, ss 34 and 39. Health regulatory bodies are discussed below at [3.64].

⁹⁸ HDC Act, ss 34 and 39. The Director-General of Health is the chief executive of the Ministry of Health.

⁹⁹ Health Practitioners Competence Assurance Act 2003 (HPCA Act), s 116.

¹⁰⁰ HPCA Act, ss 114–115.

¹⁰¹ HPCA Act, s 7.

¹⁰² HPCA Act, s 5.

¹⁰³ HPCA Act, s 3.

¹⁰⁴ HPCA Act, ss 84–85.

Health regulatory bodies: registration, oversight and scopes of practice

- 3.64 The HPCA Act provides for the appointment of health regulatory bodies.¹⁰⁵ There are 16 health regulatory bodies operating under the HPCA Act, including the Medical Council of New Zealand (the regulatory body appointed for doctors), the Nursing Council of New Zealand, the Midwifery Council of New Zealand and the Pharmacy Council.¹⁰⁶ These bodies determine the scopes of practice and required qualifications for the members of each profession.¹⁰⁷ They set standards of clinical competence, cultural competence (including in relation to the Treaty of Waitangi and Māori health¹⁰⁸) and ethical conduct.¹⁰⁹ They also issue annual practising certificates, promote education and training, and review practitioners if there are concerns about their performance or professional conduct.¹¹⁰
- 3.65 Some health regulatory bodies prescribe different scopes of practice for specialised areas to ensure practitioners in those areas are appropriately qualified. For example, the Medical Council of New Zealand has identified three categories of scopes of practice for doctors: a general scope for resident medical officers and doctors in vocational training; a vocational scope for doctors who have completed vocational training; and a special purpose scope for doctors who, for example, are teaching as a visiting expert or working as a locum. There are 36 vocational scopes, including: sexual health medicine; obstetrics and gynaecology; family planning and reproductive health; and general surgery. The Nursing Council has determined three scopes of practice for nurses (registered nurses, nurse practitioners and enrolled nurses) and the Midwifery Council has prescribed a single scope of practice for midwives.
- 3.66 Scopes of practice are reasonably broad and do not go to a procedure-specific level. For example, the scope of practice for a registered nurse includes assessing health needs and providing care, independently and with other health professionals, in a range of settings.¹¹¹ Conditions are placed in the scope of practice of some registered nurses according to their qualifications or experience, limiting them to a specific area of practice.¹¹² A doctor holding a vocational scope in obstetrics and gynaecology can diagnose and manage patients in this area, and treat and provide health care in relation to contraception, reproductive health and associated primary sexual health issues, and other reproductive issues.¹¹³

¹⁰⁵ HPCA Act, ss 114–115.

¹⁰⁶ There is also the Dental Council, the Psychologists Board and the Physiotherapy Board, among others. See the HPCA Act, ss 114–115.

¹⁰⁷ HPCA Act, s 118.

¹⁰⁸ See, for example, the Nursing Council of New Zealand *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice* (2011).

¹⁰⁹ HPCA Act, s 118.

¹¹⁰ HPCA Act, s 118.

¹¹¹ “Notice of Replacement Scope of Practice and Qualifications Prescribed by the Nursing Council of New Zealand for Registered Nurses” (26 August 2010) 6658 *New Zealand Gazette* 108 at 2916.

¹¹² “Notice of Replacement Scope of Practice and Qualifications Prescribed by the Nursing Council of New Zealand for Registered Nurses” (26 August 2010) 6658 *New Zealand Gazette* 108 at 2916.

¹¹³ “Scopes of Practice and Prescribed Qualifications for the Practice of Medicine in New Zealand 2018” (11 May 2018) *New Zealand Gazette* 2124.

Restricted activities

- 3.67 Certain activities are restricted to particular health practitioners.¹¹⁴ It is an offence for anyone other than a registered health practitioner operating within their scope of practice to perform an activity that has been designated as a “restricted activity” by Order in Council.¹¹⁵ This statutory restriction helps to ensure that medical procedures carrying a certain degree of risk are only performed by competent registered health practitioners.
- 3.68 One of the classes of restricted activities is surgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes, or teeth.¹¹⁶ This broadly covers activities that involve cutting or going below the skin or causing bleeding, which includes most surgery.¹¹⁷ It is therefore likely to cover surgical abortion, although as discussed in Chapter 6, this could be clarified to ensure certainty.

Health professional bodies: professional standards and ethical guidance

- 3.69 As well as regulatory bodies, there are professional bodies that provide education and professional development, advocacy, policies and ethical guidelines, and professional standards for their areas of practice (including direction on incorporating the principles of the Treaty). For some professions there is a main professional body that represents the entire profession and maintains the code of ethics for that profession, as well as more specialised chapters and colleges that are responsible for training, qualifications and standards for specific areas of practice.
- 3.70 For example, the New Zealand Nurses Organisation sets standards of professional practice, including the Code of Ethics, for nurses. The New Zealand Medical Association maintains and publishes the Code of Ethics for the medical profession. In order to hold one of the 36 vocational scopes, a doctor must have undertaken the required vocational training with the appropriate professional body. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), for instance, trains and accredits doctors to practise obstetrics and gynaecology. RANZCOG defines the standards of knowledge, practice and behaviour for doctors working in this area and has its own specific code of ethical practice.
- 3.71 As noted above, standards issued by professional bodies can be legally enforceable through the Code of Rights.

Consequences of failing to meet professional standards

- 3.72 The HPCA Act provides for the appointment of health regulatory bodies with a range of functions, including reviewing practitioners if there are concerns about their performance or professional conduct. Health regulatory bodies may appoint a professional conduct committee to investigate complaints received by them or referred to them by the Health and Disability Commissioner.¹¹⁸

¹¹⁴ HPCA Act, s 9.

¹¹⁵ HPCA Act, s 9(6); Health Practitioners Competence Assurance (Restricted Activities) Order 2005.

¹¹⁶ Health Practitioners Competence Assurance (Restricted Activities) Order 2005, sch, cl 1.

¹¹⁷ Ministry of Health “Guidelines for the operation of restricted activities” (22 April 2014) <www.health.govt.nz>.

¹¹⁸ HPCA Act, ss 64, 65 and 71.

- 3.73 The Health Practitioners Disciplinary Tribunal can hear and determine disciplinary proceedings brought against a registered health practitioner by a professional conduct committee or by the Director of Proceedings appointed under the Health and Disability Commissioner Act 1994.¹¹⁹ For example, this may occur if a health practitioner acts outside the relevant scope of practice or fails to meet the standards expected of the profession.¹²⁰
- 3.74 A Tribunal panel is made up of lawyers, professional peers of the health practitioner who is the subject of the hearing, and a layperson.¹²¹ The Tribunal first considers whether the practitioner has departed from acceptable standards of professional conduct, being the standards applied by competent, ethical and responsible practitioners of that profession. It then considers whether that departure was significant enough to attract a sanction to protect the public.
- 3.75 If the Tribunal finds there are grounds to make a disciplinary finding against a practitioner,¹²² it can cancel or suspend the practitioner's registration, order a period of supervised practice, censure the practitioner, fine the practitioner up to \$30,000, or order the practitioner to pay the costs and expenses of the inquiry and proceedings.¹²³

Ensuring adequacy and safety of health service provider facilities

- 3.76 Under the Health and Disability Services (Safety) Act 2001 (HDSS Act), specified providers of health and disability services including hospitals, rest homes and providers of residential disability care¹²⁴ must be certified by the Director-General of Health.¹²⁵ In order to be certified, service providers must be audited and show they comply with service standards approved by the Minister of Health.¹²⁶ Additional health care services can be brought within the regime in the HDSS Act by Order in Council.¹²⁷
- 3.77 Service standards can cover a broad range of matters, including:¹²⁸
- statements on how care should be provided and appropriate outcomes;
 - technical recommendations or specifications for particular aspects of providing services or for equipment, facilities, good or materials used in providing services; and
 - minimum numbers of nursing or other staff that must be on duty, and the minimum qualifications they must have.

¹¹⁹ HPCA Act, s 91; HDC Act, s 15. See also s 49 of the HDC Act.

¹²⁰ HPCA Act, s 100.

¹²¹ HPCA Act, ss 86–88.

¹²² HPCA Act, s 100.

¹²³ HPCA Act, s 101.

¹²⁴ Health and Disability Services (Safety) Act 2001 (HDSS Act), s 4.

¹²⁵ HDSS Act, ss 9 and 26–27.

¹²⁶ HDSS Act, ss 9 and 26–27.

¹²⁷ HDSS Act, s 7.

¹²⁸ HDSS Act, s 21.

- 3.78 The HDSS Act certification regime does not currently apply to abortion services (unless they are provided in a facility intended to accommodate two or more women at a time for more than 24 hours in order to provide the service) or to other day surgery procedures.
- 3.79 Service providers that are not required to be certified, such as medical centres and Family Planning clinics, are subject to a range of other standards and requirements, including under the Health and Safety at Work Act 2015; relevant professional standards, such as the Royal New Zealand College of General Practitioners mandatory quality standards framework for general practices;¹²⁹ and service specifications.

Laws restricting the distribution and use of medicines and controlled drugs

- 3.80 There are a number of laws restricting the distribution and use of medicines and controlled drugs, including the Medicines Act 1981, the Misuse of Drugs Act 1975 and the Psychoactive Substances Act 2013. These laws reflect the serious risk of harm to the public from untested or unsafe medicines and substances.
- 3.81 The Ministry of Health is responsible for the regulation of medicines and medical devices. Medsafe, a business unit of the Ministry, is responsible for administering the Medicines Act and associated regulations; ensuring safety standards; monitoring drug reactions; handling investigations and recalls; and licensing and auditing medicine manufacturers. The Ministry also oversees the distribution chain of medicines and controlled drugs within New Zealand.
- 3.82 The Medicines Act limits who can prescribe and supply prescription medication (including the medications used for medical abortion, mifepristone and misoprostol).¹³⁰
- 3.83 In 2014, the Medicines Amendment Act 2013 and Misuse of Drugs Amendment Regulations 2014 came into effect. These amendments provide for nurse practitioners and optometrists to be authorised prescribers. They also create a new delegated prescriber category, which enables registered health practitioners to prescribe in limited settings under the sanction of an authorised prescriber. For example, a registered nurse working in a general practice could be a delegated prescriber under the sanction of a general practitioner, with specific conditions and restrictions on prescribing. The amendments also enable nurse practitioners and midwives to prescribe a wider range of controlled drugs, and allow controlled drugs prescriptions to be generated electronically.

Strategies and policies to improve and monitor services and ensure consistency

- 3.84 The Ministry of Health develops high level strategies and policies for health and disability services, such as the Māori Health Strategy, *He Korowai Oranga*. Ministry of Health strategies identify guiding principles and key steps required to achieve desired outcomes.¹³¹ The strategies are developed in conjunction with DHB services specifications (explained below) and funding priorities, and are often accompanied by more specific action plans and policies.

¹²⁹ The Royal New Zealand College of General Practitioners Te Whare Tohu Rata o Aotearoa “Quality Standards: Foundation Standard” at <www.rncgp.org.nz>.

¹³⁰ Medicines Act 1981, Part 2. Mifepristone and misoprostol are both prescription medicines (see Medsafe “Classification Database” (23 August 2018) <www.medsafe.govt.nz>).

¹³¹ The key strategies are The New Zealand Health Strategy, The New Zealand Disability Strategy, and He Korowai Oranga.

3.85 The Ministry of Health also develops policies in relation to specific health and disability issues. These policies aim to improve services, ensure consistency of service access and provision, and provide a means of assessing the effectiveness of the actions taken by health and disability providers. For example, the Ministry of Health has developed care standards for the National Cervical Screening Programme.¹³² The Ministry is shortly to update its 2001 Sexual and Reproductive Health Strategy with a Sexual and Reproductive Health Action Plan for health care organisations,¹³³ including developing policies on delivering health care to people who are transgender/gender diverse.¹³⁴

The Nationwide Service Framework: Service Specifications

3.86 The Nationwide Service Framework is a set of guidelines used by the Ministry of Health and DHBs. Service specifications are part of this framework.

3.87 Nationwide service specifications form part of funding agreements for publicly funded services. They are developed where a level of national consistency is required for a service delivered by the public system.¹³⁵ Service specifications include a range of matters, such as:¹³⁶

- service-specific requirements to be applied consistently throughout the sector;
- consistent quality requirements;
- reporting requirements to collect information for service analysis and planning;
- methods for benchmarking and auditing; and
- clarity around the components of services and linkages between related services.

3.88 Nationwide service specifications usually have either a mandatory or recommended status and are tiered to avoid repetition where elements are common to a group or range of services:¹³⁷

- Tier 1 specifications contain overarching generic principles and common content;
- Tier 2 specifications have elements specific to that particular service; and
- Tier 3 specifications contain specific service descriptions.

3.89 For example, there are overarching mandatory Tier 1 specifications for specialist medical and surgical services (which include specialist sexual and health services),¹³⁸ and mandatory Tier 2 specifications specifically for sexual health services.¹³⁹ The Tier 1 specifications include specific provisions recognising obligations in relation to Māori involvement in development and delivery of health services, reducing Māori health inequalities and increasing access to services. There are also non-mandatory service specifications for Māori health services entering into agreements with DHBs. They include

¹³² Ministry of Health *National Cervical Screening Programme Policies and Standards* (2017).

¹³³ Ministry of Health *Sexual and Reproductive Health Strategy: Phase One* (October 2001).

¹³⁴ Ministry of Health “Delivering health services to transgender people” (17 July 2018) <www.health.govt.nz>.

¹³⁵ Nationwide Service Framework Library “About Service Specifications” (18 April 2018) <www.nsf.health.govt.nz>.

¹³⁶ Nationwide Service Framework Library “About Service Specifications” (18 April 2018) <www.nsf.health.govt.nz>.

¹³⁷ Nationwide Service Framework Library “About Service Specifications” (18 April 2018) <www.nsf.health.govt.nz>.

¹³⁸ Ministry of Health *Specialist Medical and Surgical Services – Tier Level One Service Specification* (April 2016).

¹³⁹ Ministry of Health *Specialist Medical and Surgical Services – Sexual Health Tier Level Two Service Specification* (2001).

specifications relating to the delivery of sexual health education services for Māori, promotion of sexual health services and advocacy to target Māori health inequalities.¹⁴⁰

- 3.90 New service specifications can be developed for publicly funded services in cases where a level of national consistency is required. The Ministry of Health, DHBs, relevant agencies and health practitioners work together to develop service specifications.
- 3.91 The Ministry of Health can also issue standards for specific health services, such as maternity services,¹⁴¹ that underpin the service standards and provide guidance on planning, funding and monitoring of services by the Ministry of Health and DHBs.
- 3.92 The standards of care for abortion services are currently issued by the Abortion Supervisory Committee, which is administered by the Ministry of Justice, rather than by the Ministry of Health.

Funding

- 3.93 The public health system devolves a majority of Vote Health funding to DHBs through the Crown Funding Agreement, in which DHBs agree to ensure services are funded to meet the needs of their population.¹⁴² DHBs are responsible for:¹⁴³
- assessing and monitoring the needs of their resident population;
 - planning, delivering and monitoring services;
 - providing hospital care;
 - funding services in the community through monitored service agreements;
 - issuing information to improve, protect and promote the health of their resident population in order to ensure the provision of services; and
 - establishing processes for Māori participation in and contribution to strategies for Māori health improvement, and fostering development of Māori capacity to participate in the health sector.
- 3.94 The Ministry of Health also funds some important national services directly—for example, primary maternity services, mental health services and a number of screening programmes.¹⁴⁴

¹⁴⁰ Ministry of Health *Māori Health Service Specifications: Sexual Health Educator Service* (2012).

¹⁴¹ Ministry of Health *New Zealand Maternity Standards: A set of standards to guide the planning, funding and monitoring of maternity services by the Ministry of Health and District Health Boards* (2011).

¹⁴² New Zealand Public Health and Disability Act, s 23(1).

¹⁴³ New Zealand Public Health and Disability Act, s 23(1).

¹⁴⁴ Ministry of Health “Funding” (11 July 2016) <www.health.govt.nz>.

Part One

Alternative legal models for treating abortion as a health issue

CHAPTER 4

Three models for when abortion would be lawful

INTRODUCTION

- 4.1 This chapter sets out three alternative legal models for determining when abortion would be lawful. They are referred to as Models A, B and C. The issues discussed in Part Two of this briefing paper are common to all three models. The Law Commission suggests the same approach could be taken to those issues irrespective of which of the three models may be preferred.
- 4.2 One of the models (Model A) would remove all specific regulation of abortion. Abortion would be treated like other health services, which are governed by general health laws and professional guidance.
- 4.3 The other two models would require an appropriately qualified health practitioner to be satisfied the abortion is appropriate, either in all cases (Model B) or only for abortions performed after 22 weeks gestation (Model C).
- 4.4 The key features of the three models are summarised in the table below. The discussion that follows examines the extent to which each model is likely to align with the Minister's proposed approach of treating abortion as a health issue.
- 4.5 The Commission tested the three models with health practitioners and professional bodies, abortion service providers and the Ministry of Health. Their feedback is reflected in this chapter. They did not propose any alternative models.
- 4.6 Several changes to the current law would be required under all three of the models. The models all assume the repeal of:
- the current grounds for abortion in the Crimes Act 1961; and
 - the requirement for abortions to be authorised by two certifying consultants.

The reasons for these changes are set out in Chapter 5.

ALTERNATIVE LEGAL MODELS FOR WHEN ABORTION WOULD BE LAWFUL

<p>Model A</p>	<ul style="list-style-type: none"> • There would be no statutory test that must be satisfied before an abortion could be performed. • The decision whether to have an abortion would be made by a woman in consultation with her health practitioner.
<p>Model B</p>	<ul style="list-style-type: none"> • A statutory test would need to be satisfied before an abortion could be performed, but the test would be in health legislation rather than the Crimes Act. • <i>The statutory test:</i> the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman’s physical and mental health and wellbeing.
<p>Model C (combines aspects of Models A and B)</p>	<p><i>For pregnancies of not more than 22 weeks gestation—same as Model A</i></p> <ul style="list-style-type: none"> • There would be no statutory test that must be satisfied before an abortion could be performed. • The decision whether to have an abortion would be made by a woman in consultation with her health practitioner. <p><i>For pregnancies of more than 22 weeks gestation—same as Model B</i></p> <ul style="list-style-type: none"> • The same statutory test as in Model B would need to be satisfied before an abortion could be performed. The test would be in health legislation rather than the Crimes Act. • <i>The statutory test:</i> the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman’s physical and mental health and wellbeing.

Model A

There would be no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s). General health law would apply to ensure services are provided safely and in line with best practice.

MOST HEALTH SECTOR REPRESENTATIVES SUPPORTED MODEL A

- 4.7 Health practitioners and professional bodies the Commission consulted were almost unanimous in supporting Model A.¹ They considered it would be most consistent with a health approach, because it would make abortion a matter between a woman and her health practitioner—like other health services. A number of other submitters also felt that abortion should be a private matter between a woman and her health practitioner.
- 4.8 The arguments advanced by health practitioners, professional bodies and other submitters in support of Model A included:
- women should be trusted to make decisions about what is best for their situation, with appropriate support. They are in a better position to do so than a health practitioner who may know little about the woman's circumstances.
 - Model A would help to reduce unnecessary delays, allowing abortions to be performed at earlier gestations, which is safer for women.
 - removing legal restrictions and destigmatising abortion would encourage more health practitioners to become involved in abortion care, which in turn would help to make services more accessible.
- 4.9 The Abortion Supervisory Committee (ASC) also supported Model A. The Ministry of Health did not take a position but noted there is already a general regulatory framework for health and disability services, and additional regulations for abortion are medically unnecessary.

MODEL A WOULD TREAT ABORTION LIKE OTHER HEALTH SERVICES

Promoting women's autonomy

- 4.10 Model A would prioritise the autonomy of women to make an informed decision about what is appropriate for them in the circumstances. It would treat women as fully competent to weigh the competing considerations involved in the abortion decision, with support from health practitioners and other support services (such as social workers and/or counsellors) where appropriate.

¹ This included the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the New Zealand Nurses Organisation (NZNO), the New Zealand College of Midwives and the Abortion Providers Group Aotearoa New Zealand (APGANZ). As discussed below, however, there was some support for Model C from maternal fetal medicine specialists at the Auckland District Health Board.

- 4.11 This approach would align with the principles that underlie the provision of health services generally, as set out in health regulatory laws and the codes of ethics that apply to health practitioners. These principles require health practitioners to respect the autonomy of individual patients to make informed decisions.²
- 4.12 Model A would treat abortion in the same way as most other health services, which are not restricted by statutory criteria and do not require legal authorisation.³ Instead, patient safety and wellbeing is protected through the general health regulatory framework that applies to all health services.⁴
- 4.13 The Privacy Commissioner noted that abortion is already regulated in a health context and removal of specific laws “better reflects the privacy right integral to exercising choice over abortion as a medical procedure, without over-regulating it comparative to other similar procedures”.

Improving access to services

- 4.14 Adopting Model A would promote the safety and wellbeing of women seeking abortions and may help to improve access to abortion services.
- 4.15 The current statutory restrictions on abortion single it out as being different to other health services and raise issues around its legality. Many health practitioners the Commission spoke to and members of the public who made submissions referred to the stigma surrounding abortion. They said this stigma can discourage health practitioners from providing abortion services and make the experience of getting an abortion more distressing for women. They felt that treating abortion like other health services would make it safer and more accessible.
- 4.16 Health professional bodies also said the separation of abortion from other health services means that health practitioners are not routinely trained in abortion care, which presents workforce challenges and impacts on the availability of services.
- 4.17 Some women who made submissions said they had difficulty accessing abortion services in a timely way because there was a shortage of doctors performing abortions in their area.

² New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 2 and 4; New Zealand Nurses Organisation *Code of Ethics* (2010) at 12 and 15; New Zealand College of Midwives “Philosophy and Code of Ethics” <www.midwife.org.nz>. Under the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, sch, cl 2, patients have a right to receive services that comply with professional and ethical standards (right 4(2)). They also have a right to have services provided in a manner that respects their dignity and independence (right 3).

³ A small number of medical procedures or classes of medical research are restricted by statute in some way. For example, the Human Assisted Reproductive Technology Act 2004 prohibits certain activity (such as implanting cloned or genetically modified embryos and selecting embryos on the basis of sex—ss 8 and 11) and requires approval from an ethics committee for procedures that are not “established procedures”. Most fertility treatment is, however, deemed an established procedure and does not require approval: Human Assisted Reproductive Technology Order 2005. The End of Life Choice Bill 2017 (269–1) currently before Parliament would, if enacted, require medical practitioner approval of assisted dying in accordance with statutory eligibility criteria. The Mental Health (Compulsory Assessment and Treatment) Act 1992 also sets out a statutory process for compulsory treatment of people with mental disorders.

⁴ The general health regulatory framework is set out in Chapter 3.

- 4.18 Adopting Model A would help to normalise abortion as a part of general health services and reduce the stigma associated with it. This may, in turn, improve access to abortion services and allow abortions to be performed earlier in pregnancy. Earlier abortions are safer, less complex and less costly than those performed at later gestations.⁵

A SIMILAR APPROACH IS TAKEN IN SOME OTHER JURISDICTIONS

- 4.19 Model A is similar to the law in Canada and the Australian Capital Territory. In both of these jurisdictions abortions can lawfully be performed at any gestation without needing to satisfy any statutory grounds.⁶

- 4.20 Worldwide, there has been a general trend over the past decade of removing or widening the grounds for abortion. According to a report by the United Nations Department of Economic and Social Affairs in 2014:⁷

In 2013, slightly over one third (36 per cent) of Governments permitted abortion for economic or social reasons, up from 31 per cent in 1996, while 30 per cent of Governments allowed abortion upon request, up from 24 per cent in 1996.

- 4.21 As noted in Chapter 3, international human rights law supports the removal of third party authorisation requirements and other statutory restrictions on abortion.⁸

OTHER FACTORS TO CONSIDER IN RELATION TO MODEL A

- 4.22 Many members of the public submitted that abortion is different to other health services because it involves ending the life of a fetus, and it is therefore appropriate to have specific laws governing it. Model A would not address societal concerns about protecting the life of the fetus through a legal framework.

- 4.23 As is the case for all health services, Model A would not compel health practitioners to perform abortions. It would be open to health professional bodies to develop guidance about when abortion is medically appropriate. As is currently the case, abortion service providers would also be able to choose up to what gestation they would perform

⁵ World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) at 21 (Figure 1.2) (referring to mortality data from the United States); Martha Silva, Rob McNeill and Toni Ashton “Factors affecting delays in first trimester pregnancy termination services in New Zealand” (2011) 35(2) *Aust N Z J Public Health* 140 at 140; Standards Committee to the Abortion Supervisory Committee *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*) at [6.4].

⁶ The law in Australian Capital Territory was amended in 2002 (Crimes (Abolition of Offence of Abortion) Act 2002 (ACT)). In Canada, the section in the Criminal Code that previously restricted abortion (Criminal Code, RSC 1985, c C-64, s 287—formerly s 251) was struck down by the Supreme Court in *R v Morgentaler* [1988] 1 SCR 30 (SCC). It was found to be inconsistent with cl 7 of the Charter of Rights and Freedoms—the right to life, liberty and security of the person—because it interfered with a woman’s bodily integrity and autonomy in a manner that could not be demonstrably justified in a free and democratic society. The majority of the court in *Morgentaler* did not, however, recognise a positive right to access abortion. Rather, cl 7 of the Charter was seen as protecting against government interference through the criminal law. (See Rachael Johnstone and Emmett Macfarlane “Public Policy, Rights, and Abortion Access in Canada” (2015) 51 *IJCS* 97 at 101–102.)

⁷ United Nations Department of Economic and Social Affairs, Population Division *Abortion Policies and Reproductive Health around the World* ST/ESA/SER.A/343 (2014) at 6.

⁸ See, for example, United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* E/C.12/GC/22 (2016) at [40]–[41]; United Nations Committee on the Elimination of Discrimination Against Women *Concluding Observations of the Committee on the Elimination of Discrimination against Women: New Zealand* CEDAW/C/NZL/CO/7 (2012) at [33]–[34].

abortions and in what circumstances. Other aspects of the health system, including funding and staffing matters, would also affect the availability of services.⁹

- 4.24 The removal of legal restrictions on abortion would not therefore guarantee ready access to abortion services at all gestations. For example, in Canada access to services remains variable, particularly at later gestations, despite the removal of legal restrictions on abortion.¹⁰ As discussed in Chapter 8, however, there are non-legislative mechanisms that could be used to improve access to services.
- 4.25 Some submitters expressed concern that if the grounds for abortion are removed there would be insufficient checks and balances in the system to ensure women receive appropriate support (such as counselling) to make a fully informed decision. As discussed in Chapter 9, however, the Commission considers there are already sufficient protections in place under general health law to ensure patients are appropriately supported to make informed decisions.

⁹ This is discussed further in Chapters 7 and 8.

¹⁰ Jeanelle N Sabourin and Margaret Burnett “A Review of Therapeutic Abortions and Related Areas of Concern in Canada” (2012) 34(6) JOGC 532; Rachael Johnstone and Emmett Macfarlane “Public Policy, Rights, and Abortion Access in Canada” (2015) 51 IJCS 97.

Model B

The health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing. This test would be set out in the Contraception, Sterilisation, and Abortion Act 1977 (or a replacement enactment) rather than the Crimes Act 1961.

MODEL B IS THE MOST RESTRICTIVE OPTION

4.26 Model B contains the most significant statutory restrictions on abortion of the three models. It would require an appropriately qualified health practitioner to be satisfied that a statutory test for abortion is met.¹¹ This requirement would apply at all gestations. Unlike the current grounds for abortion in the Crimes Act, however, non-compliance would not be a criminal offence.¹²

THE PROPOSED STATUTORY TEST WOULD PRIORITISE WOMEN'S HEALTH AND WELLBEING

4.27 The statutory test in Model B would leave significant discretion to health practitioners to have regard to all the circumstances of an individual case. This reflects the view, expressed to the Commission by many health practitioners and submitters, that a wide range of factors may be relevant to a woman's decision to have an abortion and these cannot be comprehensively listed in legislation.

4.28 Many health practitioners emphasised that listing the specific circumstances in which abortions can be performed in statute can result in injustice. There will always be unforeseen circumstances in which a woman does not meet the pre-determined grounds, but forcing her to continue the pregnancy would be detrimental to her health and wellbeing. For example, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) said in its submission:

No specific clinical circumstance should qualify or not qualify a woman for termination of pregnancy. The impact of any particular condition is highly individual and often complex. No list can be complete and becomes highly restrictive in the most complex of circumstances.

4.29 The test in Model B does, however, require the health practitioner to have regard to the woman's physical and mental health and wellbeing. This would provide clear statutory recognition that this should be the health practitioner's primary focus.

4.30 While most health services do not have statutory criteria requiring health practitioners to consider the patient's health and wellbeing, such a requirement is consistent with the general health regulatory framework and the ethical principles underlying medical care. For example, the New Zealand Medical Association's *Code of Ethics* requires doctors to "[c]onsider the health and well being of the patient to be your first priority".¹³ Under the

¹¹ We discuss which health practitioners should be able to perform abortions in Chapter 7.

¹² The criminal aspects of abortion law are discussed in Chapter 6.

¹³ New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 4 (principle 1).

Code of Health and Disability Services Consumers' Rights, patients also have the right to receive services in a manner that optimises their quality of life.¹⁴

HEALTH PRACTITIONERS WOULD MAKE THE FINAL DECISION

- 4.31 Another key feature of Model B is that health practitioners would need to be satisfied an abortion meets the legal requirements before it could be performed. As under the current law, the health practitioner, rather than the woman seeking the abortion, would have the final decision-making power.
- 4.32 The Model would, however, remove some of the barriers that currently exist for women seeking an abortion. Only one health practitioner—the practitioner who will perform the abortion—would need to be satisfied the abortion is appropriate. The current grounds for abortion would also be replaced with a single statutory test that would prioritise the health and wellbeing of the woman seeking an abortion.
- 4.33 The test does not limit the matters the health practitioner could take into account when assessing whether an abortion is appropriate in the circumstances. It would be open to professional bodies to develop guidance to assist health practitioners and encourage a consistent approach.
- 4.34 Having such a statutory test would prompt the health practitioner to have a discussion with the woman about her reasons for seeking an abortion. Some health practitioners and submitters suggested this exercise may in itself be of assistance to some women. It would provide an opportunity for women to disclose concerns around violence or coercion and access further support if they want it. A small number of individual health practitioners the Commission spoke to saw some value in retaining a statutory test for this reason.

THE WORDING OF THE PROPOSED STATUTORY TEST IN MODEL B

Why the test differs from the current grounds for abortion in the Crimes Act

- 4.35 Many people who shared their views with the Commission, including health practitioners, believed the “serious danger to mental health” ground in section 187A is already broadly interpreted by many doctors.¹⁵ In 2016, 97 per cent of abortions performed were authorised under the “serious danger to mental health” ground.¹⁶ Some submitters suggested the broad interpretation of this ground means the current law is sufficient to enable abortion to be treated as a health issue, so reform is unnecessary.
- 4.36 “Mental health” is not defined in the Crimes Act. The ASC has, however, indicated it is comfortable with certifying consultants applying the World Health Organization (WHO) definition of health.¹⁷ WHO defines health as “a state of complete physical, mental and

¹⁴ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, right 4(4).

¹⁵ The current grounds for abortion in section 187A, and the reasons why all three models would involve their repeal, are discussed further in Chapter 5.

¹⁶ *Report of the Abortion Supervisory Committee* (Annual Report, 2017) at 21.

¹⁷ Abortion Law Reform Association of New Zealand “The Definition of Mental Health” (11 October 2017) <www.alranz.org> (referring to a letter sent by the ASC to Dr Helen Paterson dated 3 August 2017). On inquiry by the Commission, the Abortion Supervisory Committee confirmed it was comfortable with the application of the WHO definition.

social well-being and not merely the absence of disease or infirmity.”¹⁸ This definition is consistent with the general ethical principles that underlie medical practice¹⁹ and has been endorsed in a government health strategy.²⁰ The Commission considers its adoption to be in line with a health approach to abortion.

- 4.37 The wording of the current “mental health” ground in section 187A of the Crimes Act, however, makes it unclear whether a broad definition of “health” is intended. The ground requires a “serious danger” to mental health, which suggests evidence of a probable and significant adverse health outcome is required.²¹ This may discourage a holistic approach to patient health and wellbeing, as envisaged by the WHO definition and medical best practice.
- 4.38 It is also noted that the Royal Commission report that led to the enactment of the current abortion laws explicitly rejected the WHO’s definition of “health”.²² Instead, it considered health should be defined as “a condition of physical and mental soundness”²³ and should not include socio-economic factors.²⁴
- 4.39 While it appears the broader WHO definition of “health” is often applied in practice, the Commission considers the law could be clarified to confirm that is the intended approach if abortion is to be treated as a health issue. Health practitioners should not be placed in a position of being uncertain what is required to comply with the law.
- 4.40 If a broader assessment of the woman’s health and wellbeing is required by legislation, the other grounds currently listed in section 187A would be unnecessary. The circumstances referred to in those grounds (for example, serious fetal abnormalities and pregnancies resulting from rape or incest) are likely to impact on the woman’s health and wellbeing in any case.²⁵
- 4.41 There is also a more substantive concern with the current ground that permits abortion where there is a substantial risk the child would be “so physically or mentally abnormal as to be seriously handicapped” (in modern medical terms, where there is a serious fetal abnormality). As some submitters observed, recognising fetal abnormality as a ground for abortion in itself risks devaluing the lives of people with disabilities.²⁶

¹⁸ World Health Organization *Promoting Mental Health: Summary Report* (2004) at 12.

¹⁹ See, for example, the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, sch, cl 2, right 4(4) (consumers have a right to have services provided in a manner that optimises their quality of life); New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 4, principle 1 (“consider the health and well being of the patient to be your first priority”).

²⁰ Minister of Health *New Zealand Health Strategy: Future Direction* (Ministry of Health, 2016) at 4; New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 2 and 4 (principles 1 and 8).

²¹ The Royal Commission, in recommending this approach, stated “[i]t would be wrong, on the view which we have taken of the status of the unborn child, to terminate a pregnancy because of some psychological stress which was relatively short in duration or of relatively mild intensity”: Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 270.

²² At 204 and 270.

²³ At 270.

²⁴ At 271–272.

²⁵ Indeed, this is why at least some of the grounds were inserted: Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 211.

²⁶ See also Committee on the Rights of Persons with Disabilities *Comments on the draft General Comment No.36 of the Human Rights Committee on article 6 of the International Covenant on Civil and Political Rights* (2017); Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at [3.91]–[3.95]; Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at [3.138]–[3.140] and [3.202].

4.42 The Commission considers that fetal abnormality should not be a specific ground for abortion. Rather, it is preferable to consider each case holistically, taking into account the fetus' chance of survival without substantial morbidity and impairment, as well as the potential impact on the woman and/or her family. The same view was taken by the Law Reform Commissions of Victoria and Queensland in rejecting fetal abnormality as a specific statutory ground for abortion.²⁷

Basis of the proposed test

4.43 Under the proposed statutory test in Model B, the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.

4.44 The test directs the health practitioner to consider whether the abortion is appropriate, rather than setting out specific circumstances in which abortions can be performed. This means the assessment would be made from a health perspective, rather than a legal one.

4.45 The test provides some continuity with the "serious danger to physical and mental health" ground in the current section 187A of the Crimes Act, which health practitioners are already accustomed to. The removal of the "serious danger" requirement and the new reference to "wellbeing" would, however, make it clear that a broader assessment of health and wellbeing is envisaged. The reference to "wellbeing" is based on broader health sector guidance, including the ethical principles and WHO definition of "health" discussed above.²⁸

4.46 The requirement for a health practitioner to be satisfied the abortion is "appropriate in the circumstances" is similar to wording found in the laws of Victoria and the Northern Territory (although in Victoria the requirement only applies to abortions after 24 weeks gestation).²⁹ In those jurisdictions, a health practitioner must consider an abortion is "appropriate in all the circumstances", having regard to:

- all relevant medical circumstances;
- the woman's current and future physical, psychological and social circumstances; and
- professional standards and guidelines (in the Northern Territory only).

4.47 The reference in the Model B test to the woman's physical and mental health and wellbeing is broad enough to encompass consideration of all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances. An express requirement to consider professional standards and guidelines is unnecessary, as health practitioners are already required to do so under general health law.³⁰

4.48 An "appropriate in the circumstances" test would allow health practitioners to take an individualised approach to each case and apply best practice guidance, which may evolve over time.

²⁷ Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at [3.94]–[3.95]; Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at [3.202].

²⁸ At [4.30] and [4.36].

²⁹ Abortion Law Reform Act 2008 (Vic), s 5; Termination of Pregnancy Law Reform Act 2017 (NT), s 7.

³⁰ As discussed in Chapter 3.

MODEL B DIFFERS FROM APPROACHES TAKEN IN OTHER JURISDICTIONS

4.49 None of the jurisdictions the Commission has examined that have reformed their abortion laws in recent years have adopted an approach similar to Model B (that is, applying the same statutory test at all gestations). They have either:

- removed the requirement to meet a statutory test for abortion at all gestations, making abortion a decision for a woman in consultation with her health practitioner (as in Model A);³¹ or
- removed the requirement to meet a statutory test up to a certain gestation, while retaining a statutory test for abortions performed at later gestations (as in Model C);³² or
- adopted a multi-tiered approach, with different grounds for abortion applying at different gestations.³³

4.50 As discussed above, however, the wording of the proposed statutory test in Model B (and in Model C after 22 weeks) is similar to the test adopted in some other jurisdictions.

OTHER FACTORS TO CONSIDER IN RELATION TO MODEL B

Model B may be considered inconsistent with a health approach to abortion

4.51 While Model B would prioritise the health and wellbeing of women seeking abortions, it arguably would not treat abortion as a health issue in other respects.

4.52 First, it would treat abortion differently to most other health services, which are not restricted by statutory criteria and do not require legal authorisation.³⁴ The decision whether to undergo a medical procedure is usually made by the patient in consultation with their health practitioner, based on a broad assessment of what is appropriate in the patient's individual circumstances. The risks associated with medical procedures are managed through professional standards and the general health regulatory framework.

4.53 Second, it would not give women autonomy. Model B would expressly reserve the final decision about the abortion for the health practitioner who will perform it. This is inconsistent with the general approach taken to health care and, arguably, with international human rights instruments.

4.54 As discussed in relation to Model A, health regulatory laws and codes of ethics require health practitioners to respect the autonomy of individual patients to make informed decisions.³⁵ Patients also have a right to have services provided in a manner that

³¹ As in Canada (under *R v Morgentaler* [1988] 1 SCR 30 (SCC)) and Australian Capital Territory (Crimes (Abolition of Offence of Abortion) Act 2002 (ACT)).

³² As in Victoria (Abortion Law Reform Act 2008 (Vic)) and Tasmania (Reproductive Health (Access to Terminations) Act 2013 (Tas)). This approach was also recently recommended in Queensland (Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018)) and has been adopted in the Termination of Pregnancy Bill 2018 (Qld) currently before the Queensland Parliament.

³³ As in the Northern Territory (Termination of Pregnancy Law Reform Act 2017 (NT)) and Western Australia (Health (Miscellaneous Provisions) Act 1911 (WA), s 334). The Commission has not included such a model in this briefing paper.

³⁴ A small number of medical procedures or classes of medical research are restricted by statute in some way: see footnote 3 above.

³⁵ New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 2 and 4; New Zealand Nurses Organisation *Code of Ethics* (2010) at 12 and 15; New Zealand College of Midwives "Philosophy and Code of Ethics" <www.midwife.org.nz>. Under the Health and Disability Commissioner (Code of Health and Disability

respects their dignity and independence.³⁶ United Nations commentary on international human rights instruments that New Zealand has ratified encourages removal of third party authorisation requirements for abortion, as they interfere with women's autonomy and bodily integrity.³⁷

- 4.55 Some health practitioners the Commission spoke to questioned why they should be the ones to assess whether abortion is in the best interests of the woman. They considered the woman is in the best position to assess what is right for her in her individual circumstances. The health practitioner who will perform the abortion will often have just met the woman and may not have a thorough appreciation of her circumstances. A number of submitters expressed similar views.

A statutory test and authorisation requirement for abortion may be redundant

- 4.56 Health practitioners are already required by their general professional obligations to have regard to patients' health and wellbeing.³⁸ They do not perform procedures they consider to be inappropriate, as this would breach their obligation to minimise harm to, and optimise the quality of life of, the patient.³⁹ It is therefore arguable that the statutory test in Model B would have little practical difference to Model A in terms of the circumstances in which abortions would be performed.
- 4.57 As noted above, one reason Model B might be preferred is that it would help to ensure health practitioners continue to have a conversation with the woman about her circumstances and needs. However, a statutory approval requirement may be considered unnecessary to achieve this. Most health practitioners and professional bodies considered the informed consent requirements that exist under general health law are sufficient to ensure women have an opportunity to discuss concerns or access further support.⁴⁰
- 4.58 The Commission notes there are other aspects of health care involving difficult decisions that patients may require additional support to reach—for example, decisions about whether and how to go about the process of undertaking gender reassignment surgery. There are no statutory authorisation requirements for these decisions. They are managed according to professional guidelines⁴¹ and the regulatory requirements that apply to all health services.⁴²

Services Consumers' Rights) Regulations 1996, sch, cl 2, patients have a right to receive services that comply with professional and ethical standards (right 4(2)). They also have a right to have services provided in a manner that respects their dignity and independence (right 3).

³⁶ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, right 3.

³⁷ As discussed in Chapter 3.

³⁸ New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 4 (principle 1).

³⁹ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, right 4(4).

⁴⁰ These requirements are discussed in Chapters 3 and 9.

⁴¹ See, for example, Counties Manukau District Health Board *Gender Reassignment Services for Trans People within New Zealand: Good Practice Guide for Health Professionals* (2012).

⁴² The general health regulatory framework is discussed in Chapter 3.

Model C

For pregnancies of not more than 22 weeks gestation, there would be no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s).

For pregnancies of more than 22 weeks gestation, the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing. This test would be set out in the Contraception, Sterilisation, and Abortion Act 1977 (or a replacement enactment) rather than the Crimes Act 1961.

MODEL C CONTAINS A STATUTORY TEST ONLY AFTER 22 WEEKS

- 4.59 Model C combines aspects of Model A and Model B. Up to 22 weeks gestation, Model C would impose no specific statutory restrictions, like Model A. The decision to have an abortion would be made by the woman in consultation with her health practitioner. The model would prioritise a woman's autonomy and could improve access to abortions up to 22 weeks gestation.
- 4.60 After 22 weeks, the CSA Act (or replacement legislation) would provide that abortion is lawful on the same test put forward under Model B. The health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing.
- 4.61 As discussed below, several jurisdictions frame their abortion law around a point in a pregnancy after which abortion is restricted. This is often referred to as a "gestational limit" and expressed as a week in a pregnancy's gestation.⁴³
- 4.62 Adopting a gestational limit would reflect a view that both the abortion procedure and the reasons an abortion is sought can be increasingly complex the further the pregnancy progresses. There are several reasons why increased legal oversight may be considered appropriate for abortions at later gestations.
- **The abortion procedure is different for late term abortions:** The procedures for both medical and surgical abortion change as gestation advances.⁴⁴ In the late second and third trimester, medical abortion requires increased doses of misoprostol. After 16 weeks gestation surgical abortion may only be performed by the dilation and evacuation method.⁴⁵ The ASC *Standards of Care* state that, other than in exceptional circumstances, feticide should be part of the abortion process

⁴³ Gestation is measured from the date of the pregnant woman's last menstrual period. This method of dating the start of gestation is preferred to other methods, such as the date of conception or implantation, because it is usually easier to ascertain the date of the last menstrual period: Nicola Peart "Prevention and Termination of Life before Birth" in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters) at [19.3.4].

⁴⁴ See the discussion on abortion methods above at paragraphs [2.68]–[2.90].

⁴⁵ Described at [2.80] above.

after 22 weeks gestation as the induction of labour where there is a possibility of neonatal survival is not an abortion.⁴⁶

Clinical practice recognises that late term abortions can place psychological stresses and difficulties on both the woman and health staff and that this needs to be acknowledged in the service and provided for.⁴⁷ Some district health boards (DHBs) that provided input to the Commission explained that due to the complex factors often at play in these situations, they require a woman seeking a late term abortion to undergo counselling (whereas in most DHBs counselling is optional for earlier-term abortions).⁴⁸

- **Late term abortions have more severe side effects and higher rates of complications:** Although complications are rare for all abortions, the risks to women are greater for late term abortions. For example, as noted at [2.89] above, women undergoing late term abortions may experience more pain, and incomplete abortion and haemorrhages are more common.
- **Some consider that the interest in preserving the life of the fetus increases as the fetus develops:** Some submitters expressed the view that when a fetus has reached an advanced stage of development, there should be limits on the availability of abortion.⁴⁹ The law gives increased recognition to late term fetuses in other contexts.⁵⁰ Some submitters and commentators suggest that the relevant gestational stage should be the point at which the fetus becomes “viable”. The gestational limit and the concept of viability are discussed further below.

A SMALL NUMBER OF SPECIALIST HEALTH PRACTITIONERS SUPPORTED MODEL C

4.63 Most health practitioners and professional bodies the Commission consulted did not support Model C. RANZCOG and Professor Peter Stone (Professor of Maternal Fetal Medicine at Auckland University) expressed concern that conditions affecting a pregnancy, such as viral infections or preeclampsia, can arise at any stage of pregnancy;

⁴⁶ ASC *Standards of Care*, standard 9.9.6. Feticide involves a drug injection directly into the fetus’ cardiac ventricle to stop the heart: Royal College of Obstetricians and Gynaecologists *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales* (May 2010) at 31; Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion* (Evidence-based clinical guideline number 7, November 2011) at 57.

⁴⁷ ASC *Standards of Care* at 39.

⁴⁸ Based on information DHBs provided to the Law Commission, the Commission understands that abortion service providers in at least one DHB require women to undergo counselling for abortions at all stages of gestation.

⁴⁹ This view is also recognised elsewhere. For example, in *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516–517 per Richmond P: “[i]t would, I think, be in accordance with the thinking of a great majority of people that the further a pregnancy progresses, the more stringent should be the requirements which will justify its termination”. In the well-known United States case *Roe v Wade* 410 US 113 (1973) the Supreme Court held that at an early stage of pregnancy a woman’s right to privacy arising under the United States Constitution provided the grounds for her to have an abortion. The Court held that the right diminishes as the pregnancy progresses.

⁵⁰ Under the Births, Deaths, Marriages, Relationships Registration Act 1995, the parents of a stillborn child must register the stillbirth (s 9). The definition of stillbirth under the Act is a dead fetus that weighed more than 400g or issued from its mother after the 20th week of pregnancy (s 2). The definition of a stillborn child is broad enough to include an aborted fetus that fits the Act’s definition (as was recognised by the Victorian Law Reform Commission when reviewing equivalent legislation in Victoria (Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at 52). The Burials and Cremations Act 1964 imposes a duty to bury a stillborn child’s body as there is a duty to bury any other deceased person (s 46E). The term stillborn child has the same meaning under the Burials and Cremations Act 1964 as the Births, Deaths, Marriages, Relationships Registration Act 1995. There is no duty to bury a dead fetus of less than 400g that issued from its mother before the 20th week of pregnancy.

and a woman's physical or mental health may deteriorate after a gestational limit has passed. Setting a gestational limit may mean women feel pressured and rushed into making a decision so the abortion can be performed before the cut-off.⁵¹

- 4.64 Most health practitioners felt the law should not limit the circumstances in which a woman may have a lawful abortion later in pregnancy. Professor Stone observed that a decision to have an abortion at a late stage often involves difficult and complex issues for the woman. He submitted it was not for others to judge or proscribe the reasons a woman may have for seeking an abortion.⁵² Rather, the law should allow women to make a decision that is right for them.
- 4.65 On the other hand, a small number of health practitioners saw some advantages in a model that incorporated a gestational limit, like Model C. Auckland DHB, with input from maternal fetal medicine specialists, commented that the limited number of specialists who are qualified and experienced to perform late term abortions may wish to decline to perform feticide when a pregnancy is normal and there are no medical indications for the abortion. Legal grounds for late term abortions provide a basis for declining an abortion that is considered inappropriate by the health practitioner involved.

THE GESTATIONAL LIMIT

Approaches in other jurisdictions

- 4.66 Abortion law in several other jurisdictions includes a gestational limit. For example, the laws in Tasmania and Victoria impose no statutory restrictions for abortion before 16 weeks and 24 weeks respectively.⁵³ After the gestational limit, the law limits abortion to certain circumstances.
- 4.67 The Queensland Parliament is currently considering a Bill which, based on the recommendations of the Queensland Law Reform Commission, would introduce a gestational limit at 22 weeks.⁵⁴ The Queensland Law Reform Commission explained the reasoning behind the 22 week limit in the following way:⁵⁵

[T]he Commission recommends that the draft legislation adopt an on request gestational limit, similar to Victoria, with additional requirements applying after that time. This is a pragmatic approach that recognises community concern about terminations on request without any limits, particularly in later stages of pregnancy, by ensuring that later terminations are subject to additional oversight. It also recognises concerns that, without

⁵¹ RANZCOG guidelines note that when the diagnosis and prognosis of a condition affecting the pregnancy is uncertain at an earlier stage in pregnancy, a delay in decision-making may reduce regret and uncertainty and enable much greater precision in counselling: Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Late Termination of Pregnancy* (C-Gyn-17A, 2016) at 2.

⁵² See also British Pregnancy Advisory Service *Why Women Present for Abortions After 20 Weeks* (2017), which cites reasons women might be unaware of pregnancy or reluctant to seek abortion at an earlier stage. The study concludes that much discussion about later abortion ignores the reality and complexity of women's lives; late term abortion needs to be maintained clinically and legally.

⁵³ Reproductive Health (Access to Terminations) Act 2013 (Tas), s 4; Abortion Law Reform Act 2008 (Vic), s 4. The United Kingdom, Northern Territory and Western Australia impose a gestational limit but, unlike Tasmania and Victoria, they impose legal grounds for abortion both before and after the limits: Abortion Act 1967 (UK), s 1; Termination of Pregnancy Law Reform Act 2017 (NT), ss 7–9; Health (Miscellaneous Provisions) Act 1911 (WA), s 334.

⁵⁴ Termination of Pregnancy Bill 2018 (Qld).

⁵⁵ Queensland Law Reform Commission *Review of Termination of Pregnancy Laws*, Report No 76 (2018) at [3.183].

legislative provision, a medical practitioner may be left in uncertainty as to whether a later termination is lawful.

Why 22 weeks is suggested as a gestational limit in Model C

- 4.68 Model C suggests a gestational limit at a point where a fetus is unlikely be “viable”. In this context, viability refers to the fetus’ ability to live independently if born prematurely.
- 4.69 Several health professionals stressed to the Commission that viability cannot be accurately reflected by a single watershed moment in a pregnancy. The fetus’ chance of survival without severe poor health and impairment depends on many factors in any given pregnancy, such as the weight of the fetus, its sex, the use of antenatal corticosteroids,⁵⁶ and whether the fetus is a singleton or multiple.⁵⁷ Several medical guidelines on perinatal care for preterm births say the threshold of viability is best understood as a “grey zone”, rather than being black and white either side of a gestational limit.⁵⁸ Any gestational limit to reflect fetal viability is therefore to some extent arbitrary.
- 4.70 While recognising these concerns, the Commission’s preliminary view is that 22 weeks may be an appropriate gestational limit if the Government wishes to implement one. After 22 weeks some fetuses, if born, may survive (albeit those chances may be low and highly dependent on the circumstances of each pregnancy). The Queensland Law Reform Commission recommended a gestational limit at 22 weeks because it represents the stage immediately before the “threshold of viability” under current clinical practice.⁵⁹
- 4.71 Some health professional bodies and practitioners agreed that 22 weeks gestation was the best marker of viability. Auckland DHB, with input from maternal fetal medicine specialists, said that if there is to be a gestational limit, it would advocate for a limit at 22 weeks.⁶⁰ It observed that new national and international guidance recommends a fetus of 23 weeks gestation weighing 500g or more should be considered viable.⁶¹ The Commission recognises, however, that outcomes for babies born at this stage are highly variable, and those that do survive are at risk of moderate to severe health complications.⁶²

⁵⁶ Corticosteroids are given before birth to improve lung development and function if the fetus is at risk of preterm birth: see Antenatal Corticosteroid Clinical Practice Guidelines Panel *Antenatal Corticosteroids Given to Women Prior to Birth to Improve Fetal, Infant, Child and Adult Health: Clinical Practice Guidelines* (Liggins Institute, The University of Auckland, 2015).

⁵⁷ Lynn Gillam and others “Decision-making at the borderline of viability: Who should decide and on what basis?” (2017) 53(2) *J Paediatr Child Health* 105 at 106.

⁵⁸ At 105–106. See too Department of Health, Government of South Australia *South Australian Perinatal Practice Guidelines Perinatal Care at the Threshold of Viability* (2013); *Queensland Clinical Guidelines Perinatal Care at the Threshold of Viability* (2014).

⁵⁹ Queensland Law Reform Commission *Review of Termination of Pregnancy Laws*, Report No 76 (2018) at [3.187].

⁶⁰ RANZCOG also told the Law Commission that modern neonatal care has extended survival as low as 22 weeks, although RANZCOG did not support a model based on a gestational limit.

⁶¹ The maternal fetal medicine specialists from Auckland DHB referred to a draft consensus statement developed by the New Zealand Clinical Network for consultation: *New Zealand Clinical Network Draft New Zealand Consensus Statement on the Care of Mother and Baby(ies) at Perivable Gestation* (May 2018).

⁶² The Perinatal and Maternal Mortality Review Committee data cites studies that show that at 2 years of age, 42 per cent of babies born at 23 weeks had moderate to severe morbidity such as neurodevelopmental disability and respiratory, gastrointestinal and renal complications of prematurity: Perinatal and Maternal Mortality Review Committee *Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee* (June 2018) at 24.

- 4.72 Obstetric and neonatal care units in New Zealand and overseas appear to take an active approach to resuscitation for infants born at 23 weeks. Perinatal and Maternal Mortality Review Committee data shows that, between 2007 and 2016, resuscitation was attempted for 59 per cent of live births born at 23 weeks 0 days to 23 weeks 6 days. Half of the infants on whom resuscitation was attempted survived to 28 days.⁶³ At units in Wellington and Dunedin, resuscitation was attempted in 93 per cent and 95 per cent of cases respectively.⁶⁴ The Royal College of Obstetricians and Gynaecologists states that in the United Kingdom, based on data collected in 2006, active resuscitation is attempted for 84 per cent of infants born alive at 23 weeks 0 days to 23 weeks 6 days of gestation.⁶⁵
- 4.73 On this basis the Commission has included a gestational limit of 22 weeks in Model C. The Commission would, however, envisage further consultation occurring with appropriate specialists before any particular gestational limit is adopted, if the Government wishes to implement Model C.

OTHER FACTORS TO CONSIDER IN RELATION TO MODEL C

- 4.74 Although Model C differs from Model A, its impact on abortion practice overall is likely to be similar. Abortions performed after 22 weeks gestation account for a very small minority of the total number abortions. The table below shows the numbers and percentages of abortions performed after 20 weeks gestation each year between 2013 and 2017.

ABORTIONS PERFORMED AT 20 WEEKS GESTATION AND LATER (Number of abortions and percentage of the total number of abortions)										
Duration of pregnancy	Year									
	2013		2014		2015		2016		2017	
20 weeks	9	0.06%	14	0.11%	13	0.1%	11	0.09%	24	0.18%
21 weeks	29	0.22%	19	0.14%	19	0.14%	16	0.12%	18	0.14%
22 weeks	11	0.08%	23	0.18%	15	0.11%	22	0.17%	15	0.11%
23 weeks	11	0.08%	5	0.04%	10	0.08%	11	0.09%	15	0.11%
24 + weeks	13	0.09%	20	0.15%	13	0.1%	27	0.21%	24	0.18%

⁶³ At 24.

⁶⁴ At 25.

⁶⁵ Royal College of Obstetricians & Gynaecologists *Perinatal Management of Pregnant Women at the Threshold of Infant Viability (The Obstetric Perspective)* (Scientific Impact Paper No.41, February 2014) at 6.

- 4.75 As noted above in respect of Model B, the risks or complexities of a specific medical procedure are not usually addressed through legislation. Instead, matters such as the risks to the patient and supporting patients to make difficult decisions are typically managed through standards of care and the law that applies to health procedures generally. Some of these issues are discussed further in Chapter 8. It could be argued that a legislative test is not required to deal with the risks and complexities of the abortion procedure.
- 4.76 Some health practitioners who opposed Model C pointed out that several significant conditions affecting a pregnancy and the health of the mother could arise after the gestational limit. They suggested it would be unwise to restrict abortion when these conditions may arise. This concern is likely to be addressed to some extent by the breadth of the test that would apply after the gestational limit under Model C. The test would allow abortion when appropriate having regard to the health and wellbeing of the woman.
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CHAPTER 5

Law changes required for all three models

INTRODUCTION

5.1 The previous chapter set out three alternative legal models that could be adopted to align with a health approach to abortion. All three models would involve the repeal of the current grounds for abortion in the Crimes Act 1961 and the requirement for abortions to be authorised by two certifying consultants. This chapter explains the reasons for repealing those provisions if the Government wishes to treat abortion as a health issue.

THE GROUNDS FOR ABORTION IN THE CRIMES ACT 1961 WOULD BE REPEALED

Proposal

Repeal the current grounds for abortion in section 187A of the Crimes Act 1961.

5.2 As discussed in Chapter 1, section 187A of the Crimes Act 1961 permits abortion only where one of the following grounds is met.

Current grounds for abortion in section 187A of the Crimes Act

Grounds applying up to 20 weeks gestation:

- serious danger to the woman’s—
 - life; or
 - physical or mental health;
- “substantial risk the child, if born, would be so physically or mentally abnormal as to be seriously handicapped”;
- pregnancy is caused by incest or sexual intercourse with a dependent family member; or
- woman is “severely subnormal”.

Factors that can be taken into account in assessing whether there is a serious danger to the woman’s life or physical or mental health:

- *woman is near the beginning or end of child-bearing years; and/or*
- *pregnancy is the result of sexual violation.*

Grounds applying after 20 weeks gestation:

- abortion is necessary to—
 - save the woman’s life; or
 - prevent serious permanent injury to her physical or mental health.

The grounds are inconsistent with a health approach to abortion

- 5.3 The current grounds in the Crimes Act are inconsistent with accepted standards of professional practice. Two of the core ethical principles underlying medical treatment require health practitioners to prioritise the patient's health and wellbeing and to respect their autonomy.¹
- 5.4 By restricting the performance of abortions to specific circumstances, the grounds limit the ability of health practitioners to do what they consider is best for the health and wellbeing of each individual patient and to promote the patient's autonomy by involving them in decision-making.
- 5.5 The models set out in Chapter 4 therefore suggest that, if there is a desire to have a statutory test for abortion, it should be revised to ensure it is broad enough to allow health practitioners to take all relevant factors into account.

The language used in the grounds is outdated and inappropriate

- 5.6 Some of the language used in section 187A is outdated. Many submitters considered aspects of the language to be offensive, discriminatory or derogatory. For example, one of the grounds for abortion is that the woman is "severely subnormal".² As the Abortion Supervisory Committee (ASC) has observed, "subnormal" is now considered a derogatory term and the use of it in modern legislation is inappropriate.³ The term also no longer has any statutory definition, so its meaning is unclear.⁴ Similar criticisms can be made of the reference to a child being "so physically or mentally abnormal as to be seriously handicapped".⁵

The grounds are exceptions to the criminal abortion offences

- 5.7 The Commission suggests in Chapter 6 that the criminal offences relating to abortion should either be repealed, or amended so that they do not apply to health practitioners involved in procuring abortions or to women obtaining abortions.
- 5.8 The current grounds in section 187A are exceptions to those offences. If the offences are repealed, or confined to unqualified people who perform abortions, the exceptions would no longer serve a useful purpose and should be repealed. If there is a desire to continue to limit abortion to certain situations (as in Models B and C), the relevant statutory test should be inserted into the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) or any replacement enactment.

¹ See, for example, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, rights 4, 6 and 7; New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 2 and 4 (principles 1–2, 6 and 8).

² Crimes Act 1961, s 187A(1)(d).

³ *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 4.

⁴ "Severely subnormal" is defined by reference to section 138(2). However, as a result of an amendment to that section effected by the Crimes Amendment Act 2005, it no longer uses or defines the term (instead referring to a "significant impairment"). The failure to amend s 187A appears to be an oversight. Prior to amendment, section 138(2) defined "severely subnormal" as "incapable of living an independent life or of guarding herself against serious exploitation or common physical dangers." Under the amended section, "significant impairment" is defined as an intellectual, mental or physical condition that significantly impairs a person's capacity to understand the nature of sexual conduct; to understand the nature of or foresee the consequences of decisions about sexual conduct; or to communicate decisions about sexual conduct (s 183(6)).

⁵ Crimes Act, s 187A(1)(aa).

THE REQUIREMENT FOR AUTHORISATION BY TWO CERTIFYING CONSULTANTS WOULD BE REPEALED

Proposal

Repeal the requirement in section 29 of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be authorised by two certifying consultants, and all other provisions relating to the role of certifying consultants.

- 5.9 None of the models would require abortions to be authorised by two certifying consultants, as is required under the current law. The final decision would be made either by the woman in consultation with her health practitioner (in Model A and Model C up to 22 weeks gestation) or by the health practitioner who will perform the abortion, with the woman's informed consent (in Model B and Model C after 22 weeks gestation). Chapter 7 considers which health practitioners should be able to perform abortions.
- 5.10 Many health practitioners and professional bodies, including the Abortion Providers Group Aotearoa New Zealand (APGANZ), the New Zealand Medical Association and the Royal Australia New Zealand College of Obstetricians and Gynaecologists (RANZCOG), told the Commission that the legal requirement for two doctors to certify abortions in all cases is unnecessary from a medical perspective. Many abortions, particularly at earlier gestations, are relatively straightforward for an appropriately qualified health practitioner. Requiring approval by two certifying consultants is unnecessary to protect the woman's health in these more straightforward cases and delays access to services. Some members of the public who made submissions expressed similar views.
- 5.11 RANZCOG and maternal fetal medicine specialists at Auckland District Health Board (DHB) saw value in having more than one health practitioner involved in the abortion process, particularly in complex cases or for abortions performed at later gestations. RANZCOG considered, however, that this should be a matter of clinical practice and a legal requirement is unnecessary to ensure it happens. Health practitioners already work collaboratively with colleagues in more complex cases and this would continue to occur if the certification process for abortion is removed from legislation. The maternal fetal medicine specialists at Auckland DHB supported authorisation of most abortions by two health practitioners, but did not consider they needed to be certifying consultants.
- 5.12 If it is decided to treat abortion as a health issue, a legal requirement for two doctors to certify an abortion would be unnecessary. Health practitioners are accustomed to assessing whether a second opinion should be sought in a particular case and would continue to consult colleagues where appropriate. It is notable that much more complex surgical procedures (such as spinal and neurological surgery) have no statutory consultation or authorisation requirements.
- 5.13 The certification requirement is also costly to the state. In the year from June 2016 to June 2017, the fees paid to certifying consultants totalled \$3,940,855.⁶ Some of the duties performed by the certifying consultants would still be needed regardless of the authorisation requirement, so removing the requirement would not result in savings equal

⁶ *Report of the Abortion Supervisory Committee (Annual Report, 2017)* at 29.

to that amount.⁷ However, there would likely be some savings if only one health practitioner needed to be involved in many cases.

- 5.14 The Commission notes in addition that there appears to be a shortage of certifying consultants in some areas.⁸
- 5.15 If the requirement for abortions to be authorised by certifying consultants is repealed, a number of other provisions in the CSA Act would also need to be repealed or amended for consistency.⁹
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⁷ For example, one of the certifying consultants often performs the abortion as well. One practitioner the Law Commission spoke to travels to various regions to perform abortions due to a shortage of abortion doctors, and uses the fees obtained from certification to cover travel expenses. As discussed in Chapter 8, if the requirement for certifying consultant approval is removed, funding arrangements may need to be revised to ensure adequate availability of abortion services.

⁸ Information provided by licensed institutions to the Abortion Supervisory Committee suggests that in Northland, all the certifying consultants are located in Whangarei; there are shortages of certifying consultants in Tairāwhiti, Hawke's Bay and Taranaki; and there are no certifying consultants in Timaru. In Auckland one clinic reported it has had problems hiring enough certifying consultants at times. In some regions, consultation with one of the two certifying consultants may be done by phone to address these issues.

⁹ Contraception, Sterilisation, and Abortion Act 1977, ss 29, 30, 32, 33 and 34–36 all relate to the functions of certifying consultants. As discussed in Chapter 6, the offence in s 37(1)(b) (performing an abortion otherwise than in pursuance of a certificate issued by two certifying consultants) would also require repeal.

Part Two

Other aspects of abortion law

Except where otherwise stated, the options and proposals set out in this Part could be implemented under any of the three models in Part One.

CHAPTER 6

Criminal aspects of abortion law

INTRODUCTION

- 6.1 This chapter considers the criminal and regulatory offences in New Zealand’s current abortion laws. It suggests that, if any one of the three models set out in Chapter 4 is adopted, the current offences relating to abortion should either be repealed or amended so they only apply to unqualified people who perform abortions.
- 6.2 This chapter also considers whether any new regulatory offences would be necessary to ensure compliance with abortion law if Model B or C is adopted.
- 6.3 The terms “criminal offence” and “regulatory offence” are used for convenience to distinguish between “true” criminal offences, which require proof the defendant had *mens rea* (a “guilty mind”), and regulatory offences (also known as “quasi-criminal” or “public welfare” offences), which do not.¹ Regulatory offences are, however, still a type of criminal offence as opposed to a civil enforcement mechanism (such as disciplinary proceedings).² As explained below, regulatory offences typically carry lower penalties than other criminal offences and are primarily intended to protect the public by ensuring compliance with regulatory regimes. Convictions for “true” criminal offences are generally perceived as more serious than convictions for regulatory offences and carry greater social stigma.
- 6.4 The criminal offences relating to abortion are currently set out in sections 183–187A of the Crimes Act 1961 and section 44 of the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) (together described in this briefing paper as “abortion offences”). As discussed in Chapter 1, under those provisions it is an offence:
- for a woman to unlawfully procure or attempt to procure her own miscarriage (section 44 of the CSA Act);
 - for any person to unlawfully procure a miscarriage (section 183 of the Crimes Act); and
 - for any person to unlawfully supply the means to procure a miscarriage (section 186 of the Crimes Act).

¹ See, for example, *Civil Aviation Department v Mackenzie* [1983] NZLR 78 (CA) at 83–85; A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [1.3.2(3)] and 144.

² Law Commission *Civil Pecuniary Penalties* (NZLC IP33, 2012) at [3.4]–[3.5]; A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [1.3.2(3)].

- 6.5 “Unlawfully” means the person performing the abortion does not believe one of the grounds for abortion set out in section 187A of the Crimes Act applies.³
- 6.6 There are further regulatory offences set out in section 37 of the CSA Act, which apply to people who perform abortions other than in a licensed institution or without a certificate issued by two certifying consultants.
- 6.7 This chapter:
- explains the key mechanisms currently used to enforce abortion laws and uphold professional standards of care—that is, criminal offences, regulatory offences and disciplinary proceedings;
 - describes existing criminal and health regulatory laws that apply to health services generally, which would protect against unsafe abortion practices if the abortion offences are repealed;
 - sets out two options for reform of the current abortion offences—namely, complete repeal, or retention of an offence for unqualified people who perform abortions;
 - suggests repealing the regulatory offences in section 37 of the CSA Act, which would become redundant if other reforms suggested in this briefing paper are adopted;
 - discusses options for ensuring compliance with the statutory test for abortion (if Model B or C is adopted); and
 - suggests the Minister of Health consider amending the Health Practitioners Competence Assurance (Restricted Activities) Order 2005 to clarify that unqualified people who perform abortions commit an offence under general health legislation.

ABORTION LAWS AND PROFESSIONAL STANDARDS CAN BE ENFORCED IN A VARIETY OF WAYS

- 6.8 Currently a person who is suspected of breaching abortion laws can be charged with a criminal offence or a regulatory offence, depending on the law they have allegedly breached.⁴ If they are a health practitioner, they may also be the subject of an investigation by the Health and Disability Commissioner or a professional standards committee, and/or disciplinary proceedings before the Health Practitioners Disciplinary Tribunal, if they fail to meet any relevant professional standards of conduct.
- 6.9 The differences between these types of enforcement mechanisms and the purposes for which they are used are described below. This provides important context when considering whether any offences should be retained and, if so, what kind of offence is appropriate.

³ The grounds on which an abortion may be performed up to 20 weeks gestation are: a) serious danger to the woman’s life or physical or mental health; b) substantial risk that the child would be seriously handicapped; c) pregnancy caused by incest or sexual intercourse with a dependent family member; d) woman is “severely subnormal”. After 20 weeks the abortion must be necessary to save the woman’s life or prevent serious permanent injury to her physical or mental health.

⁴ These offences are set out in ss 183 and 186 of the Crimes Act 1961 and s 37 of the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act).

Criminal offences

- 6.10 Criminal offences are used to punish conduct that causes social harm and is considered morally reprehensible or inconsistent with important social values.⁵ A key feature of criminal offences is the element of social condemnation that conviction entails.⁶
- 6.11 Criminal offences must be proved beyond reasonable doubt.⁷ They also require proof the defendant had *mens rea*—a particular state of mind such as intention, knowledge or recklessness.⁸ Conviction for a criminal offence can have serious consequences, including loss of liberty (through imprisonment) or property (through fines) and the stigma that is generally attached to a criminal conviction.
- 6.12 The abortion offences in sections 183 and 186 of the Crimes Act, which apply to people who procure or supply the means to procure an abortion unlawfully, are criminal offences. The offences are only committed if the defendant *intended* to procure a miscarriage. The defendant’s conduct must also be “unlawful”, which will be the case unless the defendant believed one of the grounds for abortion in section 187A applied.⁹ The offences carry significant penalties of up to 14 years’ imprisonment (for procuring a miscarriage) or seven years’ imprisonment (for supplying the means to procure a miscarriage).
- 6.13 The offence in section 44 of the CSA Act, which applies to a woman who procures her own miscarriage, is also best described as a criminal offence, rather than a regulatory offence. It is different to the offences in the Crimes Act, because it appears in regulatory legislation (the CSA Act) and is subject to a much lower penalty (a fine of up to \$200). Prior to 1977 however, it was contained in the Crimes Act and was punishable by up to 7 years’ imprisonment.¹⁰ In 1977 the offence was moved to the CSA Act and the penalty reduced, but the wording of the offence remained substantially the same.
- 6.14 Like the offences in sections 183 and 186 of the Crimes Act, the offence in section 44 of the CSA Act is only satisfied if the woman acts “unlawfully” (by reference to the grounds in section 187A of the Crimes Act) and with intent to procure a miscarriage.¹¹ At the time

⁵ A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [1.2.1]–[1.2.2]; JC Smith and Brian Hogan *Criminal Law* (7th ed, Butterworths, London, 1992) at 16–18; Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [18.29.2]; Law Commission *Civil Pecuniary Penalties* (NZLC IP33, 2012) at [3.4].

⁶ JC Smith and Brian Hogan *Criminal Law* (7th ed, Butterworths, London, 1992) at 21; A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [1.2.3].

⁷ *R v Siloata* [2005] 2 NZLR 145 (SC) at [34].

⁸ Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) (LDAC *Legislation Guidelines*) at 114; Garrow and Turkington’s *Criminal Law in New Zealand* (online looseleaf ed, LexisNexis) at [APPV.4]; Dennis J Baker *Glanville Williams Textbook of Criminal Law* (4th ed, Sweet & Maxwell, London, 2015) at [4–004]. The mens rea requirements applying to a particular offence will depend on the statutory language and more general issues of statutory context and purpose (*Cameron v R* [2017] NZSC 89, [2018] 1 NZLR 161 at [72]). Recklessness will usually suffice where the offence provision does not specify that actual knowledge or intention is necessary (*Cameron v R* [2017] NZSC 89, [2018] 1 NZLR 161 at [73]).

⁹ Crimes Act, s 187A(1). If, however, the person procuring the abortion is a doctor acting pursuant to a certificate issued by certifying consultants under s 33 of the CSA Act, their conduct is presumed to be lawful unless the prosecution positively establishes that they did not believe any of the grounds applied: s 187A(4).

¹⁰ Crimes Act, s 185 (now repealed).

¹¹ CSA Act, ss 44(1) and (3).

of its enactment, the purpose of the offence was to punish conduct that was considered to be morally wrong and therefore deserving of criminal censure.¹²

Regulatory offences

- 6.15 Regulatory offences form part of a regulatory regime and are designed to incentivise compliance with standards of conduct set out in legislation.¹³ They often relate to a particular trade or profession, or to a type of activity that may present a danger to others.¹⁴ They primarily aim to protect the public from people who voluntarily undertake risk-creating activities, rather than to punish moral wrongdoing or show social condemnation of the defendant's actions.¹⁵ It is sometimes said that regulatory offences relate to “quasi-criminal” rather than “truly criminal” actions.¹⁶
- 6.16 Regulatory offences are often enforced by specialist regulatory agencies rather than Police.¹⁷ For example, the Ministry of Health prosecutes people who breach the Health Practitioners Competence Assurance Act 2003 or the Medicines Act 1981.¹⁸ The penalties for regulatory offences tend to be lower than for criminal offences. Fines are frequently used, although sentences of imprisonment (usually short in duration) can also be imposed for some regulatory offences. Conviction for a regulatory offence typically does not carry the same stigma as conviction for a criminal offence.¹⁹
- 6.17 Regulatory offences are usually²⁰ “strict liability” offences, which do not require the prosecution to prove the defendant had a particular state of mind (such as intent, knowledge or recklessness) as an element of the offence.²¹ The offence is *prima facie* (on its face) established if the prosecution proves beyond reasonable doubt that the defendant engaged in the conduct prohibited by the offence. The defendant may, however, still escape conviction if they can show on the balance of probabilities that they were not at fault or that a defence applies.²²

¹² See the discussion of the Royal Commission when recommending the retention of the offence: Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand; Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 280–281. The offence was retained in order to recognise the status of the fetus.

¹³ Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [18.29.2].

¹⁴ JC Smith and Brian Hogan *Criminal Law* (7th ed, Butterworths, London, 1992) at 107–108.

¹⁵ Law Commission *Civil Pecuniary Penalties* (NZLC IP33, 2012) at [3.32]; A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [5.1.1(3)] and [5.1.2(1)]; Simon France (ed) *Adams on Criminal Law—Offences and Defences* (online looseleaf ed, Thomson Reuters) at [CA20.40]; Andrew Ashworth and Jeremy Horder *Principles of Criminal Law* (7th ed, Oxford University Press, Oxford, 2013) at 2; LDAC *Legislation Guidelines* at 114; *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA) at 81.

¹⁶ A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [5.1.1(3)(a)]; JC Smith and Brian Hogan *Criminal Law* (7th ed, Butterworths, London, 1992) at 107.

¹⁷ A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at 144.

¹⁸ The regulatory offences in these Acts that are most relevant to abortion are discussed at [6.37] below.

¹⁹ JC Smith and Brian Hogan *Criminal Law* (7th ed, Butterworths, London, 1992) at 107.

²⁰ A small number of regulatory offences are “absolute liability” offences, which means absence of fault is not a defence. Conviction follows proof of the prohibited act or omission. Absolute liability offences are rare, as courts presume a “no fault” defence applies unless legislation makes it clear that no such defence is intended. See *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA) at 84–85.

²¹ A P Simester and W J Brookbanks *Principles of Criminal Law* (2nd edition, Brookers, Wellington, 2002) at [5.1.1]; LDAC *Legislation Guidelines* at 112; *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA) at 84–85.

²² *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA) at 84–85; *Cameron v R* [2017] NZSC 89, [2018] 1 NZLR 161 at [62].

- 6.18 Section 37 of the CSA Act creates two strict liability regulatory offences. Under that section a person commits an offence if they perform an abortion somewhere other than in a licensed institution or without a certificate issued by two certifying consultants (except in cases of necessity). The section does not require the prosecution to show that the person knew they were not in a licensed institution or that no valid certificate had been issued. However, a person can escape liability if they show they believed a certificate had been issued—in other words, that they were not at fault.²³
- 6.19 The offences in section 37 aim to ensure that people performing abortions comply with the requirements in the CSA Act. The section 37 offences are subject to much lower penalties than the offences in the Crimes Act (up to 6 months' imprisonment or a fine of up to \$1,000).

Disciplinary proceedings

- 6.20 Disciplinary proceedings for professional misconduct are similar to regulatory offences in the sense that they are designed to protect the public by ensuring appropriate standards of conduct are maintained.²⁴ However, disciplinary proceedings are a civil enforcement mechanism, so professional misconduct only needs to be proved on the balance of probabilities (rather than beyond reasonable doubt, as is required for criminal offences).²⁵
- 6.21 While disciplinary proceedings cannot result in imprisonment, they can have serious professional consequences—for example, deregistration, which prevents the professional from practising.²⁶
- 6.22 Health practitioners are subject to a disciplinary regime, which is described below.²⁷

Other ways of maintaining professional standards

- 6.23 There are various other ways in which the law seeks to ensure health care services meet acceptable standards. For example, as outlined in Chapter 3, health practitioners are registered under a scope of practice (which sets out the health services they are authorised to perform), overseen by a regulatory body, and subject to professional standards and best practice guidance.²⁸ Some health care providers are subject to certification or licensing regimes.²⁹
- 6.24 There are also civil remedies that may be available in limited circumstances to a person who has been subjected to medical treatment without their consent³⁰ or has received negligent care.³¹

²³ Section 37 of the CSA Act does not specifically set out a no fault defence for the offence of performing an abortion other than in a licensed institution, although the courts would likely imply one as there is nothing in the wording of the offence to suggest absolute liability is intended.

²⁴ *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [97] per McGrath J (giving the reasons of Blanchard, Tipping and McGrath JJ).

²⁵ *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1 (SC) at [97].

²⁶ See, for example, s 101 of the Health Practitioners Competence Assurance Act 2003.

²⁷ At [6.33]–[6.35].

²⁸ See [3.64]–[3.66] above for more detail on scopes of practice and regulatory bodies.

²⁹ As discussed at [3.76]–[3.79] above and in Chapter 7.

³⁰ For example, the tort of battery may apply: PDG Skegg “Consent to Treatment” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters) at [6.2.3(1)].

GENERAL LAWS PROTECT AGAINST UNSAFE MEDICAL PRACTICE

- 6.25 Other than abortion, medical and surgical procedures are not usually the subject of specific criminal offences.³² Instead, there are general criminal laws and a regulatory regime for health care services that help to protect against unsafe or inappropriate practices.
- 6.26 The general criminal and regulatory laws that are mostly likely to apply to unsafe or inappropriate abortions are summarised below. This discussion does not include section 182 of the Crimes Act (the offence of killing an unborn child), which is considered separately in Chapter 11 and is likely to require amendment if the abortion offences are repealed.

Performing an abortion negligently or without consent may be a crime

Assault, injury or wounding offences may apply in the absence of valid consent

- 6.27 Unless the woman gives valid consent, performing an abortion is likely to constitute assault,³³ or an injury³⁴ or wounding³⁵ offence under the Crimes Act. The applicable offence (and therefore the maximum penalty a court can impose) will depend on whether and to what extent the woman suffers actual bodily harm.³⁶ Common assault, for example, does not require any actual harm—a “mere touch” is sufficient.³⁷
- 6.28 Consent is usually a defence to offences involving assault or bodily harm.³⁸ In the context of a medical procedure, consent will usually be valid as long as the patient understands in broad terms the nature of the procedure being performed.³⁹

³¹ The availability of compensatory damages for personal injury resulting from negligence is restricted by accident compensation legislation: Accident Compensation Act 2001, s 317(1). However, liability for exemplary damages or public law compensation may still be available in appropriate cases: See Joanna Manning “Civil Proceedings in Personal Injury Cases” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters), ch 32.

³² The one exception the Commission is aware of is section 204A of the Crimes Act. That section prohibits female genital mutilation (which may include a sexual reassignment procedure) unless it is performed by a medical practitioner for the benefit of the person’s physical or mental health, or in the course of labour or birth.

³³ Crimes Act, s 196: common assault. This offence is punishable by up to one year of imprisonment.

³⁴ Crimes Act, s 189(2): injuring with intent to injure or with reckless disregard for the safety of others. This offence is punishable by up to five years’ imprisonment.

³⁵ Section 188(2): wounding or causing grievous bodily harm with intent to injure or with reckless disregard for the safety of others. This offence is punishable by up to seven years’ imprisonment. “Wounding” is any rupture of the tissues of the body, internal or external: *R v Scott* [2007] NZCA 589 at [49]. “Grievous bodily harm” is really serious bodily harm: *Director of Public Prosecutions v Smith* [1961] AC 290 at 334; *R v Scott* [2007] NZCA 589 at [31].

³⁶ The Commission notes there is authority indicating that causing harm to, or the death of, a fetus may be treated as bodily harm to the woman in some contexts. In *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA) the death of a fetus was found to amount to “personal injury” to the mother for the purposes of accident compensation legislation. Overseas authority has taken a similar approach in a criminal context: *R v Sullivan* [1991] 1 SCR 489 (SCC); *R v King* (2004) 150 A Crim R 409 (NSWCCA). In New South Wales and Victoria, causing the death of a fetus is treated as “grievous bodily harm” or “serious injury” to the woman rather than being a separate offence: Crimes Act 1900 (NSW), s 4(1) (definition of “grievous bodily harm”) and Crimes Act 1958 (Vic), s 15 (definition of “serious injury”).

³⁷ *Police v Raponi* (1989) 5 CRNZ 291 (HC) at 296.

³⁸ *R v Lee* [2006] 3 NZLR 42 (CA) at [159]–[167].

³⁹ *Rogers v Whittaker* (1992) 109 ALR 625 (HCA) at 633; *Chatterton v Gerson* [1981] All ER 257(QB) at 265; *McDonald v Ludwig* [2007] QSC 028 at [80]–[84]. In general, a failure to warn a patient of the risks associated with a procedure will

6.29 However, a woman’s apparent consent to an abortion would not operate as a defence if:

- she did not understand the nature and quality of the act.⁴⁰ This could include a situation where the person performing the abortion misleads her into falsely believing they have the necessary knowledge or skills to do so safely;⁴¹ or
- the court considers there are public policy reasons for refusing to recognise consent as a defence.⁴² This may be considered necessary to protect the public from the risks associated with unqualified people performing abortions.

Performing an abortion negligently may amount to criminal nuisance or manslaughter

6.30 Under section 155 of the Crimes Act, any person who undertakes to administer surgical or medical treatment (except in the case of necessity) is under a legal duty to use the level of knowledge, skill and care that would be expected of a doctor holding themselves out as undertaking that kind of treatment.⁴³ If there is a “major departure” from that standard of care, the person will be criminally responsible for the consequences.⁴⁴

6.31 Section 155 does not create an offence on its own, but breaching it may result in liability for criminal nuisance⁴⁵ or manslaughter.⁴⁶ These offences apply where a person endangers the life or safety of another (for criminal nuisance) or causes their death (for manslaughter) through a failure to perform a legal duty.

not vitiate consent: *Rogers v Whittaker* (1992) 109 ALR 625 (HCA) at 633; *Chatterton v Gerson* [1981] All ER 257 (QB) at 265; *Reibl v Hughes* [1980] 2 SCR 880 (SCC) at [13].

⁴⁰ Simon France (ed) *Adams on Criminal Law—Offences and Defences* (online looseleaf ed, Thomson Reuters) at [CA63.08(2)].

⁴¹ While the Commission is unaware of any direct authority on this point, see the discussion in Dennis J Baker *Glanville Williams Textbook of Criminal Law* (4th ed, Sweet & Maxwell, London, 2015) at [26–031]: “An operation carried out by a skilled surgeon is fundamentally different to one carried out by a person who is not qualified to perform such an operation”; and *R v Lee* [2006] 3 NZLR 42 (CA) at [308]: “Consent will only be operative if the impugned acts come within the scope of the activity consented to ... people are unlikely to consent to the infliction of serious harm or to unreasonable risks”.

⁴² *R v Lee* [2006] 3 NZLR 42 (CA) at [300] (cited with apparent approval by the Supreme Court in *Ah-Chong v R* [2015] NZSC 83, [2016] 1 NZLR 445 at [50]). The public policy reasons must “outweigh the social utility of the activity and the value placed by our legal system on personal autonomy”. The more serious the level of harm intended or risked, the more likely it is that public policy factors will exclude consent as a defence: *S v R* [2017] NZCA 83 [41]–[43].

⁴³ *R v Myatt* [1991] 1 NZLR 674 (CA) at 682.

⁴⁴ Crimes Act, s 150A. Conversely, sections 61 and 61A provide specific protection from liability for any person who performs a surgical operation if: a) they use reasonable care and skill; and b) the operation is either i) for a lawful purpose and with the consent of the patient (or any person lawfully entitled to consent on the patient’s behalf); or ii) for the patient’s benefit and reasonable having regard to the patient’s state at the time and all the circumstances of the case.

⁴⁵ Crimes Act, s 145. Criminal nuisance does not require actual harm. It applies to a person who does an unlawful act or omits to discharge a legal duty knowing it would endanger the life, safety or health of the public or an individual. It is punishable by up to one year of imprisonment.

⁴⁶ Crimes Act, ss 171 and 177. Manslaughter can apply to a person who causes the death of another by an omission to perform a legal duty. It is punishable by up to life imprisonment. Doctors have been convicted of manslaughter arising from breaches of the duty in section 155: *R v Ramstead* CA 428/96, 12 May 1997 (a cardiothoracic surgeon) and *R v Yogasakaran* [1990] 1 NZLR 399 (CA) (an anaesthetist). However, these cases were decided before the enactment of section 150A, which changed the law to require a “major departure” from the standard of care expected of a reasonable person before the duty in section 155 would be breached. Under earlier case law ordinary negligence was sufficient: *R v Storey* [1931] NZLR 417 (CA).

6.32 Consent is unlikely to be a defence to a charge of criminal nuisance or manslaughter based on a breach of the duty in section 155.⁴⁷

Health practitioners who do not meet adequate standards may be subject to disciplinary proceedings

6.33 Health practitioners can also be disciplined by the Health Practitioners Disciplinary Tribunal if they fail to uphold the standards expected of the profession. The grounds for disciplining a practitioner include:⁴⁸

- malpractice or negligence;
- acts likely to bring discredit to the profession;
- conviction for specified offences if they reflect adversely on the practitioner's fitness to practice (including offences under the CSA Act and the Medicines Act);
- practising while not holding a current practising certificate;
- performing a health service that is not permitted by the practitioner's scope of practice (but that does fall within a scope of practice of the relevant profession); and
- failing to observe any conditions of the practitioner's scope of practice.

6.34 For example, a health practitioner could be disciplined if they performed an abortion negligently or without being registered under a scope of practice that permitted them to do so.⁴⁹ The prospect of disciplinary action helps to ensure that practitioners only perform abortions if they are adequately qualified and skilled to do so.

6.35 If the Tribunal finds that a person has committed a disciplinable act, it can make a range of orders including cancelling or suspending the practitioner's registration, imposing conditions on their practice, censuring them and/or imposing a fine of up to \$30,000.⁵⁰

Unqualified people who perform abortions may commit regulatory offences

6.36 People who undertake to perform surgical or medical procedures are subject to requirements imposed by general health regulation. The health regulatory regime is

⁴⁷ See the discussion in Simon France (ed) *Adams on Criminal Law – Offences & Defences* (online looseleaf ed, Thomson Reuters) at [CA160.17]. A breach of legal duty forms part of the *actus reus* (the physical act that constitutes the offence) of criminal nuisance (Crimes Act, s 145) or manslaughter (s 160(2)(b)). For consent to operate as a defence, the impugned acts must come within the scope of the activity consented to: *R v Lee* [2006] 3 NZLR 42 (CA) at [308]. It seems unlikely that a woman would ever consent to having an abortion performed negligently. However, if the defendant warned the patient of the risks associated with the procedure, that may be relevant in assessing whether the duty in s 155 has been breached in the first place, which would be a necessary precursor to liability for criminal nuisance or manslaughter: *R v Mwai* [1995] 3 NZLR 149 (CA) at 156.

⁴⁸ Health Practitioners Competence Assurance Act (HPCA Act), s 100.

⁴⁹ As occurred in *Dr N Health Practitioners Disciplinary Tribunal 543/Med12/224P*, 23 April 2013. In that case a doctor had prescribed and dispensed abortion medication to three women negligently and without following the procedure in the CSA Act. In addition to breaching the Act, the doctor failed to provide each patient with an opportunity to consider expected risks, side effects, benefits and costs of all options; failed to conduct appropriate clinical assessments and exclude the risk of ectopic pregnancy; and failed to document the prescribing/dispensing of medication in the patients' clinical notes. The doctor was censured, suspended from practice for six months and had conditions imposed on her practice for three years from when she resumed practice. The Health Practitioners Disciplinary Tribunal also recommended that the doctor be prohibited from prescribing or supplying misoprostol for up to three years.

⁵⁰ HPCA Act, s 101.

described in Chapter 3. That regime aims to ensure that health care services are provided safely and competently.

- 6.37 Health legislation creates several regulatory offences that may apply to people who perform abortions without the necessary qualifications. The most relevant offences are set out below.

REGULATORY OFFENCES THAT MAY APPLY TO UNQUALIFIED PEOPLE PERFORMING ABORTIONS		
Section	Offence	Maximum penalty
Health Practitioners Competence Assurance Act 2003, s 7	<i>Claiming to be a health practitioner</i> Applies to a person who claims to be a health practitioner or suggests they are practising or willing to practise a health profession, if they do not have a relevant practising certificate.	\$10,000 fine
Health Practitioners Competence Assurance Act 2003, s 9	<i>Performing a restricted activity</i> Applies to a person who performs a “restricted activity”, unless they are a health practitioner whose scope of practice permits them to perform that activity. Most surgical procedures are restricted activities, so surgical abortions are likely to be covered (although it is suggested below this could be clarified ⁵¹).	\$30,000 fine
Medicines Act 1981, s 18	<i>Selling prescription medicines</i> Applies to any unauthorised person who sells, supplies or distributes prescription medicines (including mifepristone and misoprostol, the drugs used for medical abortions ⁵²) other than through a pharmacy or hospital.	6 months imprisonment or \$40,000 fine
Medicines Act 1981, s 19	<i>Administering prescription medicines</i> Applies to any person who administers prescription medicines other than as directed by an authorised health practitioner. ⁵³	3 months imprisonment or a fine of \$500 plus up to \$50 daily while the offence continued

⁵¹ See [6.82]–[6.86] below.

⁵² Mifepristone and misoprostol are both prescription medicines (see MedSafe “Classification Database” (23 August 2008) <www.medsafe.govt.nz>). If other drugs that are not approved for use in New Zealand were used instead, that would be an offence under s 20 of the Medicines Act 1981, which prohibits the sale of new medicines without the consent of the Minister of Health.

⁵³ The term used in the legislation is an “authorised prescriber”. This includes doctors, nurse practitioners, midwives and optometrists, or other types of health practitioners approved to prescribe the particular medication under the Medicines Act regime (s 2, definitions of “authorised prescriber” and “designated prescriber”). The particular medication prescribed would also need to fall within the health practitioner’s scope of practice, or they would breach the HPCA Act (s 8) and may be disciplined by the Health Practitioners Disciplinary Tribunal (HPCA Act, s 100).

REFORMING THE CRIMINAL OFFENCES FOR ABORTION

Principles that apply in deciding whether an offence is necessary

6.38 There are various options available to the government to enforce laws or rules, from self-regulation by the relevant profession or industry, through to prosecution and criminal sanction. When developing policy proposals and legislation, government departments follow the *Legislation Guidelines* issued by the Legislation Design and Advisory Committee and endorsed by Cabinet.⁵⁴ The Guidelines state:⁵⁵

The Government should not generally become involved in enforcing rules or otherwise regulating in an area where the rules can be reliably enforced by those who are subject to them. Legislation often provides for registration and discipline of professions, but the Government has little or no ongoing involvement in administering the Act—that is left to registration bodies and the profession concerned.

6.39 In short, the general rule is that the government should intervene to the minimum extent necessary to achieve its policy objectives.

6.40 The *Legislation Guidelines* identify the following considerations as relevant when assessing whether a criminal or regulatory offence should be introduced:

- offences should not be seen as a default option for enforcing rules;⁵⁶
- criminal offences should only be included in legislation if they are necessary to achieve a significant policy objective (usually, the avoidance of harm to society generally or to particular classes of people);⁵⁷
- criminal offences should not be introduced if the policy objective can be achieved effectively through other means, such as self-regulation by the applicable industry, codes of practice or national standards, or taking action under a licensing regime;⁵⁸ and
- conduct that is already addressed by the criminal or civil law should not be further criminalised unless it would serve a purpose not currently fulfilled by the law.⁵⁹

⁵⁴ The Legislation Design Advisory Committee (LDAC) is comprised of senior public service officials and external advisers appointed by the Attorney-General. In addition to issuing guidelines on the development of legislation, the Committee advises government departments and the Attorney on legislative proposals, scrutinises aspects of Bills that raise matters of public law concern and helps to ensure legislative proposals comply with the guidelines. See <www.ldac.org.nz> for further information.

⁵⁵ LDAC *Legislation Guidelines* at 105.

⁵⁶ At 105 and 111.

⁵⁷ At 111.

⁵⁸ At 111.

⁵⁹ At 113.

6.41 The *Legislation Guidelines* also list factors that may be relevant in determining whether conduct should be criminalised:⁶⁰

- the conduct involves physical or emotional harm;
- the conduct involves serious harm to the environment, threats to law and order, fraud, bribery or corruption, or substantial damage to property rights or the economy;
- the conduct, if continued unchecked, would cause significant harm to individual or public interests such that public opinion would support the use of the criminal law;
- the conduct is morally blameworthy, having regard to the required intent and the harm that may result; or
- the harm to public or private interests that would result from the conduct is foreseeable and avoidable by the offender (for example, it involves an element of intent, premeditation, dishonesty, or recklessness in the knowledge that the harms above may eventuate).

Reforming the abortion offences to align with a health approach

6.42 The abortion offences prohibit conduct related to procuring abortions other than in certain situations—that is, where one of the grounds for abortion in section 187A applies. They have the potential to apply to:

- doctors who perform or provide the means to procure an unlawful abortion;
- unqualified people who perform or provide the means to procure an unlawful abortion; and
- women who attempt, obtain or induce an unlawful abortion.

6.43 If the law is amended to remove any statutory test for abortion (as in Model A), this would reflect a policy choice that the decision whether to have an abortion is a matter for a woman in consultation with her health practitioner. The repeal of the abortion offences—at least in relation to doctors performing or providing abortions and women who obtain them—would necessarily follow.

6.44 If Model B or Model C is adopted, the law would continue to place some restrictions on the circumstances in which abortions can be performed. A question then arises whether an offence should be retained for people who perform abortions in circumstances that do not comply with the law.

6.45 Repealing the abortion offences (Option A below) would be consistent with treating abortion as a health issue. The general health and criminal laws already in place appear sufficient to protect women against unsafe abortion practices. However, if a stronger deterrent against unsafe abortion practices is considered necessary, a criminal offence could be retained for unqualified people who perform abortions (Option B below).

⁶⁰ At 113.

Option A: repeal the abortion offences

Option A

Repeal section 44 of the Contraception, Sterilisation, and Abortion Act 1977 (offence of a woman procuring her own miscarriage) and sections 183–187A of the Crimes Act 1961 (offences of procuring or supplying the means to procure a miscarriage).

The offences are unnecessary to protect women's safety or health

6.46 For health services other than abortion, the health regulatory regime and general offences in the Crimes Act are considered sufficient to protect patients' health and safety. This includes surgical operations that are more complex and higher risk than abortions.⁶¹ These mechanisms should also be sufficient to ensure that abortions are performed safely. As explained above:

- health practitioners who perform abortions or supply abortion drugs without being qualified to do so, or who fail to meet the standards expected of their profession, may be subject to disciplinary action. The consequences of a misconduct finding can be serious—for example, the practitioner may be unable to continue practising their profession. Health practitioners may also commit a criminal offence if they perform an abortion negligently or without the woman's consent; and
- unqualified people who perform abortions or supply abortion drugs are likely to commit one of the general offences under the Crimes Act and/or regulatory offences under the Health Practitioners Competence Assurance Act or Medicines Act. The penalties for these offences can be significant, particularly if harm is caused to the woman through a failure to exercise reasonable knowledge, skill and care.

6.47 It is noteworthy that the only criminal conviction the Law Commission is aware of relating to abortion since the 1977 amendments, which involved the illegal supply of abortion medication in breach of section 186 of the Crimes Act, also led to conviction under the Medicines Act.⁶²

6.48 Repealing the abortion offences may, in fact, improve women's safety. As a number of submitters observed, if women can access abortions legally and without undue delay, they are less likely to seek unsafe abortions from unqualified people or to self-induce a miscarriage.⁶³ While there are no records to show the extent of unlawful abortions performed in New Zealand, it is clear that they do occur.⁶⁴

6.49 To the extent that any additional protections might be considered necessary to ensure abortions are performed safely, they could be part of a regulatory and/or disciplinary

⁶¹ For example, spinal and brain surgery.

⁶² *Zhu v Ministry of Health* HC Auckland CRI 2006-404-00286, 14 November 2006. The conviction was under s 186 of the Crimes Act. While there have been convictions under s 183 (unlawfully procuring an abortion), all of the cases for which court decisions are available related to assaults on women that caused (or were intended to cause) a miscarriage, as opposed to consensual abortions. For further detail see [1.14]–[1.16]. Such assaults are also prosecuted under s 182 of the Crimes Act. Options for addressing this kind of conduct are discussed in Chapter 11.

⁶³ See too World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) (WHO *Technical and Policy Guidance*) at 23.

⁶⁴ See, for example, *Zhu v Ministry of Health* HC Auckland CRI 2006-404-00286, 14 November 2006.

regime rather than the criminal law.⁶⁵ As noted above, the primary purpose of regulatory and disciplinary regimes is to protect the public by ensuring that adequate standards of care are maintained. The criminal law, on the other hand, is generally reserved for punishing conduct that is considered to be morally blameworthy.

- 6.50 Some submitters suggested that retaining the abortion offences is necessary to protect women’s health and wellbeing more broadly—for example, by ensuring they receive adequate counselling and support. Again, to the extent that any specific legal protections are considered necessary for this purpose, they might more appropriately be contained in a regulatory regime, rather than being tied to criminal liability. Informed consent and counselling are discussed in Chapter 9.

Repealing the offences may help to improve availability of services

- 6.51 The fact that abortion is a criminal offence may be detrimentally affecting the availability of abortion services. The Abortion Supervisory Committee and many of the health practitioners the Commission consulted noted there is a shortage of practitioners willing to perform or assist in performing abortions, particularly later in pregnancy. There also appears to be a significant number of general practitioners (GPs) who are unwilling to refer women to abortion service providers.⁶⁶ Some practitioners suggested the criminalisation of abortion is a contributing factor, due to the perceived legal risks and general stigma it creates.

Repealing the offences is unlikely to increase the number of abortions

- 6.52 The Commission notes some submitters expressed concern that repealing the abortion offences may increase the number of abortions performed. International evidence suggests, however, that restrictive abortion laws do not reduce the overall number of abortions.⁶⁷ Rather, they are more likely to increase the number of unsafe abortions, delay access to services (meaning that abortions are performed later in pregnancy) and lead to women seeking services overseas.⁶⁸
- 6.53 The Commission’s discussions with health practitioners and professional bodies suggest the current grounds for abortion in the Crimes Act are interpreted broadly by many certifying consultants. Submissions received by the Commission supported that view. The Commission also notes that it appears to be reasonably uncommon for women seeking abortions to be declined authorisation by certifying consultants, although the exact numbers are unknown.⁶⁹ Despite this, rates of abortion have been steadily decreasing in recent years.⁷⁰ It therefore seems unlikely that removing the abortion offences from the Crimes Act would increase the number of abortions.

⁶⁵ The option of including a regulatory offence for failing to comply with requirements of abortion law is discussed at [6.69] below.

⁶⁶ While there are no official records of the number of general practitioners (GPs) who are conscientious objectors, anecdotally the Commission heard from health practitioners that it is quite common. The Commission was told that in some parts of the country it can be difficult to find a GP who will make a referral.

⁶⁷ WHO *Technical and Policy Guidance* at 90.

⁶⁸ WHO *Technical and Policy Guidance* at 90; United Nations Department of Economic and Social Affairs, Population Division *Abortion Policies and Reproductive Health around the World* ST/ESA/SER.A/343 (2014) at 16.

⁶⁹ See [2.18]–[2.19] above.

⁷⁰ See [2.3] above.

Repealing the offences would be consistent with New Zealand's international obligations

6.54 Repealing the abortion offences would also be consistent with New Zealand's international obligations, which are outlined in Chapter 3. The United Nations Committee on Economic, Social and Cultural Rights and the United Nations Committee on the Elimination of Discrimination Against Women have urged states parties to repeal laws criminalising abortion.⁷¹ The United Nations Committee on the Elimination of Discrimination against Women has specifically recommended that New Zealand repeal the laws criminalising abortion as they may lead to women seeking unsafe illegal abortions.⁷²

Some other jurisdictions have repealed the criminal offences for abortion

- 6.55 Option A is similar to the approach taken in the Australian Capital Territory (ACT) and Canada. ACT has no criminal offences for people who perform abortions or women who self-induce miscarriages.⁷³ In Canada, the provision in the Criminal Code that restricted the performance of abortions was struck down by the Supreme Court in 1988 as unconstitutional.⁷⁴ No new abortion offences have since been enacted.
- 6.56 The United Kingdom, New South Wales, South Australia and Queensland still have criminal offences similar to those in New Zealand (although in Queensland a Bill is currently before Parliament to reform the law).⁷⁵ As discussed below, the remaining Australian states have criminal offences that only apply to unqualified people who perform abortions.

⁷¹ United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* E/C.12/GC/22 (2016) at [40]; United Nations Committee on the Elimination of Discrimination Against Women *General Recommendation No.24: Article 12 of the Convention (women and health)* A/54/38/Rev.1, chap. I, (1999) at [31(c)].

⁷² United Nations Committee on the Elimination of Discrimination Against Women *Concluding Observations of the Committee on the Elimination of Discrimination against Women: New Zealand* CEDAW/C/NZL/CO/7 (2012) at [33]–[34].

⁷³ Although there are regulatory offences for people who perform abortions without appropriate qualifications or outside an approved medical facility: Health Act 1993 (ACT), ss 81–82.

⁷⁴ *R v Morgentaler* [1988] 1 SCR 30 (SCC). The relevant section made it an offence for a person to procure a miscarriage (including the woman herself) unless the majority of members of a committee in an approved hospital agreed the continuation of the pregnancy was likely to endanger the woman's life or health: Criminal Code, RSC 1985, c C-64, s 287 (s 251 at the time of the *Morgentaler* decision). The section was found to be inconsistent with clause 7 of the Charter of Rights and Freedoms—the right to life, liberty and security of the person—because it interfered with a woman's bodily integrity and autonomy in a manner the Court did not consider was reasonable or demonstrably justified in a free and democratic society.

Other abortion-related offences in the Criminal Code were not considered by the Court and remain on the statute book: s 288 (supplying a drug or instrument intended to procure an abortion) and s 163 (advertising or selling means to cause an abortion).

⁷⁵ Offences Against the Person Act 1861 (UK), ss 58–59; Crimes Act 1900 (NSW), ss 82–84; Criminal Law Consolidation Act 1935 (SA), s 81; Criminal Code 1899 (Qld), ss 224–225 (but see Termination of Pregnancy Bill 2018 (Qld), cl 22 and 25, which would replace the current offences with one only applying to unqualified people).

Option B: amend the abortion offences so they do not apply to health practitioners

Option B

Repeal section 44 (offence of a woman procuring her own miscarriage) of the Contraception, Sterilisation, and Abortion Act 1977 and section 187A of the Crimes Act 1961 (grounds for abortion/meaning of “unlawfully”).

Amend sections 183 and 186 of the Crimes Act 1961 (offences of procuring or supplying the means to procure a miscarriage) so that it is an offence for a person other than a health practitioner to procure or provide the means to procure an abortion, unless they believe the abortion is necessary to save the life of the woman or prevent serious and imminent injury to her physical health.

- 6.57 This option would continue to criminalise the performance of abortions by unqualified people, without placing qualified health practitioners at risk of criminal prosecution.
- 6.58 If an offence for non-health practitioners is retained, an exception could be considered to cover situations where the person performing the abortion believes it is necessary to save the life of the woman or to prevent serious and imminent injury to her physical health. This would ensure a person who performs an abortion out of necessity is not criminalised.⁷⁶ A similar exception already applies under the current law.⁷⁷

Option B would enable a stronger response to abortions by unqualified people

- 6.59 This option may be preferred to complete repeal of the abortion offences if a stronger deterrent against unsafe abortion practices is considered necessary.
- 6.60 The main argument against retaining an offence for non-health practitioners is that the general legal framework for health services already protects the public against unqualified people performing surgery or supplying prescription medication. These protections are considered adequate for health services other than abortion.

Who would the offence apply to?

- 6.61 Chapter 7 considers who should be able to perform abortions. The Commission suggests there that the law should not expressly limit the types of health practitioners who should be able to perform abortions; rather, this should be determined by the scopes of practice set by health regulatory bodies. If this approach is taken, the Commission suggests health practitioners generally (rather than only certain types of health practitioners) should be exempt from any offences retained in the Crimes Act.⁷⁸

⁷⁶ Such an exception would be broadly consistent with section 182 of the Crimes Act (the offence of killing an unborn child), which includes an exception where a person acts “in good faith for the preservation of the life of the mother”. The exception the Commission suggests would also extend to situations where there is an imminent risk of serious physical injury, as in such cases there may be insufficient time to seek professional care.

⁷⁷ Crimes Act, ss 187A(1)(a) and (3). These provisions apply to “any person”, whether they are a doctor or not.

⁷⁸ The alternative would be to provide that the offences apply to any person other than a health practitioner registered under a relevant scope of practice.

6.62 As explained above, health practitioners who provide services outside their scope of practice may already be subject to regulatory offences (if the service is a restricted activity) and/or disciplinary proceedings. A criminal offence is therefore unlikely to be necessary and may have a detrimental effect on the provision of services and recruitment of staff.

A similar approach is taken in some Australian states

6.63 In the Northern Territory, Tasmania and Victoria, abortion has been decriminalised for women seeking abortions and suitably qualified health practitioners, but it remains an offence for an unqualified person to perform an abortion.⁷⁹

6.64 The Queensland Law Reform Commission recently recommended the adoption of equivalent laws.⁸⁰ This recommendation is reflected in the Termination of Pregnancy Bill 2018 currently before the Queensland Parliament.⁸¹

6.65 In Western Australia, it is still a criminal offence for health practitioners to perform an abortion that does not meet the statutory criteria, but the offence is only punishable by a fine.⁸² By contrast, unqualified people who perform abortions can be imprisoned for up to 5 years.⁸³

REPEALING THE REGULATORY OFFENCES FOR BREACHING THE CURRENT LICENSING AND CERTIFICATION REQUIREMENTS

Proposal

Repeal section 37 of the Contraception, Sterilisation, and Abortion Act 1977.

6.66 Section 37 of the CSA Act contains offences that apply to any person who performs an abortion other than in a licensed institution and under a certificate issued by two certifying consultants. In Chapters 5 and 7 the Commission suggests the repeal of the requirements for abortions to be performed in a licensed institution and approved by two certifying consultants. If those provisions are repealed then, as a matter of logic, the offences in section 37 of the CSA Act (which relate to those requirements) should also be repealed.⁸⁴

⁷⁹ Criminal Code Act (NT), s 208A(1); Criminal Code Act 1924 (TAS), s 178D; Crimes Act 1958 (Vic), s 65(1). The definition of who a “qualified” person is differs from state to state. In ACT and TAS it must be a doctor, while in NT and Vic it can include nurses, midwives and pharmacists.

⁸⁰ Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (June 2018), recommendations 3.8–3.9.

⁸¹ Termination of Pregnancy Bill 2018 (Qld), cl 25, which would insert a new section 319A in the Criminal Code (Termination of pregnancy performed by unqualified person).

⁸² Criminal Code 1913 (WA), s 199(2).

⁸³ Criminal Code 1913 (WA), s 199(3).

⁸⁴ The Commission notes that if s 37 is not repealed (for example, if the licensed institution requirement is retained), consideration could be given to amending that section to provide that it is a defence to a charge under s 37(1)(a) (performing an abortion elsewhere than in a licensed institution) if the health practitioner believed the institution was licensed. This might be the case, for instance, if an institution failed to renew its licence but did not inform staff the licence had lapsed. It is likely that a court would read in a defence of absence of fault in any case: *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA) at 84–85. However, the LDAC *Legislation Guidelines* advise against relying on the courts to do so because it creates uncertainty as to the scope of the offence (at 114–115). See also *Millar v Ministry of Transport* [1986] 1 NZLR 660 (CA) at 674.

ENSURING COMPLIANCE WITH THE STATUTORY TEST FOR ABORTION IF MODEL B OR C IS ADOPTED

- 6.67 Under Model B, the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing. Model C would include a similar requirement for abortions performed after 22 weeks.
- 6.68 If either of these approaches is adopted (or a different approach that requires a statutory test to be met for an abortion to be lawful), consideration would need to be given to how the legal requirements would be enforced. One option would be to create a regulatory offence of performing an abortion without believing the statutory test is met (Option A below). This may, however, be considered unnecessary, as the health practitioner disciplinary regime and existing regulatory offences would already apply to people who fail to comply with the law. An alternative approach would therefore be to rely on those existing mechanisms rather than creating a separate offence (Option B below).

Option A: a new regulatory offence for failing to apply the statutory test

Option A

Insert a regulatory offence in the Contraception, Sterilisation, and Abortion Act 1977 (or any replacement legislation) applying to any person who performs an abortion without believing the statutory test for abortion is met (if Model B or C is adopted).

A regulatory offence could help to ensure compliance with the statutory test

- 6.69 A regulatory offence would provide a legal mechanism for the agency responsible for enforcing any new legislation to ensure compliance with the requirement for health practitioners to be satisfied of the statutory test before performing an abortion.⁸⁵ Without an enforcement mechanism, there may be less incentive for health practitioners to give proper consideration to the test.
- 6.70 Given the significant degree of discretion the statutory test in Models B and C affords to health practitioners, the regulatory offence would only apply in rare cases. However, the offence would provide a basis for prosecuting a person who performs an abortion in circumstances that are inappropriate when judged against accepted standards of professional practice. For example, it might apply if a health practitioner performs an abortion without taking proper precautions in a case where there are complicating medical factors. As discussed below, however, it is likely the health practitioner disciplinary regime would already apply in such cases.
- 6.71 Creating a regulatory offence may also affect how the general criminal law and health practitioner disciplinary regime apply to people performing abortions.

⁸⁵ As discussed in Chapter 4, if Model B or C is adopted the statutory test for abortion would be in health legislation rather than the Crimes Act. The Ministry of Health would therefore be responsible for administering it.

6.72 **Effect on the application of the general criminal law:** committing a regulatory offence would be an “unlawful act” for the purposes of the Crimes Act. A person who performed an abortion without believing the statutory test was met might therefore be open to prosecution for:

- criminal nuisance (if the person knew their actions would endanger the woman’s life, safety or health);
- injuring by unlawful act (if the person’s failure to apply the statutory grounds caused injury to the woman); or
- manslaughter by unlawful act (if the person’s failure to apply the statutory grounds caused the woman’s death).

A conviction for one of these offences could result in a significant sentence of imprisonment.⁸⁶ However, because of the need to establish knowledge and causation, it seems unlikely a person would be prosecuted for one of these offences unless their actions presented a clear danger to the woman—for example, if they seriously departed from established best practice. In such a case liability may result in any case because there would likely be a breach of the duty in section 155 of the Crimes Act.⁸⁷

6.73 **Effect on the application of the health practitioner disciplinary regime:** one of the grounds on which the Health Practitioners Disciplinary Tribunal may make disciplinary orders against a health practitioner is if they are convicted of an offence that reflects adversely on their fitness to practice.⁸⁸ Only certain offences qualify. Currently, an offence under the CSA Act is listed as a qualifying offence.⁸⁹ If this remains the case (with amendment to refer to any new legislation that replaces the CSA Act, if required), it would provide a more direct basis for the Tribunal to make disciplinary orders against a practitioner who fails to apply the statutory test for abortion. The Tribunal would not need to find that one of the more general grounds for discipline (such as malpractice or negligence) applies. This is significant because of the different orders that can be made by the Tribunal compared to a court if the practitioner is convicted of a regulatory offence.⁹⁰

Other factors to consider

6.74 It is common practice for regulatory regimes with a public protection purpose to include offences that allow enforcement of the regime’s requirements and encourage compliance. For example, the Human Tissue Act 2008 requires a person to obtain informed consent before collecting human tissue from a body, except in certain situations.⁹¹ It is an offence to collect human tissue without informed consent (where it is

⁸⁶ The actual sentence would be highly dependent on the relevant offence and the circumstances of the case. The maximum penalties for these offences range from one year imprisonment (for criminal nuisance) to life imprisonment (for manslaughter).

⁸⁷ See [6.30]–[6.32] above.

⁸⁸ HPCA Act, s 100(1)(c) and (2)(a)(iii).

⁸⁹ HPCA Act, s 100(2)(a)(iii).

⁹⁰ For example, a practitioner’s registration can be cancelled or suspended, preventing them from practising permanently or temporarily, and they can be censured and/or ordered to pay up to \$30,000: HPCA Act, s 101.

⁹¹ Human Tissue Act 2004, s 19.

required).⁹² The Human Assisted Reproductive Technology Act prohibits selection of human embryos for implantation based on sex and makes it an offence to breach that prohibition.⁹³

6.75 If a regulatory offence were to be adopted for non-compliance with the statutory test for abortion, the penalty should (like comparable offences⁹⁴) be significantly lower than for most offences in the Crimes Act. Conviction for a regulatory offence generally also carries less stigma than a criminal conviction. A regulatory offence is therefore less likely to have a chilling effect on the provision of services and staff recruitment than a criminal offence.

6.76 On the other hand, a regulatory offence might be considered inappropriate in the context of Models B and C.

- The broad nature of the statutory test proposed in Models B and C may cause uncertainty as to the scope of the offence. As a matter of good law, offences should clearly state the conduct that is prohibited so people know what they can and cannot do.⁹⁵
- The offence is only likely to apply in clear cases of professional misconduct or where an unqualified person performs an abortion. As explained above, there are already disciplinary provisions and regulatory offences that apply in those circumstances. A regulatory offence might therefore be considered unnecessary. Conduct that is already addressed by the criminal or civil law should not be further criminalised unless it would serve a purpose not currently fulfilled by the law.⁹⁶

6.77 In Australian jurisdictions that have recently amended their abortion laws, health practitioner non-compliance with the conditions set out in abortion legislation is not an offence.⁹⁷ Rather, the general health regulatory regime applies.

Option B: apply the existing health practitioner disciplinary regime

Option B

Rely on the existing disciplinary regime in the Health Practitioners Competence Assurance Act 2003 to discipline health practitioners who fail to apply the statutory test for abortion.

An amendment to that Act could be considered to clarify that any failure to comply with the requirements of abortion law may be taken into account by the Health Practitioners Disciplinary Tribunal in determining whether a practitioner should be disciplined under section 100.

⁹² Section 22.

⁹³ Human Assisted Reproductive Technology Act 2004, s 11.

⁹⁴ For example: the offence in s 22 of the Human Tissue Act is punishable by imprisonment for up to one year or a fine of up to \$50,000; the offence in s 11 of the Human Assisted Reproductive Technology Act is punishable by imprisonment for up to one year and/or a fine of up to \$100,000; and the offence in s 18 the Medicines Act (selling prescription medicines without authorisation) is punishable by up to 6 months imprisonment or a \$40,000 fine. The current offence for breaching the licensing or certification requirements in the CSA Act (s 37) is punishable by imprisonment for up to 6 months or a fine of up to \$1,000.

⁹⁵ See the LDAC *Legislation Guidelines* at 113.

⁹⁶ LDAC *Legislation Guidelines* at 113.

⁹⁷ See Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (June 2018) at [3.44]. The Queensland Law Reform Commission similarly recommended against imposing a specific penalty for medical practitioners who fail to comply with the legal requirements for abortion (at [3.236]–[3.239]).

- 6.78 An alternative to creating a new regulatory offence would be to rely on the existing health practitioner disciplinary regime to address any failures by health practitioners to comply with the statutory requirements (under Model B or C). The same consequences would then apply to health practitioners who fail to comply with abortion law as for other kinds of professional misconduct.
- 6.79 The current grounds for disciplining health practitioners already appear broad enough to capture situations where a practitioner fails to apply the statutory test for abortion. A practitioner may be disciplined for an act or omission that amounts to negligence or is likely to bring discredit to the profession.⁹⁸ As noted above, because the statutory test in Models B and C affords significant discretion to the health practitioner, it is only likely to be breached if the practitioner acts negligently. The Commission does not therefore consider it necessary to amend the disciplinary provisions in the in the Health Practitioners Competence Assurance Act.
- 6.80 An amendment to that Act could, however, be considered if the Government wishes to emphasise that a failure to apply the statutory test for abortion may be a basis for a disciplinary finding. The Act could expressly provide that a failure to comply with the requirements of abortion law can be taken into account by the Health Practitioners Disciplinary Tribunal in deciding whether a health practitioner should be disciplined. Such an amendment may also help to reinforce the importance of compliance to health practitioners.
- 6.81 A similar approach was recently recommended by the Queensland Law Reform Commission and is included in the Termination of Pregnancy Bill 2018 currently before the Queensland Parliament.⁹⁹ The Bill includes a provision that would allow disciplinary bodies to have regard to any non-compliance with the statutory requirements for abortion when considering a health practitioner’s professional conduct.¹⁰⁰ The Queensland Law Reform Commission saw benefit in aligning abortion with other medical procedures by making use of the existing regulatory framework, rather than creating a specific offence.¹⁰¹

ENSURING ABORTIONS ARE ONLY PERFORMED BY QUALIFIED PEOPLE

Proposal

The Minister of Health may wish to review the wording of the schedule to the Health Practitioners Competence Assurance (Restricted Activities) Order 2005 to ensure that all types of surgical abortions are restricted activities.

- 6.82 Surgical abortion is likely to be a “restricted activity” for the purposes of section 9 of the Health Practitioners Competence Assurance Act. This would make it a regulatory offence, punishable by a fine of up to \$30,000, for a person to perform a surgical abortion unless they are a health practitioner permitted to do so by their scope of practice.

⁹⁸ HPCA Act, s 100(1)(a)–(b).

⁹⁹ Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (June 2018) at [3.239]; Termination of Pregnancy Bill 2018 (Qld), cl 9.

¹⁰⁰ Termination of Pregnancy Bill 2018 (Qld), cl 9.

¹⁰¹ Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (June 2018) at [3.237]–[3.238].

- 6.83 However, the current wording of the restricted activities schedule in the Health Practitioners Competence Assurance (Restricted Activities) Order leaves some ambiguity. The relevant category of restricted activities is “[s]urgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes, or teeth.”¹⁰² According to the Ministry of Health, this wording is “intended to broadly capture activities that involve cutting the flesh or doing something that causes bleeding.”¹⁰³
- 6.84 Abortion is likely to be covered by this, as it generally causes bleeding and might be said to involve a procedure “below the surface of the skin”. However, the Ministry of Health and health practitioners the Commission spoke to considered there may be some room for doubt, since surgical abortions do not necessarily involve breaking the skin. The Ministry of Health considered it would be desirable to clarify the position.
- 6.85 If the abortion offences in the Crimes Act are repealed, the Minister of Health may wish to consider whether the Health Practitioners Competence Assurance (Restricted Activities) Order 2005 requires amendment to ensure that surgical abortion is captured. Including surgical abortion in the schedule of restricted activities would seem to be consistent with the purpose of the restricted activity regime: to protect members of the public from risk of serious or permanent harm if the activity is performed by an unqualified person.¹⁰⁴ Unsafe abortions performed by unskilled people can lead to serious complications or even death.¹⁰⁵
- 6.86 The Commission notes that supply of medical abortion drugs by unauthorised people would not need to be covered by the restricted activity regime, because it is an offence under the Medicines Act.¹⁰⁶
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¹⁰² Health Practitioners Competence Assurance (Restricted Activities) Order 2005, sch, cl 1.

¹⁰³ Ministry of Health “Restricted activities under the Act” (22 April 2014) <www.health.govt.nz>.

¹⁰⁴ HPCA Act, s 9(3); Ministry of Health “Restricted activities under the Act” (22 April 2014) <www.health.govt.nz>.

¹⁰⁵ WHO *Technical and Policy Guidance* at 19–20. An estimated one in four women who undergo an unsafe abortion will develop “temporary or lifelong disability requiring medical care” (at 20).

¹⁰⁶ Medicines Act, s 18 (punishable by up to 6 months imprisonment or a \$40,000 fine).

CHAPTER 7

Access to abortion services

INTRODUCTION

- 7.1 As discussed in Chapter 2, there are a number of aspects of the current law and practice that may inhibit a woman's access to abortion services and cause delay. There is also considerable variation around New Zealand as to how long it takes to get an abortion.
- 7.2 The earlier in a pregnancy an abortion is performed, the safer it is.¹ As well as putting women's health at increased risk, delay may mean that a woman:
- can no longer choose early medical abortion, which is only available until nine weeks gestation;²
 - can no longer access services locally, if the services available in her area are limited by gestation; and/or
 - must meet stricter legal criteria to obtain an abortion, if the delay means that the pregnancy is over 20 weeks gestation. In the most extreme case, a woman may be unable to have an abortion because of the different grounds that apply after 20 weeks.
- 7.3 Numerous submitters, including the Abortion Supervisory Committee (ASC), abortion service providers and other health practitioners, expressed concern about barriers to access and the detrimental impact they have on women. Submitters commented that barriers to access have a disproportionate impact on Māori. Submitters also highlighted how barriers impact on women in rural and isolated areas; young women; women with limited financial resources; and women who are not supported by their families and whānau.
- 7.4 The World Health Organization (WHO) states that women should be given as much time as they need to make a decision whether to have an abortion (including to access any information, counselling or support required), but once the decision has been made, the abortion should be provided as soon as possible.³ The WHO recommends that

¹ Martha Silva, Rob McNeill and Toni Ashton "Factors affecting delays in first trimester pregnancy termination services in New Zealand" (2011) 35(2) Aust NZ J Public Health 140 at 140; World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, 2012) (WHO *Technical and Policy Guidance*) at 21 (Figure 1.2) (referring to mortality data from the United States).

² Some submitters said they were unable to have an early medical abortion (EMA) due to the time it took to get approval from certifying consultants and/or an appointment to have the abortion.

³ WHO *Technical and Policy Guidance* at 36.

“regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed”.⁴ Most health practitioners and other submitters who commented on accessibility echoed these sentiments.

7.5 This chapter looks at the impact the law has on women accessing services, and considers how the law could better enable women to access safe and timely abortion services. It focuses on three particular requirements in the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) that appear to be significant contributing factors to access and availability issues:

- the “woman’s own doctor” must refer a woman to certifying consultants for consideration of abortion;⁵
- abortions must take place at specifically licensed institutions;⁶ and
- abortions must be performed by a doctor.⁷

BARRIERS TO ACCESS HAVE A DISPROPORTIONATE IMPACT ON MĀORI

7.6 Health professional bodies, abortion service providers and other submitters raised significant concerns about the disproportionate impact that barriers to access have on Māori. They stated that in areas with high Māori populations there is limited access to reproductive and contraceptive health services and information generally; a shortage of general practitioners (GPs); and an even greater shortage of GPs who will refer to abortion services. Health practitioners in the Hastings/Hawke’s Bay area, for example, reported that many Māori women they work with are not enrolled with a GP.

7.7 The ASC *Standards of Care* state that Māori health must be considered in the context of colonisation; the devaluing, invalidation and marginalisation of mātauranga Māori in reproductive health care; and the resulting Eurocentric health services with persisting Māori reproductive health inequities.⁸ Research indicates that Māori adults are more likely to have an unmet need for a GP or after-hours health service due to barriers to access such as cost, lack of transport, lack of childcare and being unable to get to a medical centre.⁹

7.8 Health professional bodies, practitioners and many individual submitters also raised concerns about the lack of culturally appropriate abortion services and said this could be a barrier to accessing services. Provision of culturally appropriate services for Māori requires an understanding of key tikanga concepts¹⁰ such as tapu¹¹ and noa,¹²

⁴ WHO *Technical and Policy Guidance* at 9.

⁵ Contraception, Sterilisation, and Abortion Act 1977 (CSA Act), s 32(1).

⁶ CSA Act, s 18.

⁷ CSA Act, ss 32 and 33A.

⁸ Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*) at 11. The Standards Committee is a group of experts appointed by the ASC to develop its *Standards of Care*.

⁹ Ministry of Health *Tatau Kahukura Māori Health Chart Book 2015* (3rd ed, October 2015) at 53–55.

¹⁰ For example, this is discussed in the ASC *Standards of Care* at 11 and standard 6.3.

¹¹ Tapu denotes the intersection between the human and the divine. It indicates states of restriction and prohibition, which, if breached, result in serious consequences. It is sometimes expressed as inviolability: see Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 404.

whanaungatanga,¹³ manaakitanga¹⁴ and whakapapa.¹⁵ As indicated below, whakamā¹⁶ may also be a factor in accessing services. In addition to the possible delay in getting an appointment, for many women, having an appointment with a GP they do not know and with whom they may not feel comfortable discussing abortion, presents a significant barrier.

- 7.9 A 2016 study found that young Māori women have significant difficulty accessing reproductive health services. It also found that the negative sexual and reproductive outcomes experienced by young Māori women “signal denial of their right to make informed decisions about their own sexual and reproductive wellbeing”.¹⁷ Access to reproductive health services can be “fraught with stigma, embarrassment, a lack of information, and limited access to culturally appropriate services”.¹⁸
- 7.10 The report submitted by Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand (ALRANZ) and Family Planning New Zealand to the 70th Committee for the Elimination of Discrimination Against Women in October 2017 states that the current abortion framework creates an inequitable system with significant barriers to access for women, which disproportionately impact Māori.¹⁹ In addition, the report states that the higher pregnancy, sexually transmitted infections and abortion statistics for Māori

¹² Noa is the reciprocal of tapu, indicating freedom of restriction and neutrality: see Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 266; Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 16 and 35–36.

¹³ Whanaungatanga is linked to whakapapa and refers to the rights and responsibilities associated with being a relative. Originally it referred to blood relationships but now it is used more widely to refer to other kin-like relationships as well. It denotes the fact that in te ao Māori relationships are everything and all individuals owe certain responsibilities to the collective. See Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 32; Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 524; Law Commission *Māori Custom and Values in New Zealand Law* (NZLC SP9, 2001) at [130].

¹⁴ Manaakitanga describes the process of showing and receiving care, respect, kindness and hospitality. It is expected for all people, regardless of whether (or especially when) there is no pre-existing relationship. Thus whanaungatanga may start with manaakitanga. This duty to nurture relationships, look after people and be very careful about how others are treated underpins all tikanga. See Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 205; Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 33.

¹⁵ Whakapapa literally means to place in layers. It describes the connections between people and their responsibilities to past, present and future generations. It is the key to identity and belonging in te ao Māori. See Hirini Moko Mead *Tikanga: Living by Māori Values* (revised ed, Huia, Wellington, 2016) at 47 and Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 504 and at 511.

¹⁶ Whakamā signifies shame or abasement. It occurs when a person or group perceives that they have less mana than particular others, or lose mana as a result of their actions or those of another. See Richard Benton, Alex Frame and Paul Meredith *Te Mātāpunenga: a compendium of references to the concepts and institutions of Māori customary law* (Victoria University Press, Wellington, 2013) at 499–500.

¹⁷ Beverley Lawton and others “E Hine: access to contraception for indigenous Māori teenage mothers” (2016) 8(1) J Prim Health Care 52 at 53.

¹⁸ Beverley Lawton and others “E Hine: access to contraception for indigenous Māori teenage mothers” (2016) 8(1) J Prim Health Care 52 at 53.

¹⁹ Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand and Family Planning New Zealand *Alternate Report to the 70th CEDAW Pre-sessional Working Group* (October 2017) at [12].

indicate timely access at low or no cost to culturally responsive contraceptive and reproductive health services, including abortion services, is lacking.²⁰

- 7.11 The general reform measures discussed in this chapter, if adopted, would help to improve access to abortion services for all women. The reform measures are unlikely to address entirely the disproportionate impact of barriers on Māori women. Further operational measures would be required to ensure Māori women have access to appropriate services. Policy makers should consider Māori involvement in developing the abortion service workforce and national standards, and ensuring adequate access to information and services in areas with high Māori populations.

REFERRAL TO ABORTION SERVICES

The current referral requirements can delay access to services

- 7.12 Under the CSA Act, only a doctor (referred to as “the woman’s own doctor” in the Act) can refer a woman’s case to be considered by certifying consultants.²¹ Since the enactment of the CSA Act, the way in which people engage with health services has changed considerably. As a result, this referral requirement can delay women’s access to abortion services.
- 7.13 The legislation contemplates that women will have their own GP. However, many health practitioners and submitters made the point that many people now do not have a long term relationship with a particular GP. Even if they are enrolled at a medical practice, they may see whichever GP is available soonest rather than seeing the same GP each time they visit. The Law Commission has also been told that many women choose not to see their personal GP when seeking a referral to abortion services.
- 7.14 For many people, their main point of contact with the health profession may not be a doctor. For example, most pregnancy care is now done by midwives.²² Women may have existing relationships with a non-physician health practitioner such as a midwife or nurse, but those practitioners cannot refer women to abortion services under the current law. Both nurses and midwives submitted that this inhibits their ability to provide the best possible care for their patients. If a woman wishes to seek an abortion and consults a nurse or a midwife, the woman will then need to have another appointment to see a doctor who can make the referral.
- 7.15 Health practitioners said that getting an appointment with a GP who does not conscientiously object to referring women to an abortion service provider can take several weeks in some areas.²³ The fact that a GP objects to providing abortion-related advice or referrals may not be clear before the appointment, so the woman may then need to make a second appointment with a different GP. Health practitioners and submitters reported that access to referring GPs (and health services in general) can be a particular issue for Māori and Pacific women.

²⁰ Te Whāriki Takapou, the Abortion Law Reform Association of New Zealand and Family Planning New Zealand *Alternate Report to the 70th CEDAW Pre-sessional Working Group* (October 2017) at [6].

²¹ CSA Act, s 32.

²² Ministry of Health “Choosing a midwife or specialist doctor” (24 July 2015) <www.health.govt.nz>.

²³ Conscientious objection is discussed in Chapter 10.

- 7.16 In addition, it is common for the referring doctor to encourage the woman to take some time to think about her options and come back for a second appointment before they will refer her to an abortion service provider.²⁴ This is discouraged by the ASC *Standards of Care*, which state that sending women away to think about their decision can cause unnecessary delays, deprive women of the choice of medical abortion or necessitate second trimester services.²⁵ As noted in Chapter 2, depending on the circumstances, a woman may therefore have anywhere from one to four or more appointments before she is referred to an abortion service provider. This process can take several weeks. Each appointment may require the woman to find childcare or take time off work or school.
- 7.17 The Southern District Health Board (DHB), Mid Central DHB, and community health practitioners and abortion service providers in the Hawke's Bay and Tairāwhiti said finding GPs who would refer women to abortion service providers was a particular issue in their areas. Capital and Coast DHB also highlighted that there are a number of GPs in the Wellington region who will not refer women to abortion service providers.
- 7.18 There is an independent website that provides information on abortion service providers in New Zealand,²⁶ which includes information on accessing services and getting a referral. However, the Ministry of Health does not currently publish information about the locations or requirements for accessing abortion services, nor is this information readily available through all DHBs.
- 7.19 According to DHBs, a number of abortion service providers have adopted the approach that the “woman’s own doctor” can be a doctor at the abortion clinic. In addition, some providers, such as the one in Dunedin, have a free telephone line that women can call for information and direct access to the service. This avoids a woman needing to see a GP before attending the abortion clinic, effectively allowing her to self-refer or be referred by a nurse or midwife to the service. However, not all abortion service providers take this approach and the position is unclear under the referral provisions in the CSA Act. In addition, not all women will know where to access information about direct access to services.
- 7.20 Some health practitioners stressed that where a relationship of trust and confidence exists, for example with a GP, midwife, or school or community nurse, these health practitioners can play an important role in supporting women to access information and services and to make an informed choice. This is particularly relevant for Māori for whom relationships, manaakitanga and whanaungatanga, are central. It is also important for women who do not have ready access to the Internet, or face language or other barriers to accessing information about referral.
- 7.21 The WHO states that, as for all health interventions, an effective system for referral to appropriate services is essential for the provision of safe abortion care.²⁷ Timely referrals reduce delays, enhance safety and can reduce the severity of any complications.²⁸

²⁴ This practice was described by a number of submitters, including health practitioners. In Martha Silva and others “Ladies in waiting: the timeliness of first trimester services in New Zealand” (2010) 7(19) *Reproductive Health* 1, Table 4 shows that the majority of women surveyed had multiple appointments with the referring doctor at the doctor’s request.

²⁵ ASC *Standards of Care*, standard 6.4.

²⁶ Abortion Services in New Zealand “Where to go” <www.abortion.org.nz>.

²⁷ WHO *Technical and Policy Guidance* at 67.

- 7.22 Several submitters commented on the uncertainty and stress caused by the lengthy referral process and the number of appointments some women are required to attend before even getting to an abortion clinic.

Women could access abortion services directly without referral

Proposal

Repeal the requirement in section 32 of the Contraception, Sterilisation, and Abortion Act 1977 for women to be referred to certifying consultants by a doctor for consideration of abortion.

Women could access abortion services directly, or be referred by any health practitioner they choose to consult (for example, a GP, nurse, midwife or counsellor).

The Ministry of Health and district health boards may wish to consider publishing a list of key providers in each area (or who to contact to find out where the nearest service is).

- 7.23 The ASC, as well as most health practitioners the Commission spoke to, considered that requiring women to see a doctor for a referral is an unnecessary step and a potential barrier to accessing abortion services. It appears the requirement could be removed without compromising patient safety or the quality of abortion services. As noted, women can already effectively self-refer to some abortion service providers. Enabling women throughout the country to self-refer could have a significant positive impact on the cost and accessibility of services. It is also likely that this would lessen delays caused by GPs who do not refer women to abortion service providers due to conscientious objection.²⁹
- 7.24 In addition, the ASC recommended that the Ministry of Health make information available about key providers and who to contact. As noted above, there is an independent website that contains information about the abortion service providers available nationwide.³⁰ Some DHBs also describe the services they provide on their websites. However, it would be useful to have a comprehensive official source women can access to find information about services in their area—for example, on the Ministry of Health website. Those DHBs that do not currently make information available on their websites may also wish to consider doing so.

²⁸ WHO *Technical and Policy Guidance* at 67.

²⁹ Conscientious objection is discussed in Chapter 10.

³⁰ Abortion Services in New Zealand “Where to go” <www.abortion.org.nz>.

LICENSING OF PREMISES WHERE ABORTIONS ARE PERFORMED

The current licensing requirements may limit the availability of services

- 7.25 Under the CSA Act abortions must take place at institutions licensed by the ASC.³¹ The ASC will only grant a licence to an institution if it is satisfied the institution meets certain requirements, including having adequate surgical facilities.³² This means abortion services are generally limited to larger centres where secondary or tertiary hospital services are available. Access to services after the first trimester (that is, from 13 weeks gestation) is further limited to main centres. The location and details of the services available are set out in Chapter 2.³³
- 7.26 Some abortion service providers only have a “limited licence” to perform abortions during the first 12 weeks of pregnancy,³⁴ and some of these providers only offer abortion up to nine weeks gestation.³⁵ One abortion service provider only offers early medical abortion, while others only offer surgical abortion. This means that some women do not have a choice about the method of abortion they have. In addition, many abortion service providers that are fully licensed to perform abortions at any gestation still only offer services up to a particular gestation. After that point women are required to travel to an area where the service is provided.
- 7.27 The requirements that must be met in order to get a licence are seen by some health practitioners as a barrier to smaller providers, such as medical centres and Family Planning clinics, providing abortion services. For example, licensed institutions must have adequate surgical facilities and the ability to accommodate patients overnight.³⁶ Early medical abortion (EMA) is not a surgical procedure and could be safely administered at institutions without surgical facilities. In practice the Commission understands that very few women need to stay overnight, and the reasons for requiring an overnight stay can generally be identified in advance. In such cases, the woman could be referred to a larger facility that can accommodate overnight stays.

The current licensing requirements prevent women from taking early medical abortion drugs at home

- 7.28 The current law requires women to take both doses of EMA medication at a licensed institution.³⁷ In most cases, this means that women must attend an abortion clinic to take the first dose of medication, go home, then return to the clinic 24–48 hours later to take the second dose.³⁸ It is common for women to then go home to complete the abortion. The need to return to the clinic may require women to find additional childcare, travel on multiple occasions and take more time off work or school. For some women, the abortion

³¹ CSA Act, s 18.

³² CSA Act, s 21.

³³ At paragraphs [2.33]–[2.39].

³⁴ CSA Act, s 19. Currently the only services available in Tauranga and Palmerston North have limited licences.

³⁵ For example, the Tauranga Family Planning clinic has a limited licence but is only able to offer medical abortion up to nine weeks.

³⁶ CSA Act, s 21: Surgical facilities are required for both limited and full licences; overnight accommodation facilities are only required for a full licence.

³⁷ See *Re Abortion Supervisory Committee* [2003] 3 NZLR 87 (HC).

³⁸ The process for EMA is explained in more detail at [2.70]–[2.74] above.

can begin shortly after the administration of the second dose of medication, in some instances as they leave the clinic or while they are travelling home.

- 7.29 Most clinical guidelines recommend that misoprostol be taken 24–48 hours after mifepristone.³⁹ However, in order to increase accessibility and convenience, some abortion service providers administer both drugs at the same time so that women do not have to return to the clinic a second time.

The requirement for abortions to be performed in licensed institutions could be removed

Proposal

Repeal the requirement in section 18 of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be performed at an institution licensed by the Abortion Supervisory Committee.

Note: The safety of facilities would be governed by general health law.

Safety of facilities where EMA is administered

- 7.30 Health practitioners and professional bodies the Commission consulted generally agreed there was no need for a facility to have a specific licence to provide EMA. The ASC stated that allowing women to take the second dose of medication at home would be safer than the current arrangement, where women must take the medication at the licensed institution and may begin to miscarry while travelling home.
- 7.31 The Commission notes that enabling women to take the second dose of EMA medication at home (with appropriate information and access to additional support, if required) is consistent with international practice and professional guidance.⁴⁰ Women in Scotland and Wales can take the second dose at home, and the Government of the United Kingdom recently announced plans to enable women in England to do the same.⁴¹
- 7.32 RANZCOG and a number of health practitioners told the Commission that, with proper instruction, phone support and access to emergency care if required, EMA medication could safely be taken at home. Practitioners explained that the EMA process is very similar to a spontaneous miscarriage, which many women experience at home or in other locations with no medical supervision. Many individual submitters also suggested this.

³⁹ For example, see ASC *Standards of Care* at 38; WHO *Technical and Policy Guidance* at 43; Royal Australian and New Zealand College of Obstetricians and Gynaecologists *The use of mifepristone for medical termination of pregnancy* (C-Gyn-21, February 2016); Royal College of Obstetricians and Gynaecologists (UK) *Best practice in comprehensive abortion care* (Best Practice Paper No. 2, June 2015) at 5.

⁴⁰ See WHO *Technical and Policy Guidance* at 44; Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline* (Guideline Number 7, November 2011) at [4.28]. Self-administration of misoprostol is common in France, Sweden and the United States. See British Pregnancy Advisory Services “Home use of misoprostol” <www.bpas.org> and Thoai D Ngo and others “Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review” (Bulletin of the World Health Organization, 2011).

⁴¹ The Abortion Act 1967 (Place for Treatment of Termination of Pregnancy) (Approval) (Scotland) 2017 (see also *SPUC Pro-Life Scotland Limited v Scottish Ministers* [2018] CSOH 85, where the Court of Session Outer House dismissed a petition claiming the approval was unlawful); The Abortion Act 1967 (Place for Treatment of Termination of Pregnancy) (Approval) (Wales) 2018; and “Government confirms plans to approve the home-use of early abortion pills” (25 August 2018) <www.gov.uk>.

7.33 Home-administered EMA sent to women by post is available with telehealth support in Victoria, New South Wales, Queensland, Western Australia (with a referral from a GP), Northern Territory and Tasmania.⁴² A private member's Bill has recently been passed in the Australian Capital Territory Legislative Assembly to improve access to medical abortion by removing the legislative requirement that all abortions must take place in a licensed facility.⁴³ Health practitioners suggested that enabling provision of abortion, in particular EMA, by smaller facilities such as medical centres and Family Planning clinics could help to improve access—especially in smaller centres (such as the West Coast) where a dedicated abortion clinic may not be sustainable.

Safety of facilities where surgical abortion is performed

7.34 A number of health professional bodies and practitioners told the Commission that first trimester surgical abortion should be regulated the same way as other straightforward day outpatient procedures. They noted that a first trimester surgical abortion is a relatively minor procedure and specific licences are not required for facilities where other, higher risk surgical procedures are performed.

7.35 Some health practitioners and submitters raised concerns that if the licensing requirements in the CSA Act are removed, it may be difficult to ensure the adequacy of facilities where surgical abortions are performed. The ASC suggested that the Ministry of Health could have a certification process to ensure premises are safe and audited against any standards of care developed.

7.36 Currently, providers of some health care services (including hospital care) are subject to general certification and auditing requirements under the Health and Disability Services (Safety) Act 2001, to ensure that their facilities are safe, hygienic and appropriately equipped for the procedures that are carried out there. This regime does not currently apply to abortion services (unless they are provided in a facility intended to accommodate two or more women at a time for more than 24 hours in order to provide the service) or to other day surgery procedures. Additional services can be brought within the regime by Order in Council on the recommendation of the Minister of Health.⁴⁴

7.37 The Abortion Providers Group Aotearoa New Zealand (APGANZ) submitted that surgical abortions can be, and currently are, performed safely in community-based clinics as well as in secondary care facilities. APGANZ stated that while many of its members considered no specific certification of facilities is necessary (as is the case for other day surgical procedures), a significant proportion of its membership raised concerns about surgical abortions taking place in facilities that are not specifically certified.

7.38 Health practitioners and professional bodies the Commission consulted suggested regulation of day surgical facilities generally may warrant further consideration by the Government. They were keen, however, to stress there have been no safety issues raised and they would not want to see more certification requirements than necessary placed on providers. Smaller service providers, like medical centres and Family Planning clinics, are subject to a range of other standards and requirements, including under the

⁴² Marie Stopes “Medical abortion by phone (tele-abortion)” <www.mariestopes.org.au>; and Tabbott Foundation “Medical Termination in the Privacy of Your Home” <www.tabbot.com.au>.

⁴³ Health (Improving Abortion Access) Amendment Bill 2018 (ACT).

⁴⁴ Health and Disability Services (Safety) Act 2001, s 7.

Health and Safety at Work Act 2015 and relevant professional standards, such as the Royal New Zealand College of General Practitioners mandatory quality standards framework for general practices, and service specifications.

- 7.39 The Commission notes that the burden of complying with new regulations for day procedure centres has been cited as a reason for the closure of the abortion clinic in northern Tasmania (along with the increased availability of EMA by telehealth and an associated decrease in demand for the clinic's services).⁴⁵
- 7.40 The Commission suggests the current licensing requirements in the CSA Act should be removed. The safety of facilities would be governed by general health law, as is the case for other health services. If certification requirements are considered desirable for some or all day surgical procedures—which could include surgical abortions—the Minister of Health may wish to consider whether it would be appropriate to bring them within the existing certification regime in the Health and Disability Services (Safety) Act 2001.
- 7.41 This approach would treat abortion consistently with other procedures carrying a similar level of risk. It would avoid the need for a separate licensing body for abortion by making use of arrangements already in place. It would also avoid requiring service providers to obtain multiple different certifications for similar procedures. However, the compliance costs associated with this option would need to be considered, particularly if they have the potential to be prohibitive for smaller service providers.

PERFORMING OR ASSISTING IN PERFORMING ABORTIONS

The current restrictions on who can perform abortions may be a barrier to access

- 7.42 Under the CSA Act, only a doctor can perform an abortion.⁴⁶ As described in Chapter 3, whether a health practitioner can perform or assist in performing a particular procedure is generally determined by a range of matters, including their qualifications, registration and scope of practice. Whether a health practitioner can prescribe, dispense or administer drugs is determined by the classification of the drug and the practitioner's scope of practice.
- 7.43 Scopes of practice are set by the health regulatory bodies for each profession. Some procedures can only be performed by doctors, while some more minor procedures can be performed by a wider range of health practitioners. Some drugs can only be prescribed by doctors, but can be dispensed or administered by nurse practitioners or pharmacists. Other drugs can be prescribed by midwives or nurse practitioners as well as doctors.
- 7.44 Since the passage of the CSA Act in 1977, there have been improvements in medical technology, abortion techniques and safety—in particular with the development of EMA. Additionally, nurses and midwives now perform a wider range of tasks than was previously the case (for example, prescribing). However, the legislative restriction on who can perform abortions has meant that abortion provision has not been able to be considered or updated along with other changes to scopes of practice.

⁴⁵ Barbara Baird "Decriminalization and Women's Access to Abortion in Australia" (2017) 19(1) Health and Human Rights Journal 197 at 203.

⁴⁶ CSA Act, s 32.

- 7.45 The ASC, the Ministry of Health and health practitioners have raised concerns about the lack of doctors willing to perform abortions, particularly in smaller centres and/or after the first trimester of pregnancy.⁴⁷

Abortions could be performed by an appropriately qualified health practitioner

Proposal

Remove the requirement in sections 32 and 33A of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be performed by a doctor.

Abortions could be performed or administered by a health practitioner with appropriate qualifications and experience, as determined by the scopes of practice issued by health profession regulatory bodies. The qualifications and experience required may differ depending on the method of abortion.

- 7.46. With the development of EMA in particular, many submitters said that restricting provision of abortion to doctors is no longer necessary to ensure patient safety.
- 7.47. The WHO recommends that safe abortion care in the first trimester can be provided at a primary care level by a range of appropriately trained health workers, including nurses and midwives, to address shortages of specialist doctors and facilitate access to safe and timely care for women.⁴⁸ The WHO states that non-physician health workers can provide early abortions without compromising safety, with referral systems in place for higher level care, if required.⁴⁹
- 7.48 In a number of other jurisdictions, abortion is provided by mid-level health workers such as nurses, midwives and other non-physician health practitioners. In the United States, appropriately trained nurse practitioners, physician assistants and nurse-midwives provide first trimester medical, and some surgical, abortions in a number of states.⁵⁰ In a number of states in Australia, health practitioners including midwives, nurses and pharmacists can supply or administer abortion medication under the direction of a medical practitioner.⁵¹ In Great Britain and France, nurses are largely responsible for administering EMA.⁵² In Sweden, EMA is mostly administered by midwives.⁵³

⁴⁷ This issue is also discussed in Shelly Kirk “*An Investigation of the Nature of Termination Pregnancy Counselling Within the Current System of Licenced Abortion Facilities*” (Master of Social Work, Thesis, University of Auckland, 2016) at 55. Of the DHB managers, social workers and counsellors surveyed, over half said that their obstetrics/gynaecology consultants expressed a discomfort about abortions and declined to undertake abortion procedures.

⁴⁸ World Health Organization “Expanding health worker roles for safe abortion in the first trimester of pregnancy” (2016) <www.who.int>. See also WHO *Technical and Policy Guidance* at 65.

⁴⁹ WHO *Technical and Policy Guidance* at 65.

⁵⁰ Discussed in Marge Berer “Provision of abortion by mid-level providers: international policy, practice and perspectives” (Bulletin of the World Health Organization, 2009); see also Tracy Weitz and others “Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver” (2013) *Am J Public Health* 454.

⁵¹ See Abortion Law Reform Act 2008 (Victoria), ss 6–7; Termination of Pregnancy Law Reform Act 2017, s 8 (NT); Criminal Code 1924 (Tas) Schedule 1, cl 1 (definition of “terminate”).

⁵² In both the Great Britain and France, abortion medication must be prescribed by a doctor, but the medication may be administered by a nurse or midwife. See Marge Berer “Provision of abortion by mid-level providers: international policy, practice and perspectives” (Bulletin of the World Health Organization, 2009). Regarding Great Britain, see also Royal College of Obstetricians and Gynaecologists *The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline* (Guideline Number 7, November 2011) at [3.1].

⁵³ See Marge Berer “Provision of abortion by mid-level providers: international policy, practice and perspectives” (Bulletin of the World Health Organization, 2009).

- 7.49. A number of health practitioners, professional bodies and other submitters, including APGANZ and the Ministry of Health, supported the view that an adequately trained health practitioner working within their scope of practice should be able to perform an abortion. The Midwifery Council submission noted that abortion care sits within the scope of practice of midwives in other jurisdictions. The New Zealand Nurses Organisation (NZNO) and the Royal Australian and New Zealand College of Psychiatrists submitted that appropriately trained nurses could play a greater role in the provision of EMA, including safely prescribing and dispensing EMA medication. The NZNO further submitted that nurses could perform some early surgical abortions with appropriate supervision.
- 7.50 Feedback received from the ASC suggested that the performance of abortion, particularly surgical abortion, should be restricted by legislation to doctors, nurses and midwives with suitable training and qualifications. The Commission has taken this into account but considers it unnecessary to have such restrictions in legislation. New Zealand has a robust regulatory process for determining which procedures are within a particular practitioner's scope of practice.⁵⁴ This process is adequate to ensure the performance of abortions remains safe and consistent with clinical best practice. Other procedures, including those involving significantly more risk than abortion, are regulated in this way.
- 7.51 In discussions with the Commission, abortion service providers and health professional bodies agreed that the regulatory bodies that determine the scopes of practice for health practitioners are best placed to determine which practitioners can safely carry out abortion procedures, as they do for other procedures. The qualifications and experience necessary are likely to vary depending on the type of abortion procedure. Removing legislative restrictions would better enable scopes of practice to change as medical technology, training and best practice advance.
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⁵⁴ Health Practitioners Competence Assurance Act 2003. See also the discussion in Chapter 3.

CHAPTER 8

Oversight of abortion services

INTRODUCTION

- 8.1 Oversight of health services is important to ensure good standards of practice are met and maintained. Oversight helps to uphold safety, consistency and accountability, and assists with service planning and workforce development.
- 8.2 As set out in Chapter 3, New Zealand has a robust and comprehensive regulatory framework for health and disability services, including oversight, which would continue to apply to abortion if some or all of the current abortion laws are repealed. This would be the case irrespective of which of the legal models described in Chapter 4 may be preferred.
- 8.3 Currently, abortion is also subject to its own separate oversight regime under the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act), which is administered by the Ministry of Justice.
- 8.4 This chapter considers how oversight of abortion services could best align with a health approach to abortion. In particular, it considers whether (and to what extent) a separate oversight regime is necessary for abortion services, or whether the existing general health regulatory framework is sufficient. It concludes that the oversight functions of the Abortion Supervisory Committee (ASC) could be subsumed within the Ministry of Health. The ASC, as currently constituted under the CSA Act, would then no longer be required.

OVERSIGHT FUNCTIONS

- 8.5 Under the CSA Act, the ASC is charged with oversight of abortion services in New Zealand. The ASC has a range of statutory functions and powers including:¹
 - licensing institutions to perform abortions;
 - ensuring licensed institutions maintain adequate facilities;
 - ensuring staff at licensed institutions are competent;
 - ensuring adequate counselling facilities are available;
 - appointing certifying consultants;
 - statistical reporting;

¹ Contraception, Sterilisation, and Abortion Act 1977, ss 14, 21 and 30. For more detail see paragraph [1.29] above.

- overseeing the administration of abortion law; and
- setting maximum fees for abortion services.²

8.6 In practice, the ASC also:

- sets standards of care in relation to abortion services;³ and
- produces guidelines on what qualifications, knowledge and experience are required of different health practitioners involved in providing abortion services.⁴

8.7 The following functions currently performed by the ASC would be unnecessary if the law is amended in line with the proposals set out in this briefing paper.

- **Licensing institutions and ensuring adequate facilities:** As discussed in Chapter 7, safety of premises would be governed by the general health regulatory framework.
- **Appointing certifying consultants:** As discussed in Chapters 4 and 5, certifying consultants would no longer be required to authorise abortions. Under Model A there would be no statutory test that must be satisfied before an abortion could be performed. Under Models B and C, only the health practitioner who will perform the abortion would need to be satisfied that the statutory test is met. As discussed in Chapter 7, abortions would still be performed by appropriately qualified health practitioners (as determined by health professional bodies when setting scopes of practice).

8.8 As explained in Chapters 4 and 6, if any specific statutory provisions relating to abortion are retained they would be in health legislation. The legal framework would therefore be administered by the Ministry of Health. The Ministry would also assume responsibility for overseeing the operation of abortion law.

8.9 If any one of the legal models set out in Chapter 4 is adopted, there would remain a need to:

- ensure appropriate distribution of abortion services, including collecting any data necessary to enable this and overseeing funding arrangements; and
- uphold good standards of practice in the provision of abortion services.

ENSURING APPROPRIATE DISTRIBUTION AND FUNDING OF ABORTION SERVICES

8.10 Currently, the Ministry of Justice funds certifying consultants to perform their duties under the CSA Act. It also administers abortion legislation (the CSA Act and the Crimes Act 1961) and is responsible for funding and administering the ASC. The Ministry of Health allocates the majority of Vote Health funding to DHBs through a population-based funding formula. DHBs then fund the provision of abortion services in hospitals and clinics.

² Although the Abortion Supervisory Committee can set a maximum fee, it has never done so. It does ask for fee information when renewing licenses and may query fees.

³ Some of the content of the current standards is set out at paragraph [2.23] above.

⁴ Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*), standards 8.2.5, 8.5.1, 8.6.6 and 9.2.1.

- 8.11 The ASC is responsible for licensing institutions to perform abortions and collecting data relating to the performance of abortions. However, the ASC has no power to require DHBs to provide medical and/or surgical abortion services in a particular area or up to a particular gestational limit.
- 8.12 The Ministry of Health is responsible for ensuring appropriate distribution and funding of health services generally, as well as administering health legislation and associated regulations.
- 8.13 DHBs identify the needs of their population and determine the appropriate quantity and type of health services required for their population. The Minister of Health enters into agreements with DHBs to outline the national minimum services to be provided, and business rules and guidelines for the required services.⁵ The Ministry of Health also funds a small number of nationally important health services directly.
- 8.14 The Ministry of Health collects data to monitor health outcomes, manage funding and resource allocation, assist clinical decisions and evaluate and inform policy development.⁶ Methods of gathering data include routine administrative systems, such as prescriptions and records of hospital events, and population-based health surveys.⁷

The Ministry of Health could be responsible for ensuring appropriate distribution and funding of abortion services

Proposal

The Ministry of Health could be responsible for collecting statistics on abortion and overseeing the distribution and funding of abortion services (including counselling services).

- 8.15 Shifting responsibility for the general oversight of abortion services from the ASC, which is administered by the Ministry of Justice, to the Ministry of Health would best align with a health approach to abortion. The Ministry of Health already collects data on, and oversees the provision of, other sexual and reproductive health services, so is best placed to consider how abortion services fit within that overall framework.
- 8.16 In particular, strategies and policies relation to abortion could be considered alongside related sexual and reproductive health services, such as contraception and sexual health screening, and the provision of sexual and reproductive health information. The Ministry of Health could also continue to set minimum services to be provided by DHBs,⁸ or fund services at a national level,⁹ to ensure adequate abortion services are available throughout the country.
- 8.17 Numerous health professional bodies and health practitioners the Commission consulted with said the Ministry of Health should be responsible for general oversight of abortion services, such as data collection and distribution of services and funding. This included the Royal Australian New Zealand College of Obstetricians and Gynaecologists

⁵ New Zealand Public Health and Disability Act, s 10.

⁶ Ministry of Health “Why do we collect data?” (23 December 2009) <www.health.govt.nz>.

⁷ Ministry of Health “How is the data gathered?” (23 December 2009) <www.health.govt.nz>.

⁸ The current minimum services to be provided in relation to abortion are set out in Ministry of Health *Specialist Medical and Surgical Services: Gynaecology Services Tier Two Service Specification* (July 2015).

⁹ For example, primary maternity services, mental health services and a number of screening programmes are nationally funded: see Ministry of Health “Funding” (11 July 2016) <www.health.govt.nz>.

(RANZCOG), the New Zealand Nurses Organisation, the New Zealand College of Midwives and the Royal Australian and New Zealand College of Psychiatrists. Some practitioners felt that shifting the responsibility away from the Ministry of Justice would reduce the stigma associated with the abortion process and encourage more health practitioners to become involved, including by providing referrals to abortion service providers if required.¹⁰

Data collection

- 8.18 A number of health professional bodies and practitioners felt that the Ministry of Health having oversight could assist with service planning, including workforce development, and allow the Ministry of Health to monitor the impact of sexual and reproductive health education and contraceptive availability; pregnancy outcomes; and abortion complication rates.
- 8.19 The Ministry of Health noted that the factors that influence abortion rates (and the current declining trend) are likely to be multiple and are not fully understood at this point. Oversight of abortion services or data collection would be unlikely, on their own, to result in clear conclusions about the impact of either sexuality education or contraceptive availability.
- 8.20 The Ministry of Health would need to assess what data it requires to effectively monitor and oversee the provision of abortion services, and the most appropriate means of collecting that data.
- 8.21 The Ministry would be able to collect some of the relevant data through its reporting requirements for DHB funded services. It may need to consider further how best to collect data from private providers, if that information is required.

Funding

- 8.22 Many health professional bodies and practitioners raised specific issues relating to funding of abortion services. A common concern was that if the regulatory framework for abortion is changed, in particular if the Ministry of Justice is no longer responsible for paying certifying consultant fees, this may place the overall funding of abortion services at risk. Several practitioners told the Commission that some abortion doctors who are also certifying consultants rely on the fees paid by the Ministry of Justice to allow them to perform abortions, particularly where they are required to travel to other regions where there are shortages of doctors willing to provide services.
- 8.23 There was, however, agreement among the health professional bodies and abortion service providers the Commission consulted that abortion services should be funded through the Ministry of Health rather than the Ministry of Justice.
- 8.24 The Commission notes that if any one of the alternative legal models identified in Chapter 4 is adopted, changes to funding arrangements are likely be required. All funding for abortion services would fall under Vote Health rather than Vote Justice. The Ministry of Health would need to consider whether the funding model requires review to enable the provision of abortion services by a wider range of service providers (for example, Family Planning clinics and general practitioners (GPs)). The Ministry noted in its

¹⁰ The referral requirements, including a discussion of the possibility of self-referral, are discussed in Chapter 7.

submission that funding arrangements would need to allow for equitable and consistent access.

- 8.25 In general, DHBs have a high degree of autonomy in determining what services to fund with the money allocated to them. However, the Ministry of Health can set the minimum services DHBs must provide by including them in mandatory service specifications. The Ministry of Health can also fund important national services directly.
- 8.26 The Ministry noted that currently there is a subsidised user-pays system for primary care. If some abortion services were provided through primary care, that would be a significant departure from the current funding model. Funding arrangements would need to be fully considered to ensure no additional barriers to access are introduced.
- 8.27 Funding is not only important in the context of the medical aspects of performing abortions. The ASC, Aotearoa New Zealand Association of Social Workers, New Zealand Association of Counsellors and other health professional bodies emphasised that counselling services also need to continue to be adequately funded, both pre- and post-abortion.

The broader sexual and reproductive health strategy

- 8.28 Shifting oversight of abortion services to the Ministry of Health would allow those services to be considered in the context of the overall sexual and reproductive health strategy. Of particular relevance, the strategy focuses on reducing unintended/unwanted pregnancies by ensuring easy access to contraceptives and educating the public about safer sexual practices.¹¹ Reducing unintended/unwanted pregnancies is likely to reduce the number of abortions.
- 8.29 Many health practitioners and submitters emphasised the importance of ensuring free and easy access to a range of contraceptive options. Long-acting contraception such as the Mirena Intra Uterine Device¹² was considered to be particularly effective, but is not generally government-subsidised and can be expensive.¹³ Several health practitioners suggested it should be subsidised.
- 8.30 Sexual and reproductive health doctor and advocate for abortion law reform, Dame Margaret Sparrow, also made a submission recommending that emergency contraception be more freely available through general practitioners, trained nurses and pharmacists. She noted that although it is now available over the counter through pharmacies, access issues persist due to cost, concerns over confidentiality and health professionals not prescribing due to conscientious objections.
- 8.31 The Government may wish to consider the adequacy of current contraceptive availability alongside any changes to abortion law. Good sexuality education is also strongly associated with developing good sexual health habits. A recent Education Review Office

¹¹ Ministry of Health *Sexual and Reproductive Health Strategy: Phase One* (October 2001) at 1 and 8–11. The Ministry of Health noted that this focus is continued in its new draft Sexual and Reproductive Health Action Plan.

¹² Mirena is a hormone-releasing device that is inserted into the uterus. It is over 99 per cent effective in preventing pregnancy and can remain in place for up to 10 years. See “Intra Uterine Device (IUD)” Family Planning <www.familyplanning.org.nz>.

¹³ The Mirena is only subsidised for women with certain medical conditions. Otherwise, it costs \$340 at Family Planning. See Family Planning “Fees and Charges” <www.familyplanning.org.nz>. The Ministry of Health notes that most contraceptive medications and devices are fully subsidised, although GP visits require co-payments. A new Ministry initiative will make long-acting contraception free for very low income women, although this will not include the Mirena.

report on sexuality education found a number of areas for improvement.¹⁴ The report requested that the Ministries of Education and Health work together to action its recommendations.

ENSURING ABORTION SERVICES MEET GOOD STANDARDS OF PRACTICE

8.32 As set out in Chapter 3, the general health regulatory framework includes a range of mechanisms for ensuring adequate standards of practice and safety, including:

- scopes of practice for health practitioners;
- the Code of Health and Disability Services Consumers' Rights;
- generally applicable guidance and standards of best practice issued by the Ministry of Health;
- profession-specific guidance and standards issued by professional bodies; and
- mandatory service standards applicable to some service providers.

8.33 Currently, the ASC develops and monitors standards of care for abortion. The ASC first developed standards of care in 2009. The current *ASC Standards of Care* cover a wide variety of matters including access to services,¹⁵ provision of information,¹⁶ clinical guidance,¹⁷ provision of culturally appropriate services (in particular services to Māori)¹⁸ and required qualifications for professionals working in abortion care.¹⁹

8.34 However, the ASC cannot enforce the standards of care it sets for abortion service providers, aside from declining applications by providers to become licensed to perform abortions or to renew their licence.²⁰ Declining applications may limit women's access to services.

The Ministry of Health could set standards of care for abortion services

Proposal

The Ministry of Health could issue best practice guidelines/standards of care for abortion services, in consultation with abortion service providers and Māori.

8.35 Health professional bodies and practitioners the Commission consulted were generally of the view that the *ASC Standards of Care* are a useful way of providing professional guidance to all health practitioners involved in abortion care. They strongly supported the continuation of national standards of care for abortion services in some form.

8.36 The current standards are tied closely to the current legislation. Therefore any change to abortion law will necessitate review and updating of the standards.

¹⁴ Education Review Office Te Tari Arotake Mātauranga *Promoting wellbeing through sexuality education* (September 2018).

¹⁵ *ASC Standards of Care* standards 6.2.1–6.2.10.

¹⁶ *ASC Standards of Care* standards 7.1–7.5 and 8.1.

¹⁷ *ASC Standards of Care* standards 8.1–10.6.

¹⁸ *ASC Standards of Care* standards 6.3.1–6.3.15.

¹⁹ *ASC Standards of Care* standards 8.2.5, 8.5.1, 8.6.6, and 9.2.1.

²⁰ Licensing is discussed in more detail in Chapter 7.

- 8.37 The Commission agrees that having a national set of standards is desirable for consistency, and considers the Ministry of Health would be best placed to develop them. While a health professional or regulatory body (such as RANZCOG or the New Zealand Medical Association) could set professional guidance, it would only apply to members of a particular profession (for example, doctors). Standards issued by the Ministry of Health could encompass all health practitioners who are involved in abortion services.
- 8.38 Some health practitioners suggested the Ministry of Health should set up a national body to maintain evidence-based standards of care for abortion services and provide advice to the Ministry and DHBs, as it does for some health services.²¹
- 8.39 The current *ASC Standards of Care* were produced by a subcommittee of experienced professionals. Health professional bodies and abortion service providers the Commission consulted suggested a similar panel or advisory group should be involved in the development of any new national standards to be published by the Ministry of Health. The advisory group could consist of representatives of professions working in abortion services (including doctors, nurses, midwives, counsellors and social workers).
- 8.40 Health professional bodies, practitioners and other submitters stressed the importance of involving Māori in developing a health framework informed by mātauranga and tikanga Māori, to deliver culturally appropriate services and provide oversight. In addition, the Ministry of Health and health practitioners highlighted the need for culturally appropriate services for Pacific women.
- 8.41 Submitters also stressed the importance of developing a framework to provide culturally appropriate services generally, including use of interpreters, where required. Some submitters highlighted that the framework for provision of abortion services needs to recognise that trans men, takatāpui²² and other gender diverse people may also be capable of becoming pregnant and may need to seek abortion services.
- 8.42 The Commission does not express a view on the precise mechanism through which the standards should be developed and maintained. The Ministry of Health would need to consider the most effective way to achieve this, including obtaining appropriate input from abortion service providers. The Ministry of Health would also need to consider how best to work with Māori in good faith, as required by the Treaty of Waitangi.²³ Standards should provide best practice guidance for the provision of services that are culturally appropriate and take into account the needs of gender diverse people.

²¹ For example, the National Screening Unit within the Ministry of Health is responsible for the development, management and monitoring of nationally-organised population-based screening. With the assistance of advisory groups, it monitors and provides advice and guidance on a range of screening programmes, including the national cervical screening programme. See, for example, National Screening Unit *Guidelines for Cervical Screening in New Zealand* (Ministry of Health, April 2010).

²² Takatāpui is a traditional Māori term meaning “intimate companion of the same sex” (see, for example: HW Williams *Dictionary of the Maori Language* (7th ed, Legislation Direct, Wellington, 1971, rep 2000)). Today it is used to embrace all Māori who identify with diverse genders, sexes and sexualities: see Rainbow Youth Inc and Tiwhanawhana Trust “What does ‘takatāpui’ mean?” (2017) <www.takatapui.nz>.

²³ See the discussion at paragraph [3.43] above.

NO LEGISLATION IS NECESSARY TO ENABLE OVERSIGHT BY THE MINISTRY OF HEALTH

Proposal

Repeal the provisions in the Contraception, Sterilisation, and Abortion Act 1977 referring to the constitution, functions and powers of the Abortion Supervisory Committee. No replacement legislation would be necessary.

- 8.43 If any abortion-specific legislation is retained (as in Model B or C), it could require the Ministry of Health to set national standards for abortion care and oversee provision of abortion services. The Commission notes, however, that the Legislation Design and Advisory Committee's *Legislation Guidelines* state a new statutory power should only be created if no suitable alternative power exists that can achieve the policy objective.²⁴
- 8.44 The Ministry of Health already has the ability to establish committees and issue best practice standards, as it does, for example, with the New Zealand Maternity Standards (which guide the provision, funding and monitoring of maternity services).²⁵ It does not require specific statutory authority to do this. Further, the Ministry of Health already has the ability to (and does) collect statistics and monitor the distribution and funding of health services generally. No legislative reform is therefore necessary to enable oversight by the Ministry of Health, although considerable operational policy development would be required. The Ministry in its submission to the Commission supported the repeal of specific abortion legislation and suggested abortion services should be overseen and regulated in the same way as other health services.
- 8.45 As noted above, the other functions currently performed by the ASC would no longer be required if the proposals set out in Chapters 4, 5 and 7 of this briefing paper are adopted. All of the current provisions in the CSA Act relating to the ASC's functions and powers could therefore be repealed. No replacement provisions would be necessary.

²⁴ Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 84.

²⁵ Ministry of Health *New Zealand Maternity Standards: A set of standards to guide the planning, funding and monitoring of maternity services by the Ministry of Health and district health boards* (July 2011).

CHAPTER 9

Informed consent and counselling

INTRODUCTION

- 9.1 This chapter considers whether any particular provision is needed in abortion laws to ensure women make fully informed decisions and are given appropriate support. In particular, this chapter focuses on the law that governs informed consent, including for young women under the age of 16, and women who lack capacity to consent. It also addresses the law that applies to the availability of counselling.
- 9.2 Several submitters suggested the law should contain more specific provisions about how women consent to abortion, such as a requirement for health practitioners to disclose certain risks or for women to attend counselling. The law applying to health procedures generally, in combination with operational measures, is sufficient to ensure that women are in a position to make fully informed decisions in relation to abortion and have access to appropriate support.

INFORMED CONSENT

- 9.3 Providers of health care services may only provide services if the patient makes an informed choice and gives informed consent.¹ This requirement is not unique to abortion; it is fundamental to all health care services.² The Medical Council of New Zealand describes informed consent as:³

... an interactive process between a doctor and patient where the patient gains an understanding of his or her condition and receives an explanation of the options available including an assessment of the expected risks, side effects, benefits and costs of each option and thus is able to make an informed choice and give their informed consent.

- 9.4 Some submitters maintained that the law should require specific steps to be taken beyond the general requirements of health law to ensure a woman seeking an abortion has given informed consent. The steps commonly identified by submitters were that the law should:

¹ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Rights), sch, cl 2, right 7; Medical Council of New Zealand *Information, choice of treatment and informed consent* (March 2011) at [14].

² See, for example, *Dentist, Dr B and Dentist, Dr C* Health and Disability Commissioner, 10HDC00671, 26 June 2012 at [121].

³ Medical Council of New Zealand *Information, choice of treatment and informed consent* (March 2011) at [2].

- require that women be given specific information, particularly regarding the potential physical and mental health risks of abortion, and the developmental stage of the fetus;
- require women to wait for a certain period before making a final decision, to reflect on the information provided; and
- include specific safeguards to protect women who may be seeking abortions under coercion.

9.5 For the reasons given in this chapter, the Commission considers the general law that currently applies is sufficient to ensure women seeking abortions give informed consent.

No reform is necessary to ensure women give informed consent

Proposal

No reform is suggested to the general health law that already governs how women give informed consent to abortion.

Should the law expressly require that women be given certain information?

- 9.6 Under the Code of Health and Disability Services Consumers' Rights (the Code of Rights), every health services consumer has the right to receive information that a reasonable consumer would expect in their circumstances.⁴ This includes “an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option”.⁵ The Health and Disability Commissioner has found this right to be breached where a woman considering abortion was not informed of the possible psychological side effects of the procedure.⁶
- 9.7 The Abortion Supervisory Committee (ASC) *Standards of Care* require abortion service providers to provide women with information about possible complications.⁷ The information must cover both short-term and longer-term complications, and include emotional distress and psychological issues as well as physical complications.⁸ The information must be available to women verbally and in writing before they consent to the abortion procedure.⁹

⁴ Code of Rights, sch, cl 2, right 6.

⁵ Code of Rights, sch, cl 2, right 6(1)(b).

⁶ *Obstetrician and Gynaecologist* Health and Disability Commissioner, 97HDC9291, 9 February 2000 at 16.

⁷ Standards Committee to the Abortion Supervisory Committee *Standards of care for women requesting abortion in Aotearoa New Zealand* (January 2018) (ASC *Standards of Care*), standards 7.3–7.4.

⁸ ASC *Standards of Care*, standard 7.4. See also standard 8.3.4: “Women should be informed of the range of emotional responses they may experience before, during and after an abortion”.

⁹ ASC *Standards of Care*, standard 7.4. The use of mifepristone and misoprostol for medical abortion as recommended in the ASC *Standards of Care* varies from the use described in the Medsafe Data Sheet and is therefore an “unapproved” or “off label” use of those drugs. The Health and Disability Commissioner has held that patients should be informed if the use of medicine in proposed treatment is unapproved (*Medical Practitioner, Dr C* Health and Disability Commissioner, 10HDC00986, 29 June 2012 at [66]). Medsafe also states that if there is little or equivocal documented support for the unapproved use of the medicine, the Code of Rights requires the written consent of the patient on the basis the treatment is “experimental” (see Medsafe “Compliance: Use of Unapproved Medicines and Unapproved Use of Medicines” (22 October 2014) <www.medsafe.govt.nz>). The Abortion Supervisory Committee (ASC) considers that its recommended use of mifepristone and misoprostol is “common and usual practice” and therefore it is unnecessary to obtain specific consent for the unapproved use of the drugs for medical abortion in the context of high quality abortion care: ASC *Standards of Care* at 8.

- 9.8 The *ASC Standards of Care* also require abortion service providers to offer certain other information to women seeking services, to assist them in deciding whether to have an abortion. This includes information about:¹⁰
- basic anatomy and physiology as relevant to the length of gestation;
 - the process of abortion and its possible complications;
 - fetal development (which may include showing pictures of the stage of fetal development); and
 - how people make sense of the loss of conception in abortion, grief and loss processes, and variabilities within a contemporary cultural context in Aotearoa.
- 9.9 Submitters held different views on the extent of the possible physical and mental health risks associated with abortion. The Ministry of Health and most health practitioners submitted that abortion is a low risk, routine medical procedure. On the other hand, some submitters were of the view that abortion is associated with a wide range of adverse physical and psychological outcomes.¹¹ These submitters said that the law should require women to be fully informed about these risks.
- 9.10 Any potential adverse physical and mental health consequences of abortion ought to be disclosed to the woman as part of the process of obtaining informed consent under the current law. This is required under the Code of Rights and the *ASC Standards of Care*, and should continue to be covered by any equivalent standards of care that may be developed in the future. An express legislative requirement to provide such information is unnecessary. Consequently, no change to the current law is required.

Should the law impose mandatory wait times?

- 9.11 A small number of submitters suggested the law governing abortion should expressly require women to wait for a defined period before making a final decision about whether to have an abortion. However, a more common concern was that changing the process could mean that women will have insufficient opportunity to change their minds. Some submitters said that the process under the current law gives women time to consider their options. As noted in Chapters 1 and 7, currently a woman must be referred to an abortion service provider by a doctor, then two certifying consultants must assess whether the woman's case meets the statutory grounds.
- 9.12 The laws of some jurisdictions in Europe and the United States require mandatory wait periods.¹² In the United States, 27 states impose a wait period in conjunction with a

¹⁰ *ASC Standards of Care*, standard 8.1.1.

¹¹ The Family First submission, which was copied or endorsed by many other submitters, cited a review of several studies from which the author concluded abortion was correlated to various adverse health outcomes, including increased risk of premature delivery, breast cancer and death from suicide or other causes. Auckland District Health Board, with input from maternal fetal medicine specialists, submitted that abortion “is a medical procedure which poses risks and a clear indication is required for appropriate informed consent”. See also the discussion on the physical and mental effects of abortion at paragraphs [2.86]–[2.93] above.

¹² Sam Rowlands “Abortion: a disunited Europe” (2015) 41 *J Fam Plann Reprod Health Care* 164 at 166 states that the following European jurisdictions impose mandatory wait times: Kosovo (2 days), Slovakia (2 days), Germany (3 days), Hungary (3 days), Latvia (3 days), Portugal (3 days), Spain (3 days), the Netherlands (5 days), Belgium (6 days), Albania (7 days), Italy (7 days), Jersey (7 days) and Luxembourg (7 days). For wait times in the United States see “Counseling and Waiting Periods for Abortion” (1 September 2018) Guttmacher Institute <www.guttmacher.org>.

mandatory counselling requirement.¹³ Women are required to wait for a specified amount of time, most often 24 hours, between receiving mandatory counselling and the abortion procedure.¹⁴ There are, however, no mandatory wait periods under the law in Australia, Canada or the United Kingdom.

- 9.13 The Victorian Law Reform Commission recommended against introducing a legislative requirement for a mandatory wait period.¹⁵ It considered existing medical procedures dealing with informed consent were sufficient to ensure women were given the time they needed to reach a decision. As the Commission noted, “[t]he time taken to make the decision is unique to each woman”.¹⁶
- 9.14 Furthermore, World Health Organization (WHO) guidance states that mandatory waiting periods can delay care, jeopardising a woman’s ability to access safe and legal abortion, and demean women as competent decision-makers.¹⁷ It calls on states to “eliminate waiting periods that are not medically required”.¹⁸ The United Nations Committee on Economic, Social and Cultural Rights has also indicated that wait periods undermine women’s rights to sexual and reproductive health.¹⁹
- 9.15 Although New Zealand law does not impose a mandatory wait period, health practitioners have a general duty to ensure a person seeking health services has sufficient time to reflect on the information provided before making a decision. Failure to do so will breach of the Code of Rights.²⁰ The amount of time that must be allowed will depend on a number of factors, including the nature and cost of the proposed treatment²¹ and whether it is urgent.²²
- 9.16 As discussed in Chapter 2, all women seeking an abortion undergo a psychosocial assessment. The *ASC Standards of Care* also require abortion service providers to offer all women counselling, and to actively encourage them to see a counsellor if they have been identified during the psychosocial assessment as requiring additional support.²³
- 9.17 The general duties under the Code of Rights and the specific processes that arise under professional standards and guidelines (like those currently under the *ASC Standards of Care*) are adequate to ensure health practitioners give women sufficient time to make an

¹³ “Counseling and Waiting Periods for Abortion” (1 September 2018) Guttmacher Institute <www.guttmacher.org>.

¹⁴ “Counseling and Waiting Periods for Abortion” (1 September 2018) Guttmacher Institute <www.guttmacher.org>.

¹⁵ Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at 127.

¹⁶ Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at 127.

¹⁷ World Health Organization *Safe abortion: technical and policy guidance for health systems* (2nd ed, Geneva, 2012) (WHO *Technical and Policy Guidance*) at 96.

¹⁸ WHO *Technical and Policy Guidance* at 97.

¹⁹ United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* E/C.12/GC/22 (2 May 2016) at [41].

²⁰ *Dentist, Dr B; Dentist, Dr C* Health and Disability Commissioner, 10HDC00671, 26 June 2012 at [122] and [151] (where a dentist commenced extensive and expensive dental treatment on the same day the dentist proposed the treatment to the patient); *Urological Surgeon, Dr B; A Private Hospital Registered Nurse, Ms C* Health and Disability Commissioner, 08HDC20258, 11 November 2009 at 15 (where the nature and risks of the proposed surgery, which was new and innovative, were discussed with the patient on the evening before the operation).

²¹ *Dentist, Dr B; Dentist, Dr C* Health and Disability Commissioner, 10HDC00671, 26 June 2012 at [122] and [151].

²² *Urological Surgeon, Dr B; A Private Hospital Registered Nurse, Ms C* Health and Disability Commissioner, 08HDC20258, 11 November 2009 at 15.

²³ *ASC Standards of Care*, standard 8.2.3.

informed decision. Provided these protections remain, mandatory wait periods are unnecessary.

Should the law introduce safeguards to protect women seeking abortions under coercion?

- 9.18 The possibility that women may be coerced into seeking an abortion was a common concern among submitters. Health practitioners the Commission spoke to emphasised that issues of potential coercion arise in a range of health care contexts and health practitioners are experienced in dealing with them. They noted that appropriately trained social workers, counsellors, doctors or nurses providing abortion services carry out a basic psychosocial assessment of all women seeking abortion, as required by the *ASC Standards of Care*.²⁴
- 9.19 The *ASC Standards of Care* provide that the aim of a psychosocial assessment is to better understand the woman and any additional challenges she may be facing.²⁵ The assessment may encompass family/social history, a cultural and spiritual assessment, a financial assessment, a mental wellness assessment, a family violence risk assessment and a sexual violence risk assessment.²⁶ In addition, the *ASC Standards of Care* specifically state that all women presenting to an abortion service provider should undergo a family violence routine enquiry, and referral to appropriate community resources should be available.²⁷ All women should be given the opportunity to be seen on their own to address issues of coercion and to facilitate honest and open discussion.²⁸
- 9.20 Ultimately, a woman seeking an abortion must give informed consent. The concept of informed consent under the law applying to health procedures generally requires that consent is freely given.²⁹ If a health practitioner cannot be satisfied that a woman seeking an abortion is giving informed consent, the abortion should not proceed.³⁰
- 9.21 Abortion practice and its regulation through professional standards and the law regarding informed consent are sufficient to manage issues of coercion. The law does not require reform.

Informed consent and women under the age of 16

Consent by young women

- 9.22 Section 38 of the Care of Children Act 2004 addresses the issue of young women and their capacity to consent to abortion. It provides that consent given by a female child of any age to an abortion, or refusal to consent to an abortion, is treated as having the same effect as if the child was of full age.³¹ As a consequence of section 38, the law does

²⁴ *ASC Standards of Care*, standard 8.3.2.

²⁵ *ASC Standards of Care*, standard 8.3.

²⁶ *ASC Standards of Care*, standard 8.3.2.

²⁷ *ASC Standards of Care*, standard 8.2.6.

²⁸ *ASC Standards of Care*, standard 8.2.4.

²⁹ Health and Disability Commissioner Act 1994, s 2.

³⁰ Under the Code of Rights, sch, cl 2, services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent: right 7(1).

³¹ Section 38 of the Care of Children Act 2004 displaces the general rule under s 36 of that Act. Section 36(1) provides that the consent of a child of or over the age of 16 to any medical or surgical procedure has effect as if the child were of full age.

not require the involvement of a young woman's parents unless the young woman lacks capacity to consent for reasons other than her age.

- 9.23 Section 38 is based on the recommendations of the Royal Commission of Inquiry into Contraception, Sterilisation, and Abortion in 1977, which resulted in amendments to the Guardianship Act 1968. The Royal Commission observed that a child under 16 and her parents might disagree as to whether she should have an abortion.³² It concluded that an abortion should not be forced on a child against her will. Likewise, the Royal Commission thought that if a child met the criteria for a lawful abortion, it would be harsh and illogical to deny it to her because of her age.
- 9.24 A related issue is the extent to which parents are entitled to be notified about their child's abortion. For the purposes of accessing health information about a person aged less than 16 years, the parents are considered the representative of that young person.³³ As representatives, they may seek access to the child's health information under section 22F of the Health Act 1956 and rule 11(4) of the Health Information Privacy Code 1994. However, the person or agency that holds the health information may refuse to disclose the information if disclosure would be contrary to the child's interests, or if they have reasonable grounds for believing the child does not wish the information to be disclosed.³⁴
- 9.25 The ASC recently reviewed its *Standards of Care*. The new standards give greater guidance on the provision of abortion services to young women. They recognise that young women aged between 10 and 19 may face additional challenges relating to their age and reproductive experience.³⁵ The ASC *Standards of Care* state:
- young women should be provided with accurate, age-appropriate education, information and support;³⁶
 - abortion service providers should assess young women's specific psychosocial needs, including their level of support, current/historical mental health, care and protection and substance abuse concerns;³⁷
 - young women should be seen on their own initially to assess risk and ensure an informed and independent decision is being made. A young woman should be supported to make decisions about whether she would like family/whānau members involved in her care and/or other appropriate forms of support. The guiding principle for family involvement is to strengthen the family relationship and potential support for the future, unless a risk from within the family is identified;³⁸

³² Royal Commission of Inquiry "Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry" [1977] 11 AJHR E26 at 276–278.

³³ Section 22B of the Health Act 1956.

³⁴ Health Act, s 22F(2)(b); Health Information Privacy Code 1994, r 11(4)(b).

³⁵ ASC *Standards of Care* at 25.

³⁶ ASC *Standards of Care*, standard 8.3.5.

³⁷ ASC *Standards of Care*, standard 8.3.6.

³⁸ ASC *Standards of Care*, standard 8.3.7.

- abortion service providers should suggest or support a young woman to involve parent(s) or another adult (such as family/whānau member or specialist youth worker) but generally should not override the young woman’s view;³⁹
- before the abortion procedure, the young woman should be encouraged to give information and contact details of a “significant other” whom they trust, preferably a person over 18 years;⁴⁰
- abortion service providers should be alert to the possibility of abuse of young women, particularly when a young woman refuses to involve her parents, there is a history of repeat abortions or she is accompanied by a controlling adult;⁴¹
- post-abortion counselling and support should be offered to all young women;⁴²
- abortion service providers should establish working relationships with school/community-based youth specific health services;⁴³ and
- when following up on young women, communication technologies should be consistent with the woman’s preferred mode of communication (such as text message appointment reminders). Importance should be placed on consistent follow-up, outreach and multidisciplinary teamwork.⁴⁴

What extent of parental involvement should the law require?

Proposals

No reform is suggested to the law that currently governs how people under the age of 16 give informed consent to abortion.

No reform is suggested to the laws that apply to the disclosure of health information about a person under 16.

9.26 Several submitters said the law should require greater parental involvement. Some considered that minors were vulnerable people and should not make a decision as significant as whether to have an abortion without their parents’ consent. Other submitters said the law should provide that parents must be notified about their child’s pregnancy before an abortion is performed so they can support the child.

9.27 In 2015 a petition was presented to Parliament requesting:⁴⁵

That the Parliament pass legislation providing that a parent of a woman under the age of 16 years has the right to know if that woman has a pregnancy confirmed before she is referred for any resulting medical procedure, and that any consent sought for the medical procedure be fully informed as to procedure, possible repercussions, and after-effects.

9.28 Parliament’s Justice and Electoral Select Committee considered the petition. The Committee agreed that the “best-case scenario for any young person who undergoes

³⁹ ASC *Standards of Care*, standard 8.3.8.

⁴⁰ ASC *Standards of Care*, standard 8.3.9.

⁴¹ ASC *Standards of Care*, standard 8.3.10.

⁴² ASC *Standards of Care*, standard 8.3.11.

⁴³ ASC *Standards of Care*, standard 8.3.12.

⁴⁴ ASC *Standards of Care*, standard 8.3.13.

⁴⁵ *Petition 2014/0011 of Hillary Kieft and 6 others* (26 May 2015).

any medical procedure is to have the full support of their parents.”⁴⁶ However, it noted that in some situations parental notification may place the young woman at risk of violence⁴⁷ or result in them being forced to make a decision against their own wishes.⁴⁸ Requiring parental notification might deter some young women from seeking medical help with their pregnancy.⁴⁹

- 9.29 The Committee concluded that parental notification should not be mandatory,⁵⁰ but that young women—particularly those without parental support—should receive additional support from the health system.⁵¹ It made recommendations aimed at strengthening the support provided, including that the ASC publish best-practice guidelines for pre- and post- abortion care and mandatory follow up for women under 16 years.⁵²
- 9.30 The Justice and Electoral Select Committee’s approach is consistent with international guidance. The WHO recommends that policies and practices should encourage but not require parents’ involvement through support, information and engagement.⁵³ The United Nations Committee on the Rights of the Child has said that the voluntary and informed consent of an adolescent should always be sought for any medical treatment or procedure.⁵⁴ The Committee supported a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health services.⁵⁵
- 9.31 In his submission to the Law Commission, the Privacy Commissioner said that if a young woman who has been found to be mentally competent is able to give or refuse consent to an abortion, she also has the right to keep her personal medical information private from her parents. The Commissioner submitted that the current privacy laws protect a minor’s right to privacy while also giving an appropriate level of discretion to doctors when faced with whether or not to disclose the minor’s personal information in a specific set of circumstances.
- 9.32 The Law Commission also sought feedback from the Office of the Children’s Commissioner (OCC). The OCC’s view was that no change is required to the current law regarding consent to abortion by women under 16 or parental notification. The OCC emphasised, however, that as a matter of practice, young women who have or seek an abortion should be encouraged to talk with their parents or other adults in their life that they trust for support.
- 9.33 In light of these considerations, there is insufficient justification for reforming the current law. Parental involvement should be encouraged but not compulsory. Regulation is best left to professional standards and guidelines. In addition, it should be noted that following

⁴⁶ *Petition 2014/11 of Hillary Kieft and 6 others: Report of the Justice and Electoral Committee* (7 July 2016) at 3.

⁴⁷ At 6–7.

⁴⁸ At 7.

⁴⁹ At 7.

⁵⁰ At 6–7.

⁵¹ At 7.

⁵² At 2.

⁵³ WHO *Technical and Policy Guidance* at 68 and 95.

⁵⁴ United Nations Committee on the Rights of the Child *General Comment No.20 (2016) on the implementation of the rights of the child during adolescence* CRC/C/GC/20 (2016) at [39].

⁵⁵ The United Nations Committee on the Rights of the Child *General Comment No.20 (2016) on the implementation of the rights of the child during adolescence* CRC/C/GC/20 (2016) at [39].

the Select Committee's recommendations the ASC has now amended its *Standards of Care* to include the provisions dealing specifically with young women, as set out at [9.25] above. The ASC *Standards of Care* affirm that best practice is to encourage and support young women to involve their parents or some form of adult support.⁵⁶

Informed consent and women with limited mental capacity

Proposal

Repeal section 34 of the Contraception, Sterilisation, and Abortion Act 1977, which addresses people with limited mental capacity and informed consent to abortion. Consent by people with limited mental capacity should be governed by general health law and any relevant professional standards or guidelines.

- 9.34 In some cases an abortion may be sought by or in relation to a woman who is not competent to make an informed choice and give informed consent to the procedure. Where this occurs, the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) requires the certifying consultants to consult a doctor or other person they believe is suitably qualified and experienced to assess the woman's condition and the likely impact of continuing the pregnancy or performing an abortion.⁵⁷
- 9.35 There are also regulatory requirements and medical standards that provide guidance to health practitioners when dealing with capacity issues. Under the Code of Rights, every person is presumed to be competent to give informed consent unless there are reasonable grounds for believing otherwise.⁵⁸ If a consumer is not competent to give informed consent, a legal guardian or a person holding an enduring power of attorney may consent on their behalf.⁵⁹ If there is no one available who can consent on the consumer's behalf, a health practitioner may still provide the service if:⁶⁰
- (a) it is in the best interests of the consumer; and
 - (b) reasonable steps have been taken to ascertain the views of the consumer; and
 - (c) either—
 - (i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
 - (ii) if the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

⁵⁶ The ASC noted in its 2016 report that further dialogue with DHBs and the Ministry of Health was needed to develop better post-abortion care and counselling support for young women. The Committee said that such support is a core health care service that needed to be managed by DHBs, medical practitioners and the Ministry as with any other medical procedure. See *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 6.

⁵⁷ Contraception, Sterilisation, and Abortion Act 1977 (CSA Act), s 34.

⁵⁸ Code of Rights, sch, cl 2, right 7(2).

⁵⁹ A legal guardian is a parent or a guardian under the Care of Children Act or a welfare guardian under the Protection of Personal Property Rights Act 1988. See Medical Council of New Zealand *Information, choice of treatment and informed consent* (March 2011) at [21].

⁶⁰ Code of Rights, sch, cl 2, right 7(4).

- 9.36 If the health practitioner is unable to ascertain the consumer's views or those of other suitable persons, the Medical Council recommends that they consult an experienced colleague before proceeding.⁶¹
- 9.37 Although several submitters noted the additional support women with capacity issues require, no submitters suggested that specific legislative provision was needed for women who lack capacity to consent to an abortion.
- 9.38 The provisions addressing women who lack capacity to consent should be repealed from the CSA Act. The Act's requirement to consult a third party who is suitably qualified is unnecessary because of the existing regulatory requirements and professional standards and guidelines that deal with consent and capacity issues generally.

COUNSELLING

- 9.39 The CSA Act only requires women to be informed of their right to seek counselling after the certifying consultants have made a decision to authorise or refuse to authorise an abortion.⁶² In practice, however, women are usually offered counselling before their case has been considered by certifying consultants, either by their general practitioner (GP) or Family Planning doctor, or when they first attend the abortion clinic.
- 9.40 A failure to offer counselling as required by the CSA Act can amount to a breach of right 4(2) of the Code of Rights, which requires health practitioners to deliver services in accordance with all relevant standards.⁶³
- 9.41 The *ASC Standards of Care* likewise require abortion service providers to have professionals available with suitable training in counselling.⁶⁴ The *ASC Standards of Care* state that women should be offered pre-decision/pregnancy options counselling and pre-abortion counselling.⁶⁵ The *ASC Standards of Care* also require providers to offer post-abortion counselling, although there is no such requirement in the CSA Act.⁶⁶
- 9.42 The *ASC Standards of Care* state that counselling must be free and easily accessible.⁶⁷ Counselling should be available on-site and without the need for a further visit,⁶⁸ although this is not currently the case at all abortion clinics.⁶⁹
- 9.43 While the CSA Act and *ASC Standards of Care* only require that counselling be offered, in practice some abortion service providers require all women to see a counsellor before having an abortion.⁷⁰ Health practitioners also told the Commission that counselling is

⁶¹ Medical Council of New Zealand *Information, choice of treatment and informed consent* (March 2011) at [23].

⁶² CSA Act, s 35.

⁶³ *Obstetrician and Gynaecologist* Health and Disability Commissioner, 97HDC9291, 9 February 2000 at 15.

⁶⁴ *ASC Standards of Care*, standard 8.2.4.

⁶⁵ *ASC Standards of Care*, standard 8.2.2.

⁶⁶ *ASC Standards of Care*, standard 8.2.2.

⁶⁷ *ASC Standards of Care*, standard 8.2.1.

⁶⁸ *ASC Standards of Care* at 23.

⁶⁹ According to information provided to the Commission by the ASC, in Tauranga and Whāngarei women are referred to counselling services off-site.

⁷⁰ Martha Silva and others "Ladies in waiting: the timeliness of first trimester services in New Zealand" (2010) 7(19) *Reproductive Health* 1 at 4. Of the nine clinics that participated in the study, six required all patients to see a social worker or counsellor prior to seeing a certifying consultant.

usually required for women considering later term abortions, because of the complexity of these cases.

- 9.44 There are no formal statistics collected on how many women choose to undertake counselling when given a choice. Among the district health boards (DHBs) that provided information to the Commission, there was considerable variation in the proportion of women who access counselling before or after an abortion. Some DHBs reported that in their district as few as 15 per cent of women choose to access optional counselling at any stage. Others reported much higher rates, some as high as 80 to 90 per cent. Most DHBs, however, reported rates of between 20 and 50 per cent.
- 9.45 Although one DHB reported that around half of the women access post-abortion counselling, most DHBs reported that very few women take up the opportunity of post-abortion counselling.
- 9.46 Abortion counselling services are mostly provided by social workers, but may also be provided by counsellors or nurses with counselling training. The *ASC Standards of Care* require all professionals providing abortion counselling to hold a relevant qualification or have equivalent training, be a registered member of their profession, be engaged in abortion counselling on a regular basis and have regular clinical supervision and peer review.⁷¹
- 9.47 Abortion counsellors are also required to have knowledge in specific areas.⁷² They must have an understanding of the relevant laws, pregnancy options (including parenting, adoption and abortion), contraceptive choices, fetal development and abnormalities, abortion procedures, availability of abortion services and social services, and relevant cultural practices and religious beliefs.

Should counselling be mandatory?

Proposal

Counselling should not be mandatory. If specific abortion legislation is enacted (under Model B or Model C), the Government could consider including a statutory requirement for abortion service providers to offer counselling.

- 9.48 Some submitters suggested the law should require women to undertake counselling before making a final decision to have an abortion.
- 9.49 Mandatory counselling is a feature of abortion law in some other jurisdictions. In the United States, 33 states require women to receive counselling before an abortion is performed.⁷³ Counselling is also compulsory in several Central and Eastern European countries.⁷⁴
- 9.50 In New Zealand, most abortion service providers do not require a woman to have counselling, although all offer counselling. Several health professional bodies that submitted to the Commission opposed any measures to introduce mandatory

⁷¹ *ASC Standards of Care*, standard 8.2.5.

⁷² Counselling Advisory Committee to the Abortion Supervisory Committee *Standards of Practice for the Provision of Counselling* (April 1998) at 7–8.

⁷³ “Counseling and Waiting Periods for Abortion” (2018) Guttmacher Institute <www.guttmacher.org>.

⁷⁴ See Leah Hoctor & Adriana Lamačková “Mandatory waiting periods and biased abortion counselling in Central and Eastern Europe” (2017) 139 *Gynecology & Obstetrics* 253.

counselling. These submitters included the New Zealand Association of Counsellors, the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). The Ministry of Health also opposed mandatory counselling. These submitters reasoned that many women do not require counselling; they are competent and confident to make informed decisions without assistance. A requirement to undergo counselling could undermine the autonomy of those women and unnecessarily delay access to services.

- 9.51 Most submitters did, however, affirm the benefits that accessible counselling could provide to women when offered and taken up voluntarily. The New Zealand Association of Counsellors, for example, explained:

Most women are very competent and confident to make a decision about whether to end a pregnancy when they meet with a health practitioner. Some women may be conflicted, and will work through these feelings with a partner, family and close friends. And of course there will be some women who may really struggle with the decision to end a pregnancy and will need additional support through professional counselling. This should be available and accessible for women who need it, before and after the termination of pregnancy process. Counselling often identifies depression and social stress. It also at times leads to revelations of coercion to terminate.

- 9.52 Similarly, the Aotearoa New Zealand Association of Social Workers (ANZASW) explained that abortion counselling helps people explore inter-personal and intra-personal influences that impact on the decision-making and abortion preparation process. ANZASW emphasised that counselling should be encouraged as part of any abortion care pathway.
- 9.53 The WHO has recommended that where a woman has made a decision to have an abortion before seeking care, that decision should be respected without subjecting the woman to mandatory counselling.⁷⁵ The counselling for those women who desire it should be voluntary, confidential, non-directive and by a trained person.⁷⁶
- 9.54 The Commission recognises the importance of having counselling services available to women. However, on balance there should not be a requirement for women to undergo counselling before making a final decision to have an abortion.
- 9.55 If Model B or Model C is preferred and specific abortion legislation is retained, the Government could consider including a statutory requirement for abortion service providers to offer counselling both before and after the abortion procedure, and in the event a woman decides not to proceed with an abortion. However, the availability of counselling could equally be ensured through means other than a legislative requirement. For example, the requirements could be set out in standards of care issued by the Ministry of Health (as discussed in Chapter 8). Access to counselling could also continue to be included in service specifications for DHBs, as is currently the case.⁷⁷

⁷⁵ WHO *Technical and Policy Guidance* at 36.

⁷⁶ WHO *Technical and Policy Guidance* at 36.

⁷⁷ Ministry of Health *Specialist Medical and Surgical Services: Gynaecology Services Tier Two Service Specification* (July 2015) at 3–4.

Oversight of counselling

Proposals

Service standards and/or standards of care should require abortion service providers to have counselling available to women considering abortion or who have had an abortion, and set out the necessary qualifications and knowledge for counsellors.

The Ministry of Health should be responsible for ensuring adequate availability and standards of abortion counselling services.

- 9.56 Currently the ASC has a duty to take “all reasonable and practicable steps to ensure that sufficient and adequate facilities are available throughout New Zealand for counselling women who may seek advice in relation to abortion”.⁷⁸ It also has a function of approving counselling services, although in practice DHBs decide how to provide counselling services within their districts.⁷⁹ As noted above, the ASC has published guidance on counselling, set out in the ASC *Standards of Care* and in the *Standards of Practice for the Provision of Counselling*.⁸⁰
- 9.57 Responsibility for ensuring adequacy and availability of counselling should shift to the Ministry of Health. The Ministry would work with DHBs to ensure access to counselling services for women considering abortion and women who have had abortions. The Ministry would also be responsible for issuing service specifications and standards of care that regulate counselling and set out the necessary qualifications and knowledge for counsellors. This would fit within the broader oversight role suggested for the Ministry of Health in Chapter 8.
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⁷⁸ CSA Act, s 14(1)(e).

⁷⁹ CSA Act, s 31.

⁸⁰ Counselling Advisory Committee to the Abortion Supervisory Committee *Standards of Practice for the Provision of Counselling* (April 1998). Standard 8.2 of the ASC *Standards of Care* acknowledges the need to update the counselling standards to reflect changes in abortion services and changes in social work and counselling practice.

CHAPTER 10

Conscientious objections

INTRODUCTION

- 10.1 Some health practitioners do not provide services in relation to abortion on the basis that it would be contrary to their conscience or beliefs. Section 46 of the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) and section 174 of the Health Practitioners Competence Assurance Act 2003 (HPCA Act) recognise health practitioners' rights to refuse to provide treatment. The New Zealand Bill of Rights Act 1990 (NZBORA) likewise affirms the right to freedom of conscience and belief.
- 10.2 The current law imposes a duty on practitioners refusing to provide services to inform a woman that she can obtain the services elsewhere.¹ However, some people believe this obligation does not go far enough to guard women against the delays, costs and stress of having to find another health practitioner.
- 10.3 This chapter addresses the law applying to health practitioners' conscientious objections. In this context, "conscientious objection" is a health practitioner's refusal to provide, or be involved in, a lawful treatment or procedure on the basis that it goes against their conscience or beliefs.
- 10.4 The Government may consider reform is necessary to ensure women can access abortion services without undue delay. If this is the case, the law could be amended to explicitly require health practitioners with conscientious objections to refer women seeking abortion services as soon as reasonably practicable to another health practitioner who is able to provide the services. This would go beyond the current requirement to merely inform women they can seek services from another practitioner.

CONSCIENTIOUS OBJECTIONS UNDER NEW ZEALAND'S CURRENT LAW

Legislation that addresses conscientious objections in relation to abortion

- 10.5 Two provisions in New Zealand's legislation directly address conscientious objections in relation to abortion.
- 10.6 Section 46 of the CSA Act provides that no doctor, nurse or other person is under any obligation to perform or assist in the performance of an abortion if they object to doing so on the grounds of conscience.
- 10.7 Section 174 of the HPCA Act provides that when a person requests a health practitioner to provide a service with respect to reproductive health services (including abortion) and the practitioner objects to providing the service on the grounds of conscience, the practitioner must inform the person that they can obtain the service from another health

¹ Health Practitioners Competence Assurance Act 2003 (HPCA Act), s 174(2).

practitioner or Family Planning clinic.² There is no duty on the health practitioner to take steps to refer the woman directly to an abortion service provider or to an alternative health practitioner.

10.8 In *Hallagan v Medical Council of New Zealand* the High Court considered a doctor's duties under section 174 of the HPCA Act when a woman requests the doctor to arrange an abortion for her.³ The Medical Council argued that section 174 of the HPCA Act did not excuse doctors from considering a woman's request and referring her case to be determined by certifying consultants in accordance with sections 32 and 33 of the CSA Act.

10.9 The Court held that a doctor who is approached by a woman seeking an abortion has two options if that doctor has a conscientious objection to abortion:⁴

- if the doctor's conscience would be infringed by arranging for the case to be dealt with under sections 32 and 33 of the CSA Act, the doctor may decline the patient's request to do so. In that event, section 174 of the HPCA Act requires the doctor only to inform the woman she can obtain the service from another doctor or Family Planning clinic; or
- if the doctor's conscience would not be infringed by referring the woman to a doctor who would consider her case in accordance with sections 32 and 33, the doctor must take that step.

10.10 The Court further held that if a doctor "engages medically with the case", they come under a statutory and professional responsibility to deal with the case in accordance with sections 32 and 33. A doctor cannot consider the case and then invoke a conscientious objection.⁵ At the initial stage of the doctor/patient consultation, before there has been "an involvement of a medical character", it was appropriate that the focus be on the doctor's rights to freedom of conscience under sections 13 and 15 of the NZBORA.⁶ At a later stage when the doctor has undertaken the task of considering the case, the focus is on the rights of the patient.

Human rights

10.11 Section 13 of the NZBORA affirms that "[e]veryone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference." Section 15 affirms that every person has the right to manifest their religion or belief.⁷ A person's rights to freedom of thought, conscience and religion have been

² The terms of s 174 of the HPCA Act were carried forward from the former Medical Practitioners Act 1995, s 11 and the Medical Practitioners Act 1968, s 43A. The provision was introduced into the Medical Practitioners Act 1968 in 1977 as part of the wider reforms regarding contraception, sterilisation and abortion. See Contraception, Sterilisation, and Abortion Bill 1977 (57—1), cl 66 and the Medical Practitioners Amendment Act 1977, s 2.

³ *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010.

⁴ At [20].

⁵ At [22].

⁶ At [23].

⁷ Rights to manifest religion and freedom of thought, conscience and belief are also protected at international law: International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), ratified by New Zealand 28 December 1978, art 18.1.

described as far-reaching and profound,⁸ and one of the foundations of a democratic society.⁹

10.12 Accordingly, health practitioners have rights under the NZBORA that allow them to object to providing services that would infringe their conscience.¹⁰ These rights may, however, be subject to reasonable limits as discussed below.

10.13 The willingness of health practitioners to provide services to patients is fundamental to ensuring access to health care. This is especially true for abortion under the current legal framework, as the CSA Act provides that only doctors may refer a woman to certifying consultants, who will then consider the woman's case.¹¹

10.14 As discussed further below, several submitters explained that women may encounter delays, costs and stress if a health practitioner refuses to assist them on the grounds of conscience. Conscientious objections can therefore create barriers to accessing abortion services. In Chapters 2 and 7 the Law Commission noted that barriers to accessing services may infringe women's human rights. For this reason several international bodies have called on states to regulate the practice of conscientious objections. The United Nations Committee on Economic, Social and Cultural Rights has recommended that, when health care providers invoke conscientious objections, states must:¹²

...appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and that it does not inhibit the performance of services in urgent or emergency situations.

Professional standards that address conscientious objections generally

10.15 Professional standards also set out the responsibilities health practitioners are expected to observe if they object to providing health services generally. The New Zealand Medical Association *Code of Ethics* states:¹³

Doctors have the right, except in an emergency, to refuse care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.

⁸ United Nations Human Rights Committee *CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion)* CCPR/C/21/Rev.1/Add.4 (1993) at [1]; *Nakarawa v AFFCO New Zealand Ltd* [2014] NZHRRT 9 at [54].

⁹ *Eweida v United Kingdom* (2013) 57 EHRR 8 (ECHR) at [79]; Paul Rishworth and others *The New Zealand Bill of Rights* (Oxford University Press, Melbourne, 2003) at 277; Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [14.1.10].

¹⁰ *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010 at [23].

¹¹ Contraception, Sterilisation, and Abortion Act 1977, ss 32–33. See discussion above at [7.12]–[7.24].

¹² United Nations Committee on Economic, Social and Cultural Rights *General comment No. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* E/C.12/GC/22 (2016) at [43]. In its review of Poland, the Committee on Economic, Social and Cultural Rights expressed concern that because of doctors' and clinics' refusal to provide abortions based on conscientious objections, women would have to turn to clandestine abortions. The Committee called on Poland to pass legislation to implement appropriate referral mechanisms in cases of conscientious objection: United Nations Committee on Economic, Social and Cultural Rights *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant: Concluding observations of the Committee on Economic, Social and Cultural Rights: Poland* E/C.12/POL/CO/5 (2009) at [28].

¹³ New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 6 (recommendation 17).

10.16 Similarly, the Medical Council of New Zealand's *Good Medical Practice* states:¹⁴

Your personal beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right.

10.17 The Royal Australian New Zealand College of Obstetricians and Gynaecologists (RANZCOG) statement *Termination of Pregnancy* addresses conscientious objections specifically in relation to abortion. It states:¹⁵

No member of the health team should be expected to perform termination of pregnancy against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained.

10.18 It should be noted that the legislation and professional standards regarding conscientious objections do not expressly apply to non-health practitioners.¹⁶ This does not mean administrative staff cannot raise conscientious objections. Rather, employers may need to consider the extent of their staff's obligations to undertake certain tasks associated with abortion in light of the employees' NZBORA rights and any justifiable limitation imposed by their employment.¹⁷ The New Zealand courts have not considered conscientious objections held by administrative staff.

RESPONSE FROM SUBMITTERS

10.19 Several submitters stated that practitioners who refuse to refer women to abortion service providers on the basis of conscientious objections can create difficulties for women. Some district health boards (DHBs) explained that health practitioners refusing to provide services on the basis of conscientious objection inevitably cause delays to women as they must find another practitioner and make another appointment. RANZCOG submitted that unless the practitioner with an objection makes an effort to refer the woman to another doctor, there can be delays, particularly for vulnerable women who may struggle to navigate the health system without assistance. Some submitters said that health practitioners refusing to refer on the basis of conscientious objection can impede access to services in smaller or remote communities because women may have to travel to see practitioners without an objection.

10.20 Submitters explained that when women seek services in relation to abortion it is often a stressful and traumatic time. If women encounter a health practitioner who refuses to refer them to abortion service providers on the basis of conscientious objection, it may

¹⁴ Medical Council of New Zealand *Good Medical Practice* (December 2016) at [20].

¹⁵ Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Termination of pregnancy* (C-Gyn-17, July 2016) at [4.6].

¹⁶ A health practitioner is defined in s 5 of the HPCA Act as a person who is registered as a member of a health profession that comes under the Act. The professions the Act applies to include doctors, midwives, nurses, pharmacists and psychologists. See Ministry of Health "Responsible authorities under the Act" (4 May 2015) <www.health.govt.nz>.

¹⁷ The New Zealand Bill of Rights Act 1990 (NZBORA) may apply to public sector employers, including district health boards, pursuant to s 3. However, private health providers may not come under the NZBORA. See too *Doogan v Greater Glasgow and Clyde Health Board* [2014] UKSC 68, [2015] AC 640 at [24] where the Supreme Court of the United Kingdom observed that in spite of the specific conscientious objection provision in s 4(1) of the Abortion Act 1967 (UK), state employers were still obliged to have regard to their employees' rights under the European Convention on Human Rights.

add to the stress and trauma the women face, in addition to the inconvenience and delay of finding an alternative practitioner.

- 10.21 Similarly, the Ministry of Health submitted that conscientious objection stigmatises women and delays their access to an abortion referral, which may have negative health implications.
- 10.22 Some health professional bodies, including the New Zealand College of Midwives and the New Zealand Nurses Organisation, considered it part of the responsibility of practitioners who provide services to women of reproductive age to give women accurate and timely information about abortion services and referrals to those services. Some submitters felt that a health practitioner's personal views should not influence a woman's access to services. Instead health professionals should be required to provide services within their scope of practice, regardless of their personal objections.
- 10.23 On the other hand, some submitters, including the New Zealand Medical Association and Nurse Practitioners New Zealand, supported the retention of the existing provisions for conscientious objection. Some practitioners considered it was important for practitioners to work according to their conscience and that no person should be compelled to play any part in the abortion process.
- 10.24 Many health professional bodies and submitters said that an ability to object should remain, but practitioners with conscientious objections should be required to go beyond simply telling a woman she can receive services from another practitioner. These submitters included the New Zealand College of Midwives, Royal Australian and New Zealand College of Psychiatrists, RANZCOG, Family Planning New Zealand and the National Council of Women. They considered that conscientious objectors should either refer a woman in a timely manner to another practitioner who does provide the services she seeks, or provide the woman with sufficient information about practitioners who provide the services to enable her to access those services.

JUSTIFIED LIMITATIONS ON THE RIGHTS TO FREEDOM OF CONSCIENCE AND BELIEF

- 10.25 Section 5 of the NZBORA provides that the rights and freedoms contained in the NZBORA may be subject only to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". Consequently, any restrictions on health practitioners' rights to freedom of conscience and belief should be considered in light of section 5.¹⁸

¹⁸ The Legislation Design and Advisory Committee *Legislation Guidelines* state that if proposed legislation would limit a right under the NZBORA, every attempt should be made to eliminate the inconsistency or ameliorate its impact so that the limit meets the standard of reasonableness set out in section 5: Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 33.

10.26 The courts have held that, in order to determine whether a limit is reasonable and demonstrably justified, it is necessary to inquire:¹⁹

- (a) does the proposed limit on a right serve a purpose sufficiently important to justify limiting a right?
- (b) if so:
 - (i) is the limiting provision rationally connected to its purpose?
 - (ii) does the limit impair the right no more than is reasonably necessary for sufficient achievement of the purpose?
 - (iii) is the limit proportionate to the importance of the objective?

10.27 Ensuring women can access abortion services without delay, inconvenience and stress is likely to be a sufficiently important goal to justify limiting health practitioners' rights to conscientiously object.²⁰ As noted above, conscientious objections that impede access to abortion services could infringe women's rights. The key issues in relation to any provision restricting conscientious objections are likely to be whether the restriction impairs the right no more than reasonably necessary and is proportionate to the importance of the objective.

10.28 The extent to which a provision limiting rights to conscientiously object is reasonable and justified for the purposes of section 5 of the NZBORA must be considered in the context of the wider legal framework governing abortion. This briefing paper contains advice on how the law might improve access to abortion services. Some of the possible reforms identified include:

- allowing women to self-refer to abortion service providers without needing a doctor's referral;²¹
- removing the requirement for abortions to occur in specifically licensed institutions;²² and
- allowing appropriately trained health practitioners to provide abortions, rather than only doctors.²³

¹⁹ *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 at [104].

²⁰ In *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario* 2018 ONSC 579, 140 OR (3d) 742 at [142]–[150], the Court found that the objective of a professional policy that required physicians to refer women to abortion service providers when requested was of sufficient importance to warrant overriding physicians' rights of religious freedom. See too *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill* (4 August 2017) at [63]–[65]. The Attorney-General commented on an obligation of referral under the End of Life Choice Bill for medical practitioners with conscientious objections to assisted dying. Clause 7 requires medical practitioners who have a conscientious objection to assisted dying to tell the person requesting services that the person may ask the "Support and Consultation for End of Life in New Zealand" group for the name and contact details of a replacement medical practitioner. The Attorney found that cl 7 was justified for the effective functioning of the assisted dying regime created by the Bill.

²¹ See paragraphs [7.23]–[7.24] above.

²² See paragraphs [7.30]–[7.41] above.

²³ See paragraphs [7.42]–[7.51] above.

10.29 These reforms, if implemented, could reduce the impact of health practitioners refusing to provide services in relation to abortions, as it may be easier for women to access services directly and from a wider range of health practitioners. This should be borne in mind when assessing whether any limitations on the rights of conscientious objectors are reasonable and justified for the purposes of section 5 of the NZBORA.

OPTIONS FOR REFORM

10.30 The Commission considered two options relating to the law that currently addresses conscientious objection.

10.31 These two options would both retain specific legislative provisions dealing with conscientious objections in relation to abortion. Some health practitioners and professional bodies suggested to the Commission that the law should not contain any specific legislative provision dealing with conscientious objections in relation to abortion. They explained that having a standalone provision singles out abortion as a procedure to which practitioners may legitimately hold objections. They suggested that such a provision may encourage practitioners to refuse to provide abortion services.

10.32 On balance, the Commission considers it is preferable to set out practitioners' obligations in legislation because:

- legislation is the strongest means of imposing duties on practitioners when they have objections to providing services;
- repealing the current provisions with no replacement might mean that health practitioners' duties are unclear, which could result in worse outcomes for women seeking abortion services; and
- professional standards and guidelines that attempt to regulate objections in the absence of legislation may be disputed, as shown by legal challenges to professional guidelines both in New Zealand and overseas.²⁴

Option A: retain the current law

Option A

Maintain the current law regarding conscientious objection.

10.33 This option would maintain the current law without change. The Government may consider the current law provides sufficient protections to both objecting health practitioners and women seeking an abortion. In addition, as noted above, the Government may consider that broader reforms to abortion law will sufficiently reduce delays in accessing abortion services caused by doctors with conscientious objections.

10.34 If Model A (outlined in Chapter 4) is adopted, the Government may wish to consider introducing a provision similar to section 46 of the CSA Act into the HPCA Act alongside section 174 of the HPCA Act. If Model B or Model C is adopted, and legislation is enacted to replace the CSA Act, the replacement legislation could contain a provision similar to section 46 of the CSA Act.

²⁴ See, for example, *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010 and *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario* 2018 ONSC 579, 140 OR (3d) 742.

Option B: require health practitioners with conscientious objections to refer women to another health practitioner or health care provider

Option B

If a woman requests a health practitioner to provide advice relating to abortion, perform an abortion or assist in performing an abortion, and the health practitioner objects on the grounds of conscience, the health practitioner would be required, as soon as reasonably practicable, to:

- (a) disclose the fact of their objection to the woman; and
- (b) refer the woman to another health practitioner or abortion service provider that is able to provide the service.

Note: Health practitioners have duties to provide prompt and appropriate assistance in a medical emergency. Practitioners' conscientious objections in relation to abortion should not affect their broader duties in a medical emergency.

10.35 This option for reform could:

- improve women's access to services by obliging conscientious objectors to refer women as soon as reasonably practicable to a practitioner who is able to provide services, rather than just informing them they can access services elsewhere; and
- provide a balance between the rights of health practitioners who do not wish to be directly involved in abortion and the rights of women who seek abortion services.

10.36 The requirement to disclose a conscientious objection is in keeping with people's rights to receive information they would expect to receive when receiving health care, including any information required by legal, professional, ethical and other relevant standards.²⁵ It is also recommended by the Medical Council of New Zealand's *Good Medical Practice*.²⁶

10.37 The requirement to refer women as soon as reasonably practicable to another health practitioner or abortion service provider is intended to strike a balance. It would help to ensure that women who may struggle to access services without assistance are given the support they need to obtain health care in an appropriate timeframe. The abortion procedure is generally safer and less stressful for women the earlier in pregnancy it is performed. The obligation to refer as soon as reasonably practicable would minimise delays women may experience if they are left to find alternative services on their own. At the same time, health practitioners would not be required to give advice about abortion, or perform or assist in performing abortions.

10.38 Option B was supported by the majority of health professional bodies that submitted on the issue. It is also consistent with recent law reforms in Australia.²⁷

²⁵ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch, cl 2, right 6(1).

²⁶ Medical Council of New Zealand *Good Medical Practice* (December 2016) at [20].

²⁷ See Termination of Pregnancy Law Reform Act 2017 (NT), s 11; Abortion Law Reform Act 2008 (Vic), s 8; Reproductive Health (Access to Terminations) Act 2013 (Tas), ss 6–7. Recently, the Queensland Law Reform Commission recommended that Queensland's abortion law be reformed to contain materially similar provisions: Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at 152–153 (recommendations 4-1–4-3). The Commission's recommendations have been carried into cl 8 of the Termination of Pregnancy Bill 2018 (Qld), which is currently before the Queensland Parliament.

10.39 As noted above, if the Government wishes to progress Option B, it will need to be assessed under section 5 of the NZBORA.²⁸ That assessment should be undertaken with reference to any wider reforms to abortion law that may occur.

Scope of Option B

10.40 Option B would only impose obligations on health practitioners. It would not address situations where administrative staff hold conscientious objections. Administrative staff could still raise conscientious objections, and their employers may need to consider the extent of staff's obligations in light of the employees' NZBORA rights and any justifiable limitation imposed by their employment.²⁹

10.41 The Commission recognises that women seeking abortions or advice in relation to abortion do not rely on administrative staff in the same way as they do health practitioners. Accordingly, conscientious objections held by administrative staff are less likely to affect access to abortions.

10.42 The obligation to refer suggested in Option B would only apply when a health practitioner is requested to provide advice relating to abortion, perform an abortion or assist in performing an abortion. It would not apply to other aspects of health care, such as post-abortion care of women.³⁰

10.43 Clinics, hospitals or DHBs do not have rights to object on the grounds of conscience because rights under the NZBORA apply only to natural persons. Option B would not affect this position. Nor would it impose any obligation to refer on clinics, hospitals or DHBs. Rather, the obligation to refer would rest with the individual health practitioner consulted by a woman considering abortion.

What constitutes a referral?

10.44 The Commission considers it is preferable not to define in legislation what steps are required to make a referral. The process for making referrals is a matter best dealt with as a matter of clinical practice.³¹ Referral procedures and professional obligations may change over time and legislation could become outdated. What is important is that health practitioners make referrals they are reasonably confident will be effective so women receive the services they seek in an appropriate timeframe.

²⁸ Section 7 of NZBORA requires the Attorney-General to bring to the attention of the House of Representatives any provisions of a Bill that appear inconsistent with the rights and freedoms contained in the NZBORA.

²⁹ The NZBORA may apply to public sector employers, including district health boards, pursuant to s 3. However, private health providers may not come under the NZBORA.

³⁰ In *Doogan v Greater Glasgow and Clyde Health Board* [2014] UKSC 68, [2015] AC 640 at [34]–[39], the Supreme Court of the United Kingdom considered the extent of the conscientious objection provision under s 4(1) of the Abortion Act 1967 (UK). The Court considered whether nursing care in relation to medical abortion constituted “treatment authorised by the Act”. The Court held that the “treatment” began with administration of the abortion drugs. Treatment included the medical and nursing care connected with the process of undergoing labour and giving birth, the monitoring of the progress of labour, the administration of pain relief, the giving of advice and support to a patient, delivery of the fetus, and disposal of the fetus, placenta and membrane. In some cases specific aftercare may be required as a result of the birth process, such as repair of an episiotomy. But “treatment” under the Act did not include ordinary nursing and pastoral care of a patient who has just given birth.

³¹ The Queensland Law Reform Commission likewise recommended that abortion law should not define the term “refer”: Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at [4.163]. See too the Termination of Pregnancy Bill 2018 (Qld), cl 8. Additionally, no comparative legislation the Law Commission has reviewed either in New Zealand or overseas has prescribed what steps must be taken to make an effective referral.

10.45 The Queensland Law Reform Commission has suggested:³²

4.124 An example of a referral could be giving a woman enough information to contact an alternative practitioner or health service provider about obtaining the requested service (for example, their name and contact details), or providing a written referral to another medical practitioner (for example, an obstetrician).

4.165 Where it is not practicable for a woman to make the arrangements to see another doctor, it might be appropriate for an objecting practitioner to make the necessary arrangements on her behalf. For example, in a hospital, the woman's care could be transferred to another equivalent practitioner.

Health practitioners' duties to assist in a medical emergency would be unaffected

10.46 Several health professional bodies and health practitioners the Commission consulted supported a requirement for practitioners to assist a woman in a medical emergency. This view is consistent with the New Zealand Medical Association *Code of Ethics* noted above³³ and the law in several Australian states.³⁴

10.47 Under Option B, the proposed provision would not excuse a health practitioner from any duties that might apply in an emergency situation. However, the option recognises that a health practitioner's duty to provide prompt and appropriate assistance in a medical emergency is best governed by general health law.³⁵ The extent of those duties is highly dependent on several factors that are context-specific, such as the nature of the emergency, the skill level and competence of the practitioner, and the availability of other health services.³⁶ It would be both impractical and inappropriate for abortion law to attempt to prescribe a health practitioner's duties.³⁷ Similarly, the definition of a medical emergency, in which those duties would apply, is best left to professional standards and guidelines.³⁸

³² Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018).

³³ New Zealand Medical Association *Code of Ethics for the New Zealand Medical Profession* (2014) at 6 (recommendation 17).

³⁴ See Abortion Law Reform Act 2008 (Vic), s 8; Reproductive Health (Access to Terminations) Act 2013 (Tas), ss 6–7; Criminal Law Consolidation Act 1935 (SA), s 82A.

³⁵ See Medical Council of New Zealand *A doctor's duty to help in a medical emergency* (August 2006) at [9]–[11]. Right 4(2) of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, sch, cl 2, provides that "every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards". Under s 151 of the Crimes Act 1961, everyone who has care of a vulnerable adult who is unable to provide himself or herself with necessaries is under a legal duty to: a) provide that person with necessaries; and b) to take reasonable steps to protect that person from injury. This may include a doctor asked to look after a person in a medical emergency: See Medical Council of New Zealand *A doctor's duty to help in a medical emergency* (August 2006) at [10]; Simon France (ed) *Adams on Criminal Law – Offences and Defences* (online looseleaf ed, Thomson Reuters) at [CA151.03]–[CA151.04].

³⁶ See Medical Council of New Zealand *A doctor's duty to help in a medical emergency* (August 2006) at [5].

³⁷ See Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at [4.169]: "The imposition of a positive duty to act in an emergency would be difficult to monitor and enforce, and would impose a duty that some doctors could not comply with, for example due to lack of training."

³⁸ Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at [4.171]. It should be noted that the Medical Council of New Zealand's statement *A doctor's duty to help in a medical emergency* (August 2006) sets out the ethical and legal duties on doctors in a medical emergency. The statement defines medical emergency as "a sudden, unforeseen injury, illness or complication, demanding immediate or early professional care to save life or prevent gross disability, pain or distress": at [1].

Legislative changes needed to implement Option B

- 10.48 The reform suggested in Option B would require legislative amendment. The form that amendment would take would differ depending on which of the models outlined in Chapter 4 is preferred.
- 10.49 If Model A was implemented, no specific legislation governing abortion would remain and it would be necessary to amend section 174 of the HPCA Act.
- 10.50 If Model B or Model C was implemented, the statute that continues to regulate abortion could contain the suggested reform. Section 174 of the HPCA Act would also still need to be amended as it deals with conscientious objections towards “contraception, sterilisation, or other reproductive services”. It would be necessary to exclude abortion from its ambit and signal that the provision in the abortion legislation is to take priority.
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CHAPTER 11

The offence of killing an unborn child

INTRODUCTION

- 11.1 Section 182 of the Crimes Act 1961 makes it an offence to kill an unborn child in a manner that would amount to murder if the child had been born.
- 11.2 The Minister of Justice, in his letter to the Law Commission requesting this briefing paper, stated that he did not expect the Commission to review section 182. The Minister did, however, note the Commission may wish to “highlight any adjustments to that provision that would be needed because of the options discussed”.¹
- 11.3 As discussed in this chapter, there is some uncertainty about the scope of section 182. The section was not enacted with abortion in mind and has only been used to prosecute people who have assaulted pregnant women causing the death of the fetus. However, the wording of the section is broad enough to apply to abortions performed at later gestations.
- 11.4 If the abortion offences are repealed or amended, section 182 may require amendment to reflect the Government’s policy decisions about when abortion should be lawful. This chapter suggests some possible approaches to amending section 182.

SCOPE OF SECTION 182 OF THE CRIMES ACT

Section 182 has only been used to address assaults on pregnant women, but could also apply to abortion

- 11.5 Under section 182(1) it is an offence, punishable by up to 14 years’ imprisonment, to cause the “death of any child that has not become a human being” in a manner that would amount to murder “if the child had become a human being”. A child “becomes a human being... when it has completely proceeded in a living state from the body of its mother.”²
- 11.6 Section 182(2) creates an exception to the offence for any person who “before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother.”

¹ Letter from Hon Andrew Little to the Hon Sir Douglas White QC (27 February 2018) (Appendix 1).

² Crimes Act 1961, s 159.

- 11.7 The nature of the relationship between section 182 and the abortion offences is uncertain. This uncertainty arises because, as explained below:
- the section was not drafted with abortion in mind; but
 - the wording of the section is wide enough to apply to abortions performed at later gestations—although the precise point at which a fetus becomes a “child” for the purpose of section 182 is unclear.³
- 11.8 On its face, section 182 applies to the killing of a child at any time before or during its birth. It is not expressly limited by gestation. However, the use of the word “child” (rather than “embryo or fetus”, as is used in the abortion offences⁴) limits the application of the section to later gestations. “Child” is not defined in the Crimes Act, but case law suggests section 182 does not apply to an abortion during the first trimester of pregnancy (that is, the first 12 weeks after conception).⁵ The courts have, to date, declined to be more prescriptive about when a fetus becomes a child for the purpose of section 182.⁶

Purpose of section 182

- 11.9 The legislative history of section 182 provides some insight into the purpose of the provision.⁷ A predecessor to section 182 appeared in New Zealand’s first Criminal Code of 1893⁸ and was based on the report of a United Kingdom Royal Commission in 1879.⁹ The United Kingdom Royal Commission recommended the introduction of an offence for the narrow purpose of addressing the act of “killing a child *in the act of birth, and before it is fully born*”, which did not appear to be an offence at that time.¹⁰
- 11.10 The offence was intended to bridge the gap between homicide offences and abortion offences.¹¹ This gap arose because:
- the killing of a child can only qualify as murder if the child has “become a human being”—that is, when it has “completely proceeded in a living state from the body of its mother”;¹² whereas

³ As noted by Miller J in *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [72], s 182 “covers death caused before birth but does not establish a time frame within which death must occur.”

⁴ Crimes Act, ss 182A, 183 and 186.

⁵ *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516, per Richmond P (one of the majority). The other two judges did not address the issue. The Royal Commission of Inquiry appeared to assume Richmond P’s approach was correct in recommending that no amendments to s 182 were necessary: Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 279. See also *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [72]–[73] and *The Abortion Supervisory Committee v Right to Life New Zealand Inc* [2011] NZCA 246, [2012] 1 NZLR 176 at [13] and fn 13.

⁶ *R v Henderson* [1990] 3 NZLR 174 (CA) at 179.

⁷ The history of section 182 was helpfully summarised by the Court of Appeal in *R v Henderson* [1990] 3 NZLR 174 (CA) at 179–182.

⁸ Criminal Code Act 1893, s 200.

⁹ Criminal Code Bill Commission *Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences* (London, 1879).

¹⁰ Criminal Code Bill Commission *Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences* (London, 1879) at 25.

¹¹ *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516; Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 144–145; *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [72]–[73]; Nicola Peart “Prevention and Termination of Life Before Birth” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (online ed, Thomson Reuters) at [19.3.7].

- the abortion offences only apply to the destruction, death or premature expulsion of an “embryo or fetus”,¹³ which arguably excludes the killing of a child during its birth.

11.11 The original intent of the section, as recommended by the United Kingdom Royal Commission, was therefore to address the killing of a child during its birth.¹⁴ However, as the Court of Appeal observed in *R v Henderson*, the section as adopted in the New Zealand Criminal Code Act 1893 appears to have had a broader purpose.¹⁵ The New Zealand Statutes Revision Commission, which drafted the predecessor to section 182, explained the rationale for the provision in the following terms:¹⁶

If injuries be inflicted on a child while in the womb, which result in the death of the child after it is born, the person causing them is guilty of murder, and it seems inconsistent to hold him harmless if the child is never born.

11.12 The New Zealand Commission envisaged the section being used to prosecute people who caused the death of a child through injuries inflicted “while in the womb”. It recommended some minor changes to the wording of the section drafted by the United Kingdom Royal Commission,¹⁷ which the Court in *Henderson* considered meant the section “lost the flavour of a provision directed to an act causing death at the time of birth”.¹⁸

11.13 The wording of the provision has not changed in substance since the Criminal Code of 1893, and now appears in section 182 of the Crimes Act. When the Royal Commission on Contraception, Sterilisation, and Abortion considered section 182 in 1977, it did not recommend any changes because it did not consider section 182 applied to abortion. The Royal Commission referred to the narrower view that the section’s purpose was (as in the United Kingdom) to fill the gap between homicide and abortion offences.¹⁹

¹² Crimes Act, ss 158–159. As to the position at common law, see the discussion in *R v Henderson* [1990] 3 NZLR 174 (CA) at 176.

¹³ Crimes Act, s 182A.

¹⁴ While subsequent case law and the Royal Commission report in 1977 refer to the killing of a child “in the course of birth”, “during the process of birth” or “at the time of birth”, they do not clarify exactly what this means in practical terms—that is, the point at which “birth” begins. See, for example, *Right to Life New Zealand Inc v The Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) at [72] and Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 279.

¹⁵ *R v Henderson* [1990] 3 NZLR 174 (CA) at 180.

¹⁶ Criminal Code Bill 1883 (8–1) at 50 (commentary on cl 203, which later became s 200).

¹⁷ The New Zealand version omitted the word “living” before “child” and the word “fully” before “born”. The two versions of the provision are compared in *R v Henderson* [1990] 3 NZLR 174 (CA) at 179–180.

¹⁸ *R v Henderson* [1990] 3 NZLR 174 (CA) at 180.

¹⁹ Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 279.

How section 182 has been applied in case law

- 11.14 In practice section 182 appears to have been used only to prosecute people for assaults on pregnant women with the intention or result of causing a miscarriage.²⁰ So far as the Commission has been able to establish from available court judgments, it has not been used to prosecute a person for the death of a child during birth.
- 11.15 In *R v Henderson* the section was used to successfully prosecute a man who assaulted a pregnant woman, killing the fetus, at approximately 26 weeks gestation.²¹ The Court of Appeal found that the fetus in that case was a “child” for section 182 purposes, noting that it was well past the 20 weeks gestation period referred to in section 187A of the Crimes Act.²²
- 11.16 The Court in *Henderson* declined to set out a general rule as to when a fetus becomes a child for the purposes of section 182, saying only that “the ordinary and natural meaning of the word “child” is such as to include the foetus in the present case”.²³ However, the decision suggests that some abortions performed at later gestations might be captured by section 182. The Court expressly recognised that “in many cases, an offence under s 183 [of procuring an abortion] would also be an offence under s 182.”²⁴
- 11.17 Cases decided since *Henderson* have not specifically considered the point at which a fetus becomes a “child” for section 182 purposes, so the precise scope of the section remains unclear. Section 182 has, however, generally been applied to assaults causing the death of a fetus at later gestations of pregnancy.²⁵ Similar assaults at earlier gestations have been prosecuted under section 183 (the offence of procuring an abortion).²⁶ There is therefore considerable overlap between sections 182 and 183.

The exceptions to the abortion offences do not apply to section 182

- 11.18 If, as it appears from the case law, section 182 is capable of applying to abortions performed at later gestations, this may lead to inconsistencies with the abortion offences. The definition in section 187A of when abortion is unlawful (which effectively creates exceptions to the abortion offences) does not expressly apply to section 182.²⁷ On the plain wording of the Act, it would therefore be possible for a court to find a

²⁰ See, for example, *R v Clarken* HC Auckland CRI-2005-044-6760, 3 November 2006; *R v Fitness* HC Hamilton T 7-95, 7 March 1996; *R v Wells* HC Wellington T 85-96, 27 September 1996; *R v Henderson* [1990] 3 NZLR 174 (CA).

²¹ *R v Henderson* [1990] 3 NZLR 174 (CA).

²² At 179.

²³ At 179.

²⁴ At 177.

²⁵ See *R v Clarken* HC Auckland CRI-2005-044-6760, 3 November 2006 (5 months gestation); *R v Wells* HC Wellington T 85-96, 27 September 1996 (5-6 months gestation); and *R v Henderson* [1990] 3 NZLR 174 (CA) (24-26 weeks gestation). There was one conviction under section 182 for attempting to cause the death of an unborn child at 13 weeks gestation, but the defendant pled guilty so there was no analysis of how section 182 applied: *R v Fitness* HC Hamilton, T 7/95, 7 March 1996.

²⁶ *R v Mosen* [2013] NZHC 2540 (one month gestation); *R v Fonoti* HC Auckland CRI-2006-092-13045, 28 November 2008 (15 weeks gestation).

²⁷ The only exception to the offence in section 182 is if the death of the child is caused by means employed in good faith to preserve the life of the mother (s 182(2)). It appears this situation resulted because the Royal Commission that recommended the introduction of section 187A did not consider section 182 applied to abortion: Royal Commission of Inquiry “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 at 279.

person who performs an abortion guilty of an offence under section 182 even if the abortion was lawful for the purposes of section 183 and the CSA Act.

- 11.19 In addition, while section 183(2) states that the woman shall not be charged as a party to the offence of procuring an abortion, there is no such provision in section 182. In theory, this means a woman who consents to the performance of an abortion or self-induces a miscarriage could be liable under section 182.

But the courts interpret section 182 consistently with the abortion offences

- 11.20 Because of the overlap between sections 182 and 183, however, the Court in *Henderson* recognised the desirability of ensuring they are consistently applied. It therefore found that any acts that would be lawful under section 187A should not result in conviction under section 182.²⁸ In light of this decision it is unlikely that a person who performs or obtains an otherwise lawful abortion would be convicted under section 182 under the current law.

IMPLICATIONS FOR SECTION 182 IF THE ABORTION OFFENCES ARE REPEALED

Abortion is more likely to be an offence under section 182

- 11.21 If sections 183–187A are repealed,²⁹ the exceptions in section 187A—and the need to ensure consistency with section 183—would no longer apply. As a result, the courts are more likely to find that performing an abortion is an offence under section 182, particularly at later gestations.
- 11.22 There are general provisions in the Crimes Act that protect any person from criminal liability for performing a surgical operation if:³⁰
- (a) they use reasonable care and skill; and
 - (b) either:
 - (i) the operation is performed for a lawful purpose and with the consent of the patient or any person lawfully entitled to consent on the patient’s behalf; or
 - (ii) the operation is for the patient’s benefit and is reasonable having regard to the patient’s state at the time and all the circumstances of the case.

- 11.23 These provisions are likely to protect most health practitioners from prosecution for performing surgical abortions. However, because they only cover surgical operations, they would not protect health practitioners who administer medication to induce an abortion or women who self-induce a miscarriage.

The legal status of assaults on pregnant women may be unclear

- 11.24 As noted above, the courts have interpreted “child” in section 182 in part by reference to the 20 week gestational limit in section 187A and the need for consistency with section 183. The application of section 182 has generally been confined to assaults at later gestations, while section 183 has been relied on at earlier gestations. If sections 183 and

²⁸ *R v Henderson* [1990] 3 NZLR 174 (CA) at 183.

²⁹ As discussed in Chapters 4–6.

³⁰ Crimes Act, ss 61–61A.

187A are repealed, it is unclear how that might affect the interpretation of section 182 and the law relating to assaults on pregnant women causing the death of the fetus.

- 11.25 If section 183 is repealed, amendments to the Crimes Act may be desirable to clarify how assaults on pregnant women should be addressed. It is likely that such assaults would already be covered by other offences in the Crimes Act, as discussed below. However, because assaults on pregnant women have historically been dealt with under sections 182 and 183, the repeal of section 183 could create uncertainty in the absence of a clear legislative statement.

ENSURING SECTION 182 DOES NOT APPLY TO ABORTION

Proposal

Consider either:

- (a) amending section 182 of the Crimes Act 1961 to ensure it does not apply to abortion; or
- (b) repealing section 182 of the Crimes Act 1961.

Note: People who assault pregnant women causing the death of the fetus could be prosecuted under other provisions in the Crimes Act 1961.

- 11.26 If the abortion offences are repealed or amended so that they only apply to unqualified people,³¹ the Government may wish to consider amending section 182 or repealing it altogether to ensure it does not apply to abortion. The policy intent behind full or partial decriminalisation would not be achieved if people performing otherwise lawful abortions could be convicted under section 182.
- 11.27 As noted by the Victorian Law Reform Commission, “[i]f the parliament wishes to regulate late abortion, it should do so under laws specifically designed to deal with abortion”.³² This will ensure that the penalties and level of censure are appropriate to the conduct involved. For example, Chapter 6 discussed the option of retaining an offence for unqualified people who perform abortions. Such people will usually act with the woman’s consent, so their conduct is substantively different to people who assault a pregnant woman causing the death of the fetus. A lower penalty may well be appropriate for consensual abortions and the stigma associated with conviction may be quite different.
- 11.28 In light of the Minister’s indication that he did not expect the Commission to review section 182, the Commission has not undertaken a detailed analysis of the policy behind that section. Further work would be required before any amendments are proposed. The Commission has, however, identified two possible approaches for further consideration.
- 11.29 In addition to clarifying that abortion is not an offence under section 182, these two approaches would clarify the legal status of assaults on pregnant women causing the death of a fetus. Under both approaches, such assaults would be dealt with in the same way regardless of gestational age.³³

³¹ As discussed in Chapter 6.

³² Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at [7.95].

³³ The Commission notes that if any new legislation were to include a gestational limit, it may be considered desirable to treat assaults causing the death of a fetus as a more serious offence after that gestational limit has passed. If that were the case, s 182 could be retained and expressly limited to the killing of a fetus after the gestational limit. Similar assaults

Section 182 could be amended to clarify its scope

11.30 One way of ensuring section 182 does not apply to abortion would be to create specific exceptions to the offence. It may be desirable to make these exceptions consistent with the general defences in the Crimes Act relating to surgical operations.³⁴ For example, section 182 could state that it does not apply to miscarriages induced:

- by the woman;
- with the consent of the woman or any person lawfully entitled to consent on her behalf; or
- for the woman’s benefit and in circumstances that are reasonable having regard to the woman’s state at the time.

11.31 The last exception would cover situations where a woman is unable to consent (for example, because she lacks mental capacity) and there is no one entitled to consent on her behalf. There are guidelines about the procedure health practitioners must follow in such cases.³⁵

11.32 A further amendment to section 182 may also be desirable to state that it applies to the death of a “fetus” (rather than, or in addition to, a “child”). Section 182 could then apply at any stage of pregnancy, rather than only at later gestations. This would mean assaults on pregnant women that might previously have been prosecuted under section 183 would be covered by section 182.

Or section 182 could be repealed and assaults on pregnant women prosecuted under other provisions in the Crimes Act

11.33 An alternative way of ensuring section 182 does not apply to abortion would be to repeal the offence altogether. As noted above, the section has never been used in relation to the killing of a child during its birth.³⁶ The conduct it is used to address—assaults on pregnant women intended to cause a miscarriage—is likely to be covered by other offences in the Crimes Act. As discussed below, this could be clarified to avoid any doubt.

11.34 An assault on a pregnant woman causing the death of the fetus may amount to the offence of wounding with intent to cause grievous bodily harm³⁷ (if the defendant intended to cause a miscarriage) or a lesser wounding or injuring offence.³⁸ There is case law indicating that causing harm to, or the death of, a fetus may be treated as bodily

at earlier gestations could be dealt with under other offences in the Crimes Act, such as wounding with intent (s 188), as discussed under Option 2 below.

³⁴ See ss 61 and 61A of the Crimes Act.

³⁵ As discussed in Chapter 9.

³⁶ See also the Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at [7.14]–[7.19], [7.70] and [7.93]–[7.94].

³⁷ Crimes Act, s 188(1).

³⁸ Such as wounding with intent to injury (Crimes Act, s 188(2)) or injuring with intent (s 189)).

harm to the woman, although the point has not been expressly considered in a criminal context in New Zealand.³⁹

- 11.35 If section 182 was repealed, the Crimes Act could be amended to provide that grievous bodily harm includes causing the death of the fetus of a pregnant woman, other than in the course of a medical procedure performed in the circumstances described at [11.30] above. Assaults causing the death of a fetus would then be captured by the offence of wounding with intent to cause grievous bodily harm, but lawful abortion would not be.
- 11.36 The offence of wounding with intent to cause grievous bodily harm is punishable by up to 14 years' imprisonment.⁴⁰ This is the same maximum penalty as section 182.⁴¹ This approach would not, therefore, reduce the seriousness of a conviction.
- 11.37 In Victoria, a provision similar to section 182 was repealed in the context of abortion law reform.⁴² An assault on a woman causing the death of the fetus is now treated as a "serious injury" to the woman.⁴³ A similar approach is also taken in New South Wales.⁴⁴
- 11.38 Alternatively, if an offence is retained for unqualified people who perform abortions,⁴⁵ assaults on pregnant women causing the death of the fetus could be captured by that offence. As discussed above, however, it may be preferable to address consensual abortion and assaults through separate offences as the appropriate penalty may differ.

³⁹ The death of a fetus has been found to amount to "personal injury" to the mother for the purposes of New Zealand accident compensation legislation: *Harrild v Director of Proceedings* [2003] 3 NZLR 289 (CA). There is also overseas authority reaching similar conclusions in a criminal context: *R v Sullivan* [1991] 1 SCR 489 (SCC); *R v King* (2004) 150 A Crim R 409 (NSWCCA). See also Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008) at [7.95] (in relation to similar provisions): "If Parliament wishes to clarify the law concerning assaults upon a pregnant woman, the Crimes Act should be amended to make it clear that destruction of a fetus caused by assault of a pregnant woman falls within the definition of 'serious injury' to the woman. *The current assault provisions in the Act probably cover this behaviour but legislative amendment will remove any doubt.*" [Emphasis added.]

⁴⁰ Crimes Act, s 188(1).

⁴¹ Crimes Act, s 182(1).

⁴² The offence was contained in s 10 of the Crimes Act 1958 (Vic) (now repealed).

⁴³ Crimes Act 1958 (Vic), s 15 (definition of "serious injury").

⁴⁴ Crimes Act 1900 (NSW), s 4(1) (definition of "grievous bodily harm").

⁴⁵ See Chapter 6.

CHAPTER 12

Areas for further consideration

INTRODUCTION

- 12.1 During the course of the Law Commission’s review, two issues came to the Commission’s attention that have not been included in the options for reform set out in this briefing paper but may warrant further consideration by the Government. This chapter briefly outlines those issues.
- 12.2 First, the Commission considered the possible introduction of “safe access zones” around abortion clinics to protect women accessing abortion services from intimidation by protesters. At this time, the Commission does not see a strong case for this. However, the Government could consider the issue further if demonstration activity becomes problematic in future and cannot be adequately addressed by the current law.
- 12.3 Second, some submitters and health practitioners raised concerns about abortions being performed based on the sex of the fetus or because the fetus suffered impairment. As explained below, this issue is closely related to laws and policies around prenatal screening and human assisted reproductive technology, and would need to be considered in that broader context. The Commission does not express a view but notes further consideration of these issues may be desirable if abortion law reform is progressed.
- 12.4 The Commission also notes it is required, when making recommendations, to have regard to the desirability of simplifying the expression and content of the law as far as practicable.¹ The current legislation relating to abortion is outdated and confusing. If it were to be retained, much could be done to improve its expression. This briefing paper does not give advice on that, as the proposed policy objective signalled by the Minister of Justice is likely to require repeal or significant reform of the current law. However, if aspects of the current law are retained, consideration should be given to updating how the law is expressed.²

SAFE ACCESS ZONES

- 12.5 Some submitters and organisations the Commission consulted, including district health boards (DHBs), abortion service providers and the Abortion Supervisory Committee

¹ Law Commission Act 1985, s 5(2)(b).

² The Abortion Supervisory Committee has raised a number of areas of possible concern with the wording of the current legislation. See, for example, *Report of the Abortion Supervisory Committee* (Annual Report, 2016) at 3–5.

(ASC), told the Commission that people sometimes gather outside abortion clinics to demonstrate against abortion. The types of demonstration differ. The Commission was told that, in some instances, demonstrators have held vigils. Often demonstrators have held signs or pictures of fetuses and babies. On some occasions, demonstrators have approached women to provide them with information or to attempt to dissuade them from having an abortion.

- 12.6 At one demonstration, women were given toy babies by groups opposing abortion.³ In 2012, the Invercargill abortion clinic reportedly opened in secret in order to protect staff safety.⁴ The Southland DHB refused to say whether clinic staff members were from the area or travelling from other regions, as a group called “Southlanders for Life” had vowed to “name and shame” clinic staff.
- 12.7 Submitters and abortion service providers noted that demonstrations can be distressing for women accessing clinics and staff providing services. Some women require reassurance from clinic staff after encountering demonstrators.
- 12.8 There are several laws in New Zealand that could address intimidating or anti-social behaviour at places where abortions occur. The following table summarises some criminal offences that are particularly relevant.

EXISTING OFFENCES ADDRESSING INTIMIDATING OR ANTI-SOCIAL BEHAVIOUR

Legislation	Prohibited conduct
Summary Offences Act 1981, section 4(1)(a), (b) and (c)	<p><i>Offensive behaviour or language</i></p> <ul style="list-style-type: none"> • Behaving in an offensive manner in or within view of a public place. • Addressing words to any person intending to threaten, alarm, insult, or offend that person in a public place. • Using threatening or insulting words and being reckless as to whether any person is alarmed, in or within view or hearing of a public place.
Summary Offences Act 1981, section 21(1)(d) and (e)	<p><i>Intimidation</i></p> <ul style="list-style-type: none"> • With intent to frighten or intimidate any person, or knowing that the conduct is likely to cause that other person reasonably to be frightened or intimidated: <ul style="list-style-type: none"> ◦ watching or loitering near a place where that person works, carries on business, or happens to be; or ◦ stopping, confronting, or accosting that person in any public place.

³ Claire Trevett and Sarah Harris “Abortion ‘no-protest’ zone suggested” *The New Zealand Herald* (online ed, Auckland, 16 August 2016).

⁴ Marika Hill “Abortion clinic opens in secrecy to protect staff” *Sunday Star Times* (online ed, Auckland, 14 October 2012).

Summary Offences Act 1981, section 22	<p><i>Obstructing a public way</i></p> <ul style="list-style-type: none"> Obstructing a public way without reasonable excuse and, having been warned by a constable to desist, continuing the obstruction, or desisting but subsequently obstructing the public way again.
Trespass Act 1980, section 3	<p><i>Trespass after warning to leave</i></p> <ul style="list-style-type: none"> Neglecting or refusing to leave a place after having being warned to leave that place by an occupier of that place.

12.9 Several other jurisdictions have reformed their law to strengthen remedies against harmful gatherings and demonstrations in relation to abortion. A common reform has been to introduce “safe access zones”. Safe access zones are areas within a specified radius of an abortion clinic. The law makes certain prohibited behaviour within the zone an offence, such as:

- harassing, hindering, intimidating or obstructing any person entering or leaving the premises where abortions are performed;
- interfering with or impeding footpath or vehicle access to the premises where abortions are performed;
- communicating with any person accessing the premises where abortions are performed in a way that is likely to cause distress or anxiety;
- protesting against abortions; or
- capturing visual data of people accessing or attempting to access premises where abortions are performed.

12.10 Several states and provinces in Australia,⁵ Canada⁶ and the United States⁷ have introduced safe access zones.

12.11 Few submitters addressed safe access zones when sharing their views with the Commission. Of those that did address the issue, several submitters considered that safe access zones would be useful. These submitters emphasised the distress demonstrators cause women. They submitted that women accessing abortion services are entitled to protection and respect. Some suggested that safe access zones could provide a useful tool if protest activity was to increase.

⁵ Health Act 1993 (ACT), ss 85–87; Public Health and Wellbeing Act 2008 (Vic), ss 185A–185H; Public Health Act 2010 (NSW), ss 98A–98F; Reproductive Health (Access to Terminations) Act 2013 (Tas), s 9; Termination of Pregnancy Law Reform Act 2017 (NT), ss 14–16. The Queensland Law Reform Commission recently recommended that Queensland law introduce safe access zones: Queensland Law Reform Commission *Review of termination of pregnancy laws*, Report No 76 (2018) at 187–188 (recommendations 5-1–5-7). The Commission’s recommendations have been adopted in Part 4 of the Termination of Pregnancy Bill 2018 (Qld), which is currently before the Queensland Parliament.

⁶ Access to Abortion Services Act RSBC 1996 c 1; Access to Abortion Services Act SNL 2016 c A-1.02; An Act Respecting Health Services and Social Services RSQ c S-4.2, ss 9.2, 16.1 and 531.0.1; Safe Access to Abortion Services Act SO 2017 c 19; Protecting Choice for Women Accessing Health Care Act SA 2018 c P-26.83.

⁷ For an overview of the law in the United States regarding safe access zones see “Protecting Access to Clinics” (1 August 2018) Guttmacher Institute <www.guttmacher.org>.

- 12.12 The Commission sought input from health professional bodies, abortion service providers and health practitioners about safe access zones. The majority felt that safe access zones were not needed. The Abortion Providers Group Aotearoa New Zealand (APGANZ) explained that only a minority of clinics had been targeted by distressing behaviour around their premises. Some abortion service providers reported that where women had been harassed or distressed by demonstrators in the past, Police responded effectively by moving the protestors on. Family Planning New Zealand noted that in its experience Police only intervened if demonstrators attempted to verbally engage with patients or staff at the clinic.
- 12.13 Some health professional bodies and practitioners thought that, if more abortions were performed through a greater range of community health care providers, it would become more difficult for demonstrators to target premises where abortions are performed. Some were concerned that safe access zones could serve to emphasise demarcation around abortion clinics and encourage demonstrations at the zone boundaries.
- 12.14 The Commission has not seen any clear evidence that the existing laws around intimidating and anti-social behaviour are inadequate, as would be required to justify the introduction of safe access zones.⁸ The Commission is also mindful that safe access zones would have to be considered for consistency with rights under the New Zealand Bill of Rights Act 1990, such as the rights to freedom of expression,⁹ freedom of peaceful assembly¹⁰ and freedom of association.¹¹ Any limits on those rights through the imposition of safe access zones would need to be carefully considered to ensure they are reasonable and justified.
- 12.15 For these reasons, the Commission does not suggest the introduction of safe access zones. However, if demonstration activity were to intensify in the future, the Government could consider such a reform.

SEX SELECTION AND FETAL IMPAIRMENT

- 12.16 Several submitters expressed concern that if there were no statutory rules restricting when abortions could be performed, there is a risk that some people would seek abortions for reasons many people would consider inappropriate. In particular, some submitters were concerned about abortions sought because of the fetus' sex, or because the fetus suffered from some impairment.

Abortions and sex selection

- 12.17 Some health professional bodies and practitioners expressed discomfort to the Commission about performing abortions based on the sex of the fetus. Some said it would be inappropriate to perform abortions on the basis of sex unless there were other factors indicating abortion was appropriate in the circumstances. However, many health practitioners explained that in practice they would never be faced with the issue because

⁸ Legislation should only include criminal offences if they are necessary to achieve a significant policy objective that cannot be achieved effectively through other measures: Legislation Design and Advisory Committee *Legislation Guidelines* (March 2018) at 111.

⁹ New Zealand Bill of Rights Act 1990, s 14.

¹⁰ Section 16.

¹¹ Section 17.

it was highly unlikely a woman would disclose she was seeking an abortion because of the sex of the fetus.

- 12.18 The Commission has not seen any evidence of sex-selective abortions in New Zealand. There is some, albeit limited, evidence to suggest that they occur in countries New Zealand often compares itself to. Researchers have studied male:female ratios among recent births in Canada and in Victoria, Australia. In Canada, the law does not restrict when an abortion may be performed lawfully. In Victoria, restrictions only apply after 24 weeks gestation. The studies found higher rates of male births for mothers among immigrant communities, particularly among women who already had children, suggesting that prenatal sex selection is practised.¹²
- 12.19 There have been initiatives to introduce restrictions on sex-selective abortions in Canada, the United States, the United Kingdom and Australia. However, lawmakers to date have not chosen to adopt the proposed law changes.¹³
- 12.20 New Zealand law prohibits the selection of in vitro human embryos for implantation based on the sex of the embryo.¹⁴ The Human Assisted Reproductive Technology Act 2004, which regulates procedures and research that assist people who are unable to have children, deems such activities to be “unacceptable”.¹⁵

Abortions and fetal impairment

- 12.21 Several submitters expressed concern about abortions sought on the basis on fetal impairment. Although the current law allows abortions on the grounds of fetal impairment, the threshold is that there is a substantial risk the child would be born “seriously handicapped”.¹⁶ Two main issues were raised regarding removal of the current statutory grounds for abortion in section 187A of the Crimes Act 1961.
- 12.22 First, several submitters were concerned that a relaxation of the law could mean an increase in abortions performed because the fetus would otherwise be born with disabilities. For example, high rates of abortions following prenatal diagnosis of Down syndrome have attracted comment both in New Zealand¹⁷ and overseas.¹⁸ The

¹² Abdool Yasseen and Theirry Lacaze-Masmonteil “Male-biased infant sex ratios and patterns on induced abortion” (2016) 188(9) CMAJ 640; Marcelo Urquia and others “Sex ratios at birth after induced abortion” (2016) 188(9) CMAJ 181; Kristina Edvardsson and others “Male-biased sex ratios in Australian migrant populations: a population-based study of 1 191 250 births 1999-2015” (2018) Int J Epidemiol 1.

¹³ In Canada, Conservative MP Mark Warawa introduced private members’ motions to the House of Commons on two occasions to condemn discrimination against females via sex selective abortions (M-408 in 2012 and M-77 in 2016). The motions failed to proceed. In the United States, the Susan B Anthony and Frederick Douglass Prenatal Nondiscrimination Bill of 2009 proposed to impose criminal penalties on any person who knowingly attempts to perform an abortion sought on the basis of the sex, gender, colour or race of the child or parent. The Bill languished in the House Judiciary Committee of the House of Representatives and did not make it to the Senate. In the United Kingdom, a private member’s Bill was introduced in 2014 to clarify the illegality of sex-selective abortions under the Abortion Act 1967 (UK) (Abortion (Sex-Selection) Bill 2014–15 (UK)). A revised Bill was tabled for its second reading, but after debate the proposed amendment was rejected. In Australia the Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013 was introduced to limit Medicare benefits for abortions carried out solely because of the sex of the fetus. The Bill lapsed at prorogation.

¹⁴ Human Assisted Reproductive Technology Act 2004 (HART Act), s 11.

¹⁵ HART Act, s 3(b).

¹⁶ Crimes Act 1961, s 187A(1)(aa).

¹⁷ See for example Ruby Nyika “Mothers of children with Down Syndrome encouraged to terminate” (20 April 2017) Stuff <www.stuff.co.nz>; Tessa Prebble “Are we sleepwalking into a world without Down Syndrome?” (11 October 2006) The Spinoff <www.thespinoff.co.nz>.

Commission has not seen any statistics about the rates of abortions in New Zealand following positive prenatal diagnoses of Down syndrome, but in some of the countries New Zealand often compares itself to the rate is over 90 per cent.¹⁹ Submitters were concerned that without adequate legal safeguards over when abortion can be performed, these trends may continue unscrutinised.

- 12.23 As noted in Chapter 3, New Zealand's Independent Monitoring Mechanism on the Convention on the Rights of Persons with Disabilities has observed that an approach that has the effect of preventing the births of a protected minority group could be discriminatory.²⁰ It increases stigma in society, means there are fewer people with lived experience to advocate for protections and services, and adds to the notion that disability is a negative experience rather than a facet of human diversity.
- 12.24 Second, there is a fear that abortions will be performed if fetuses are affected by conditions some would consider insufficiently severe to justify abortion. For example, there have been concerns expressed in other jurisdictions where late term abortions have been performed because fetuses were diagnosed with conditions like a cleft lip and palate or a club foot.²¹
- 12.25 The availability of prenatal screening is closely connected to this issue. Sophisticated screening techniques are developing. These techniques make it possible to determine a fetus' whole genome sequence, although presently such testing is relatively inaccessible. Some consider that the availability of such information during pregnancy, for example whether a fetus carries genetic markers which indicate susceptibility to certain diseases

¹⁸ Alison Gee "A world without Down's syndrome?" (29 September 2016) BBC News <www.bbc.com>; Dave Maclean "Iceland Close to Becoming First Country where no Down's Syndrome Children are born" (16 August 2017) The Independent <www.independent.co.uk>.

¹⁹ For example, a 2010 report from England and Wales found that after the prenatal diagnosis of Down syndrome 92 per cent of affected pregnancies were aborted: Joan K Morris and Anna Springett *The National Down Syndrome Cytogenetic Register for England and Wales: 2009 Annual Report* (Queen Mary University of London, December 2010) at 4. See also Robert Cole and Gareth Jones "Testing times: do new prenatal tests signal the end of Down syndrome?" (2013) 126(1370) *N Z Med J* 96; *Parliamentary Inquiry into Abortion on the Grounds of Disability* (Parliament of the United Kingdom, 2013). It has been reported that close to 100 per cent of Icelandic women and 98 per cent of Danish women who receive positive prenatal diagnoses of Down syndrome choose to abort: Julian Quinones and Arijeta Lajka "What kind of society do you want to live in?: Inside the country where Down syndrome is disappearing" (15 August 2017) CBS News <www.cbsnews.com>; Dave Maclean "Iceland Close to Becoming First Country where no Down's Syndrome Children are born" (16 August 2017) The Independent <www.independent.co.uk>.

²⁰ New Zealand Independent Monitoring Mechanism under the Convention of the Rights of Persons with Disabilities *Submission from New Zealand's Independent Monitoring Mechanism to Inform the Development of the List of Issues Prior to Reporting for New Zealand's 2nd Periodic Review under the Convention on the Rights of Persons with Disabilities* (2017) at 10.

²¹ A Parliamentary Inquiry in the United Kingdom heard evidence about cases where abortions were performed because the fetus suffered from conditions like cleft lips and club foot: *Parliamentary Inquiry into Abortion on the Grounds of Disability* (Parliament of the United Kingdom, July 2013) at [22] and [30]. In *Jepson v The Chief Constable of West Mercia Police Constabulary* [2003] EWHC 33158, a member of the public sought to judicially review the Police decision not to prosecute a doctor who terminated a pregnancy of 24 weeks gestation because the fetus had been diagnosed as suffering from a cleft lip and palate. Section 1(1)(d) of the Abortion Act 1967 (UK) allows late term abortion where "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped". The applicant argued the fetus was not seriously handicapped. The High Court granted the applicant permission to proceed with the claim for judicial review. The Crown Prosecution Service later reviewed the Police decision not to prosecute and upheld the decision. The applicant did not pursue the application.

or genetic conditions, may redefine what is understood as a normal and healthy pregnancy.²²

12.26 Again it should be noted that New Zealand law applying to assisted reproductive technology restricts prenatal testing. Pre-implantation genetic diagnosis (PGD) of embryos for implantation as part of in vitro fertilisation procedures is only permitted in cases where disorders run in the family or the woman is at particular risk because of her age or previous histories with pregnancies.²³

12.27 Some commentators suggest that the rationale for allowing PGD in these circumstances is to align with abortion law. Professor Mark Henaghan observes:²⁴

One factor which must be taken into account when regulating PGD is achieving, at the least, consistency with the law in relation to abortion, which has already placed a value on the moral status of the embryo. Reproductive autonomy is emphasised in abortion law where a pregnancy may be terminated on the basis of prenatal testing. This reflects reproductive choice as a high-end value. If the abortion framework in a jurisdiction is essentially permissive, this will have implications for the lawful parameters of PGD.

Discussion

12.28 Some submitters commented on the difficulty of the decisions women face when learning the condition of the fetus is not as they hoped or expected. They said, in these circumstances, the decision to abort is a matter for the woman alone to determine in her circumstances. Some said that what may be a serious issue for some women may be less so for others. It was not for others, or society, to judge a woman's decision. Other commentators have noted the family or societal pressures some women may face in relation to the sex of the fetus they are carrying.²⁵

12.29 These matters are complex.²⁶ Ultimately, the broader societal concerns and implications of abortions sought on the grounds of sex or fetal impairment are outside the scope of the advice the Commission has been asked to provide. These matters are also inseparable from the law and policy around prenatal screening, which is likewise beyond the scope of this briefing paper. These are matters the Government may wish to consider further.²⁷

²² Greer Donely Sara Chandros Hull and Benjamin E Berkman "Prenatal Whole Genome Sequencing: Just Because We Can, Should We?" (2012) 42(4) Hastings Cent Rep 28.

²³ Human Reproductive Technology Order 2005, s 5 and sch, pt 2, cl 6.

²⁴ Mark Henaghan *Choosing Genes for Future Children: Regulating Preimplantation Genetic Diagnosis* (Human Genome Research Project, University of Otago, 2006) at 304.

²⁵ The British Pregnancy Advisory Service (BPAS) notes that some women in minority ethnic communities in the United Kingdom may face abuse or even murder if they give birth to a girl. BPAS observes that criminalisation of sex selective abortion does nothing to address these issues; in fact it is more likely to expose vulnerable women to the risk of further victimisation and potentially place the babies they are forced to carry to term in danger of neglect or harm: British Pregnancy Advisory Service "Sex Selection" <www.bpas.org>

²⁶ For example, for arguments in favour of permitting abortion on the basis of sex see Toi te Taioa—the Bioethics Council *Who Gets Born? A report on the cultural, ethical and spiritual aspects of pre-birth testing* (June 2008) at 51; Rachael Wong and Grant Gillet "Think of the Children: Sex Selection and Child Welfare" (2015) 22 JLM 751.

²⁷ One submitter, a manager at a DHB, suggested that a good system needed to be in place to monitor abortion practice, with the potential for future legal changes if it was thought necessary to address problematic practices.

List of proposals and options

PART ONE: ALTERNATIVE LEGAL MODELS FOR TREATING ABORTION AS A HEALTH ISSUE

Three models for when abortion would be lawful

1A *Model A*

There would be no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s). General health law would apply to ensure services are provided safely and in line with best practice.

1B *Model B*

The health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing. This test would be set out in the Contraception, Sterilisation, and Abortion Act 1977 (or a replacement enactment) rather than the Crimes Act 1961.

1C *Model C*

For pregnancies of not more than 22 weeks gestation, there would be no statutory test that must be satisfied before an abortion could be performed. The decision whether to have an abortion would be made by a woman in consultation with her health practitioner(s).

For pregnancies of more than 22 weeks gestation, the health practitioner who intends to perform the abortion would need to reasonably believe the abortion is appropriate in the circumstances, having regard to the woman's physical and mental health and wellbeing. This test would be set out in the Contraception, Sterilisation, and Abortion Act 1977 (or a replacement enactment) rather than the Crimes Act 1961.

Changes required for all models

2 *The grounds for abortion in the Crimes Act 1961*

Repeal the current grounds for abortion in section 187A of the Crimes Act 1961.

3 *The requirement for authorisation from two certifying consultants*

Repeal the requirement in section 29 of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be authorised by two certifying consultants, and all other provisions relating to the role of certifying consultants.

PART TWO: OTHER ASPECTS OF ABORTION LAW

Except where otherwise stated, the options and proposals set out in this Part could be implemented under any of the three models in Part One.

Criminal aspects of abortion law

4 *Criminal offences for abortion*

Either:

A Repeal section 44 of the Contraception, Sterilisation, and Abortion Act 1977 (offence of a woman procuring her own miscarriage) and sections 183–187A of the Crimes Act 1961 (offences of procuring or supplying the means to procure a miscarriage).

or

B Repeal section 44 (offence of a woman procuring her own miscarriage) of the Contraception, Sterilisation, and Abortion Act 1977 and section 187A of the Crimes Act 1961 (grounds for abortion/meaning of “unlawfully”).

Amend sections 183 and 186 of the Crimes Act 1961 (offences of procuring or supplying the means to procure a miscarriage) so that it is an offence for a person other than a health practitioner to procure or provide the means to procure an abortion, unless they believe the abortion is necessary to save the life of the woman or prevent serious and imminent injury to her physical health.

5 *Regulatory offences for breaching the current licensing and certification requirements*

Repeal section 37 of the Contraception, Sterilisation, and Abortion Act 1977.

6 *Ensuring compliance with the statutory test if Model B or C is adopted*

Either:

A Insert a regulatory offence in the Contraception, Sterilisation, and Abortion Act 1977 (or any replacement legislation) applying to any person who performs an abortion without believing the statutory test for abortion is met (if Model B or C is adopted).

or

B Rely on the existing disciplinary regime in the Health Practitioners Competence Assurance Act 2003 to discipline health practitioners who fail to apply the statutory test for abortion.

An amendment to that Act could be considered to clarify that any failure to comply with the requirements of abortion law may be taken into account by the Health Practitioners Disciplinary Tribunal in determining whether a practitioner should be disciplined under section 100.

7 *Ensuring abortions are only performed by qualified people*

The Minister of Health may wish to review the wording of the schedule to the Health Practitioners Competence Assurance (Restricted Activities) Order 2005 to ensure that all types of surgical abortions are restricted activities.

Access to abortion services

8 *Referral to abortion services*

Repeal the requirement in section 32 of the Contraception, Sterilisation, and Abortion Act 1977 for women to be referred to certifying consultants by a doctor for consideration of abortion.

Women could access abortion services directly, or be referred by any health practitioner they choose to consult (for example, a GP, nurse, midwife or counsellor).

The Ministry of Health and district health boards may wish to consider publishing a list of key providers in each area (or who to contact to find out where the nearest service is).

9 *Licensing of premises where abortions are performed*

Repeal the requirement in section 18 of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be performed at an institution licensed by the Abortion Supervisory Committee.

Note: The safety of premises would be governed by general health law.

10 *Performing or assisting in performing abortions*

Remove the requirement in sections 32 and 33A of the Contraception, Sterilisation, and Abortion Act 1977 for abortions to be performed by a doctor.

Abortions could be performed or administered by a health practitioner with appropriate qualifications and experience, as determined by the scopes of practice issued by health profession regulatory bodies. The qualifications and experience required may differ depending on the method of abortion.

Oversight of abortion services

11 *Ensuring appropriate distribution and funding of abortion services*

The Ministry of Health could be responsible for collecting statistics on abortion and overseeing the distribution and funding of abortion services (including counselling services).

12 *Ensuring abortion services meet good standards of practice*

The Ministry of Health could issue best practice guidelines/standards of care for abortion services, in consultation with abortion service providers and Māori.

13 *No legislation is necessary to enable oversight by the Ministry of Health*

Repeal the provisions in the Contraception, Sterilisation, and Abortion Act 1977 referring to the constitution, functions and powers of the Abortion Supervisory Committee. No replacement legislation would be necessary.

Informed consent and counselling

14 *Informed consent*

No reform is suggested to the general health law that already governs how women give informed consent to abortion.

15 Informed consent and women under the age of 16

No reform is suggested to the law that currently governs how people under the age of 16 give informed consent to abortion.

No reform is suggested to the laws that apply to the disclosure of health information about a person under 16.

16 Informed consent and women with limited mental capacity

Repeal section 34 of the Contraception, Sterilisation, and Abortion Act 1977, which addresses people with limited mental capacity and informed consent to abortion. Consent by people with limited mental capacity should be governed by general health law and any relevant professional standards or guidelines.

17 Counselling

Counselling should not be mandatory. If specific abortion legislation is enacted (under Model B or Model C), the Government could consider including a statutory requirement for abortion service providers to offer counselling.

18 Oversight of counselling

Service standards and/or standards of care should require abortion service providers to have counselling available to women considering abortion or who have had an abortion, and set out the necessary qualifications and knowledge for counsellors.

The Ministry of Health should be responsible for ensuring adequate availability and standards of abortion counselling services.

Conscientious objection**19 Options for reform**

Either:

A Maintain the current law regarding conscientious objection.

or

B If a woman requests a health practitioner to provide advice relating to abortion, perform an abortion or assist in performing an abortion, and the health practitioner objects on the grounds of conscience, the health practitioner would be required, as soon as reasonably practicable, to:

- a) disclose the fact of their objection to the woman; and
- b) refer the woman to another health practitioner or abortion service provider that is able to provide the service.

Note: Health practitioners have duties to provide prompt and appropriate assistance in a medical emergency. Practitioners' conscientious objections in relation to abortion should not affect their broader duties in a medical emergency.

The offence of killing an unborn child

20 *Ensuring section 182 of the Crimes Act 1961 does not apply to abortion*

Consider either:

- a) amending section 182 of the Crimes Act 1961 to ensure it does not apply to abortion; or
- b) repealing section 182 of the Crimes Act 1961.

Note: People who assault pregnant women causing the death of a fetus could be prosecuted under other provisions in the Crimes Act 1961.

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Appendix 1

Letter from the Minister of Justice requesting advice on abortion law

Hon Andrew Little

Minister of Justice

Minister for Courts

Minister for Treaty of Waitangi Negotiations

Minister Responsible for the NZSIS

Minister Responsible for the GCSB

Minister Responsible for Pike River Re-entry



The Hon Sir Douglas White QC
President
Law Commission
PO Box 2590
WELLINGTON 6011

27 FEB 2018

Dear Sir Douglas

Thank you for meeting with me on 15 December 2017 to discuss the Law Commission's work programme. As I mentioned at that meeting, the Government is considering how best to ensure New Zealand's abortion laws are consistent with treating abortion as a health issue.

Accordingly, I am requesting under section 7(3) of the Law Commission Act 1985 that you prioritise a briefing to me with the Law Commission's advice. Given our intention to propose a policy shift to treat abortion as a health issue, I would like the Law Commission's advice on what alternative approaches could be taken in our legal framework to align with a health approach.

Specifically, I expect the scope of the Law Commission's advice to include reviewing the criminal aspects of abortion law, and the statutory grounds for an abortion and process for receiving services, which are contained in both the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.

A draft bill is not required, however, you may wish to provide drafting to illustrate the options the Law Commission identifies. I do not expect you to review the offence of killing an unborn child in the Crimes Act 1961, but you may wish to highlight any adjustments to that provision that would be needed because of the options discussed.

I would like the Law Commission to review and report back to me within an eight-month time frame. I expect the Law Commission to seek some input from appropriate health professionals in developing its advice. I also ask that you provide an opportunity to receive the public's views to inform the Law Commission's advice.

Please work with officials from the Ministry of Justice and the Ministry of Health in developing your plans and processes for providing me with this advice.

I appreciate the Law Commission will need to commence work on this request prior to other existing projects being completed. I understand my staff have arranged for us to meet on Wednesday the 28th of February to discuss the Law Commission's work programme.

Yours sincerely

A handwritten signature in black ink, appearing to be 'A Little', written over a vertical line that extends downwards from the signature.

Hon Andrew Little
Minister of Justice

Appendix 2

Glossary

Glossary

<p>Abortion</p>	<p>Abortion refers to the intentional termination of an established pregnancy at any gestation.</p> <p>The Contraception, Sterilisation, and Abortion Act 1977 defines abortion (in section 2) as a medical or surgical procedure carried out or to be carried out for the purpose of procuring—</p> <ul style="list-style-type: none"> • the destruction or death of an embryo or fetus after implantation; or • the premature expulsion or removal of an embryo or fetus after implantation, otherwise than for the purpose of inducing the birth of a fetus believed to be viable or removing a fetus that has died.
<p>Abortion clinic</p>	<p>Premises where abortions are performed or administered (including hospitals, community-based sexual health clinics and private clinics).</p>
<p>Abortion service providers</p>	<p>This term is used in a broad sense in this briefing paper to cover both:</p> <ul style="list-style-type: none"> • organisations that offer abortion services; and • individual health practitioners that perform abortions, administer abortion medication or are otherwise involved in providing care to women seeking abortions (including counselling).
<p>Abortion Supervisory Committee (ASC)</p>	<p>The regulatory body established under the Contraception, Sterilisation, and Abortion Act 1977. Its functions include:</p> <ul style="list-style-type: none"> • general oversight of abortion law; • licensing institutions to perform abortions; • ensuring licensed institutions maintain adequate facilities; • ensuring adequate counselling services are available; • maintaining a list of certifying consultants; and • monitoring and disseminating information about the performance of abortions in New Zealand.
<p>Certifying consultants</p>	<p>Doctors appointed by the Abortion Supervisory Committee to consider whether a proposed abortion is lawful based on the grounds in section 187A of the Crimes Act 1961.</p>
<p>Clinic</p>	<p>See “abortion clinic”.</p>
<p>Conscientious objection</p>	<p>This briefing paper uses the term “conscientious objection” to describe a health practitioner’s refusal to provide services in relation to abortion because providing those services would be contrary to the practitioner’s conscience or beliefs.</p>

District health boards (DHBs)	Statutory bodies established under the New Zealand Public Health and Disability Act 2000 that are responsible for providing or funding the provision of health services in their district.
Doctor	See “medical practitioner”. The term “doctor” is generally used in this briefing paper as it is more commonly understood.
Early medical abortion (EMA)	A medical abortion performed in the first nine weeks of pregnancy.
Embryo	See “fetus”.
Feticide	The act of causing the death of a fetus. In a medical context, this involves the injection of a drug directly into the fetus’ cardiac ventricle to stop the heart.
Fetus	This briefing paper uses the term “fetus” to refer to a fertilised human ovum at any stage of gestation (including an embryo). In technical literature “fetus” or “foetus” refers to a fertilised human ovum more than eight weeks after conception. Between two and eight weeks after conception the term “embryo” is used. A fertilised ovum that has not yet developed into an embryo is called a “zygote”.
First trimester	The first 12 weeks of gestation.
Gestation	The stage of the pregnancy and development of the fetus, usually measured in weeks from the date of the pregnant woman’s last menstrual period. The length of gestation in a healthy pregnancy varies but is commonly estimated to be around 40 weeks. This is divided into three periods called trimesters. The first trimester is from 0 weeks to week 12. The second trimester is from week 13 to week 27. The third trimester is from week 28 to birth.
Gestational limit	A point in the pregnancy, usually expressed as a certain number of weeks gestation, after which the law restricts or further restricts abortion.
Code of Health and Disability Services Consumers’ Rights (the Code of Rights)	Regulations that set out the rights of individuals who access health care services and the duties and obligations of health care providers. (Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, schedule, cl 2)
Health practitioner	A person who is registered as a practitioner of a health profession under the Health Practitioner Competence Assurance Act 2003. This includes nurses, midwives, doctors and psychologists.
Health professional bodies	Health professional membership organisations. Health professional bodies may provide education and professional development, advocacy, policies, guidelines and professional standards. For some professions there is a main professional body that represents

	the entire profession and maintains the code of ethics for that profession, as well as specialised chapters and colleges responsible for training, qualifications and standards for specific areas of practice.
Health regulatory bodies	Bodies appointed under the Health Practitioners Competence Assurance Act 2003 (referred to in the Act as “authorities”) that are responsible for the registration and oversight of practitioners of a particular health profession. Their functions include prescribing scopes of practice, issuing practising certificates, reviewing the competence of health practitioners and setting standards of ethics and clinical competence.
Licensed institution	A hospital or clinic that the Abortion Supervisory Committee has licensed as a place where abortions may be performed. Institutions with a full licence can perform abortions at any gestation. Institutions with a limited licence can only perform abortions up to 12 weeks gestation.
Mātauranga Māori	Māori knowledge—the body of knowledge originating from Māori ancestors, including Māori world view and perspectives, Māori creativity and cultural practices (John C Moorfield <i>Te Aka: Māori–English, English–Māori Dictionary and Index</i> (2011, Pearson, Auckland)).
Medical abortion	An abortion carried out by a woman taking drugs that cause a miscarriage. The drugs used for medical abortions in New Zealand are mifepristone and misoprostol, which are taken in combination. See also early medical abortion (EMA) and surgical abortion.
Medical practitioner	A health practitioner registered with the Medical Council of New Zealand as a practitioner of the profession of medicine. Often referred to as a doctor. The term “doctor” is generally used in this briefing paper as it is more commonly understood.
Regulatory offence	A type of criminal offence that is intended to protect the public by ensuring compliance with regulatory regimes. Regulatory offences typically carry a lower penalty than other criminal offences.
Royal Commission of Inquiry into Contraception, Sterilisation, and Abortion	The Royal Commission that, between 1975 and 1977, inquired into the legal, social and moral issues relating to contraception, sterilisation and abortion in New Zealand. Many of the Commission’s recommendations in “Contraception, Sterilisation, and Abortion in New Zealand: Report of the Royal Commission of Inquiry” [1977] 11 AJHR E26 were implemented through the Contraception, Sterilisation, and Abortion Act 1977.
Safe access zones	Areas within a specified radius of abortion clinics in which it is unlawful to demonstrate or protest, or interfere with any person entering or leaving the premises.
Scope of practice	Scopes of practice define the health services a health practitioner is authorised to perform. They are determined by the regulatory body for each health profession. (Health Practitioners Competence Assurance Act 2003, s 5)

Second trimester	Weeks 13–27 of gestation.
<i>Standards of Care for Women Requesting Abortion in Aotearoa New Zealand (Standards of Care)</i>	<p>The standards produced by the Standards Committee of the Abortion Supervisory Committee (ASC). The Standards Committee is a group of experts appointed by the ASC.</p> <p>The <i>Standards of Care</i> apply to health practitioners involved in abortion care in New Zealand. They cover matters such as:</p> <ul style="list-style-type: none"> • access to abortion services; • information that should be provided to women considering abortion; • clinical guidance for health practitioners involved in abortion care (from supporting women in making decisions through to post-abortion follow-up care); • provision of culturally appropriate services for Māori; • the qualifications, knowledge and experience required of certifying consultants, doctors, counsellors, nurses and midwives involved in abortion care; and • minimum theatre safety requirements for facilities that perform surgical abortions.
Surgical abortion	An abortion performed by way of a surgical procedure that empties the contents of the uterus.
Third trimester	From week 28 of gestation until birth.
Woman/women	This briefing paper refers to the “woman” seeking an abortion and uses the pronouns she/her. In doing so, the Commission intends to include any person who is capable of becoming pregnant. The Commission acknowledges that not every person seeking an abortion is a woman; trans men, takatāpui (a term encompassing diverse Māori gender and sexual identities) and other gender diverse people may also become pregnant and seek an abortion.

Appendix 3

The Abortion Supervisory Committee's care pathway for women requesting abortion

Care pathway for women requesting abortion

This care pathway was developed by a Standards Committee of the Abortion Supervisory Committee (ASC) and published in the ASC *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand* (2018). It is reproduced with the permission of the ASC.

FIRST CONTACT

1. Woman confirms her pregnancy and initiates discussion with a health care provider
2. Woman requests consideration of abortion

BEFORE THE ABORTION

1. Verification of gestational age
2. Woman offered referral for professional counselling
3. Identification of women who require extra support before, during or after their abortion
4. Blood tests and genital swabs
5. Discussion of medical or surgical abortion
6. Discussion of post abortion contraception
7. Appointments made to meet certifying consultants

AT THE ABORTION SERVICE

1. Identification of women who require extra support
2. Legal certification by two certifying consultants
3. Informed consent
4. Medical or surgical abortion
5. Contraception
6. Verification and documentation of completion of procedure
7. Legal notification of abortion
8. Discharge planning and advice
9. Arrangement for follow-up of women requiring additional support, especially those under the age of 16

ABORTION FOLLOW UP

1. Clinical assessment of physical and emotional health
 2. Contraception follow-up
 3. Post abortion counselling information
 4. Active follow-up of women requiring additional support, especially those under the age of 16
-

Appendix 4

Consultation

Consultation

INTRODUCTION

1. The Minister of Justice in his letter (Appendix 1) asked the Law Commission to provide advice “on what alternative approaches could be taken in our legal framework to align with a health approach” to abortion. The Minister specified that he expected the Commission “to seek some input from appropriate health professionals in developing its advice”; to work with the Ministries of Health and Justice in developing processes and plans for providing the advice; and to “provide an opportunity to receive the public’s views to inform [its] advice”.
2. The Commission’s consultation process was designed to meet these requirements and fell into two distinct parts. The first part was the consultation with health professionals and relevant statutory bodies. The second part was receiving submissions from the general public.

PART ONE: HEALTH PROFESSIONALS AND STATUTORY BODIES

3. As an initial step in its consultation with health professionals, the Commission met with bodies representing various professions (general practitioners (GPs), obstetricians and gynaecologists, nurses, midwives, social workers and counsellors) and organisations that provide abortion services or represent health professionals involved in abortion care (such as Family Planning New Zealand and the Abortion Providers Group Aotearoa New Zealand (APGANZ)).
4. Added to this group were relevant statutory entities and health regulatory bodies, most notably the Abortion Supervisory Committee (ASC), the Health and Disability Commissioner and the Medical Council of New Zealand
5. Mindful also of the Commission’s statutory obligation under section 5(2)(a) of the Law Commission Act 1985 to take into account te ao Māori in all its work, health organisations with a specifically Māori orientation were included. These included Ngā Māia Māori Midwives Aotearoa; Te Whāriki Takapou (formerly Te Puāwai Tapu, a kaupapa Māori organisation providing Māori sexual and reproductive health promotion and research services); as well as the kaiwhakahaere for the New Zealand Nurses Organisation. Several other organisations were contacted but were unable to provide a response.
6. The full list of organisations the Commission met with or spoke to is as follows:
 - Ministry of Health
 - Ministry of Justice
 - Abortion Supervisory Committee
 - Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
 - Royal New Zealand College of General Practitioners, Te Whare Tohu Rata o Aotearoa
 - New Zealand Medical Association, Te Hauora mō ngā Iwi Katoa
 - New Zealand Nurses Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa

- New Zealand College of Midwives, Te Kāreti o nga Kaiwhakawhanau ki Aotearoa
 - Ngā Māia Māori Midwives Aotearoa
 - Aotearoa New Zealand Association of Social Workers (ANZSAW)
 - New Zealand Association of Counsellors, Te Roopu Kaiwhiriwhiri o Aotearoa
 - Medical Council of New Zealand, Te Kaunihera Rata o Aotearoa
 - Health and Disability Commissioner, Te Toihau Hauora, Hauātanga
 - Office of the Children's Commissioner, Manaakitia a Tātou Tamariki
 - Family Planning New Zealand
 - Abortion Providers Group Aotearoa New Zealand (APGANZ)
 - Te Whāriki Takapou (formerly Te Puāwai Tapu)
7. The Ministry of Health also surveyed all district health boards (DHBs) about the provision of abortion services, using questions provided by the Commission.
8. Later in the project when proposals were being formulated, the Ministry of Health hosted a meeting with representatives of health professional bodies and abortion service providers. This meeting allowed the Commission to test its thinking and understanding with particular reference to health issues. The invitation list for that meeting was developed by the Ministry of Health, with input from the Commission. The following organisations were represented at the meeting:
- DHBs: Auckland, Waikato, Lakes District, Hauora Tairāwhiti, Mid Central, Canterbury, Southern
 - Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
 - New Zealand Nurses Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa
 - New Zealand College of Midwives, Te Kāreti o ngā Kaiwhakawhanau ki Aotearoa
 - Aotearoa New Zealand Association of Social Workers (ANZSAW)
 - New Zealand Association of Counsellors, Te Roopu Kaiwhiriwhiri o Aotearoa
 - Family Planning New Zealand
 - Abortion Providers Group Aotearoa New Zealand (APGANZ)
 - Ministry of Health
 - Ministry of Justice
9. The Commission gratefully acknowledges the assistance of the Ministry of Health throughout the process of consulting with health professionals.
10. The Commission also held a discussion with its Māori Liaison Committee (MLC). The MLC has seven permanent members and five advisory members, with a range of backgrounds including in tikanga and te reo Māori, legal practice, judicial office and academia. The MLC nominated a member to participate in a follow-up meeting.

PART TWO: PUBLIC INPUT

11. The Commission created a website that set out the existing law and the nature of the Minister's request for advice. It described the channels by which submissions could be

made and invited members of the public to share their views. The Commission did not request comment on any specific issues or questions, so that submitters could respond in a way that best reflected their personal stories and viewpoints.

12. The period for submissions was a little over 6 weeks (4 April to 18 May 2018). In total, 3,419 submissions were received. A summary of these submissions is attached as Appendix 5.
-

Appendix 5

Summary of submissions

Summary of submissions

INTRODUCTION

Background

1. On 27 February 2018 the Law Commission received a request from the Minister of Justice under section 7(3) of the Law Commission Act 1985 for a briefing paper advising what alternative approaches could be taken in New Zealand's legal framework to align with a health approach to abortion. The Minister also asked the Commission to provide an opportunity to receive the public's views.
2. The Commission published a website with a description of the requested work and an outline of current abortion law and processes on 4 April 2018. Members of the public were invited to provide their views by 18 May 2018. The Commission did not request comment on any specific issues or questions, so that submitters could respond in a way that best reflected their personal stories and viewpoints. This document summarises the submissions received.
3. The Commission also conducted meetings with health sector bodies during the course of its review, both during and after the public submission period. Information provided at those meetings has informed the Commission's briefing paper to the Minister, but it has not been included in this summary of submissions. Many of the health sector bodies also made submissions, which are reflected in this summary.

Submissions received

4. The Commission received a total of 3,419 submissions from a diverse range of individuals and organisations. The Commission thanks all who shared their personal stories, professional expertise and views.
5. Of the total submissions received, 61 were from organisations such as government bodies, professional organisations, academic groups, religious organisations and interest groups. A further four submissions were made by peer groups within professions. The remaining 3,354 submissions were from people speaking in their personal capacity. A significant number of personal submissions were based on the Family First New Zealand pamphlet "I'm with both", which was produced to assist people to make a submission. These submissions followed similar themes and included similar or identical comments.
6. Submissions varied considerably in their complexity and the number of issues they addressed. Some addressed many issues potentially raised by the decriminalisation of abortion and its treatment as a health issue. Others addressed a single issue. Most were in-between, addressing those issues of concern to the submitter. Some submitters simply shared personal stories without stating their wider views.
7. It should be noted that although 3,419 submissions were received, this does not mean 3,419 separate viewpoints were expressed. Some submitters made duplicate or follow up

submissions, which were recorded as separate submissions.¹ In addition, as noted above, most submitters addressed only a small number of issues which were of particular concern to them or did not express a view on law reform.

Structure and content of this summary

8. This summary follows the structure of the Commission's briefing paper to the Minister. The analysis is at a high level, intending to provide an overview of the submissions and a summary of key points. Although it is not possible to include the detail of every response in this document, every submission was read, and key points were noted for the purpose of preparing this summary and to inform the briefing paper to the Minister.
9. The Commission has not provided specific numbers of submitters who supported or opposed the issues covered in the briefing paper to the Minister, other than with respect to those who supported or opposed decriminalising abortion and treating it as a health issue. This is because the majority of submitters commented on the decriminalisation of abortion, but generally did not comment on all or even most of the other issues covered in the briefing paper. Consequently, referring to specific numbers of submitters with regard to these other issues would not provide useful information and could have a distorting effect.
10. The language used in this summary generally reflects the language used in the submissions. Some caution is therefore required because certain terms that might have a technical meaning in the legislation or amongst health professionals were used more broadly by submitters. Similarly, words like "woman" and "mother" are used interchangeably as they were by submitters.

GENERAL RESPONSES TO THE PROPOSAL TO TREAT ABORTION AS A HEALTH ISSUE

11. 2,280 submitters addressed the issue of whether abortion should be decriminalised and treated as a health issue. Of these, 1,677 opposed decriminalisation, while 603 supported treating abortion as a health issue. The remaining 1,139 submitters did not expressly address decriminalisation, but 671 of those submitters did express support for the law protecting the life of the fetus.

Opposition to decriminalisation

12. Almost half of all submitters expressly stated their opposition to the decriminalisation of abortion. Of those opposed to decriminalisation, many expressed the view that the current law did not go far enough and that access to abortion should be further restricted.

Human life should be protected

13. The reasons most frequently given for opposing change to the law centred on the humanity of the unborn and their separate nature and standing from their mother. Submitters stated that it is a crime to end a human life and that the unborn have rights

¹ Some of these were able to be identified, but there are likely to be others that were not. The Commission allowed submissions to be made anonymously in order to protect individuals' privacy. Where subsequent submissions by the same submitter were identified, they were grouped together with the original submission for analysis purposes.

and/or need legal protection. Reference was made to the New Zealand Bill of Rights Act 1990 (NZBORA) and the United Nations Convention on the Rights of the Child (UNCROC). Many expressed their understanding that the current law recognises there are two lives involved in every pregnancy and protects both interests. Several submitters considered it inconsistent for “wanted” unborn babies to be protected under the Crimes Act, but “unwanted” unborn babies to be able to be freely killed.

Balance of rights and interests

14. Many submitters saw the current law as striking, or attempting to strike, an acceptable balance between protecting the rights and interests of the mother and the unborn baby. Many submitters suggested the current approach works sufficiently well and existing safeguards should be retained in order to protect all parties involved.

A legal issue and a health issue

15. A significant proportion of those opposed to decriminalisation based their submission on the arguments made in the Family First New Zealand pamphlet “I’m with both”, maintaining that abortion should be treated as both a health issue and a legal issue.
16. A few submitters considered abortion was not a health issue at all, but rather a criminal, human rights, justice or moral issue.

Impact on women

17. A large number of submitters expressed concern about the long term impacts abortion may have on women’s mental and physical health, commenting that it can lead to grief, regret, depression and suicide. Several noted that the mental impacts of abortion extend to fathers, families, extended whānau and medical staff who carry out abortions. A few submitters commented on the cost to the health system of the increase in mental health problems resulting from abortions. Many submitters also thought abortion poses a serious risk to women’s physical health, pointing to research that suggests a link to complications such as infertility, premature birth and breast cancer.
18. Many submitters thought the law either does or should ensure the safety of women who have abortions by keeping abortion service providers accountable and protecting women from unlicensed practitioners and unlicensed premises. Several submitters noted that the current law protects doctors who perform abortions legally.
19. Many submitters were concerned women must be protected from external pressure and coercion to have an abortion. Some suggested that abortion is strongly connected with intimate partner violence and slavery/trafficking of women. Several submitters thought the current law protects women from crimes such as violence, rape, incest and abuse. Some were concerned that decriminalisation would provide a cover for such crimes against women and would lead to an increase in sexual abuse and child abuse.
20. Many submitters argued that the current law does not “criminalise” women and it is misleading to suggest otherwise.
21. Several submitters commented that a woman with an unexpected pregnancy is dealing with shock and stress, and that the current law ensures she has an opportunity to process the unplanned pregnancy, talk to health professionals and be fully informed about the risks and options. Some submitters suggested decriminalisation may mean

women do not obtain proper information on abortion-related risks or get independent pregnancy counselling.

Abortion rates

22. Some submitters were concerned decriminalisation would result in an increase in the abortion rate and/or would result in more late term abortions. Submitters also noted the abortion rate has dropped and suggested this shows the current law is working.

Sex and disability discrimination

23. A commonly expressed concern was that decriminalisation would lead to an increase in sex-selective abortions and abortions due to disabilities or perceived abnormalities. Some submitters stated abortion based on disability is discrimination against the disabled and were worried about the message it sends about how people with disabilities are valued by society.

Slippery slope

24. Many submitters were concerned decriminalisation would be a slippery slope and it could undermine the law against taking another person's life, which meant no person or group would be safe. A number also referred to the sanctity of life and expressed concern about society and its values being under threat if there is insufficient protection in the law for the unborn.
25. Some submitters expressed the view that abortion has a negative impact on society. Several thought that if life is not respected, society will be under threat. Some submitters commented that ending abortion would enable repopulation and address workforce issues and issues of an aging population.

No mandate for change

26. Many submitters pointed to various polls and petitions that they said indicate New Zealanders are against law change to make abortions more easily available. Others argued there is no demand or political mandate to liberalise the law.
27. Several submitters commented that the current law is already sufficiently liberal or too liberally applied. A number thought that the current law is appropriate but not enforced as strictly as it was intended to be.

Alternatives to abortion

28. Many submitters thought alternatives to abortion, such as adoption or whāngai, should be explored and promoted. Submitters commented there are many couples in New Zealand who would like to adopt unwanted babies. A few submitters also expressed the view that adoption laws should be reformed and updated to make this process easier.
29. A large number of submitters were concerned to ensure that pregnant women receive good care and support. Some suggested that with the right love and support these women could be encouraged in their motherhood, rather than resorting to abortion, while the current law would continue to allow an abortion for those who really need one.
30. A few submitters thought it was preferable to address the underlying issues pregnant women face, such as poverty, insecure housing, domestic violence, a lack of sex education and possible cultural shame, rather than change the law on abortion. Some

commented that abortion is often not a choice, but a result of feeling like there are no other options.

Public perception

31. Some submitters commented that abortion for convenience or selfish reasons is unacceptable. Several submitters were worried that decriminalisation would change the perception of abortion for many people and make it seem more morally acceptable. There was concern about abortion being treated too casually. Submitters stated that abortions should not be too easy to get and should not be considered a method of contraception.

Freedom of conscience

32. A few submitters were concerned that a law change could result in loss of freedom of conscience for health care providers.

Protecting the life of the fetus

33. Some submitters did not expressly address decriminalisation, but did support the law protecting the fetus. Many of these submitters' comments overlapped with the comments made by submitters who opposed changes to the current criminal offences or opposed decriminalisation. However, the majority of submitters who supported the law protecting the fetus focused on the right to life of the unborn. A substantial number of submitters addressed the various points between conception and birth at which they thought human life could be said to begin. Many commented that medical advances have demonstrated human life begins before birth and should therefore be protected. Several submitters referred to human rights instruments such as the NZBORA, the Magna Carta and the preamble to the UNCROC, which they said support these arguments.
34. In addition, some submitters commented that:
- the law must reflect the sanctity, preciousness and value of life;
 - abortion is inconsistent with other laws and efforts to preserve life and protect against discrimination;
 - life is God's gift and abortion is a sin;
 - the fetus can feel pain and is aware during abortion;
 - abortion takes away an individual's chance to lead a rewarding life.

Support for decriminalisation

35. The submitters who expressly stated their support for treating abortion as a health issue or removing abortion from the Crimes Act tended to focus on the rights, interests, health and wellbeing of women.

Right to bodily autonomy

36. The most common reason for supporting the decriminalisation of abortion was a woman's right to bodily autonomy. A few submitters commented that autonomy/tino rangatiratanga is a right guaranteed by the Treaty of Waitangi. Submitters objected to women being forced to continue with unwanted pregnancies and emphasised a woman's right to make her own reproductive choices.

37. Submitters noted that a health approach is consistent with obligations under various international conventions such as the Convention on the Elimination of Discrimination Against Woman, the International Convention on Civil and Political Rights, the International Convention on Economic, Social and Cultural Rights, the UNCROC, and the Convention on the Rights of People with Disabilities.
38. Submitters also argued that a health approach is important for gender equality, as women bear the burden of pregnancy and childbirth, including significant effects on the body and long term effects on quality of life. Several submitters noted that abortion is a difficult decision and said the law should support women to make the right decision for them in their circumstances, not make it harder for them.
39. A few submitters commented on the fetus, expressing the view that it is not yet a human being, or that its life should not be valued over that of an adult living person.

Health issue

40. Many submitters who supported decriminalisation did so because they see abortion as a medical procedure or health care issue. Some considered decriminalisation to be crucial for women's mental and physical health and wellbeing. Others expressed the view that women and their families need support and care around having an abortion, so it is not helpful to approach abortion as a criminal issue.
41. Some submitters commented on the stress that the current process for obtaining an abortion places on women. A view was also expressed that culturally-informed, evidence-based abortion services should be part of comprehensive sexual and reproductive services for all. Several submitters commented that health practitioners providing legal, core health services should not face potential criminal liability.

Safety and accessibility

42. A major theme in many submissions was that abortion should be safe and accessible. Many said that the current system has too many barriers. They considered decriminalisation is needed to ensure timely and equal access to services and to simplify the clinical care pathway to promote earlier, and therefore safer, abortions. The current process was described as inappropriate, degrading, culturally insensitive and prohibitive for some, especially those who do not live in a major city.
43. It was also noted that access to early safe abortion would mean that every child would be a wanted child.

Abortion rates

44. Some submitters suggested restricting abortion does not stop or reduce abortion, but forces it underground, where it is unregulated and unsafe. It was also noted that lower abortion rates would be better achieved by increasing access to contraception and sexual and reproductive health education.

Current law not fit for purpose

45. Many submitters described the current law as outdated or not fit for purpose. Some stated that the law is out of step with countries New Zealand often compares itself to and does not reflect technological or medical advancements. Several submitters expressed the view that the law should not be influenced by moral or religious arguments.

Current law interpreted liberally

46. A few submitters said the current law is interpreted “benevolently” and that, consequently, the current process requirements for obtaining an abortion serve no real purpose and are a waste of time and resources. It was also pointed out that the current law could easily be interpreted to restrict abortion.

Stigma

47. Many submitters who supported decriminalisation did so because they thought that under the current law women are stigmatised, criminalised, humiliated and made to feel guilty. A few submitters noted that criminalising abortion also stigmatises abortion service providers.

Mental health

48. A recurring theme in the submissions that supported the decriminalisation of abortion was that women should not need to lie about their mental state or be declared mentally unfit to access abortion services. Submitters considered this to be demeaning, traumatic and not reflective of reality. Some also noted it is offensive to those that do in fact have a mental illness.

Privacy

49. A few submitters also expressed concerns around privacy. Abortion was described as a deeply personal decision and a private health care issue. Inclusion of abortion in the criminal law was said to raise major issues regarding exposure of sensitive health information to the criminal justice system.

WHEN ABORTION WOULD BE LAWFUL

Who should make the final decision?

The woman

50. Most submitters who commented specifically on the issue of who should make the final decision about abortion supported decriminalisation and thought that the woman should be the only one to make the decision.
51. The submitters primarily focused on the following reasons: the woman has a right to bodily autonomy; it is the woman’s right (and no one else’s) to make the decision and thereby determine her own fate; and the right to decide is a human right.
52. Many submitters commented that the woman is best placed to decide whether abortion is appropriate, that women do not take the decision lightly, and that a woman should not have to explain her reasons to anyone or “jump through hoops”.

53. Some submitters commented that as women bear the risks and costs of pregnancy, they should make the decision about whether to continue with a pregnancy.
54. Several submitters pointed to the unnecessary cost and delays caused by the current certifying process as a reason why the woman should make the decision herself.
55. A few submitters noted that the woman would need appropriate medical advice from health professionals, including in relation to options and risks.

The woman and her health practitioner

56. Some submitters thought the decision about abortion should be made by the woman and her doctor (or other health practitioner). There was some overlap between the reasons in these submissions and the submissions supporting the woman's right to make the decision.
57. Some submitters criticised the current process, commenting that requiring three doctors to agree is unnecessarily drawn out and traumatic, causing delay in accessing safe abortions.
58. Other submitters focused on abortion as a health and bodily autonomy issue. They considered that abortion is a private health issue between a woman and her doctor. They said that because abortion is a medical procedure, a woman needs to see or consult with a doctor or other health professional.

Other

59. Some submitters thought that one or more doctors should have to agree to the abortion and certify it. These submitters considered it was necessary to have some assessment or involvement by a doctor, but not all agreed two specialists were required.
60. There were various preferences including one doctor, one specialist, two specialist doctors or a panel of doctors.
61. Some submitters made other suggestions as to who should make the final decision on abortion. These included: the father; the father and mother together; the woman and her parents; a panel of medical specialists; a competent authority; two senior physicians or nurse practitioners qualified in primary health or obstetrics; a clinical psychologist, a clinical psychiatrist and a judge; a judge; a board; many advisors; or the Ministry of Health Crisis Assessment Team with respect to mental health grounds.

Statutory test and gestational limits

62. Submitters had mixed views as to whether the law needs to provide a statutory test for when an abortion should be lawful. Many submitters supported the current law under which there is a statutory test. Many others thought there should be no test. Some thought that a test should only apply after a certain point in gestation (a "gestational limit"). A few thought that a different test should apply at different stages of the pregnancy, similar to the current law. A significant number of submitters did not express a preferred model, but instead argued that various criteria in the current statutory test are inappropriate, either because they are too restrictive or not restrictive enough.

There should be a statutory test to justify an abortion

63. Submitters who supported there being a statutory test thought there needed to be some protection for the unborn child by limiting the reasons for abortion. In particular,

submitters thought the law should prevent abortion on the basis of disability or fetal abnormalities and/or the sex of the unborn baby. Some submitters were of the view that abortion should only be permitted in extreme circumstances, for example when the mother's life is in danger.

There should be no statutory test required to justify an abortion

64. Most submitters who argued there should be no statutory test for abortion considered that abortion should be available to any woman who wants it, so there is no need for any criteria.
65. The reasons why submitters thought there should be no statutory test included: women should have autonomy over their own bodies; women should be able to choose as for any other medical issue; women know what is best for their bodies, families and lives; requiring grounds is patronising and moralistic; no unwanted children will be born; general standards of health care provide sufficient regulation and the current law just adds stress and inconvenience; any restrictions on abortion should be imposed through the usual channels for health care; grounds are barriers and drivers of delay, coercion and discrimination; contraceptive accidents happen and having a child is life-changing; each woman's case is individual and often complex; and no list of grounds can be complete so any list becomes highly restrictive.
66. Some submitters who supported having no grounds thought abortion is never justified so there could be no criteria under which abortion should be allowed.

Submissions on the current statutory test

67. Many submitters expressed the view that the current statutory test (or aspects of it) is inappropriate. This included both submitters who thought the current test is too restrictive, and those who thought the test should be more restrictive. Of those who wanted a more restrictive test, many suggested that the only ground should be a serious threat to the woman's life or health.
68. Some submitters argued generally that the current statutory test is illogical, outdated or offensive. Most comments focused on particular grounds such as mental health, rape or fetal abnormalities.
 - **Mental health:** This ground attracted a wide range of comments from submitters, most of whom considered it to be inappropriate. Many submitters argued that the mental health ground is unnecessary, demeaning or offensive. Others argued the mental health ground is interpreted so loosely as to be meaningless. Some also noted it may be demeaning to those who do in fact have mental health issues.
 - **Rape:** It was not always clear whether submitters thought rape was a ground under the current statutory test for abortion or not, but many submitters commented on whether or not it should be. Some thought rape should be specifically included as part of the statutory test because the unwanted pregnancy would compound the trauma of the rape. Others thought it should not be a ground because the unborn baby was innocent and precious regardless of the manner in which it was conceived
 - **Fetal abnormalities:** Submissions were again divided. While some argued fetal abnormality should be a ground for abortion, most considered it should not be

because even imperfect life is precious and it would amount to discrimination against the disabled.

69. A few submitters suggested new criteria for the statutory test. These included: unsuitable timing; inability to adequately care for the child; continuing the pregnancy would affect a mother's ability to adequately support other children; family violence; rape/incest; economic reasons; under-age sex (as it is not consensual); and fetal abnormality that is incompatible with survival outside the womb.

Should there be a gestational limit?

70. Many submitters supported having a gestational limit. The reasons given were that this was consistent with a health-centred approach, early abortion is better for both the fetus and the mother, and risks increase and social acceptance declines as the pregnancy advances. Those who supported having a gestational limit either thought there should be no grounds until after a certain gestation, or that grounds should always be required, but they should be different after a gestational limit is reached.
71. Some submitters did not support having a gestational limit. The reasons given were that gestational limits might be unnecessary or cause problems, as the proportion of women electing to have late term abortions for any reasons other than medical ones is extremely small; issues of timing are complex; arbitrary gestational limits place a burden on women and add to the pressure of decision-making; and that usually after 20 weeks a baby is wanted, and if a decision is made to abort at that point there is a good reason.

If so, what should the gestational limit be?

72. Of those submitters who commented on having a gestational limit, the majority favoured a limit lower than the current 20 weeks. The suggestions covered a range from five to 18 weeks. A significant number of submitters expressed a view that "the law should limit the timeframe for having an abortion, except in exceptional circumstances".
73. The reasons for supporting a lower gestational limit included that: women should know before 20 weeks if they want to continue the pregnancy; polls show that is what New Zealanders want; and the fetus can feel pain earlier than 20 weeks.
74. Many submitters supported retaining the current limit at 20 weeks. The reasons were that it is necessary to limit on-demand abortion to pre-viability; 20 weeks is ample time to make an informed decision; the unborn child can feel pain at around 20 weeks; after 20 weeks babies can survive outside the womb; and polls indicate that the gestational limit should not be increased.
75. A few submitters supported having a higher gestational limit than 20 weeks. The reasons included that later abortions should be acceptable and viability is around 23 to 24 weeks.
76. Some submitters suggested a non-time-based gestational limit such as the development of a heartbeat, viability outside the womb, or when it is scientifically determined that the fetus can feel pain.

CRIMINAL ASPECTS OF ABORTION LAW

77. Some submitters supported retaining the current legal regime, so the criminal aspects of the law would remain as at present.

78. Other submitters addressed what the consequences of failing to comply with the law would be if abortion is treated as a health issue. These submissions are described below.
79. Some submitters thought the current law regulating health practitioners and the provision of health services was enough to regulate abortion as a health service. It was noted that New Zealand does not have separate legislation for other medical procedures.
80. A few submitters thought even if other abortion offences were repealed, it should still be a criminal offence for anyone other than a qualified health practitioner to perform an abortion. Some wanted offences for “unregistered abortionists” and for using “unlicensed premises” retained or increased.
81. A small number of submitters directly addressed the question of whether a woman should be liable for procuring her own miscarriage. Of those, most thought she should not.
82. A small number of submitters who supported abortion remaining under the Crimes Act thought the penalty for a woman who procures her own miscarriage should be increased.

ACCESS TO ABORTION SERVICES

General access issues

83. Many submitters expressed concern at process barriers under the current law that delay access or make it difficult to access abortion services.
84. Submitters identified barriers to access as being the lack of abortion services outside of main centres (particularly in rural areas), the number of appointments required, lack of information, cost, doctors who refuse to make a referral because they have a conscientious objection, and stigma. These barriers were said to impact particularly on Māori women, rural women and poor or disadvantaged women, and to lead to inequity of outcomes.
85. Delay in accessing abortion services was said to cause suffering and trauma, force women to endure an unwanted pregnancy for longer, prevent women from having the option of early medical abortion, result in women resorting to unsafe methods, and cause women to pay for an abortion at a private clinic to ensure they meet the gestational timeframe. Submitters commented that earlier abortion is ethically preferable, results in better health outcomes, and is less stressful and less risky.
86. Many submitters considered abortion services should be available in more places. Submitters commented on the negative impacts of needing to travel to access abortion, including needing to take time off work or from education, needing to arrange childcare and lack of continuity of care. Submitters suggested various solutions including that: abortion service providers should be available at a greater range of facilities including Family Planning or other health care clinics, hospitals, all secondary hospitals where there is gynaecological back-up, and in primary settings; DHBs should establish abortion services that encompass all forms of abortion; and all pharmacists and community clinics should have at least one practitioner willing to provide abortion services.

87. Many submitters commented that women should not have to see so many health practitioners to access abortion. Not only did they consider the process to be drawn out, traumatic and unnecessary, they commented that it was hard for women in rural areas to find certifying consultants nearby. Submitters thought that the requirement to convince multiple consultants is demeaning and sexist and limits the human right to self-determination; that there is no need for certifying consultants if abortion is a health issue; that it only benefits the certifying consultants, who earn a fee; that obtaining certifying consultant approval requires women to take further time off work or education; that it is a waste of health resources; and that it leads to later, higher risk and more expensive abortions.
88. Several submitters said that some or all abortions and appointments to access abortions should be free or cheap to ensure equity of access. A few submitters stated that travel and/or accommodation costs should be covered.

Who should be permitted to refer people to abortion services?

89. Only a handful of submitters commented on the issue of who should be permitted to refer people to abortion services. Some submitters thought the woman seeking the abortion should be able to self-refer or be referred by any health practitioner she consults. The reasons included that: it is the woman's body, and therefore her choice; the referral process causes unnecessary delays; it will improve access; and it will remove hurdles, expense and complexity in accessing abortion.
90. A few submitters suggested that health professionals such as midwives and nurses, as well as doctors, should be able to refer women to abortion services. Submitters commented that this would reduce barriers and improve timeliness of access to services.

Who should be permitted to perform or assist in performing abortions?

91. Not many submitters commented specifically on who should be permitted to perform or assist in performing abortions. Of those who did, most suggested that adequately trained health professionals other than just doctors should be permitted to perform or assist. Suggestions included experienced and well trained nurses, 'mid-level health professionals' during the first trimester, midwives or general practitioners (GPs) for medical abortions, and registered health professionals with appropriate training and qualifications. Submitters commented that using other health professionals would reduce cost and improve access.
92. A few submitters said that only surgical abortions need to be performed by doctors. Medical abortions could be administered by health professionals such as trained nurses, pharmacists and midwives.

Licensing of institutions and medical abortion

Licensing of institutions

93. A few submitters addressed the issue of whether institutions that perform abortions should be specifically licensed.
94. Some of these submitters supported a requirement for specific licensing. The reasons given were that the health and wellbeing of the woman is important, there should be minimum standard requirements for facilities and providers, and that standards ensure women receive the information and support they are entitled to. A few submitters

thought that a licence should only be required for institutions performing surgical abortions, not medical abortions.

95. Some submitters did not comment directly on licensing, but were concerned that if the current specialist abortion clinics did not continue, access may decline due to the reluctance on the part of some GPs to provide a service because of conscientious objection or lack of confidence, knowledge or time.
96. A handful of submitters thought that no specific licence should be required to perform abortions because existing health regulation is sufficient to ensure safety of facilities.

Early medical abortion

97. Some submitters commented specifically on early medical abortion, arguing it should be more widely available. Submitters stated that early medical abortion is safe, that easier access would prevent delays, and that the current restriction on where the medication can be taken severely limits uptake.
98. Some submitters thought women should be able to administer the medication themselves at home. The reasons given included that: there is no medical reason why the medication needs to be taken at a licensed institution; it would save time and avoid the stress of multiple clinic visits; it would assist with access, particularly for women in more isolated rural areas or lower socio-economic groups; it would avoid the risk of the woman miscarrying on her way home; and the requirement to take the medicine at a licensed institution compounds issues of childcare, time off work or education and transport. Some submitters thought women should be able to at least take the second dose at home, for similar reasons.
99. Very few submitters thought that both doses should have to be taken at a medical facility. Those who did considered the risks are significant enough to warrant medical supervision.
100. A small number of submitters stated that the woman should be able to choose where the medication is administered.

OVERSIGHT OF ABORTION SERVICES

Abortion and legislation that is not in the Crimes Act

101. A small proportion of submitters made comments about abortion-related legislation other than the Crimes Act.
102. Some submitters considered there does not need to be any specific legislation relating to abortion and that the existing health regulation is sufficient.
103. A few submitters supported retaining the current legislation, commenting that guidelines and oversight are important.
104. Some submitters thought that there needs to be abortion-related legislation but there should be some changes because the current law is outdated and failing. The main suggestions were that the language used should be updated to be more inclusive and less offensive—particularly words like “subnormal”—and that the legislation needs to reflect developments in technology and health care. Some referred specifically to the certifying consultant process in this context and argued that it is unnecessary.

Oversight

105. A few submitters commented specifically on the oversight role currently performed by the Abortion Supervisory Committee. Most thought an oversight body is needed. Some thought it should continue to be the Abortion Supervisory Committee. A few others suggested an alternative oversight body such as the Ministry of Health or a body within the Ministry. A few submitters commented that more stringent oversight is needed.

COUNSELLING AND INFORMED CONSENT

Counselling

106. A large proportion of submitters considered the ability of pregnant women seeking abortion services to access quality counselling is very important.
107. Most submitters emphasised the need for counselling that is independent and of a high professional standard. Some commented that current counselling services are inadequate and not always easy to access.
108. Some submitters also emphasised the need for ongoing counselling and aftercare following an abortion, not just pre-abortion counselling. A few thought counselling should also be available to partners and families.
109. Submitters commented variously that counselling should be independent, balanced, free or low cost, unbiased, empathetic, client-centred, compassionate, non-judgemental and culturally appropriate.
110. While most submitters commented that counselling should be provided or available, some submitters stated specifically that counselling should be mandatory for anyone seeking an abortion. One of the main reasons given for mandatory counselling was to ensure that women are presented with all relevant information and the options available to them from an unbiased and non-judgemental source. There was also concern to ensure women are not being coerced or subjected to domestic violence.
111. A few submitters were explicitly against mandatory counselling. The main reasons given were that mandatory counselling is an additional burden on women and an infringement on their personal autonomy.

Informed consent

112. There was significant concern amongst submitters about informed consent and the need to ensure that women receive appropriate information to enable them to make a properly informed decision. A lot of the comments overlapped with the comments on counselling and many submitters did not appear to distinguish between the two.
113. Most submitters who addressed this issue thought it important that there be specific provision in the law around informed consent. A majority of these submissions articulated the “I’m with both” submission’s position that “the law should promote and facilitate informed consent through specific measures”. These submitters emphasised the need for women to be presented with all relevant information about abortion-related risks, and for safeguards to ensure women are not being coerced into having an abortion.
114. Some submitters were less specific than the “I’m with both” submission but also thought that there should be special provision in the context of abortion to ensure that women are supported to give informed consent.

115. Various comments were made as to what information and support should be provided to ensure informed consent. Many submitters considered women need to be provided with information on the physical and mental health risks of abortion; details of the process of the abortions; and information about fetal development including an ultrasound scan. Some submitters commented on the need for the information to be complete, true, and unbiased.
116. Many submitters considered that as part of the informed consent process, women should be advised of alternatives to abortion, such as adoption. Some went further and suggested that health practitioners should not just advise but promote other options to women.
117. Some submitters thought the general requirement for health practitioners to give information and support patients to give informed consent is sufficient and no further provisions are required.
118. Several submitters thought that time is needed to make an informed decision, with a few suggesting a stand-down period before an abortion is carried out.

Abortion and people under the age of 16

119. A number of submitters addressed the issue of whether parents should be notified of, or required to give consent to, abortions for those under 16. A majority of these did not support the current law that allows a female of any age to consent to abortion without the need to notify or involve parents/caregivers.
120. Some submitters thought that those under 16 should be able to consent, but that the parents or a caregiver must be notified. The reasons given included that: young pregnant girls need parental involvement and/or support; it is consistent with the parental duty of care; polls show it is what New Zealanders want; it is the parents who will have to deal with the young woman as she processes the decision; and it is the parents who are left to pick up the pieces when the young woman suffers the after-effects of abortion, such as depression, guilt or attempted suicide. A handful of submitters thought the parents of both the boy and girl should be notified so they can provide support. Several submitters who supported parental notification commented that while there may sometimes be a good reason not to inform the parents, exceptions to notification should be made on a case-by-case basis.
121. Some submitters thought parental consent as well as notification should be required where a girl under 16 is seeking an abortion. The reasons included that: children cannot give consent to other medical procedures; it is inconsistent that parental consent is required for a school trip but not an abortion; and teenagers need parental support to make such a decision.
122. Many submitters expressed the view that the law should require parental involvement but were not specific as to what this would entail. The reasons given were similar to those mentioned above.
123. A few submitters supported the current law, which allows a female of any age to consent to or refuse an abortion with no requirement to notify or involve her parents or caregiver. The reasons given were that young women have a right to privacy, a parental consent requirement unjustifiably limits reproductive autonomy, and not all parents have their children's best interests at heart. A few submitters suggested that while parental consent

should not be a requirement, policies and practice should encourage parental engagement and support.

Coercion

124. Many submitters were concerned about women being coerced into having an abortion and emphasised the need for safeguards against coercion.
125. Some thought the current law sufficiently protects women and their unborn children from coercion or external pressure, expressing concern that if abortion was removed from the Crimes Act, women would be more vulnerable to coercion. Some thought the law needs strengthening in this respect. Suggestions for strengthening the law against coercion overlapped with comments made about improving provisions around counselling and informed consent.
126. Some submitters specified various sources of coercion and external pressure, including partners, families, traffickers and abortion service providers. Others talked about coercion in more general terms.
127. A handful of submitters thought the law should expressly prohibit coercion.

CONSCIENTIOUS OBJECTIONS

128. Some submitters directly addressed the issue of whether health practitioners should be able to refuse to provide abortion services because to do so would be contrary to their conscience or beliefs. Of those, most supported there being some provision in the law for conscientious objection.
129. Submitters who addressed this issue mostly supported retaining the current approach of allowing doctors to refuse to provide abortion services but requiring them to inform the woman that she can seek services elsewhere. The main reason given was that no practitioner should be compelled to provide services they disagree with.
130. Some submitters supported a slight variation on the current approach, which would require doctors who refuse to provide abortion services to refer women to another doctor that could provide the service. The main reason given was that women should not have to shop around in an unfamiliar environment during a traumatic time in order to find someone willing to carry out the abortion.
131. A few submitters thought doctors should be allowed to refuse to provide abortion services and refuse to refer women to other doctors, again emphasising that doctors should not have to participate in any way in a procedure they are ethically or morally opposed to.
132. Other submitters thought the current legal provisions permitting conscientious objection should be removed altogether. The reasons given included that: it is not aligned with a health approach, and in no other context does the law permit doctors to refuse to provide services that their role and training directs them to provide; doctors should keep their personal views to themselves; and it puts an unnecessary burden (including a financial burden) on the woman to find other health professionals.
133. A few submitters suggested that: doctors should provide clear prior notification of their position to prevent unnecessary delay and expense for women; there should be a

national register indicating which doctors are willing or unwilling to be involved in abortion services; and/or the rights of conscientious objection should extend to other medical professionals.

PROTECTION OF WOMEN AND SAFE ACCESS ZONES

134. A small number of submitters expressed support for safe access zones for women entering abortion clinics or thought that it should be illegal to protest or to hinder women from accessing abortion services. The reasons given included that: women accessing abortions must be free from intimidation, harassment and abuse; protesting at abortion clinics is sexist and unsafe; no one should have their autonomy in making health decisions challenged through public protest; and the right to free speech needs to be balanced against the need to protect women at a vulnerable time.

OTHER POINTS RAISED

Contraception and education

135. Quite a few submitters commented on the need for improved access to contraception/ family planning and better sex education to reduce the need for abortions.
136. Suggestions about contraception included that it should be free or cheap and easy to access, including procedures such as vasectomies and tubal ligation.
137. Submitters wanted to see better sex education in schools covering a range of topics including consent and respect, abstinence, fetal development, relationships and the consequences of casual sex.

Funding

138. A few submitters commented on funding for abortion-related services. Some thought abortion should be fully or partially funded (as with other health procedures), while others objected to any taxpayer money being spent on abortion. Several submitters commented that money currently spent on the certifying process could be better spent on other areas such as sexual health education, maternal health and counselling.

Data and research

139. A small number of submitters suggested better data should be collected, or more research be carried out, to assist with service delivery planning; to enable trends to be monitored; to identify Māori women's experiences; and to identify the causes, risks and effects of abortion.
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Appendix 6

Comparative analysis of international abortion legislation and recent reform initiatives

Comparative analysis of international abortion legislation and recent reform initiatives

1. This appendix provides an overview of abortion legislation and recent reform initiatives in jurisdictions New Zealand often compares itself to. The first section sets out notable recent developments that have led to the reform of that law; reforms currently under consideration; and reforms that have recently been proposed but not implemented. The second section contains a table summarising the key aspects of abortion law in selected jurisdictions.

RECENT DEVELOPMENTS AND REFORMS UNDER CONSIDERATION

Australia

Australian Capital Territory

2. Australian Capital Territory reformed its law through the Crimes (Abolition of Abortion) Act 2002 (ACT), which repealed the former criminal offences applying to abortion. The Health Act 1993 has since regulated abortion.
3. In March 2018, a private member introduced the Health (Improving Abortion Access) Amendment Bill 2018 (ACT) to remove the current legislative requirement that all abortions must take place in an “approved facility”. The ACT Legislative Assembly passed the Bill into law on 19 September 2018.

New South Wales

4. In 2016, a private member’s bill, the Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2016 (NSW) was introduced. It proposed to remove abortion from the Crimes Act but contained no provisions on a substitute legal framework. It did, however, contain provisions regarding conscientious objections and safe access zones. The Bill was voted down at its second reading in May 2017.
5. Safe access zones were, however, introduced in July 2018 through the Public Health Amendment (Safe Access to Reproductive Health Clinics) Act 2018 (NSW), which made amendments to the Public Health Act 2010 (NSW).

Northern Territory

6. Abortion law in the Northern Territory was recently reformed through the Termination of Pregnancy Law Reform Act 2017 (NT), which commenced on 1 July 2017. The reforms in 2017 were based on a review undertaken by the Northern Territory Department of Health.¹ They are reflected in the summary table in the second section of this appendix.

Queensland

7. On 16 July 2018, the Attorney-General tabled the Queensland Law Reform Commission's final report *Review of Termination of Pregnancy Laws*, Report No 76 (2018) in the Queensland Parliament. On 22 August 2018, the Attorney-General introduced the Termination of Pregnancy Bill 2018 (Qld) into Parliament. The Bill reflects the Commission's recommendations that:
 - for pregnancies of not more than 22 weeks gestation, there should be no statutory restrictions on when abortion is lawful;
 - a medical practitioner should perform the abortion;
 - after 22 weeks, an abortion should be lawful if two medical practitioners consider that, in all the circumstances, the abortion should be performed;
 - health practitioners with conscientious objections should be under a duty to disclose the objection to the woman and refer her to a practitioner or health service provider that does not have a conscientious objection;
 - criminal offences should remain for abortions performed by an unqualified person; and
 - safe access zones should be introduced.

South Australia

8. Abortion law was last amended in South Australia in 1969. There have since been no major law reform initiatives.

Tasmania

9. Tasmania reformed its abortion law through the enactment of the Reproductive Health (Access to Terminations) Act 2013 (Tas). The Reproductive Health (Access to Terminations) Bill 2013 (Tas) was introduced into the Tasmanian Parliament following the publication of an Information Paper² and consultation process through the Tasmanian Department of Health.

¹ See Department of Health (NT) *Termination of Pregnancy Law Reform: Improving access by Northern Territory women to safe termination of pregnancy services: Discussion paper* (December 2016).

² Department of Health and Human Services (Tas) *Information Paper relating to the Draft Reproductive Health (Access to Terminations) Bill: Revised pregnancy termination laws proposed for Tasmania* (March 2013).

10. The Bill as introduced proposed a gestational limit of 24 weeks. However, during its passage through the lower house of the Tasmanian Parliament, the limit was lowered to 16 weeks as a “compromise position”.³
11. As the Bill passed through the upper house of the Parliament, a Government and Administration Committee was established to call for submissions and hear evidence on the Bill. The Committee released a *Report on Reproductive Health (Access to Terminations) Bill 2013*, shortly after which the Bill was enacted into law.

Victoria

12. The Abortion Law Reform Act 2008 (Vic) was based on the work of the Victorian Law Reform Commission. In its report *Law of Abortion*, the Law Reform Commission presented three models as potential options for reform.⁴ Lawmakers ultimately favoured Model B, which proposed a gestational limit at 24 weeks, prior to which there were no statutory restrictions on abortion.

Western Australia

13. Western Australia amended its abortion law in 1998. The Acts Amendment (Abortion) Act 1998 repealed the former criminal offences under the Criminal Code 1913 and made changes to the Health Act 1911.
14. In 2002, a government review of the legislation concluded that the law was “working in the manner in which Parliament intended”.⁵

Canada

15. Since the Supreme Court decision in *R v Morgentaler* [1988] 1 SCR 30, no federal legislation has been passed in Canada that restricts the circumstances in which abortion is lawful.
16. Health Canada only authorised the use of mifepristone for medical abortions in 2015, which was relatively late compared to other countries.⁶

Ireland

17. Ireland’s law prohibits abortion unless it is necessary to save the life of the woman. The law reflects the Eighth Amendment to the Constitution of Ireland, which added Article 40.3.3° to the Constitution, providing:

The State acknowledges the right to life of the unborn and, with due regard to the equal right of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right.

³ Legislative Council Government Administrative Committee “A” *Report on Reproductive Health (Access to Terminations) Bill 2013* (Parliament of Tasmania, 2013) at 31.

⁴ Victorian Law Reform Commission *Law of Abortion*, Report No 15 (2008).

⁵ The Acts Amendment (Abortion) Act 1998 Review Steering Committee *Report to the Minister for Health on the Review of Provisions of the Health Act 1911 and the Criminal Code Relating to Abortion as Introduced by the Acts Amendment (Abortion) Act 1998* (Department of Health (WA), 17 June 2002) at 12–13.

⁶ *Health Canada Regulatory Decision Summary: MIFEGYMISO* (29 July 2015).

18. On 25 May 2018, Ireland held a referendum on whether to replace Article 40.3.3^o in the Constitution with a provision that would allow the law to regulate abortion. A majority of 66.4 per cent voted in favour of the amendment.
19. The Irish Government has proposed to introduce a Bill to the legislature that would provide:
 - before 12 weeks gestation, there would be no statutory restrictions on when abortion would be lawful;
 - after 12 weeks, but before the fetus has reached viability, abortion would be lawful where two medical practitioners consider:
 - there is a risk to the life, or serious harm to the health, of the pregnant woman; or
 - there is a condition affecting the fetus likely to lead to its death before or within 28 days of birth;
 - it would be an offence to intentionally end the life of a fetus otherwise than in accordance with the Bill; and
 - no person would be obliged to perform an abortion, but where a person has a conscientious objection they would be required to make such arrangements for the transfer of care of the woman as may be necessary to enable the woman to obtain an abortion.
20. The Bill has not yet been introduced to the legislature.

Northern Ireland

21. In December 2016, a private member's bill was introduced into the Northern Ireland Assembly to make abortion lawful on the grounds of fatal fetal abnormality—the Abortion (Fatal Fetal Abnormality) Bill 2016 (NI). The Bill fell when the Northern Ireland Assembly was dissolved in early 2017 (meaning the Bill was not carried over into the following Parliamentary term).
22. In *In the Matter of an Application by the Northern Ireland Human Rights Commission for Judicial Review*, the Supreme Court of the United Kingdom considered whether Northern Ireland's abortion law was consistent with the European Convention on Human Rights (ECHR).⁷ The Northern Ireland Human Rights Commission argued that the law breached the ECHR because it did not permit abortion in the circumstances of fatal fetal abnormality and of pregnancy due to rape or incest. The majority of the Court found that the applicant lacked standing, so the Court did not make the declarations sought. However, the members of Court went on to discuss the merits of the application.
23. The Court observed that the prohibition infringed a woman's right to respect of private and family life under article 8(1) of the ECHR. The issue was whether the infringement would be justified under article 8(2) as "necessary in a democratic society ... for the protection of health or morals". The majority did not agree that the law's prohibition of

⁷ *In the Matter of an Application by the Northern Ireland Human Rights Commission for Judicial Review* [2018] UKSC 27, [2018] HRLR 14.

abortion in the circumstances of fatal fetal abnormality and of pregnancy due to rape or incest was a proportionate means of achieving the aim. The community had no interest in obliging a woman to carry a pregnancy to term when there was no viable life to protect.⁸ Likewise, the majority concluded that in the case of rape, a woman's rights should prevail. They observed that women should have the right to exercise their autonomy by terminating a pregnancy that was the result of rape and that these rights outweighed the community interest in the continuance of the pregnancy.⁹

United Kingdom (Excluding Northern Ireland)

24. The Abortion Act 1967 (UK) was last substantively amended in 1990 by the Human Fertilisation and Embryology Act 1990. It lowered the gestational limit from 28 weeks to 24 weeks gestation, after which point abortions may only be performed to prevent grave permanent injury to the woman, to prevent risk to her life, or where there are fetal abnormalities meaning the infant would be born “seriously handicapped”.
25. In 2006, the Science and Technology Committee of the House of Commons reviewed scientific developments relating to abortion.¹⁰ In its report, the Committee concluded:
 - survival rates below 24 weeks gestation had not significantly improved since the law was last reformed, and the 24 week limit in the Abortion Act 1967 remained appropriate;
 - work may be needed to clarify the definition of “seriously handicapped”;
 - the requirement for two doctors’ signatures did not provide any meaningful safeguard, at least in the first trimester, but instead, the requirement may have caused delays in access to abortion services;
 - nurses and midwives could be permitted to prescribe and administer drugs for early medical abortions (EMA) and perform early surgical abortions; and
 - the law should allow women to take the second dose of EMA pills at home.
26. No law reforms followed the Committee’s report.
27. In March 2017, the House of Commons voted in favour of giving leave for a private member’s bill to be brought—the Reproductive Health (Access to Terminations) Bill 2017 (UK). The Bill would have repealed the criminal provisions applying to abortion and introduced some regulation on when the procedure would have been lawful. The Bill fell when a general election was called and Parliament was dissolved on 3 May 2017 (meaning the Bill was not carried over into the following Parliamentary term).

⁸ At [28] per Lady Hale; [123] and [133] per Lord Mance; [331]–[332] per Lord Kerr (with whom Lord Wilson agreed); and [368] and [371] per Lady Black. Note the bench was reluctant to impugn the law for failing to allow abortion in the case of serious fetal abnormality that would likely lead to the birth of a seriously disabled child (at [133] per Lord Mance).

⁹ At [26]–[27] per Lady Hale; [127] per Lord Mance; [326] per Lord Kerr (with whom Lord Wilson agreed).

¹⁰ House of Commons Science and Technology Committee *Scientific Developments Relating to the Abortion Act 1967* (United Kingdom Parliament, 12th Report of Session 2006-07, HC 1045-I, 6 November 2007).

28. In 2017, Scottish Ministers made an approval under section 3A of the Abortion Act 1967 (UK) to allow a woman to take misoprostol at home.¹¹ On 20 June 2018, the Welsh Ministers followed suit and granted an approval for women to take misoprostol at home.¹² On 25 August 2018, the Government of the United Kingdom announced plans to legalise the home use of EMA pills in England by the end of 2018.¹³

¹¹ The Abortion Act 1967 (Place for Treatment for the Termination of Pregnancy) (Approval) (Scotland) 2017. See also *SPUC Pro-Life Scotland Limited v Scottish Ministers* [2018] CSOH 85 where the Court of Session Outer House dismissed a petition claiming the approval was unlawful.

¹² The Abortion Act 1967 (Approval of Place for Treatment for the Termination of Pregnancy) (Wales) 2018.

¹³ Department of Health and Social Care “Government confirms plans to approve the home-use of early abortion pills” (25 August 2018) <www.gov.uk>.

ABORTION LEGISLATION IN OTHER JURISDICTIONS							
	When abortion is lawful	If abortion is only lawful on certain grounds, who decides the grounds are met	Criminal aspects of abortion law	Conscientious objection	Where an abortion must be performed	Provision for informed consent or counselling	Safe access zones
Australian Capital Territory	No statutory restrictions on when abortion is lawful		<ul style="list-style-type: none"> ✓ Regulatory offence for unqualified person to perform an abortion ✓ Regulatory offence to perform a surgical abortion outside an approved medical facility <i>Health Act 1993 (ACT), ss 82 and 83</i>	<ul style="list-style-type: none"> ✓ Statutory provision that health practitioners are not required to perform or assist an abortion if they object on the grounds of conscience <i>Health Act 1993 (ACT), s 84</i>	<ul style="list-style-type: none"> ✓ Abortion must be performed in an approved clinic/hospital <i>Health Act 1993 (ACT), s 82</i> Reform under consideration – see notes above		<ul style="list-style-type: none"> ✓ <i>Health Act 1993 (ACT), ss 85–87</i>
New South Wales	<ul style="list-style-type: none"> ✓ If risks to the physical or mental health of woman <i>Crimes Act 1900 (NSW), ss 82-84 prohibits “unlawful” abortions. Common law governs what constitutes an “unlawful” abortion.</i>		<ul style="list-style-type: none"> ✓ Criminal offence to perform an unlawful abortion <i>Crimes Act 1900 (NSW), ss 82–84</i>				<ul style="list-style-type: none"> ✓ <i>Public Health Act 2010 (NSW), ss 98A–98F</i>
Northern Territory	<ul style="list-style-type: none"> ✓ If the abortion is appropriate in all the circumstances <i>Termination of Pregnancy Law Reform Act 2017 (NT), s 7–8</i>	Pre-14 weeks: A suitably qualified medical practitioner	<ul style="list-style-type: none"> ✓ Criminal offence to perform an unlawful abortion ✓ Criminal offence for unqualified person to perform an abortion 	<ul style="list-style-type: none"> ✓ Statutory requirement for the practitioner with an objection to refer the woman to another practitioner/service provider 			<ul style="list-style-type: none"> ✓ <i>Termination of Pregnancy Law Reform Act 2017 (NT), s 14–15</i>

<p>Northern Territory (continued)</p>		<p>14–12 weeks: Two suitably qualified medical practitioners <i>Termination of Pregnancy Law Reform Act 2017 (NT), ss 7–8</i></p>	<p><i>Criminal Code Act (NT), s 208A</i></p>	<p><i>Termination of Pregnancy Law Reform Act 2017 (NT), s 11</i></p>			
<p>Queensland</p>	<p>✓ If risks to the physical or mental health of woman <i>Criminal Code 1899 (Qld), ss 224–225 prohibits “unlawful” abortions. Common law governs what constitutes an “unlawful” abortion</i> Reform under consideration – see notes above</p>	<p>Reform under consideration – see notes above</p>	<p>✓ Criminal offence to perform an unlawful abortion <i>Criminal Code 1899 (Qld), ss 224–225</i></p>	<p>Reform under consideration – see notes above</p>			<p>Reform under consideration – see notes above</p>
<p>South Australia</p>	<p>✓ If risks to the physical or mental health of woman ✓ If fetal abnormalities ✓ If the abortion is immediately necessary to save the life, or to prevent grave injury to the physical or mental health of the woman <i>Criminal Law Consolidation Act 1935 (SA), s 82A</i></p>	<p>Two medical practitioners <i>Criminal Law Consolidation Act 1935 (SA), s 82A</i></p>	<p>✓ Criminal offence to perform an unlawful abortion ✓ Criminal offence for a woman to unlawfully procure her own miscarriage ✓ Criminal offence for an unqualified person to perform an abortion <i>Criminal Law Consolidation Act 1935 (SA), ss 81, 82A.</i></p>	<p>✓ Statutory provision that health practitioners are not required to perform or assist an abortion if they object on the grounds of conscience <i>Criminal Law Consolidation Act 1935 (SA), s 82A</i></p>	<p>✓ Abortion must be performed in an approved clinic/hospital <i>Criminal Law Consolidation Act 1935 (SA), s 82A</i></p>		

<p>Tasmania</p>	<p>Up to 16 weeks: No statutory restrictions on when abortion is lawful</p> <p>After 16 weeks: ✓ If risk to the physical or mental health of the woman</p> <p><i>Reproductive Health (Access to Terminations) Act 2013 (Tas), ss 4–5</i></p>	<p>After 16 weeks: Two medical practitioners</p> <p><i>Reproductive Health (Access to Terminations) Act 2013 (Tas), s 5</i></p>	<p>✓ Criminal offence for an unqualified person to perform an abortion</p> <p>✓ Criminal offence to perform an abortion without the woman’s consent</p> <p><i>Criminal Code Act 1924 (Tas), ss 178D–178E</i></p>	<p>✓ Statutory provision that health practitioners are not required to perform or assist an abortion if they object on the grounds of conscience</p> <p>✓ Statutory requirement for the practitioner with an objection to provide information about other practitioners/service provider</p> <p><i>Reproductive Health (Access to Terminations) Act 2013 (Tas), s 6</i></p>			<p>✓</p> <p><i>Reproductive Health (Access to Terminations) Act 2013 (Tas), s 9</i></p>
<p>Victoria</p>	<p>Up to 24 weeks: No statutory restrictions on when abortion is lawful</p> <p>After 24 weeks: ✓ If the abortion is appropriate in all the circumstances</p> <p><i>Abortion Law Reform Act 2008 (Vic), s 5</i></p>	<p>After 24 weeks: Two medical practitioners</p> <p><i>Abortion Law Reform Act 2008 (Vic), s 5</i></p>	<p>✓ Criminal offence for an unqualified person to perform an abortion</p> <p><i>Crimes Act 1958 (Vic), s 65</i></p> <p>✓ Criminal offence to cause serious injury either intentionally or recklessly without legal excuse (which expressly includes destruction of a fetus other than in the course of a medical procedure)</p> <p><i>Crimes Act 1958 (Vic), ss 15–17</i></p>	<p>✓ Statutory requirement for the practitioner with an objection to refer the woman to another practitioner/service provider</p> <p><i>Abortion Law Reform Act 2008 (Vic), s 8</i></p>			<p>✓</p> <p><i>Public Health and Wellbeing Act 2008 (Vic), ss 185A–185H</i></p>

<p>Western Australia</p>	<p>Pre-20 weeks:</p> <ul style="list-style-type: none"> ✓ If the woman consents ✓ If the woman will suffer serious personal, family or social consequences if the abortion is not performed ✓ If risks to the physical or mental health of woman <p>After 20 weeks:</p> <ul style="list-style-type: none"> ✓ If the woman has a severe medical condition which justifies the abortion <p><i>Health (Miscellaneous Provisions) Act 1911 (WA), s 334</i></p>	<p>After 20 weeks: Two medical practitioners from an appointed panel</p> <p><i>Health (Miscellaneous Provisions) Act 1911 (WA), s 334</i></p>	<ul style="list-style-type: none"> ✓ Criminal offence to unlawfully perform an abortion ✓ Criminal offence for an unqualified person to perform an abortion <p><i>Criminal Code 1913 (WA), s 199</i></p>	<ul style="list-style-type: none"> ✓ Statutory provision that health practitioners are not required to perform or assist an abortion if they object on the grounds of conscience <p><i>Health (Miscellaneous Provisions) Act 1911 (WA), s 334</i></p>	<ul style="list-style-type: none"> ✓ Abortions of at least 20 weeks must be performed in an approved clinic/hospital <p><i>Health (Miscellaneous Provisions) Act 1911 (WA), s 334(7)</i></p>	<ul style="list-style-type: none"> ✓ Informed consent requires a medical practitioner to: <ul style="list-style-type: none"> (a) counsel the woman about the medical risks of abortion and carrying the pregnancy to term; (b) offer her counselling; and (c) inform her that counselling will be available upon abortion or after carrying the pregnancy to term <p><i>Health (Miscellaneous Provisions) Act 1911 (WA), s 334(5)</i></p>	
<p>Canada</p>	<p>In <i>R v Morgentaler</i> [1988] 1 SCR 30, the Supreme Court struck down the former s 287 of the Criminal Code RS 1985 C-34 as inconsistent with the Canadian Charter of Rights and Freedoms. No federal legislation has since been passed restricting abortion.</p>						<p>In British Columbia, Newfoundland and Labrador, Quebec, Ontario and Alberta</p> <p><i>Access to Abortion Services Act, RSBC 1996, c 1; Access to Abortion Services Act, SNL 2016, c A-1.02; An Act Respecting Health Services and Social Services, CQLR c S-4.2, ss 9.2, 16.1 and 5310.0.1; Safe Access to Abortion Services</i></p>

Canada (continued)							<i>Act, SO 2017, c 19; Protecting Choice for Women Accessing Health Care Act, SA 2018, c PP-26.83A</i>
Ireland	<ul style="list-style-type: none"> ✓ If serious risk to the life of woman ✓ If real and substantial risk of loss of the woman's life by suicide <p><i>Protection of Life During Pregnancy Act 2013 (Ire), ss 7–9</i></p> <p>Reform under consideration – see notes above</p>	<p>Two medical practitioners if certifying there is a risk to the life of the woman</p> <p>One medical practitioner if there is an immediate risk to the life of the woman</p> <p>Three medical practitioners if there is a risk to the woman's life by suicide</p> <p><i>Protection of Life During Pregnancy Act 2013 (Ire), ss 7–9</i></p> <p>Reform under consideration – see notes above</p>	<ul style="list-style-type: none"> ✓ Criminal offence to unlawfully perform an abortion ✓ Criminal offence for a woman to unlawfully procure her own miscarriage <p><i>Protection of Life During Pregnancy Act 2013 (Ire), s 22</i></p> <p>Reform under consideration – see notes above</p>	<ul style="list-style-type: none"> ✓ Statutory requirement for the practitioner with an objection to transfer care of the woman to enable her to avail of the medical procedure concerned <p><i>Protection of Life During Pregnancy Act 2013 (Ire), s 17</i></p>	<ul style="list-style-type: none"> ✓ Abortion must be performed in an approved clinic/hospital <p><i>Protection of Life During Pregnancy Act 2013 (Ire), ss 7–9</i></p>		
Northern Ireland	<p>Before fetus is “capable of being born alive”:</p> <ul style="list-style-type: none"> ✓ if serious risk to health or life of woman 		<ul style="list-style-type: none"> ✓ Criminal offence to unlawfully perform an abortion ✓ Criminal offence for a woman to unlawfully procure her own miscarriage 				

<p>Northern Ireland (continued)</p>	<p>After fetus is “capable of being born alive”: ✓ if risk to the life of the woman</p> <p><i>Offences Against the Person Act 1861, ss 58–59 prohibits “unlawful” abortions. Common law governs what constitutes an “unlawful” abortion. Criminal Justice Act (NI) 1945, s 25</i></p>		<p><i>Offences Against the Person Act 1861, ss 58–59</i></p>				
<p>United Kingdom (excluding Northern Ireland)</p>	<p>Pre-24 weeks: ✓ if risk to physical or mental health of woman</p> <p>After 24 weeks: ✓ if serious risk to health or life of woman ✓ if fetal abnormalities</p> <p><i>Abortion Act 1967 (UK), s 1</i></p>	<p>Two medical practitioners</p> <p><i>Abortion Act 1967 (UK), s 1</i></p>	<p>✓ Criminal offence to unlawfully perform an abortion</p> <p>✓ Criminal offence for a woman to unlawfully procure her own miscarriage</p> <p><i>Offences Against the Person Act 1861, ss 58–59</i></p>	<p>✓ Statutory provision that health practitioners are not required to perform or assist an abortion if they object on the grounds of conscience</p> <p><i>Abortion Act 1967 (UK), s 4</i></p>	<p>✓ In England only, abortion must be performed in an approved clinic/hospital</p> <p><i>Abortion Act 1967 (UK), s 1(3)</i></p> <p>Reform under consideration – see notes above</p>		