MAXIM INSTITUTE

SUBMISSION TO THE ABORTION LEGISLATION SELECT COMMITTEE: THE ABORTION LEGISLATION BILL

Danielle van Dalen, Gael Goulter, Jessie Duffin

WE WISH TO APPEAR BEFORE THE COMMITTEE TO SPEAK TO OUR SUBMISSION

EXECUTIVE SUMMARY

We are opposed to the Abortion Legislation Bill 2019. The Bill arose from a prior policy decision that abortion should be decriminalised and made to align with health law. As a result, it has not had the benefit of robust consideration of the wider ramifications of this policy shift. The combined effect of the Bill's provisions will be to increase the risks to women accessing abortion services, to make late term abortions more easily accessible, and to unjustifiably infringe on the basic rights and freedoms of New Zealanders.

Decriminalising abortion and treating it as a health issue is not the appropriate response. The Bill's objective of decriminalising women seeking abortions can be achieved by removing s.44 of the Contraception, Sterilisation, and Abortion Act 1977. Decriminalising abortion itself by removing criminal sanctions for providers of unlawful abortions goes too far. It is inconsistent with accepted legal and social treatment of the unborn child, and it weakens protections necessary to ensure a high standard of health care for women accessing abortion services.

- The Bill will increase the risks to women accessing abortion services.
- The Bill poses particular risks to vulnerable women accessing abortion services, such as minors, women who lack capacity to consent, and women who are being coerced into an abortion.
- The Bill deregulates abortion to such an extent that women could be exposed to greater risks from unsafe abortion practices.
- The Bill removes the protection and oversight that the Abortion Supervisory Committee provides, without sufficient justification.
- The Bill undermines the ability of women to give properly informed consent to an abortion.

The Bill does not provide enough protections around late term abortions. The Bill's attempt to restrict abortions after 20 weeks' gestation is too broad and essentially unenforceable. The Minister of Justice has stated that late term abortions are only intended for "very extreme circumstances." To achieve this, the Bill should retain the current post-20 week test, limiting late term abortions to situations that are "necessary to save the life of the woman … or to prevent serious permanent injury to her physical or mental health."

The Bill unjustifiably impacts on fundamental rights and freedoms.

- The Bill fails to restrict abortions sought solely on the grounds of the disability or sex of the unborn child.
- The Bill introduces "safe areas" which would limit the right to freedom of expression. There is simply not enough evidence to support such a provision.
- The Bill's restrictions on freedom of conscience are an unjustified and concerning impingement on fundamental rights, requiring robust justification. Again, there is simply not enough evidence to support such a provision.

Further research is needed before advancing law reform. Although we oppose the Bill, we propose a number of recommendations to improve it, should it pass. However, we consider that the Bill should not be progressed any further without a Royal Commission of Inquiry to provide a thorough, grounded, nationwide investigation and report into all relevant matters relating to abortion law, as was the case last time we considered this kind of significant change.

1. INTRODUCTION

We are opposed to the Abortion Legislation Bill 2019.

Any conversation about abortion involves consideration of complex, deeply-held convictions about the correlating and competing rights and interests of a pregnant woman and her unborn child.[1] There are no easy answers. In this submission, we seek to provide an arms-length analysis of the Bill's provisions and their potential impact.

The Bill arose from the Government's prior policy decision that abortion should be decriminalised and made to align with health law.[2] As a result, it has not had the benefit of robust consideration of the wider ramifications of this policy shift. The rationale behind decriminalisation of abortion is that women should not be criminalised for having an abortion. We consider that this can be effectively achieved while still maintaining a criminal offence for someone who provides an unlawful abortion. Maintaining a criminal offence is necessary for two reasons. First, it prioritises a high standard of health care for the safety of the pregnant woman; and second, it recognises that the unborn child has interests that require consideration.

The Bill goes well beyond decriminalisation of abortion to make a number of far-reaching reforms that could result in concerning unintended consequences. The combined effect of the Bill's provisions will be to increase the risks to women accessing abortion services, to make late term abortions more easily accessible, and to unjustifiably infringe on the basic rights and freedoms of New Zealanders.[3] These issues are fundamental and cannot be remedied by a few minor tweaks to the Bill. Although we oppose the Bill, we also propose a number of recommendations to improve it, should it pass. However, it is our view that the Bill should be put to the side while a Royal Commission of Inquiry undertakes a thorough, grounded, nationwide investigation and report into all relevant matters relating to abortion law, as was the case last time we considered this kind of significant change.

We would like to appear before the Select Committee and make an oral submission.

2. DECRIMINALISATION IS NOT AN APPROPRIATE RESPONSE

As outlined in the Explanatory Note, the Bill's stated purpose is to "decriminalise" abortion.[4] That is, to take abortion out of the Crimes Act 1961 (Crimes Act) and treat it as a health matter. This would allow abortion "to be treated like other health services, which are governed by general health laws and professional guidance."[5] Under the proposed legislation, all Health Practitioners will be excluded from criminal liability, and abortion will only be subject to criminal sanctions when someone other than a Health Practitioner procures or performs an abortion.

A key driver of the Government's policy is a concern that women should not be criminalised for seeking or undergoing an abortion.[6] However, decriminalising women seeking abortions could be achieved without decriminalising abortion itself, which in our view would go beyond the policy intent of the Bill and could lead to serious unintended consequences.

2.1 A minor amendment would ensure women are not criminalised

The Crimes Act specifically excludes women from liability for having an unlawful abortion.[7] Although under s. 44 of the Contraception, Sterilisation, and Abortion Act 1977 (Contraception, Sterilisation, and Abortion Act), it is an offence for a woman to undergo (or attempt to undergo) an unlawful abortion, punishable by a maximum penalty of a $200 fine.[8] There is no record of any woman having been convicted of this offence.[9] Rather, the concern appears to be that women feel criminalised. In over 97 percent of cases women rely on the statutory criteria in s.187A(1)(a) of the Crimes Act (the "mental health" exemption) in order to qualify for a lawful abortion.[10] Many women feel uncomfortable or offended by the need to give a potentially disingenuous reason in order to qualify for a lawful abortion under the Crimes Act.[11]

Repealing s.44 of the Contraception, Sterilisation, and Abortion Act would achieve the goal of ensuring that women are not actually criminalised for accessing abortion services. Reviewing the criteria for a lawful abortion would address concerns about women feeling criminalised, and is the sort of review that could be undertaken by a Royal Commission. However, removing criminal sanctions against Health Practitioners, or others, who provide an unlawful abortion goes beyond this scope and would create legal inconsistencies and other unintended consequences, as outlined below.

2.2. Decriminalising abortion is inconsistent with legal and social treatment of the unborn child

Placing abortions within health law makes an abortion solely about the woman, without any recognition that the unborn child also has interests that need to be considered and protected in certain situations. New Zealand law does not recognise a legal right to abortion.[12] Neither does it recognise a right to life of the unborn child.[13] Instead, it currently recognises that the State has an interest in protecting the unborn child, and that the woman's and unborn child's interests are entwined, and often competing, during pregnancy.[14] Currently our abortion law seeks to balance these competing interests by requiring each prospective abortion to qualify under statutory criteria and by making unlawful abortions subject to criminal provisions. In the words of the High Court: "the legislature has recognised, through the abortion law, that the unborn child has a claim on the conscience of the community."[15] We therefore consider it is both unprincipled and inconsistent with aspects of our current law to entirely disregard the interests of an unborn child, as the Bill proposes.

Decriminalising abortion is inconsistent with how New Zealand law treats the unborn child in other contexts. Under s.182 of the Crimes Act, it is an offence to kill an unborn child (for example, as a result of an assault upon a pregnant woman), with a maximum penalty of 14 years imprisonment.[16] Moreover, there are instances of the law recognising that an unborn child has interests that require protection.[17] For example, the Courts have appointed a guardian for an unborn child in a situation when that unborn child's birth was going to be filmed in a pornographic movie.[18]

Decriminalising abortion is also inconsistent with New Zealand's societal treatment of the unborn child. In other contexts, we collectively recognise and value the inherent dignity of the unborn child. We grieve miscarriages and stillbirths, and have even considered introducing bereavement leave for these situations.[19] The Government provides a range of free maternity services to the pregnant woman for the benefit of her unborn child, such as pregnancy vaccinations, scans, and midwifery services. The Government also funds education campaigns on safe practices during pregnancy (including in relation to diet, sleeping positions, and avoiding smoking and alcohol consumption), recognising that this benefits the unborn child.[20]

2.3. Decriminalising abortion removes appropriate sanctions for unqualified abortion providers

The Bill repeals all current offences relating to abortions and replaces them with a new offence of "abortion procured by person other than Health Practitioner."[21] This means that only those people who are not Health Practitioners who perform or procure an abortion would face criminal sanctions. Unqualified Health Practitioners, such as a chiropractor, who perform or procure an abortion would not be subject to criminal prosecution. The Explanatory Note of the Bill states that "existing health law continues to recognise the right of health care consumers to receive an appropriate standard of care by a suitably qualified and competent health practitioner."[22] We consider that maintaining a high standard of health care requires all unqualified persons to be open to criminal prosecution, regardless of whether they happen to be registered as a member of an unrelated health care profession.

Further, and in contradiction to its Explanatory Note, the Bill does not include an offence for someone other than a Health Practitioner to supply the means for procuring an abortion, such as surgical equipment or medication. It is unclear whether this was intentional, or an oversight. The effect is that if someone who is not authorised to supply the means for an abortion does so, they can only be pursued under health law. Given the potential for very serious consequences that could result from substandard abortion medication or equipment, we consider it appropriate to include this criminal offence in the Bill.

2.4 Recommendations:

- Repeal s.44 of the Contraception, Sterilisation, and Abortion Act to meet the overall aim of decriminalising women.
- Retain the current model of a criminal offence applying to providers of unlawful abortion services.
- Amend proposed s.183 of the Crimes Act to include all unqualified providers of unlawful abortion services, as well as unauthorised suppliers.

3. THE BILL WILL INCREASE THE RISKS FOR WOMEN ACCESSING ABORTION SERVICES

Although the Bill intends to support women's reproductive freedom and to simplify the abortion process, we are of the view that the Bill is likely to have a negative impact on women. Broadening the category of person authorised to provide an abortion, removal of the oversight of the Abortion Supervisory Committee (the Supervisory Committee), removing protections around obtaining abortion medication, and allowing abortions to be administered away from licensed premises combine to increase the risks to women from an abortion procedure. The desire to increase access must not outweigh safety.

Further, the Bill's provisions do not adequately provide for the needs of vulnerable women, including women who are susceptible to coercion, women under the age of 16, and women who lack capacity to make informed choices as a result of mental illness or intellectual disability. These women require additional protections to ensure that their consent to an abortion is fully informed and freely given.

3.1 Disestablishment of the Supervisory Committee removes an instrumental protective mechanism

The Supervisory Committee has an important role in maintaining a high standard of care to ensure the safety of women in an abortion procedure. The Bill disestablishes the Supervisory Committee. All its functions, including its remit to review abortion law and practice, licence abortion premises, prescribe standards regarding abortion facilities and staff, collect and analyse information, appoint doctors to consider cases, and provide annual reports, will cease when the Bill comes into law. Abortion legislation in New Zealand will instead be administered by the Ministry of Health.[23]

While existing health law and practice will go some way to ensuring that women obtaining an abortion receive an appropriate standard of care, the disestablishment of the Supervisory Committee removes the protection of a body whose focused role was to ensure that abortion services are safe, accessible, and regulated. There are no guarantees about how the Ministry will regulate or fund abortion services or what standards of practice it will put in place. Significant detail surrounding the provision of abortion services is open to interpretation, to be determined by the Ministry and its subsidiary bodies without the rigour and legitimacy of the democratic process.[24]

Disestablishment of the Supervisory Committee raises further concerns about the quality of abortion-related data collection and reporting. Although the Bill requires that "the Director-General of Health ... collect, collate, analyse, and publish information about abortion services and also the provision of counselling services," the Ministry of Health has recognised that the data collection required in respect to abortions is far more detailed than the type of reporting that District Health Boards (DHBs) are currently required to undertake.[25] As a result, an entirely new process for data collection and reporting would need to be created and implemented across New Zealand's DHBs. The Ministry has recognised that this will be a lengthy process and that there will be data gaps in the early phase.[26] Reliable, thorough, and regular data collection is essential for assessing whether the law is working appropriately. This is particularly important in the case of abortions, which involve the competing interests of the woman and the unborn child, where a robust understanding of why women are accessing abortion services will assist the Government to better focus its resources.

3.2 Deregulation of abortion services poses risks to women

Currently, an abortion, whether surgical or medical, must be performed by a Medical Practitioner (doctor) in a licensed institution.[27] Any Medical Practitioner who performs an abortion must fulfil several requirements including undergoing training in women's health, performing abortions and managing complications.

The Bill extends the category of abortion provider to a Qualified Health Practitioner.[28] There are a wide range of Health Practitioners, and because there is no explicit definition in the Bill it remains to be seen which of these professions will be deemed qualified to perform abortions, and what, if any, training will be required.[29] This will be at the discretion of the various health bodies, termed Authorities, who determine which activities an Health Practitioner is permitted to perform (under their Scope of Practice).[30] It is reasonable to expect that midwives and nurse practitioners will be able to provide medical abortions, but the ambit could be wider. Again, the Bill leaves this crucial decision to delegated Authorities rather than an elected Parliament.

The Bill also proposes the removal of requirements for licensing abortion facilities. In the case of medical abortion, the Bill removes the current requirement that the abortion medication be taken at a licensed abortion facility, following consultation with a Medical Practitioner, and under the supervision of trained staff.[31] If, for example, midwives and nurses are authorised as Qualified Health Practitioners, medical abortion pills could be prescribed in homes, schools,

family planning clinics, hospitals, and maternity services. In many parts of Australia women can initiate the abortion process with a phone call and receive home-administered early medical abortion medications by courier without being assessed or examined by a Health Practitioner.[32] The Bill would not prohibit this in New Zealand.

It is important to note that the current safeguards are not in place to make the process more cumbersome, but for the safety of women. Physical assessment by a Medical Practitioner ascertains the gestation and location of the pregnancy and whether there are any risk factors for the woman in taking the abortion medication. Psychosocial assessment reduces the possibility of coercion, and allows for referrals to support agencies where needed. Ingestion at a licensed facility ensures that the correct dose is taken by the correct person, and avoids the serious consequences of unauthorised use. A follow-up physical assessment ensures that the medical abortion is complete. Although all medications involve risks, the Medsafe Data sheet (which is produced by the pharmaceutical company selling the medicine) outlines a number of not-insignificant risks associated with the relevant termination medication.[33]

The Bill also fails to clarify who will be enabled to perform surgical abortions, and where. Instead, it leaves it to the discretion of the Minister of Health's administrative bodies to determine this.[34] We are of the view that it is essential that our law continues to focus on protecting women from the possibility of unsafe abortions. The best way to do this is to specify who may perform surgical abortions, and where, in legislation, as is currently the case. As noted by the Law Commission, "unsafe abortions performed by unskilled people can lead to serious complications or even death."[35] Appropriate safeguards are necessary to minimise the chance of unsafe abortions, especially if there is a possibility that an unqualified person could perform a surgical procedure.

3.3 The Bill's provisions undermine informed consent

Under health law, all patients have rights and all Health Practitioners have corresponding duties.[36] Patients have the right "to make an informed choice and give informed consent" to any health procedure (being consent that is freely given, and obtained in accordance with the Code of Health and Disability Services Consumers' Rights (Health Code)).[37] Health Practitioners have a duty to effectively communicate full and accurate information.[38] Legally, informed consent is not a single act, but an ongoing, patient-centred process, which includes the right to refuse health services, or to withdraw consent that has been previously given.[39] In fact, in each individual case, the Health Practitioner has a duty to assess whether the patient has the capacity to give informed consent.[40]

In the case of abortion, the Supervisory Committee has recognised the gravity of a woman's decision, and it has developed mandatory Standards of Care to ensure that the woman is given the following information:[41]

- *Basic anatomy and physiology as relevant to their gestation*
- *An understanding of the process of abortion and its possible complications*
- *Foetal development (which may include showing pictures of the stage of foetal development)*
- *Information about the advantages of having an abortion earlier rather than later in a pregnancy and the differences between a medical and surgical abortion*
- *Products of conception – kai atawhai or disposal options*
- *An understanding of how people make sense of the loss of conception in abortion, grief and loss processes, and variabilities within a contemporary cultural context in Aotearoa*
- *Contraception education*

Under the Bill, the Standards of Care will not continue in effect unless the Ministry of Health incorporates them into new standards. Although the Health Code requires that a certain standard of information be provided, it is unclear what particular information this will include, and therefore whether it will be mandatory for women to be given the level of impartial, accurate, and fulsome information that is essential to provision of informed consent to an abortion.[42]

Further provisions of the Bill potentially compromise the ability of women to give informed consent, such as the ability to self-refer to an abortion provider, shorter timeframes, and removal of the involvement of two doctors (one being an obstetrician or gynaecologist). In addition, the Bill removes the current provisions relating to counselling services (including that abortion counselling services must be "directed by an experienced and professionally trained social worker," and that "every counsellor should be thoroughly familiar with all relevant social services and agencies") and replaces them with comparatively vague provisions.[43] In the case of an abortion, it is important to ensure that women have sufficient time, information, and support in making the decision, recognising the often-emotional context of an unplanned pregnancy. It is essential that measures to protect informed consent are not neglected in favour of a simplified process.

3.4 The law relating to minors is inconsistent with other health procedures

It is the stated aim of the Bill to "better align the regulation of abortion services with other health services."[44] If that is the case, s.38 of Care of Children Act 2004 (Care of Children Act) requires repeal. This section provides that a female child (of any age) can provide consent to an abortion as if she were of full age.[45] In all other health contexts, the Health Practitioner is required to assess the child's capacity prior to a medical procedure, and, where capacity is lacking, obtain the consent of a parent or guardian.[46] Without repealing s.38 of the Care of Children Act girls of all ages will remain able to consent to abortion as though they were adults, without consultation with their parent or guardian.[47] We are of the view that removal of current safeguards makes pregnant minors even more vulnerable, and makes it even more essential that the Health Practitioner be required to assess the child's capacity prior to undertaking an abortion. In those situations where a minor does not have capacity to consent, involvement of the parent or guardian should be required. If there is a concern in individual cases that a minor could be at risk if her parents were notified, the law already provides alternative solutions.[48]

3.5 Removal of safeguards raises particular concerns for women vulnerable to coercion

We are concerned that simplifying the abortion process by removing current safeguards decreases the opportunities to identify coercion. Proponents for the Bill have claimed that women are to be trusted and given freedom and choice over their own bodies.[49] For women who are susceptible to abuse (or strong pressure from a family member or a partner), however, abortion may not always be a free choice. In other contexts, society recognises that women are at times particularly vulnerable, for example in instances of intimate partner violence, or Battered Women's Syndrome.[50] In the context of abortion, we cannot dismiss the possibility of coercion, and measures are needed to prioritise and protect vulnerable women.

3.6 The Bill is likely to negatively impact women who lack capacity to consent to an abortion

The lack of procedural safeguards could have concerning implications for women who do not have capacity to consent to an abortion.

First, as noted above, by removing the requirement for a woman to meet with a doctor prior to consenting to an abortion, the Bill raises the risk that the Qualified Health Practitioner may not have the necessary training to detect whether a woman has sufficient capacity to consent.

Second, in the case of women who are found to lack capacity due to mental illness or intellectual disability, the Bill repeals the current requirement that two Certifying Consultants must seek a specialist opinion from a doctor or other person qualified and experienced in her condition.[51] If the Bill becomes law, a Qualified Health Practitioner, who is not necessarily a doctor, will be authorised to perform an abortion in consultation solely with the woman's welfare guardian

rather than a specialist medical professional, thereby removing an invaluable layer of protection. The vulnerability of women who lack capacity to consent is highlighted by a recent decision in the English Courts which found that it was in the "best interests" of a 24-year-old woman with a learning disability to compel her to have an abortion that she did not want.[52] While this decision was urgently overturned on appeal, it highlights the necessity for robust safeguards to protect vulnerable women.[53]

3.7 Recommendations:

- Retain the Abortion Supervisory Committee and all of its current functions and powers.
- Maintain the requirement that all abortion services be provided by a Medical Practitioner in Licensed Premises.
- Repeal s. 38 of the Care of Children Act to ensure that minors seeking abortions are given the same protections as in other health procedures.
- Retain s. 34 of the Contraception, Sterilisation, and Abortion Act to ensure that women without capacity to consent are given sufficient protections.
- Insert a statutory list of factors that should be considered when determining what is in an individual woman's best interests when she lacks capacity to consent to an abortion.
- Retain s. 31 of the Contraception, Sterilisation, and Abortion Act which provides for more robust counselling provisions.
- Introduce a thorough reporting and evaluation process. This will enable the Government to better focus its resources towards the safety of women accessing abortion services.
- Ensure measures are in place to protect the informed consent of women considering an abortion. Examples include:
    - A stand down period of three days, as seen in Ireland.
    - A mandatory ultrasound to confirm the gestation and location of the woman's pregnancy.
    - A mandatory provision in respect to the information that is required to be given to women prior to an abortion, in line with the current Standards of Care.

4. THE BILL PROVIDES INSUFFICIENT RESTRICTIONS FOR ABORTIONS POST-20 WEEKS

We consider that it is appropriate to restrict access to abortions in the later stages of pregnancy. On an initial reading, it may appear that the Government shares this view given that it has retained a statutory test for pregnancies after 20 weeks. On closer inspection, however, the test is so broad and unenforceable that it risks being meaningless in practice. As a result, late term abortions will be lawful for significantly broader reasons than the law currently provides for.[54]

4.1 Restriction of late term abortions is appropriate

By retaining the gestational limit of 20 weeks, the Bill's proponents have recognised that it is appropriate to place restrictions around abortion in the later stages of a pregnancy. We support this position, noting the following reasons in support of a gestational limit as outlined by the Law Commission:[55]

- The abortion procedure changes as the gestation advances, which can result in psychological stress and practical difficulties for both abortion providers and women. For a medical abortion, increased doses of Misoprostol are

required. For surgical abortions, dilation and evacuation is required. After 22 weeks, the Standards of Care require that feticide (involving a fatal drug injected directly into the unborn child's heart) is part of the abortion process other than in exceptional circumstances.

- Late term abortions have more severe side effects and higher rates of complications for women.
- Some consider that the interest in preserving the life of the unborn child increases as the unborn child develops. For example, in the Court of Appeal it was said that: "[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."[56] Also, in the well-known case of *Roe v Wade* the Supreme Court of the United States held that the right to an abortion diminishes as the pregnancy progresses.[57]
- The law gives increased recognition to post-20 week unborn children in the contexts of stillbirths.[58]

4.2 The new statutory criteria for post-20 week abortions is too broad

Although the Bill imposes a gestational limit, the post-20 week test for a lawful abortion is so broad that it will place minimal practical restrictions on access to late term abortions. Under the current law, abortion is only lawful after 20 weeks' gestation if two doctors believe it is "necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health."[59] In contrast, the Bill provides that late term abortions will be available provided one Health Practitioner "reasonably believes that the abortion is appropriate in the circumstances," having "regard to the woman's physical health, and mental health, and well-being."[60] Thus, the Bill significantly extends the circumstances that will be deemed relevant to the appropriateness of a late term abortion.

The test is so broad that it is difficult to envision a scenario in which the Health Practitioner could be found not to have reasonably believed that the abortion was appropriate in the circumstances. This was acknowledged by the Law Commission who confirmed that:[61]

> *The test does not limit the matters the Health Practitioner could take into account when assessing whether an abortion is appropriate in the circumstances ... [the test] is broad enough to encompass consideration of all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances.*

When it provided its various options for reform, the Law Commission stated that its Model A (which would allow abortion without restriction) and Model C (which is very similar to the proposed law) would have a "very similar" impact on abortion practice overall.[62] Indeed, when considering whether a regulatory offence for a breach of this test should apply, the Law Commission stated that the scope of the test is so broad that Health Practitioners would not know which conduct was prohibited.[63]

In public discourse about the Bill's effect on late term abortions, the Justice Minister has made it clear that the intention of the Bill is not to liberalise abortion up to birth.[64] Rather, he has stated that the Bill's criteria for post-20 week abortions are intended for "very extreme circumstances."[65] If this is the intention, we consider that the Bill's provision for late term abortions requires amendment. A statutory restriction comparable to the current post-20 week test, limiting late term abortions to situations that are "necessary to save the life of the woman or girl to prevent serious permanent injury to her physical or mental health," strikes the appropriate balance between the woman's health and the broader societal interests in reducing late term abortions wherever possible.[66]

4.3 The new statutory criteria for post-20 week abortions is unenforceable

As well as being too broad, there is an equally fundamental flaw that the statutory test is unenforceable. In the rare event that the Health Practitioner was found to have breached the test, there would be very little in the way of effective repercussions. As noted by the Law Commission, "without an enforcement mechanism, there may be less incentive for Health Practitioners to give proper consideration to the test."[67] In practice, the test will not be enforceable for the following reasons:

- Health Practitioners who do not apply the test adequately are not subject to criminal sanctions. As noted above, we consider that it is both appropriate and necessary for a criminal offence to apply to Health Practitioners who do not adequately apply the test. This would help to incentivise, and ensure, compliance.
- The Ministry of Health does not appear to have the power to review the individual decisions of Health Practitioners. Under the Bill, the Supervisory Committee will be disestablished, and the Ministry will be responsible for the administration of abortion law. In considering the Supervisory Committee's power to review decisions of Certifying Consultants, the Supreme Court found that without a specific power of review, the most that the Supervisory Committee could do is "ask a consultant how he was approaching decision-making in general."[68] By failing to provide the Ministry with a specific power to review individual Health Practitioners' decisions, it would be almost impossible to obtain the necessary information to assess whether the statutory test was accurately applied, unless the woman involved co-operated.
- Health law is not equipped to enforce the test. Although the Health and Disability Commissioner has extensive powers of review, he or she can only become involved if the pregnant woman's rights are breached in the process of a Health Practitioner authorising an abortion. The Commissioner is not empowered to review a case on behalf of the unborn child, because an unborn child would not qualify as a "health consumer" for the purposes of the Health and Disability Commissioner Act 1994 or Health Code.[69] This means that the Commissioner would likely only investigate any individual case if the woman involved complained – which she would be unlikely to do if she desired and consented to an abortion which did not meet the statutory test.
- The Police are unlikely to have any effective powers of enforcement, other than in cases involving a non-health practitioner, or gross misconduct against the woman. This is a consequence of decriminalisation, as the Bill repeals all crimes relating to abortion except when a person other than a Health Practitioner performs or procures an abortion.[70]
- Finally, there are significant limitations on the ability of third parties, other than the woman or Health Practitioner, to seek judicial review of a Health Practitioner's decision. The High Court has found that third parties cannot demonstrate a "personal interest" in the exercise of statutory powers (meaning they lack standing to bring a claim in their own right), and it is not possible for them to bring a claim on behalf of the unborn child's interests.[71] The Court has further held that even if an applicant for judicial review was found to have standing, the scope of review would be extremely limited, and a high level of deference given to the Certifying Consultants.[72]

For the test to be meaningful in practice, the Bill needs to include a specific power of enforcement. This must include the power to review a Health Practitioner's application of the test.

4.4 Recommendations:

- Retain current criteria for abortions performed after 20 weeks' gestation.
- Provide the Ministry of Health (or the Supervisory Committee, if retained) with a specific power to review Health Practitioners' decisions in individual cases.

5. THE BILL UNDULY LIMITS FUNDAMENTAL RIGHTS AND FREEDOMS

The Bill impacts on fundamental rights and freedoms that are protected by the New Zealand Bill of Rights Act 1990 (Bill of Rights Act) and the Human Rights Act 1993 (Human Rights Act). The Bill of Rights Act prescribes that a limitation of one's rights and freedoms must be "reasonable," and "demonstrably justified in a free and democratic society."[73]

5.1 The Bill allows discrimination on the basis of the unborn child's disability

The Bill's proposed criteria allow for an abortion to be lawfully obtained on the basis of a risk of disability of the unborn child.[74] We consider that this will result in indirect discrimination (being a practice that "has the effect of treating a person or group of persons differently"), which could negatively impact on New Zealand's disability community.[75]

New Zealand's Independent Monitoring Mechanism on the Convention on the Rights of Persons with Disabilities notes that:[76]

> *disability-selective antenatal screening 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.*

Abortions on the grounds of the unborn child's disability are already happening.[77] As a matter of course, women are offered publicly-funded tests to determine the risk of Down Syndrome or other chromosomal or genetic conditions. Further disabilities can be detected by way of ultrasound screening. Data about screening and termination rates in New Zealand are limited. A review of comparable international jurisdictions, however, has found that there is "very clear evidence that in response to moderate to severe foetal abnormality, the majority of women choose to terminate their pregnancy."[78] Furthermore,[79]

> *internationally screening/termination practices are at such a rate that Down Syndrome could soon be eliminated from regions of the world. Iceland, for example, has reportedly not had any Down Syndrome births for five years while in 2014, termination rates in Denmark [for Down Syndrome] were reportedly 98 percent*.

When Crown Law assessed whether the provisions of the Bill will result in indirect disability discrimination, it concluded that because the Bill does not make express reference to disability, "the Bill is less likely than the present legislative regime to lead to indirect discrimination on the basis of disability."[80] With respect, we disagree. Remaining silent on a discriminatory practice does not make it less likely to happen. In fact, quite the opposite. The Bill's removal of current restrictions significantly widens the ability for a woman to have an abortion on the grounds of disability.[81]

The Bill does away with any restriction for abortions prior to 20 weeks.[82] As such, there will be no discretion for a Health Practitioner to deny an abortion sought solely due to the unborn child's disability, regardless of the degree of severity.

For pregnancies of more than 20 weeks' gestation, the Bill makes abortions on the grounds of disability of the unborn child significantly more accessible than under the current law. Currently, in order to have an abortion on the basis of disability, two Certifying Consultants must believe that the unborn child's potential disability would cause serious permanent injury to the woman's mental health.[83] In contrast, the Bill requires only one Health Practitioner to reasonably believe that the abortion is in the interests of the woman's mental health, physical health, and well-being. Given that the test is at the discretion of the Health Practitioner, and that there is very limited, if any, ability to review the Health Practitioner's decision, it will be lawful to abort unborn children on the basis of their disability alone, regardless of its severity, right up until they are fully born.[84] Concern has already been expressed about late term abortions that have

been performed in the United Kingdom on the basis of conditions such as a cleft lip and palate or a club foot.[85] Under the Bill, this would not be prohibited in New Zealand.

We believe that the Bill's criteria for abortions will exacerbate discrimination against New Zealand's disability community, such that people with disabilities will be viewed and treated differently on the basis of their disability. Indeed:[86]

> *The birth of a child with a disability now increasingly becomes a matter of conscious choice, since the option to detect and terminate an affected pregnancy is available. In this environment, parents who do not choose to terminate, or who do not even use the prenatal diagnosis, may come to be seen as acting irresponsibly or recklessly. People with disabilities (especially ones that are recognisably genetic or prenatal in origin, such as Down's Syndrome and Spina Bifida) may come to be seen as accidents that should never have happened. Such a change of attitude, especially if widespread, could indeed lead to increased discrimination against people with disabilities. This could take the form of increasing stigmatisation of people with disabilities as a burden upon society, and their increasing social marginalisation.*

5.2 The Bill allows discrimination on the basis of the unborn child's sex

The Bill's proposed criteria allows for an abortion to be lawfully attained on the basis of the unborn child's sex alone.[87] The Human Rights Act expressly prohibits discrimination on the basis of sex.[88] We consider that the Bill's provisions constitute sex discrimination, in that they could directly lead to the birth of fewer children of a particular sex; or indirectly have "the effect of treating a person or group of persons differently" by reason of their sex.[89]

There are generally two categories of reasons for sex-selective abortion. The first is medical sex selection. That is, terminations of pregnancy to avoid gender-linked diseases such as haemophilia A and B or Duchenne muscular dystrophy, diseases that a male child inherits from his mother.[90] The second category is non-medical sex selection, resulting from a strong preference for a child of a particular sex. In many cultures, this results in disproportionate abortion of female unborn children due to a strong preference for male children.[91] For example, "over the next 20 years in large parts of China and India there will be a 10% - 20% excess of young men."[92] Non-medical sex selection, however, is not confined to cultural values and preferences. Sometimes, "a couple who has a child or children predominantly of one sex might opt to use [noninvasive prenatal testing] followed by abortion … so as to have a child of the other sex."[93] This practice is commonly referred to as "family balancing."[94]

Research suggests that significant numbers of sex-selective abortions, as have been seen in China and India, may result in serious social consequences. This includes increased sexual violence and human trafficking of women, as well as decreasing the value and worth that society places on women.[95] The concerns of sex selection, however, are not limited to Asian countries, where the practice is most prevalent. The Law Commission has noted that it "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 [namely Canada and Australia] … The studies have found higher rates of male births for mothers among immigrant communities, particularly among women who already had children, suggesting that prenatal sex selection is practiced."[96]

There are also concerns that sex selection on the basis of "family balancing" is problematic.[97] At its core, sex selection affirms gender-stereotyping children, and some commentators have argued that it may increase the "risk that resulting children would be treated as vehicles of parental satisfaction, rather than as ends in themselves."[98]

It is Crown Law's position that the Bill does not impinge on the right to be free from discrimination:[99]

> *The Abortion Legislation Bill does not include reference to the sex of the [unborn child] as a ground for obtaining an abortion in either new section 10 or 11. Nor are there any identified elements of the Bill that create limits or tests that would indirectly result in discrimination on the basis of sex. It has not been shown that provisions in the Bill will result in the birth of fewer children of a particular sex with the effect of treating a person or group of persons differently.*

Again, we counter that just because the Bill is silent about sex selection does not in any way prohibit or prevent the practice. In fact, quite the opposite. The Bill's removal of current restrictions widens the ability for a woman to have an abortion on the grounds of the sex of the unborn child. The Bill fails to include any restrictions for abortions prior to 20 weeks' gestation. As a result, there will be no discretion for a Health Practitioner to deny an abortion sought solely due to the unborn child's sex. Post 20-weeks' gestation, abortion on the basis of a woman's preference for the sex of her child would be lawful if a Health Practitioner "reasonably believes [it] is appropriate in the circumstances," having "regard to the woman's physical health, and mental health, and well-being."[100] As noted above, this is a broad and discretionary test, with very limited means of review, if any. Therefore, it is possible that lawful abortions will be carried out on post-20 week unborn children on the basis of sex alone.

To avoid the risk of discrimination on the basis of sex, it is our view that explicit prohibition is required. Parliament has done this in other comparable situations, such as in the practice of In Vitro Fertilisation (IVF), where sex selection of an embryo is expressly prohibited except "to prevent or treat a genetic disorder or disease."[101] While the prohibition of sex-selective abortions would be more difficult to enforce in practice than sex-selective IVF, a statutory prohibition of this nature would send the message that our society does not condone discrimination on the basis of sex. Further, it would signal to the international community that New Zealand is committed to the equal rights of men and women. The relationship between the law and societal practices is such that this would likely result in fewer sex-selective abortions.

5.3 The Bill's provision for safe areas is an unjustified limitation on rights and freedoms

We consider the introduction of safe areas would be an unjustified limitation of fundamental rights and freedoms, most notably the right to freedom of expression.[102] The importance of freedom of expression has been well-recognised by our Courts:[103]

> *Freedom of expression is a right which is basic to our democratic system. As the Supreme Court of Canada has said: "The core values which free expression promotes include self-fulfillment, participation in social and political decision making, and the communal exchange of ideas. Free speech protects human dignity and the right to think and reflect freely on one's circumstances and condition.*
>
> *[...] In assessing the particular weight to be given to freedom of speech in a protest context, respecting the freedom to choose the means of protesting which are seen to be most effective is important. Respect for protest as a means of pressing for change in official policy or conduct is very much part of New Zealand's culture and societal values. [...] As Andrew Geddis has put it:*
>
> *"[T]he overall health of our body politic may be judged by how far our legal ordering provides [the individual dissenter] with the space to make her opinions known to the public.*

Despite the importance of the right to freedom of expression, this right is not absolute, and is subject to "such reasonable limits ... as can be demonstrably justified in a free and democratic society."[104] Our Courts have held that making this assessment involves determining whether the proposed limit "serve[s] a purpose sufficiently important to justify" limiting a right, and if so, whether the limit is "rationally connected with its purpose," "impair[s] the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose," and is "in due proportion to the importance of the objective."[105]

5.3.1 The introduction of safe areas fails to serve a sufficiently important purpose

The proposed limit to fundamental rights does not serve a sufficiently important purpose because there is insufficient evidence that safe areas are needed in New Zealand. The Law Commission considered the introduction of safe access zones. It sought input from health professional bodies (including DHBs and the Supervisory Committee), abortion service providers and Health Practitioners.[106] It considered the types of demonstrations that people have experienced in accessing an abortion (such as vigils, holding signs or approaching women to give information) and it concluded that: [107]

> *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 ... the Commission does not suggest the introduction of safe access zones.*

Legislation should only include criminal offences if they are necessary to achieve a significant policy objective that cannot be achieved effectively through other measures.[108] The Summary Offences Act 1981 prohibits disorderly or offensive behaviour against public order, intimidation (which includes stopping, confronting, or accosting someone in a public place), and obstructing a public way.[109] As a result, the safety and well-being of women and abortion providers are already protected from inappropriate protest actions. The implementation of safe areas is thus an unnecessary restriction on the rights of New Zealanders to freedom of expression.

In its assessment, Crown Law asserted that "there is good reason to believe that anti-abortion demonstration activity could become more widespread and intrusive." We consider that the reasons provided by Crown Law were inadequate, as follows:[110]

1. Crown Law asserted that because the Bill would allow abortions to be provided at locations other than hospitals, this could result in more demonstrations because premises of abortion providers will lack the security and physical features of a hospital. First, not all abortions are provided from hospitals in New Zealand.[111] Second, as noted by the Law Commission, if abortions are available from more locations, it could be more difficult for demonstrators to target the premises of abortion providers.[112]
2. Crown Law relied on the online claim of one person that she had been a "sidewalk counsellor" as evidence that "some activity in New Zealand is more intrusive than silent protest." This is hardly evidence of a widespread problem.
3. Crown Law referenced Canada where after decriminalisation the climate around some abortion clinics became unpleasant and frightening. This does not provide reliable evidence that decriminalisation would have the same effect in New Zealand. Crown Law then referenced the Regulatory Impact Statement and stated: "The Regulatory Impact Analysis also notes research concluding that such protest action causes anxiety and distress among people seeking and delivering abortion services, and that protest would deter health professionals from delivering abortion services." Crown Law failed to reference the following sentence of the Regulatory Impact Statement: "there is limited evidence of the degree of harm protesters may have on Medical Practitioners or women accessing abortion services."[113]

We are of the view that laws, and particularly laws that restrict fundamental rights and freedoms, should never be made on the basis of mere speculation.[114] Should anti-abortion protest become widespread and intrusive to such an extent that our current legal framework is unable to provide adequate protection, a legislative response can be considered at that juncture.

The British Parliament recently considered this issue and concluded that implementing safe areas would not be a proportionate response. After an extensive review, the Home Office found that only a small percentage of their clinics had experienced anti-abortion protesting and their current legislation provided sufficient protection from harm. In his Written Ministerial Statement Sajid Javid, Secretary of State for the Home Department said:[115]

In this country, it is a long-standing tradition that people are free to gather together and to demonstrate their views. This is something to be rightly proud of. However, it is vital that how views are demonstrated is carried out within the law, and never more so than on such an issue that can have such a personal impact on individuals. This Government is absolutely clear that no-one should feel harassed or intimidated simply for exercising their legal right to pregnancy advice and abortion services, and I am adamant that where a crime is committed, the police have the powers to act so that people feel protected.

5.3.2 The creation of safe areas is not a rational, reasonable, or proportionate response

We consider the Bill's provisions in respect to safe areas do not meet the second limb of the justification test: that the limit be a rational, reasonable, and proportionate response to the objective.

The Minister of Health "may recommend the making of regulations [to prescribe a safe area] if the Minister is satisfied that prescribing a safe area is necessary to protect the safety and well-being, and respect the privacy and dignity, of persons accessing … [or] providing … abortion services…" [116] This test is so broad that there is a wide potential ambit of what would be considered adequate to make a safe area "necessary." Although the Minister is required to consider whether the need for a safe area is "demonstrably justified in a free and democratic society," we do not consider this to be a sufficient safeguard. Essentially, such a significant power to restrain freedoms should not be delegated to subordinate instruments, but rather, should remain in the hands of an elected Parliament. The potential ambit of this power is broad, in that the Bill removes the requirement that abortion services only be provided at licensed premises. As a result, a wide range of public spaces could be captured by the prohibition, including family planning clinics, hospitals, GP clinics, schools, and so on.

Once a safe area has been created, the Bill provides that any information that "would cause emotional distress to an ordinary reasonable person in the position of the person" would be prohibited within the safe area.[117] The provision does not require that actual emotional distress is caused. Given the wide range of reasons for seeking abortion services, and the fraught emotional complexity often involved, it would be very difficult to formulate and apply a general legal test for what would cause emotional distress to an "ordinary reasonable person" who is seeking, or providing, abortion services.[118] We are concerned that the threshold would accordingly be set very low, in practice creating a total restriction on freedom of expression within the safe area.

Crown Law again speculates that the Courts are "likely" to maintain a distinction between criminalised harm and "mere annoyance or irritation." If this is the desired policy intent, it should be expressly legislated. As noted by Crown Law, "the proposed offence goes to the heart of the classic justification for freedom of expression, the 'marketplace of ideas;' that is, the public airing of controversial views, which may be distasteful to some, in a way that gives pause or discomfort to the audience and causes them to evaluate whether that view is correct."[119] A sweeping prohibition cannot reasonably be seen to be a justified limitation on this freedom.

5.4 The Bill's provisions in respect of freedom of conscience are an unjustified limitation on rights and freedoms

The Bill maintains the current provision that a person with "a conscientious objection to providing, or assisting with providing, an abortion" is not required to undertake or assist with the procedure and must tell the woman of their objection "at the earliest opportunity."[120] However, the Bill goes further than the current law in its requirement that a conscientious objector must "tell [the woman] how to access the list of abortion service providers" maintained by the Ministry of Health.[121] We consider this duty impinges on the Health Practitioner's right to freedom of thought, conscience, religion, and belief, because:[122]

Requiring a person with a conscientious objection to providing a particular service to refer a woman to a provider of the service, may result in the Health Practitioner feeling complicit with the provision of that service despite their objection.[123]

Referring a woman, or advising her of how to access a list of abortion service providers, amounts to participation in the overall provision of abortion services. The potential effect that this could have on the conscience and well-being of a Health Practitioner with a genuinely held personal conviction about abortion should not be minimised or underestimated.[124]

5.4.1 The Bill's requirement to provide information is an unjustified restriction on the Health Practitioner's freedoms

We are of the view that the Bill's imposition of a duty to provide information is not justified in a free and democratic society. The first limb of the justification test is that the proposed limit "serve[s] a purpose sufficiently important to justify" limiting a right.[125] Crown Law states that:[126]

> *Facilitating access to abortion services is a legitimate goal to achieve by legislating. Furthermore, delay in the administration of an abortion can be dangerous for pregnant women, as it can lead to more severe side effects and higher rates of complications, as well as significantly more pain for women seeking medical abortions. The objective of the referral duty is therefore sufficiently important.*

There is limited evidence to suggest that the current lack of a referral duty results in undue delay for a woman to access abortion services, particularly a delay so significant that it would result in more danger or pain to the pregnant woman.[127] Even if there was evidence that our current system results in undue delays, the combined effect of other provisions in the Bill will make abortions more widely and easily accessible. For example, women will be able to self-refer for abortions, persons other than doctors will be able to provide abortion services, and abortion premises will not need to be licensed. The Bill also requires the Director-General of Health to "make and maintain a list of abortion service providers," which is likely to be easily accessible online.[128] These provisions all serve to undermine any justification that Health Practitioners who conscientiously object be required to actively participate in a woman's decision to have an abortion.

5.4.2 Allowing employers to discriminate on the basis of conscientious objection is an unjustified restriction on rights and freedoms

The Bill also amends the current law to allow an employer to discriminate on the basis of conscientious objection, contrary to the right not to be discriminated against on the basis of religious belief, ethical belief, or political opinion.[129] The Human Rights Act prohibits discrimination in the employment application process.[130] The Bill provides that it will be a legitimate part of the employment process for an employer to ask a job applicant questions about whether they conscientiously object to an abortion.[131] Further, the Bill provides that if an employer considers that an employee (or job applicant's) conscientious objection would "unreasonably disrupt the employer's activities," the employer can take any of the following actions:[132]

- Refuse to hire someone;
- Offer the employee "less favourable terms of employment" and "opportunities for training, promotion, and transfer";
- "Terminate the employment of the employee";
- "Subject the employee to any detriment"; or
- "Retire the employee, or … require or cause the employee to retire or resign."

The Bill does not restrict this limitation to the Health Practitioner. It provides that an employee or job applicant "who is qualified for work in connection with the provision of those services" may be lawfully discriminated against.[133] Depending on the Court's interpretation of "qualified," this arguably extends the reach of this section to include all staff connected to the provision of the abortion service.

We are of the view that the Bill's provisions allowing an employer to discriminate on the basis of an employee, or

job applicant's, conscientious objection is unjustified. As noted above, justification involves determining whether the proposed limit "serve[s] a purpose sufficiently important to justify" limiting a right, and if so, whether the limit is "rationally connected with its purpose," "impair[s] the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose," and is "in due proportion to the importance of the objective."[134]

First, the apparent purpose of this provision "is to ensure conscientious objection does not render an abortion provider ineffective through lack of available staff to perform certain procedures."[135] There is no evidence, other than anecdotal, that conscientious objections are currently impacting on the ability of abortion providers to find available staff.[136] A clause of this nature was not considered by the Law Commission and, as such, it has not had the benefit of prior consideration and submissions from interested parties. Further, widening the range of those empowered to provide abortions beyond Medical Practitioners will surely widen the available pool of abortion service providers, rendering such a drastic limitation on fundamental freedoms even less necessary.

Second, in the event that the purpose is seen to be sufficiently important, we do not consider the Bill's response is proportional or that it impairs the right no more than is reasonably necessary. If the purpose of the provision is to ensure that an abortion provider has sufficient staff to perform abortions, a proportional response would be to allow an employer to consider a job applicant's conscientious objection at the point of hiring someone, and to refuse to hire someone on account of that conscientious objection if they cannot be reasonably accommodated. The Bill goes significantly further than that. It provides that an employer can offer the employee "less favourable terms of employment" and "opportunities for training, promotion, or transfer," "terminate the employment of the employee," "subject the employee to any detriment," or "retire the employee, or … require or cause the employee to retire or resign" on account of their conscientious objection.[137] In short, the person's entire employment relationship can be adversely affected on the basis of a personal belief that they sincerely hold. Such an extensive limitation on fundamental rights requires far greater justification than this.

5.5 Recommendations:

- Prohibit abortions sought solely on the basis of the unborn child's disability or sex.
- Remove the Bill's provisions relating to safe areas.
- Retain the current provisions relating to the rights of persons with a conscientious objection to providing abortion services.

6. CONCLUSION

We submit that the Bill will have concerning consequences at both an individual and a societal level. Indeed, the combined effect of the Bill's provisions will be to increase the risks to women accessing abortion services, to make late term abortions more easily accessible, and to unjustifiably infringe on the basic rights and freedoms of New Zealanders.

Further, we are of the view that the Bill is poorly drafted. It leaves significant and important detail to be determined by the Ministry of Health. This is concerning for two reasons. First, it is difficult to assess what the actual impact of the Bill will be as this will depend on the views and priorities of the Minister of Health and their delegated authorities. Second, important decisions like this should not be made without the consideration of our elected Parliament. Without this, there is no real possibility of informed public debate and deliberation, which is crucial to a functioning democracy.

Although we have made a number of recommendations throughout our submission, we consider that the Bill should not be progressed any further without a Royal Commission of Inquiry conducting a full and robust investigation. Without this, we simply do not have the necessary data to make good law.[138] This is particularly important in the context of abortion law, given that it is a complex and divisive issue with significant potential ramifications. A Royal Commission was established the last time changes to our abortion laws were considered, and if the Government wishes to make these equally significant changes, it should do the same again.

7. ENDNOTES

1 "Unborn child" is the term used in the Crimes Act 1961 and Contraception, Sterilisation and Abortion Act 1977.

2 Andrew Little, 2019, *Letter to the Law Commission*, www.lawcom.govt.nz/sites/default/files/projectAttachments/180227-LITTLE%20Hon%20A-Law%20Commission%20referral%20re%20abortion%20law.pdf, accessed 13 September 2019.

3 For the purposes of this submission, the term "late term abortion" means an abortion accessed after 20 weeks' gestation.

4 Abortion Legislation Bill 2019, Explanatory Note.

5 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.2. While the Law Commission refers to Model A here, this also shows the intent of the Bill.

6 New Zealand Parliament, 2019, First Reading of the Abortion Legislation Bill, 8 August 2019, Andrew Little, www.parliament.nz/en/pb/hansard-debates/rhr/document/HansS_20190808_054000000/little-andrew, accessed 13 September 2019.

7 Crimes Act 1961, s.183(2).

8 Contraception, Sterilisation and Abortion Act 1977, s.44.

9 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper*, (2018) at 1.19.

10 Crimes Act 1961, s.187A(1)(a), namely, that "the person doing the act believes that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl;" Report of the Abortion Supervisory Committee 2018, 21.

11 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018), Appendix 5, "Summary of Submissions," at [48].

12 *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 at [98].

13 *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 at [102].

14 *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 at [1] and [79].

15 *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 at [5].

16 Crimes Act 1961, s.182.

17 *Re an Unborn Child* [2003] 1 NZLR 115; Re *Ulutau* (1988) 4 FRNZ 512.

18 *Re an Unborn Child* [2003] 1 NZLR 115.

19 Holidays (Bereavement Leave for Miscarriage) Amendment Bill (No. 2).

20 For example; Ministry of Health, *Alcohol and Pregnancy: A practical guide for health professionals*. (Wellington, 2010); and Ministry of Health, *Stop Smoking, drinking alcohol and using drugs in pregnancy*, www.health.govt.nz/your-health/pregnancy-and-kids/pregnancy/helpful-advice-during-pregnancy/stop-smoking-drinking-alcohol-and-using-drugs-pregnancy, (May 2018) accessed 5 September 2019.

21 Abortion Legislation Bill 2019, cl.12 (proposed s.183 Crimes Act 1961).

22 Abortion Legislation Bill 2019, Explanatory Note.

23 Contraception, Sterilisation and Abortion Act 1977, ss.14 and 15; Abortion Supervisory Committee, *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand*, 2018, https://www.justice.govt.nz/tribunals/abortion-supervisory-committee/standards-of-care/, accessed 16 September 2019.

24 This includes the rights conferred on all patients under the Code of Health and Disability Services Consumers' Rights; requirements on health professionals under the Health Practitioners Competence Assurance Act 2003; and restrictions requiring only certain Health Practitioners to prescribe and administer restricted medicines under the Medicines Act 1981.

25 Abortion Legislation Bill 2019, cl.7 (proposed s.18 of Contraception, Sterilisation, and Abortion Act 1977); Regulatory Impact Statement, "Abortion Law Reform," at 37.

26 Regulatory Impact Statement, "Abortion Law Reform," at 36.

27 Contraception, Sterilisation and Abortion Act 1977, ss.18 and 32.

28 Abortion Legislation Bill 2019, cl. 7 (proposed s.2 of Contraception, Sterilisation, and Abortion Act 1977): "a Health Practitioner who is acting in accordance with the Health Practitioners Competence Assurance Act 2003."

29 The category of Health Practitioners include doctors, nurses, midwives, psychologists, pharmacists, chiropractors, dietitians, optometrists, occupational therapists, podiatrists, and a number of other professions. (Health Practitioners Competence Assurance Act 2003, Schedule 2).

30 Authorities are able to amend Scopes of Practice at any time, leaving it at their discretion to determine which Health Practitioners will be empowered to provide abortion services and to authorise an abortion after 20 weeks: Health Practitioners Competence Assurance Act 2003, s.14.

31 Although it is unknown, we expect that the Minister of Health will introduce similar guidelines to those currently in place requiring second and third trimester abortions only take place in units with gynaecological specialist support and an operating theatre: *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand*, January 2018, Standard 9.9.7.

32 As cited in New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 7.33: Marie Stopes, Medical abortion by phone (tele-abortion), www.mariestopes.org.au, accessed 11 September 2019; and Tabbott Foundation, Medical Termination in the Privacy of Your Home, www.tabbot.com.au.

33 The risks outlined include:

1. Women should never be able to use mifepristone to terminate a pregnancy without confirming the gestation of pregnancy and the location of the foetus by way of ultrasound or biological tests;
2. Women should never be able to use mifepristone to terminate a pregnancy after 9 weeks;
3. There are currently no reports of overdose but the possibility of this is increased if women are able to ingest this medicine otherwise than at a licensed facility. The data sheet notes that an overdose may result in signs of adrenal failure;
4. The follow up dose should be taken after 36-48 hours;
5. There is a "non-negligible risk" of the medical abortion not being successful and requiring a surgical abortion (in 1.3-7.5% of cases). As a result a third follow up visit 14-21 days later is essential to ensure that the abortion is complete;

6. Bleeding (which may be heavy) occurs in almost all cases, for an average of 12 days, and is "not in any way a proof of complete expulsion;"
7. There have been serious cases (including deaths) of toxic shock and septic shock following infection due to unauthorized use of other abortion medicine, misoprostol;
8. Mifepristone is excreted during breastfeeding.

See Medsafe, Datasheet Mifegyne, www.medsafe.govt.nz/profs/datasheet/m/Mifegynetab.pdf, accessed 6 September 2019.

34 We expect that surgical abortions are likely, although not certain, to remain "restricted activities," meaning that only surgeons will be able to perform them. We propose that this should be specifically legislated, not left to the determination of the Ministry of Health; Health Practitioners Competence Assurance (Restricted Activities) Order 2005, cl.3.

35 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 6.83-6.86.

36 Code of Health and Disability Services Consumers' Rights, cl. 1.

37 Code of Health and Disability Services Consumers' Rights, Right 7; Health and Disability Commissioner Act 1994, s.2.

38 Code of Health and Disability Services Consumers' Rights, Right 5 and Right 6.

39 Code of Health and Disability Services Consumers' Rights, Right 7(7).

40 Rebecca Keenan (ed),) *Health Care and the Law* 5th ed, (Thompson Reuters, Wellington, 2016) 106; Code of Health and Disability Services Consumers' Rights, Clause 3.

41 Abortion Supervisory Committee, *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand*, 2018, Standard 8.1.1, https://www.justice.govt.nz/tribunals/abortion-supervisory-committee/standards-of-care/, accessed 16 September 2019.

42 The Code of Health and Disability Services Consumers' Rights will continue to require a certain standard of information to be provided to women considering an abortion, including (Right 6(1)):

- An explanation of the options available, and an assessment of the expected risks, side effects, benefits and costs of each option;
- A level of information that a reasonable consumer in her circumstances would need to make an informed choice and to give informed consent; and
- Honest and accurate answers in response to questions.

43 Contraception, Sterilisation and Abortion Act 1977, s.31.

44 Abortion Legislation Bill 2019, Explanatory Note, General Policy Statement.

45 Care of Children Act 2004, s.34.

46 Care of Children Act 2004, s.36; *Hawthorne v Cox* [2008] NZFLR 1.

47 Care of Children Act 2004, s.38.

48 Potential avenues of redress include an application pursuant to the Oranga Tamariki Act 1989.

49 New Zealand Parliament, 2019, *First Reading of the Abortion Legislation Bill*, 8 August 2019, Andrew Little, https://www.parliament.nz/en/pb/hansard-debates/rhr/document/HansS_20190808_054000000/little-andrew, accessed 13 September 2019.

50 New Zealand Law Commission, *Battered Defendants: Victims of Domestic Violence who Offend* NZLC PP41, (2000).

51 Contraception, Sterilisation and Abortion Act 1977, s.34.

52 *An NHS Foundation v AB* [2019] EWCOP 26, at [62].

53 *AB v An NHS Foundation* [2019] EWCA Civ 1215, at [71].

54 Abortion Legislation Bill 2019, cl.7 (proposed s.11 of Contraception, Sterilisation, and Abortion Act 1977).

55 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.62.

56 *R v Woolnough* [1977] 2 NZLR 508 (CA) at 516–517 per Richmond P, as quoted in New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.62.

57 *Roe v Wade* 410 US 113 (1973); as quoted in New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.62.

58 "Under the Births, Deaths, Marriages, and 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;" as quoted in New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.62.

59 Crimes Act 1961, s.187A(3).

60 Abortion Legislation Bill 2019, cl.7 (proposed s.11 of the Contraception, Sterilisation and Abortion Act 1977).

61 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.33 & 4.47.

62 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 4.74.

63 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 6.70 & 6.76.

64 When asked if the Bill is "liberalising abortion right up to birth," the Justice Minister responded that "no that is an absurd sort of statement that gets made by the fanatic anti-abortion people." See Jack Tame, Q+A with Justice Minister Andrew Little on Abortion Reform Plan, *1 News Now*, www.tvnz.co.nz/one-news/new-zealand/full-interview-q-justice-minister-andrew-little-abortion-reform-plan, accessed 10 September 2019.

65 Jack Tame, Q+A with Justice Minister Andrew Little on Abortion Reform Plan, *1 News Now*, www.tvnz.co.nz/one-news/new-zealand/full-interview-q-justice-minister-andrew-little-abortion-reform-plan, accessed 10 September 2019.

66 Crimes Act 1961, s.187A(3).

67 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 6.69.

68 *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2012] NZSC 68 at [40].

69 This point has not been tested at law, but is very likely given the operation of s.159 of the Crimes Act 1961 and s.2 of the Health and Disability Commissioner Act 1994.

70 Abortion Legislation Bill 2019, cl. 12 (proposed s.183, Crimes Act 1961).

71 *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 740-741.

72 *Wall v Livingston* [1982] 1 NZLR 734 (CA) at 741.

73 New Zealand Bill of Rights Act 1990, s.5.

74 Abortion Legislation Bill 2019, cl.7 (proposed s.10 and 11 of Contraception, Sterilisation, and Abortion Act 1977).

75 Human Rights Act 1993, s.65.

76 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, 30 November 2017.

77 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.24.

78 Lynn Gillam, "Prenatal diagnosis and discrimination against the disabled," *Journal of Medical Ethics* (1999), 25:163-171.

79 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, 30 November 2017.

80 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, para 18.

81 Currently, s.187A of the Crimes Act 1961 limits abortions for foetal disability to instances where the pregnancy is no more than 20 weeks' gestation, and "there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped."

82 Abortion Legislation Bill 2019, cl.7 (proposed s.10 of Contraception, Sterilisation, and Abortion Act 1977).

83 Crimes Act 1961, s187A(3).

84 Abortion Legislation Bill 2019, cl.7 (proposed s.11 of Contraception, Sterilisation, and Abortion Act 1977) does not provide a gestational endpoint for the provision of abortion services. Section 159(1) of the Crimes Act 1961 provides that "a child becomes a human being within the meaning of this Act when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not."

85 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.24.

86 Lynn Gillam, *Prenatal diagnosis and discrimination against the disabled,* Journal of Medical Ethics 1999; 25:163-171.

87 Abortion Legislation Bill 2019, cl.7 (proposed ss.10 and 11 of Contraception, Sterilisation, and Abortion Act 1977).

88 Human Rights Act 1993, s.21.

89 Human Rights Act 1993, s.21.

90 J.M. Johnston, "Are Sex Selective Abortions Wrong?," *New Zealand Bioethics Journal*, (February 2001), 2(1), 9.

91 Therese Hesketh et al, "The consequences of son preference and sex-selective abortion in China and other Asian countries," *Canadian Medical Association Journal*, (September 2011), 183(12), 1374-1377.

92 Therese Hesketh et al, "The consequences of son preference and sex-selective abortion in China and other Asian countries," *Canadian Medical Association Journal*, (September 2011), 183(12), at 1375.

93 Audrey R. Chapman & Peter A. Benn, "Noninvasive prenatal testing for early sex identification: a few benefits and many concerns," *Perspectives in Biology and Medicine,* (September 2013), 56(4), 536.

94 New Zealand Bioethics Council, "Who Gets Born? A Report on the Cultural, Ethical and Spiritual Aspects of Pre-Birth Testing," (2008) at 23.

95 Therese Hesketh et al, "The consequences of son preference and sex-selective abortion in China and other Asian countries," *Canadian Medical Association Journal*, (September 2011), 183(12), 1374-1377.

96 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.18; Abdool Yasseen and Theirry Lacaze-Masmonteil "Male-biased infant sex ratios and patterns on induced abortion," *Canadian Medical Association Journal,* (2016) 188(9) 640; Marcelo Urquia et al "Sex ratios at birth after induced abortion," *Canadian Medical Association Journal,* (2016) 188(9), 181; Kristina Edvardsson et al, "Male-biased sex ratios in Australian migrant populations: a population-based study of 1191 250 births 1999-2015," *International Journal of Epidemiology,* (2018), 1.

97 Audrey R. Chapman & Peter A. Benn, "Noninvasive prenatal testing for early sex identification: a few benefits and many concerns," *Perspectives in Biology and Medicine,* (September 2013), 56(4), 540.

98 Audrey R. Chapman & Peter A. Benn, "Noninvasive prenatal testing for early sex identification: a few benefits and many concerns," *Perspectives in Biology and Medicine,* (September 2013), 56(4), 540.

99 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, para 24.

100 Abortion Legislation Bill 2019, cl.7 (proposed s.11 of Contraception, Sterilisation, and Abortion Act 1977).

101 Human Assisted Reproductive Technology Act 2004, s.11.

102 Bill of Rights Act 1990, s.14: "Everyone has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form."

103 *Brooker v Police* [2007] NZSC 30 at [114] - [117].

104 New Zealand Bill of Rights Act 1990, s.5.

105 *R v Oakes* [1986] 1 SCR 103; adopted in New Zealand by *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 (SC).

106 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.12.

107 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.14.

108 Legislation Design and Advisory Committee Legislation Guidelines (March 2018) at 116.

109 Summary Offences Act 1981, ss. 3, 4, 21 & 22.

110 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 38.1.

111 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 2.38.

112 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 12.13.

113 Regulatory Impact Statement, "Abortion Law Reform," at 3.6.

114 The Bill provides for Safe Areas to be created but "there is no New Zealand data available on the impact on women accessing abortion services of the behaviour around these services of anti-abortion groups or individuals. The information relied upon in the analysis was that gathered by the Law Commission." See Regulatory Impact Statement, "Abortion Law Reform," at 5.

115 UK Parliament, "Outcome of the Abortion Clinic Protest Review: Written statement HLWS927,", www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Lords/2018-09-13/HLWS927/, accessed 12 September 2019.

116 The assessment of need involves very broad grounds including the safety, well-being, privacy, and dignity of the person. See Abortion Legislation Bill 2019, cl.7 (proposed s.17 of Contraception, Sterilisation, and Abortion Act 1977).

117 Abortion Legislation Bill 2019, cl.7 (proposed s.15 of Contraception, Sterilisation, and Abortion Act 1977).

118 Given the vastly different experiences of women accessing an abortion, it is difficult to determine the interpretation that will be given to the concept of an "ordinary reasonable person."

119 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 32.

120 Abortion Legislation Bill 2019, cl.7 (proposed s.19 of Contraception, Sterilisation, and Abortion Act 1977).

121 Abortion Legislation Bill 2019, cl.7 (proposed s.19(2)(b) of Contraception, Sterilisation, and Abortion Act 1977).

122 New Zealand Bill of Rights Act 1990, s.13.

123 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 60.

124 New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at Appendix 5, at 131.

125 *R v Oakes* [1986] 1 SCR 103; adopted in New Zealand by R v Hansen [2007] NZSC 7, [2007] 3 NZLR 1 (SC).

126 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 63.

127 There are no official records of the number of General Practitioners who are conscientious objectors and evidence that this results in undue delays is anecdotal at best, see New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 6.51.

128 Abortion Legislation Bill 2019, cl.7 (proposed s.19 of Contraception, Sterilisation, and Abortion Act 1977).

129 It is currently unlawful for an employer to discriminate against an employee or job applicant on the grounds of their conscientious objection to abortion, see Human Rights Act 1993, sss.21 and 22; Contraception, Sterilisation, and Abortion Act 1977, s. 46; The High Court has interpreted section 174 of the Health Practitioners Competence Assurance Act 2003 as allowing doctors with a conscientious objection to decline to consider a woman's case or to refer her to another doctor, see *Hallagan v Medical Council of New Zealand* HC Wellington CIV-2010-485-222, 2 December 2010.

130 Human Rights Act 1993, s.23.

131 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 66.

132 Abortion Legislation Bill 2019, cl.7 (proposed s.20 of Contraception, Sterilisation, and Abortion Act 1977).

133 Abortion Legislation Bill 2019, cl.7 (proposed s.20 of Contraception, Sterilisation, and Abortion Act 1977).

134 *R v Oakes* [1986] 1 SCR 103; adopted in New Zealand by *R v Hansen* [2007] NZSC 7, [2007] 3 NZLR 1 (SC).

135 Crown Law letter to the Attorney General reporting on the Bill's consistency with the Bill of Rights Act, 1 August 2019, at 70.

136 There are no official records of the number of General Practitioners who are conscientious objectors, see New Zealand Law Commission, *Alternative Approaches to Abortion Law, Ministerial Briefing Paper,* (2018) at 6.51.

137 Abortion Legislation Bill 2019, cl.7 (proposed s.20 of Contraception, Sterilisation, and Abortion Act 1977).

138 For example, the Bill provides for Safe Areas to be created but "there is no New Zealand data available on the impact on women accessing abortion services of the behaviour around these services of anti-abortion groups or individuals. The information relied upon in the analysis was that gathered by the Law Commission." See Regulatory Impact Statement, "Abortion Law Reform," at 5.