

CONTENTS

VISITORS	1193
Howard Springs Primary School.....	1193
SPEAKER'S STATEMENT	1193
Harmony Day.....	1193
TERMINATION OF PREGNANCY LAW REFORM BILL	1193
(Serial 15)	1193
TERMINATION OF PREGNANCY LAW REFORM BILL	1215
(Serial 15)	1215
ADJOURNMENT	1275

Madam Speaker Purick took the Chair at 10 am.

VISITORS
Howard Springs Primary School

Madam SPEAKER: Honourable members, I advise of the presence in the gallery of Year 5/6 students from Howard Springs Primary School—another bright rural school—accompanied by their teachers Naomi Rodriguez and Kylie Koeford. On behalf of honourable members, welcome to Parliament House. I hope you enjoy your time here.

Members: Hear, hear!

SPEAKER'S STATEMENT
Harmony Day

Madam SPEAKER: Honourable members, on your desks are ribbons for Harmony Day, which is today, 21 March. Our diversity makes Australia a great place to live. Harmony Day is a celebration of our cultural diversity, a day of cultural respect for everyone who calls Australia home. Held every year on 21 March, the day coincides with the United Nations' International Day for the Elimination of Racial Discrimination.

The message of Harmony Day is 'Everyone belongs'. The day aims to engage people to participate in their community, respect culture and religious diversity and foster a sense of belonging for everyone. Since 1999 more than 70 000 Harmony Day events have been held in childcare centres, schools, community groups, churches, businesses and federal and state-level government agencies across Australia.

TERMINATION OF PREGNANCY LAW REFORM BILL
(Serial 15)

Continued from 15 February 2017.

Mrs FINOCCHIARO (Spillett): Madam Speaker, I rise to indicate the opposition's support for the Termination of Pregnancy Law Reform Bill 2017. There is no doubt that the bill before us addresses a very emotive issue for Territorians. Over the past few months I, as the shadow minister for Health, have had the opportunity to speak to stakeholders from across the Northern Territory with a variety of views.

My office has received many emails and letters on this subject from individuals and organisations across the country, and I thank each of those people who have taken the time to make contact with me and make their views known. I respect the views of all those, both from within and outside the Territory, who have contributed to this important debate.

However, I feel it is important to note that the debate we are having today is not about the threshold question of whether abortion should be legal, but about expanding the methods available to women seeking a termination of their pregnancy in the Northern Territory. In addition, this bill repeals Division 8 of the Criminal Code, which outlaws the termination of pregnancy, except in certain limited circumstances, and replaces this division with a framework which enables both surgical and medical terminations to be performed by properly-qualified and accredited medical practitioners.

Termination of a pregnancy by surgical procedure is already legal in this jurisdiction and has been for many years. The bill before us does not alter this fact. What it does is legalise access to medical abortion through the use of the medication commonly referred to as RU486 and establishes a framework for its regulated prescription and use.

Statistics from other jurisdictions indicate that when both medical and surgical termination options are available, approximately 50% of women still choose to access surgical termination. The legalisation of medical terminations outside of a hospital environment is not new in this country. In fact, the Northern Territory is the only jurisdiction in Australia where it is not a legal means to terminate a pregnancy.

This legislative debate about medical termination was commenced in the federal parliament in 2005 by a coalition of Liberal, Labor and Greens women. Since then all other jurisdictions have legalised medical termination. Territory women have not been given the opportunity to decide for themselves, based on factual and clinical information, and the opposition believes that, subject to adequate clinical guidelines set in a Northern Territory context, it is time that medical terminations become an option for women facing one of the biggest decisions of their lives.

In preparation for the debate of this bill I took the opportunity to consult with a number of individuals and organisations, including, but not limited to, the Australian Medical Association Northern Territory, WHAT RU4 NT?, Family Planning, Top End Women's Legal Service, the Australian Christian Lobby, YWCA, the Bishop of Darwin, the Order of Malta, the Central Australian Aboriginal Congress and Danila Dilba.

From these numerous meetings it became clear to me that the primary concerns in relation to this bill, and termination generally, are the rights and safety of women in the Northern Territory. The opposition shares these concerns. That is why I have asked many questions during my briefings with the minister's office, and relayed the concerns I have received from the community so they can be considered and, where appropriate, incorporated into the clinical guidelines.

The bill, if passed, will not come into force until its gazettal, which the opposition has been advised will be on or around 1 July this year, in conjunction with the clinical guidelines, which are yet to be finalised. It is the opposition's position that the clinical guidelines that accompany this bill should have been prepared and available for consultation with the bill; however, we have been advised by the minister that they will be put out for public consultation, which is likely to occur in May.

I feel, from the information I have received, that these guidelines will address a number of the concerns raised with me in relation to the health and safety of women seeking a medical termination. Whilst it would have been useful for these guidelines to be available for members to scrutinise during the course of this debate, I appreciate the complexity and time required to complete such a monumental task.

I am grateful for the advice on the likely contents of the guidelines from the ministerial and departmental staff I have received briefings from. I am of the view that the feedback I have contributed, based on my conversations with people, has been fairly given weight; however, I will watch with great interest the drafting process and final guidelines produced by the Department of Health. I look forward to contributing to the final version when it comes out for consultation.

I indicate to honourable members that I will have a series of questions for the responsible minister regarding several clauses within the bill during the consideration in detail stage. It is important that those who have raised concerns with me during the extensive consultation we have engaged in on this bill receive assurances from the minister, on the record, that their issues have been addressed. I will be grateful if the minister can address these concerns in her summation at the conclusion of the second reading debate.

While the opposition supports this bill we hold several overarching concerns with its context, including:

1. how, in operation, a safe zone will be monitored and how harassing, hindering, intimidating, interfering with, threatening or obstructing behaviour, described as prohibited conduct within the bill, will be interpreted in practice. Will the current provisions in this bill affect those, as is the case currently, who stand outside locations such as Royal Darwin Hospital and pray? Will this form of quiet religious observants be caught by these new provisions, and what type of conduct specifically relating to prayers constitutes 'heard' or 'seen'?
2. how and when reports of the performance of a termination need to be made to the Chief Health Officer and what will happen with that information
3. how the health and safety of women accessing a medical termination in remote and rural areas will be maintained.

In our consultation with a number of stakeholders the opposition has formed the view that, within the clinical guidelines, it is important that consideration is had to:

- individuals who are accessing medical termination remaining with two hours of a facility that can provide emergency medical care should complications arise
- documentation which may be provided to all practitioners, particularly those who may be considered conscientious objects, which could be given to patients seeking a medical termination—information regarding the procedure, alternative options and contact details of locations which provide medical terminations. Such a document would allow practitioners who are conscientious objectors to fulfil their referral obligations under this bill without having to seek out other practitioners who would carry out a medical abortion. It would also allow a patient to contact the other practitioner without any delay.

- consideration for the practitioner to make prior to prescribing the medication for a medical abortion, such as whether the individual will be returning to a safe, supportive and hygienic environment, with individuals who could render assistance after the first medication is taken; whether the practitioner is satisfied that the patient will take the second set of medication within the required time frame, which is usually 48 hours, and whether the practitioner is satisfied that the patient will return within the required time frame, usually 14 days, so they can be tested to ensure the termination has been completed.

Such guidelines will need to be made in the context of the unique situation of the patient seeking a medical termination, and should be made in line with those guidelines recommended by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

It is important to note that for a practitioner to offer medical terminations within the Northern Territory under this bill they will be required to become suitably qualified as defined in this bill, which will require the completion of training and receiving accreditation from the manufacturer of the drug, namely RU486, which is necessary to perform a medical termination. Some practitioners will also be required to take out additional practising insurance to prescribe such medication, which, from what the opposition has been advised, can be quite expensive and may provide a practical impediment to some practitioners providing medical terminations.

Apart from legalising medical termination, the bill now requires one suitably qualified medical practitioner to consider the termination appropriate in pregnancies up to 14 weeks in order for it to legally occur. This would include the option of medical termination, which would become legal up until nine weeks, and for two medical practitioners to consider a termination appropriate in pregnancies between 14 and 23 weeks.

The opposition is supportive of the gestational limit of 23 weeks proposed by the bill being the latest stage of a pregnancy at which a woman can access a termination. However, it is important that the Minister for Health keeps her promise to conduct a review of the bill, including this clause, within 18 months of the bill's gazettal.

In conclusion I reiterate the opposition's support for the passage of this bill. Whilst I understand this legislation is a conscience vote for the government, it is not for the opposition as it is the policy position of the Country Liberals. I am confident that with the passage of this bill and the issuing of appropriate clinical guidelines in the months to come, women in the Northern Territory will be supported by modern legislation in accessing a termination of pregnancy.

While we face unique social and geographic challenges in the Northern Territory, these challenges are not insurmountable. With robust and contemporary clinical guidelines which set the rules for practitioners to administer medical terminations safely, the time has come for the Territory to be brought in line with other jurisdictions.

Madam Speaker, I commend the bill to the House.

Mr GUNNER (Chief Minister): Madam Speaker, I support the bill and, on a personal note, I thank the Deputy Leader of the Opposition for her comments to the House, and the opposition for its support of this bill.

This bill is about improving women's access to medical services. It is about equality of access to medical services. It brings the Territory laws into the 21st century, establishes the regulations and safeguards to ensure medical expertise and medical best practice supports women and families in the choices they make. It is about recognising advancements in medical science.

I thank everyone for their valuable contributions in this space, particularly you, Madam Speaker, and the Health minister. The Health minister has worked tirelessly and diligently, consulted broadly, collected community views, best-practice standards and legislation, research and expert opinion to bring this bill to the House. I thank her for the considerable body of work she has done with the department through what is, for many, a difficult debate.

I also thank the Member for Nelson. We disagree on this issue, but I respect the work he has done and that he speaks for members of the community who approach this debate differently to the way I do. For me this is a debate about equity of medical access for Territory women, for them to have the same medical access as other women in Australia.

There will be few more passionately debated topics in this place than the Termination of Pregnancy Law Reform Bill. I thank everybody who has taken the time to reach out to me or to allow me to talk with them. There has been a widespread set of views on this topic. I thank everyone for taking the time to participate in the debate and the process that led us here.

On our side of the Chamber this is a conscience vote. All views are welcome and valid, but all members, and the community, can have faith that the hard work has happened to produce the safest and most decent bill possible. That is why I am happy to support this bill. The work of the Health minister and the department in providing this—I especially thank the practitioners in this space for the advice they brought forward about how to best do this legislation in the Northern Territory.

This bill will bring the Territory into line with other jurisdictions. The legislation is based on contemporary and working legislation in other states. We have taken on board the advice of the Australian Medical Association, and the strict written guidelines of professional bodies like the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

The current *Medical Services Act* requires that termination of a pregnancy of less than 14 weeks can only be performed in a hospital, that two medical practitioners must examine the woman and at least one of these must be a gynaecologist or obstetrician. This means Darwin Private, Royal Darwin and Alice Springs hospitals are the only options for termination. I believe this is excessively restrictive to the thousands of Territory women who live so far from these centres.

Our legislation will provide for the termination of pregnancy by medical practitioners outside of hospital settings, using drugs such as RU486, so long as its use complies with professional standards and guidelines. Because of our current restrictions, women are forced to travel interstate to terminate pregnancies. Going across state lines or, for those traveling from remote places, to Darwin or Alice Springs, may mean women are without the support of family and friends at an incredibly difficult time. That is one of the reasons I support this bill. It will lead to women making decisions safely with their doctor, which will lead to greater support for them at a difficult time.

Termination drugs are being purchased online and self-administered, which is a risk we need to be aware of. This can be dangerous without appropriate medical supervision, and it is an unacceptable state of affairs. While there will still be a number of surgical terminations at the big hospitals, this allows a medical practitioner, based on the clinical assessment of a woman and her access to emergency services, to recommend alternatives to surgical termination.

For a woman between 14 and 23 weeks gestation, assessment for termination of pregnancy will be undertaken by two suitably qualified practitioners, removing a curious anomaly of the existing legislation which does not mandate this appropriate level of rigor. These assessments will include medical circumstances, the current and future physical health outlook, and psychological and social circumstances. If both practitioners are satisfied, one of them will be able to perform the termination in line with the applicable professional standards and guidelines.

For community and individual confidence in this legislation, the bill provides the definition of a 'suitably qualified medical practitioner' as someone holding the qualification of an obstetrician or gynaecologist, or they have completed training and are credentialed as prescribed by the Chief Health Officer in accordance with regulations.

This bill is about choice, so it must also recognise that there may be medical practitioners who, for personal reasons, choose to object to assisting in the termination of pregnancy. The current legislation respects conscientious objectors, and this bill will also respect them. We have taken steps in this legislation so that an objecting medical practitioner must inform the woman and take steps to refer her to services where there is no such objection. We have to provide, in this bill, for the woman to have access to a doctor who can treat her fully.

This is not about legalising abortion. That debate has been had, for better or worse, depending on your personal views, long ago. This bill is about giving women appropriate and safe access to health care under the existing laws and providing Territory women with equality of access and treatment. It is also about trusting doctors and medical practitioners in the Northern Territory, as they are trusted in other states of Australia. Doctors are qualified to prescribe medicine and provide treatment plans. We do, and should, trust them to work with a woman and provide the best medical advice for her.

While I respect every member's right to vote with their conscience and their beliefs, it is my belief that existing Territory legislation unintentionally discriminates against Territory women. The current laws mean that, for some women, accessing their rights is extremely difficult.

In the Territory we have led the nation in progressive reform. Unfortunately on this issue we have lagged intolerably behind, to the detriment of the rights and health of Territory women. It is time this legislation is debated before the House. We made an election promise that we would bring forward a bill, properly constituted and developed with the department, and with the best advice on what shape the bill should take so we can have a fulsome debate in this Chamber.

I acknowledge the work the Member for Goyder did in the last Assembly, from the cross bench, to the best of her ability with the resources she had. In government we can work with the department to ensure we have a fully-considered bill that takes into consideration the practical impacts and the advice from the department and the medical experts there.

It is time to allow contemporary medical practice to improve the range of services available and the access to services that individuals require. This is modern legislation reflecting the evolution of community standards and medical science. It is researched, consultative, progressive and, I believe, long overdue for Territorian women. That is why I am happy to support this legislation. It is time for the Northern Territory to allow women to access the same advice from their doctors as other women in Australia.

Mr PAECH (Namatjira): Madam Speaker, I acknowledge the Member for Goyder for the original introduction of the private member's bill on this matter in 2015, and all previous members who participated and provided support in relation to the bill at that time. I also thank women from across the Northern Territory for their advocacy and patience for the arrival of RU486. Let us turn this vision into a reality.

Sisters, today you are not doing this for yourselves; today I stand with you to make this happen. Are you ready?

The introduction of medical abortion to the Northern Territory health system is crucial to the fight for equality. I reiterate the sentiments of my colleagues that this is not the time or place to debate abortion. To debate abortion would be to debate a woman's right to make choices about her body, her family and her future goals. This is a debate about access to a medical procedure which has benefit to the community, a procedure that can actively aid women seeking autonomy and can reduce trauma and stigma around a woman's reproductive choices.

As a man I acknowledge that I will never truly be able to empathise with a woman who is facing an unwanted pregnancy. I thank my colleagues and Territory women for giving their voice, their personal stories and their experiences, and allowing others, such as me, an insight into how crucial it is for women to achieve reproductive freedom in line with the rest of the country.

The path to obtaining a surgical abortion, as it stands, is a journey that is full of both physical and social barriers, especially in the Northern Territory, where women have to travel to Alice Springs or the Royal Darwin Hospital as options for treatment.

As the Member for Namatjira—an electorate which covers 350 000 square kilometres, and many communities and outstations—access to healthcare is an issue that is very important to me and my constituents. The limited number of locations for access to this procedure is an issue that affects all my constituents. Those who may already be affected by entrenched poverty are forced to travel, find accommodation and stay in a town that is not their home and does not allow them the support networks while they wait for surgery. In every other state and territory RU486 is available as a non-surgical, medical alternative.

Interstate travel may be an option for a privileged few, but may further entrench already existing divides. Only the privileged can travel for abortions. By increasing the access points through surgeries and clinics that will have the ability to administer this drug, and increasing the choices and options for those who find themselves in need, we can do a great service for Territory women.

Access to this drug will mean having more options for support. It will allow women to no longer feel criminalised for seeking this medical service or made to feel ashamed for undergoing a treatment that occurs 80 000 times a year in this country alone. It will allow many women in the Territory to actively make decisions about their families and their lives.

A decade has passed since the introduction of this drug to Australian shores. It has been implemented in various countries around the world. It is presently on the World Health Organization's list of essential medicines. What is it about the Northern Territory that means we do not already have access to this drug and service?

If men were able to fall pregnant, I reckon we would see RU486 vending machines in every pub. Seriously though, it is vital that we modernise our current approach to this issue. I want residents of Namatjira and the Northern Territory to have resources, support and the ability to make their own choices as to whether they will create a family or grow their families. I want them to be able to make these decisions as easily as other Australians and have readily-available options and support for whichever path they may decide upon.

It is also important to ensure that once these choices are made they are supported by the government. One of the ways we can support these decisions is to implement exclusion zones around hospitals, clinics and surgeries. To provide medical abortion services we need to provide safe spaces. It is totally unacceptable that women and health professionals should be subject to bullying, threats and harassment when accessing medical services.

Like, I am sure, most members of this House, I have been receiving many emails and Facebook messages about this issue. I seek leave to table an email I received from Right to Life Australia.

Leave granted.

Mr PAECH: The email says it is a media release. One would question that.

The vast majority of the correspondence I have received about this bill has been from people outside the Northern Territory, and I respect their right to have their voices heard. But an email I received yesterday, which I just tabled, got under my skin. It was from the organisation, Right to Life, and the comments of the President, Margaret Tighe, are offensive, outrageous and downright racist.

I respect that Right to Life, of course, will oppose this bill; I expect nothing less from this group. However, to suddenly profess a concern for Aboriginal women in a desperate effort to give itself a legitimate voice in this debate is crass and downright racist. How dare they assume that somehow Aboriginal women in the Territory are less able or competent to make informed decisions about their reproductive choices. Shame! To try to tie access to RU486 to what Margaret Tighe calls 'Aboriginal welfare and the tragedy of foetal alcohol syndrome' is blatant race-based opportunism.

Her ignorance of this bill and the reality of access to safe reproductive health services by Aboriginal women living in remote communities is apparent. Aboriginal women and their rights cannot be used by Margaret Tighe to further her bigoted stance on this matter. I call on Right to Life to apologise to Aboriginal women for these disgusting comments.

From all accounts, both from individuals and research bodies, the provision of this drug will allow victims of traumatic events an alternative to invasive procedures that can only exacerbate existing trauma. I am proud to be in a position where I can help Territory women take control of their own futures and make decisions about their lives.

While this country denies my full rights, I will be damned if I stand silent in this Chamber and see the rights of Territory women denied. Territory women deserve legal and affordable access to sexual and reproductive health services. I am proud to be part of a government that will make that happen. I hope I am part of a government that will one day extend the same basic rights to all Territorians, regardless of their race, gender, location or sexual orientation.

In this place we do not need to talk about the inaccuracies of how this drug will work. Our clinical experts and practitioners will work on protocols and risk minimisation. What we need to do today is assert the rights of women throughout the Territory to make their own choices and decisions about the timing and the size of their families.

Increasing access to medical abortion will do nothing but increase the choice and self-determination of women Territory-wide. I do not believe that abortion is a 'fashion'. It is a valid procedure intended to allow women to make choices about their lives, health and families. If we can facilitate an environment where women are able to make decisions about their lives and bodies free from physical and social barriers then that will be an important step towards achieving equality for all Territory women.

I urge my parliamentary colleagues in this Chamber to support the bill to allow women the right to this vital service.

Mr WOOD (Nelson): Madam Speaker, this is one of the most important bills to come before this House. To put it simply, it is a matter of life or death. Those supporting this bill say a woman has the right to terminate the life of another human. For others, like me, it is about whether our most vulnerable and defenceless form of human life, the unborn, will be protected by this parliament.

It is about whether we will continue to stop somewhere between 600 and 1000 unborn Territorians ever being able to reach their full potential. It is about whether we can find a way to solve the problem of unwanted pregnancy without using the termination option, which, today, seems to be the option of first resort.

There will be some who argue that we already have abortion. Yes, but this legislation repeals that act and replaces it with new legislation that will allow the unborn to be terminated using two drugs. It will make abortion more accessible, and I have no doubt it will increase the number of abortions in the Territory. On top of that, by removing the restrictions on having an abortion in the existing act, it will be easier still.

This bill is not just about abortion; it is about freedom of speech and the right to absolute freedom of conscience. Unfortunately, from the beginning, a proper and measured debate on this bill was never allowed.

Firstly we are told by the minister there has already been plenty of debate on a previous private member's bill. That is simply not true. The bill came in two parts and was different to this bill. I had 10 minutes to respond, and then was cut off. The private member's bill also did not repeal the existing bill, as this one does, but only tried to amend it. Then the minister announced a discussion paper over the Christmas holidays, which was hardly the best time for any government to release any discussion paper. And the discussion paper was a one-sided discussion.

By February they had received 147 submissions but refused to release them, arguing that permission had not been given to release submissions. All that was needed was an email to the submitters. The bill was introduced soon after, in February. A request to send it to a parliamentary committee was refused by the government, even though its own select committee recommended in its draft recommendations that this sort of legislation should go to a committee as the norm; so much for opening parliament to the people.

Eventually the department gave its biased summary of the submissions, but no submissions were released to check against the summary. The department itself was promoting this bill. I then asked the department, through FOI, for a copy of the submissions. Finally the government gave in and released them one week out from the debate on the bill. Since then the original summary was shown to be inaccurate. Just last Friday, after someone complained on Facebook that the government was not correcting its mistakes, a new summary was released. Of the 74 submissions released, 57% were opposed to the bill.

There is no doubt that the process has been weighted in favour of pushing this bill through as quickly as possible. Throw in the media, which is also backing the changes, and you can see what an uphill battle this has been. Have you also noticed, in this whole debate, how the word 'Aboriginal' was not mentioned in the discussion paper or the second reading? The fact is that Aboriginals have not been consulted. That is perhaps why the government was not interested in a parliamentary committee, as the committee would have gone to Aboriginal communities and given people there a chance to understand what this is all about, and provided a chance for the government to hear their views.

People applauded Sister Anne Gardiner for becoming the Senior Australian of the Year, especially when she spoke about consultation with Aboriginal people. It is funny that when I spoke to her a few weeks ago she said that people on the Tiwi Islands knew nothing about the bill. How many other communities are in the same boat, the same vacuum of information? One gets the impression that the Department of Health knows what is best in the bush; 'Trust us, we are from the government.'

This bill affects Aboriginal women, their culture and Aboriginal health practitioners. Has anyone asked whether these communities want RU486, or will they eventually get it through the side door with the help of telemedicine, coming to a clinic near you? Will Aboriginal communities be able to refuse the drug being allowed on the land, the same as grog?

Simply put, the government has not properly consulted with Aboriginal people. Why is that consultation so important? Because this piece of legislation will allow the dispensing of RU486 by Aboriginal health

practitioners in the future. With the introduction of telemedicine, ultrasound equipment and extra training, it will be possible to have remote communities as abortion clinics. Do Aboriginal people know that?

Why is it that a number of submissions opposing the introduction of this drug are concerned about the dangers of supplying this drug to people who have a higher risk factor due to many diseases and ailments, and who live in areas where access to proper medical facilities may be problematic, especially in the Wet Season? Dr Gawler, who was chief surgeon of Darwin hospital for many years, said in his submission:

In remote settings in the Northern Territory, air evacuation may not always be possible during the Wet Season; furthermore, even in good weather, because of the tyranny of distance, and because not every remote community has a plane sitting on the airstrip, there can be very prolonged aviation delays.

...

Skilled ultrasound assessments are not usually available in rural and remote NT clinics; and so RU486 is an inappropriate drug.

...

Due to language difficulties (English not first language), and cultural reasons Indigenous people often do not comply with attendance at medical appointments and medical instructions, which may result in serious consequences for the patient.

... in summary, medical (RU486) abortion is not a procedure that can be safely used. Especially in remote communities in the Northern Territory; or even in Darwin and other NT towns, there will be health risks to patients who are non-compliant or who abscond. Without doubt, there will also be deaths or serious complications among young women.

In the light of the RANZCOG statements, these deaths will be the result of negligence on the part of the authorities who sanction such use and practitioners who ignore the advice of the foremost clinical authority in obstetrics and gynaecology in Australia.

...

Furthermore, I find it strange that this proposed legislation does not encourage patients to consider other options, such as adoption or foster care within the extended family. Frequently, if a pregnant patient is provided with social, emotional and financial assistance, she will wish to continue the pregnancy. In order for a woman to truly make an informed 'choice', she should be fully informed regarding options other than abortion. She should also be allowed a 'cooling off' period, such as is available in Consumer Law regarding purchases. Such counselling should not be provided by those with a vested interest, such as the abortionist. Extensive counselling may not be available at a remote clinic.

I respectfully suggest that a parliamentary enquiry should be conducted regarding the safety and ethics of these proposed laws and that all regulations regarding the use of MS 2-Step should be enshrined in legislation for the protection and welfare of all Northern Territory women, and in particular, remote Indigenous women.

Dr Gawler is well respected, yet it seems government continues to ignore his advice. Dr Parker, president of the AMA said in the *Guardian* in 2015, there is a group of:

"empowered female lawyers" who "don't give a stuff" about medical guidelines for advocating abortion law reform in the Territory.

Dr Parker was reported by the *Guardian* as saying:

... complications from the "potentially fatal side effects" of the RU486 drug, which he said were "very uncommon", were too risky for patients and doctors, and the Northern Territory, with its "tyranny of distance" was different from other states where most of the population had ready access to hospitals.

There is a Central Australian doctor who wrote, in submission number 80:

Considering that Aboriginal patients have a disproportionate usage of healthcare services in the NT, and that Aboriginal women have higher fertility rates than other women in Australia, I would hope that Aboriginal stakeholders are adequately consulted regarding this proposed change in legislation. Noting that many of my Aboriginal patients of reproductive age have low health literacy and low literacy in general, I imagine that this discussion paper is not accessible to many (or even most of) them. What steps are being taken to ensure that the discussion is not biased towards people who have Internet access and are highly literate?

The doctor writes much more, but those three quotes highlight, more than ever, that we need to send this legislation to a parliamentary committee to be looked at more thoroughly.

I will comment on abortion. People say, 'This is not about abortion', but it is. It is interesting to hear people speak passionately in this House about domestic violence. We recently debated a bill which will make it easier for police to apprehend those who commit violence in the family home so members of the family are protected from violence. But is not the termination of human life using a suction device or abortifacient no different? Is that not domestic violence against the unborn human? Why do we not make a fuss about that? We talk about stolen generations, but if the Territory is losing 600 to 1000 unborn Territorians each year is that not a stolen generation lost each year? Why do we not make a fuss about that?

The bill is not moving into the 21st century; it is heading back to the dark ages. If it was about moving into the 21st century we would be concentrating on saving lives, not destroying them. Look at all the marvellous medical advances that save lives from cancer, heart disease, stroke and other diseases. Look at the effort to save the life of a premature baby. We have Save The Children Fund and Royal Commissions into protecting children, but we never have a Royal Commission into abortions or the unborn.

Have we ever passed out in this parliament a ribbon or badge such as this one, which shows the feet of a nine-week-old baby? Perhaps we should as part of unborn remembrance day. You will notice in the discussion paper the pro-abortion submissions in the minister's third reading—there is no mention of the unborn. The closest you get is the euphemism 'products of conception', meaning bits of a human life.

There is a deliberate avoidance of what is being destroyed. The lawyers and women's groups talk about women's rights—the right to reproduce, control over their bodies, no restrictions on abortions—as if it is an overriding right, but at no stage is there any mention of someone else who is involved in this—another human being and their rights. They will not recognise that the unborn is not part of a woman—a biological fact. It is a separate individual surrounded by a placenta. Women may have a right to do with their bodies as they want, but this tiny individual human life is not her or hers to destroy. It is not an arm or a leg.

The empowered female lawyers and judges of this world may decide you and I do not count until we are born, but some judge making a legal ruling about when I am protected from being killed and when I am not does not stop the fact that, from a biological aspect, I am a human being from the time I am conceived to the time I die. The sad thing is that I have a one in four chance of being terminated in the Northern Territory, before I am born. I have a much better chance of surviving a car accident—one in 114.

The rights of the unborn are conveniently ignored in this debate. The *Universal Declaration of Human Rights* of 1948 talks about the inherent dignity and the equal inalienable rights of all members of the human family. Surely the unborn are part of the human family; after all, they are human. The more I hear from those supporting this bill, the more I believe this is being driven by an ideology which excludes the unborn and the rest of us. In the 21st century we try to find ways of saving lives on our roads, making cars safer, educating people how to drive better and telling them not to drink and drive, so why are we not standing here today working to save lives?

About 600 to 1000 babies are aborted each year in the Territory, which is strange considering we are trying to attract more people to the Territory. It is strange that we are trying to close the gap, advocating to protect our children from physical and sexual harm, promoting healthy living, putting in a big effort to save the environment, but the same people seem to show little concern for unborn humans.

Why can we not spend the time, effort and money on saving the 600 to 1000 little people? Would it not be great if the Chief Minister said the goal is no abortions and that we would have an inquiry to see how that can be achieved. Would that not be a breath of fresh air: the Territory leads the way in reducing and eventually stopping the destruction of the unborn?

Unfortunately the government, or at least some members, want to go into the 21st century using and promoting new ways of terminating human lives, and there will be people cheering today who think that is a

great thing for the Territory. Instead of reducing the numbers, if this bill is passed it will increase the numbers, not only because abortion will become more accessible but, as some people from the AMA said, it will be used like a contraceptive. 'If I missed my pill before I had sex, I can always drop into my local GP and ask for RU486'.

I hope people will look at rejecting this bill and see it as an opportunity to help people who find themselves in difficult circumstances for a range of reasons, but without using abortion as the solution.

There is no mention of counselling, except in a definition. Counselling is most important, and I will move a number of amendments to fill that gap. Dr Gawler, in his submission, mentioned that it is essential, and the Central Australian doctor also summed it up in her submission. She said:

In a situation of a woman who is distressed by an unplanned pregnancy, she should first be offered non-directive and supportive decision-making counselling which provides her with emotional support to make a confident and informed rather than panicked decision regarding her pregnancy, based on her values, the options available, and availability of other forms of support. If, after the non-directive, supportive decision-making counselling, she then makes the informed choice of having a ToP, she must then be given a second, different type of counselling, namely pre-procedure counselling, where she is informed and is given the opportunity to discuss what will happen to her before, during and after the medical or surgical procedure (which is what should be available to all patients before any procedure). It is imperative that both types of counselling are offered to every woman to ensure that she makes informed decisions regarding her own health, wellbeing, and that of her baby.

...

For an important decision such as ToP, seeing two medical practitioners theoretically provides the woman with a 'cooling-off period' to think through the information that the first medical practitioner has offered, and to discuss it with the second if she wishes. Other elective medical procedures are never done immediately to allow the patient time to think and discuss with family and friends. Even activities as important or mundane as purchasing a house or joining a gym have a cooling-off period, so I am concerned that the proposed change to the ToP legislation does not give that option for a decision that has long-term consequences.

The legislation, in clause 6, also allows abortion by 'any other action', yet neither the explanatory notes nor the second reading explain what that means. As we have now taken abortion out of the Criminal Code, except for offences by a non-qualified person, what happens to someone who uses any other action that may be outside the guidelines—cruelly enough, a coat hanger? Can they be prosecuted if the person is a suitably qualified medical practitioner? It seems the worst that could happen to a person is to be deregistered. What happens if a person is coerced into having an abortion by the medical practitioner?

This legislation is about making abortion available on demand, as you can see from the legislation. There will practically be no impediments to stop a woman having an abortion. This is the slippery slope from when abortion was originally allowed on medical grounds—now it is open

The unborn had some protection before, even in theory, but now—nothing. If someone does not like the gender of their baby, is there anything in this legislation to stop an abortion for that reason? We have legislation that does not distinguish between surgical and medical abortions. It does not state when and where RU486 can be given. It can be taken home up to nine weeks—where to after that? The TGA says the drug should only be used up to 63 days, but clause 6 says 14 weeks.

We have changes to the law about minors which make no mention of whether a law has been broken and reported. They also seem to ignore the rights of the parents, who are the legal guardians of the child. The legislation makes no mention of the rights of the male. Of course, with legislation which has a heavy feminist backing—that is obviously why the male partner is dismissed. It takes no account of the effect on the male partner who may want the child to be born, when the woman insists on an abortion. Or it could be the reverse.

This legislation wants to make medical practitioners who disagree with abortion sell their conscience if they want their jobs. If they break this section of the law, they are likely to be deregistered by the Australian medical board. It wants to punish doctors who have a true conscientious objection. Article 18 of the *International Covenant on Civil and Political Rights*, adopted by the General Assembly of the United Nations on 19 December 1966, says:

Everyone shall have the right to freedom of thought, conscience and religion.

Has the government had any legal advice on whether this clause of the bill is in breach of the *International Covenant on Civil and Political Rights*? How can a person be forced, against his or her conscience, to do something which will, by default, result in an act to which he or she, in conscience, is totally opposed?

If I am against killing but there is someone I do not like and I hire someone else to do the job, do you think the police will let me off the crime of murder? What is the difference? Is there a penalty or will the doctor be deregistered? By requiring a doctor to comply with the new clause are you not coercing him or her to go against his or her conscience by creating a law which, if they do not obey it, will possibly mean they will be deregistered?

In Western Australia the Department of Health tried to use the following AMA guidelines on this issue:

Where a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.

The doctors' legal safeguard group responded:

This is a serious misapplication of the AMA Guidelines. The AMA statement refers to therapy, not to abortion. The AMA is not suggesting to its members who refuse to perform some non-therapeutic procedures ... that they have a duty to refer the patient to another doctor, or to give assistance at all to find someone else who will do the job instead. Doctors have no duty—legal, moral or medical—to make themselves accomplices in these practices by providing referrals, names, phone numbers or anything else.

In the same way, abortion cannot be described as a therapy. An untimely or undesired pregnancy may be a problem, but it is not a medical problem. Pregnancy is not an illness, and the termination of pregnancy cannot be called the treatment of an illness.

You will now punish a doctor for sticking to his beliefs. Will the Health department report it to the Australian medical board if a doctor is reported for breaking the law?

This legislation is designed to promote abortion—to make it as easy as possible to obtain and to silence anyone who might have an alternative view. How about safe access zones as another example of trying to silence people? I am not sure why we have to have access zones in the first place, as we already have legislation—section 47 of the *Summary Offences Act* says:

Every person who is guilty:

(a) *of any riotous, offensive, disorderly or indecent behaviour, or of fighting, or using obscene language, in or within the hearing or view of any person in any road, street, thoroughfare or public place;*

(b) *of disturbing the public peace;*

...

(e) *of unreasonably causing substantial annoyance to another person; or*

(f) *of unreasonably disrupting the privacy of another person,*

shall be guilty of an offence.

Penalty: \$2,000 or imprisonment for 6 months, or both.

Or section 47A:

Loitering – general offence

(1) *A person loitering in any public place who does not give a satisfactory account of himself when requested so to do by a member of the Police Force shall, on request by a member of the Police Force to cease loitering, cease so to loiter.*

Penalty: \$2,000 or imprisonment for 6 months, or both.

- (2) *Where a person is loitering in a public place and a member of the Police Force believes, on reasonable grounds*
- (a) that an offence has been or is likely to be committed; or*
 - (b) that the movement of pedestrian or vehicular traffic is obstructed or is about to be obstructed, by that person or by any other person loitering in the vicinity of that person;*
 - (c) that the safety of the person or any person in his vicinity is in danger; or*
 - (d) that the person is interfering with the reasonable enjoyment of other persons using the public place for the purpose or purposes for which it was intended, the member of the Police Force may require any person so loitering to cease loitering and to remove from that public place any article under his control, and a person so required shall comply with and shall not contravene the requirement.*

Penalty: \$2,000 or imprisonment for 6 months, or both.

The law is discriminatory. Why does it not apply to people working at Santos to stop those workers being harassed by anti-fracking groups? There are many other issues about this clause which I will touch on during the consideration in detail stage. I do not support people bullying and harassing people going to an abortion clinic, but I question whether we need this law to.

As an example, this law says you cannot do something which can be seen or heard which may deter someone from having an abortion. A mother pleading outside a clinic for her daughter not to have an abortion would, in theory, be breaking the law. I will quote again from the Central Australian doctor, who is also concerned.

She said in her submission:

I am very concerned about the proposed Safe Access Zones. While I have limited experience in legal matters surely there are existing laws that deal with people who harass, intimidate, interfere with, threaten or obstruct others in public or private areas and those existing laws would surely be applicable to anyone who demonstrates these anti-social behaviours against pregnant women.

Furthermore, legislation to prevent intentionally communicating in relation to treatment in a way that is seen or heard by another person seems to me a draconian limitation on free speech. I do not wish to create a society where ordinary citizens cannot express their diverse opinions.

A parallel example is vaccination. As a public health physician who is a very enthusiastic supporter of vaccines I am very frustrated by anti-vaccine campaigners who mislead parents of vulnerable children. At the same time, out of respect for free speech anti-vaccinators have the right to distribute their misinformation even though I would prefer that they did not. I would not want a law enacted to prevent them from expressing their opinions, strange or wrong as they may be, nor from approaching vaccination clinics. Hence, using a law to silence people who may have strong and differing views on termination is very worrying to me.

I trust that all points that I raise above will be given serious consideration and I look forward to receiving a substantial response.'

I have no doubt there will be many people today who will clap and cheer if this legislation is passed, but I want to go home tonight knowing that I am not a paper politician, and that even though I am not perfect, I have tried my best to convince you, my fellow politicians, to take a new road, not the road based on the thoughts of a French drug company, the NT family planning association, Emily's List or the YWCA—or just because the other states allow it.

Why do we not drop this legislation and call for an inquiry? Why do we not look at this properly and look at all the options? I have asked this many times. It is the government's policy to open up this parliament. You can see from the few debates we have had that there are many issues that need to be thrashed out through a better process than just this one day of debate.

We need to do something positive for life, and give life a chance. That would be Territory proud.

Norman J Ford wrote in his book *The Prenatal Person*:

The fetus is defenseless and totally dependent on the mother for support and survival. Janet Podell, a former pro-choice feminist, changed her mind after her first child:

It was impossible to ignore the plain fact that this baby was the same living being who had been kicking me in the ribs for months. His life was clearly an unintermittible continuum that had begun long before I could feel him move ...

Abortion deprives a real person, not merely a potential person, of life and of the opportunity to develop to the age of reason when free and morally responsible acts can be made. One should always treat illness and alleviate suffering of a pregnant woman but not by direct abortion, which is a breach of the duty of care owed to the fetus by the mother and doctors.

I have said before that I am a Catholic, and I am not ashamed to say it. I believe that human life is sacred. As a human being I believe human life is sacred. As a member of this parliament I believe human life is sacred. My very inner soul says human life is sacred and we should do our best to protect it. That is what I hope people will think about today.

I understand that abortion is legal, but as I have said to people, 'If you approve of someone getting hit by a car, then you are happy for them to be hit by a bus?' We have an opportunity to rethink where we are going as a Territory. We have an opportunity to say that we do have abortion laws, but perhaps the 21st century approach is not to make abortion more available but to ask how we can turn it around. How can we help people who are in unfortunate circumstances, financial and emotional? How can we help them not use abortion as the means to overcome those problems?

Why can we not do something that does not copy the other states? Why cannot we, as the Territory, lead the way and say we will do something about protecting the unborn. We will do something to not have another stolen generation. We have the opportunity to do something that will turn things around instead of just copying what others do.

I thank other speakers for their points of view. This debate is difficult. I also thank the many people, both for and against, who have sent me emails and letters—I understand, very much. I thank the doctors who have contacted me and given their points of view. I am not an expert in this area; I rely on people who are, so I thank them. Some of the information I have given today is not my personal information, but it makes a lot of sense to me. It has come from people in the medical fraternity who have concerns about the introduction of this drug into the Northern Territory.

I urge the parliament, at the very least, to put this legislation on hold and take it to a parliamentary committee. Take it to Aboriginal communities and find out what people in those communities have to say. They have not been consulted. The discussed paper finished on 27 February. How many Aboriginal people, as the doctor from Central Australia mentioned, knew this was going on? I say to the government, please consider putting this legislation on hold, sending it to a committee and bringing back some recommendations.

Ms LAWLER (Education): Madam Speaker, I support this bill as a born and bred Territory woman, a mother, grandmother and auntie to nine nieces and eight nephews, ranging in age from 14 to 40. One of my nieces is here today, and it is lovely to see her here supporting me. As an older sister of a family of six, who, at my age, has experienced a very broad life with all its highs and lows—with births, death, illnesses and challenges—I support this reform which will give Territory women another option to access safe termination of pregnancy services.

I am also respectful of the views of others, like the Member for Nelson, who spoke before me, who do not support the termination of pregnancy. Those are not my views, nor do I believe they are the views of the majority of people in my electorate of Drysdale. I thank my constituents who have contacted me, spoken to me and shared their views.

These reforms will create contemporary legislation that will align the Territory with other states. It will give Territory women what other states and territories have, which is a choice of safe options for the termination of pregnancy.

Let us be clear, like others have said today, this legislation is not a debate about the moral rights and wrongs of terminations of pregnancies. Those debates were had long ago. This is about creating legislation that enables women of the Territory to have the same access to termination of pregnancy services as other women across Australia.

This legislation will provide the option for a termination to be completed outside of a hospital in an appropriate clinical setting. We heard from the Member for Namatjira about the difficulty a large number of Territory women have in accessing those services. This law will allow termination of pregnancy by medication. It will be available for an approved medical centre, health centre or hospital. It will also still be available by operation. That bit does not change. There is still the option for women to go to the hospital in Darwin or Alice Springs and have an operation to terminate a pregnancy.

There is still an option for women to choose to go interstate for privacy reasons, if they can afford to do that. As the Member for Nelson said, women have been doing that. Figures state that there are approximately 600 terminations and 4000 live births in the Northern Territory. For those 600 terminations, if the termination occurred very early in the pregnancy, up to nine weeks, it could have been done by taking medication. The medication could have been taken at the health centre or at the woman's home, if that is what she wanted to do.

It is about choice, and that is why I support this legislation. A lot of women, including me, would like privacy in this time, and to be supported by their partner, a family member or friend, instead of being in a hospital with all that comes along with that. Hospitals can be noisy and busy, and there can be a lack of privacy.

We talk about the rights of the unborn child, but it is also about the rights of women to have the choice to do this in their own homes. I support the legislation changes that would allow terminations to be completed outside of hospitals, in appropriate clinical settings, such as day surgeries or clinics with access to emergency services. To reduce risk, if a woman chooses to terminate a pregnancy by taking medication at home, she must be close to a hospital emergency department for treatment should there be any complications. The legislation is very clear about that.

We need to be reminded that this is not only an issue for young women. So often we hear the stereotype of a teenager finding herself pregnant, but it is about women of all ages, up to menopause. For a variety of reasons women can find themselves with an unwanted pregnancy. Whether you are in your 50s or a young girl—it is about finding yourself in the situation of an unwanted pregnancy. The reasons for a pregnancy being unwanted are varied and many.

I am sure all women who make the decision to terminate a pregnancy will tell you it was one of the hardest decisions of their life. Possibly all of us here have friends or relatives who have had to make that very hard decision. Some of them seek counselling and support, but I am sure all of them would say it was the hardest decision of their life.

After ensuring the woman is healthy and after offering counselling before the decision is made, the doctor follows medical guidelines and strict rules under the Therapeutic Goods Administration act for writing a script. The legislation states that nurses, midwives, Aboriginal health practitioners and pharmacists can only give these drugs to women under the direction of a specialist trained doctor.

Member for Nelson, Indigenous women are just like other Territory women; they can make an informed choice about termination, with their doctors, and the best method for them. All Indigenous women can and should have that choice, just like all other Territory women.

I support the changes to the legislation to set up safe access zones in the vicinity of premises where terminations are provided. It would be nice if it was not needed. I am respectful of those who hold opposing views to mine on terminations of pregnancy, but that does not mean women who have made a choice—one of the most difficult decisions of their life—deserve to be abused or harangued for it. I hope both sides can be understanding and respectful of others' views and choices.

This legislation is not about forcing or encouraging someone to terminate a pregnancy, or making it all too easy. It gives Territory women the choice of having a termination by medication rather than an operation. Women have been seeking and having terminations of pregnancy for many years. This will give Territory women, at all ages and stages of life, the same choice women in other states and territories have.

Madam Speaker, I acknowledge the work you did as the Member for Goyder. I also acknowledge the hard work of the Minister for Health in bringing this legislation to the House. It has been hard work, but all the

members on this side have taken the time to speak with their constituents and hear the views of people across the Territory.

I support this legislation. It is long overdue.

Mr KIRBY (Port Darwin): Madam Speaker, I support this bill. I thank the Minister for Health for bringing this important matter to the Assembly. This government has recognised on a number of occasions that it would face some extremely challenging decisions over the next few years, but we probably will not face many more challenging than this. I commend the government and everybody in the Chamber for how they have come to make the decision in a proactive and positive way.

The consultative and proactive way the minister, the department and the Territory as a whole has embraced this debate shows that, as a society, we are ready to move forward in a progressive and sophisticated way.

As a male entering into this debate it has been, at times, confronting. My upbringing and beliefs are that everyone, especially women, have the right to decide their own future. It has been a confronting set of circumstances. I have been in the position, in previous roles, of being able to advocate on behalf of women within trades and male-dominated industries, and I have had immense pleasure in doing so. But it does not give me the right to decide for women. We are put in that position in the House, as elected members and decision makers, and the best I can do is represent those who have asked me to speak on their behalf.

I have been fortunate to advocate on behalf of women. I have had the good fortune of working intricately with the Sparkettes, our award-winning Territory electricians. The things those women do in society and to encourage women into electrical trades is fantastic. To be able to orchestrate their inaugural women's conference in the Northern Territory was an honour for me—working and speaking with those women, not deciding their future for them.

For the Territory to recently have an apprentice electrician nominated to represent us at the national training awards was a fantastic achievement. To have that apprentice come from humble beginnings in Tennant Creek was an amazing achievement. For the apprentice to be a female Territorian shows that we can be at the forefront of equality in the debates we have in the Territory and this Chamber. Sadly, women's reproductive health is not one of the areas we are leaders in. In the Territory we have great women leaders within sport, the public sector, business and this Chamber.

I have engaged with members of the Port Darwin electorate on this bill. I acknowledge there has been a wide range of views. This is an extremely emotive topic. I am grateful for members of the electorate, the public, who have taken the time to share their views and stories with me. Some very personal stories have been shared with me, and I am sure that is the same for everybody in the House. That is not always an easy thing, so I thank and acknowledge those who have taken the time to share their opinions with us. Overwhelmingly the feedback from my electorate has been one of support often mingled with a high degree of surprise that Territory women do not have access to the same healthcare as women interstate.

For me, this bill is not just about giving women the right to decide what happens with their own pregnancies. That right was fought for and won by strong women decades ago, who demanded they have the final say in what happens with their bodies. This bill is about ensuring all women around the Territory have adequate access to appropriate, evidence-based reproductive healthcare. It is about a woman and her health professional determining the safest way for that woman to end a pregnancy, if that woman and her health practitioner decide that is the safest and best option for her future. That is where the debate begins and ends for me, with a woman and her health professional.

This bill will modernise the reproductive healthcare that Territory women are able to access. It will ensure there are robust protections for women seeking to end a pregnancy. As with all evidence-based healthcare decisions around this, treatment will be based on strong, professional guidelines in line with the health and wellbeing of each woman seeking to terminate a pregnancy.

This bill also provides for safe access zones around facilities that provide treatment. We would all hope that that would never be necessary, but it is important to highlight that there have been incidents in other states that are regrettable and have highlighted the necessity for safe zones.

I can only imagine that this must be one of the most traumatic decisions that any woman has to make. To be ridiculed or made to feel unsafe, as a woman seeking to legally avail themselves of necessary healthcare, is unacceptable in this day and age. I acknowledge that not everyone supports such medical treatments,

and I note that there are provisions in this bill for conscientious objections and referral to another practitioner.

I acknowledge the hard work that you contributed during the last Assembly, Madam Speaker, in bringing this topic to the House as a private member's bill. Many of my female friends, and some are here today, commend you for your hard work on this matter and acknowledged it at the time; they were very appreciative.

All in this House acknowledge this would never be an easy debate and it was guaranteed that we would never all agree. I commend my colleagues for the manner in which we have gone about a mature debate. I have been fortunate, in my career, to be able to advocate for workers' rights and, at times, for human rights. On this occasion I am very proud to be able to advocate for women's rights.

This has been particularly gruelling for some ministers and members, and I praise them for their mature conduct through the debate. I applaud the minister for her tireless work in bringing this bill to the House under circumstances that few of us will ever fully be able to understand.

I thank the minister for the bill and I commend the bill to the House.

Ms NELSON (Katherine): Madam Speaker, I take the opportunity to speak to one of the most important pieces of legislation we will debate during this term of government. It is a bill that will make a difference to every woman in the Northern Territory who has to face what is perhaps the most agonising decision of her life.

The Termination of Pregnancy Law Reform Bill 2017 has been inaccurately cast as a spiralling descent towards free-for-all abortions in the Northern Territory by those in this parliament and the wider community who oppose it.

Let us be clear about what we are debating today. This debate is not about the legal right to abortion. It is about women's health and their choices in a country where termination of pregnancy is already performed. This access is particularly important for women living in remote and regional communities. It is important for everyone to understand that, ideology aside, the safety and wellbeing of women is important, and abortion needs to be available safely, legally and affordably.

We, as the appointed representatives of the people of the Northern Territory, are being asked to decide whether or not the women who helped elect us into the privileged positions we find ourselves in should be afforded the same standard of healthcare that those living in other Australian jurisdictions have enjoyed for more than a decade. When you peel away the layers of rhetoric, distorted facts and intensely personal prejudices it becomes apparent that the legislation is born of a simple desire to ensure that women who call the Northern Territory home achieve equality in accessing a standard of medical care that reflects current best practice.

Opponents of the bill would have Territorians believe that, at its core, it is legislation that will clear a path for the legal termination of pregnancies. What they will not tell you is that abortion has been legal in the Northern Territory since the now-antiquated *Medical Services Act* was adopted by the first Legislative Assembly in 1974. This happened because Dawn Lawrie advocated and lobbied for abortion law reform.

For more than four decades Territory women have been well within their rights to terminate a pregnancy of up to 23 weeks gestation by surgical intervention as a hospital in-patient. What this government is aiming to achieve today by passing the Termination of Pregnancy Law Reform Bill 2017 is an extension of that right to include a non-invasive option that is accepted globally.

As a woman, this bill is incredibly close to my heart, and I echo the sentiment the Health minister expressed during the second reading on 15 February:

It will probably be the most passionate, personal and controversial issue for women in this House to debate—for Territorians in this House to debate.

There is no doubt that debate in this parliament, either for or against the bill, will be forged by personal circumstances and beliefs, ethical constraints and religious obligations.

I have my own story about having to make the decision to terminate a pregnancy, but this debate is not about me or my story. I am only one woman in the Northern Territory. As the elected Member for Katherine

I am here to represent and speak for the women of Katherine, who I have consulted extensively over the last 18 months, not just since the bill was presented in February.

Last year I sat in the gallery on the day the parliament debated the Medical Services Bill, feeling anger and dismay that some of the elected members who sat in this Chamber made statements that insinuated that women like me who support and advocate for women's rights are immoral and unethical.

I tend to think that the opponents of this bill, at times, are not really serious about the argument of safety, which is what they always resort to. If they are talking about safety, why would they not be arguing for similar bans on tranquilisers, mood elevators—Valium, Prozac—or many other drugs that are available? Many of these drugs have some very serious and questionable social and medical consequences. Arguably, they have many more side effects and adverse consequences, and some may even lead to deaths. Yet we do not hear or see passionate protests about these medications as we do about RU486.

RU486 is a drug recommended by the World Health Organization, particularly in developing countries. It is a drug that provides an alternative to a surgical procedure for the termination of pregnancy and therefore gives women more choices.

It seems to me that the majority of the opponents of this bill are more concerned about the social dissemination of their ideologies, of their moral code being spread and enshrined into law. Before I continue with my speech, I take the liberty of asking those who oppose the legislation for a pharmaceutical alternative for abortion to consider the personal circumstances of the women, like me, who have had to make the harrowing decision to terminate their pregnancy and that when they keep that in their thoughts, they temper their statements accordingly.

For the last six months I have been inundated with emails both in support and opposition of this bill. I have also spoken with several women in my electorate who have shared their stories with me, either supporting the bill or opposing it. I have, at times, been very humbled by their personal accounts. To everyone who has reached out to me to share their comments and opinions, I thank you. I also thank those who have given their time to answer my questions and provide clarification.

As elected members of this parliament, do we not have a responsibility to ensure the women in our electorates have every medical option available to them, during what will be one of the toughest situations they will have to go through, without judgment or prejudice? How can we be willing, as a parliament, to recognise their long-standing legal right to terminate a pregnancy but be historically reluctant to allow them to do so in a manner which medical experts and research asserts is less traumatic than the invasive option currently available?

The existing limitations of the *Medical Services Act* are extremely restrictive when it comes to a woman making a decision about how and where to terminate her pregnancy. The only option available to a Territory woman today who decides to terminate her pregnancy is to have a surgical procedure under general anaesthetic or to travel interstate to seek treatment.

In addition to being invasive, the surgical procedure can only be carried out at three hospitals in the Northern Territory, two in Darwin and one in Alice Springs. How can these choices represent equitable healthcare when so many women live in regional towns and remote communities, and in many cases, as the Member for Namatjira highlighted, thousands of kilometres away from the medical facilities that provide for the surgical termination of a pregnancy. Traveling to Darwin, Alice Springs or interstate, many women are forced to leave behind their families and support networks, and face the magnitude of their decision, as well as the confusion of a strange environment, all alone.

The existing legislation means women in my electorate of Katherine are unable to terminate a pregnancy locally, despite having access to skilled and empathetic medical practitioners. As an elected representative who has campaigned fervently for equality and women's rights, I believe that what we currently have in place is an archaic situation. I will do everything in my power to ensure the women of Katherine and the Northern Territory no longer have to consider this as their only option if they choose to terminate a pregnancy.

Since this bill was introduced late last year I have witnessed many opponents base their objections on the misconceived notion that the introduction of a drug like RU486, by offering women a non-surgical option for abortion, will somehow lead to a decrease in safe sex practices. What it will not allow for is unfettered access to the drug or usage where there has not been a thorough clinical assessment of the patient that meets professional and community standards. Make no mistake, this bill will not lead to women walking the

streets of the Northern Territory choosing this option in a devil-may-care fashion, as if it was as easy as choosing what to wear that day or what to have for lunch. To suggest that it will is spiteful and cruel, and does not take into account what an incredibly difficult and considered decision it is for a woman to terminate a pregnancy. To put it quite bluntly, it is an insult to the intelligence and morals of every Territory woman.

Some of my esteemed colleagues seated here today may be reluctant to enter the debate because they think, as men, the bill seeks to provide an alternative solution to an issue that is not relevant to them. It is a position which is shared by some men in my own electorate, as it would be by others scattered across every square kilometre of the Northern Territory. The problem with that leaning is that it fails to acknowledge that this bill addresses an unacceptable existing failure to provide Territory women equality in healthcare.

Territory time is something those of us who live and play in this magical part of Australia embrace with a carefree acceptance, but it is not an attitude that should extend to legislative decisions that leave 21st century women in the medical Dark Ages. Australia had the debate about the prescription and administration of drugs like RU486 at a federal level in 2006. It defies logic as to why women in the Northern Territory have been left behind for 11 years.

You may possess a Y chromosome and believe this bill does not affect you, but how dramatically would your perspective change if a woman in your life needed to make a decision about terminating a pregnancy? Ensuring Territory women are on an equal footing to their interstate contemporaries when it comes to healthcare and societal expectation in regard to the termination of pregnancy is something we are all responsible for in this Chamber.

It has been inspiring to work alongside my Territory Labor colleagues, those in opposition and the Independents who support this bill becoming legislation, to bring it this far. At a time when any issue seems to be one that both sides of politics will happily use to incite—and divide. I am proud to be part of a bipartisan outlook that rejects the notion that equality and the health of Territory women are things to be exploited in the quest for political points.

Because abortion has been legal in the Northern Territory since the *Medical Services Act* came into effect, what we are being asked to consider and vote on has little to do with our personal, ethical and religious dispositions, and more to do with what we promised the people who entrusted us to represent them we would do when we were sworn in as members of the Legislative Assembly.

Section 11 of the *Legislative Assembly (Members' Code of Conduct and Ethical Standards) Act* 2008 states that:

... members must seek to ensure their decisions and actions are based on an honest, reasonable, and properly informed judgment about what will best advance the common good of the people of the Territory.

We cannot, in good conscience—I certainly cannot—tell our constituents that we did everything in our power to advance the common good on their behalf if we fail to allow women access to what every jurisdiction in Australia, except the Northern Territory, considers to be best medical practice.

There is no empirical evidence in the jurisdictions that have legislated access to pharmaceutical abortions that supports this ludicrous supposition. The important reality to keep in mind is that the supply of the drug this government is seeking to introduce will be heavily regulated and supervised. The roles of health professionals throughout the process are carefully spelled out in the bill.

If the bill passes it will allow a suitably qualified practitioner to prescribe and administer the drug, and a registered pharmacist to supply it, while a nurse, midwife or Indigenous health practitioner will have the capacity to administer it at the direction of a medical practitioner. The drug will not be able to be prescribed if the medical practitioner is not satisfied that the patient has access to 24-hour emergency care in the event of a complication. This will allow for the termination of pregnancy in a safe, supportive, out-of-hospital environment for the woman.

If we vote against this bill based on our own personal beliefs and prejudices we will have refused Territorian women the basic human right to equality and, in doing so, will have foregone our right to look them in the eye as long as we remain members of this Legislative Assembly.

Madam Speaker, I thank you for your tenacity and fortitude in bringing your private member's bill to parliament in 2015. I also acknowledge our federal colleagues who championed this same reform at their level in 2006. I urge all members to commend this bill to parliament to ensure women in the Northern Territory are afforded access to healthcare that is in line with our contemporary counterparts throughout Australia.

I commend the bill to parliament.

Mr MILLS (Blain): Madam Speaker, judging by the comments so far, we acknowledge this is a very difficult issue, and the debate is framed in certain ways.

I acknowledge that this is a seriously challenging issue for many in our community to contend with. I feel, as a male, that I am discounted because of my gender. Nonetheless, when we remove the principle of gender and acknowledge that the principle this issue rests upon is choice or life—the two grand principles of pro-choice or pro-life—I fall on the side of recognising that we are dealing with life. From that flows a number of consequences. I have held that view since I was a child, and I still hold it today. It has been reinforced by my moral considerations of what underpins this issue.

I also am pleased I live in a society that acknowledges freedom of conscience, belief and thought. I attended a parliamentary conference in December where that was the grand theme. It is under assault all around the world, and that is a matter to be considered here.

It is not a trampling of one view over another; it is about how we coexist and work through this together. It is not to extinguish one so another can live. That is like blowing out someone else's candle so there would be more light. We need all the light on this so we can see more clearly and learn how to navigate in these difficult circumstances.

Many have spoken in a personal way. I introduce myself as being a grandfather of two young boys. Next month there will be a third, God willing. We have delighted in every step of that process—the expectation and anticipation—and that life has been with us since the moment the news reached our ears. I am a father of two children. I am the son of a mother and father. I was also once an unborn child, as we all were. The moral consideration is that if it is wrong to end my life now that I am alive, I cannot see how it was not wrong when I was unborn. That is the inconvenient truth that underpins all of this.

Some of us who have heard other voices speaking to us find it difficult to manage this because of the depth of this and principles upon which the alternate positions rest. I find it personally, as many do in our community—it is an inconvenient truth that we are dealing with human life. Therefore I feel qualified—if we are going to speak of gender, I will speak of 50% of those who are aborted being male.

Those who are at the centre of this, at the consequences of the decisions we make in this parliament, do not have a voice. There are some who will give them a voice. I can do nothing else. I commend the Member for Nelson for the extraordinarily good work he has done, and the support he has been to me and to many in our community.

It is an important debate because it weighs on very deep issues. It has a positive effect; it helps us consider what is really important. We have heard words of freedom, ideology and so on, but when it rests on the deeper issues of human life, so much flows from that. It is our regard for one another and how we work through these things.

I acknowledge that the decision has been made regarding abortion. I will continue to stand and advocate for life. I will do that until I have no life left on this earth. I will continue to speak for my female friends who have been through these difficult situations, one way or another, how our hearts have broken, and how we have worked with them to provide support for whatever decision they made. I have those experiences as well. Why I, and others like me, are motivated as such is because we care for the value of human life. It motivates us to certain actions—how difficult it is to have made a decision to terminate.

Those of us who hold the view regarding the value of human life are required to draw deeply on compassion for those put into a situation, one way or another, where that decision has been made. I have encountered that personally with close friends, through university and up until today. A depth of compassion is required; it is essential, otherwise our arguments either way mean little.

That is the principle. For those who oppose this, it is on the basis of human life. We acknowledge the decision has been made in the parliament but we are compelled to speak. What is the effect of this? I argue that we now have an opportunity to consider how we proceed.

I think the Member for Nelson is correct. In such a matter as this we need to respectfully engage the community. There was a sense this was accelerated and positioned in such a way as to reduce the exposure to the community so no more voices could weigh into it. It should not be a battle of ideology; it should be allowing a very difficult decision to be properly assessed and adjudicated on. Remember we are, in spite of all of this and the alternate positions we have, in a democracy, which will be strengthened if alternate voices are respectfully heard from both sides.

I support the Member for Nelson in encouraging members of government and this Chamber to provide for the opportunity for respectful and more broadly-based engagement by this going to a parliamentary committee.

I respect that if we operate from the basis that this is about human life, and those who have an alternative view, which some might find offensive—I can do nothing else than see that this is about human life. If that is the case, measures should be put in place out of respect for those voices that will never be heard—that we would be able to find a way together to reduce the number of abortions in our community. How could that occur? Through compassion and support, and the offering of alternatives.

How many in this Chamber have seen that magnificent movie *Lion*? How many were moved to tears when they saw the mother reunited with the child? I cannot tell by anyone's response whether they have seen the movie. It was about a mother who lost a child, someone choosing to care for that child through adoption and the reunion of the mother and the child—from Tasmania to India.

These wonderful gifts could be created if we take an approach such as that, if we recognise that there are alternative views. There is the 'choice' position, and there is the 'life' position. Together we could come to a position where there could be greater richness created if we find ways of reducing the number of abortions and provide compassionate support for those who are faced with that difficult decision.

The flow-on benefits would be an increase in the respect for human life. We are dealing with social issues at the moment. If we bring in that deeper consideration of what life is, it would assist us in thinking more carefully about how we manage social issues. If we take the opportunity to value, correctly, freedom of speech, conscience and thought, we increase and strengthen our civil society and give ourselves greater capacity.

I am particularly concerned about—matters that I trust will be debated further—the freedom of speech issue when it comes to safe zones. To me that indicates that there is a sensitivity about this issue, and we will push on and prevent anyone being challenged with the seriousness of the decision they are faced with by removing any alternative voice in that space.

There are already existing laws. If we cannot use them they are effectively meaningless. We must use and value the existing laws rather than remove the freedom within our community. If we cannot manage that we are losing something very serious. That worries me deeply. Use the existing laws, strengthen them but do not remove freedom. Come back to the Chamber if this becomes a social issue. That is a significant loss, a reduction of freedom in our community. The consequences of that are significant.

I am also very concerned about the issue of someone who is a conscientious objector. Not understanding or valuing the nature of that conscientious objection by putting that person into the position where they are required to refer to another is, to me, paying little respect or regard to the nature of conscientious objection—what are they objecting to and on what basis? I am particularly concerned about the effect of this. It would not surprise if, over time, some would take the deliberate action of going to a medical practitioner for the very purpose of creating a problem in this space. It has happened repeatedly and does not stop. I raise that and will be watching, as many will be, to see if that so-called protection of conscientious objection is not exploited for ideological gain, because that has occurred before. I hope it does not happen here. It should not happen if we have due respect for the nature and basis of conscientious objection.

With that said, I have no other position other than acknowledging that this is about human life as far as I and many in our community see it, and we all have an obligation to provide compassionate responses to those who are facing very difficult decisions. The decision has already been made; the laws have already been passed. We have had debates in here before. Those of you who remember the debate about the

Kaden bill—I brought that to this House many years ago, which is probably a subject for another discussion at another time. The fact is there are some implications flowing from this bill that will require attention—freedom of speech and conscience.

Ms MANISON (Deputy Chief Minister): Madam Speaker, I support this bill presented by the Minister for Health with regard to changes to the *Medical Services Act* and the new Termination of Pregnancy Law Reform Act. The legislation removes the outdated section 11 of the *Medical Services Act* and replaces it with this new bill. It also updates sections of the *Criminal Code Act*.

This legislation aims to put Territory women on an equal footing with other Australian women and to modernise an aged and outdated *Medical Services Act* when it comes to access to services for the safe termination of pregnancy.

I cannot believe that it is 2017 and Territory women are in the position they are of not having the same choices as other Australian women when it comes to accessing medical termination of pregnancy, something many women overseas have had the choice of for decades. Surgical options for termination are still confined to hospital settings in the Northern Territory, which is not in line with contemporary practices and puts additional and unnecessary pressures on our hospitals, which are already very busy places.

There are other changes to this bill to ensure that only suitably qualified medical practitioners can perform or supervise terminations, as well as setting up safe access zones for women in the vicinity of where they are accessing a termination. This work will also ensure that terminations are performed in an appropriate setting and in places with access to hospital emergency services if that is required after the procedure. It also covers the areas of conscientious objections for medical staff and placing upper limits on the termination of pregnancy to 23 weeks.

I acknowledge that the government allows a conscience vote on this bill and the nature of its contents. To me it is a very straightforward issue; however, I acknowledge that to other members of this parliament this deeply challenges their religious beliefs, and I respect their views and the important role this parliament plays in ensuring they get a right to express them in debate of this bill, as we have heard.

I have also been very impressed with the respectful level of debate on this issue from both sides of the argument. I thank those who have been involved in the public consultation process and the respectful way in which they have approached this.

I acknowledge that the purpose of this bill is, effectively, to modernise and expand medical services already available to Territory women. Let us be clear, this is not a debate about the issue of women having the right to obtain a termination of pregnancy. That debate occurred a long time ago and women in the Territory have had that choice for a long time now. It is important that the rights of women to make decisions for themselves are upheld and maintained. This debate is about modernising those services so the Territory finally moves in line with other jurisdictions. The Territory systems are outdated and have fallen far behind.

As part of the process to present this bill the Health minister has embarked on an extensive public consultation process, which attracted 142 submissions, a terrific response which has ultimately ensured the best bill is delivered. A range of people voiced their views, including individual and representative views from medical, Aboriginal health and religious sectors, community services, primary health, legal and government agencies, and general members of the public.

It is important to acknowledge that this is the second time in recent history that this parliament has explored modernising these medical services. In the 12th Assembly of the Northern Territory the Member for Goyder brought forward amendments to the *Medical Services Act*, and provided very extensive community debate at that time, for which processes around this bill—it ensured that, with the commitment of this government to look at this issue, we had an informed and engaged group of people across the Territory in relation to this issue.

There is a range of reasons that I support this bill. Firstly, we all know that no woman takes the decision to terminate a pregnancy easily. I thoroughly believe that women in the Territory should have the same rights as women around the country when it comes to the choices they make to terminate a pregnancy, and that is lacking here.

I have taken the time to understand the issues around the termination of pregnancy from a range of women, some for, and some are vastly against. I have also spoken to women about their experiences in obtaining an abortion in the Northern Territory as well as elsewhere. I have had the opportunity to speak to

people who have the capacity to expand surgical options in the Northern Territory for termination of pregnancy outside of hospitals.

The hardest stories I have heard were when people were willing to share their experiences with me of being confronted with the devastating choice, knowing their child would not survive birth. The feedback I have received from those women who have been faced with that unbearable decision was that having choices when dealing with that devastating situation made it a little easier. That is why it is important to have a contemporary and modernised act, so women and families have choices, in the Northern Territory, on access to medical services for termination.

One key component of this bill is in relation to having access to medical termination of pregnancy, which is not currently available in the Territory. This means women can abort an early pregnancy by being prescribed a medical termination drug, commonly referred to as RU486 or MS 2-Step. This is a practice that has been available for decades overseas, and in Australia for the last 10 years. Territory women currently do not have this choice. Territory women wishing to access a medical termination have no choice but to go interstate or procure that drug by other means. This is simply not good enough because it puts a woman's safety at risk, emotionally and physically.

We want to make sure that if a woman undergoes this procedure she is a suitable candidate and has access to the appropriate medical and emotional support she may need. By not allowing access in the Northern Territory, women are put in potentially compromising situations. It is also important to acknowledge that there is a great deal of rigor and appropriate checks to ensure someone is a suitable candidate for a medical abortion.

As the minister said in her second reading:

Women are prescribed MS 2-Step by a medical practitioner who has registered with and completed a TGA-certified training program. MS 2-Step is dispensed by certified pharmacists. The first medication, RU486, is taken by the woman under the supervision of the prescribing medical practitioner or a registered nurse, midwife or Aboriginal health practitioner acting under the direction of the prescribing medical practitioner.

At the moment, in all other Australian jurisdictions the woman may be given the second medication to take at home providing she remains within reasonable proximity to emergency services and has 24-hour access to an emergency department.

The two medications induce termination of pregnancy, which has the same effect as a naturally occurring miscarriage.

There is a suitable number of processes and checks a woman must undergo to procure a medical termination. As the Health minister referred to in her speech, the practitioner must also comply with the relevant legislation, such as the *Therapeutic Goods Act*, certification to use medication and professional guidelines set by organisations such as the Royal College of Obstetricians and Gynaecologists, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in relation to the management of terminations of pregnancy and the performance of early medical termination of pregnancy.

Potential candidates for medical termination will have the appropriate health checks, such as blood tests, ultrasounds and discussions with their medical practitioner. They will be asked questions about where they will be undergoing the procedure to ensure they have a safe place and will be in reasonable proximity to a hospital with 24-hour access.

It is not the case that people turn up to a pharmacy or doctor and walk away procuring the drugs to undergo a medical termination. There is a lot of rigor around this process to ensure a woman is an appropriate candidate for it.

I have full faith in our medical practitioners to do their job. We trust them on all sorts of matters every day. We put our trust in our doctors. They are well trained in this country. They are professional and uphold their profession highly. I have faith they are able to ensure that if a woman chooses to undergo a medical termination, she is an appropriate candidate for it.

Another important component of this bill is allowing for surgical terminations to be performed outside of hospitals, at suitable surgeries. This is a change I cannot believe has taken so long to implement in the Northern Territory. It is a sensible change and is in line with contemporary practices. It will reduce demand

on our hospital systems where these procedures can be performed safely outside of them. This is a practice widely available in other parts of Australia. It should be no different in the Northern Territory.

I am very supportive of the inclusion of safe access zones in the legislation. This is an important component to ensure women seeking termination can safely access the procedure without fear of being intimidated, harassed or interfered with.

I commend the Member for Nightcliff for the leadership she has taken in bringing this bill forward. She has been consultative and thorough, and has allowed people of all walks of life and faiths to put their views across. I thank you, Madam Speaker, for your work in the last term of this parliament to bring forward changes from the cross benches. That is a difficult task when you do not have the resources of a government department to do it.

I pay particular tribute to two people who I first met about this legislation in 2014; they are Robyn Wardle from family planning NT, and Dr Suzanne Belton. They have been very patient. They helped educate and inform me about the processes in the Northern Territory and why we need to modernise access to medical services for the termination of pregnancy.

I pay my respects to those opposed to the legislation for the respectful way they have conducted themselves. I appreciate their passion and faith, and how difficult this bill can be for them.

I thank the Minister for Health and the staff of her department who have worked on this bill. It has been a very thorough process. It will mean the Territory finally puts women on an equal footing with others around the country and the world. It is about time.

Debate suspended.

The Assembly suspended.

TERMINATION OF PREGNANCY LAW REFORM BILL (Serial 15)

Continued from earlier this day

Mr SIEVERS (Brennan): Madam Speaker, I understand that terminations are already legal in the Northern Territory and having the procedure is an enormous decision for any person or family to undertake. I am also aware that the process is subject to some very serious requirements. It is carried out under very restrictive conditions, through many consultative steps, in the care of specialist medical staff.

I am aware that every jurisdiction in Australia has had this medical option, RU486, available for their patients for the past 10 years, and in some places around the world it has been available since the 1980s. Currently it is still not available in the Northern Territory.

I will always support equal rights for women and men. It is a fundamental necessity of society. It is about providing access and equity for all Territorians. It is very clear that these principles are not within the current NT legislation. This new bill will update Territory legislation to provide this fairness and choice for women and men in the Territory. It offers them an alternative and a safer type of treatment.

We live in a democracy, a society with so many cultures, a society that has evolved over thousands of years and during this time medications, medical practices and choice have also evolved. We live in a world where, if you truly believe in democracy and equal rights, then we need to provide choices. We need choices that are safer and provide more options, and that are contemporary, to meet the needs of patients.

I strongly believe Territorians deserve the best medical options and the best healthcare available. We have heard today that the NT is still over 10 years behind the rest of Australia in this medical practice. I have listened to people in my electorate. Some support this bill and some do not; however, I have found that all people are in support of women having choices, being consulted, being treated fairly in today's world and making decisions for themselves.

The new bill takes into consideration many aspects of the patient—the partner, the family and the environment—and is about providing the best medical care and safety for the patient. The bill has also been established in line with current professional standards and evidence-based medical guidelines and

practice. I stand here as a man able to make my own choices, and I support men and women to also have that right of choice in the Territory.

This bill is not about what I want others to do with themselves; it is about giving people the right medical advice and the best medical practice and care, conducted in a safe and supportive environment with contemporary medical options.

Ms PURICK (Goyder): Mr Deputy Speaker, I support this government bill. This debate has been two years in the making. I started to talk about a private member's bill in 2015. In the lead-up to the election in 2016 the Labor Party committed to introducing legislation, which I welcomed, as did many Territorians.

There has been reference made this morning about there not being much consultation. This debate has been on the table for two years. In the time that I did the private member's bill I had consultations, spoke to AMSANT, the Catholic Diocese, the Anglicans, family planning and the Criminal Lawyer's Association. I had meetings with the AMA and discussions with doctors from the Palmerston super clinic, Darwin and Jabiru, and corresponded by email with medical specialists interstate. I also spoke to legal people and the general public. I could have kept going. I did not get to meet with Danila Dilba and many other people I wanted to meet with. I met with some pharmacists; one of whom I have known for a long time, and her family. I also spoke to people interstate about the drug.

To say there was not much consultation is not correct. When Labor got into power it developed the discussion paper. Individual members would have been talking with their constituents, both pro and against what the legislation was trying to achieve.

To say that Aboriginal have not been consulted—that does not wash. You should not be singling out a group of people. Why is no one asking why all the Isolated Children's Parents' Association mothers were not consulted? They are in remote parts of the country. Perhaps they have young daughters who might want to know about these kinds of things. To separate one group out from all the others is not right. There should be consultation across the board—as best you can do.

Somewhere along the way you have to draw a line in the sand and say, 'That is it. I think we have done enough consultation, as best we can.'

I, too, got lots of emails and letters. I have a whole swag from last time, let alone this time. They are mostly polite letters, and I try to reply to them all. I have not received any offensive material, but I know other members in this Chamber have. To hear that some members were threatened with particular activities is appalling. Because government members were taking a particular stance on this they were going to have red paint thrown all over them. I heard that this came from a professionally-qualified person, which is worse in my view. Thankfully that has not happened, and I do not expect that kind of stuff to be there in today's society; it should not be there.

The bill has come about because for too long women in the Territory have been left waiting for fairness and equity. For too long women have been dictated to by people who have no interest in their personal and mental wellbeing. For too long women have had decisions made about them by people who will never have, and never will, become pregnant through rape, incest or failed contraception.

The bill before the parliament is not about me. It is not about any of the members in this Chamber. It is about the women of the Territory, their rights and our role in the community. This bill is not about abortion; in some ways it is not even about providing women alternate options for termination of pregnancy. This bill is about pro-choice—giving women the choice.

When a woman is considering whether to terminate her pregnancy I am sure there is much soul searching, anguish, pain, regret and, perhaps, doubt. No woman takes the decision lightly. For there to be a suggestion that a woman has an abortion because that is the thing currently on the fashionable list is outrageous. I have not had an abortion or a child, but I know women who have had an abortion. It is not easy, fun or pleasant. It will be a part of a woman's internal makeup and leave an indelible mark on her soul, I am sure.

It makes not a difference to me whether a woman chooses to continue her pregnancy or end it. It is none of my business or anyone else's in this Chamber. What I care about is that it is the woman who decides. In making that decision she must have a full and proper range of services available. That is not the case at the moment, but hopefully it will be by the end of this week.

Women are currently forced to make a decision or do not have the availability to make an informed decision because the legislation does not allow it to occur. This will now change. The content of the decision matters only to the woman and her loved ones, but the act of making that decision and exercising moral choice is something we all have a real interest in defending, so you should all be defending it.

This is about women and a choice being taken by an individual over a key aspect of her life and future. There is a phrase for that: moral autonomy. Territory women should have moral autonomy, and currently they do not. This bill is about Territory women. As elected members of this parliament I am hopeful that all members will support this bill.

Fifty per cent, give or take, of people in my electorate are women. Agreed, not all women support this bill, but I know from the work I have been doing and the feedback I have received from women and men in this House and the community that a vast majority of Territory women do support this bill, regardless of whether they would choose to terminate a pregnancy or not.

Throughout this debate people have focused on a range of matters associated with the bill, which are credible or simply inaccurate. Some have focused on the evils of the medication. That is a view they hold and that is okay for them, even if they are not correct. This medication has been approved for use around the world. There are factual guides on many websites, from medical people to research agencies and universities, that show the medication used for this procedure is considered safe by the medical world.

As I and other members have mentioned in this parliament, when I introduced this bill and today, it is listed on the World Health Organization's essential medicines for developing countries, because women in those countries often do not have access to surgical abortions. That would not occur if there was a doubt as to its safety and efficacy.

Only recently I was sent a document by one of the people who have been helping me, called *Australian Doctor*, which cites new Australian research into medical abortions. The original research was published in the *Australian and New Zealand Journal of Obstetrics and Gynaecology* on Friday 17 March, just last week. It says medical abortion using RU486 drugs is effective and safe for termination of pregnancies up to 62 days gestation, data from the Australian clinics show. A review of outcomes for 13 000 women who attended the 16 Marie Stopes international clinics between 2013 and 2015 found medical abortion was successful in 95% of cases. Medical termination involved in-clinic administration of 200 mg of the oral first drug, followed by 800 ug of the second drug self-administered at home 24 to 48 hours later.

There can be issues with any medication you take—there could be side effects—even Panadol. The Member for Katherine talked about medications that calm people down and put them to sleep; they have associated risks. There are risks associated with giving medication to young children who have bad acne; that can create problems.

The most common complication was incomplete abortion requiring surgical intervention—4.8%. Continuing pregnancy—0.76%—was rare as was infection—0.11% and haemorrhage—0.13%. The safety and efficacy data for these drugs as used in Australia was similar to rates seen in international studies.

These are doctors and medical people saying it is safe to administer to women.

Some people have focused on the health of women and how they will die a horrible death. Some have attempted to muddle the matter with unrelated matters such as Aboriginal health workers and their role in administering the medication, which will not happen as they are not medical practitioners. Some have genuine concerns and objections on religious grounds and for right to life reasons. I respect those views and their positions. It is an emotive and sensitive matter, and that should never be underestimated.

Some have suggested that a black market in the medication will evolve. That is also not correct. RU486 is subject to strict licensing requirements under the Therapeutic Goods Administration. One of those requirements is that only certain doctors can prescribe RU486, not all general GPs, and certainly not Aboriginal health practitioners, on any qualification, in remote areas.

This bill and the subsequent guidelines will fully detail requirements for people who are qualified to administer this medication. Only suitably qualified medical practitioners can legally prescribe the medication, which is detailed in the legislation. I will read out what is considered to be a suitably qualified doctor. This came from Dr Jacqueline Murdoch's paper, which she gave to me previously. She is in the gallery. She has been a great help. Thank you, Dr Jacqui. It details exactly what is required. This suitably qualified person is:

Specialist gynaecologist, GPs who have completed a Diploma in Obstetrics and Gynaecology—a 12-month qualification, GPs who have completed the accredited training program that covers eligibility, administration, side effect and complications and registered as a certified prescriber with the manufacturer. RU486 also can only be dispensed by registered pharmacists.

So I do not believe it will ever get into any would-be black market. That is rubbish.

Some people think that the proposed 'one doctor' is wrong, that there must be two. No other medical intervention requires two doctors, not heart surgery, cancer treatment, chopping off limbs, transplants, cosmetic surgery ...

Ms Nelson: Or a vasectomy.

Ms PURICK: Nor a vasectomy. Thank you, Member for Katherine.

Multiple doctors may be involved in an operation, but it is only one doctor who says, 'Yes, you might need that medication or operation'.

There are no laws setting out what doctors can do where. The law is silent on when a premature baby can go home, where a person can receive dialysis, and whether you should fly in an aeroplane after certain operations. It is the doctors who make the assessments and judgment calls, based on clinical guidelines, not the law books. Doctors make medical judgment calls every day across the Territory.

Doctors in remote WA and Queensland make medical calls every day, including for termination of pregnancy, at times using RU486 medication. In my view, no self-respecting doctor, professionally trained, qualified and holding a Hippocratic Oath—old or modern version—would put a woman's health at risk. When treating a female, it is about her health and wellbeing, not the doctor's. I think most of them know that, and that is how they operate.

The Northern Territory is not special; we are just behind the rest of the country. That needs to change, and it will change. Territory women deserve the same rights as every other Australian woman.

I place on the record the names of the people who have helped me get to the position I have today. Some of them are in the gallery, and I thank them for their support: Aditi Srinivas; Suzanne Belton; Nikki Lane; Sally Bolton; Robyn Wardle; and Jacqueline Murdoch. Thank you for your help, advice and guidance. It has made it all happen. Without you I would not know as much as I know now. My family thinks I am a smart alec, but that is good. They have been enlightened, as well, that this is not the morning after pill; it is completely separate. I had to tell someone today that this debate is not about abortion; it is not about the morning after pill; it is about giving Territory women choice if they are placed in the position of wanting to terminate a pregnancy. It is not something that is off the shelf.

This is about putting Territory women on the same footing, rights wise, as all other Australian women.

Mrs WORDEN (Sanderson): Mr Deputy Speaker, I have said before, as others have, that we are not having a debate on whether abortion is legal. It is a fact that Northern Territory women can seek an abortion with appropriate support and medical assessments. We cannot allow this to be dragged out time and time again. It is an important matter to many people, but the time for that debate has passed.

We are here to discuss and vote on whether Territory women have the right to access medication that can terminate a pregnancy, whether a Territory woman should have to continue to have a surgical intervention or go interstate when she has chosen to terminate a pregnancy, and whether women in the Territory can have the same rights as women in every other state and territory of Australia, and, for that matter, in other places, such as the United Kingdom and the USA.

As far back as 2008, in the United States 17% of terminations were early medical terminations; that is how far back it goes. Currently in England termination of pregnancy is legal up to 24 weeks, and up to 55% of terminations are carried out medically. We are very behind.

We are here to discuss and vote on whether we introduce a new Territory law to allow the same rights enjoyed by women all over the world—the termination of pregnancy by medication, which includes the drug RU486. This debate has been going on in Australia for some 10 years and across the globe for some 20 years.

There is no doubt it is a very difficult time both politically and socially. Whilst the last few months of consultation have been challenging for us all, I believe the consultation on this bill has been wide ranging and respectful of both points of view. I have enjoyed the fact that the people who have chosen to speak to me in person—some of them are here today—have listened and been non-judgmental about my conclusions. I thank them for that.

In Sanderson I spoke to a broad representation of women from across the multicultural spectrum and across a wide range of age brackets. I have called for opinions through my newsletter and met with people one on one. I have spoken to people at mobile offices, pizza afternoons and community barbecues. There is a resounding voice: Territory women want the same rights as other Australian women.

I have come to the conclusion that we are not in this House today to represent ourselves. This is a serious issue that requires us to walk outside ourselves, even if for just a moment, and our own opinions, and represent the will of the people we represent.

In some ways if this was a decision I was taking on personal grounds I may have found my decision a little more challenging, but I am not here for me today. I am here for all Territory women, particularly the women who live in my electorate of Sanderson, women who this change of law will affect, women who are of child-bearing age and women of the future.

There are many reasons a woman may consider termination of a pregnancy. She may feel she is trapped or she cannot give a child the home or life it requires to thrive; she may be facing difficult medical or personal circumstances. Who are we to judge what those reasons are? We should be more concerned that she has access to a range of options and is supported in her decision-making. That is by far and away the more human thing to do.

The current system already supports this approach, but it does not cater for all women, particularly those outside major centres. It does not cater for nurses and other women and their need for privacy at a difficult time.

Being a woman carries with it the burden and job of many things, none greater than, in my opinion, bringing into the world our next generation. In my case I have much to be grateful for, but during my time I have had several circumstances where the option to terminate has not only been put on the table but encouraged by those around me. I feel that it is an important day today to put on the record those circumstances so those reading this later can fully understand why I made my decision today.

I have brought into this world three beautiful girls, and now they have brought into the world four equally amazing grandchildren. I am very lucky. As I have said before in this House, I was a mother of two girls by the time I was 19. I was pregnant at 17, a stereotypical teenager, I think I was called this morning by the Member for Drysdale. Thank you. I was pregnant again nine months later.

In both pregnancies I was encouraged by doctors and some family members to have a termination. In the first instance I was unwell with a kidney infection in a remote part of the Territory. I was provided drugs for treatment not realising nor advised that I could get pregnant. I returned to Adelaide and went to a doctor, and as I continued to be sick I was asked for the first time whether there was a chance I was pregnant. I did the test and was probably at that time at least 20 weeks pregnant. I was in shock and walked out crying, and then was faced with—underscored, in bold—options.

Lots of people told me that it would be easier not to have the baby. I clearly said no, and now my 30 year-old daughter is probably very grateful for that decision. Looking back now I understand how many people would have stared at me in the street. I did look like a child carrying a child, but I have no regrets.

Again, nine months later, faced with the decision to be a young mum and have to care for two small children, I again contemplated my choices. Again, I chose to keep my baby and, again, I have no regrets. But I made my own decisions and would I change them if had my time over? No, my children are my greatest joy.

I have also experienced my greatest pain, and that is the loss of a child. Time never heals that pain. My husband and I wanted another child together. It was not to be so. I miscarried four children before the birth of our youngest daughter and then, seemingly miraculously, I carried a baby boy, who seemed like a great gift. Early on there were issues and he was diagnosed with Trisomy18, which is quite a rare condition, often presenting with very severe mental and physical deformities. It is condition that is most often fatal. Studies

have shown that only 50% of babies carried to term will be born alive. Baby girls have a higher rate of live births than baby boys.

I was well-supported in my pregnancy here in the Territory, and as part of the process I was again offered the option of surgical termination, which again was refused. I became resolute. A gift was a gift. At just over 21 weeks my child made that decision for himself. I have always been glad that I did not choose a termination. I was happy with my choice. I know that many women in my position would have chosen another path, and that is okay. I know that because they have told me so.

Of course, the mere thought of raising a very disabled child kept me awake at night—the thought of facing that and what it meant for my family, my child at home, my job, our home. It was unfathomable but I had options, a choice, and I made it. Other women should have their choice. If that choice can provide more privacy and a non-invasive procedure then I support that.

When I think of one of my own girls having to make such a decision, and one day they may, I want them to know the choices they have are safe and they will be supported through the process. Today's decision does not take this away from them. It provides a further, non-invasive, safe option. It is very hard for me to stand here today and not say yes to this legislation.

If I had my time again would I make the same decisions? Absolutely, yes. Would the availability of nonsurgical termination change my mind? Absolutely not. But that is me, and I am not here representing me. I am representing Territory women, who are equal to any other woman on the planet. Women do not make decisions to terminate a pregnancy for reasons of convenience. I find that suggestion very offensive.

I have come to the conclusion that this is simply another option. It is a safe one. It is not one I may choose, but it does not take away the right of a surgical procedure or the right to keep your baby. It just allows women a further choice in terminating a pregnancy, a right they already have. It is simply about choice.

I am convinced, given the following circumstances that support legislation, that this law should pass. We have heard that medical practitioners will have special qualifications and experience. Women will still have appropriate health checks and will be supported in their decision-making. Doctors must follow medical guidelines. Drugs can be provided by nurses, midwives, Aboriginal practitioners and pharmacists under the direction of a specially-trained doctor. Women must also be close to a hospital emergency department so she can seek quick treatment if there are complications.

There is a very broad-ranging debate with plenty of viewpoints, from Christian views to pro-choice and beyond. We have heard them all. I stand with the Member for Namatjira in regard to one issue he raised earlier, which I also picked up in the information circulated to us. There is one piece of propaganda that I have heard over the last few weeks, which is that this legislation may be used by social engineers who wish to control the Indigenous population because of the rising cost of Aboriginal welfare. I find this notion completely abhorrent.

I have been told firsthand and over many years that many Indigenous women have wanted to not have children, but due to requirements to present in hospitals, often face difficult travel arrangements, the shame associated with a lack of privacy and an element of fear, they most often have the baby. Is this not an injustice in itself? Is this not denying Indigenous women the same rights and access as non-Indigenous women? This is a law that will bring them on to an equal footing, and allow them, in safe circumstances, to have choices. I have considerable disgust at such a suggestion.

It is time we stepped into the light and came into line with contemporary thinking. We are not talking about an ill-thought-out law. We are talking about one that has included expert opinion and has the support of the medical profession and women. We are the ones affected. We are the ones who should make this decision. The presence of so many women in this parliament gives me great faith that this will occur today.

I commend the bill to the House.

Ms WAKEFIELD (Territory Families): Mr Deputy Speaker, I support this bill, which will repeal and replace section 11 of the *Medical Services Act*, which currently deals with the termination of pregnancy in the Northern Territory. I also support the consequential amendments to the *Criminal Code Act*, which will decriminalise terminations performed by health practitioners with relevant qualifications. I also support the provision for non-surgical medical termination.

Whilst I appreciate the need for a conscience vote on this issue, I was elected to represent the people of Braintree. I have received significant correspondence; however, the majority has not been from my electorate. Prior to the election I was clear that I supported equal healthcare access for Northern Territory women. Since my election the majority of people who have raised this issue with me have also supported this reform we are debating today.

I respectfully acknowledge that there will be people in Braintree who have strong views against the termination of pregnancy. I personally made a decision a long time ago that a termination of pregnancy would not be an option for me. It is a decision that is deeply personal, and I do not believe I have the right to impose that choice on anyone else. It is my individual choice, based on my life and my privilege. Every other woman has the right to make her own personal choice.

It is one of the great joys that through my professional and personal life I have met a great number of extraordinary and diverse people from all walks of life. I have had the privilege, as a professional social worker in medical and crisis settings, to support people through extremely difficult and complex decision-making, including whether or not to have a termination.

I have had personal, intimate conversations with thousands of people in my 28 years in the social services. The biggest lesson I have taken from this experience is that life is rarely a straight line. Life is unexpected, messy and complex. Every person's story is unique. One of the great honours of my profession is to witness people make the best decisions they can on a range of difficult issues.

Termination of pregnancy is no different. Therefore, I think as parliamentarians our role is to provide a legislative framework that provides people with the ability to make the decisions that are best for their life and set of circumstances.

I have known many women who have chosen to have a termination and many who have chosen to keep an unplanned child. Some women have found the decision easy and straightforward and some have found it difficult. There is no formula we can place into this legislation that will support the decision-making process for the number of individuals it impacts. This is why we need to empower health professionals to use their skills every day in supporting people to make a range of complex decisions about their healthcare.

Every day, health professionals ensure people have the right information to reach the threshold of informed consent and have access to the least intrusive and risky option for their individual medical situation. As someone who has worked in hospitals and medical settings for a long period of time, I am confident that these processes are currently in place, they already work well and they have been well tested over long periods of time. I am confident this bill does not need further safeguards.

I want to make comment on safe zones. In the 1990s I walked past an anti-choice protest outside an abortion clinic every morning on my way to work. On several occasions I had to physically intervene to support women trying to run the gauntlet. This is unacceptable. If we are to respect people's choices we cannot accept that complete strangers have the right to intimidate and harass someone who is trying to access a completely legal medical procedure. The right to protest is protected in this legislation, and I commend the Attorney-General for including a safety zone.

I believe every Territory woman has the right to access the most safe and effective medical treatment available. This bill allows Territory women to access a well-tested drug, modernises legislation to support health professionals with increased clarity and provides safe access to services.

I commend this legislation to the House.

Mr COLLINS (Fong Lim): Madam Speaker, I do not intend to speak for long today, not out of disrespect for the issue, quite the opposite.

I have watched, over many years, how male-dominated legislatures around the world have made decisions about women's rights. Things are improving and we in the Territory lead the way in some ways. Twelve of our 25 members in this Chamber are women. Both the government and the opposition have 50% women representatives, and there are five women in a Cabinet of eight. Congratulations to all of you. We have a lot to be proud of in the Territory.

Despite these great advances, though, we lag in certain areas. The passage of this bill today will correct one of those. I indicate my support for the passage of this bill and signal categorically my support for women's rights generally and, in particular, their rights with regard to reproductive issues.

As a man, I take counsel on the issue of women's rights from the inspiring women in my life—my family, my friends, some of whom are in the gallery, and my colleagues. As the Member for Namatjira quite correctly said earlier, as men we are never truly able to empathise with women and the choices they are at times forced to make with regard to their own bodies. We can sympathise and provide support, but we cannot truly empathise.

I have four children, three of whom are women or girls. My eldest, Alyssa, is a medic in the Royal Australian Air Force and a qualified registered nurse. Alyssa and I have discussed this bill and I am well aware of her complete support for it and the issues it encompasses. My two youngest, Sophie and Eloise—enjoying cake next door at the moment—are too young to comprehend the nuisances of the debate; however, I am comfortable supporting this legislation so that in future, should they find themselves in the unfortunate circumstance of having to access the provisions of this bill, like women in every other state and territory, the option will be available to them.

Make no mistake, no one who supports this legislation thinks a woman's decision or need to access the provisions of this bill will be done lightly. The decision will always be an incredibly difficult one for the woman involved, as we have heard clearly from my friend, the Member for Katherine. I congratulate her on her courage and openness.

Like other members of this Assembly, I have received a large amount of correspondence imploring me not to support the bill. Not one of these emails or letters has come from a resident of my electorate, and the vast majority of them have come from people who do not even live in the Northern Territory. They live in states or territories where women already have access to the medical services provided by this bill.

I acknowledge Daly Kelly, a friend of mine who is a resident of my electorate of Fong Lim. Mr Kelly approached me recently and indicated that, following some consideration, he did not think he could support the bill. We had a very respectful conversation, and I thank Daly, not only for his opinion but also for taking the time to make me aware of it. Apart from Mr Kelly, the other residents of Fong Lim who have taken the time to contact me have encouraged me to support the bill.

I am satisfied that the consultative process undertaken by the Minister for Health with regard to the consideration of the bill was both extensive and appropriate in the circumstances. More importantly, I am satisfied that the relevant debate has been around long enough that there is no need to extend the consultative or review process any further, as requested by the Member for Nelson. In this regard, I acknowledge your efforts, Madam Speaker, in the 12th Assembly, and congratulate you on your leadership in this area.

Purely and simply, this bill is about access to medical services; it is not about opening the door to termination of pregnancies. As we have heard, that debate was determined a long time ago. This bill is about providing Territory women with the same access to medical services every other woman in Australia already has access to. This bill provides for equity, and for that reason alone I would support it. But in the end, I support this bill because it provides support for women to make their own decisions about their own bodies, as personally difficult as they may be in the circumstances. It is way beyond the time when women should be given the rights they have always deserved.

Madam Speaker, I commend the bill to the Assembly and I will be supporting its passage as it stands.

Ms AH KIT (Karama): Madam Speaker, I am grateful to be afforded the opportunity to speak about this important and sensitive topic, the reform of termination of pregnancy legislation. This legislation was introduced by my colleague, the Minister for Health, to provide access to terminate a pregnancy outside a hospital setting. This access is already afforded to other Australian women.

We are not here today to debate whether termination of pregnancy should occur. We are debating whether or not to allow women greater access to a medical termination. I have weighed up the pros and cons of this legislation, and I have spoken to constituents and community and religious groups about this. I found the entire process to be quite challenging because of the sensitivity surrounding this topic and the passion displayed by all those I spoke to.

I thank everyone who contacted me to put forward their viewpoints on this proposed legislation, especially those in my electorate who took time out of their busy schedules to meet with me and share their stories. Each story I was privileged to have shared with me was full of emotion and lessons. I would like to share a few today.

During a doorknock I spoke to a woman who is alive today because her mother's two attempts to abort her failed. This woman told me she is not supportive of abortion and is glad to have survived the two attempts on her life. She is grateful to have a legacy to leave behind in the form of her own child. This woman went on to become an advocate for the rights of the unborn. She even offered to adopt a child if the mother felt she could not cope after giving birth. I thank this strong woman for paying it forward and using her experience to help benefit others.

I was fortunate enough to speak with a range of community members about their thoughts on the proposed legislation as well. Two of the key lines from these conversation were along the lines of, 'Pregnancy is women's business so it should be left up to the woman to decide about issues relating to her sexual reproduction'. The second was, 'The NT is so far behind. It is unbelievable that in 2017 access to RU486 has not already been made available.'

It was great to have people from both sides of the debate speak candidly with me about their stance. From these conversations there were a number of common themes that arose, including the need for additional support to be provided to pregnant women at the beginning of their pregnancy and following termination, as well as the need for more safe sex education to be provided to young Territorians. I agree wholeheartedly with both of these things. We can always do more in this space to support Territorians.

This proposed legislation amendment will provide access to a safe option for the termination of pregnancy for women in the NT. It will also provide more privacy for a woman to undertake a termination of pregnancy in the comfort of her own home instead of in a hospital setting. The NT is a small place, and privacy cannot always be afforded. I worry that it may not be possible to receive medical treatment inside one of our great hospitals without others finding out.

We live in the digital age in which people have to ask their friends and family to not post on social media about their business, so they can contact those closest to them to advise them firsthand. It is sad to have to worry about your personal business finding its way out into the open, especially at a time when stress and anxiety is often heightened. This should not happen, but sadly it does.

I cannot help but worry about the mental state of a woman who finds out she is pregnant. I worry if this woman has someone she can talk to about this. I worry if this woman knows and understands her options for termination or adoption. I worry if she feels supported to make the best decision for her. I am pleased to see these questions have been considered in the legislation, and that women will continue to have access to counselling and other services. I am also pleased to see that medical best practice will support women in this process and allow them to make the best decision, one that suits them.

Pregnancy is not an issue taken lightly, nor is the termination of pregnancy. I know this because I was 19 years old. I was alone. I was pregnant. I was scared. I chose to terminate my pregnancy. I felt it was the best decision for me, and I wish I had access to RU486 back then. I make no apologies for my life or my choices, and I do not expect others to either.

I thank my parliamentary colleagues for contributing to this debate, especially the Member for Katherine for her strength today. I thank you, Madam Speaker, for your hard work on this important issue.

In closing, I support this bill and I thank the Minister for Health for bringing this important piece of legislation before the House.

Mr GUYULA (Nhulunbuy): Madam Speaker, this bill is a difficult matter for me to deal with as I am a male. In Yolngu law, which most of my electorate remains subject to, men are not to interfere with the governance of pregnancy. Pregnancy is the symbolic power base by which women in my society demand and have political equality. Men and women decision makers meet at a level of Dhuni. That is why I have engaged in Dhuni forums to consult around this matter.

With the short time frame pursued for this bill I have only been able to receive formal feedback from one women's Dhuni forum. They met independently in February. Before I talk about their position I must tell you a little about Yolngu society.

To us, sex is like a ritual or relational commitment. Traditional marriage happens with agreement between families and with consummation. This is a mutual agreement and consummation is by consent only. It is not by force. This connection between sex and committed relationships means sex cannot be a free thing without education and discipline.

Yolngu relationships also do not support the promiscuous behaviour often represented in Anglo or western culture. Promiscuity is a behaviour introduced into Yolngu society, and it badly affects our otherwise closed and caring kinship structure.

I believe this structure, this cultural outlook, is the background to the women's forum's resistance to medical abortion. The women do not want more availability of abortion. They do not want to encourage the philosophy of free sex. They want to promote the knowledge that sex needs to be respectful, caring and responsible to the closed relationship it promotes.

Plainly, sex should also be treated with respect because it is also, by nature, about human reproduction. Yolgnu leadership takes this matter seriously. The integrity of our society depends on it. Dhuwa and Yirritjam and Yothu Yindi separations of governing powers depend on restrictions on the people we can have sexual relationships with.

The strength of our madayin ringitj alliance connecting Yapa, Mari with the related clan alliances that protect the territorial and governing integrity of our estates also depend on good marriages. Even our genetic integrity depends on our proper flow of genes, which depends on marriage between proper kin. There is an advantage for a child who is born through the right skin, right kinship and clan relationships. He or she will be endowed with spiritual marr, or power. They will be strong in their integrity and have the world open to them in terms of clear rights.

The women's forum did not want to expand the availability of abortion because it could promote promiscuity and wreck our good marriage culture. Most strongly, the women's forum did not support abortion at all. Abortion is not really required in our society; this is because a child born in any circumstances can be adopted into an appropriate family, even in cases where people have a sexual relationship with the wrong kin. Shame is not on the child. Instead, they are placed into a family with the right kin relationships.

For example, in the past if a Dhuwa had a sexual relationship with another Dhuwa person, which is incest and illegal, the man might have been judicially killed, leaving the child to be adopted by a Yirritja man, which is correct. Today we do not judicially kill; however, the children continue to be adopted into right kin relationships.

Nonetheless, it was identified by a women's group that some situations might arise where abortion is used by some. In those cases they prefer this happens away from community, prying eyes and potential offensive situations where a person is recovering from the process within a crowded family housing situation.

The forum also identified concerns about supervision of medical abortion, which was not an issue with surgical abortion. The Yolngu experience of surgical abortion is that it happens in a hospital with recovery also happening in the hospital. Medical abortion, as so far discussed, is being presented as happening around community medical clinics, and the miscarriage and recovery happening at home.

The forum was also concerned that children might be able to access an abortion without parental consent. The expectation of Yolngu leadership is that they are involved in such decision-making for a juvenile.

I quote the independent consultation notes. 'For young people in this situation, in Yolngu culture, any female relatives are able and should be involved in providing care and guidance.'

There was discussion about how the family members' responsibility for their children is important and involves providing support and encouragement, talking to them about these issues, providing education and caring for and looking after one another.

For issues such as pregnancy and childbirth, or how many children a couple will have, we have a responsibility within our family to talk about this. These responsibilities do not end when someone reaches 16 or 18 years old. This involvement continues in adult children's lives.

Motives for medical abortion technology was also raised as a concern. Is it an attempt to lower Indigenous birth rates? If it is not, will it be used in this way by individual hospital or clinic staff? This probably sounds excessive to an outsider, but since the intervention we have heard and experienced all sorts of racist things. The women's forum ended with an agreed suggestion that it would be better to give a group like the independent group of female elders funds to run a program with a reproductive education and discipline focus to prevent young people getting pregnant.

These were results from one community's Dhuni women's forum in my electorate. I will not feel informed until another two communities can also provide feedback. I have received no other formal communication from my electorate. The bill was not raised by members of my electorate at the community forum in Nhulunbuy two weeks ago. There has been some weary and non-committal feedback towards the bill from individual health workers but nothing formal to me.

The end point is that I require more time to properly consult my electorate. I will vote no if the question is put during this sitting period, based on the formal feedback I have received.

Mr McCARTHY (Housing and Community Development): Madam Speaker, I thank the Attorney-General for the respect she has afforded all Caucus members in regard to this legislation. I acknowledge the Chief Minister for his leadership and for supporting a conscience vote on this legislation. I acknowledge the Member for Nelson, a man of great faith and courage. I am in admiration of that in an abstract way that is not best expressed in this House.

My position on this was firmly stated in the 12th Assembly when I contributed to the debate. I used two very personal and emotional stories to tell the parliament and the constituency about the challenges of health services in regional and remote areas. These two stories did not really resonate with the intellect of the political commentators, nor many of my Labor Party colleagues. It was stereotyped into the grieving father and family of a stillborn son. Three weeks later my three-year-old son was burnt, with full thickness burns to 40% of his body.

That time in the parliament, the sharing of those personal stories, related to a young family in Borroloola which had to manage critical medical incidents with no services. It was as simple as that, but it did not resonate with the intellect of the political commentators nor many of my colleagues.

It is worth repeating, and mentioning one of the most courageous and strong women I know, my wife, Dawn McCarthy, who managed the family as well as her own personal situation through both of those events. She was the most qualified in terms of burn survivor of rehabilitation and recovery in the Territory, acknowledged by the Northern Territory Health Department, who put their hands up and said, 'Just go anywhere you want because we cannot deal with this'.

It was not so much about the emergency. It was about the rehabilitation and recovery, and a family returning into a regional remote area with no wraparound health services. That is what those stories were about.

We are survivors. Simon Peter did not survive, but Joseph McCarthy certainly did, and I challenge anyone to take him on. We had to survive. My point is that this legislation puts vulnerable Territorians in regional and remote areas at risk; it is as simple as that. I divorced myself from my faith, personal opinions and any attack on women's rights. I have said before and I say again, I had to form a clear position, so I took the position of a Territory legislator, something I take very strongly.

In this round, where this legislation has returned, it is quite obvious it will pass; it has the numbers. So I had to prepare my position and put that position to the constituency I represent. I prepared a statement and published it, and I stand by it as the Member for Barkly representing Territorians who live in some of the most remote parts of not only the Northern Territory but of the country.

As a Northern Territory legislator I hold enormous responsibility for making sure our laws are fair, just, equal and right. As the Member for Barkly I represent approximately 7000 constituents governed by Northern Territory laws.

The Michael Gunner Labor government's planned amendments to the *Medical Services Act* impact significantly on the termination of pregnancy law. Currently women can terminate a pregnancy at the Royal Darwin Hospital, the Darwin Private Hospital or the Alice Springs Hospital by surgical procedure. In February 2017 the Minister for Health, Hon Natasha Fyles, introduced a bill adding a new law about how women can access termination of pregnancy services. The new law will allow termination of pregnancy by medication, the drug RU486, made available from an approved medical centre, health centre or hospital.

The new law allows for pregnancies to be terminated up to 23 weeks; however, advice provided stated that pregnancies from nine weeks to 23 weeks could only occur in Darwin or Alice Springs hospital settings due to the considerable risks and possible emergency surgery requirements. The law states that a doctor who administers RU486 must have special qualifications and experience; however, the drug can be dispensed at a health centre or at a woman's home.

The Therapeutic Goods Administration sets strict rules where medications are only available through a specially-trained doctor's prescription and that nurse, midwives, Aboriginal health practitioners and pharmacists can only give RU486 to women under the direction of a trained doctor.

Department of Health officials state that if a woman chooses a termination of pregnancy by RU486 at home, she must be within two hours' travel time of a recognised hospital emergency department for surgical treatment of possible life-threatening complications. Department of Health officials advised that in a formal briefing. The Department of Health officials advised that while the legislation provides for widespread use across the Territory, there was little chance regional or remote women would access RU486 as the risks were too great, appropriate medical services were not available and establishing a service model would take decades.

As a local member forming a position on this new law, I sought comprehensive briefings from medical experts, legal practitioners, remote health staff and constituents as the Department of Health's consultation focused more on the large allied health organisations. Using Ali Curung and Jilkminggan as community studies, within two hours of a hospital, I have serious concerns about the health and safety of regional and remote women being prescribed RU486 in the absence of appropriate critical healthcare services, psychosocial allied health support—and privacy within their own home.

It was clear from health professionals, including the minister's staff, that RU486 would not be administered in regional and remote areas and that the Tennant Creek hospital was deemed inadequate—inadequate surgical services necessary for providing safeguards for women experiencing complications.

Therefore the law is effectively discriminatory, as it supports Territory women in cities and major towns yet provides uncertainty and critical risk for those living in regional and remote areas. Discriminatory law is bad law, and unsubstantiated claims about health services improving in the regions to support the use of RU486 in the future reflects politicians passing new laws before minimum standards are met.

The Northern Territory parliament will decide the law in March; however, I view the legislation as being more about political agendas than improved health services, and I will not support it. It has been interesting to listen to the debate in this House where learned colleagues are using the words 'modernised' and 'expanding medical services'. I bring people's attention to the fact that the 'modernising' and 'expanding medical services' is for some Northern Territory women. As a legislator I take this very seriously. Other members who have joined this House should seriously think about legislation, its implications and its application.

This is a serious business that we are tasked with. It is a great responsibility, and I have certainly tried my best to come to terms with this legislation, but as I have told the constituency I represent as the Member for Barkly, I cannot guarantee any certainty around this law in this parliament because, essentially, it will not include the majority of the constituency I represent, which was made very clear by the Health department.

It is also important to share in this House that I travelled to remote clinics and tried to engage the clinicians on this. There was a very common caring and sharing approach to their responses, because it was quite challenging. Remember the definition of 'politician' and 'bureaucracy'—people were guarded. To give you a summary of what remote clinicians said, many of them said, 'We are on the front line of acute care. We are battling some of the most challenging health issues on this planet. We cannot support this drug and we are not confident in the support of women in regional and remote areas who use this drug.'

It was as simple as that. It was a very professional approach to my question and the debate. I took that on board. It is hard on the frontier and anybody who goes there—anybody who has done real consultation with the Department of Health in the Northern Territory and had the facts put to them that if you are a representative of a regional and remote area, this will not apply to your constituents because it is too high risk. There are too many risks to the health and the safety of the woman.

I do not see that this has improved since the last time it was debated in this House. I do not see that we have anything more than a promise that, over the next two decades, we will improve surgical services across regional and remote areas that will address any complications from the use of this drug that could be life-threatening.

I will also make a quick comment about hate mail. There have been discussions about members in this House who support this amendment to the *Medical Services Act* and the criticisms and mail they have been attracting. If you do not support this you receive your fair share of hate mail too. I have dealt with my fair share.

I want to make comment on piece of correspondence that I found deplorable. I received it over social media. I was in Ali Curung. Just think about Ali Curung. Visualise the community of Ali Curung, where this government is now entering a 10-year plan to try to turn around the conditions and disadvantages. In housing alone, think of the overcrowding and the amenity of those houses, the position the women of Ali Curung are living in and our government's plan to try to address that.

I was at Ali Curung's art centre, of all places, and there was a workshop about foetal alcohol spectrum disorder. The students at that workshop were eight young dads. I was invited to that workshop, so I shared in a male space with eight young dads who were being educated about foetal alcohol spectrum disorder and foetal alcohol syndrome. Then I received this hate mail over social media, saying, 'How dare you? How dare you participate in anything like that when you will not get up in parliament and support the amendment to the *Medical Services Act*?'

I found that despicable. It was not the right time or place. It resonated with me. It showed me some of the negative elements of our society and community that we need to work on. Those young men completed that workshop. We left there knowing a lot more about foetal alcohol spectrum disorder and foetal alcohol syndrome, particularly regarding our responsibilities as males. That was the most important lesson from the workshop that day.

I cannot really find a way through this to support the Attorney-General and the government. I have completely separated my personal beliefs and position, and focused on our responsibility as legislators. I honestly believe this bill will pass. I know for a fact that the regional and remote women and constituents I represent will not have access to this drug. It simply will not be provided because, let us face it, it is too dangerous in the circumstances they reside in. I also understand that if they need to access services then they can access them in Alice Springs or Darwin.

As the inconvenience it may provide—it is the only safe place to be. I am not denying women of the Barkly their rights, but I am clearly saying, as a legislator, as your elected member, as your representative, I cannot guarantee your safety and security. I cannot support you being ignored, neglected or discriminated against in this legislation, this generic approach to all women of the Territory—it is clearly not.

I leave this House today with my position set in this debate for a second time. I leave this House today with my concerns regarding the constituency I represent. The last time I spoke on this issue I also raised another concern, a great concern that has come to me in my electorate in regard to traditional cultural context around stillborn babies and the number of babies we have in morgues throughout Territory hospitals, and the struggle, not only as an elected member but on a personal level where I am trying to support families in their closure. No one was interested in it then, and no one seems too interested in it now. The Health department provided me with some assurances that it will look into it.

I was very critical of one element of this legislation. I will leave this parliament very concerned about an element of this legislation that remains unexplained to me and my constituency. I have challenged this legislation about the termination of pregnancy up to 23 weeks. It was explained to me by the department that that would never occur in a regional or remote area, that I should not have concerns for my constituents. It would only occur in an urban setting, such as at the Royal Darwin Hospital, Alice Springs Hospital or Darwin Private Hospital, where there are appropriately-qualified and trained people, and the complete surgical services necessary to deal with that instance.

I have a major concern that will haunt me. My readings on RU486 have shown me that it is a possibility that a medical termination at 23 weeks could deliver a baby that is alive. If that were the case—the what-if factor when you, as legislators, make Territory law—would that child be euthanised or would they be left vulnerable to the elements to perish?

Ms UIBO (Arnhem): Madam Speaker, I support the minister's bill. I stand here as a young Aboriginal woman who wants to have the same rights as my fellow female Australians in every other state and territory.

I love the Northern Territory and I protect it fiercely. I want to preserve the uniqueness of the NT and ensure that women have every opportunity to take charge of their own bodies and minds. It is time for women's reproductive health and rights in the Northern Territory to be reflective of the communities we represent and the contemporary era we live in. I acknowledge that this is a sensitive debate, and I thank all members for their contributions thus far.

I, similarly to the Health minister, believe that the current laws do not provide for choice of treatment options, places of treatment, health practitioner or contemporary healthcare practices. The current NT services rely on a small group of specialist medical practitioners who are only located in the major population centres. This disadvantages women in regional and remote parts of the Territory. My electorate of Arnhem already suffers from many disadvantages in regular access to healthcare services.

The lack of access to safe termination options of pregnancy is yet another issue that leaves women at the bottom rung of society. Women's bodies are often objectified, and a demonstration of control over women's bodies seems to be everybody else's business except the individual woman. This needs to stop.

The Center for Reproductive Rights, or CRR, based in the USA, is an organisation that professes to use the law to advance reproductive freedom as a fundamental human right. In the words of the CRR:

We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination.

This is something I want for the Northern Territory.

I agree with the CRR's vision statement. Also included in that paragraph is that women have the right to:

... access to reproductive healthcare, including birth control, safe abortion, prenatal and obstetric care, and unbiased information.

In October 2012, Michelle Bachelet said:

It must be reinforced: women's rights are not a bargaining chip. Women's rights are not up for negotiation. Women's rights are fundamental to global development, and to international peace and security.

As a background, for those who do not know, Ms Bachelet became Chile's first female president, from 2006 to 2010, and again in 2014, and is the current serving president of Chile.

Ms Bachelet also stated in 2012 that, worldwide, 47 000 women die from unsafe abortions every year. Can you imagine that statistic? That is nearly a quarter of the Territory's population. The weight of that number is heavy.

As Ms Bachelet also stated, 'Women must enjoy full and equal rights to sexual and reproductive health, to education, to be equal participants and leaders in their economies and societies, and to be free from violence and discrimination'.

In 1971 the Levine ruling in New South Wales allowed practitioners to take into account economic and social stress pertaining to the time of an abortion. This was a positive step to take in the needs of a woman through a holistic lens.

There are many reasons for an unwanted pregnancy. I feel I do not need to give examples of these situations, as they are diverse and often sensitive in nature. This bill goes to the heart of one of the issues that plagues not only the Territory and Australia, but the global community. That issue is gender equality. How can society expect women to be empowered if they do not have the right to speak, act and make decisions about their bodies? This is the height of power play, that another person has the right to tell a woman what she can and cannot do with her own body.

The Levine ruling also agreed that one doctor's opinion would suffice, rather than two, and an abortion does not need to be carried out in a hospital, provided there are the required services to support the woman. I remind the House that this ruling was made in 1971, 46 years ago. Why then is the NT still lagging behind in reproductive rights for women? It is 2017 and time to transform and change legislation to support our contemporary community.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists states:

Medical, rather than surgical, termination of pregnancy is an alternative method which may be offered to women when it is available and suitable for them.

Let us look at that in a little more detail—an alternative method which should be offered to women when it is available and suitable for them. The proposed bill before the House does just this. It allows changes in the Territory to provide a medical termination of pregnancy to be available and accessible only when suitable and appropriate for a woman. This is not opening the floodgates to access to medical termination services, as some suggest, but rather the focus is providing a safe and alternative option for Territory women.

This bill takes into consideration the point made by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists:

Medical termination should not be performed in an isolated or an inaccessible setting which lacks ready access to suitable emergency care ...

This will not be an open door to all medical centres to be able to access and administer drugs for the medical termination of pregnancy. There will be strict guidelines and regulations to meet to be able to offer this service to women, ensuring their safety, state of mind, comfort and access to emergency care if required.

As Darwin GP, Dr Jacqueline Murdoch, stated in the *Sunday Territorian* opinion piece of 7 February 2017, the NT laws make accessing abortions difficult and women have long waits.

I have not met Dr Murdoch, but I understand she is in the gallery today watching. Thank you for your attendance.

Dr Murdoch also made the point that women do not have to explain themselves to two doctors for any other medical procedure, including life-threatening ones. This demonstrates a highly unusual situation—that a medical expert needs a validation from another medical expert simply because it is a woman's choice to terminate a pregnancy. I understand that in cases of endangerment to a woman, or fear for the health of a foetus, a doctor may, in extreme circumstances, seek further medical advice from a colleague, in the situation of life and death. However, to mandate for a woman to have to consult twice with doctors is clearly an inconvenience for any woman going through this very difficult process.

I have received many letters and emails about this bill, as I know many of my parliamentary colleagues have also. I appreciate the effort people have made in contacting members of parliament to share and voice their concerns from an either pro-life or pro-choice perspective.

I found it very interesting that people who do not even reside in the Territory are concerned enough that they feel they must lobby from interstate. I am very interested to see if these people feel the same about the inequality which many remote Territorians face and lobby for better access to roads, infrastructure, education and housing in our remote and disadvantaged areas.

It would be great to have that kind of support from people around the country—from the various states and territories—for other affairs of the Northern Territory. But, somehow, I doubt this interest level will be sustained in caring about the deeper issues that face the Northern Territory, which our Labor government is committed to delivering on for all Territorians.

I am appalled that some lobbyists are trying to make this a race issue. Trying to divert and disguise the real issue, which is gender equality. Aboriginal women, believe it or not, are diverse in nature, opinion, culture, language, beliefs, needs and wants. I do not claim to speak for any other Aboriginal woman in the Territory, and I hope no one else would claim to do so.

I was alarmed at some suggestions by lobbyists that Aboriginal women are not educated enough to make decisions for themselves. I find this sentiment offensive, shameful and racist. How dare people suggest Aboriginal women in the NT, who descend from the oldest living cultures in the world, do not have the education, sense and state of mind to make decisions for their own bodies. Shame on them.

I support the access to safe zones which has been imbedded into this bill. I read a document regarding the comparison of legislation for each state and territory with penalties for violating these safety access zones. The minister's reform sits in between some of the states and territories in terms of penalties and prohibited behaviour in safe access zones. This is an important part of the reform as women who make this hard choice deserve dignity and privacy at a time when they may be feeling vulnerable. The last thing they need to go through is pressure from lobbyists and strangers for making a choice for themselves which is their right and freedom.

The Member for Nelson, who I respect immensely, in his speech referred to a stolen generation—I found that statement offensive. To compare the systematic removal of children from their families over an extended period of history—it is a completely different matter to the right of a woman to choose if she has a pregnancy or not. This bill does not promote abortion, unlike the suggestion made by the Member for Nelson in his speech. This bill provides women with another safe option to undertake a termination of pregnancy if she chooses to do so.

A decision to terminate a pregnancy is not a decision taken lightly. Whether alone or supported, women have this decision to make for themselves. Counselling is already a service that is accessible to those thinking of making this decision for themselves. There is access to counselling from GP services, hospitals, private psychologists, family planning NT, various government organisations, phone counselling services and online support, and there is research information.

The Territory likes to hold its head up high and say it does things the Territory way, and I am proud of that most of the time. On this issue, however, it is not worth sacrificing the choice of Territory women, digging our heels in saying we do not need to do it just because the rest of Australia has allowed this. These proposed legislative changes in the Territory will, in the words of the CRR:

... fundamentally transform the landscape of reproductive health and rights ...

As the Minister for Health stated in February, women can only receive termination of pregnancy treatment as a surgical procedure as an inpatient in hospitals in Darwin and Alice Springs. The other option is to travel interstate. They may not be able to have their friends and family around them for support, and to help them in the important decision-making process. This is a lonely trip. It is one I have done, with the support of my family.

I stand in support of this bill so Territory women no longer have to make these long journeys away from their homes in the NT to access this service and make their own choice. This bill is about NT women having access to choose safe, evidence-based healthcare in a supportive environment. This bill will ensure standardised practices occur in relation to the provision of termination of pregnancy services for Territory women that are in line with the rest of the country.

I commend the minister for bringing this sensitive and important issue to the House, and I acknowledge the work that Madam Speaker, the Member for Goyder, made in starting this process as a private member's bill. The progressive measures being undertaken by the minister are strong steps forward for women in the Territory and for all Territorians. If we have a society which has strong, capable and empowered women then the community as a whole will benefit.

Ms MOSS (Casuarina): Madam Speaker, I too speak in support of the bill in front of us. I have thought long and hard about my contribution to this important debate as another member who has been through both stages of this debate over the last couple of years. I commend the Minister for Health for bringing the termination of pregnancy law 2017 to the House.

The Chief Minister committed to introducing these changes, if we were elected to government, at the NTCOSS forum last year, and I am glad that commitment to Territory women has been met today. I hope it will be passed.

As the Minister for Health has said, this is a deeply personal issue, particularly for women in the Chamber. As many of my colleagues have, I recognise and commend your hard work, Madam Speaker, Member for Goyder, in bringing this issue to the House in December 2016 through amendments to the *Medical Services Act*.

Frustratingly this was never able to be debated through to a vote in the last Assembly. It is positive to see a bill that is much more comprehensive, ensuring Territory women will be able to receive appropriate medical assistance when they need it.

I thank the many people and organisations who took the time to get in contact with me and other members of the Chamber about the termination of pregnancy laws, both for and against, and all of those who made submissions.

Make no mistake, this is a significant debate. It is an emotional debate that, in some cases, opens divisions in our community. But it is not new, not to this Assembly or, indeed, nationally or globally.

Recently we have seen millions of women marching worldwide, standing up against threats to women's rights, particularly those relating to reproductive health and a woman's right to choose. This is an issue that impacts on the rights of women right across our jurisdiction, including in my seat of Casuarina, and I take it very seriously. I acknowledge that there have been Casuarina constituents in the gallery today, and there are now as well.

It was without doubt that the debate today would sway to one about the ethics of abortion. In supporting this bill I continue to come back to the need for our laws related to medical practices and access to health services to evolve with modern practice and to come into line with the needs of Territory women.

I read many passionate letters and submissions to the discussion paper on this bill when we were debating this issue in the last Assembly. Many, in fact the majority, focused on whether abortion, in and of itself, is right, a debate that was had in the 1970s, as has been said many times in this debate today. However, it is important that all views are respected. I respect the right of Territorians, and of all Australians who have an interest in this issue, to hold and share these views.

I too will pick up on what the Members for Arnhem and Fong Lim said. There has been a lot of correspondence to us from other jurisdictions. I have read it, and I respect the rights of those people in this debate, but much of it has come from jurisdictions which already have these rights and services in place for women. First and foremost we are here to represent the interest of Territorians and Territory women.

It is not a debate about the rights and wrongs of abortion. It is about whether Territory women should have the same access to health services as women in other jurisdictions in this country and across the world, health services that some women have had access to for decades in some jurisdictions.

Women seek termination of pregnancy services for a diverse range of reasons but whatever the reason there is no doubt that this is one of the hardest and most heartbreaking decisions a woman will ever make in her lifetime.

Women deserve agency over their own bodies, and they deserve to be able to make a decision, fully informed and without the fear of demonisation. After all, we are more than just vessels for childbearing. This bill seeks to repeal parts of the *Criminal Code Act* which, as they stand, restrict and stigmatise the choice to terminate a pregnancy.

The introduction of a 150 metre safe access zone will better protect women who have made the difficult choice to terminate a pregnancy, and their loved ones, from harassment at what is already a stressful and traumatic time for them.

These laws are already in place in other Australian jurisdictions, including the Australian Capital Territory, Victoria and Tasmania. While we sometimes do things differently in the Territory, a woman's right to choose should be universal.

Each and every day we trust our qualified medical practitioners to ethically dispense listed pharmaceuticals and provide adequate through-care. We trust them to do so for so many other pharmaceuticals with similar or higher risk profiles. Why would we not do so for pharmaceuticals like Mifepristone?

Qualified medical practitioners will be following the guidelines set by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in administering Mifepristone, just as they follow the relevant medical guidelines for other pharmaceuticals on a daily basis. These guidelines state that complication rates are comparable to surgical termination of pregnancy. Mifepristone is a drug with:

... an extensive body of literature to support its use.

It has been in use since the 1980s.

In general considerations the guidelines state:

All women should be given accurate information and appropriate counselling should be available

And:

The prescribing practitioner must supervise and take responsibility for the entire process of termination of pregnancy ...

I put those on the record to show there are clear guidelines about the level of support and care that should be afforded to women who choose to medically terminate a pregnancy, as there is with a range of other pharmaceuticals that medical professionals dispense on a daily basis as part of their important work.

In opposing this bill fellow members in this House and members of the community have talked about the importance of giving support to women when pregnant, particularly if they are facing challenging circumstances. As someone who has advocated passionately for greater provision and promotion of mental health services over many years, I definitely agree with this. There is always more we can be doing to support people in our community when they are facing difficult times.

Others have talked about the need to reduce unwanted pregnancies in the Northern Territory, and I agree with that too. We must maintain and enhance our focus on sexual health education and promoting healthy, respectful relationships. We must have open dialogue about the importance of contraception and make sure it is readily accessible.

We will not achieve this by restricting access to services and shutting up shop. This is one of the driving reasons behind this government's investment in strengthening families through programs such as Families as First Teachers and the health system. We must do more to ensure families get the best start in life, but none of these things are mutually exclusive.

Sex education, access to contraception and stronger families do not preclude the need for women to have better access to health services. History shows us that restricting access to termination of pregnancy options puts women's physical and mental health at greater risk and forces them into unsafe decisions.

This was discussed at length at a forum organised by the Menzies School of Health Research late in 2014. It was a packed forum. I attended with the former Member for Nhulunbuy, who was the former shadow minister for Health, Lynne Walker. I was commenting to her earlier how this felt like *déjà vu*, having this debate in this House again.

It was attended by representatives from a range of backgrounds, including health professionals and legal advocates. They shared stories from their different experiences of the consequences of denying women access to these important health services, of denying women agency over their own bodies.

I thank those who, over a long period of time, have continued to fight for the rights of women in our community: Dr Suzanne Belton, Aditi Srinivas, Dr Jacqueline Murdoch, Robyn Wardle and many others who have been in the Chamber today or might be watching. Thank you; you have worked tirelessly to keep this on the agenda. It is an important and historical moment that we are debating this. Hopefully we will pass this bill.

As the Minister for Health outlined, at present a termination of pregnancy can only be performed surgically as an inpatient at either Darwin or Alice Springs hospital. This means that for many Territory women termination of pregnancy services are not easily accessible. There is a lack of equity in the system, particularly for women living in remote and regional parts of the Territory, putting them and their health at risk. But increasing access, and that is ensuring more equitable access, does not, by any means, equate to such a decision being taken lightly or that, as some members have wrongly insinuated, more equitable access means women will suddenly start using medical termination like contraception. These views demonstrate an utter misunderstanding of what a difficult decision this is for all women and a complete lack of respect for the women who find themselves in the position of having to make such a decision.

I, too, I have spoken to a number of people who disagree fundamentally with termination of pregnancy, and we have all received correspondence from across the spectrum. I have had discussions within my own electorate. I was recently on the Tiwi Islands and had the opportunity to speak to a small group of women there as well. I acknowledge and respect the differing perspectives on this, and all those discussions have been respectful.

A common theme, certainly from the remote women I have had the opportunity to speak to, was that there are concerns, and I completely understand that. The Minister for Health will talk through some of those in her wrap as well. But they were not judgmental of those who have made the choice to terminate a pregnancy or who may need to in the future. They expressed the importance of sexual health education involving both men and women.

I respect the views of others in this debate and the time that people have taken to discuss with me their perspectives. I know my colleagues from right across the Chamber have also had many conversations with

members of the community, and that the Minister for Health and her departmental staff have consulted far and wide on this critical issue.

I recognise that while I speak for many Territory women in this debate, I certainly do not speak for all women, but it is now time to resolve this issue once and for all in such a way that recognises and respects the right of women to make informed decisions about their own bodies and allows them to access the health services they need once they have made those decisions.

I thank the Minister for Health, and I appreciate the opportunity to speak in this debate. This debate is no longer dominated by men, as it would have been in years not long past. That is certainly a good thing.

Madam Speaker, I commend the bill to the House.

Mrs LAMBLEY (Araluen): Madam Speaker, I stand here with a great sense of relief and pleasure that this bill has finally come to the House. It is something I started to work on about three years ago when I was the Minister for Health. The Member for Goyder did a lot of work in this direction, and for this government, only in power for seven months, to have this on the table for debate this week is impressive. I congratulate the Attorney-General and all the people who have been a part of this bill coming before the House tonight.

My comments will be brief. I agree with a lot of the sentiment in the room. I also deeply respect the people in the room who do not support this bill. I was moved by the speech by the Members for Nelson, Blain, Nhulunbuy and Barkly. You have to be true to yourself on these issues; it is a conscience vote. I do not particularly enjoy dealing with these highly emotive issues. I know that is a part of our job, but it is a lot easier to talk about roads, infrastructure budgets and schools—the Palmerston hospital for instance.

This sort of stuff can really turn colleagues against each other. It is very difficult for a range of reasons, but I have always supported the right of women to choose to terminate a pregnancy. Clearly, this bill is not about the legalisation of abortion; that debate happened decades ago. We are not here to discuss that old chestnut.

This Termination of Pregnancy Law Reform Bill will make the existing antiquated Northern Territory legislation pertaining to abortion more relevant, contemporary, effective, and safer, making abortion more accessible to all women faced with an unwanted pregnancy. I support this bill because I believe it will give women greater safety, dignity and access to termination of pregnancy services.

I was briefed by senior health officials on this bill a couple of weeks ago. I am confident that this legislation addresses all safety issues and risk factors involved with the termination of pregnancy using medical and surgical methods. This legislation is consistent with all abortion legislation across the country. It is a very positive advancement.

I commend the minister for her work in this area, and I will be supporting this bill.

Mr McCONNELL (Stuart): Madam Speaker, I speak in favour of the Termination of Pregnancy Law Reform Bill. I respect the rights of women over their own bodies; I respect their right to make these decisions. I have witnessed situations where men have been involved in these decisions as well, and that is an important thing to acknowledge.

I have seen people who have, together, had to make hard decisions about the termination of a pregnancy. I have seen men very damaged from being involved in that issue. I say that from a cultural context; I have seen it in the Aboriginal way where decisions have had to be made on a termination for medical reasons for the safety of the mother. This is primarily an issue about women making decisions over their own bodies.

As a man I found this challenging to think through. An important part of my job, and that of everyone in here, is to think through things using an evidence base to make decisions. I am comfortable with the decision I have made to support this bill. I think there is adequate safety in it.

Being a person who is open about who I am—I will never have to make this decision, as a man or in a relationship, because I cannot have children. That has been a real thing for me to consider in these discussions, hearing people who have had to make decisions on terminations. That has, in part, informed my decision-making.

I have given this legislation a lot of thought and I understand I am here to represent the interests of all constituents of the electorate of Stuart. I am also very aware that there is a wide variety of people living in Stuart, with a wide variety of views on the reform before us.

I have spoken to a number of people in my electorate on this issue through my normal constituent consultations. I have received a number of emails from people throughout the Territory as well. Other than those of the people who became a little offensive and vitriolic, I respect all those opinions. The opinions that were put forward to me have helped, in part, to inform my decision.

I was moved by the Member for Barkly's speech this evening, but I will refer to something the member reminded me of in a different setting. Whenever we debate anything, the more emotional it gets the more we need to remember common sense and good manners. Some of the people trying to talk to us, both for and against, forgot their common sense and good manners. Gerry McCarthy, the Member for Barkly, will probably get sick of me quoting that line, but it had an influence on me, so I thank him for that. I see its relevance in the context.

A number of Aboriginals in my electorate are deeply religious and have concerns about abortion in general. I am also aware that a number of people throughout the Territory, religious or not, have concerns about the termination of pregnancy through abortion. As has been established by many speakers before me, this bill is not about abortion. I have explained to those whom I have had the opportunity to discuss the legislation with directly that we are not debating the right to abortion. Abortion is legal in the Northern Territory already. Once people understood that the issue at hand is making available a second method of termination of pregnancy—a medical method of abortion—most people were not opposed to this.

In general I have found people I have spoken with have been reasonably well informed about the issue. I do not use the word 'reasonably' to be in any way disrespectful. People have many issues to be aware of in their lives. Some people have English as a second language or even beyond. I was quite surprised that when I spoke to people about this they had a fairly ready response.

For me the question comes down to whether this type of termination is safe and is medical best practice. The research demonstrates that it is. Those statements have been made by numerous speakers before me better than I can make them. Clearly the Health minister and her staff have done an excellent job in looking at best practice from other jurisdictions and the best way to take this forward for Territory women.

As with all procedures, complications may arise, but this appears to happen in a low percentage of cases. Complications may include excessive bleeding, infection, continuing pregnancies or incomplete abortions. Some of these concerns may also be the case with current forms of abortion.

Even reading those words is very difficult for me. I understand that this is an extremely emotive issue for people. I respect the fact that this has been brought forward as a conscience vote. It clearly demonstrates that it is important to have a conscience vote. It is not surprising that some of the concerns with making medical abortion available here may arise from whether or not Northern Territory patients understand the procedure, will follow the protocol and will follow-up if there are any complications.

Is our health system good enough in the Northern Territory to ensure patients follow medical protocols? Not always. I imagine no health system can ever be 100% compliant. However, I believe our healthcare system is good enough to identify the patients who are unlikely to follow medical protocols and either provide extra support or suggest an alternative procedure. This belief does not preclude the fact that we need to continue to provide better preventative health education, including sexual health education on the prevention of sexually transmitted diseases, and access to birth control, particularly for our remote communities.

In remote Aboriginal communities these types of education programs must involve Indigenous health practitioners and other community members to ensure the delivery of sexual health education is done in a culturally sensitive—and that means appropriate—and effective way.

Having English as a second language does not have to be a barrier to acquiring knowledge, particularly medical and health information.

A number of people believe this is a women's issue and a women's rights issue. What right do I have, as a man, to talk about this? What cultural authority do I have? What right does the government have over an individual's body? It comes down to the heart of the matter. As a society we are better off with women who have choices, access to medical information, best-practice medical care and birth control.

I believe very few, if any, women take the decision to have a termination lightly. It must be an incredibly hard decision. For me it feels like punishment if we do not provide women the best-possible options in these circumstances. Medical terminations of pregnancy are safe, less invasive and, hopefully, less traumatic procedures than surgical terminations. Women in the Northern Territory deserve no less, and that is why I support this bill.

Ms FYLES (Health): Madam Speaker, I acknowledge every member who has spoken today and thank them for their thoughtful contributions and the respect displayed throughout this debate of a sensitive and important topic. I acknowledge that this legislation is of critical importance to Territory women, and also to Territory men.

I thank the Chief Minister for his leadership in allowing me to bring forward this legislation as a priority in the early days of the government's term. I acknowledge the Member for Araluen's comments, thanking us for bringing this on early in our term. I acknowledge that she started discussions in this space when she was the Minister for Health. And I acknowledge you, Madam Speaker, for bringing the private member's bill to the House.

I also acknowledge the community. This is an example of community debate, conversation and lobbying. This has taken place over a long period of time but the end result is a bill that has bipartisan support, and I am pleased to deliver this bill.

I appreciate—I have listened to the stories and the debate—the personal emotional investment in discussing the termination of pregnancy. I understand it can reflect on a member's spiritual views, their personal experience of children and family and that they may have happy or sad circumstances, but I thank you all for having the courage to share your stories. Listening to this debate, I have learned more about my parliamentary colleagues today than I have over the last eight months.

Having said that, I remind members that this debate is not about permitting terminations; it is not about the moral rights or wrongs of terminations; that argument was had many years ago. Today's bill starts from the position that terminations are already lawful to provide or obtain in the Northern Territory.

Today's bill seeks to provide reasonable access to safe termination and pregnancy services for women in the Northern Territory. It does not seek, in any way, shape or form, to allow open slather to enable any doctor to offer a termination to every woman who looks a bit surprised or distressed when they find out they are pregnant, whether it is by choice, accident or more traumatic circumstances.

This bill proposes a framework built on a solid foundation of well-proven and documented safety guidelines under the authority of the professional, medical Royal College of Obstetricians and Gynaecologists in the United Kingdom, with its solid evidence-based standards, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

In addition, these guidelines will be strengthened to meet the unique challenges and conditions of the Northern Territory, with specific clinical guidelines being developed by the NT expert advisory group, endorsed by the Chief Health Officer, our most senior clinical position, with statutory powers under numerous health acts.

We debated this subject matter at length in 2015 and 2016 with your private member's bill, Madam Speaker. We engaged in community consultation at that time, driven by What RU4 NT? and I acknowledge that many of those people are in the Chamber this evening.

Since I became the Minister for Health, with the support of the Chief Minister and my parliamentary colleagues—we had a significant seven-week public consultation process, led by the Department of Health. We received many letters and emails and had direct contact—not only with me as the Minister for Health but also other ministers. People have spoken this evening about the huge amount of correspondence they have had.

We had a number of briefings and meetings with representatives from a number of religious groups. I made sure I availed myself to anybody who wanted to talk about this issue: the Christian Lobby, our church leaders, medical professionals, non-government legal and health services, government agencies, and, importantly, our Aboriginal health, legal and community services. Members also talked to constituents in their electorate offices.

We met with a number of Aboriginal health services. I take a moment to acknowledge them: Danila Dilba, in the Top End, Wurli, in Katherine; Miwatj, in East Arnhem; Anyinginyi, in Tennant Creek; Congress, in Alice Springs; and AMSANT.

I had numerous meetings with stakeholders who hold opposing views to me or needed more information. Those conversations, whilst they were difficult at times, were genuinely respectful and provided me with further insights to gain a full appreciation of the issues before us today.

I believe this bill is robust and solid. It protects Territory women and the health professionals involved in providing these services. It is a contemporary piece of legislation that gives us the ability to adapt to changes and new evidence in the medical world. I have committed to reviewing this legislation within 12 to 24 months. This is the responsible and sensible action to take.

Before I turn to reflect on the comments made during this debate, I sincerely thank the many officers in the Department of Health for the months of excellent work they have dedicated to the development, consultation on and progress of this legislation. Many members have spoken about their briefings. The Department of Health has taken this on board and has delivered for the people of the Northern Territory. It has worked hard and diligently. It has briefed members, provided information and followed a strong process. I recognise that its job is far from over as it will continue to work on the development of the clinical guidelines, service models, client information resources and implementation strategies.

I acknowledge and thank the Office of Parliamentary Council for its tireless efforts in drafting this bill and ensuring it is of high quality, equal to any legislation in the rest of Australia.

During this debate we have heard from most members within the Chamber, and it was an emotive debate. I will touch upon the issues people raised. The Chief Minister allowed us to bring this bill into the House with a conscience vote for the government members. He acknowledged the need for equality for Territory women and to bring the Northern Territory legislation up to date with the rest of Australia. He recognised that this bill is progressive, well researched and consultative, and will stand the Territory in a good position in the future. I thank him for that.

The Deputy Chief Minister raised important points about providing safe choices for Territory women, the options for care in and out of hospital settings providing greater flexibility for women and health professionals, and about reducing the demand on inpatient hospital services and allowing hospitals to focus on caring for patients in critical and emergency care.

The Member for Namatjira spoke passionately on behalf of the Aboriginal community he represents and the need to have the same rights as access to safe services as all Australian.

Thanks to the Member for Katherine for her powerful speech on safety and wellbeing, and providing services equal to the rest of Australia, as well as her own personal experiences and reflection on consultation she had with people in her electorate over the past 18 months. I acknowledge that would not have been easy.

Thank Member for Port Darwin reinforced the benefits of this bill in delivering equality for Territory women. Madam Speaker I again acknowledge you and your efforts in bringing this debate forward to the Northern Territory parliament in 2015, and your support today in the Chamber. I thank the Member for Brennan for his comments. The Member for Sanderson spoke very emotionally about her experiences. Members took the time to consult with their communities, and they did that in unique ways. Thank you, Member for Drysdale, for talking about focusing on women and the choice they have.

Concerns were raised by members who do not agree with this bill. I acknowledge the way in which they have handled themselves in allowing the debate to be respectful. That is very important. Not everyone in the House agrees with what we have before us today, but this is a good bill. We worked hard. The Department of Health has been driving this bill, and we have used resources from across government.

I will now focus on some of the issues raised by members. The first one is conscientious objections. We have carefully considered this topic and believe this bill provides the best protection for Territory women without infringing on health providers' rights to object.

Medical and health practitioners holding a conscientious objection to the provision of termination of pregnancy services will not be required to perform termination services except where a termination of pregnancy is required to preserve the life of the pregnant woman. If a medical practitioner holds a

conscientious objection to the provision of termination services, the practitioner will be required to inform the woman of the objection and refer her to seek services elsewhere.

The requirement to refer the woman to another practitioner or organisation providing the services sought is in line with the Victorian legislation and the current recommendations of professional associations. The AMA issued a statement on conscientious objection which acknowledged a doctor's refusal to be clinically involved in a termination of pregnancy because of his or her personal convictions. It also encourages those practitioners to not impede the patient's access to treatment or services.

The code of conduct of the Medical Board of Australia also includes an item on encouraging medical practitioners who hold a conscientious objection about treatments to inform their patients and colleagues of this objection, and not to use their objection to impede access to treatments that are legal. Under the bill it is acceptable for a medical practitioner who has a conscientious objection to refer a woman to a healthcare facility, for example, the Royal Darwin Hospital, rather than to another suitably-qualified medical practitioner.

Under the bill, through regulations, NT health clinical guidelines will contain referral processes for circumstances where the medical practitioner has a conscientious objection. This requirement does not pose any conflict between this bill and religious freedoms proposed in the international charters discussed today. The rights of individuals need to be viewed in the context of other competing rights or interest, one of which is reasonable access to lawful medical treatment.

The international organisations responsible for those instruments recognise the value of providing women with access to medical services that are lawful. Suitably qualified medical practitioners who fail to refer a woman to another practitioner or service where the termination services could be provided will be in breach of the requirement to refer women. Although there is no offence provision for this contained in the bill, the failure to comply may result in civil action being brought against the medical practitioner. Medical practitioners may also be found to be in breach of the medical board's code of conduct and face disciplinary proceedings.

NT consumer health information will provide information about access to public health services and the making of a complaint, for example, to the Australian Health Practitioner Regulation Agency or the Northern Territory Health and Community Services Complaints Commissioner, when access to treatment has been impeded.

There were a number of issues raised about consent and counselling today. This bill does not contain an express provision about the appropriate personal method of obtaining informed consent for the performance of termination services. The effect of this is that the common law principles of informed consent will apply. In relation to adult women this will mean that the medical practitioner will be required to make suitable inquiries about the woman's ability to make decisions for herself, and where the medical practitioner deems the woman to be competent to do so, to undertake the usual informative process to obtain her consent to treatment.

To achieve an appropriate level of understanding, women need to be informed about the medical conditions, alternatives available for treatment or other management, consequences of each treatment or not receiving treatment, and risks of each of the outcomes. The medical practitioner will also offer access to counselling and support services if a woman requests this or it was of the opinion of the medical practitioner that this would assist in the decision-making process to achieve a level of informed consent.

For women who are deemed to lack the competence to give informed consent about the treatment options, it will be necessary to obtain informed consent from another person having authority in law, for example, a guardian appointed under the relevant law, a person having parental responsibility or a person appointed by the court for that purpose.

Safe access zones are something a number of members spoke about. A safe access zone is defined as an area of 150 metres from the boundary of, and including, the premises for performing terminations. I will outline why this is in the legislation and what it will ensure. It will ensure that women can access health facilities in privacy, free from intimidating conduct at a distressing time in their life, respecting the privacy and dignity of women accessing the service and the staff who work there. Three other jurisdictions have safe access zones, introduced in 2015: Victoria, Tasmania and the Australian Capital Territory. People remain free to express anti-abortion sentiments, just not in a place that prevents women from exercising their right to privacy in reproductive healthcare.

In respect to the issues raised by the Members for Spillett, Nelson and Blain—there was conversation on the floor of the Chamber today and they also raised it formally in their speeches—about a friend or relative speaking against the termination to a woman inside the safe zone—clause 14 provides for the creation of a safe access zone around premises where terminations are performed.

It is important to establish an area as a safe passage to the premises where terminations are performed for both the women seeking services and the persons working there. We need to acknowledge that a facility such as Royal Darwin Hospital, a big facility with many entrances, varies greatly to a small day surgery facility that may just have one small entrance. It is important to understand that the safe access zones are not created to stifle or prevent the freedom of speech of those who oppose the termination of pregnancy. Those persons can freely express their opinions in any other location, providing they do so in lawful ways.

Safe access zones will provide persons with a means of entering and leaving the premises without intimidation, harassment or interference. It is particularly important that there is a balanced approach to the rights of women accessing the premises for a termination or any other medical service that may be offered there; they should have the right to an unimpinged access to those medical services.

Clause 14(1) expressly provides for an offence where a person intentionally engages in prohibited conduct within safe access zones and the person is reckless in relation to that circumstance. Clause 14(4) provides a definition of prohibitive conduct. Importantly, the conduct described includes harassing, hindering, intimidating, interfering, threatening or obstructing a person without their consent and without a reasonable excuse. The conduct described needs to be seen or heard by a person in the vicinity of the premises must be an act which may result in deterring the person from entering or leaving the premises. The combined effect of the criteria in this section provides a significant barrier to frivolous or unwarranted charges being made.

Default elements of recklessness in the circumstances contained in section 43AK(2) of the *Criminal Code Act* would also need to be made out for an offence to be proven. Having regard to each of the provisions of clause 14 and section 43AK of the *Criminal Code Act* it would be highly unlikely for an offence to be made out against a person in some of the circumstances we spoke about this morning where somebody may be talking with the person and making a comment that could be seen as trying to change their view. To be prohibited conduct it would need to be harassing, hindering or intimidating. It needs to have that stronger threshold.

The *Summary Offences Act* is not relied upon for the safe access zone as it does not adequately address the prohibited conduct within the context of seeking lawful medical treatment. There was a question in relation to that today.

The Member for Spillett raised other important questions, and I appreciate the interest she has taken with this bill in consulting widely. I thank the opposition for its support. The Member for Spillett has met with a number of stakeholders and attended a number of briefings with the department. I have, in presenting this bill to the Assembly, provided access to the Department of Health and the services that provide me with information and briefings to any Member of the Legislative Assembly.

I reassure the member that we will proceed with developing the reporting requirements with the regulations. It is proposed that the regulations will require the reporting of minimal information about the performance of termination services for the purpose of collecting statistical data. The information to be reported will be relevant to the same level of access to services and the provision of safe termination services. Consumer information resources are being developed about termination services, pregnancy options and procedures to assist with decision-making.

This was raised through stakeholder engagement, making sure women, it does not matter of what age or situation—that in the Northern Territory we provide information so they understand their rights and the access to services—the provision of written information about choices of termination methods to assist a woman before she makes a decision, so she can make a more informed decision. Aboriginal organisations have recommended that this information be made available in printed and electronic formats, and I have committed to providing that. When we review the legislation in 12 to 24 months we can look back at this and see what may need to be improved.

I acknowledge the Member for Nelson for the thoughtful consideration he gave throughout the consultation process and leading up to this debate. Although I know, Member for Nelson, we do not agree on the fundamental positions, you made a significant contribution to the discussion. I acknowledge that there are a number of amendments you have shared, but I find your position counteracts the intent of the bill by

seeking to restrict health professionals in their practice and limiting the ability to respond to the future advances in treatment, and it includes unsubstantiated claims that medical terminations will be freely available, implemented unsafely and used as contraceptive means.

This concerns me greatly as it displays a level of mistrust in our health professionals and their intention to provide the best possible care for Territory women. I appreciate that you have a deep and personal interest in the subject, but, Member for Nelson, we cannot let personal religious views dictate over the evidence of the medical profession for the best care and treatment for Territorians.

I have spoken about the issues of conscientious objections and the safe access zones, and evidence from other jurisdictions has not shown that providing women with a choice of termination procedures results in a significant overall increase in the number of terminations. There is evidence that there is a substitution of surgical treatment for medical procedures close to the rate of 50/50.

The Members for Nelson and Blain have requested referring this bill to a select parliamentary committee, suggesting it will ensure that members of parliament and the public are fully informed about implications of these changes and that they can participate in the debate. I do not support this request on the grounds that it is not a new debate. This was debated in the last parliament. This was an election issue last year. I think every one of us, whether it was in our electorate or we were emailed, were asked our opinion and what we would do in the situation of this vote. This bill is long overdue, and sending it to a select committee would only unnecessarily delay the process further. Members of the House have had the opportunity to engage with their communities and consult on the changes, and I feel that a select committee is merely a delay tactic.

I acknowledge the Member for Barkly. We are close colleagues and this has been a difficult issue, but we have, in the most professional relationship, worked through this. But he did state in his opinion piece in the *Tennant Creek Times* on the 10 March that this law is:

... discriminatory as it supports Territory women living in cities and a major town yet provides uncertainty and critical risks for those living in regional and remote areas.

With all due respect, I disagree with the Member of Barkly's claims. One of the primary objects of the act is to enable reasonable and safe access by women to the termination of pregnancy. We are not accepting any scenario that will place remote women at critical risk. We have ensured safe access to termination of pregnancy services as a paramount consideration, and we have ably provided it by the provisions in the bill, along with the capacity for regulations, requirements, professional standards and guidelines.

Health professionals need to be willing to provide this service within all the guidelines for safety. If they or the organisation do not have the adequate capacity to achieve these guidelines, then the woman will be supported to go to the nearest centre for this treatment.

Similarly, the issue of adequate emergency service capacity in the Tennant Creek Hospital will dictate the ability to provide medical terminations in the region. If the Chief Health Officer and the executive director of medical services deem that is in not adequate, Barkly women will be supported to travel and stay in Alice Springs for the procedure.

That raises an important point. In terms of this legislation—its availability will be at the five hospitals in the Northern Territory and approximately a two-hour distance from those hospitals. But Territory women will be supported. If they need to travel to a major centre or to Darwin they will be cared for under the patient travel scheme and supported as they would be with any other medical procedure.

I question the Member for Nhulunbuy, who first contacted me about this legislation very late on Friday. Fourteen weeks have passed since the discussion paper was released. I acknowledge that this is a very difficult topic for a man to discuss with Aboriginal women and, appropriately, he sought the female Aboriginal clan leadership to assist. However, during all that time, over the past 14 weeks, he has not been able to convene one forum with the female clan leadership group or with the non-Aboriginal members of his electorate. He has not sought additional briefings from my office or from the Department of Health.

Fortunately, the department has been widely consulting with Aboriginal medical services, including Miwatj in Nhulunbuy, which provides services across a number of the communities in East Arnhem Land. Miwatj is very interested in supporting the provision of these services, with the support of the Gove District Hospital for any emergency care if complications arise.

I thank all members who have provided comment today on this significant legislation for Territory women. The Termination of Pregnancy Law Reform Bill will provide a framework for the lawful provision of termination of pregnancy services by medical practitioners in suitable medical facilities across the Northern Territory, in line with professional standards and guidelines.

The bill provides for the repeal of section 11 of the *Medical Services Act*, which deals with the provision of termination services in more limited circumstances, and consequential amendments to the *Criminal Code Act* to provide for the lawful performance of a termination of pregnancy by suitably qualified medical practitioners and health practitioners assisting with these procedures.

This significant change seeks to increase access for women to safe termination of pregnancy services, either in hospital or out-of-hospital settings; make available medical and surgical options; require health practitioners to apply principles of evidence-based practice when assessing and treating women; require consideration by medical practitioners of all relevant matters, including the appropriate means of obtaining consent; require consideration and application by medical practitioners of relevant professional standards and guidelines in the delivery of termination services; provide for the introduction of safe access zones to enable privacy, and unimpeded access by women and staff to the health facilities providing termination services.

I am confident this legislation will pass the House today, and once it does we will continue working on a schedule with the intention to seek commencement of the act from 1 July 2017, following assent and gazettal. Along with the implementation of the Northern Territory clinical guidelines to support the practice of termination of pregnancies under the new laws, the immediate work is now with the Department of Health, led by the advisory group on the development and finalisation of the NT political guidelines, and I acknowledge the members of that group and the hard work they have put in.

The clinical guidelines will be published by the Department of Health for use by public, non-government and private providers. Consumer information and resources are being developed to provide clear advice on counselling services, available pregnancy options, the referral process, transport and transfer, accommodation, informed consent and public and private organisations performing termination services.

As I have outlined, printed information will be made available at the request of the Aboriginal medical organisations which described a lack of access to Internet for consumers and cultural preference to give information directly to women. There will be significant communication and education provided to health professionals who wish to be involved in providing these services within their auspicing organisation.

I will move an amendment to the bill in the consideration in detail stage as a minor drafting error has been identified. I have spoken with my colleagues and members in the Chamber about that.

Madam Speaker, I thank all those who have supported us to get here today. Some women need to access this service. For all of them it is a challenging time. They have found themselves in a situation they did not expect. Some women do not want to terminate their pregnancy but for every woman, family and Territorian this would be the hardest decision in the world. We cannot judge or provide comments on women who use this change in our legislation. As members of this parliament it is our duty to simply pass the legislation that will give Territory women choice.

Motion agreed to; bill read a second time.

Consideration in Detail

Clauses 1 to 3:

Mr WOOD: Minister, clause 3(c) says:

... to regulate health practitioners performing terminations.

I am a little confused. The term 'health practitioner' is in the definitions, and we will come to that. Does that term cover medical practitioners, or does 'medical practitioners' cover health practitioners?

Ms FYLES: This is a protected title under the *Health Practitioner Regulation National Law Act*. It means a person who is registered as a medical practitioner within the meaning of the Health Practitioner Regulation National Law, other than as a student.

Mr WOOD: To make sure I am reading it right, a health practitioner is a medical practitioner?

Ms FYLES: Yes, Member for Nelson. Under clause 4 of the bill a suitably qualified medical practitioner is a medical practitioner, meaning registered as such within the meaning of the Health Practitioner Regulation National Law, other than as a student, and having additional qualifications and experience of (a) an obstetrician or gynaecologist, or (b) is credentialed in the provision of advice, performance of procedures and giving treatment in the area of fertility control. The termination of pregnancy bill makes the distinction to highlight those medical practitioners who can lawfully perform terminations.

Mr WOOD: So 'medical practitioner' will also cover the definitions of health practitioner, Aboriginal and Torres Strait Islander health practice, medical, nursing, midwifery and pharmacy, is that correct?

Ms FYLES: Sorry, I did not catch the last part of your question. If you go to the page ...

Mr WOOD: I will stay with just this section and when we get to definitions I might ask you then. There might be a clearer way. In relation to clause 3(c), 'to regulate health practitioners' that term includes doctors?

Ms FYLES: Yes, Member for Nelson.

Mr WOOD: If a doctor is not in the business of performing terminations is the doctor not covered by this piece of legislation?

Ms FYLES: All health practitioners are covered.

Mr WOOD: But it says 'to regulate health practitioners performing terminations'. If a doctor does not perform terminations are they therefore exempt from this act?

Ms FYLES: It is everyone listed there, but if you cannot perform it under the act, then you will not be doing it lawfully—you are choosing not to.

Mr WOOD: I did not mean that. It might be a doctor who does not deal with terminations.

Mr GUNNER: It still covers them if they choose not to do it.

Ms FYLES: Yes, there are some medical doctors who will choose not to, but ...

Mr GUNNER: It is still regulated by the act.

Ms FYLES: ... it is regulated and they have to do the training to choose to do it.

Mr WOOD: This might sound as if I am harping, but the issue for me is that if a doctor has a practice which might not be involved in gynaecology or obstetrics—he might be in another field of medicine—does that doctor come under this legislation because he is not performing terminations?

Ms FYLES: No.

Mr WOOD: Are you saying a doctor who is not dealing with that will not come under this legislation?

Ms FYLES: We are going around in circles here. Doctors, if they have the training, come under this legislation. They can choose to become a doctor who does the training and comes under this. But if they choose not to, they do not have to.

Mr WOOD: What I am trying to get at is if there is a doctor who does not deal with terminations, then the issue of conscientious objection does not apply to him, as under this act? If this legislation does not apply to a certain group of doctors who do not deal with terminations, are those doctors, because they do not come under the objects of the bill, not required to come under the section of the bill which covers conscientious objection?

Ms FYLES: There are two groups of medical practitioners outlined in the bill: the qualified medical practitioners and the suitably qualified.

Mr WOOD: We might get on to that, but it has not answered the question. If the doctors do not deal with terminations or births but just general practice and this is not the area they are involved in, are they then

bound by the clause in this bill which deals with conscientious objection? This one of the the objects of the act is to:

... regulate health practitioners performing terminations.

If there are health practitioners not performing terminations, are they exempt from the conditions of this act?

Ms FYLES: Member for Nelson, it comes up further under clause 11. Do you want to go to that now or do you want to keep going through in order?

Mr DEPUTY SPEAKER: We will go through it in order.

Mr WOOD: All right. I hoped that question could be answered at the start because it gets to the heart of the objects of the act. That bottom line needs clarification. I will leave it at that for the moment.

Clauses 1 to 3 taken together and agreed to.

Clause 4:

Mr WOOD: Mr Chair, I move amendments 1.1. I am asking for a definition of abortion because abortion is mentioned throughout the act but there is no definition. The definition I put is that:

abortion means the termination of pregnancy:

(a) by medical means (the use of a drug or drugs); or

(b) by surgical means (the use of surgical instruments); or

(c) by a combination of medical and surgical means.

There is no definition of abortion in this legislation. The term is used in the legislation, for example, in clause 6(1). This addition also identifies the means of procuring an abortion, which should be made clear to those reading the legislation.

The next one was approved information. That relates to a clause I have put in as an amendment to the legislation. This definition is defined in my proposed clause 17(1), which deals with the ministerial consultative committee:

The Minister must establish a consultative committee to advise the Minister about information (the approved information) to be given to women who are contemplating a termination.

I have also put in a definition of 'hospital', to have the same meaning as in the *Medical Services Act*. This defines a hospital as the term used in clause 9(c).

Ms FYLES: This is outdated terminology; it is a restricted definition that will not allow for contemporary future medical practices. For example, medical terminations were non-existent in the 1970s when our current act was drafted.

Mr WOOD: I do not think it is out of date; that is exactly the definition of abortion. If the government wants to introduce a new definition it can do that, but there is no definition of abortion in this legislation.

Ms FYLES: It is not needed. Medical termination is the term used. That was not in existence in the 1970s when the current act was drafted, but it is contemporary for the legislation now.

Mr WOOD: It is not mentioned; there is no definition. You use it in this document but you do not define it.

Ms FYLES: We say it is termination of pregnancy right throughout the bill, for the reasons I just outlined.

Mr WOOD: I understand that, but clause 6(1) uses the term.

Ms FYLES: This bill is around the termination of pregnancy; it is not abortion.

Mr WOOD: But if the word 'abortion' is in clause 6(1), what do you mean?

Ms FYLES: We are talking about the performance of a termination of a pregnancy, and that is how it is referred to in modern practice.

Mr WOOD: I understand that but your bill uses the term abortion in clause 6(1). Why does it not occur in the definitions?

Ms FYLES: I have outlined the answer to the question and we are just repeating ourselves.

Mr WOOD: That was not a satisfactory answer.

Ms FYLES: Mr Deputy Speaker, can we lose the judgment calls and focus on the bill?

Mr DEPUTY SPEAKER: We will focus on clause 4. Member for Nelson, are there any further comments in relation to the amendments you are moving?

Mr WOOD: I will include the definitions of 'approved information' and 'hospital'. I do not know whether the minister will accept any of those definitions.

Amendment not agreed to.

Mrs FINOCCHIARO: Minister, in relation to the definition of 'safe access zone', what is considered to be the boundary of a premises? Is it the external wall of the building, the fence or the boundary line?

Ms FYLES: It is the legal boundary of the area, for example, the property, garden area and fence line.

Mrs FINOCCHIARO: What was the decision to go with 150 metres based on?

Ms FYLES: That was based on the Victorian legislation.

Mrs FINOCCHIARO: In relation to the definition of 'suitably qualified medical practitioner', please advise what the practitioner would need to satisfy in order to be considered to be 'credentialed in the provision of advice, performance of procedures and giving treatment in the area of fertility control', as outlined in that definition.

Ms FYLES: 'Credentialed' means having verified qualifications, training, experience, professional standing and other relevant professional attributes of a medical practitioner used for the purpose of forming a view about the competence, performance and professional suitability of the medical practitioner.

The suitably qualified medical practitioner will be credentialed by the medical director of his or her healthcare organisation, and credentialing of a sole suitably qualified medical practitioner is under discussion with the Northern Territory Primary Health Network. Solutions include participation in this process by partner organisations, and credentialing requirements will be included in the NT health clinical guidelines.

Mr WOOD: What is the clear definition of 'medical practitioner'? We have a definition for 'suitably qualified medical practitioner'; what is a 'medical practitioner' and what groups come under that term? Can we have a list of the groups that come under that term?

Ms FYLES: A medical practitioner is a protected title under the *Health Practitioner Regulation National Law Act*. It means a person who is registered as a medical practitioner within the meaning of the Health Practitioner Regulation National Law, other than a student.

Mr WOOD: I need to have it clarified because when I looked under the Health Practitioner National Law it had a definition for 'health profession'; it did not have a definition for 'medical practitioner'. Are the two the same?

If I said to you that throughout this bill the term 'medical practitioner' can be taken to be Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medical, medical radiation service ...

Ms FYLES: It is the ones listed in the definition, which are Aboriginal and Torres Straight Islander health practice, medical, nursing or midwifery, or pharmacy.

Mr WOOD: The ones you have on page 4 under definitions, where it says 'health practitioner', are actually medical practitioners, is that correct? In your definition, which is Aboriginal and Torres Straight Islander ...

Ms FYLES: I am reading from page 2 of the bill, which clearly states 'health practitioner'.

Mr WOOD: Yes, but I am trying to get the terminology right. Throughout this document the phrase 'medical practitioner' is used, yet there is nothing in the definitions to tell me what that means and who comes under that definition. It is used quite a bit throughout this legislation. I have searched the Health Practitioner National Law, and the closest I have found is 'health profession' and 'health practitioner'.

Mr GUNNER: This may help or not, but my interpretation of that is that 'health practitioner' in clause (b)—it is clear that is someone who is registered under one of those professions. 'Medical practitioner' is listed at (b), so it is someone who is registered. That covers 'medical practitioner'.

Mr WOOD: It is just that it is used quite commonly throughout this bill.

Ms FYLES: To help you clarify, that group is referred to as 'health'. Each of those individuals is a medical practitioner. For example, Aboriginal and Torres Straight Islander health practice, medical, nursing or midwifery, or pharmacy. Each individual is a medical practitioner but the grouping is health. Does that help?

Mr WOOD: Yes, and when I come up with it I will just ask you to explain if that is what it is meant to be.

I also have questions regarding the safe access zones, which the Member for Spillett asked about. Is the only reason that figure was picked is because it is from Victoria?

Ms FYLES: As I outlined in my speech, this legislation allows procedures to be provided at venues other than main hospitals where there are many entrances and exits. It is about making sure there is a safe zone for those working there and those attending treatment. There have been incidents in other jurisdictions that call for—that is why we are providing good legislation with a safe access zone. One-hundred-and-fifty metres is a reasonable figure that provides safe access but still allows people to have freedom of speech.

Mr WOOD: In the case of RDH, the boundary is a long way from the hospital itself, so what if a private house is within the 150 metres? Can people put a sign up on private land?

Ms FYLES: It would depend on whether it is harassing or intimidating. We need to make sure there are provisions in the legislation that protect people. This is not designed to stop the prayer group that operates at Royal Darwin Hospital. This is designed to provide safe access but still allow for freedom of speech.

Mr WOOD: I am looking at the technicalities of you telling someone who is within 150 metres that they cannot do something. You cannot harass people under the *Summary Offences Act*. I will give another example ...

Ms FYLES: It is prohibited contact, defined as harassing, hindering, interfering with threatening or obstructing a person. It was outlined in my speech.

Mr WOOD: I am working on the safe access zone, not so much the details of what is in it. Can you apply a safe access zone within a shopping centre, for instance? If you have a surgery in a shopping centre does that require permission from the owners of the shopping centre?

Ms FYLES: If you have a surgery within a shopping centre, which is a public space, the safe access zone would be enacted.

Mr WOOD: If there is a group with alternative ideas which has a small office or a shop within that shopping centre—they might be pregnancy help—are they permitted to continue, or are they within that access zone and therefore not allowed to continue?

Ms FYLES: That would be fine; it is only when they are participating in prohibited conduct.

Mr WOOD: Prohibited conduct is 'act or be seen or heard'.

Ms FYLES: Prohibited conduct is harassing, hindering, interfering, threatening or obstructing.

Mr WOOD: Minister, it is more than that. Your bill says more than that.

Ms FYLES: Member for Nelson, I remind you that it needs to be intended. It is quite clear in the definition around what harassment is; it needs to be intended. I have spoken in detail about that.

Mr WOOD: It says:

an act that could be seen or heard by a person in the vicinity of premises for performing terminations, that may result in deterring another person from ...

Ms FYLES: Entering the premises.

Mr WOOD: No, 'in deterring'.

Ms FYLES: It goes on to say 'in deterring a person from entering premises for terminations or performing or receiving a termination of pregnancy'. It is quite clear that it needs to be an intended act that deters a person.

Mr WOOD: I will get to that section when we get to that section. I want to work out how the government has the right over private land to do that. In the case of Aboriginal land, does it apply to Aboriginal land if there is a clinic?

Ms FYLES: It is legislation; it is the law. It is the same as the environmental—in terms of noise pollution and things like that. Just because it is on private land—legislation is still in place.

Mr WOOD: Is a chemist required to have a safe access zone?

Ms FYLES: No, a chemist does not need the safe access zone. It is the boundary of a premises where terminations are performed. It says it in the top point.

Mr WOOD: Do nurse practitioners come under the definition of nursing and midwifery. Are they covered by that?

Ms FYLES: Yes.

Mr WOOD: I move amendment 1.2. In my amendment I am asking that 'termination' means 'intentionally terminating the life of an unborn human'. I have put that in because nowhere in this act does it specifically say what really occurs. We know it is a termination of pregnancy, but the process to get to a termination of pregnancy is that the life of an unborn child, an unborn human, is terminated. I would have thought that a reasonable thing to have in the definition so people understand what this is all about.

Ms FYLES: With all due respect, that is inconsistent with the intention of this bill; it is not in line with interstate jurisdictions. It seeks to claim rights for an unborn child that do not exist, and that is said with all due respect.

Mr WOOD: I am not concerned about other states' views of the world. This ...

Ms FYLES: It is quite clear from my first part of the comment; it is inconsistent with the bill.

Mr WOOD: I am not sure why because you would just be putting in a definition explaining exactly what occurs when a pregnancy is terminated. I think that is a reasonable thing to have within our legislation—not Victorian legislation. I am not sure why it should not be there.

Mrs FINOCCHIARO: Mr Deputy Speaker, as with the Member for Nelson's amendment 1.1, the opposition does not support amendment 1.2.

Amendment not agreed to.

Clause 4 agreed to.

Mr DEPUTY SPEAKER: Before we go on to clause 5, I take this opportunity to remind members that consideration in detail is not a policy debate. There are two purposes: to ask questions to seek clarification, not to debate responses, and to move amendments. For the purpose of clarifying, for each clause I will ask members to ask their question. If an amendment is proposed it will be called and moved, then put at the end. We will have questions first, then amendments, then, if need be, the process further on.

Clause 5 agreed to.

Clause 6:

Mr WOOD: There are two amendments; one is a grammatical amendment to allow for a section of the next clause to be omitted. I move amendments 1.3 and 1.4 to clause 6

Minister, clause 6(1) says, under 'Performing a termination':

- (1) *A medical practitioner who does any of the following, intending to induce an abortion, performs a termination*
 - (a) *performs a surgical procedure;*
 - (b) *prescribes, supplies or administers a termination drug;*
 - (c) *any other action.*

Would that only be a suitably qualified medical practitioner?

Ms FYLES: Yes, Member for Nelson.

Mr WOOD: But it says a 'medical practitioner'; it does not say 'a suitably qualified medical practitioner'.

Ms FYLES: The reason for that, Member for Nelson, is that an ordinary medical practitioner has to do it in a life-saving event, so it applies to all medical practitioners.

Mr WOOD: Is that clear in the bill that it is only when that occurs? All right.

The section I would like omitted is 'any other action'. There is no definition of 'any other action' in this document. There is nothing in the explanatory notes or your second reading. As I said in my speech, a doctor could technically use some instrument ...

A member interjecting.

Mr WOOD: Well, he could, technically, because he is not covered by anything except the guidelines of his practice ...

Ms FYLES: Member for Nelson, what medical guidelines would allow for that?

Mr WOOD: If he went against his own medical guidelines.

Ms FYLES: There is the answer. If you went against medical guidelines that would be assault and that would be a matter for the police.

Mr WOOD: What does 'any other action' mean?

Ms FYLES: This is to future proof the bill. It allows for new medical treatments or a combination of medical and surgical procedures to be used. What you are talking about would be going against their medical guidelines. Different instances have been floated which would be assault. There are clear guidelines.

Mr WOOD: Then why is that not defined in this? There is no definition. While it is an open definition, it is open for interpretation. You have given me a definition now ...

Ms FYLES: We are creating contemporary legislation that will be future proofed because we acknowledge it has been 40 years since we last had a bill. I hope that if there needs to be amendments made by future parliaments, it does not drag for another 40 years. We are creating contemporary legislation that will future

proof to allow for advancements in medicine. But we must acknowledge that if medical practitioners do not follow their guidelines, that would be considered assault.

Mr WOOD: That may be the case, but all you need to do is leave this out and when the time comes an amendment can be brought to this parliament about so-called new methods. That would be appropriate. You are asking us to support something when we have no idea what it is or what it could mean.

Ms FYLES: I clearly outlined to the House what that would be and that we are creating contemporary legislation. I have also clearly outlined that the circumstance you have mentioned would go against medical guidelines and be considered assault.

Mr WOOD: Why would it be assault if, basically, it is a termination? This is about how to procure a termination, it does not say what method ...

Ms FYLES: I will say it one more time, then I will leave it. Medical professionals have to comply with their medical guidelines. If they do not do then that is, potentially, assault and a matter for police.

Mr WOOD: Then why not have it in the *Criminal Code Act*? You have just removed the options of doing that.

Mr GUNNER: It is my understanding, Member for Nelson, that this is within the context of this legislation. It is not an open field, and from the experience we have recently been through—and by recently I mean the last year or so; in the context of the debate, in many respects, that is recent—it takes considerable time to bring amendments to this legislation through this House. This is very much about making sure, within the context of this legislation, medical guidelines and regulations—there are all those precautions, which means the examples which have been given are not accurate—we provide a capacity for future medical advancement to be covered within the intention of this bill. It is within the cautions and protections context that it is considered, but it is providing the capacity for changes—as we have seen already and the whole reason we are here.

Also, it has taken us a long time to get here, so this is simply an ability, as the minister said, to future proof it, because this is a very difficult thing to bring through this Chamber. That is all.

The example given today—I do not want to reference it—is not possible under this proposal. It is simply, in the context of the legislation, the regulations and the medical guidelines, providing some capacity for evolution without having to go through the drama a lot of Territory women have gone through in recent years.

Mr DEPUTY SPEAKER: Member for Nelson, do you have any further questions that have not already been answered?

Mr WOOD: Mr Deputy Speaker, that was a broad statement. In response to the Chief Minister, we are not asking that in the future you do the whole bill; it is simply an amendment—one amendment which would allow any new processes to be debated.

Ms FYLES: Mr Deputy Speaker, I will say it one more time. We are creating contemporary legislation that entrusts medical professionals with making decisions. We want to future proof this legislation because we want contemporary legislation that caters for advancements in medicine.

Mrs FINOCCHIARO: Mr Deputy Speaker, something just occurred to me and perhaps the minister can seek counsel from the departmental draftsman, but should there be an 'or' after the semicolon in 6(1)(b)?

Mr GUNNER: After 'supplies'?

Mrs FINOCCHIARO: After 'drug'—prescribes, supplies or administers a termination drug; or.

Ms FYLES: The advice I have just received is that they do not believe so.

Mrs FINOCCHIARO: For the record, the opposition does not support amendment 1.3 as proposed by the Member for Nelson.

Amendments not agreed to.

Clause 6 agreed to.

New clauses 6A and 6B.

Mr WOOD: I move amendment 1.5 to insert new clauses 6A and 6B

Ms FYLES: We will not be supporting the amendments you put forward today, if that helps you in the debate before us. I apologise; I thought I said that earlier.

Mr WOOD: I presumed it to some extent, but we will battle on.

There is no mention of counselling in the legislation, except a single mention under the definition of professional standards and guidelines. Is the legislation so biased that it basically silences any other options being available? According to the statements by RANZCOG regarding the use of Mifepristone for the medical termination of pregnancy, 3.5, 'General considerations prior to pregnancy termination' says:

All women should be given accurate information and appropriate counselling should be available.

In Western Australia, the booklet *Termination of pregnancy: Information and legal obligations for medical practitioners* says:

The medical practitioner must obtain informed consent from the woman before referral for termination, should she choose that option. The obtaining of informed consent is defined by the following actions:

- *A medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term.*
- *A medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and*
- *A medical practitioner has informed her that appropriate and adequate counselling will be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.*

Today I read out a submission from a Central Australia doctor who said exactly the same thing. Her concern about not having counselling—she said:

In the situation of a woman who is distressed by an unplanned pregnancy, she should first be offered non-directive and supportive decision-making counselling which provides her with emotional support ..

As she said, there should be a cooling-off period. A number of people have said that.

The amendments I bring forward today do exactly that. They allow non-judgmental counselling and provide a cooling-off period.

My amendment to insert new clause 6A says:

- (1) *A suitably qualified medical practitioner may perform a termination under this Act on a woman only if:*
 - (a) *the termination is performed not less than 5 days after the woman first requested the termination from a suitably qualified medical practitioner; and*
 - (b) *the woman, since first requesting the termination, has obtained a certificate of counselling from a suitably qualified counsellor who is independent from each of the following:*
 - (i) *each health practitioner involved, or proposed to be involved, in the performance of the termination;*
 - (ii) *the premises for performing terminations proposed to be used for the termination;*

- (iii) *the person who, or entity that, owns or operates the premises mentioned in subparagraph (ii); and*
- (c) *the medical practitioner has provided the approved information to the woman and has informed the woman:*
 - (i) *of the risks associated with terminations; and*
 - (ii) *of the alternatives to termination; and*
- (d) *the woman affirms that she:*
 - (i) *understands the risks associated with terminations; and*
 - (ii) *has been informed of the alternatives to termination; and*
 - (iii) *has had explained to her the procedure involved, the risk of complications and the possible effects of the termination on her, and has had her questions in relation to these matters answered; and*
 - (iv) *provides her consent freely and without coercion; and*
 - (v) *has been supplied with a list of the providers of support services for women seeking a termination.*

- (2) *A person commits an offence if:*

- (a) *the person performs a termination on a woman; and*
- (b) *the person knows that the requirements of subsection (1) have not been complied with.*

...

- (3) *In this section:*

certificate of counselling means a certificate supplied by a suitably qualified counsellor confirming that the counsellor has consulted with the woman and has:

- (a) *informed the woman of the various alternatives to termination; and*
- (b) *counselled the woman concerning any needs she may have in respect of any of the following:*
 - (i) *domestic violence;*
 - (ii) *housing and support services;*
 - (iii) *mental health;*
 - (iv) *pregnancy counselling and support services;*
 - (v) *psychological, social, emotional, physical or health distress; and*
- (c) *supplied the woman with a list of providers, registered under the Regulations, of various support services for women seeking terminations including:*
 - (i) *health services; and*
 - (ii) *domestic violence support services; and*
 - (iii) *housing and support services; and*
 - (iv) *mental health support services; and*

(v) *pregnancy counselling and support services; and*

(vi) *other support services.*

suitably qualified counsellor means a person who is one of the following:

(a) *a general practitioner;*

(b) *a psychologist;*

(c) *a psychiatrist;*

(d) *a credentialed counsellor.*

I believe that is a well-balanced approach to the issue of counselling. I am not the only one saying it. Dr Gawler said it in his submission and the Central Australian doctor said the same thing. It makes sense. If we are to give a non-judgmental view of this really important issue then counselling surely is a requirement that is needed in this important legislation. This is a difficult time for women; I understand that. Sometimes it is difficult for families, but when you are under pressure or stressed it is not the right time to make a decision.

This says that to have informed consent you need proper counselling; there is a requirement for informed consent. New clause 6A would allow that to happen.

Ms FYLES: We trust our medical and health practitioners to provide the best care for Territory women. These stipulations are routine. Common law is used for informed consent and does not need to be specific to the legislation, as per any other medical procedure.

Conditions of the independence of a counsellor could make it exceedingly difficult for regional women to access a counsellor in a timely manner. How would proposed counselling be relevant to a woman who has a foetal abnormality, for example? In terms of our piece of legislation, the clinical guidelines will set out advice regarding providing counselling for women.

I point to evidence in the United Kingdom professional standards and guidelines which states that counselling should not be a precondition to the performance of a termination of pregnancy. The United Kingdom's Royal College of Obstetrics and Gynaecology says all women will require a discussion to determine the degree of certainty in their decision and the understanding of the implications with their medical practitioner. Those who require additional support and counselling, including young women with mental health problems and women with poor social support—if there is any evidence of a concern, that can be provided. The UK study in the 1980s found that of the 91% of women with unwanted pregnancies, only 6% were unsure of their decision to terminate. A study in Scotland in 2006 found that over 90% of 316 women seeking a termination clearly indicated that they had an unintended pregnancy.

Staff caring for women requesting abortion should identify those who require more support in the decision-making process, and women who are certain of their decision to undergo a termination of pregnancy should not be subjected to compulsory counselling. There is evidence from overseas—the professional standards guideline talks about the availability of support services, including counselling, and that will be met.

The professional guidelines refer to support services and offers of counselling, and the health guidelines will contain counselling. Our consumer information sheet will refer to counselling. We believe that cooling-off periods pose an unreasonable impediment to access to medical services.

Mr WOOD: I do not think any of this was intended to actually hurt a woman; it was to make sure the decision the woman was making was done ...

Ms FYLES: Mandating potentially has that impact.

Mr WOOD: I do not know why it would because as someone said ...

Ms FYLES: I have just clearly outlined it to you.

Mr WOOD: The intent of this clause was to make sure that a woman—it is a very serious decision. I have heard everyone here today speak ...

Ms FYLES: Coming back to my question, how would the proposed counselling be relevant to a woman with a pregnancy with a foetal abnormality?

Mr DEPUTY SPEAKER: Member for Nelson, before you start I remind all honourable members that one member will talk at a time while we are in consideration of detail.

Mr WOOD: I am not a doctor, but if there was a foetal abnormality I imagine that would come under exceptions—emergency—but there would be other ways of dealing with that issue.

Ms FYLES: This would come under the legislation. We believe the way we have placed it under the professional standards ...

Mr WOOD: It might come under the rest of your legislation about saving a woman's life; it could come under that. That is the reason people used to get abortions, because of foetal abnormality, but you still had to get it checked. You still had to make sure that was the case.

Ms FYLES: Your clause mandates counselling for everyone who has access to or undergoes an abortion in the Northern Territory; that would include those people.

Mr WOOD: I would imagine, unless it was a life or death situation ...

Ms FYLES: If you place in there that you are mandating.

Mr WOOD: Regardless of what the issue is, the cooling off period will not make any difference. The whole idea is that if it is a medical issue—the counselling will tell the woman that. That is all this is doing. It is well balanced. It is independent, and it makes sure a person has been counselled before they give permission, or informed consent.

Ms FYLES: I will say it one last time. We believe that, under professional standards and guidelines, subclause (e):

the availability of support services, including counselling.

provides for that without mandating it, without legislating that all women who have access to termination of pregnancy have to go to counselling. We know that will have an impact on women seeking this service.

Mrs FINOCCHIARO: The opposition does not support the Member for Nelson's proposed amendment for the reasons outlined by the Attorney-General. We would not support mandating counselling as a precondition. Harm can be caused to a woman by extending the length of her pregnancy by any time. Five days, while it appears arbitrary, could mean the difference between someone being within the 14, nine or 23 week period, which can have serious consequences. We will not be supporting those amendments.

Mr WOOD: Clause 6B, based on the RANZCOG recommendations, says follow up should be undertaken to ensure the termination is complete. Local protocols should be developed which include clinical assessment, and, if indicated, HCG estimations and or ultrasound examination. Follow-up should also confirm ongoing access to and use of effective contraception.

The clause I put forward, 6B, says, under 'Follow-up':

A suitably qualified medical practitioner who performs a termination on a woman must:

- (a) conduct a follow-up consultation with the woman between 3 and 7 days after the termination, or as near to that timeframe as practicable in the woman's circumstances;*
- (b) consider whether the woman has any ongoing healthcare counselling or welfare needs including in respect of:*
 - (i) housing and support services; and*
 - (ii) mental health; and*
 - (iii) psychological, social, emotional, physical or health distress; and*

- (c) *take reasonable steps, or make reasonable enquiries or referrals, to seek to address those needs.*

It is simply putting a recommendation from RANZCOG into the legislation.

Ms FYLES: A point of order, Member for Nelson! The RANZCOG guidelines say there should be a two-week follow-up.

Mr WOOD: This came from a doctor and that is what he has put in.

Ms FYLES: I am quoting the guidelines. The bill provides for, as recommended, the two-week follow-up, based on the guidelines. I question that your information is accurate.

Mr WOOD: I will leave it at that. You are not going to support it anyway. Do you support any follow-up?

Ms FYLES: Under the TGA guidelines, two-week follow-up.

Mr WOOD: TGA? I am quoting RANZCOG.

Ms FYLES: It does not give a time period, as I understand.

The rationale for us is that there is no rationale. What you are proposing is inconsistent with evidence-based practice.

Mr WOOD: What would be evidence-based practice? It is simply a follow-up. It is something to make sure ...

Ms FYLES: In this bill we are providing follow-up at two weeks, based on guidelines. Your proposed amendment does not have an evidence base for it.

Mr WOOD: It was RANZCOG that we took it from.

Ms FYLES: Can you table that document because we do not have that.

Mr WOOD: I need the document at the moment.

Mrs FINOCCHIARO: Just for clarity, the opposition supports the 14-day follow-up.

Amendment not agreed to

New clauses 6A and 6B not agreed to.

Clause 7:

Mr WOOD: Minister, what does 'considers ... is appropriate in all circumstances' mean?

Ms FYLES: I am seeking advice, Member for Nelson, but, as I understand it, everything under the guidelines. The professional standards guidelines dictate everything you must take into account.

Mr WOOD: Which of the professional guidelines are you referring to?

Ms FYLES: The UK and Australian.

Mrs FINOCCHIARO: Could the minister please explain why it was decided to only require one practitioner in considering the termination?

Ms FYLES: The working group, the senior clinicians, endorsed that.

Mr WOOD: If one circumstance is not appropriate—this is what we were talking about—is an abortion still permitted?

Ms FYLES: Early termination is considered low risk.

Mr WOOD: That was not the question. It says:

A suitably qualified medical practitioner may perform a termination on a woman who is not more than 14 weeks pregnant, if the medical practitioner considers the termination is appropriate in all the circumstances ...

If one of those circumstances is not appropriate, is an abortion allowed to go ahead?

Ms FYLES: Up until 14 weeks, if all those aspects are taken into account, then it can proceed. I am seeking advice on your further question.

If they cannot, then they seek a second opinion.

Mr WOOD: It might have been a good idea to keep the two doctors in the first place ...

Ms FYLES: No. As I outlined in my point before, early termination of pregnancy is seen as lower risk, so:

A suitably qualified medical practitioner may perform a termination on a woman who is not more than 14 weeks pregnant, if the medical practitioner considers the termination is appropriate in all the circumstances, having regard to:

The keys in that point are 'may' and 'having regard to' (a), (b) and (c). If they do not feel they can meet that, they seek a second opinion.

We are trying to provide in amenity to early stage, low risk ...

Mr WOOD: I am a little confused. If one doctor says not all circumstances are appropriate, having had regard to the other sections in this clause, and then the woman goes to another doctor who gives a second opinion saying everything is appropriate, then it is okay?

Ms FYLES: They have sought the second medical opinion, so it would be okay.

Mr WOOD: What would happen to a doctor who had not considered all the circumstances and gone ahead with an abortion? Has he or she committed an offence?

Ms FYLES: It is not an offence, but it is not meeting the guidelines.

Mr WOOD: What would happen to the doctor if he induced an abortion and had not had regard to (a), (b) and (c)?

Ms FYLES: It could be civil or disciplinary action. I am answering the question you just asked.

Mr WOOD: Does 'having regard to' mean 'must'? In the next section the word 'must' is used under clause 8; there is no 'having regard to'. Does 'having regard to' mean he or she must take those things into consideration?

Ms FYLES: Up until 14 weeks, because it is considered lower risk in medical terms—and I say that with respect. Post 14 weeks—he must.

Mr WOOD: To clarify that, clause 8 deals with pregnancies before 14 weeks, and clause 8(2) says:

In considering whether the termination is appropriate, as mentioned in subsection (1), the medical practitioner must have regard to each of the matters ...

Ms FYLES: When he is directing another health practitioner he 'must' have regard.

Mr WOOD: Why is it not the same in clause 7?

Ms FYLES: I think we are playing with semantics.

Mr WOOD: Sometimes semantics are very important when you are dealing with legislation.

Clause 7 is the basis for changing the restriction on abortion. You are intending to get rid of the *Medical Services Act*, which basically says a woman's life has to be in danger or the child might be deformed et cetera, to summarise it. You are removing that.

The reasons that a person can get an abortion now—they have to have all their relevant circumstances checked. The woman's current and future physical, psychological and social circumstances have to be checked and have to follow professional standard guidelines. We have gone from some restrictions to basically ticking the box; this a much easier process than we had previously.

Ms FYLES: With all due respect to those who first brought this legislation into the Northern Territory, the previous legislation was flawed. If you were under 14 weeks pregnant you had to have two doctors and if you were post 14 weeks you had to have one doctor. We are making sure there is provision that if it is lower risk then it is one doctor. If it is considered to be higher risk then it is two doctors. Mr Deputy Speaker, that is all I can answer on this. I think we are going around in circles.

Mr WOOD: The question is not about having two doctors; the question is whether this legislation is allowing for abortion on demand?

Mr DEPUTY SPEAKER: That is out of order; it is not in that clause and that is not why we are here to debate.

Mr WOOD: It certainly is in the clause, because we are dealing with the circumstances which are now required for women to get an abortion, compared to what was required in the previous act. The previous act was has been dismissed and these are the new requirements.

Ms FYLES: Under the previous act there was still the same level of assessment; it is a difference I pointed out earlier, and it is the same level of assessment under this act.

Mrs FINOCCHIARO: Is your concern, Member for Nelson, that 'having regard to' is not strong enough?

Mr WOOD: My concern is the ability to get an abortion is completely different to what is in the existing *Medical Services Act*, which was a lot stricter. This is a lot easier. But I will move on.

Could the Minister for Health please explain to me what 'physical, psychological and social circumstances' will mean?

Ms FYLES: That is fairly self-explanatory and it will be in the clinical guidelines.

Mr WOOD: What do social circumstances mean, especially if you are considering future circumstances? How do you deal with this ...

Mr DEPUTY SPEAKER: Member for Nelson, the Minister of Health has just answered that.

Mr WOOD: No, section (b) says:

the woman's current and future physical, psychological and social circumstances.

How do you make the judgment on those future circumstances?

Mr DEPUTY SPEAKER: The Minister for Health has answered that question.

Mr WOOD: I have a point of difference. The bill says 'current' and the second part says 'future'. I am asking how you ...

Ms FYLES: The woman's future physical, psychological, social circumstance—her work situation—her situation; that is the future that is referenced.

Mr WOOD: Under this legislation can a woman select the gender of the baby, and if so ...

Mr DEPUTY SPEAKER: Member for Nelson, that is not in the clause.

Mr WOOD: Excuse me. We are dealing with ...

Mr DEPUTY SPEAKER: Member for Nelson, you are not excused. That is not in the clause, therefore it is not up for discussion.

Mr WOOD: It is up for discussion. I have to ask what is available under this new clause. This is the clause that allows abortion. I need to know what is or is not allowed, and one of the issues is gender selection. Is gender selection allowed under this legislation or is it prohibited?

Ms FYLES: Mr Deputy Speaker, no.

Mr WOOD: What stops it? That is all I am asking.

Ms FYLES: It is not the intent of the legislation and it is not in the legislation. There is no reference to it. It is not about that. It is about providing better access for Territory women to terminate a pregnancy by allowing surgical and medical abortions to take place.

Mr WOOD: So if a patient said, 'I do not want this boy or girl', can a doctor go ahead with that abortion?

Ms FYLES: How would that be relevant to medical circumstances? I will end that there because I have made it clear that it is not the intent of the legislation.

Mr WOOD: In relation to GP clinics, under this some of them can become abortion clinics. Can they be used for both surgical and medical abortions, and who will licence them?

Mr DEPUTY SPEAKER: Member for Nelson, where is that in clause 7?

Mr WOOD: We have a bill which will allow termination of pregnancies to occur, and this is one of the few parts where you can ask if the termination of pregnancies will be allowed in GP clinics. That is the intention of the bill, as the minister put forward.

Mr DEPUTY SPEAKER: Member for Nelson, that was in the second reading debate.

Ms FYLES: Mr Deputy Speaker, I am happy to answer the question. If they met all of the regulations, had all the appropriate facilities and met the guidelines, it would be possible.

Mr WOOD: This is dealing with terminations up to 14 weeks. My understanding from the TGA ...

Ms FYLES: That would be surgical, in response to my previous answer.

Mr WOOD: Medical abortion using MS 2-Step, according to the TGA, can only be used up to nine weeks. How is it allowed to be used to 14 weeks if it is off label?

Ms FYLES: Up to nine weeks you can take the medicine home. From nine to 14 weeks you need to take it on site, and up to 23 weeks.

Mr WOOD: The TGA *Australian Public Assessment Report for Mifepristone* says:

Mifepristone Linepharma 200 mg tablet is indicated in women and adolescent girls of childbearing age for:

1. *Medical termination of a developing intra-uterine pregnancy. In sequential combination with a prostaglandin analogue up to 49 days of gestation*

How does that fit in with the use of it up to 14 weeks, and how is that allowed?

Ms FYLES: Up to 63 days can be at home and beyond 63 days, in a facility with suitably trained staff and within two hours of access to a hospital.

Mrs FINOCCHIARO: Between nine and 14 weeks you can still have a termination by the drug as long as it is in a facility?

Ms FYLES: An appropriate facility.

Mrs FINOCCHIARO: Is that outside of the drug's own rules in the Therapeutic Goods Administration guidelines?

Ms FYLES: It is within the guidelines.

Mr WOOD: The RANZCOG guidelines, but the TGA says 49 days.

Ms FYLES: I was just reading from the TGA guidelines.

Mr WOOD: They are the ones who put the label on the product? It is regarded as off label.

Ms FYLES: They do the safety assessments, and that was what I was reading.

Mr WOOD: From a legislative point of view, who do we go to if TGA says 49 days and you say that RANZCOG ...

Ms FYLES: No, I was reading from TGA.

Mr WOOD: I am reading from TGA—when it did the assessment of the drugs. Unless you have a different paper to me—page 83.

Ms FYLES: I am quoting from the Australian public assessment report.

Mr WOOD: I am reading page 83.

Ms FYLES: What year is your report?

Mr WOOD: The year of the report is 2012. I am confused, I have heard this a number of times, and I thought here was the place to clarify it. MS-2 Step can be used at home up to nine weeks. After nine weeks it has to be done in a hospital or a clinic. Is that right? I need to know where it can be used after the nine weeks.

Ms FYLES: Page 63 of the document clearly outlines it.

Mrs FINOCCHIARO: Would the woman then be required to remain in the facility for the 14 days or is it just for the dispensing of the medication?

Ms FYLES: She takes the tablet at the facility but needs to remain within two hours of the facility for the period of time—whatever that may be for her. That was where I was indicating that patient travel would be provided for, for women who may have to travel if they live more than two hours from a facility.

Mr WOOD: We know they have to be within two hours, so from nought to nine weeks, if a woman takes the drug she has to be within two hours of the clinic. From nine weeks to 14 weeks—what happens there?

Ms FYLES: She takes the tablet within a facility and has to remain within two hours of the facility.

Mr WOOD: Is the only difference that she takes the drug within the facility? She does not take it at home like in the first case?

Ms FYLES: Yes, because it is early pregnancy so it is considered lower risk.

Mr WOOD: Is someone there to make sure she will come back on the third day for the second drug? That is one of the problems.

Ms FYLES: That is part of the assessment; the clinician makes an assessment.

Clause 7 agreed to.

Clause 8:

Mr WOOD: Am I right in saying this section will allow the Department of Health to set up remote clinics or facilities for abortion using telemedicine?

Ms FYLES: We need to remember that all times you must be within two hours of one of the five gazetted hospitals. If there is a clinic that meets that, then potentially. If you are outside that time frame, then no. That is two hours driving time, and it is the responsibility of the practitioner to make an assessment of road

conditions and things like that to ensure it is appropriate. We have a unique environment in the Territory, even the rural areas of Darwin can be cut off at certain points. It is up to the practitioner to make the assessment.

We also need to be careful of the definition of 'clinic'. In the Territory when we refer to a 'clinic' it is generally a remote clinic, but it could be a day surgery clinic.

Mr WOOD: The concern I have about this legislation is if you allow a doctor who can be in Darwin, theoretically, through telemedicine and a clinic has an ultrasound machine—you are saying they will not be able to direct ...

Ms FYLES: The woman has to be within two hours.

Mr WOOD: Say they are within two hours. That clinic could, using this section of the bill, use an Aboriginal and Torres Strait Islander practitioner, nurse or midwife to do the abortion via telemedicine. A doctor can be in town, assess an ultrasound which can pass that process, and hopefully someone is trained enough to ensure the patient does not have contraindications. This could allow that to happen, is that right?

Ms FYLES: The use of this, at all times, has to be within two hours of a hospital. Then they have to follow the guidelines and legislation. If they follow that then that is acceptable. If they are outside the guidelines, the legislation and two hours, then no.

Mr WOOD: In forming this piece of legislation, what consultation was done with rural and remote communities as to whether they want their health clinics to have this available? That is one of my concerns. In the response from the Central Australia doctor, her concerns were that people had not been given time to understand what was happening. The Member for Nhulunbuy also raised those questions. If it is the government's intention to eventually have remote communities with the ability to administer and supply RU486, has there been consultation with members of those communities?

Ms FYLES: Member for Nelson, I outlined in my closing speech that there has been significant consultation across the Northern Territory. The five main Indigenous health services have been consulted, and they welcome this legislation, but there are strict guidelines around it.

I keep coming back to the point that you must be within two hours of a hospital. That is the current manufacturer's guideline, and that is what is in place. We are starting to peddle mistruths when we start talking about remote clinics, and we need to be careful. We are providing health services. We are broadening it so it is more easily accessible, but safety is paramount. You need to be within two hours of those five hospitals, and you must uphold the guidelines and meet the legislation.

In Alice Springs, Congress was consulted on this. We need to be fair about this legislation. We are not rolling this out in remote clinics across the Northern Territory. Yes, we are providing more services, but it is a completely controlled environment where safety is paramount.

Mr GUNNER: Member for Nelson, I apology if I am not understanding exactly what you are saying, but I want to flag a concern that if we are essentially saying consultation leading to exclusion of access to a health service at a particular clinic—we have, in the bill, picked up the principle of the conscientious objection to allow for that. I would have concerns if we were consulting about the exclusion of access to a health service.

For me it is very much about, as the minister said, providing these services within two hours, as based on the advice. That is the framework of the conversations. Another part of your question was if there can be consultations for exclusions, as in whether this health service is offered at all at a clinic. That principle is picked up in the conscientious objection part. I flag a concern about consulting for exclusion.

Mr WOOD: I do not quite agree, but we will not go there. I was not saying that remote communities should be outside the two hours. I have never said that. I know the guidelines as well.

You have in here that an authorised chemist may supply a termination drug. I have a research article here called *Mifepristone (RU486) in Australian pharmacies: the ethical and practical challenges*.

Can a chemist, if he morally does not support termination of pregnancies, refuse to supply that drug?

Ms FYLES: The conscientious objection would come in. They would need to refer to a pharmacy that did provide it. Pharmacists deal with highly dangerous drugs all the time. They go through specialised training, but there is additional training for them to dispense this drug. There is provision, for example, that under nine weeks, someone would get the script and it could be filled and they could take it, but from nine to 14 weeks there is the general expectation that the pharmacist would deliver the filled script back to the doctor so they meet that provision of the legislation.

Mr WOOD: We went off the point there. The question was: does a pharmacist have to supply the drug if they do not want to? What concerned me then was you said he would have the right under conscientious objection. That is why I was asking what the definition of 'medical practitioner' was. The section under conscientious objection only deals with medical practitioners. Are you telling me that a chemist is a medical practitioner? That is not the way I read the legislation. The way I read it, the chemist does not have to supply the drug in his chemist if he does not want to.

Mr GUNNER: Member for Nelson, my understanding is that in clause 4(d) under 'health practitioner', pharmacy is listed, and 3(c) says, 'to regulate health practitioners'. If you go across the page you see that a pharmacy is a health practitioner. My interpretation is that 'pharmacy' is included under the definition of 'health practitioner'.

Ms FYLES: In clause 12, 'Authorised health practitioner who has a conscientious objection', it says:

This section applies if a suitably qualified medical practitioner directs an authorised ATSI health practitioner, authorised midwife, authorised nurse or authorised pharmacist ...

If the pharmacist objects, then the medical practitioner will find another pharmacist.

Mr WOOD: That is different to what you said originally. The interpretation I got was ...

Ms FYLES: Sorry, I did not mean to give you the wrong impression.

Mr WOOD: It is important because it also applies to nurses working out bush. Again, I quote from the Central Australian doctor who made a submission. She talked about where you get an isolated clinic and she said in her ...

Mr DEPUTY SPEAKER: Member for Nelson, is there a question?

Mr WOOD: Yes, there is.

Mr DEPUTY SPEAKER: Can you get to the question, please?

Mr WOOD: Yes. I am allowed 10 minutes to get to the question, which is related to an authorised health practitioner, midwife or nurse who may supply the drug. The question the Central Australian doctor put in her submission—it is a long submission of four pages, so I will not read it all—was in relation to a clinic that has just a nurse who has a conscientious objection to handling or supplying the drug. She is covered, I presume, by clause 12 of the bill? So the decision ...

Ms FYLES: A point of order, Mr Deputy Speaker. I feel we have answered this question and we are being repetitive.

Mr WOOD: One was the chemist and one was the health practitioner. They are important questions because they come down to people who work in this industry who have a conscientious objection. I need to make it clear, as distinct from what the medical practitioners' restrictions are. Will those things apply to the chemists or ATSI workers? You have clarified that.

Mr DEPUTY SPEAKER: Member for Nelson, the Minister for Health has answered that question. Are there any further questions?

Clause 8 agreed to.

Clause 9:

Mr WOOD: My amendment to clause 9 is simply an inclusion to make it clear that a termination of up to no more than 23 weeks must be performed in a hospital. This amendment makes it clear that abortion

performed under this section must be performed in a hospital; a hospital is more likely to be a place, as RANZCOG says, where there will be people with more specific staff, experience and expertise, which will be needed.

Could you tell me if that is the intention of this section?

Ms FYLES: Can you repeat the start of your question?

Mrs FINOCCHIARO: Can I interrupt? Are we dealing with the amendment or are we not meant to be speaking more generally when we deal with the amendment?

Mr WOOD: The amendment is that the termination is performed in a hospital, right? So I am just trying to find out ...

Mrs FINOCCHIARO: I am just asking because I have a general question.

Mr DEPUTY SPEAKER: Thank you, Member for Spillett. We are talking in general now and will then progress onto the amendment.

Mrs FINOCCHIARO: Can the minister please advise why it was decided not to require one of the practitioners to be an obstetrician or gynaecologist?

Ms FYLES: The advice I have had is that 'two suitably qualified' provides for the coverage to make sure we have the resource available.

Mr WOOD: Minister, today you heard a concern at the end of the Member for Barkly's speech about live birth. This section allows termination of pregnancy by suitably qualified medical practitioner at not more than 23 weeks. What is the legislation in regard to a live birth at this stage? Is there a requirement to do the best you can to make sure that child lives?

Ms FYLES: Live birth is registered as a live birth and must be treated accordingly.

Mr WOOD: I am taking up the concerns of the Member for Barkly. From a clarification point of view, is there anything in any act where it says that is what the rules are in relation to a live birth? Is there a section of the act?

Ms FYLES: It is under the Births, Deaths and Marriages Act.

Mr WOOD: I presume that all terminations between 14 and 23 weeks must be performed in a hospital.

Ms FYLES: That would be inconsistent with the bill. No locations are specified for any terminations. It would restrict access for private day surgeries to provide the service.

Mr WOOD: Does this include medical abortions up to 23 weeks?

Ms FYLES: It is in a suitable facility.

Mr WOOD: The question was, will this section allow medical abortions to occur? That is, will MS 2-Step be allowed up to 23 weeks?

Ms FYLES: That would be up to the practitioner, subject to the professional standards.

Mr WOOD: What do the professional standards say?

Ms FYLES: At the moment it would be a facility that is approved by the Commonwealth for a surgical procedure.

Mr WOOD: To clarify, a person has been given approval to have MS 2-Step up to 23 weeks. She would have to be assessed; someone would have to administer the drug and she would have to be back in three days. Will that all occur within a hospital or, as the Member for Barkly was concerned about, could someone have this drug, late term, 23 weeks, and end up with a live birth nowhere near help?

Ms FYLES: I feel we are wandering here, but the more advanced the pregnancy the more likely the termination will be surgical in a hospital. The drug can be used to assist, but it is more likely to be surgical. I think we are getting in ...

Mr WOOD: You have a section here that says 'Termination of pregnancy by a suitably qualified medical practitioner at not more than 23 weeks'. You have to remember you have changed the terminology. The previous act only dealt with surgical. Now we are dealing with medical, so we have included that in the one term: 'termination of pregnancy'. I am not trying to be smart, I am trying to say ...

Ms FYLES: We are trusting medical practitioners to make the best decision.

Mr DEPUTY SPEAKER: Order! Minister for Health and Member for Nelson, please wait. One person will speak in this Chamber at a time. Minister, were you finishing?

Ms FYLES: We are trusting medical practitioners to make a judgment. These are their patients and they are caring for them. The advice I received from the Health department is that as the weeks of a pregnancy go on, the procedure changes and we are relying on the health practitioner. It is more likely to be a surgical termination of pregnancy, and it may be assisted by medical. That is for health practitioners to decide.

Mr WOOD: My concern is that is very loose and I thought ...

Ms FYLES: I do not think so. That is unfair criticism. I refer you to point seven.

Mr DEPUTY SPEAKER: Minister for Health, please hold. There is no difference between consideration in detail and any other business of this House. We will have one member speak at a time, and we will wait until they have finished before we talk. Member for Nelson, please continue.

Mr WOOD: I am trying to clarify—you are allowing the use of MS 2-Step up to 23 weeks. It would be good to hear from the government what the restrictions are on the use of that drug, and where and who can administer and make sure the drug is used in a safe way so the woman's life is not in danger.

Ms FYLES: I again remind the Member for Nelson that the TGA guidelines provide for—I again refer him to section 7 of the bill, in terms of what the medical practitioner must consider.

Mrs FINOCCHIARO: The way the section is worded is future proofing, as you mentioned before, so that if a different drug or advancements in the drug—and TGA or the drug company change the guidelines around it and RANZCOG changes its guidelines, then there would not be the requirement to amend the section.

We are delving into the clinical guidelines space and, in my briefings, use of the drug up to 23 weeks was never described to me. I do not see the need for it to be prescribed—what stage you stop allowing the use of MS 2-step and when a surgical procedure needs to happen. But in terms of the development of our clinical guidelines, it should adopt what RANZCOG and other guidelines say, and that is that it is used up to nine weeks.

Going into 14 weeks, I would like to see that prescribed in the guidelines, and that was always my understanding of what would happen.

Ms FYLES: After 14 weeks gestation a woman seeking a termination of pregnancy is likely to require a surgical procedure, in a suitable day surgery, clinical facility or hospital. The MS 2-Step medication may be used for pre-operative preparation. Due to the larger size and longer term of the pregnancy post 14 weeks, a surgical procedure is highly likely, to ensure proper evacuation and to reduce the effects of haemorrhage.

Drugs alone could be used if the medical practitioner considers it suitable, in a facility with access to operating theatre facilities. The advice is that it would be most likely used as a combination, but we are providing that for the health practitioners to decide. Under the bill, through regulations, the NT health clinical guidelines will set standards for suitable locations for performance of surgical termination of pregnancy.

The procedure and the associated anaesthetic should be, as with any other medical intervention, performed by appropriately trained doctors in premises approved by the recognised health standards authorities, such as The Australian Council on Healthcare Standards.

Mrs FINOCCHIARO: Do both the medical practitioners have to determine the cause of action taken to induce the termination? Do they have to agree on it—a combination, or one or the other?

Ms FYLES: Yes, 9(a) says:

the medical practitioner has consulted with at least one other suitably qualified medical practitioner who has assessed the woman ...

Mrs FINOCCHIARO: But that is in regard to assessment. They have to have a meeting of the minds on the treatment.

Did you say 9(b) answers my question?:

each medical practitioner considers the termination is appropriate in all the circumstances ...

is different to what type of termination will proceed.

Mr GUNNER: My understanding of what the minister said is that 9(a) is about whether they consulted and then 9(b) is that the termination is appropriate in the circumstances, as in that they have gone through the guidelines and made the right medical determination. My understanding of the answer is that the question was answered in the two parts, 9(a) and 9(b). That was my interpretation of what the minister said.

Mrs FINOCCHIARO: To confirm, do the two practitioners have to agree on the type of termination conducted?

Ms FYLES: They both have to consider it.

Mrs FINOCCHIARO: Which doctor decides how it goes ahead?

Ms FYLES: The principle treating doctor.

Mr DEPUTY SPEAKER: I believe that general questions have been exhausted. I understand, Member for Nelson, that you have amendments you would like to speak to. Before you start, Member for Nelson, the amendments have been circulated and will be tabled in the parliamentary *Minutes of Proceedings*, so you do not need to read them out if you do not want to.

Mr WOOD: There may be people listening, and they have to understand.

Mr DEPUTY SPEAKER: Absolutely; you are more than welcome to do that.

Mr WOOD: My proposed amendment to insert new clause 9A, 'Determining weeks of pregnancy,' says:

- 1) *This section applies if a suitably qualified medical practitioner is determining the number of weeks for which a woman has been pregnant.*
- 2) *The practitioner must make the enquiries, and perform or cause to be performed the medical examinations and tests, that a reasonably prudent medical practitioner, knowledgeable about the case and the medical conditions involved, would consider necessary to make an accurate determination of the matter.*

This section is to ensure the practitioner has done all the right things before he makes a decision for an accurate determination. So many of the decisions in the subsequent treatment depend on accurate diagnosis of the gestation of the baby.

Mr DEPUTY SPEAKER: Member for Nelson, we need to discuss amendments 1.6 and 1.7 before we go on to 9A, because that will impact on 9A.

Mr WOOD: I move amendments 1.6 and 1.7 to clause 9.

Amendments not agreed to.

Clause 9 agreed to.

New clause 9A:

Mr WOOD: I move amendment 1.8. That is the proposed new clause, which I will not repeat. This section is to ensure the practitioner has done all the right things before he makes a decision for an accurate determination. So many of the decisions in the subsequent treatment depend on accurate diagnosis of the gestation of the baby. The risk is if he or she has not done this, there could be legal action against the practitioner.

I am proposing this clause simply because I know from reading some of the literature from Western Australia that doctors have to be very careful about what they do. They also have to be careful about ensuring the gestation period is right. Sometimes that refers back to the issue of telemedicine, in which a judgment is being made from a distance. This clause would protect a practitioner if he has complied with that section of the act.

Ms FYLES: This is unnecessary and clumsy. The college guidelines provide directions on assessment, including ultrasound, to answer your query.

Amendment not agreed to.

New clause 9A not agreed to.

Clause 10 agreed to.

Clause 11:

Mr WOOD: I move amendments 1.9 and 1.10, inviting defeat of clause 11 and proposing a new clause 11, which I will speak to. This clause is about a medical practitioner who has a conscientious objection. We need to allow a person to have conscientious objection. For years and years we have had this definition:

A person is not under any duty to terminate or assist in terminating a woman's pregnancy, or to dispose of or assist in disposing of an aborted foetus, if the person has a conscientious objection to doing so.

That is a much better clause. It is one we have lived with in the Territory for a long time, so did conscientious objection suddenly change? It is not like drugs or new cars. Conscientious objection is an important part of every person's right.

Ms FYLES: The amendment is outdated. That is why it is being amended. The updated amendment is more restrictive than the current act. It is not consistent with guidelines—UK, RANZCOG, medical board, AMA.

Mr WOOD: I dispute the AMA's—it talks about therapy. This is not regarded as therapy. It is an attack on the right of a person not to do something they disagree with. If there is a person I dislike, and I am against murder, so I ring a person up the road who I know is a hitman and say, 'Here is \$1000. Can you do the job for me?' The police will arrest me because I was the person who organised it.

You cannot move something away from yourself. You are saying a doctor who has a conscientious objection to the termination of pregnancy has to send a woman to someone who they know will do the very thing they do not want to happen. That is wrong.

When the minister spoke about the International Covenant on Civil and Political Rights she discussed the section on religion. The first section is not about religion. The first section is:

Everyone shall have the right to freedom of thought, conscience and religion.

This goes against those rights because you have put a restriction on that conscience. You have told someone, 'You can have your conscience to a point'; that is what is different. It is fundamentally wrong for you to do that.

I do not know whether it is in contravention of the International Covenant, but I believe if we had a parliamentary committee and new ways of doing things we would be required, before we put this piece of legislation through, to check whether it goes against any international agreements our country has made.

My understanding is that the AMA simply says that when a moral judgment or religious belief prevents a doctor from recommending some form of therapy they should so inform the patients. The doctors who responded to this said 'The AMA statement refers to ...'

Ms FYLES: A point of order, Mr Deputy Speaker! The AMA has issued a statement on conscientious objection which acknowledges a doctor's refusal to be clinically involved in the termination of a pregnancy because of his or her personal convictions but also encourages those practitioners to not impede the patient's access to treatment services. We need to make sure we read the full quotes.

Mr WOOD: We are probably looking at two different AMA statements. One says 'encouraging', it does not say 'you will'. Your legislation says it will. You are forcing a doctor, on the pain of being deregistered. What will that say to trainee doctors who do not agree with abortion? Are they going to ...

Ms FYLES: A point of order, Mr Deputy Speaker! We are going a fair way off the clauses being discussed.

Mr WOOD: A point of order, Mr Deputy Speaker! This bill means a person cannot hold an unfettered right to a conscientious objection. Therefore, it could have implications on young doctors who wish to join the profession who do not agree with termination of pregnancy. They may say, 'I have a risk of being deregistered'. You said in today's debate that a doctor is likely to be deregistered. They will be sent to the Australian medical board.

Ms FYLES: They have different rights. The rights of patient must prevail at some point.

Mr DEPUTY SPEAKER: Member for Nelson, please hold. The Member for Spillett has a point of order.

Mrs FINOCCHIARO: I just had a question.

Mr DEPUTY SPEAKER: If you are going to raise a point of order, then please have the number for me because I will check it in the book.

Member for Nelson, are you asking the minister a particular question?

Mr WOOD: I am giving a response to the minister.

Mr DEPUTY SPEAKER: The minister did not ask a question.

Mr WOOD: The minister made a statement; I have to respond to it.

Ms FYLES: I am happy to go on and answer that question because I have decent information.

Mr DEPUTY SPEAKER: Order! Sit down, both of you, please.

Member for Nelson, I understand you have moved an amendment and you are speaking to that amendment. Following that, are there any questions you have in relation to the amendment for the minister?

Mrs FINOCCHIARO: Are we not in general discussion of the section first before we move into the amendments?

Mr DEPUTY SPEAKER: That time has passed. The Member for Nelson has moved the amendment.

Ms FYLES: I am happy to take the Member for Spillett's question.

Mrs FINOCCHIARO: Will material be provided to practitioners who are conscientious objectors so they can provide it to patients who come to them seeking a termination which they will not perform, and, if so, what will that material contain? I know the minister has the same information I was given, which the Australian Capital Territory uses. It is a very small booklet which seems to go some way in comforting conscientious objectors because it contains all options available for women, including termination.

What details might conscientious objectors be provided so they can in turn provide them to the patient so the patient is not bumped from conscientious objector to conscientious objector?

Ms FYLES: Medical practitioners and health practitioners holding a conscientious objection to the provision of termination of pregnancy services will not be required to perform termination services except where a termination of pregnancy is required to preserve the life of the pregnant woman. If a medical practitioner holds a conscientious objection to the provision of termination services the practitioner will be required to inform the woman of the objection and provide sufficient information to the woman to enable her to seek the services elsewhere.

We did discuss providing information for women on all options for them. I do not have the exact quotes from my speech—providing them with information on their options if they find themselves in an unintended pregnancy and making sure they fully understand their rights to services. Consumer information resources are being developed to provide clear advice on counselling services, pregnancy options, referral processes, transport and transfer accommodation—PATS—informed consent, and public and private organisations that perform termination services. Further, printed information will be made available at the request of Aboriginal medical organisations. In my consultations with them they described a lack of access to Internet for consumers and a cultural preference to give the information directly to women. We will make sure that is catered for.

Mrs FINOCCHIARO: Please explain to the House what a clinically reasonable time would be for the conscientious objector to refer a patient to another medical practitioner. Presumably if this information was available it would be dispensed by the practitioner immediately, but assuming that does not take place, if you could outline what the reasonable time would be.

Ms FYLES: Of course we hope medical practitioners would have that information to hand but if they do not, it is two days, as per the UK guidelines.

Mr WOOD: Taking up what the Member for Spillett said, whether there is any way for a medical practitioner not to be deregistered, I do not know. If it is a conscientious objection they will not do anything. They cannot change it because someone is trying to make it easier for them. If you believe something is wrong, you believe it is wrong and you stick by what you believe. This takes that right away. I thought this parliament would understand that.

Ms FYLES: A point of order, Mr Deputy Speaker!

Mr WOOD: Hang on, I have not finished!

Ms FYLES: I have my standing order.

Mr DEPUTY SPEAKER: Member for Nelson, please, order!

Ms FYLES: Standing Order 38—you can check the book—tedious repetition.

Mr DEPUTY SPEAKER: I will check the book.

I have checked the book. Member for Nelson, the minister has already answered that question.

Mr WOOD: I will stick with your ruling, but, as I said, sometimes this is the only time we can fully, as a unicameral House, look at the bill in detail.

I have a couple more questions. This definition is different to what was put forward in the discussion paper, which included nurses and other people ...

Ms FYLES: So does this.

Mr WOOD: That is why I asked what a medical practitioner—are you telling me?—we need to get this clear. Is a nurse, if asked to send someone to a place to get an abortion, covered under this clause?

Ms FYLES: No, under clause 12.

Mr WOOD: That is what I am asking. We are dealing with clause 11 ...

Ms FYLES: Yes, but I just said clause 12.

Mr WOOD: This was raised by a constituent. Under the existing act a person is not required to clean up—the act says a person is not under any duty to dispose of or assist in disposing of an aborted foetus if the person has a conscientious objection to doing so. If an orderly does not want to work there, but has been told to clean up, can they use their conscientious objection to say, ‘I do not want to work in that abortion clinic’.

Ms NELSON: Then they do not work there.

Mr WOOD: Not that simple if you get ...

Mr DEPUTYSPEAKER: Order!

Ms FYLES: Member for Nelson, conscientious objection applies to the health practitioner; that is based on the UK legislation. If someone has an ongoing conscientious objection to a workplace, we encourage them to work through that. We are getting into the ins and outs here. We have a provision for medical staff, and we have based that on legislation in the United Kingdom.

Mr WOOD: With all due respect, minister, the existing act protects those people. Will those people still be protected? The word I have is that if they do not do as they are told, they will lose their jobs.

It was put in here specifically for those people to be protected. The new legislation does not give that protection. I am asking whether those people will be protected, as in the existing *Medical Services Act*?

Ms FYLES: I feel I have answered the question.

Mr WOOD: So you cannot answer that?

Ms FYLES: I have already answered the question.

Mr WOOD: But will they be protected?

Mr DEPUTY SPEAKER: The minister has indicated she has already answered the question, Member for Nelson.

Amendments not agreed to.

Clause 11 agreed to.

Clause 12 agreed to.

Clause 13 agreed to.

New clause 13A:

Mr WOOD: I move amendment 1.11, with a general explanation of where it has come from. This comes from the Western Australia legislation. It says there is no duty to participate in termination unless to save a life:

Except when necessary to save the life of a pregnant woman as mentioned in section 13, no person, hospital, health institution or other institution is under a duty, whether by contract, statutory duty or other legal requirement, to participate in the performance of a termination.

There might be a private hospital or clinic that does not want to participate in the termination of pregnancy. This allows the institution or person to be exempt from that. It makes it clear that if they do not want to participate they are protected by this clause.

Ms FYLES: We believe it is in direct opposition to duty of care—providing access to treatment. Public health services have no right to refuse lawful treatment. The conscientious objection covers this. We followed the Victorian law reform, which refers to practitioners, not organisations. We disagree with Western Australia.

Mr WOOD: I am pretty sure the Cabrini Hospital in Melbourne does not allow abortion, so what would happen if you had a similar hospital in the Northern Territory?

Ms FYLES: We cannot answer questions on behalf of Victoria. I have outlined the reasons ...

Mr WOOD: This is Victorian legislation, nearly all of this.

Ms FYLES: You just asked a question about a Victorian hospital. I have outlined why we have this in the Northern Territory legislation.

Mr WOOD: I am giving you an example of a hospital that does not have to perform abortions.

Mr DEPUTY SPEAKER: Order! Member for Nelson, can you please ask the question you intend to ask.

Ms FYLES: I will make one point, Mr Deputy Speaker, and then refer to Standing Order 38 again. If every doctor in the hospital clearly had a conscientious objection then that hospital would not offer that service. It is coming back to the conscientious objection of the practitioner.

Mr WOOD: I am referring to the management of the hospital. The owner of the hospital may not wish to participate, and I am asking if they have that right.

Mr GUNNER: This goes back to an earlier clause where we had a discussion about the policy we are taking. You were talking about consultation and exclusion. I said that was not the principle we took, and that we thought it was captured in conscientious objection—through that principle. A hospital cannot opt in or out. A practitioner can. The conscientious objection is possible at the practitioner level. It is done through the person, rather than the clinic or hospital. It is about the practitioner who is registered, or capable of being registered, under this

Conscientious objection is the way we have taken this. It goes to the conversation we had earlier when we discussed consultation for possible exclusion in remote clinics. The same principle applies here. We are applying it to the person, not the place.

Mrs FINOCCHIARO: For the record, the opposition does not support amendment 1.11 for the reasons outlined by the Attorney-General and the Chief Minister moments ago.

Mr WOOD: In response to the Chief Minister ...

Ms FYLES: A point of order, Mr Deputy Speaker! Standing Order 38: repetition.

Mr DEPUTY SPEAKER: Member for Nelson, you may ask a question and then seek a response from the minister, so long ...

Ms FYLES: He is making comment on the Chief Minister's statement.

Mr WOOD: We are allowed to. The Chief Minister made a statement, and I am asking him—you have surgeries in Darwin and the owner of the surgery ...

Ms FYLES: A point of order, Mr Deputy Speaker! I ask you to rule.

Mr DEPUTY SPEAKER: Member for Nelson, please. Minister for Health, you have raised a point of order. The point of order is?

Ms FYLES: Standing Order 38, repetition.

Mr DEPUTY SPEAKER: Member for Nelson, you were going to ask a question?

Mr WOOD: The Chief Minister made a statement, I was going to ask him—Chief Minister, in the Darwin suburbs there are surgeries in shopping centres, usually owned by a doctor. Has the doctor or the owner of that surgery the right to say these are the only services ...

Ms FYLES: A point of order, Mr Deputy Speaker! Standing Order 38: repetition. I answered this question moments ago.

Mr WOOD: It is an important question.

Ms FYLES: And I have answered it.

Mr WOOD: It is more than just conscientious objection. This is why this clause is here. You are going to force a ...

Mr DEPUTY SPEAKER: Member for Nelson.

Mr GUNNER: It is the practitioner.

Mr DEPUTY SPEAKER: The minister has indicated she will not answer the question because she feels it has already been answered.

Mr GUNNER: It is not the landlord; it is the practitioner.

Mr WOOD: It has not been answered, it has been moved.

Mr DEPUTY SPEAKER: Member for Nelson, do you have any further questions?

Mr WOOD: No.

Amendment not agreed to.

New clause 13A not agreed to.

Clause 14:

Mr DEPUTY SPEAKER: The Member for Nelson and the Minister for Health both propose amendments to clause 14, and they are in conflict with each other. If the Assembly agrees to an amendment which is found to conflict with a subsequent amendment, the subsequent amendment cannot be moved without first rescinding the earlier decision.

I therefore ask the Member for Nelson and the Minister for Health to explain why their amendment should be preferred.

Mrs FINOCCHIARO: Mr Deputy Speaker, I raised these questions in my contribution, but for clarification I would appreciate if the minister could indulge me. Can the minister advise what kind of conduct would be considered harassing, hindering, intimidating, interfering with, threatening or obstructing that would warrant a prosecution for a breach of this section?

Ms FYLES: I did acknowledge this in my second reading speech. I am not sure if what I am going to read will answer your question, but I am sure you will let me know if it does not. Are you referring to the safe zone?

Mrs FINOCCHIARO: Yes.

Ms FYLES: Clause 14 provides for the creation of a safe access zone around premises where terminations are performed. It is important to establish this area as a safe passage to the premises where terminations are performed, for both the women seeking the services and for the persons working there.

It is important to understand that safe access zones are not created to stifle or prevent the freedom of speech of those opposed to termination of pregnancy. Those persons can freely express their opinions in any other location provided they do so in lawful ways.

Safe access zones provide persons a means of entering or leaving the premises without intimidation, harassment or interference. It is particularly important there is a balanced approach to rights. Women accessing premises for a termination or any other medical services offered at such a premises should have a right to unimpeded access to those medical services.

Clause 14(1) expressly provides for an offence where (a) a person intentionally engages in prohibitive conduct, (b) within the safe access zone, and (c) the person is reckless in relation to that circumstance.

Clause 14(4) provides a definition of prohibited conduct. Importantly, the conduct described includes harassing, hindering, intimidating, interfering, threatening or obstructing a person without their consent and without reasonable excuse, and the conduct described needs to be seen or heard by a person in the vicinity of the premises and which may result in deterring the person from entering or leaving the premises.

The combined effect of the criteria in this section provides a significant barrier to frivolous or unwarranted charges being made. The default element of recklessness in this circumstance as contained in section 43AK(2) of the *Criminal Code Act* would also need to be made out for an offence to be proven.

Having regard to each of the provisions of clause 14 and section 43AK of the Criminal Code it would be highly unlikely for an offence to be made against a person faced with the circumstances described in this morning's debate, and the *Summary Offences Act* is not relied upon for the safe access zone as it does not adequately address the prohibited conduct within the context of seeking lawful medical treatment.

You raised questions this morning, and we certainly will proceed with developing the reporting requirements with regulations.

Mrs FINOCCHIARO: One of the key examples given to me was some of the people who engage in quiet prayer. Assuming they are not wearing shirts and do not have placards. If, for example, four people were sitting within 50 metres of the hospital, within the safe access zone, quietly praying, they would not be caught by this section because they are not being reckless in harassing or hindering someone; they are just sitting on the park bench praying.

Ms FYLES: To add further explanation, if they were holding items—objects—they would need to be at the 150 metre mark or beyond, but if they were just gathered together—it is very hard to explain circumstances. I think the legislation is quite clear about what is prohibited conduct, but if four people were sitting together talking—it is difficult to judge, but if they were holding objects it could be perceived as hindering, and then it would fall under prohibited conduct with 150 metres.

Mrs FINOCCHIARO: I believe the minister has answered that question.

Ms FYLES: The aim of this is to ensure women can access health facilities in privacy, free from intimidating conduct at a distressing time—respecting their privacy and the privacy of the women who work there. The Minister for Territory Families and I have spoken about this issue in depth, as she has had firsthand experience when she lived and worked in Melbourne some time ago. It is about providing a safe passage for women attending, and the family members and friends supporting them, and people who work at that facility. It is about putting in place protections, and I think I have clearly outlined what the offences would be—prohibited conduct.

Mrs FINOCCHIARO: Some people I consulted with were concerned that, perhaps inadvertently, clause 14.4(b) could capture people standing around having a chat about something different but if the woman seeking the termination decided to leave the premises as a result of overhearing conversation then those people having the conversation would be caught by it. I think you have addressed that in relation to 43AK.

Ms FYLES: The situation you described this morning, and just described again, would not meet all the elements of prohibited conduct.

Mr DEPUTY SPEAKER: Member for Nelson, do you have questions to ask or are you looking to move your amendment?

Mr WOOD: I have one question to ask and then I will go back to the amendments.

It seems to be a bit of a funny clause that you have in here about harassing and hindering—part of prohibited conduct, that you cannot harass, hinder, intimidate, interfere, threaten or obstruct people within 150 metres. If I was to use the reverse logic, it is okay to do it outside the 150 metres.

Ms FYLES: With all due respect, that would fall under the *Summary Offences Act*. This is providing extra provisions because we have seen examples around the world and other jurisdictions in Australia where this protection is needed to afford those working at and attending those clinics.

Mr WOOD: I understand that but that is why I quoted that section this morning. You already have that section.

Clause 3(b) says:

for subsection 4(b), it is immaterial whether a person was entering or leaving, or attempting to enter or leave, premises for performing terminations for an offence to be committed.

I will not debate 4(b).

Mr DEPUTY SPEAKER: Member for Nelson, are you moving your amendment to then speak on it? Before you do that, the Member for Spillett has a question to ask.

Mrs FINOCCHIARO: I assume in drafting this section that Parliamentary Counsel, the department and whoever else was involved would have had regard to section 116 of the Constitution around religious freedoms. I was thinking minister, in your comments about depending on what they were holding—as the Member for Nelson mentioned, if four people were sitting on a park bench 50 metres away from a facility where abortions take place, holding rosary beads and praying, you would assume that would not fall within this conduct, as distinct from if they had banners, picketing material and other types of offensive or harassing material.

Ms FYLES: Clause 14(1) expressly provides for an offence where a person intentionally engages in prohibited conduct. It needs to be intimidating behaviour. There might be lots of circumstance in the future—we do not want to comment here, but there are key words there that make sure there are protections in place whilst providing for people to move and speak freely.

Mr WOOD: I move amendments 1.12, 1.13, 1.14 and 1.15 to clause 14. I would just like to talk on 1.12.

What I found amazing, and I was not the only person—there has been a series of articles written about the right for people to protest outside abortion clinics. There is no way I would support people harassing or bullying people going to an abortion clinic, nor would I support them if they went to Santos because they did not agree with fracking. One group of people is selectively protected when there are other groups that should be selectively protected as well.

In the *Summary Offences Act*, the loitering section, the penalty is \$2000—that was a few years ago—and/or six months' gaol. This was raised in regard to the Victorian legislation, where a scrutiny committee published a document that describes the debate in relation to the safe access zones.

The committee raised a lot of good issues, but unfortunately the government did not take a lot of notice of them. It raised the issue of penalties. For loitering and harassing—\$2000 fine and six months' gaol. Under this legislation you will have 100 penalty units, which is around \$15 000, or imprisonment for 12 months.

Ms FYLES: That is the maximum.

Mr WOOD: That is right, but so is the other one. It seems out of sync that a group that harasses on the other side of the 150 metres receives a lower penalty—\$2000 and six months' gaol. On the other side you are going to hit people with a penalty of \$15 000 or 12 months gaol. People in my position would not be allowed to protest there. If I get a 12 months' gaol sentence I am not in this job anymore.

I just wondered why? My amendment is to make it at least close to what is a reasonable penalty when compared with existing penalties.

Ms FYLES: Intent and context would be different within the zone to outside the zone. We believe that your amendment is inconsistent with legal policy for offence provisions. The default position for all Territory offences is set out by section 38DA(2) of the *Interpretation Act*, which says:

The maximum fine is worked out by multiplying 100 penalty units by the term of imprisonment expressed in years ...

This means that if the penalty is up to one year in prison, the fine will be 100 penalty units. We do not agree with your amendment for the reasons I have just outlined.

Mrs FINOCCHIARO: The opposition would not support any situation where a woman was harassed, hindered, intimidated, et cetera, as set out in the safe zone provision. Whilst understanding where the Member for Nelson is coming from, we believe the current penalty is appropriate and we will not be supporting the amendment.

Mr WOOD: I was coming from the public health and wellbeing safe access bill, which raised the same issue, but I move on.

I would like to omit clause 14(3):

For subsection 4(b), it is immaterial whether a person was entering or leaving, or attempting to enter or leave, premises for performing terminations for an offence to be committed.

Clause 4(b) says:

an act that could be seen or heard by a person in the vicinity of premises for performing terminations ...

Et cetera.

That is nonsense. You have it covered already. This one says that, late at night, if I want to go up and down making a lot noise, I can be charged because it is immaterial whether anyone was entering or leaving or attempting to enter or leave. I can make a fuss outside an empty clinic. No one is going in there; it could be 10 pm. This legislation says that I am offending. Why is it in there in the first place, because you cover it in what prohibited conduct is. It does not make sense that you can say someone could be offended if they are not there.

Ms FYLES: I do not agree with the Member for Nelson that it is nonsense. There is no validation to remove this provision. The Victorian law provides similar legislation.

Mr WOOD: What does it mean in relation to when the clinic is shut?

Ms FYLES: Clause 14(4) is a definition, with parts (a) and (b).

Mr WOOD: That is right, but part (b) says:

an act that could be seen or heard by a person in the vicinity of premises for performing terminations, that may result in deterring the person ...

Here it says it is immaterial whether a person was entering or leaving, or attempting to enter or leave. Someone who is thinking of an abortion could just be wandering down there and people are outside protesting after the place has shut. This law seems to be for no reason. It is covering every base and it does not make any sense.

Ms FYLES: I have made the point clear. It does not matter what time of the day it is. We want to ensure these facilities are protected.

Mr WOOD: I wonder whether the frogs are going to get it at 12 am. I do not think it makes any sense.

Ms FYLES: There can be protests at night and we need to protect those facilities.

Mr WOOD: I am not asking people to smash them. That is criminal activity.

Ms FYLES: But you do not know if people are inside working.

Mr DEPUTY SPEAKER: Order! Can this be run through the Chair, please.

Mr WOOD: I move on to 1.14. I do not think section needs to be there. The Member for Spillett has raised a number of questions already and mentioned people saying prayers. If they take a statue there will someone automatically say they are anti-abortion? They might be going there because it is a special day for the hospital; I do not know. As that lady from Central Australia said, you are starting to get into areas where you are restricting people's rights to political communication. An article by Professor Nicholas Aroney, Professor of Constitutional Law at the University of Queensland, spoke about exactly the same thing in an article on the health law reform amendment bill of 2016.

Have we checked to see whether some of these restrictions go against our constitution and the right of people to have political discussion, which is part of our constitution? It does not seem to me that you have bothered with those issues. You have just said, 'This will happen and that will be the case'. During the debate I asked something a woman asked me. She said, 'If my daughter went to a clinic and I try to deter her from having an abortion'—under this section, is she not breaking the law? It simply says:

an act that could be seen or heard by a person in the vicinity of premises for performing terminations, that may result in deterring the person or another person from:

- (i) *entering or leaving the premises; or*
- (ii) *performing a termination, or receiving a termination at the premises.*

Is that mother breaking the law?

Ms FYLES: I have said numerous times, Member for Nelson—without wanting to sound like a broken record, it comes back to recklessness. I have been through, both in my closing remarks and just moments ago, in what constitutes (a) and (b). There is provision for the different examples we have talked through. There needs to be intentional recklessness to have the offence upheld.

Mr WOOD: Can you put up a poster within the 150 metres? It is not reckless. If you put up pregnancy help phone number is that regarded as reckless.

Mr DEPUTY SPEAKER: Member for Nelson, the minister has answered that question.

Mr WOOD: No, it is a different question. This is important here. You are restricting the right of people—that is an important matter for this parliament to discuss. There are restrictions on whether people can be seen or heard.

Ms FYLES: Member for Nelson, with all due respect, I argue that is recklessness because they are not respecting the law—that there is a 150 metre safe zone. Mr Deputy Speaker, I am happy to take new questions from the Member for Nelson, but we are getting back into the territory of Standing Order 38.

Mr DEPUTY SPEAKER: Member for Nelson, are there any additional questions that have not already been answered by the minister?

Mr WOOD: Who will decide if someone has been deterred from entering?

Ms FYLES: Member for Nelson, as per most instances around this type of issue, police would act on a complaint. If your neighbours are blaring loud music at night and you feel that is breaking a law, you ring police and they act on it. If someone feels they have been harassed, hindered or intimidated, police would act on the complaint. That is what the legislation provides for.

Mr WOOD: Then why do we not apply this law to other businesses? Why is it not applied to workers who go to Santos and have a protest five metres from the front door? Why are they allowed ...

Mr DEPUTY SPEAKER: Member for Nelson, how does that relate to the clause?

Mr WOOD: Because it is discriminatory. This law only applies to one aspect.

Ms FYLES: With all due respect ...

Mr DEPUTY SPEAKER: Minister, please hold. The minister has answered that question.

Mr WOOD: I did not know she answered the one on Santos.

Mr DEPUTY SPEAKER: No, because we are not ...

Ms FYLES: It is not in my portfolio.

Mr WOOD: But it is in your principle.

Mr DEPUTY SPEAKER: Order! The minister has answered that question. Member for Nelson, do you have any further questions which the minister has not already answered?

Mr WOOD: Even the ones she has not answered will probably—do not worry. We will move on. Amendments not agreed to.

Ms FYLES: Mr Deputy Speaker, I move amendment 2 to clause 14(3). This is a minor error that was identified during the final review of the bill by Parliamentary Counsel. An amendment is required at the consideration in detail stage. I advised members earlier today that I would need to bring this amendment

before the House earlier today. If people needed to be briefed I provided for that, and I am happy to take questions.

Clause 14(3) of the bill currently states:

For (4)(b), it is immaterial whether a person was entering or leaving, or attempting to enter or leave, premises for performing terminations for an offence to be committed.

Clause 14(4) provides a definition of 'prohibited conduct', which includes paragraphs (a) and (b). The reference to paragraph (b) is to the paragraph within the definition, not the subsection itself. Clause 14(3) therefore requires an amendment to provide for conduct mentioned in paragraph (b) of the definition 'prohibited conduct'—it is immaterial whether a person was entering or leaving or attempting to enter or leave premises for performing terminations for an offence to be committed.

The amendment to clause 14 would be made—I believe it has been circulated.

Mrs FINOCCHIARO: The opposition supports the minister's technical amendment.

Ms FYLES: Thank you; we appreciate that. It was an inadvertant drafting error—a minor error.

Amendment agreed to.

Clause 14, as amended, agreed to.

Clauses 15 and 16 taken together and agreed to.

Clause 17:

Mrs FINOCCHIARO: Could the minister advise if it is anticipated that statistics of terminations will be collected, and whether they will be published, as well as the detail around what type of information is anticipated to be collected and published.

Ms FYLES: The statistics will be collected. Some statistics are published currently, and there is indication that some other states publish them. I would be willing to consider that or seek further advice on that. They certainly will be collected for medical purposes.

Mrs FINOCCHIARO: What type of details would be collected? Women's names or location or just the fact that a termination took place and the type of termination?

Ms FYLES: It would be completely anonymous and would provide for statistical data regarding what procedure took place, ensuring we have provision of health services. I am happy to seek further advice on publication and brief you on that.

Mrs FINOCCHIARO: Some people were concerned that if the information being reported to the Chief Health Officer included location it might give away the identity of the woman.

Ms FYLES: Privacy provisions would be upheld. In smaller communities we would ensure privacy is respected and that data does not implicate people.

Mr WOOD: That general question seem to be attached to some more exact questions, because that is what I am dealing with in new clause 17A.

I move amendment 1.16, inviting defeat of existing clause 17:

Amendment not agreed to.

Clause 17 agreed to.

New clauses 17 and 17A

Mr WOOD: I move amendment 1.17 to insert new clauses 17 and 17A:

17 Ministerial consultative committee:

- (1) *The Minister must establish a consultative committee to advise the Minister about information (the approved information) to be given to women who are contemplating a termination.*
- (2) *The members of the committee are to be persons with appropriate knowledge and experience in providing medical information, counselling and support services to pregnant women.*

I put that forward as a means of making sure any woman considering a termination of pregnancy is provided information put together by a consultative committee to make sure the advice is backed up by people experienced in providing that medical information, and counselling and support services.

Ms FYLES: Mr Deputy Speaker, we believe it would be inappropriate. The statistics need to be determined by the advisory group and approved by the Chief Health Officer to make sure reporting criteria is not intrusive and is useful for service improvements. We do not agree with the clause.

Mr WOOD: I understood that. I will save my breath, what is left of it.

Mrs FINOCCHIARO: The opposition will not support that amendment either.

Mr WOOD: Clause 17A adds to an existing clause. It says:

- (1) *A medical practitioner who performs or directs the performance of a termination under this Act must provide to the CHO:*
 - (a) *The following information prescribed by regulation within the time prescribed by regulation.*

This partly covers what the Member for Spillett was saying:

- (i) *the number of terminations performed by the medical practitioner;*
 - (ii) *the reasons for which terminations were performed;*
 - (iii) *the ages of the women concerned;*
 - (iv) *the number of weeks, determined in accordance with section 9A, for which the women had been pregnant at the time of the termination;*
 - (v) *the number of women who had previously had a termination; and*
- (b) *the additional information prescribed by regulation, within the time prescribed.*
- (2) *The medical practitioner must ensure reports provided under subsection (1) do not contain information that could identify a woman on whom a termination has been performed.*

Professor de Costa, in her report which the Royal Darwin Hospital released some years ago, said proper recording of abortions in our hospitals was definitely needed. That is why, when I said today about between 600 and 1000 abortions—I have had figures given to me from Professor de Costa's report and at Estimates Committee hearings. That is how I came to that figure. Surely hospitals keep some records. If we are to know whether there is a reduction in the number of abortions or if there are issues in relation to termination of pregnancy, we need to keep good records.

I do not think this is intended to be public information, by the way, but there may be some indication of how many abortions are occurring each year. Some basic information may be freely available, but some of the other information may have to be collected only for medical purposes or restricted information. That has also been proposed.

Ms FYLES: Member for Nelson, for this we provide for the collection by the Chief Health Officer statistical matters relating to terminations under clause 18(e). It is referred to in regulations. We believe it is inflexible to place it in the legislation. It should be dealt with in the regulations regarding matters being outdated quickly. We also need to cater for the private sector, where we believe there will be procedures taking place away from the public hospital setting.

We understand the need to collect data, although we need to acknowledge that some reporting criteria is intrusive and is not useful for future service improvements. We need to be able to trust our health

professionals to provide the best care for Territory women and provide data that is useful. We believe it is catered for in the regulations.

Mrs FINOCCHIARO: The opposition feels that this type of detail is best placed in the regulations.

Mr WOOD: I am happy if that is there. What we are trying to get from the government is to ensure it happens ...

Ms FYLES: It is under clause 18.

Mr WOOD: I realise that. Will that information be made public? If I ask in an Estimates Committee hearing how many terminations of pregnancies—which I have asked before—I can get a detailed number. Presently, according to Professor de Costa, those figures are not easily available.

Ms FYLES: Statistical data will be available, but making sure we have protections—obviously acknowledging we have a small community and even through just numbers alone, people can be identified.

Mr WOOD: Without location. I am not asking for that.

New clause 17A not agreed to.

Clauses 18 and 19 taken together and agreed to.

Clause 20:

Mr WOOD: This section here on termination of pregnancy—the only offence we have now under termination of pregnancy is if a person is not a qualified person. Why is it not that there is a section for a qualified person who does something against section 17, 18 and 19?

Ms FYLES: This is a consequential amendment to the *Criminal Code*. What you have just raised would already be captured.

Mr WOOD: I have a concern that basically we are dealing with a serious piece of legislation dealing with a woman's life and an unborn child's life. To me there does not seem to be enough teeth in this to make sure a suitably qualified person does not do the wrong thing as well.

Ms FYLES: The suitably qualified person comes under the whole bill that we have just been talking about. This is a consequential amendment to the *Criminal Code*.

Mr GUNNER: If could talk further to that. These are consequential amendments to pick up here, termination of pregnancy performed by an unqualified person—if a qualified person does something wrong or criminal, it is already captured within the existing *Criminal Code*. If you perform an action, then the *Criminal Code* already captures that, and the Attorney-General spoke to a couple of examples earlier in debate. I understand your question is why is it not captured here. It is because the consequential amendments were not necessary; the *Criminal Code* already covers if you behave in a certain way.

Clause 20 agreed to.

Remainder of the bill, by leave, taken as a whole and agreed to.

Ms FYLES (Health): Madam Speaker, I move that the bill be now read a third time.

The Assembly divided.

Ayes 20

Noes 4

Ms Ah Kit
Mr Collins
Mrs Finocchiaro
Ms Fyles
Mr Gunner
Mr Higgins
Mr Kirby

Mr Guyula
Mr McCarthy
Mr Mills
Mr Wood

Mrs Lambley
Ms Lawler
Mr McConnell
Ms Manison
Ms Moss
Ms Nelson
Mr Paech
Ms Purick
Mr Sievers
Ms Uibo
Mr Vowles
Ms Wakefield
Mrs Worden

Motion agreed to; bill read a third time.

Madam SPEAKER: Thank you, honourable members. It has been a good day. It has also been a good day for democracy in the Northern Territory Legislative Assembly.

ADJOURNMENT

Ms FYLES (Leader of Government Business): Madam Speaker, I move that the Assembly do now adjourn.

Ms MOSS (Casuarina): Madam Speaker, how incredible it is to see the termination of pregnancy law pass in this House. I give my commendation to the Minister for Health for her incredible work. What a fantastic, historic day and moment this is for this Chamber.

I will put on the record tonight some achievements from my electorate. I will congratulate and talk about a number of people in my electorate. Two impressive young Territorians from the Casuarina electorate, Rian Smit from Lyons and Brooke Perris from Tiwi, are finalists in the upcoming Young Achiever Awards, which is incredible.

Rian Smit has been a fierce mental health advocate, both personally and professionally, working to smash mental health stigma. I am really pleased that Rian has been through the Foundation for Young Australians' Young Social Pioneers program—a program I have also been a part of—and is now part of that network and alumni. She has also worked with the Live it Speak it program through the National Centre of Excellence in Youth Mental Health. Rian has also contributed to headspace's services through the headspace Youth National Reference Group and co-designed a youth specific LGBTQI group.

I wish her all the best and every success. It is inspiring to see young Territorians contributing to the community around them to improve our health services.

Another impressive young Territorian from the Casuarina electorate is Brooke Perris. Hers is a name that will be well known around the sporting scene of Darwin. She represented Australia at the 2014 Commonwealth Games and went to Rio as a Hockeyroo. She contributes hugely on the local sporting scene. She was a graduate of the NT Institute of Sport and she was the NT Sports Awards winner in 2014.

I wish them both all the very best of luck, and all the finalists in the young achiever awards coming up in April.

This year marks the 40th anniversary of the Casuarina Football Club. The club has a long family tradition and links to the Darwin community. Many, if not the majority, of players are generational football players from the Portuguese and Timorese community, with family members who have played for the Casuarina Football Club dating back to the 1970s. Many of them were the founding members of the Portuguese and Timorese Social Club.

The club had its sign-on day in February and I was pleased to go along and help with the sausage sizzle and drink sales. I wish them all the very best for their 40th year and hope to go along and see some of their matches. My electorate officer signed up to play, so that was an awesome outcome as well.

On 8 March, International Women's Day, as the Minister for Education spoke about last week, early educators from Casuarina Childcare Centre walked off the job at 3.20pm as part of the International

Women's Day Big Steps campaign. The time of 3.20 pm represented the time that women stop being paid if you look at the pay gap between men and women. It was a really rainy afternoon, as it has been today, but it did not stop the educators campaigning for fair and equitable wages. I support them, as the Minister for Education has and other members of our team.

I was pleased on that day to give a speech here in the main hall on behalf of the Minister for Territory Families and talk about many of the issues facing women today, including the debate that just passed in this House today. It is always amazing to see the diversity of the women who turn out for the march, and, of course, the men who support women in our community, to celebrate and mark the contribution of women to community and recognise we have a long way to go in fighting for equality. I am really pleased we could go some of that way today in the Territory.

I also give many thanks to Vicki Manley from Nakara Primary School. She retired at the end of last year, and I want to ensure I put my thanks on the record. She was a highly-valued member of Nakara Primary School and a valuable member of the staff body. She was loved by students. She was no stranger to bringing her Year 6 students to Parliament House. She worked at Nakara from 2004, starting as a preschool assistant and then working as a classroom teacher. She will really be missed from the school community. I wish her a very happy retirement.

Ms MANISON (Wanguri): Madam Acting Deputy Speaker, I adjourn tonight in memory of Roberto Cagnetti, known as Robert to his colleagues, a long-standing and highly-respected employee of the Department of Treasury and Finance who tragically passed away on 3 February this year at the age of 45.

Robert was diagnosed with a rare and aggressive cancer in mid-2016. He immediately sought the best treatment options in Australia and relocated to Sydney, where he was treated at the Chris O'Brien Lifehouse.

Robert was the oldest son of Charlie and Loretta Cagnetti, icons of the Darwin community and well known for their Italian restaurant and Charlie's famous chilli bugs. Robert, not surprisingly, also loved Italian cooking and cuisine. How could he not, being the son of Charlie and growing up working at Charlie's, the family restaurant on Knuckey Street.

Robert would have his friends in fits of laughter telling stories about the old days working in his parents' restaurant. I am told it made *Fawlty Towers* look tame in comparison, but, jokes aside, Robert's parents, migrants from Italy, worked incredibly hard to provide a life and legacy for their three children.

Robert's untimely death leaves a huge gap in the lives of his brother, Carlo; sister, Lucy; brother-in-law, Jeff; and niece, Christina, as well as his extended family in Adelaide.

Robert's life took a very different and unexpected turn following his diagnosis, leaving behind the job he loved in the Department of Treasury and Finance, where he was director of the commercial unit in the economic group.

Robert was an economist through and through, and while he found his job challenging and sometimes frustrating, he loved every minute of it. His many colleagues describe how he loved nothing more than an in-depth debate over economic and financial policies and markets in the Australian and European contexts, especially given his parents' birthplace of Italy, and, most recently, the United States context, with the election of President Donald Trump. Robert was passionate about the world and through his travel could see how the lives of ordinary people were impacted in real ways, both good and bad, by economic choices made by governments.

His cancer treatment was extremely gruelling and debilitating, but he maintained his fabulous sense of humour throughout, as well as his intense interest in world events and the world of work in Treasury and Finance. Whatever Robert was going through on a daily basis with his treatment, and even with his health failing and energy diminishing, he always had time for discussions about the world, the economy and the challenges faced by the Territory, Australia and the global economy. These conversations often involved lots of Robert's booming laughter.

Robert was a highly-valued friend and colleague. Even he expressed surprise at how many of his work friends visited him during his treatment in Sydney and Adelaide. Not only did he receive visits, he received hundreds of phone calls, text messages of support, cards, photos and plenty of updates about what was happening in the office in Darwin.

Due to his treatment he was unable to return to Darwin, something he greatly regretted. He often expressed how he wished he could come to Darwin to experience another Dry Season, see the wonderful results of the landscaping of his mother's garden and enjoy the food. Robert leaves big shoes to fill both personally and professionally. He was an integral part of the Treasury economic team, and he will be greatly missed.

It was very clear how wonderful a person Robert was and how greatly admired and respected he was in the Department of Treasury and Finance just by seeing the faces of the staff from Treasury on the week he passed away. He was a much-loved and valued member of that team, someone people had a lot of time for. It has been a great loss to the staff at Treasury. They are missing him.

I pass on my condolences to the Cagnetti and Robson families, the Clavio family in Adelaide and to friends and colleagues of Robert Cagnetti. Rest in peace, Robert. Thank you so much for your contribution; you will be missed.

Ms UIBO (Arnhem): Madam Acting Deputy Speaker, tonight I rise to share with the House a recent trip I took. I spent a week traveling to Groote Eylandt, Bickerton Island and Numbulwar. The trip was organised by the Arnhem Electorate Liaison Officer, Kara Burgoyne, who lives in Angurugu, on Groote Eylandt. She did an amazing job organising her first itinerary for me and three people who travelled with me: Senator Malarndirri McCarthy; Lianne Jarrett Simms, the early childhood adviser from Minister Lawler's office; and Joanne Nicol from the Katherine office of Hon Warren Snowdon, the Member for Lingjari.

Kara organised a wonderful trip. She did a fantastic job. I would love to share some of the visits we made during the time I spent traveling through the Arnhem electorate.

I always managed to avoid the 6 am flight to Groote Eylandt while I was living in Numbulwar but, unfortunately, I had to take the 6 am on Monday 6 March to be able to fit in the jam-packed itinerary.

The first trip was a visit to Umbakumba. It is a beautiful spot. There is no mobile reception, beautiful blue water on the bay—somewhere people would love to visit, if they have not done so already. The first visit was to Umbakumba School, which has a new principal, Irene Singleton, who is the previous principal of Bulman School. I knew Irene's name from emails whilst I was campaigning last year but we never crossed paths. She was usually busy when I was traveling through Bulman or out when I got to visit the school. It was really good to meet Irene in person.

I had a visit with Irene and then went to the Umbakumba FaFT, which is run by Michaela Renders. It is a really lovely, little area with a beautiful outdoor garden space. A couple of families are working there—as well as the crèche that is linked in with the FaFT. That was a nice visit.

Next we visited the Umbakumba aged care, run by Wendy Haydock and Sheena Whatabuy Wanambi. That was really lovely. There were several older ladies sitting there relaxing. Their activity of choice that day was movies. They were watching an action movie, as you can imagine. They were waiting for a hot meal. It is a lovely space for them to be able to connect with each other.

I jumped in the food van with Sheena; she was my boss for the day. I was helping hand out the meals to the other elderly people in Umbakumba. She was ticking off the list and telling me what to do. It was nice having Sheena guide and direct me around Umbakumba.

The next visit was to one of my favourite people on Groote Eylandt, Mr Percy Bishop, who was the Umbakumba sport and rec manager. He is also the self-professed Umbakumba radio guru. Every time I have been to Umbakumba I have been interviewed by Umbakumba radio, 106.3. I have a really good time with Percy. He asks great questions.

When I visited with the Chief Minister, when he was the Leader of the Opposition last year, he jumped in the hot seat. Percy is always ready for polities to drop in. If anyone is visiting Umbakumba they have to see Percy at the radio station. Tell him I sent you.

Next we walked across the road to the Aminjarrinja office, which is the Aboriginal enterprise based in Umbakumba, to visit the CEO, Keith Hansen, and hear about some of the projects of Aminjarrinja Enterprises. It is doing some interesting projects, including a school program and a respite program where they send some of the elderly people from Umbakumba, Angurugu and Bickerton to Cairns. They have an 11-day trip which is fully funded by the social program at Aminjarrinja Enterprises. We are getting really positive responses to that.

The last visit in Umbakumba that day—still on the Monday after the 6 am flight across—was to the government engagement coordinator, Pandora Noronha, who works in Umbakumba and covers Bickerton, and the Indigenous engagement officer, Mildred, who works there as well. It was great hearing about the Remote School Attendance Strategy and its implementation, some of the challenges they are facing and some of the successes as well. It is good to hear some positive stories.

We raced across to the other end of the island that same evening. Senator Malarndirri McCarthy arrived at Groote Eylandt and we had a meet and greet with residents in Alyangula at the golf club. If you are ever looking for a good feed, I recommend Alyangula Golf Club. It catered for about 50 people and we ate a lot of food that night.

It was great to meet with some of the residents of Alyangula township and some of the fly-in fly-out workers, hearing the different perspectives of people who are living and working at Groote and Alyangula. It was nice to share that evening with Senator Malarndirri McCarthy.

The next day was Tuesday and we had a day in Angurugu visiting the government engagement coordinator, Don Fry, and his offsider, Elaine, who is the Indigenous engagement officer. Next we visited Angurugu School. The principal, Stephanie Blitner, showed us around, and we also visited FaFT at Angurugu, which is being run by Stephanie's sister, Camelina Blitner. My cousin, Karina, is the family liaison officer. It is great to see local people working in the school on the island they are from.

We visited the Angurugu aged care, which is a beautiful facility at the back of the Angurugu township. It backs onto a beautiful garden with lots of fresh fruit and vegetables they plant and give out to locals. They have a lovely spot and are doing a great job. Thanks to Loretta for showing us around. They gave us morning tea, which was a nice and unexpected bonus.

Our next meeting was visiting the Groote Eylandt Aboriginal Trust building. One of the new corporations working hard over there is the Anindilyakwa Services Aboriginal Corporation. We had a chat with a couple of people there. We visited the art centre they run, heard about the bush medicine business and visited the linguistics centre, which is wonderful. We walked in at the right time; the ladies were translating from English into Anindilyakwa and to Wubuy. It was fun because I could contribute to the Wubuy, but not so well with my Anindilyakwa. We also heard about the Men's Shed they run at the back of the aged care. They are doing some great stuff there.

We had a quick lunch break at the takeaway shop then we headed over to Bickerton. We visited Milyakburra School on Bickerton. The principal, Sarah Rowe, was wonderful and welcoming. She remembers Minister Manison from Wanguri and had some good things to say about visits from Minister Manison.

We visited the Milyakburra store and saw Saum, the manager. We saw some family members working there, which was great. The council office was closed because they were at Groote, so we did not visit but we did walk past some of the facilities.

Then we headed back to Groote Eylandt. It is a 10-minute charter flight. Leanne did a good job. She does not like small planes so I was proud of her jumping on a five-seater plane to go across the water. Hopefully she was distracted by the beautiful view.

That afternoon we visited the Angurugu CDEP office with Fiona, who has been wonderful every time I have visited—hearing in depth about some of the good programs they have there. They now have a full-time RTO trainer based on Groote rather than a fly-in fly-out, which is having some positive outcomes.

At the end of the day we visited the Angurugu council office and I met the new service manager based at Groote, Allan Hawke. He was wonderful and has some good ideas about building local talent and capacity for people within the East Arnhem Regional Council. It was nice to meet Alan and I look forward to working with him when I visit.

Senator McCarthy, Leanne and Jo Nicol left that afternoon, then we had a Wednesday visit to Alyangula Area School; the Alyangula township office, with South32; the Anindilyakwa Land Council, which is very important in deciding on the future of Groote Eylandt; the township office at Groote Eylandt and Bickerton Island Enterprises, where Coralie was wonderful in letting us know of some of the projects there—I am only halfway through my trip.

The last visit on Wednesday afternoon was to the Angurugu church lawns; it was wonderful to visit and meet the senior police sergeant in charge, Tania Woodcock, who is working on some great initiatives at Groote.

Ms NELSON (Katherine): Madam Acting Deputy Speaker, I want to put on record my disappointment and disgust at today's proposal by the Prime Minister of Australia to change the section 18C laws. I find it disappointing that in such a multicultural country where we take much pride in our values, particularly Labor values of a fair go and inclusion, this has been passed through federal parliament.

We have spent the entire day talking about passing a bill that gives women equal access to healthcare services in the Northern Territory so they are in line with their counterparts all over Australia. We spent a significant amount of time trying to define what the word 'harassment' meant. Yet a federal bill is about to be changed which will create further confusion, especially legal confusion. I put on record that I am disappointed that this passed, especially today, on Harmony Day, which is a day to celebrate multiculturalism and inclusion in Australia.

Motion agreed to; the Assembly adjourned.