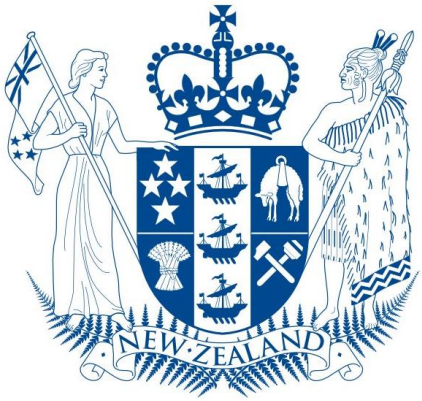

Report of the

ABORTION SUPERVISORY COMMITTEE

2020

Presented to the House of Representatives
pursuant to Section 39 of the
Contraception, Sterilisation, and Abortion Act 1977

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INTRODUCTION

On 24 March 2020 the Abortion Legislation Act 2020 came into force. From this date, the Abortion Supervisory Committee (ASC) was disestablished.

Schedule 1, part 1(5), inserted into the Contraception, Sterilisation and Abortion Act 1977 states that the ASC must arrange for a final annual report of the ASC be submitted to Parliament as soon as is practical after the [24 March] commencement date of the new Act.

This report is the final report of the ASC and contains statistics for the 2019 calendar year. Part statistics for the 2020 year up to 24 March are not yet available. These statistics will be made available by the Ministry of Health once provided by Stats NZ.

ABORTION LEGISLATION BILL - TIMELINE

In February 2018, the Minister of Justice, Hon Andrew Little, sought advice from the Law Commission on alternative approaches within our legal framework to align abortion with a health approach. The Law Commission was asked to provide a ministerial briefing paper, which was completed in October 2018.

A Bill was introduced to Parliament on 5 August 2019 and passed its first reading on 8 August 2019.

The Abortion Legislation Committee (ALC) was set up, and the Chairperson, Hon Ruth Dyson, called for public submissions on the Bill, which closed on 19 September 2019. 25,718 written submissions were received by the ALC, followed by 160 submitters being invited to be heard during oral hearings. The ASC appeared before the ALC and discussed its views on the proposed new legislation.

All submissions can be viewed on the Parliament website: https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_89814/tab/submissionsandadvice

Once the ALC reported back to Parliament with its recommendations on 14 February 2020[1], amendments were made to the Bill and it passed its second and third readings respectively on 3 and 18 March 2020.

The Abortion Legislation Act 2020 received Royal assent on 23 March 2020.

[1] Link to ALC report

COMMITTEE MEMBERSHIP 1977-2020

Dame Augusta Wallace 1977-1979 (Chair)

Dr Bruce Grieve 1977-1980

Dr Heather Thomson 1977-1980

Mrs Vivienne Boyd 1979-1980 (Chair)

Mrs Heather White 1981-1994 (Chair)

Dr Sydney Hawes 1980-1992

Dr Dennis Heginbotham 1980-1992

Dr Michael Cussen 1992-1993

Dr Paul Hutchison 1992-1997

Dr Christine Forster 1993-2001 (Chair)

Mrs Marlene Lamb 1994-2005

Dr John Whittaker 1997-2001

Dr Lesley Rothwell 2001-2007 (Chair)

Dr Papaarangi Reid 2001-2007

Professor Dame Linda Holloway 2007-2020 (Chair)

Dr Rosemary Fenwicke 2007-2010

Rev Patricia Allan 2007-2015

Dr Tangimoana Habib 2011-2020

Mrs Carolyn McIlraith 2015-2020

ABORTION SUPERVISORY COMMITTEE REPORTS - LEGISLATION

Over the 43 years that the ASC has been appointed to oversee the abortion sections of the Contraception, Sterilisation and Abortion Act 1977 (CSA Act) there have been 19 members and 6 Chairs of the Committee.

Oversight of the abortion sections in the CSA Act were not without challenge for the entirety of its existence. Abortion is an issue that people can have strong and deeply held views about. Medical professionals and hospitals that are positioned to provide an abortion service had the discretion to decide the availability or lack thereof of abortion services. For many years access to services throughout New Zealand were patchy and very dependent on the views of those within communities, District Health Boards and those tasked with providing women's health services.

Over the years the legislation became outdated and impractical. Advancements in medicine allowed for medical abortions to be carried out but were not accounted for under the old Act. Unfortunately

medical best practice was not able to be utilised in hospitals and clinics due to the particular wording of this Act.

While well intentioned in 1977, the Act proved to be impractical in a real world setting and resulted in unnecessary challenges to all those involved with abortion care and to women receiving abortion services.

The following section will outline some of the concerns various ASC members raised in their Annual Reports to Parliament regarding the legislation and its responsibilities under it:

1980

> *"Medical practitioners have always held fast to the view that independence of their clinical judgment is paramount, and that no external pressure can or should be allowed to influence it. Any attempt by the Committee to achieve a degree of consistency – what might be termed a median stance relating to abortion – is seen by those whose views are more liberal or more conservative as outside interference. Thus there has been opposition to the Committee's attempts to have the indications for abortion set out in finer details, and there has been criticism of any approach to a doctor whose assessments according to the committees figures are at variance with the average."*

1981

> *"During their short term in office, members of this committee have been examining the implications of the CSA Act and the exercise of their functions under it, and they recognise that the outgoing committee spent three difficult years working to achieve a fair and even-handed administration of the present law."*

1986

> *"… During the 5 years the Committee has been subjected to the continual barrage of criticism and advice, both fervent and diverse, much of it emanating from the same sources publicised prominently when the CSA Act was initially debated in Parliament. As then, critics vary from those who claim that in this country abortion has been liberalised to the point of "abortion on request", to those who regard the existing law as ill-contrived, restrictive and inconsiderate of women's rights of self-determination. It is evident to this Committee that no legislation to concerning abortion or constitution of membership to administer that legislation will satisfy every section of opinion on abortion."*

"Great trust is placed in the integrity of those men and women, few relative to the number of doctors practising in this country who are prepared to serve as certifying consultants. Our critics tell us their number should be reduced still further. This Committee takes the opposite view and would welcome more, even all, medical practitioners taking a more active role in considering those cases in which abortion is requested. If the legislation is to be modified it would be logical to acknowledge that any registered medical practitioner is capable of forming an opinion regarding the desirability of a pregnancy being terminated or continued. Registration of a medical practitioner confers the right to select those patients whom narcotic drugs may be prescribed, to certify death and to certify persons considered sufficiently mentally unstable to be committed to mental institutions. This Committee believes it would be reasonable to expect theses same doctors to be responsible for authorising abortions."

1988

"During the past ten years the [CSA Act], and its 1978 amendment have not fulfilled the expectations of the legislators. There have been instances of dissatisfaction being expressed and claims by some that the legislation is not now applicable or, indeed even enforceable."

"In the past year three reports all with relevance to various parts of the [CSA Act] have been published. After wide consultation, both the "Women's Health Committee Report"[2] *and the report "Abortion Services in New Zealand*[3]*" recommended that the abortion section of the Act be reviewed in the hope that more equitable access to services be made available."*

1990

"The original suggestion that all doctors should be able to consider, and where legal authorise, (as one of two medical practitioners) a safe legal abortion for their own patients was also a request made in and Annual Report by this Committee. It is disappointing that the introduction of the legislation to do this has prompted attempts to re-open the centuries-old philosophical debate about abortion per se when in fact the changes proposed relate only to the provision of services and do not address s. 187A of the Crimes Act which codifies the grounds for legal abortion in this country."

[2] Women's Health Committee Report 1985-1988 for New Zealand Board of Health

[3] Abortion Services in New Zealand; a report prepared for the Women, Children and Family Health Programme

1992

"Access to abortion in New Zealand is often problematical, especially for women in small centres and country areas. There are still gatekeepers in all sorts of guises. There is the doctor who interprets the law conservatively and does not refer the patient to a certifying consultant, the clerk behind the desk at Social Welfare who exerts a personal moral judgement and when approached by a very low income earner will not make emergency finance available. Unfortunately, there are also a few certifying consultants who although they are at present well reimbursed by the system, also make quite significant financial demands on their patients."

1993

"Abortion beyond 20 weeks where there are major fetal abnormalities incompatible with life has posed some dilemmas. The current law does not permit abortion to be carried out for fetal reasons when gestation is beyond 20 weeks. Under the law abortion may be carried out on maternal health grounds only the Committee was reminded that the late Sir William Lilley saw there being a clear indication to terminate a pregnancy in a woman who was carrying an anencephalic fetus. The Committee believes there is a case to change the present law in this area."

This was raised again in the 2000 Annual Report.

1996

"The Committee believes that if New Zealanders wish to have openness and honesty in contemporary New Zealand society then it is important that our legislation reflects the reality of what is happening. The Committee advocates that socio-economic factors should be taken into account when determining the grounds for an abortion. Thus when reactive depression is cited as grounds for abortion the certifying consultant should annotate accompanying factors such as rape, extremes of age and socio-economic factors."

1998

"It is time to frame a law which reflects the greatly changed social situation in the nineties and the changed needs of women.

The present law is written in gender-specific language, which is demeaning, for example section 32(2)(a) referring to the woman's own doctor…

'Where he does not propose to perform the abortion himself, he shall refer a case to another registered medical practitioner…'"

"While the abortion law of 1977 improved the position of women, it is now time to progress further and frame a law which reflects the greatly changed needs of women in 1998."

"Recommendation

That the Minister of Justice arrange a review of the CSA Act in the interests of the women of New Zealand."

This was raised again in 2016.

1999

"The fact that abortion has to be considered under the criminal law has prevented abortion services from becoming an integral part of women's health services and funded under the health system. Attempts to change the law have met with strong resistance from vested interests within the medical profession, and from groups and individuals on both sides of the abortion debate. After several years of investigation it is the Committee's considered opinion that a decision to have an abortion should only be between the woman and her doctor.

In the past 20 years there have been technological changes that the law has not kept pas with, for example, the introduction of ultrasound scans. The widespread use of this technique as a routine procedure means, in the Committee's opinion, that it is no longer necessary to have one certifying consultant designated as a "specialist", as long as the clinic is under the medical supervision of an obstetrician and gynaecologist. The requirement to appoint specialist certifying consultants has placed considerable pressure on the Committee to giver general practitioners specialist status outside the Committee's criteria."

"In the past 11 years the Committee's Reports have recommended a number of legislative changes. We were disappointed the Minister of Justice, the Rt Hon Sir Douglas Graham, immediately responded to the 1998 Report by saying 'the government did not see any need for a full review of the [CSA Act] at this time.' 'The [CSA Act] appears to be working as well as is possible in balancing both views about the issue and there is no need to resurrect the debate.' His successor, the Hon Tony Ryall has refused to meet with the Committee to discuss the issue and other matters of concern. This attitude of not 'rocking the boat' does a disservice to New

Zealand women and it may be that women Members of Parliament will eventually prevail upon their male colleagues to take a m ore realistic approach to the issue."

2000

The Act is outdated in its language and content. Its procedures are too complex and are not being followed as the law intended. Its provisions for providing legal, safe abortions are not being consistently applied throughout the country. The Act is demeaning to women in requiring a medical procedure to be considered under the Crimes Act. It is also misleading that 98.2 percent of abortions have to be granted under mental health provisions.

Principles the Committee accepts

- *Abortion should be decriminalised and become an integral part of women's health services, funded under the health system.*
- *The decision to have an abortion should be made only by the woman and her own medical practitioner.*
- *The procedures for obtaining an abortion should be simplified so that the abortion can be performed as early as possible.*
- *Although the woman should be informed that counselling is available, it should be provided only if she requests it.*
- *The need to reduce the level of abortion and decrease the number of unplanned pregnancies, especially among at-risk groups, must be recognised.*
- *The Government should implement and co-ordinate a national strategy to reduce the need for abortion and should also encourage all groups involved in sexual education and health, including the media, private and government agencies, to work co-operatively in this area."*

2001

"In February 2000 the Committee met with the Hon Phil Goff, Minister of Justice, and in March with the Hon Annette King, Minister of Health, and was encouraged by their enthusiasm for a review of the abortion law. It was disappointing therefore to learn in November 2000 that the law was not to be reviewed. It is a great pity that the Government and Members of Parliament do not wish to recognise that the law that was enacted in 1977 is no longer relevant to women in the 21st century. To not review the law does the women of New Zealand a disservice."

"The Minister of Health has indicated that medical abortion will be available to the women of New Zealand if the appropriate authorities approve the use of mifepristone (RU486). If RU486 is used here it will be necessary under the present law for the woman to remain in a licensed institution until the fetus is expelled. The Committee is aware of confusing and conflicting views on the use of RU486 and expects that all licence holders who propose to use the drug, if it is approved for use, will consult with the Committee on issues such as safety, complications and the accurate reporting of all procedures."

2003

"Consequent on the 2003 financial review by the Justice and Electoral Committee the Abortion Supervisory Committee, at the Select Committee's request, supplied a summary of all recommendations that it has made in its annual reports. The Supervisory Committee had felt that a degree of mutual understanding had been achieved and was disappointed that the subsequent report did not reflect this accord."

2004-2015

Fewer mentions of legislative change featured in annual reports after this period. The ASC was largely preoccupied with various topics including:

- Court cases
- Issues of access
- Abortion trends
- Counselling
- Harassment
- Contraception
- The increased use of medical abortion
- Standards of care documentation

It is not until 2016 that this Committee raised specific concerns about legislation.

2016

"The legislation that governs abortion law in New Zealand, which is overseen by the Abortion Supervisory Committee, will be entering its 40th year since enactment in 1977. Over the last four decades, there have been significant changes to healthcare delivery as well as technological advancements in how we approach medicine. It is important to ensure that the legislation reflects the health sector as it currently is, and modern society.

We believe there could be changes to parts of this legislation that would maintain the integrity and purpose for which the Act was originally written (i.e. adequate access to abortion services, safety, and robust consultation processes), but would allow for improvements in providing healthcare services at an operational level and more accurately reflect modern language and processes.

Some of the wording in the Act is outdated and clumsy. The ASC is often asked to clarify the unnecessarily complicated wording set out in sections of the Act, particularly around referrals and consultation processes. Clearer wording would be of great assistance to medical and other health professionals working in the field.

It is notable that terminology has been repealed and redefined on various occasions in the more recent past, yet the related and consequential provisions have been left intact. In some cases the changes are incompatible with the wording that has been repealed and have not been replaced in the body of the Act. We believe the wording of the Act should be updated to reflect the changes made to date and a review of additional areas that need attention. For example:

Section 34 – Special provisions where a patient mentally subnormal

The term 'mentally subnormal' is not only outdated but is considered a derogatory term and the use of it in modern legislation is inappropriate. The wording should be 'patient lacks mental capacity to consent'. Reference could be made to section 6 of the Protection of Personal and Property Rights Act 1988, which sets out the circumstances in which a person lacks capacity."

2017

"In its 2016 Annual Report and during its appearance before the Justice and Electoral Committee in 2017, the ASC has made calls for changes to be made to the Contraception, Sterilisation and Abortion Act 1977 to bring it more in to line with modern healthcare delivery, reflect advancements in technology and correct outdated and unhelpful language.

The legislation is now forty years old and has not yet been reviewed or updated. The ASC would be concerned if another decade was to come to pass and it was still required to govern under such old and outdated language. More importantly that medical professionals would be required to operate around processes and language that, in many places, is no longer applicable or practical in our society today.

The ASC does not propose amendments that would change the original intent of the Act. The ASC recognises the merit in having a robust pathway in place, which requires certifying consultants to assess and certify patients and to ensure counselling is offered. However, some of the language and restrictions set out in the Act as it stands is confusing or creates unnecessary barriers to access that the ASC believes could be improved. Progress on any legislative changes is now in the hands of Parliament."

HISTORICAL LITIGATION

Litigation under the Contraception, Sterilisation, and Abortion Act 1977 prior to the Abortion Legislation Act 2020

The CSA Act (prior to the 2020 amendment) had not been materially amended for over 40 years. The outdated language and concepts of the legislation pre-amendment inevitably resulted in various legal challenges, brought primarily by interest groups opposed to termination of pregnancy. A brief summary of that litigation follows.

1. Challenges to the decisions of certifying consultants

1982: Wall v Livingston[4]

In his early case under the Act, a paediatrician sought to prevent a young woman from having an abortion when two certifying consultants had certified that a termination of her pregnancy was justified under the CSA Act.

The Court of Appeal held the plaintiff had no standing to challenge the certificate and that any interests of the unborn child were indirectly protected by the mechanisms provided for in the legislation.

2012: Right to Life New Zealand Inc v Abortion Supervisory Committee[5]

The obligations of the Committee in relation to supervision of certifying consultants were the subject of this long running litigation (2004 to 2012) brought by an anti-abortion group. A 3:2 majority of the Supreme Court determined the case in the Committee's favour, accepting that the Committee had no obligations or powers to second-guess the decisions of doctors.

[4] [1982] 1 NZLR 734, (1982) 1 NZFLR 417 (CA).
[5] [2012] NZSC 68, [2012] 3 NZLR 762.

2. Litigation regarding medical termination of pregnancy

2003: Re Abortion Supervisory Committee[6]

The High Court found that the Act required a woman undergoing medical termination to take the second dose of medication on the premises of the abortion clinic on the basis that the Act required any abortion to "performed" within a licensed institution.

This decision proved to have unfortunate consequences, particularly for women who needed to travel to their abortion provider. Specifically, the effect of this decision was that the health of such women could be put at risk as a result of having to travel home after taking the second dose of medication.

2015: Right to Life New Zealand Inc v Abortion Supervisory Committee[7]

In this case before the High Court, the Committee's ability to grant a licence to a clinic that would perform only early medical abortions was the subject of challenge. Right to Life argued that the Act required any clinic to be resourced (including with the necessary personnel) to provide surgical abortions, even though the licensee sought to provide only early medical abortions. The Judge accepted the Committee's submission that the Act should be interpreted so as to apply to modern circumstances, which resulted in a finding that the Committee could grant the licence. New Zealand Family Planning participated in the case and provided evidence to the effect that there was no medical or safety rationale for Right to Life's recommended approach.

3. Conscientious objection – interplay with professional standards

2010: Hallaghan v MCNZ[8]

In this case, Dr Hallaghan (a medical practitioner opposed to abortion) challenged a proposed statement of the Council in relation to doctors' obligations to a woman requesting consideration of termination of pregnancy. The result of that judgment was that a doctor could refuse to refer a patient presenting for advice on termination of pregnancy to another practitioner on the ground of conscientious objection and provide no details at all to enable her to access services from another provider. The Medical Council did not pursue its appeal of the decision. (This judgment is superseded by s 14 of the Act as amended, which provides that a practitioner with a conscientious objection must

[6] [2003] 3 NZLR 87 (HC).
[7] [2015] NZHC 2393.

[8] High Court, Wellington, 2/12/2010, CIV-2010-485-222, MacKenzie J.

notify the woman of that objection and provide details of the closest alternative provider of abortion services).

IMPROVED ACCESS

A matter of continuous concern over the previous 43 years has been around adequate access to abortion services. While the Ministry of Health consistently agreed that abortion services are considered a core health service, the availability of licensed institutions have not always been satisfactory.

In many instances, hospitals provided very limited services and only under particular circumstances. For a number of years women were forced to travel long distances to obtain first trimester services.

This ASC, as well as previous Committee's, worked hard to attempt to encourage various DHB's to provide local services. The CSA Act provides no powers to mandate a DHB or the Ministry of Health to provide a service in every region. The decision to provide a service is subject to the willingness and ability of each individual institution. Unfortunately, the ultimate consequence of this was to the women of New Zealand who had to receive care outside of their region.

The ASC was pleased that Gisborne, Invercargill, Palmerston North and Rotorua started services in recent years. Despite the myths spread by some member of the public, this did not result in increased numbers of abortions. We have consistently seen that access to local services does not increase abortion rates, it just makes the process less stressful for those that need to use it. The ASC also believe it ensures that women are able to make the most appropriate decisions for their health instead of rushing into a decision due to the effort they have already made to simply see a provider.

Medical abortion procedures have also allowed for better access in New Zealand with clinics like Tauranga Family Planning being in a position to offer medical abortion procedures without having to have a full surgical clinic. Barriers still remained, however, due to limitations in the legislation that held that women must received both sets of abortion pills on a licensed premise. This was impractical and not medical best practice. The ASC is pleased that the change to legislation has now meant that access to medical abortion procedures will able to be accessed locally without the need for an abortion licence as well as women being able to take the second dose of medication in a space that is more comfortable for her rather than on a licensed premises.

OPERATING DOCTORS

It has always been a challenge to identify the true number of doctors who perform abortion procedures in New Zealand. Each doctor also has their own limitations on what gestation they are willing or able to perform up to, as well as the circumstances of that authorised abortion (i.e. some doctors will only perform abortions in cases of serious fetal abnormality or in the event a woman's health is at imminent risk).

During the submission process, the ASC made a submission to the Abortion Legislation Committee that outlined the information the ASC did have. The following is the specific information provided to the ALC in 2019:

> *"The workforce of medical professionals currently providing abortion services consists of doctors with experience or an interest in women's health, specialists in obstetrics and gynaecology, Maternal Fetal Medicine (MFM) specialists, counsellors, social workers and nurses.*
>
> *While the CSA Act does not require doctors who perform abortions (known as 'operating surgeons') to be appointed as a certifying consultant under section 30 of the Act, the vast majority of doctors that perform abortions happen to also be certifying consultants.*
>
> *Currently, there are 182 certifying consultants holding an appointment. Each consultant must reapply for appointment from the ASC annually. Of these 182 consultants, only 61 of these perform abortion procedures with 51 of these specialising in obstetrics and gynaecology.*
>
> *An area of concern is the number of operating surgeons willing to perform abortions between 15 and 20 weeks. The majority of hospitals and clinics licensed to perform abortions in New Zealand only offer 1st trimester services or instances where MFM specialists are required. Only 8 operating doctors have advised they are willing to provide abortion services after 15 weeks. Despite the woman and her health practitioner deciding an abortion is warranted, there may be access issues around obtaining the procedure if operators are unwilling to perform an abortion at that gestation."*

ACKNOWLEDGEMENTS

The ASC would like to thank all those involved in abortion care over the years under what, in many cases, has been difficult or less than ideal circumstances.

We must acknowledge the certifying consultants who dedicated many years to providing abortion services; some working for several decades and long after the retirement age. Other certifying consultants travelled throughout the country to provide services that were otherwise not provided locally due to reluctance from local professionals. The ASC heard from consultants and providers who experienced harassment in the form of distasteful letters and threats – even affecting their families in the community. The ASC would like to express its gratitude to all medical professionals who worked in the field to ensure the women of New Zealand received the care they needed.

The ASC would like to express its warm thanks to the Secretary of the ASC for her work over the previous ten years. During this period, she has shown considerable dedication, hard work and passion for the work of the ASC jurisdiction. The last few years that have been particularly challenging for the ASC we have been grateful to have had a secretary who is highly competent and supportive of the ASC members.

The ASC would also like to thank the Ministry of Justice staff who provided the ASC with amazing professional support. And to the Ministers of Justice over the 43 years the CSA Act was in force. It was particularly helpful when the ASC was provided with an opportunity to meet with the Minister of the day to discuss the work of the ASC and raise concerns we had about how the Act was being applied in practice.

Thanks to the ASC Standards of Care Committees who worked tirelessly to put together comprehensive Standards of Care documents. As well as Counselling Advisors who provided much insight to ASC Members over the years.

A very special thanks to the ASC's counsel, Wendy Aldred. An exceptional woman with a special passion for this area of work, who represented the ASC over the years not only with legal advice, but a number of court cases brought against this particular ASC over the previous ten years. Wendy has been an important member of the extended ASC team and we would like to express our appreciation.

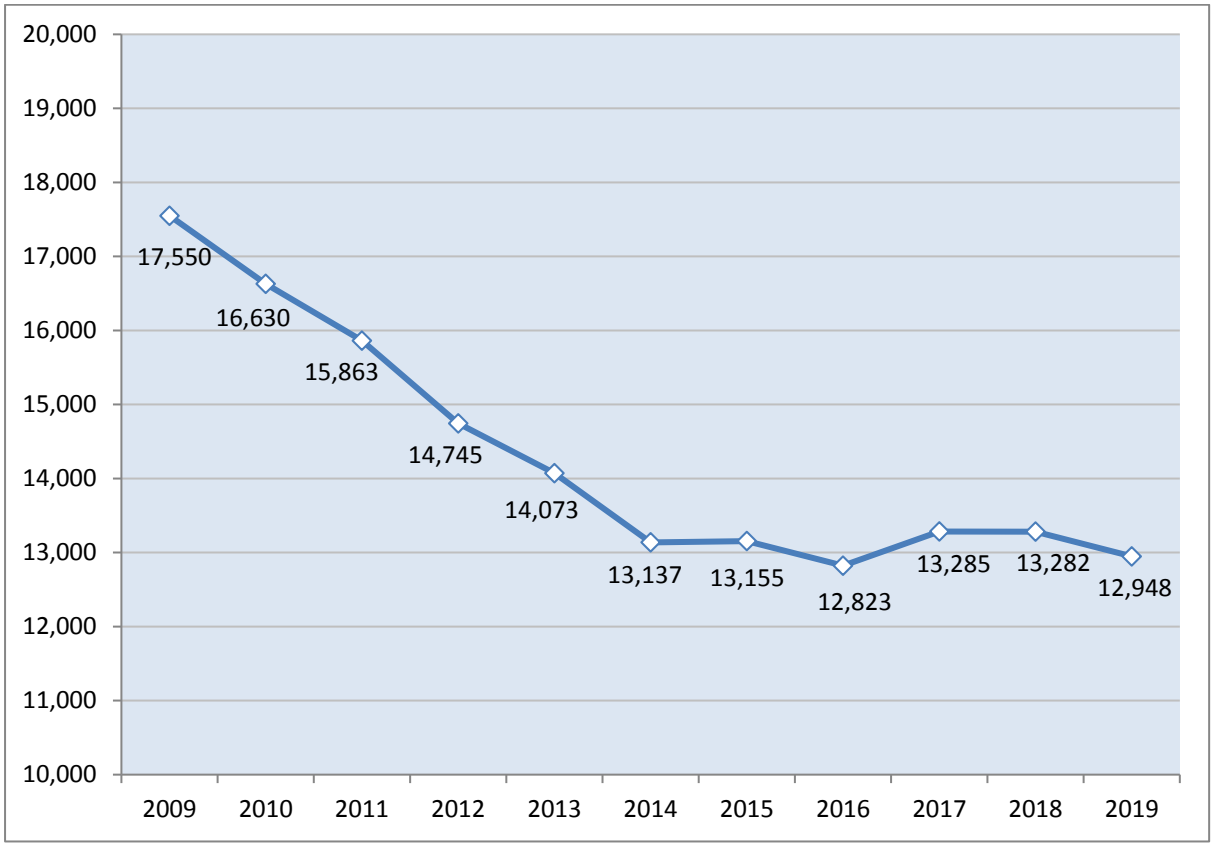
STATISTICAL ANALYSIS AND TRENDS

In this section the ASC presents its analysis of the New Zealand abortion statistics for the 2019 calendar year. Further statistics in tabular form are available to view online at the Statistics New Zealand website: http://www.stats.govt.nz

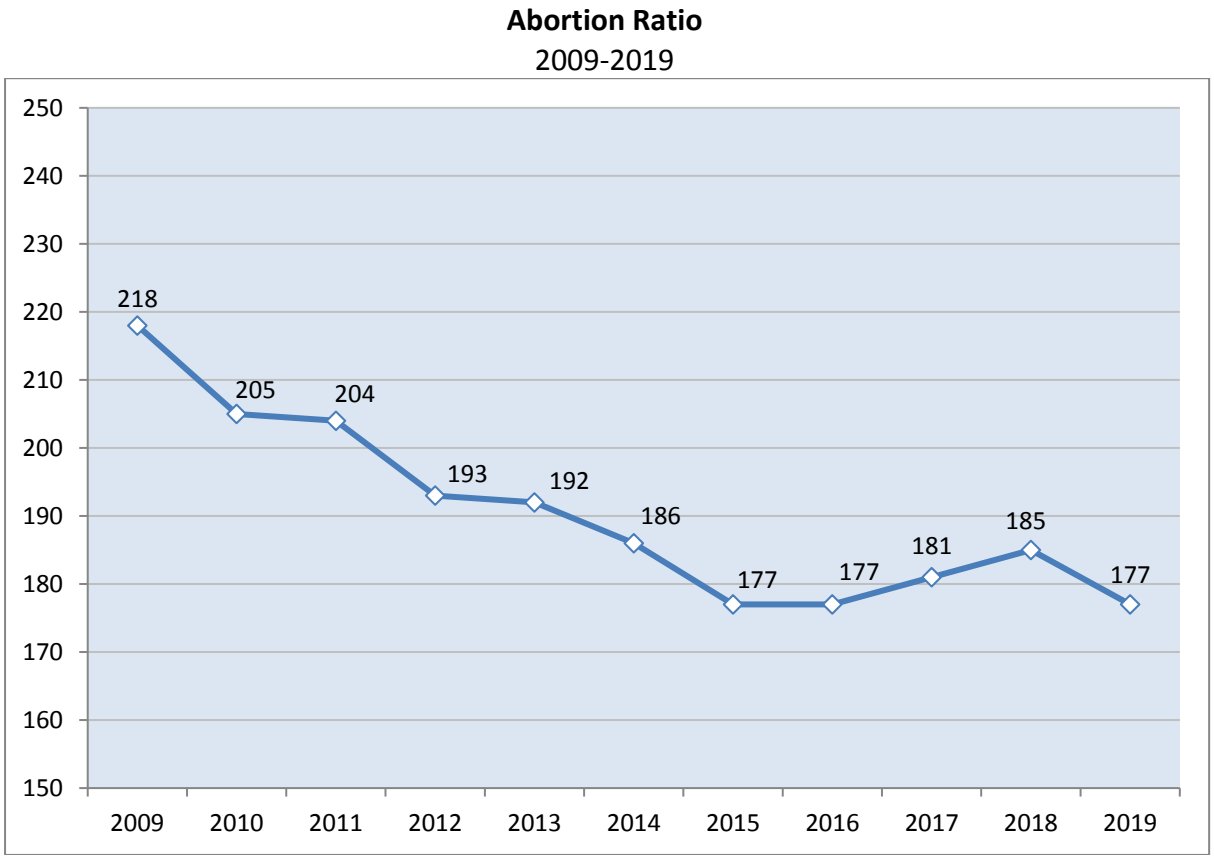
1. Induced Abortions, Rates and Ratios

Graph 1.1

Number of Induced Abortions
2009-2019

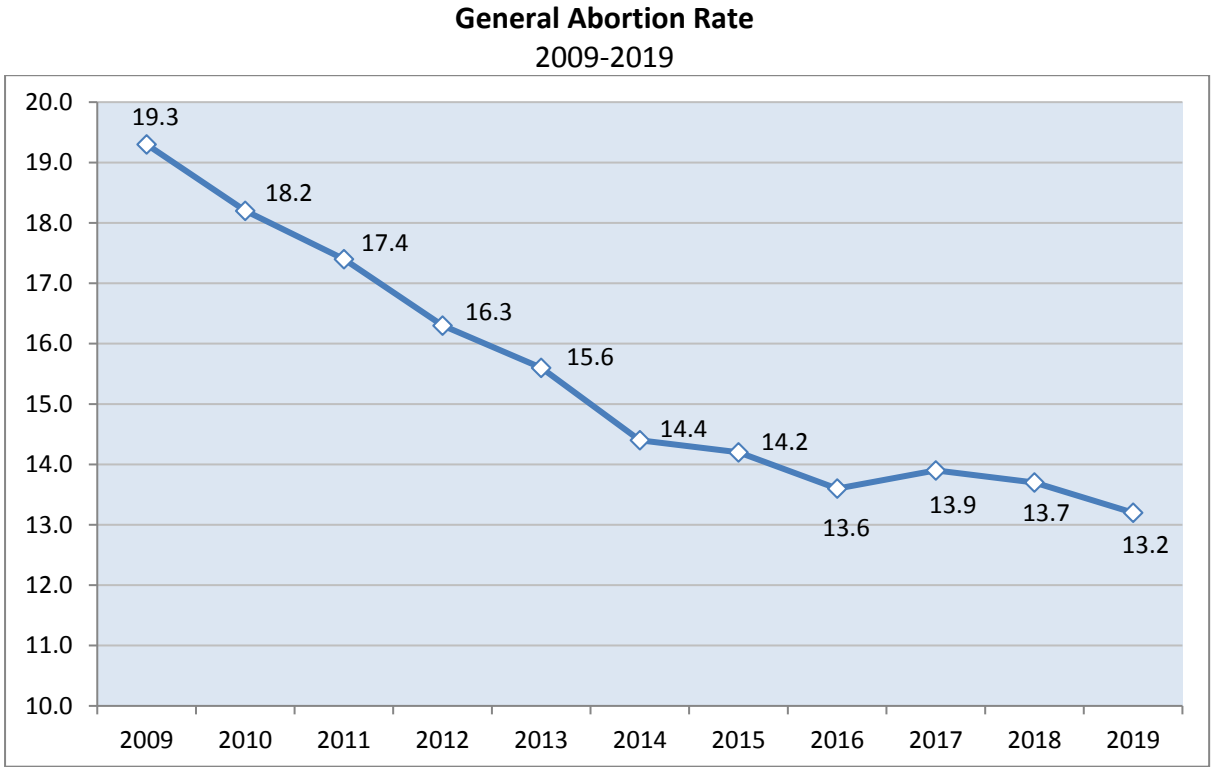


Graph 1.2



The abortion ratio is the number of abortions per 1,000 known pregnancies. Known pregnancies include live births, stillbirths and induced abortions combined, but does not include miscarriages.

Graph 1.3

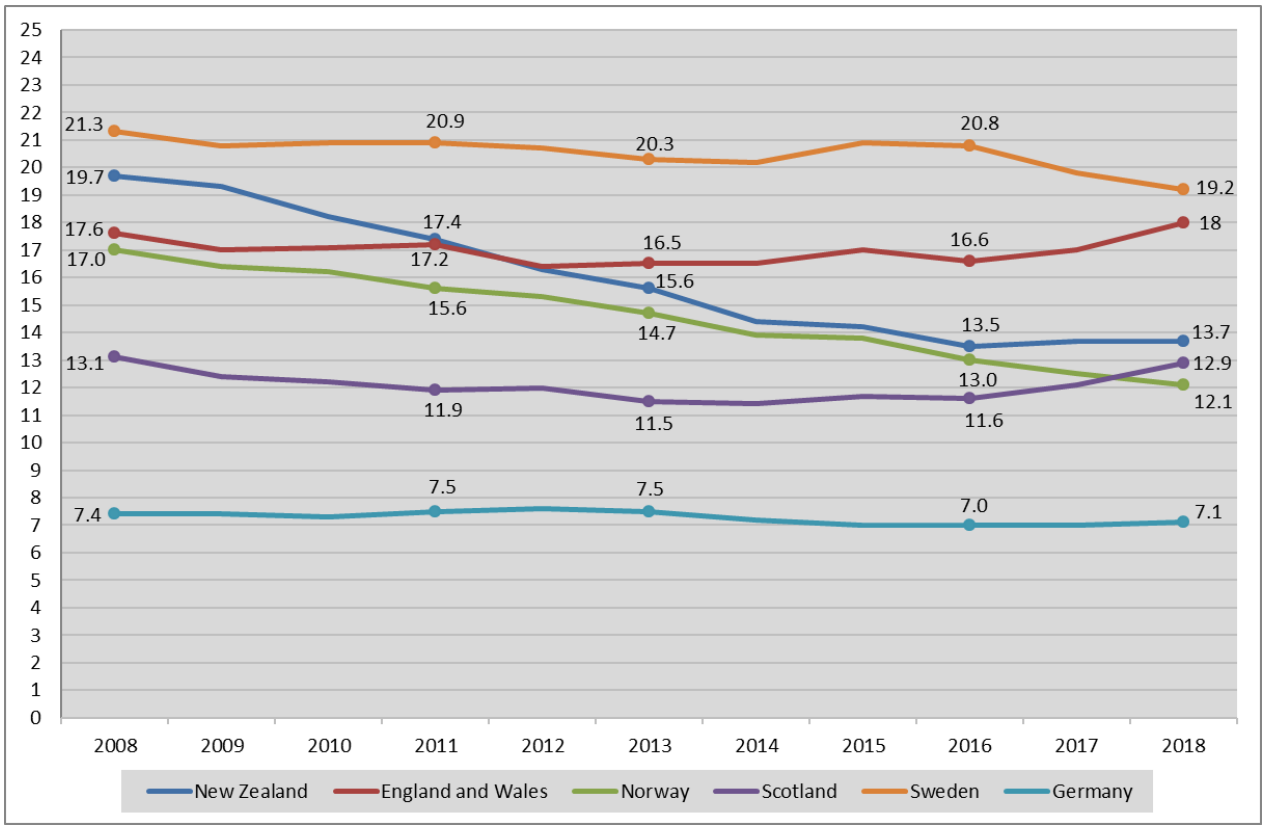


The general abortion rate is the number of abortions per 1,000 of the mean estimated population of women aged 15-44 years.

Graph 1.4

General Abortion Rates in Selected Countries

2008-2018



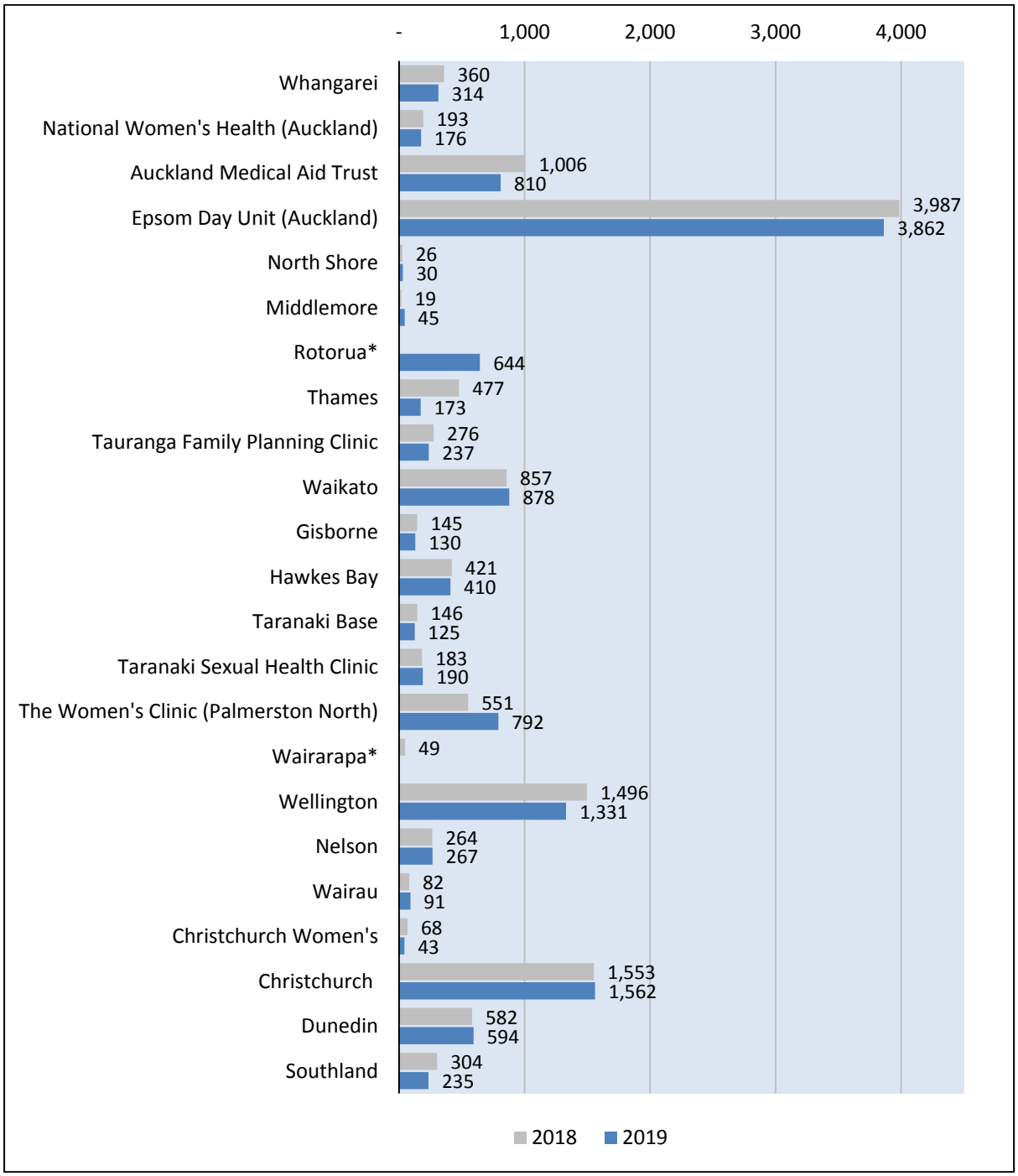
The general abortion rate is the number of abortions per 1,000 of the mean estimated population of women aged 15-44 years. Statistical coverage and laws relating to induced abortion affect international comparisons of abortion statistics. Induced abortions are not a notifiable procedure in many countries and statistics on abortion rates are not available for many countries. Consequently, differences between abortion rates for New Zealand and other countries should be interpreted with care.

International data for 2019 is not available for many countries, so comparisons are made using 2018 data.

2. Hospital and Residence

Graph 2.1

Number of Abortions by Hospital
Calendar Years 2018 & 2019



Three other hospitals performed a total of 9 abortions:

Wairarapa Hospital
Palmerston North
Hutt Hospital

Graph 2.2

Induced Abortions by Residence of Woman
Regional Council
Calendar Years 2018 & 2019

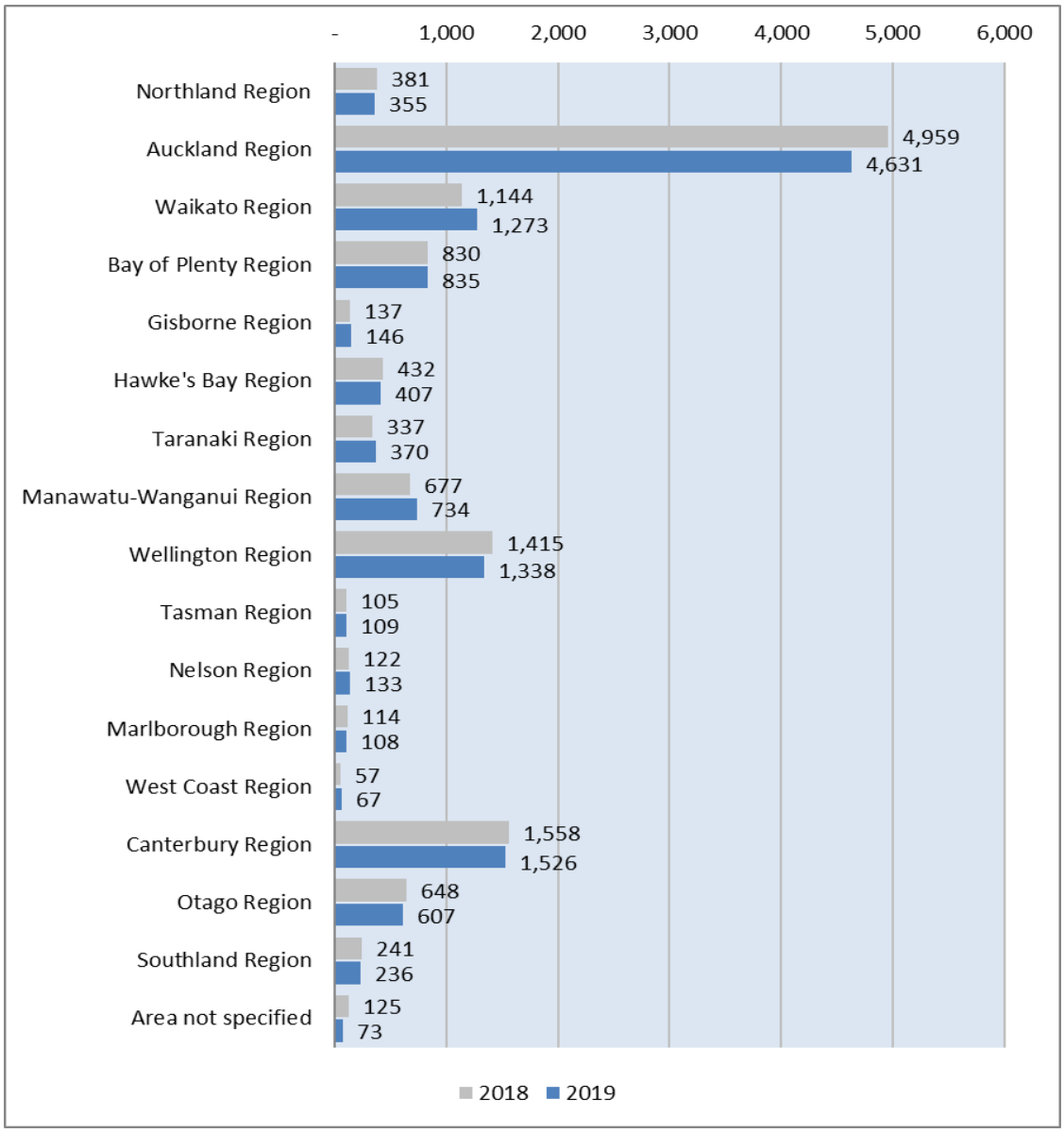


Table 2.3

Induced Abortions by Residential Status of Woman
Calendar Year 2019

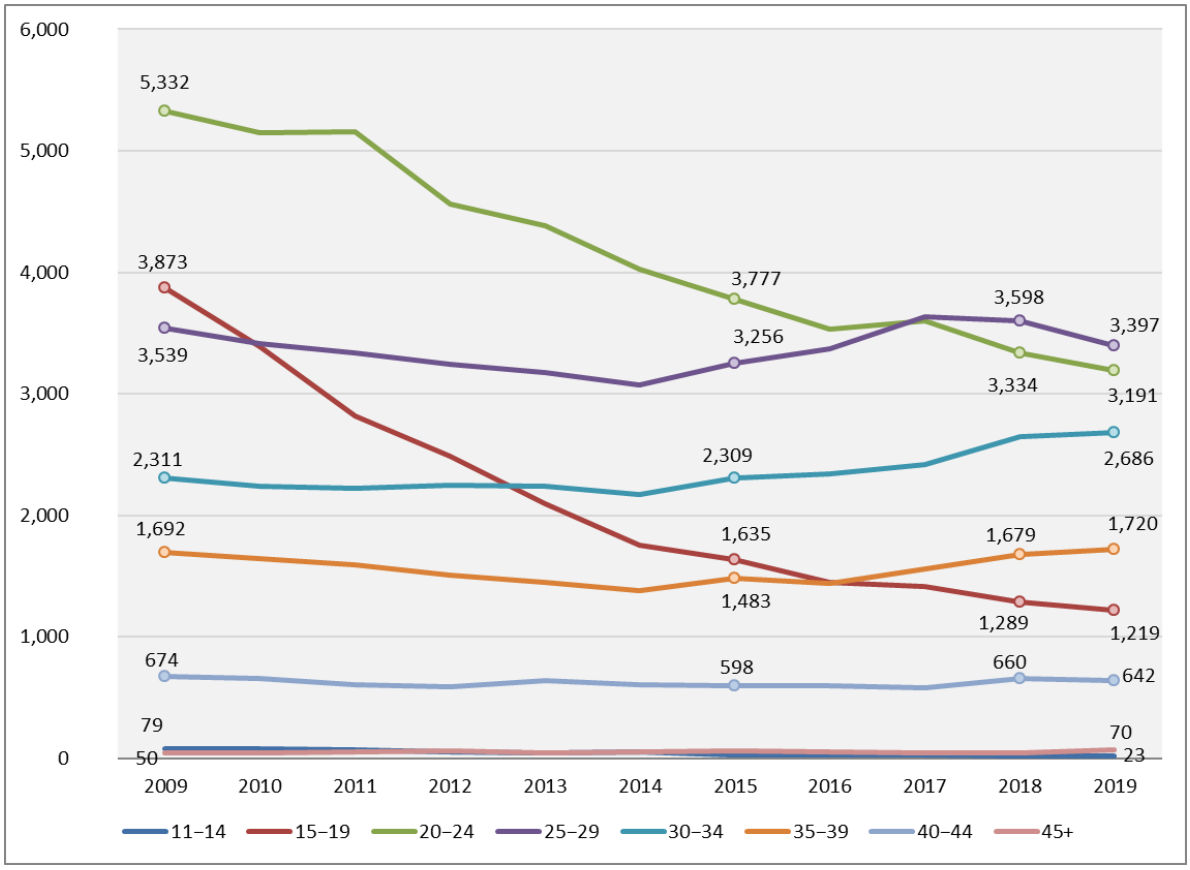
Residential Status [9]	Number
New Zealand Resident	11,662
Non-Resident	1,248
Not Stated	38
Total	**12,948**

[9] Residential status is not the same as place of residence.

3. Age of Woman

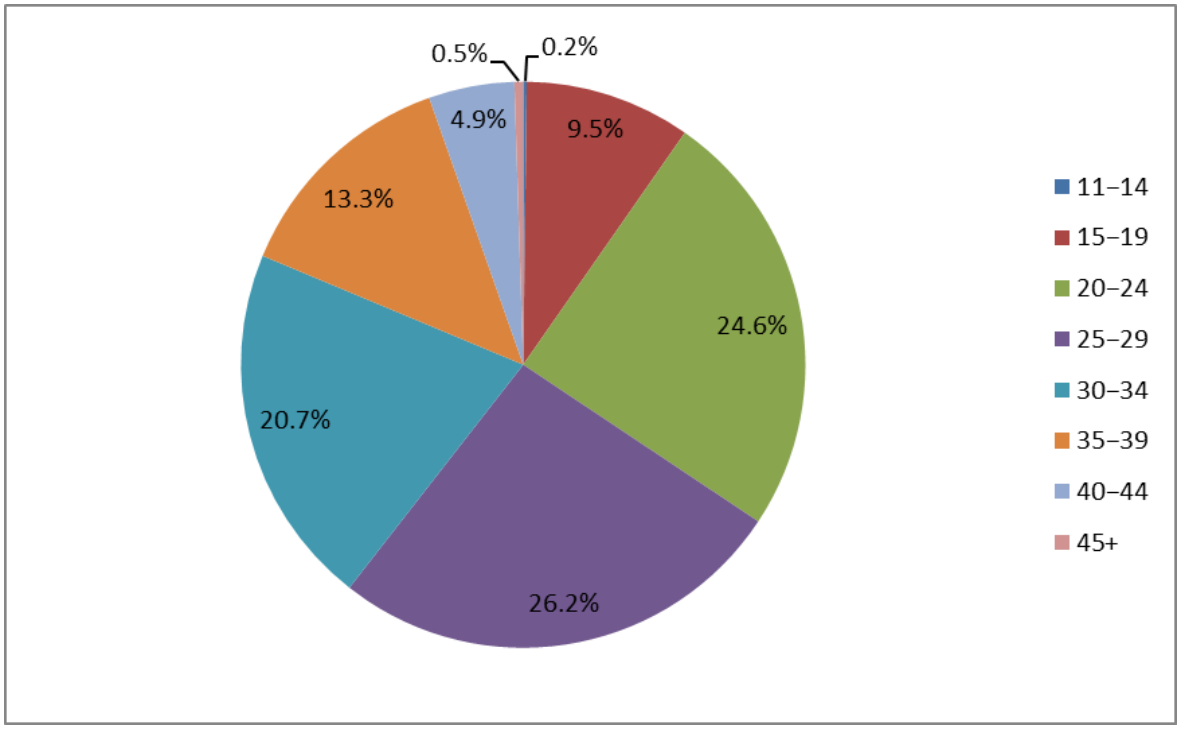
Graph 3.1

Number of Abortions by Age
2009-2019



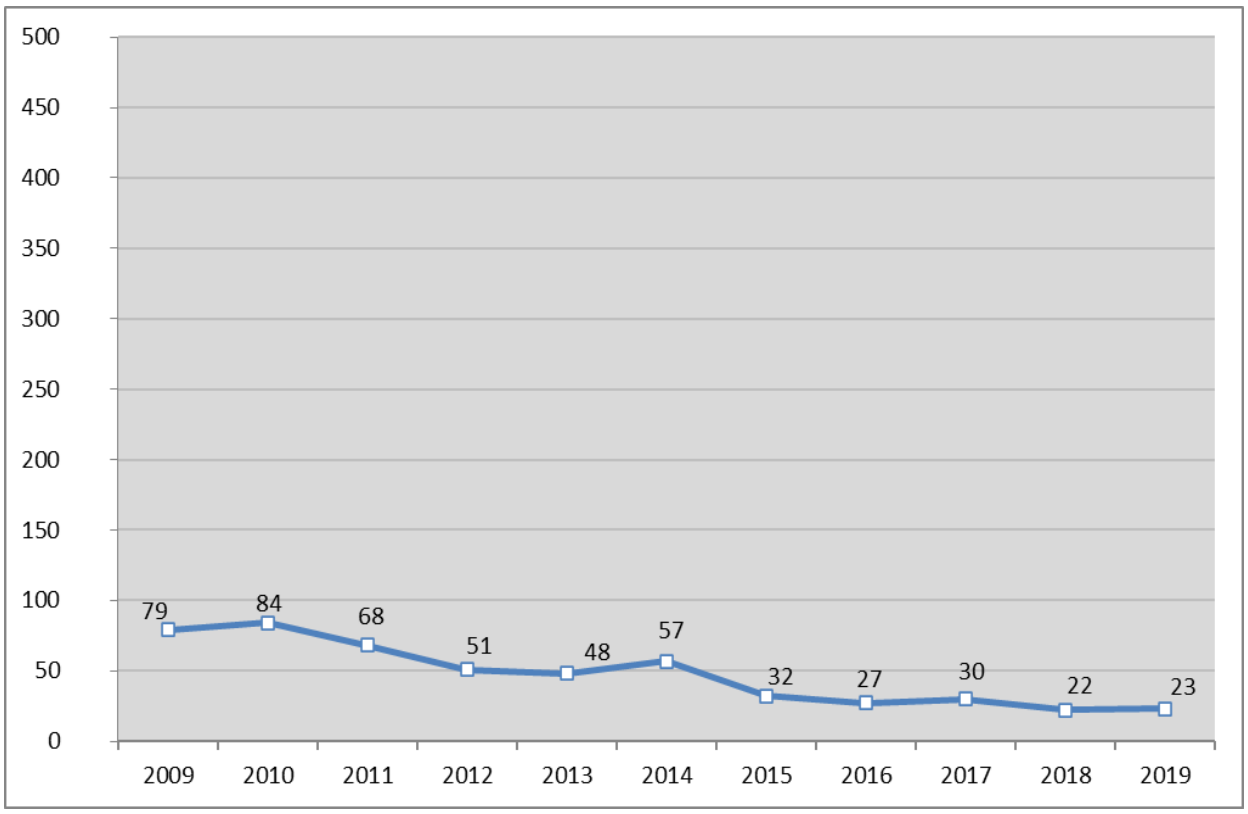
Graph 3.2

Number of Abortions by Age in Percentages
Calendar Year 2019



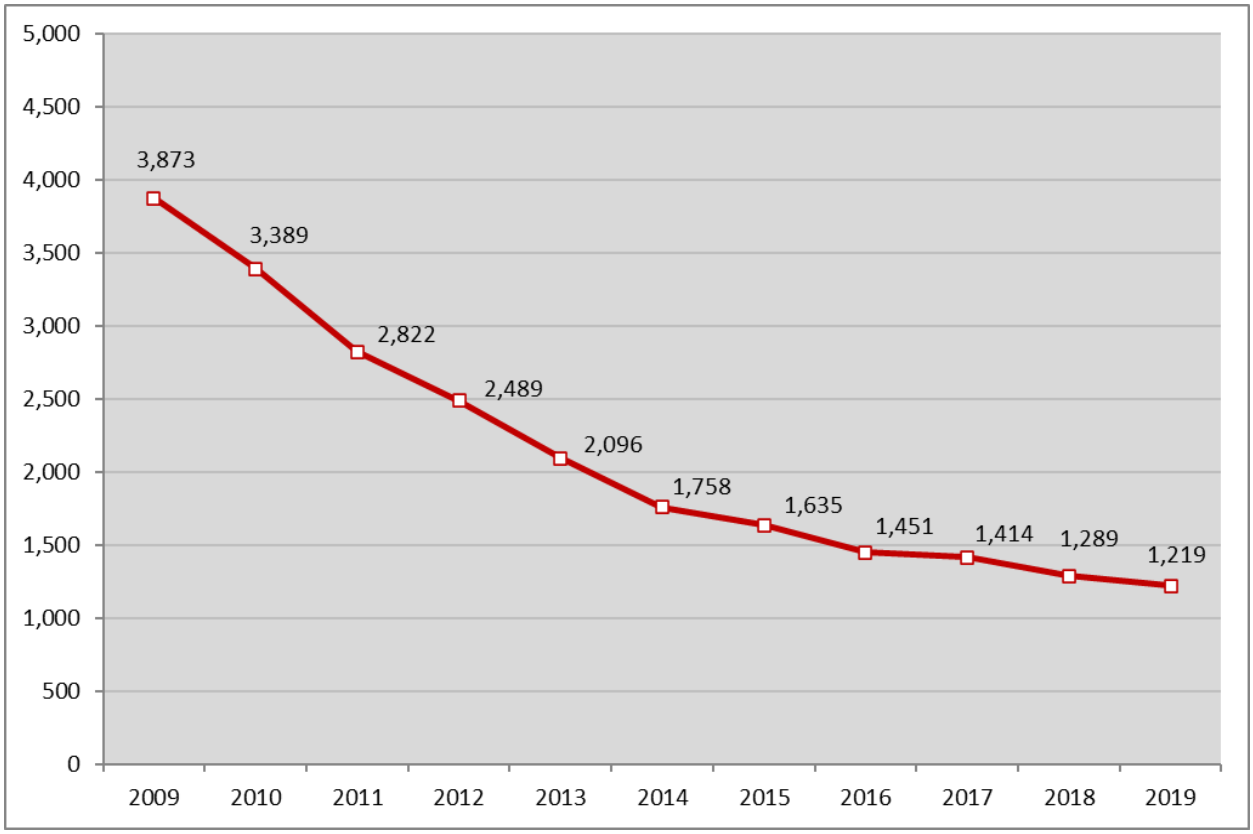
Graph 3.3

Number of Abortions for Ages 11-14
2009-2019



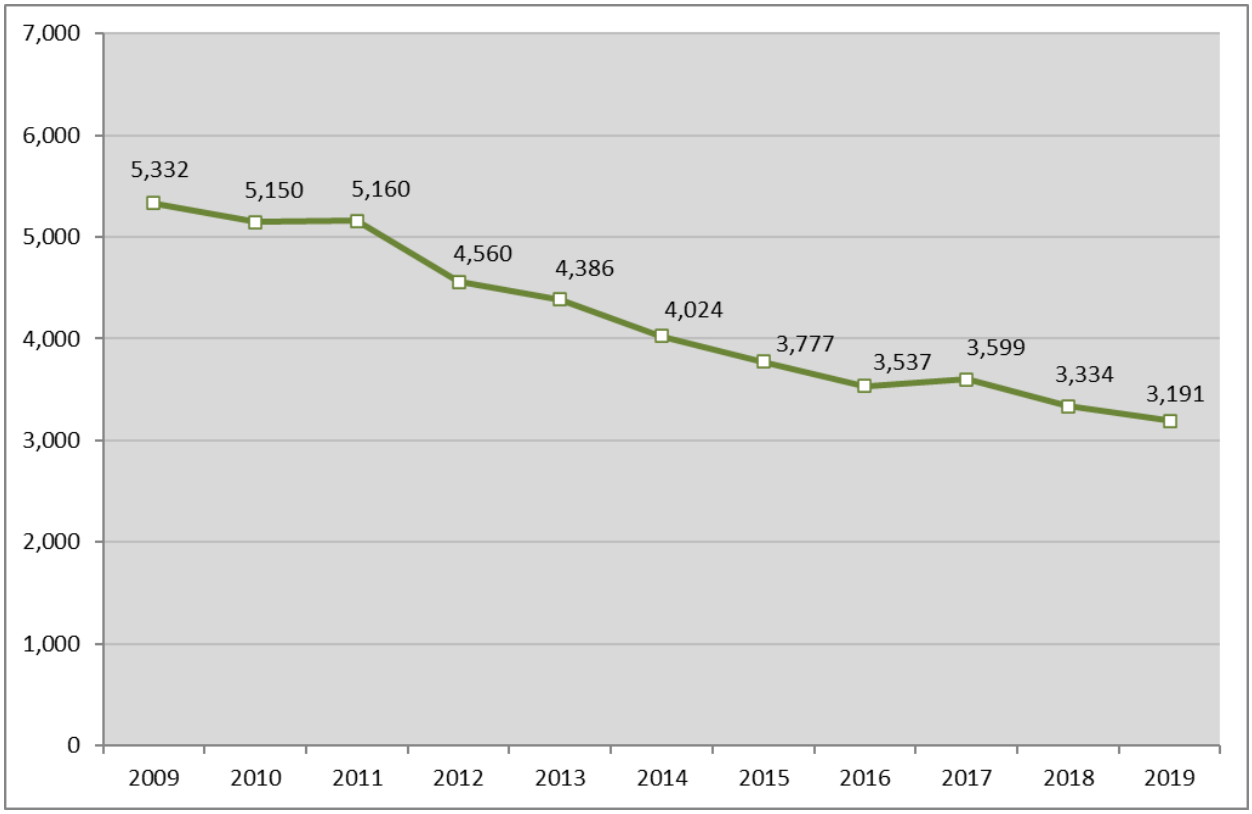
Graph 3.4

Number of Abortions for Ages 15-19
2009-2019



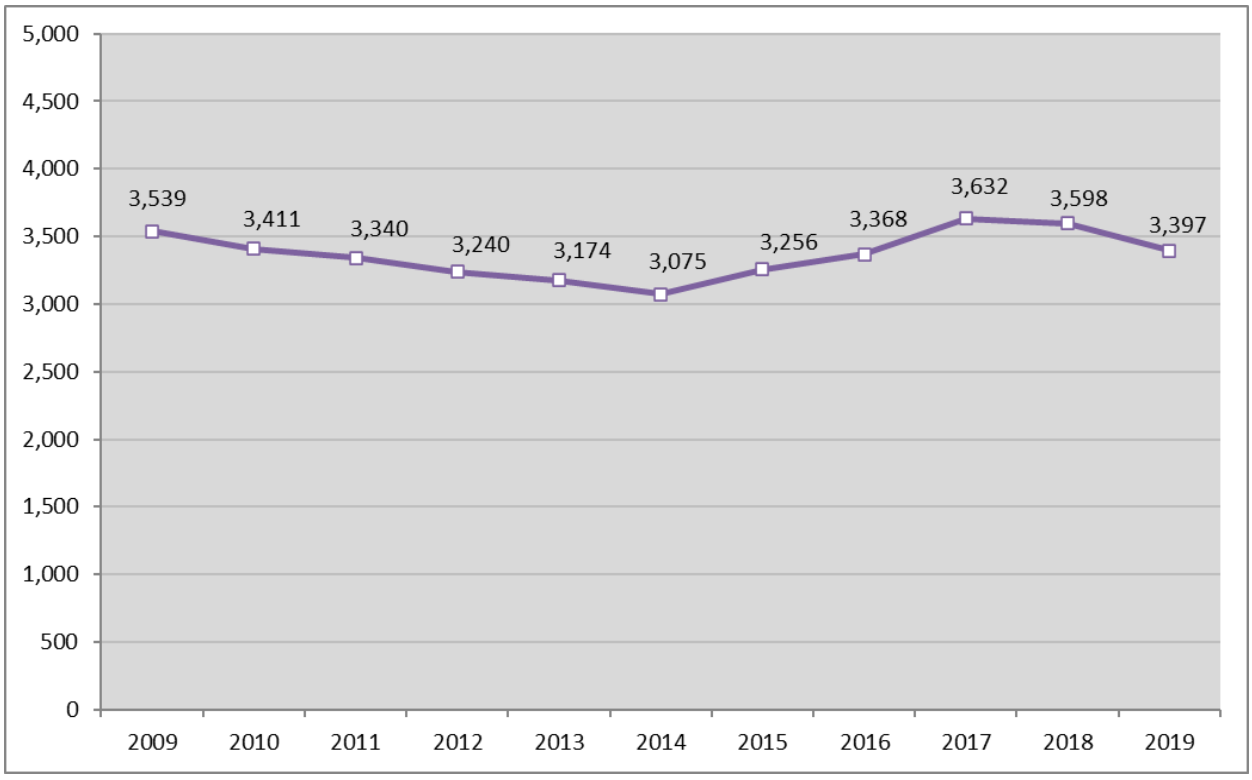
Graph 3.5

Number of Abortions for Ages 20-24
2009-2019



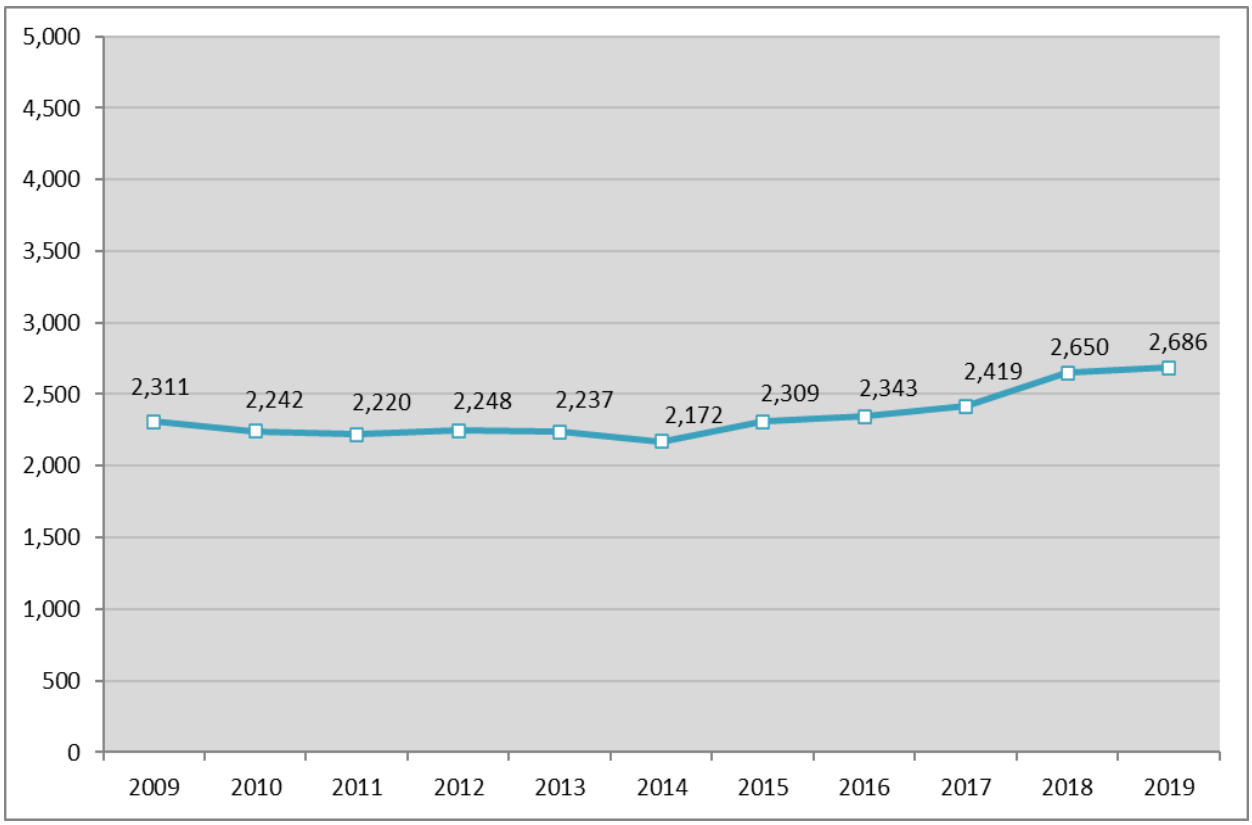
Graph 3.6

Number of Abortions for Ages 25-29
2009-2019



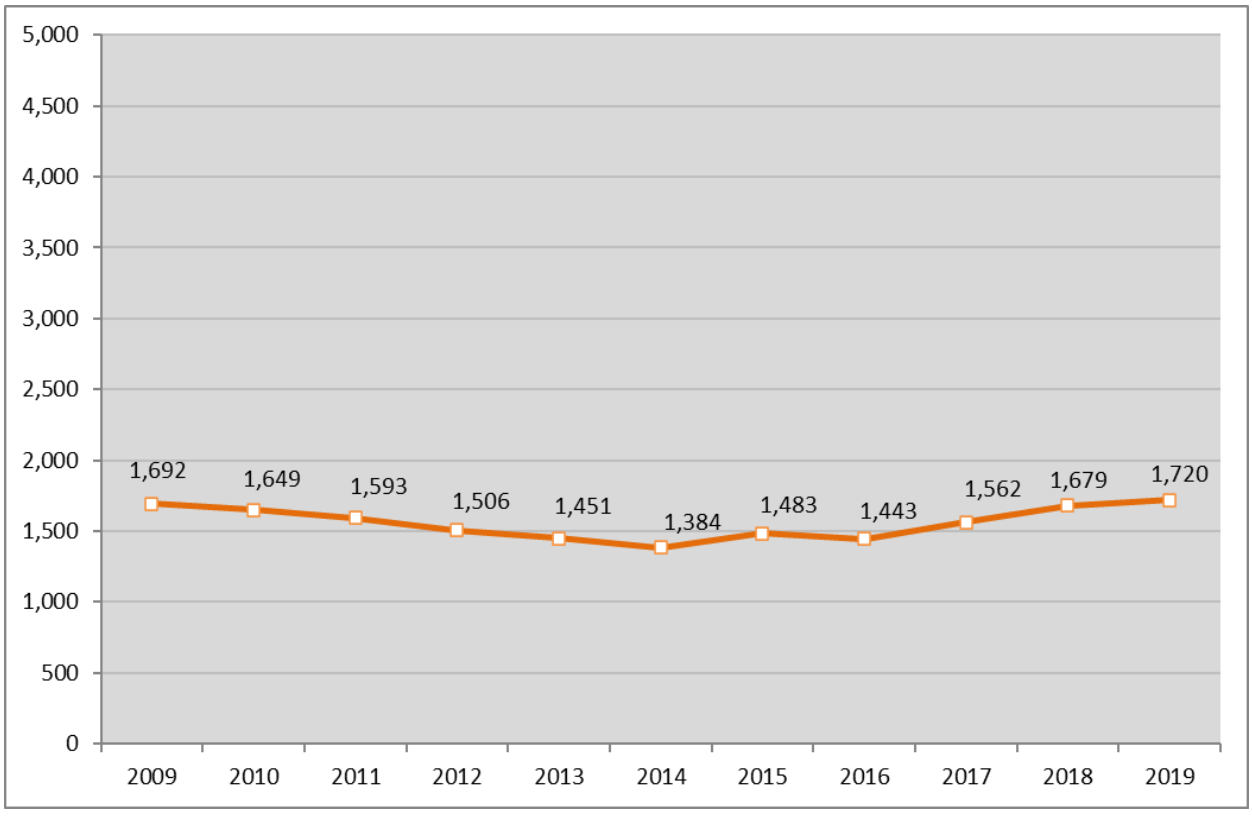
Graph 3.7

Number of Abortions for Ages 30-34
2009-2019



Graph 3.8

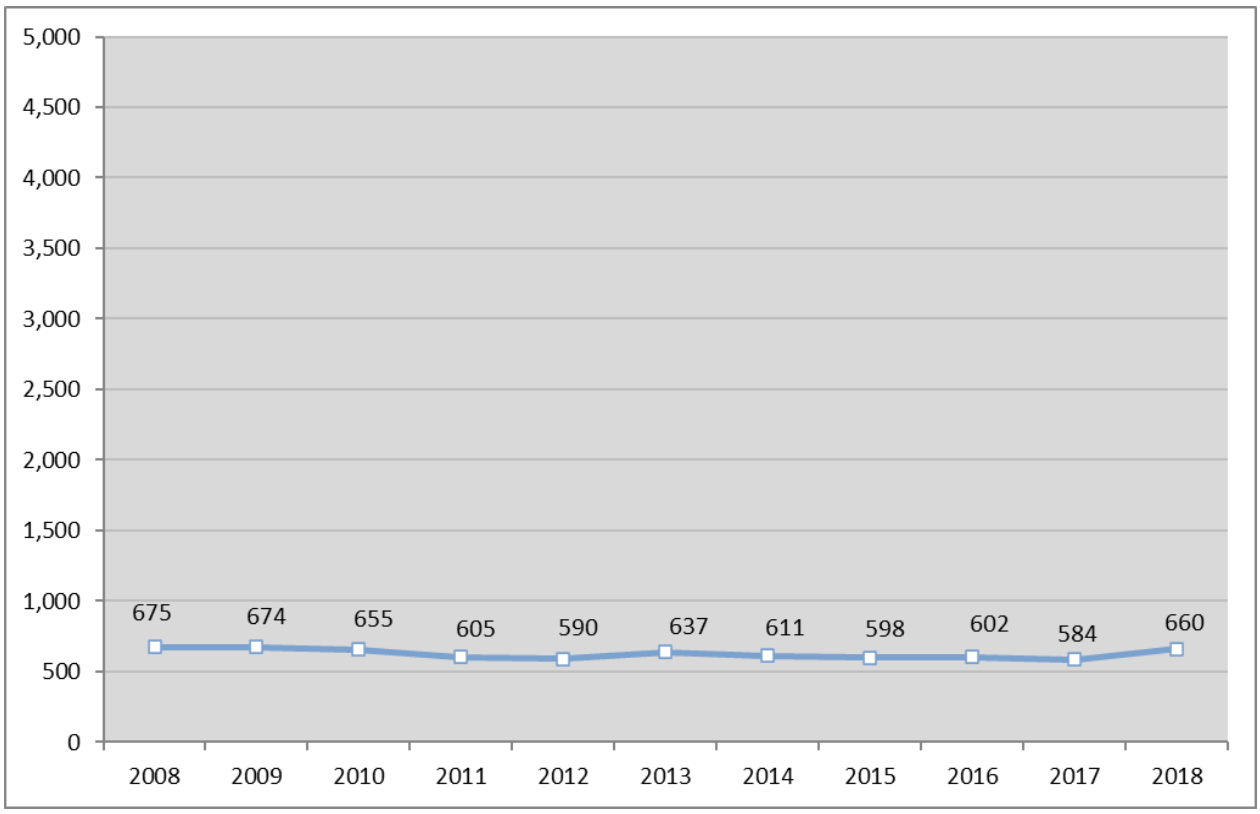
Number of Abortions for Ages 35-39
2009-2019



Graph 3.9

Number of Abortions for Ages 40-45

2009-2019



Graph 3.10

Number of Abortions for Ages 45+

2009-2019

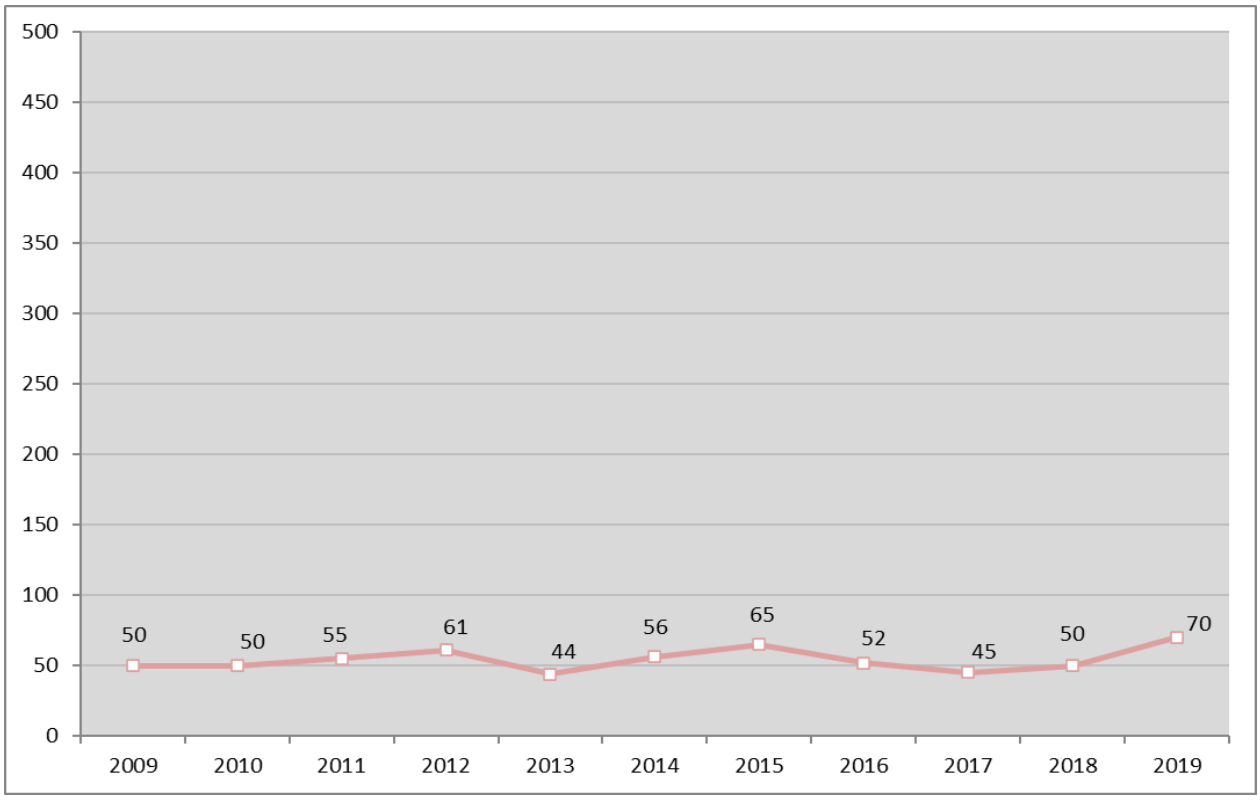


Table 3.11

Induced Abortions by Age – Under 16 Years
Calendar Year 2019

Age (Years)	Number
11	-
12	1
13	4
14	18
15	55
Total	**78**

4. Previous Live Births

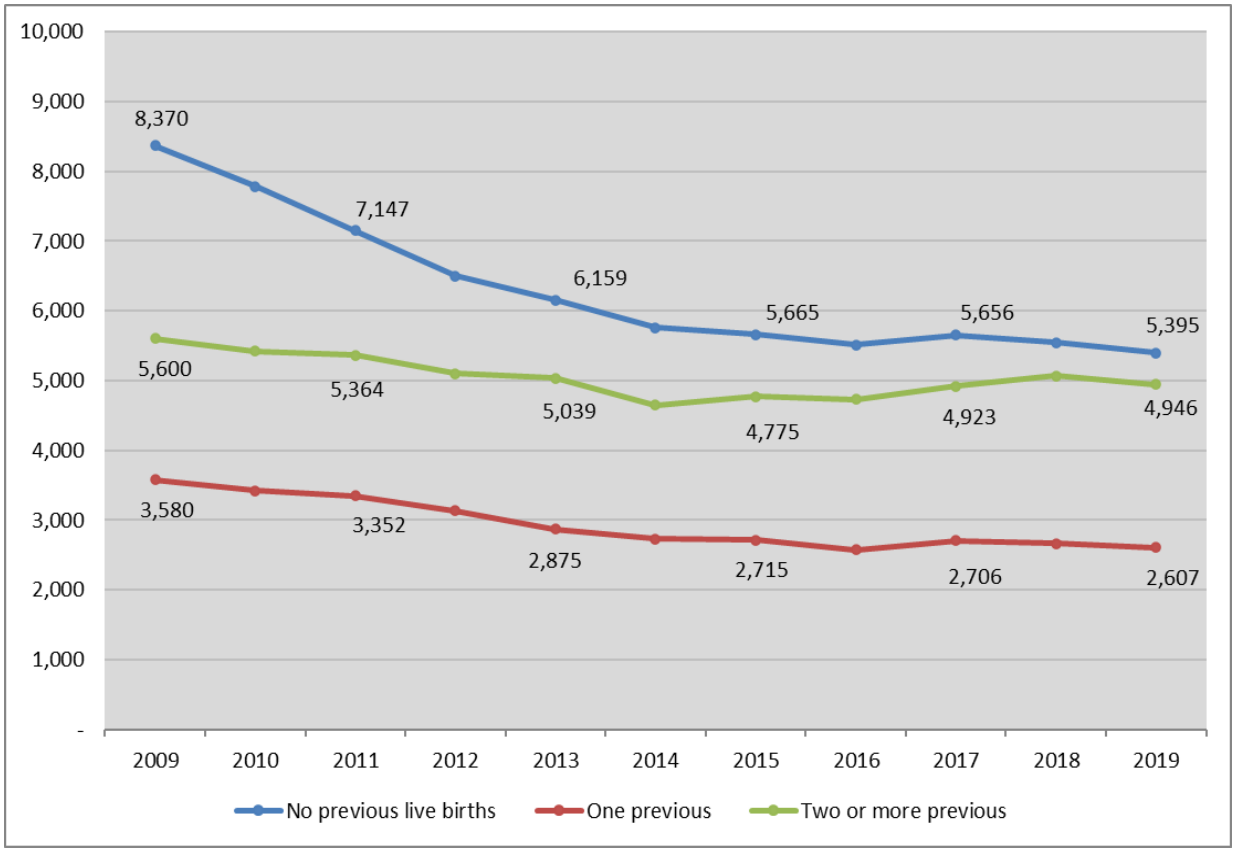
Table 4.1

Induced Abortions by Age and Previous Live Births
Calendar Year 2019

Age (years)	Previous Live Births								
	Total	0	1	2	3	4	5	6	7 or More
All Ages	**12,948**	**5,395**	**2,607**	**2,899**	**1,313**	**449**	**164**	**77**	**44**
Under 15	23	23	-	-	-	-	-	-	-
15-19	1,219	1,095	111	13	-	-	-	-	-
20-24	3,191	2,045	653	364	99	30	-	-	-
25-29	3,397	1,349	787	749	368	100	33	6	5
30-34	2,686	615	607	834	392	151	51	23	13
35-39	1,720	208	315	668	316	111	57	30	15
40-44	642	54	116	253	118	53	23	15	10
45 and Over	70	6	18	18	20	4	-	3	1

Graph 4.2

Number of Abortions by Previous Live Births
2009-2019



5. Previous Induced Abortions

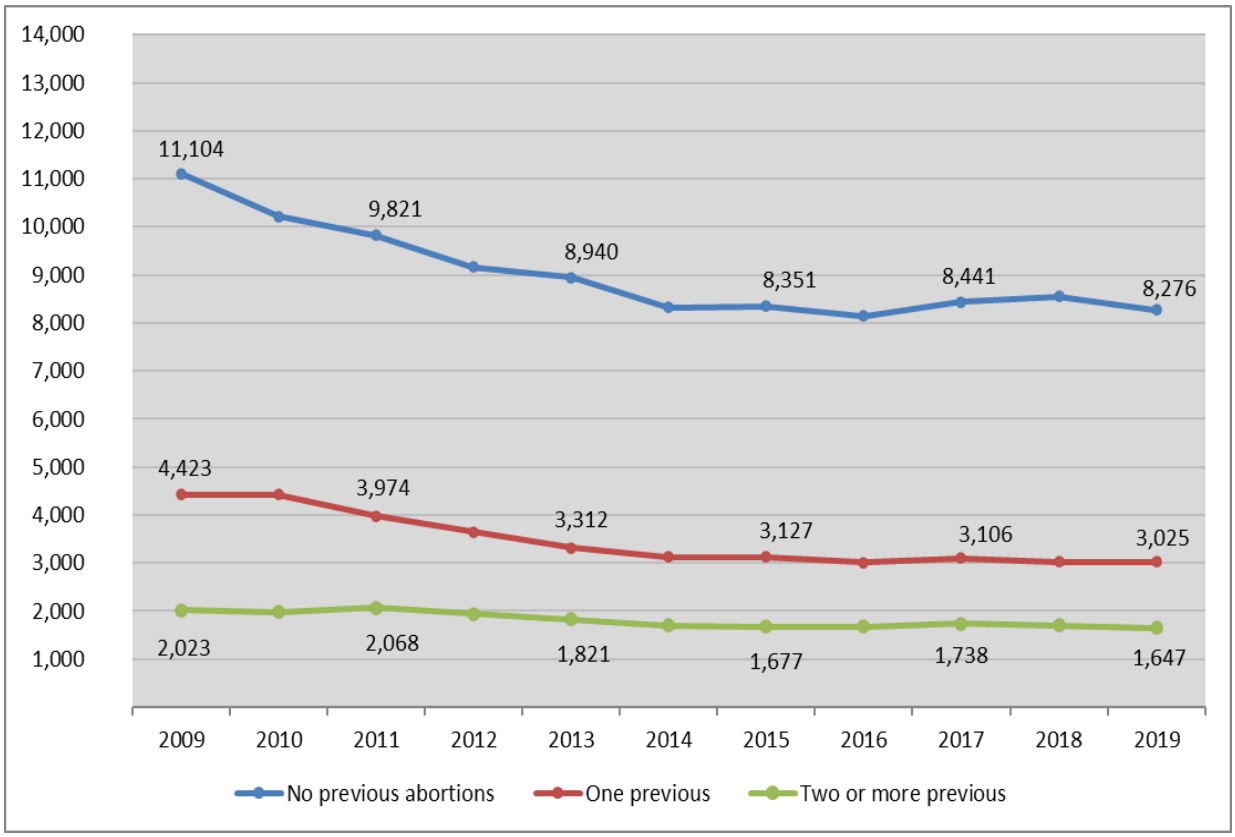
Table 5.1

Induced Abortions by Age and Previous Induced Abortions
Calendar Year 2019

Age (years)	Previous Abortions							
	Total	0	1	2	3	4	5	6 or more
All Ages	**12,948**	**8,276**	**3,025**	**1,087**	**327**	**133**	**63**	**37**
Under 15	23	23	-	-	-	-	-	-
15-19	1,219	1,105	100	13	1	-	-	-
20-24	3,191	2,421	612	130	23	1	4	-
25-29	3,397	2,052	866	345	81	33	12	8
30-34	2,686	1,452	737	322	109	38	14	14
35-39	1,720	856	506	198	77	50	22	11
40-44	642	326	183	73	34	11	11	4
45 and Over	70	41	21	6	2	-	-	-

Graph 5.2

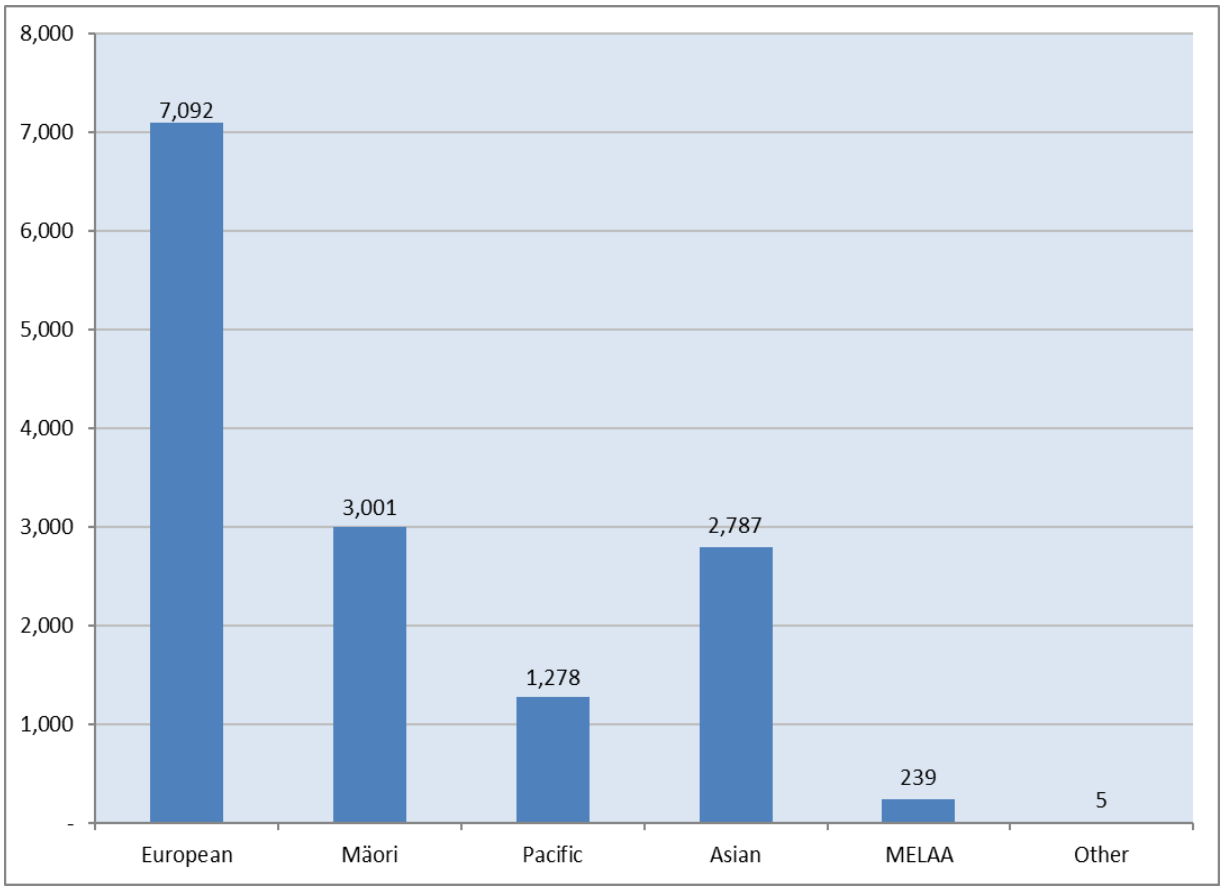
Number of Abortions by Previous Induced Abortions
2009-2019



6. Ethnic Group

Graph 6.1

Number of Abortions by Ethnic Group
Calendar Year 2019



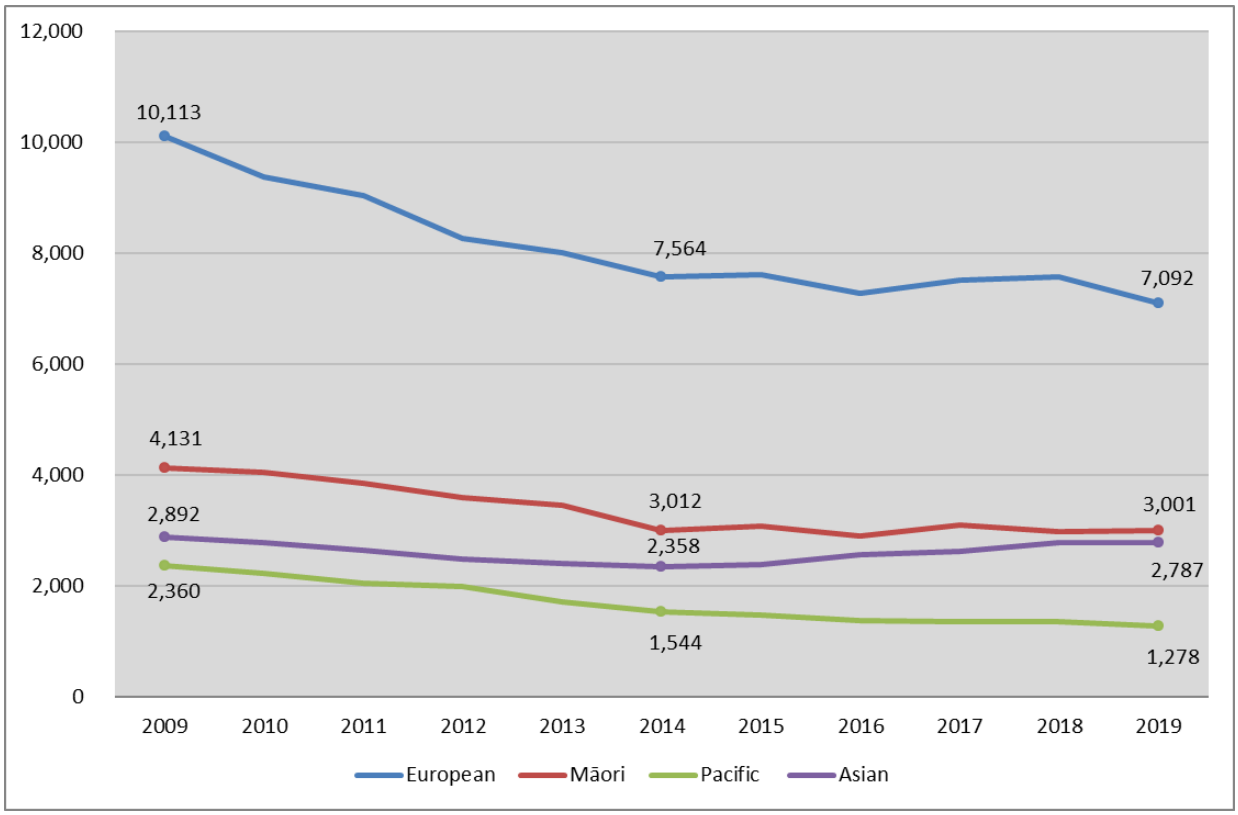
Each abortion has been included in every ethnic group specified. For this reason, some abortions are counted more than once.

Note:
(a) MELAA = Middle Eastern, Latin American and African
(b) Other includes New Zealanders.

Graph 6.2

Number of Abortions by Ethnic Group

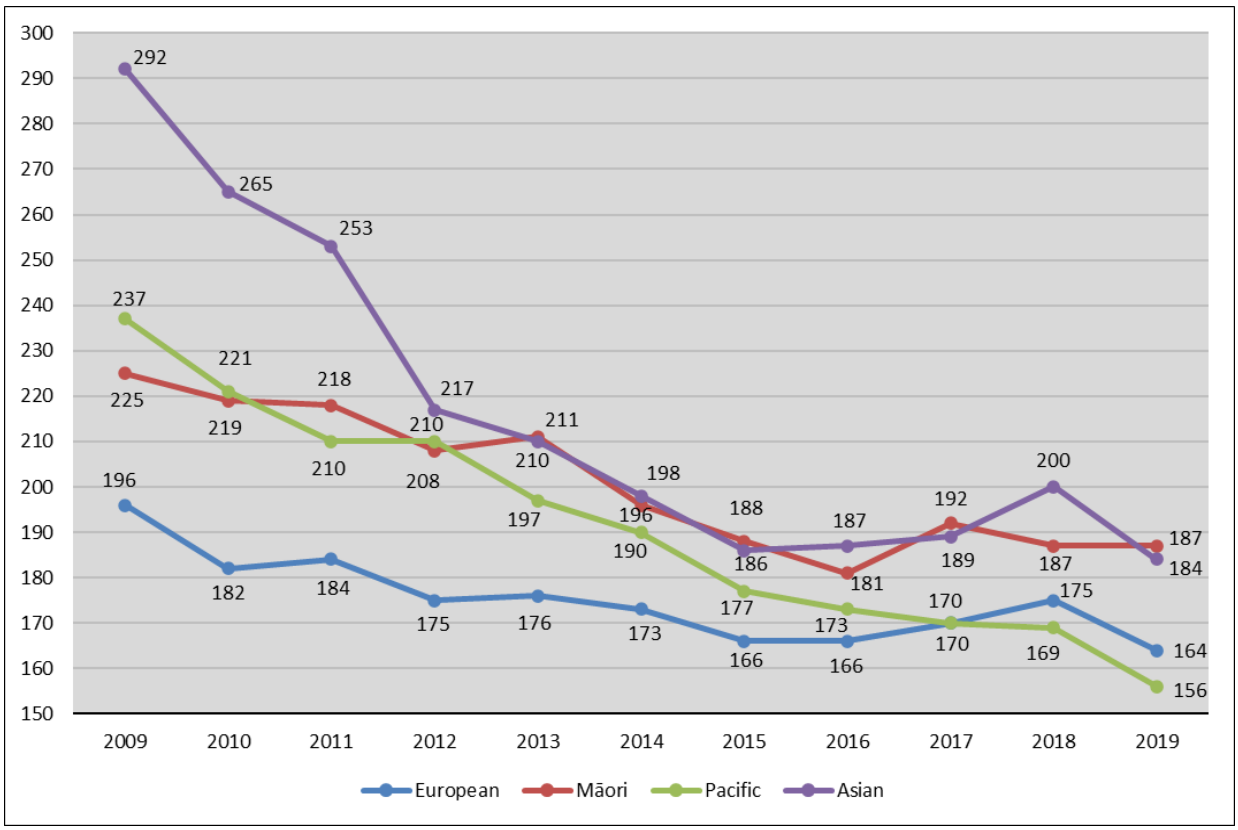
2009-2019



Graph 6.3

Induced Abortions by Ethnicity Ratio

2009-2019



Ratio: Induced abortions per 1,000 known pregnancies including live births, stillbirths and abortions combined, but does not include miscarriages.

7. Duration of Pregnancy

Table 7.1

Induced Abortion by Age and Duration of Pregnancy

Calendar Year 2019

Age (years)	Duration of Pregnancy (weeks)					
	Total	Under 8	8-12	13-16	17-20	Over 20
All Ages	**12,948**	**3,504**	**8,087**	**1,051**	**236**	**70**
Under 20	1,242	295	795	116	35	1
20-24	3,191	835	2,060	240	48	8
25-29	3,397	950	2,110	282	43	12
30-34	2,686	747	1,644	217	51	27
35-39	1,720	467	1,061	134	41	17
40-44	642	184	381	57	15	5
45 +	70	26	36	5	3	-

Table 7.2

Induced Abortion by Duration of Pregnancy

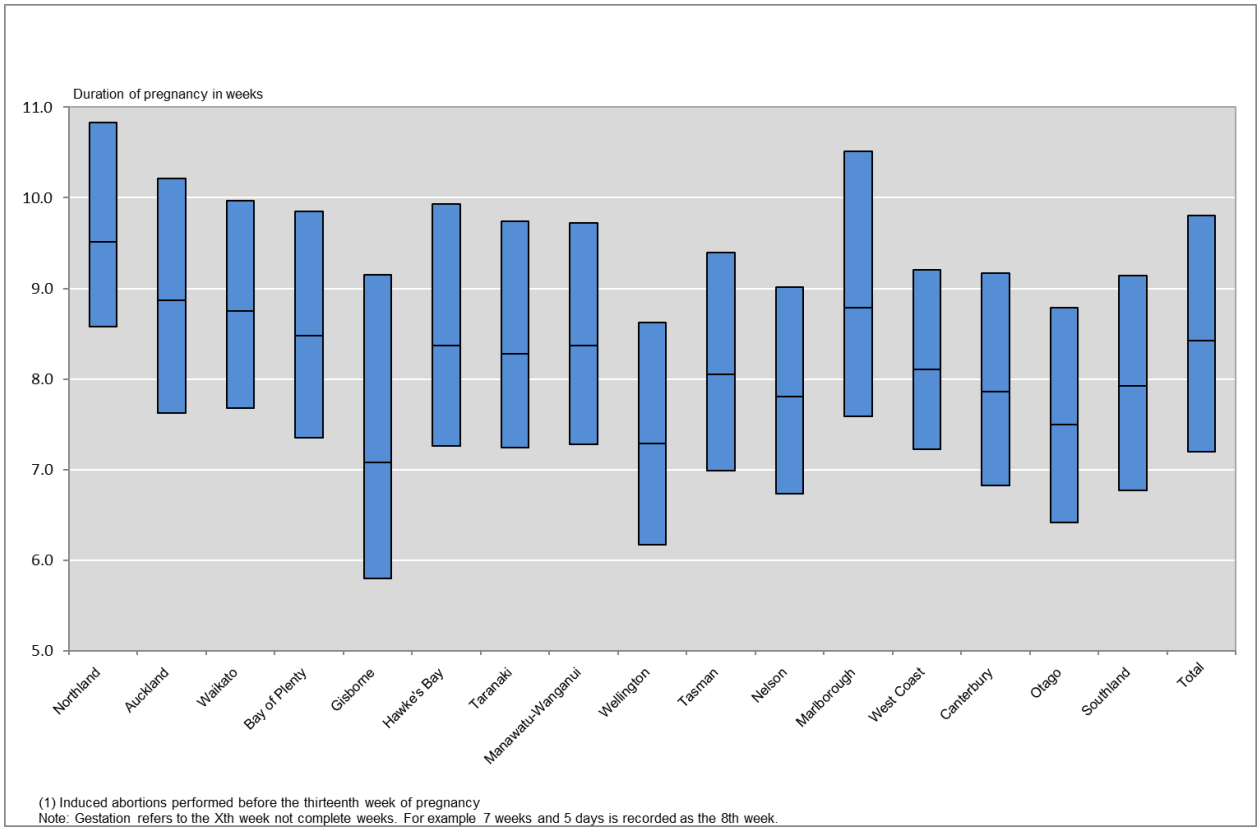
2009-2019

December year	Duration of pregnancy (weeks)								Total abortions
	Under 8	8	9	10	11	12	13	14+	
				Number					
2009	1,941	3,294	3,580	3,149	2,412	1,768	408	998	17,550
2010	2,168	3,836	3,316	2,601	1,993	1,364	470	882	16,630
2011	1,893	3,518	3,289	2,561	1,930	1,364	400	908	15,863
2012	2,031	3,066	3,053	2,349	1,730	1,264	409	843	14,745
2013	2,516	2,735	2,683	2,251	1,571	1,169	358	790	14,073
2014	2,558	2,557	2,323	1,858	1,420	1,136	504	781	13,137
2015	2,465	2,452	2,357	1,833	1,507	1,203	553	785	13,155
2016	2,433	2,452	2,444	1,808	1,315	1,058	512	801	12,823
2017	3,096	2,365	2,325	1,765	1,334	989	597	814	13,285
2018	3,180	2,532	2,289	1,618	1,266	980	626	791	13,282
2019	3,504	2,676	2,172	1,418	1,090	731	538	819	12,948

Table 7.3

First Trimester Abortions [(1)] by Duration of Pregnancy 2019

25th, 50th, and 75th percentiles by regional council



(1) Induced abortions performed before the thirteenth week of pregnancy
Note: Gestation refers to the Xth week not complete weeks. For example 7 weeks and 5 days is recorded as the 8th week

The 'box-plot' graph above shows the median duration of pregnancy (indicated by the line in the middle of each box) for first trimester abortions in each region (by regional council areas).

The top of the box is the 75th percentile (that is three-quarters of first trimester pregnancies were terminated within this number of weeks) and the bottom of the box is the 25th percentile (that is, one-quarter of first trimester pregnancies were terminated within this number of weeks).

8. Grounds for Abortion

Table 8.1

Induced Abortion by Grounds for Abortion
Calendar Year 2019

Grounds for Abortion	Number	Percent
Total	**12,948**	**100.0**
Danger to Life	19	0.1
Danger to Physical Health	13	0.1
Danger to Mental Health	12,572	97.1
Danger to Life and Physical Health	5	0.0
Danger to Life and Mental Health	1	0.0
Mental and Physical Health Danger	114	0.9
Other Physical/Mental/Health Combination	2	0.0
Handicapped Child and Physical Danger	1	0.0
Handicapped Child and Mental Danger	117	0.9
Handicapped Child, Physical and Mental Danger	6	0.0
Handicapped Child and Other	1	0.0

9. Procedure

Table 9.1

Induced Abortions by Procedure and Duration of Pregnancy
Calendar Year 2019

Procedure	Under 9 weeks	9th week and over	Total
Total	**6,180**	**6,768**	**12,948**
Surgical	3,310	5,952	9,262
Medical only (no surgery)	2,838	779	3,617
Failed medical only followed by surgical	26	25	51
Failed surgical followed by medical	6	3	9
Other	-	9	9

10. Complication

Table 10.1

Induced Abortions by Complication
Calendar Year 2019

Complication	Number	Percent
Total	**12,948**	**100.0**
None	12,864	99.4
Haemorrhage (500ml or more)	35	0.3
Retained placenta/products	32	0.2
Other	8	0.1
Haemorrhage and retained placenta/products	5	0.0
Perforation of Uterus	2	0.0
Haemorrhage and perforation of uterus	1	0.0
Perforation of uterus and Other	1	0.0

Note: Percentages may not sum to stated totals due to rounding

11. Contraception

Table 11.1

Induced Abortions by Contraception Used
Calendar Year 2018

Contraception Used	Number	Percent
Total	**12,948**	**100.0**
None	7,802	60.3
Condoms	2,889	22.3
Combined oral contraceptives	1,086	8.4
Progesterone only contraceptives	515	4.0
Emergency contraception	206	1.6
Natural family planning	200	1.5
Intra-Uterine contraceptive device without hormones	107	0.8
Depo provera injections	75	0.6
Intra-Uterine contraceptive device with hormones	40	0.3
Long-acting implant	15	0.1
Other	13	0.1

Graph 11.2

Percentage of Abortions by Contraception Used
Calendar Year 2019

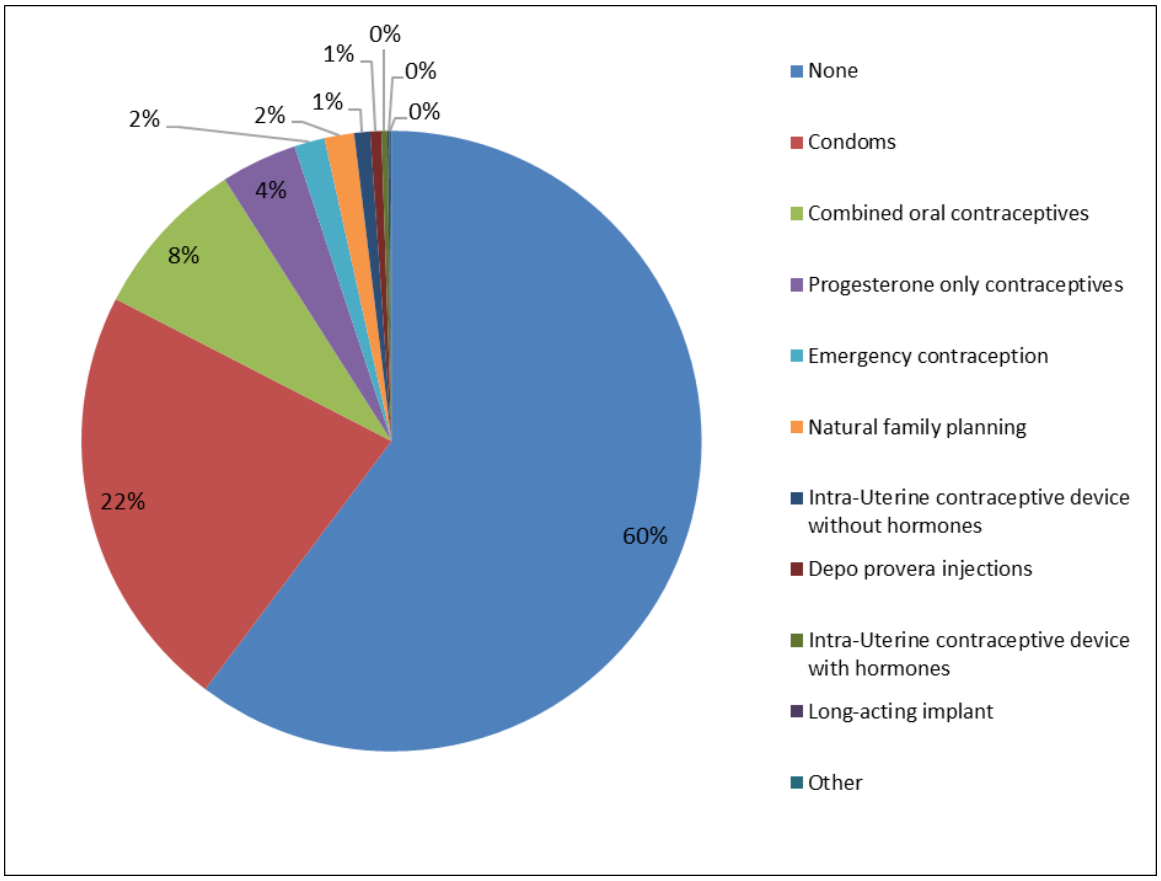


Table 11.3

Induced Abortions by Age and Contraception Use
Calendar Year 2019

Age Group (years)	Total	No Contraception Used	Contraception Used
All Ages	**12,948**	**7,802**	**5,146**
Under 20	1,242	801	441
20-24	3,191	1,915	1,276
25-29	3,397	1,977	1,420
30-34	2,686	1,619	1,067
35-39	1,720	1,021	699
40 and Over	712	469	243

Graph 11.4

No Contraception Used by Age Group
Calendar Year 2019

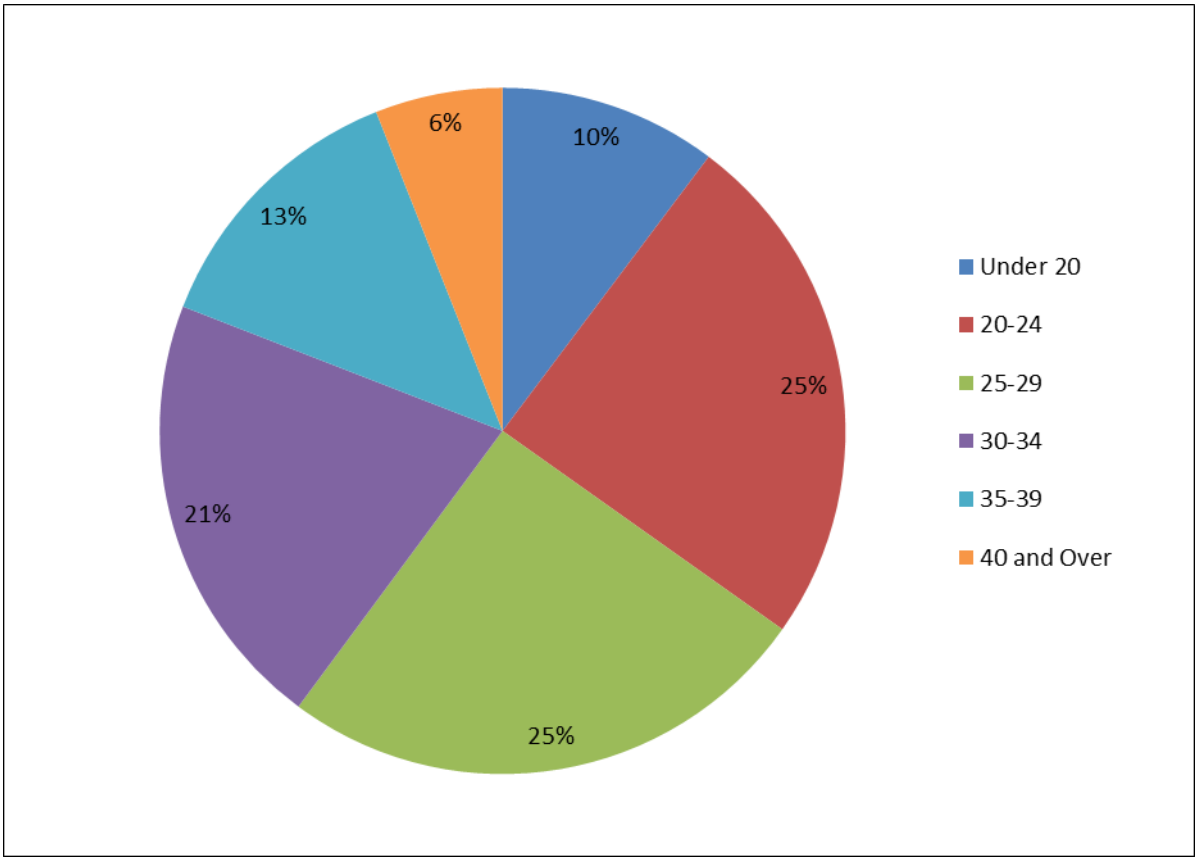


Table 11.5

Contraception
Women who have had Previous Live Births and Previous Abortions
Calendar Year 2019

Number	Previous Live Births			Previous Abortions		
	Total	No Contraception Used	Contraception Used	Total	No Contraception Used	Contraception Used
Total	**12,948**	**7,802**	**5,146**	**12,948**	**7,802**	**5,146**
0	5,395	3,111	2,284	8,276	5,051	3,225
1	2,607	1,652	955	3,025	1,759	1,266
2	2,899	1,690	1,209	1,087	651	436
3	1,313	832	481	327	193	134
4 or more	734	517	217	233	148	85

Table 11.6

Contraception Provided at the Time of the Procedure
for Women who have had Previous Abortions
Calendar Year 2019

Previous abortions	Total	Type of contraceptive						
		None	IUCD	Implant	Oral Contraceptives	Depo Provera	Condoms	Other
Total	**12,948**	**1,626**	**4,538**	**1,364**	**2,829**	**1,121**	**1,535**	**190**
0	8,276	1,075	2,760	883	1,884	628	1,090	127
1	3,025	340	1,144	286	623	327	323	43
2 or more	1,647	211	634	195	322	166	122	20

Note:
(a) Because a small number of women are provided with more than one type of contraceptive, contraceptives provided sum to more than the number of abortions.
(b) 'Referred to general practitioner' or 'referred for vasectomy' responses are in the 'none' category.
(c) 'Oral Contraceptives' includes combined oral contraceptives and progesterone only contraceptives.
(d) 'Other' contraceptives are largely the emergency contraceptive pill.

Table 11.7

Induced Abortions by Contraception Provided at the Time of the Procedure

Calendar Year 2019

Contraception Used	Number	Percent
Total	**12,948**	**100.0**
IUCD insertion	4,504	34.8
Combined oral contraceptives	2,159	16.7
None	1,626	12.6
Implant insertion	1,354	10.5
Condoms	1,297	10.0
Depo provera injections	1,114	8.6
Progesterone only contraceptives	604	4.7
Condoms and emergency contraceptive pill	179	1.4
Progesterone only contraceptives and condoms	30	0.2
IUCD insertion and combined oral contraceptives	14	0.1
Combined oral contraceptives and condoms	13	0.1
Other	13	0.1
IUCD insertion and condoms	11	0.1
Emergency contraceptive pill	9	0.1
IUCD insertion and depo provera injections	3	0.0
IUCD insertion and progesterone only contraceptives	3	0.0
Implant insertion and condoms	3	0.0
Depo provera injections and condoms	2	0.0
IUCD and implant insertion	2	0.0
Implant insertion and combined oral contraceptives	2	0.0
Implant insertion and progesterone only contraceptives	2	0.0
Depo provera injections and combined oral contraceptives	1	0.0
IUCD insertion and emergency contraceptive pill	1	0.0
Implant insertion and depo provera injections	1	0.0
Progesterone only contraceptives and emergency contraceptive pill	1	0.0

Notes:
(a) 'Referred to general practitioner' or 'referred for vasectomy' responses are in the 'none' category.
(b) 'Other' contraceptives are largely sterilisation.

Table 11.8

Contraception Provided at the Time of the Procedure by Residence of Woman

Regional Council

Calendar Year 2019

Regional Council	Total	Type of contraceptive						
		None	IUCD	Implant	Oral Contraceptives	Depo Provera	Condoms	Other
New Zealand	**12,948**	**1,626**	**4,538**	**1,364**	**2,829**	**1,121**	**1,535**	**190**
Northland Region	355	36	163	9	60	73	14	-
Auckland Region	4,631	618	1,570	465	881	299	805	92
Waikato Region	1,273	89	477	159	285	113	181	38
Bay of Plenty Region	835	70	289	106	205	82	96	32
Gisborne Region	146	10	78	18	20	18	3	-
Hawke's Bay Region	407	68	102	59	116	36	26	-
Taranaki Region	370	84	120	53	77	31	10	-
Manawatu-Wanganui Region	734	145	201	100	173	86	31	-
Wellington Region	1,338	200	547	141	278	80	94	1
Tasman Region	109	37	30	4	19	9	7	-
Nelson Region	133	41	37	12	21	12	8	-
Marlborough Region	108	15	25	17	44	4	2	-
West Coast Region	67	7	32	4	14	9	1	-
Canterbury Region	1,526	100	610	93	379	169	174	1
Otago Region	607	61	174	70	180	63	66	24
Southland Region	236	24	65	48	65	32	6	-
Area Outside Region	73	21	18	6	12	5	11	2

Note:

(a) Because a small number of women are provided with more than one type of contraceptive, contraceptives provided sum to more than the number of abortions.

(b) 'Referred to general practitioner' or 'referred for vasectomy' responses are in the 'none' category.

(c) Oral Contraceptives includes combined oral contraceptives and progesterone only contraceptives.

(d) 'Other' contraceptives are largely the emergency contraceptive pill.

Table 11.9

IUCD and Implant Contraception Provided at the time of Abortion

December Years 2014-2019

Year	Total abortions	Number and percentage of total uptake	
		IUCD	Implant
2014	**13,137**	4,455 (34%)	2,050 (15%)
2015	**13,155**	4,749 (36%)	1,804 (14%)
2016	**12,823**	4,764 (37%)	1,542 (12%)
2017	**13,285**	4,650 (35%)	1,715 (13%)
2018	**13,282**	4,673 (35%)	1,516 (11%)
2019	**12,948**	4,538 (35%)	1,364 (10%)

Table 11.10

Medical Termination of Pregnancy (MTOP)

December Years 2014-2019

Year	Total abortions	MTOP	Percentage
2014	**13,137**	1,627	12%
2015	**13,155**	1,769	13%
2016	**12,823**	1,972	15%
2017	**13,285**	2,745	21%
2018	**13,282**	3,191	24%
2019	**12,948**	3,626	28%

With an increase of women opting to have medical abortions, the opportunity to provide a long acting reversible contraception (LARC) at the time of the abortion may reduce.

Anecdotal evidence suggests that an increased use of LARCs has contributed to the steadily reducing number of abortions carried out each year in New Zealand.

The ASC believe it is important for the Ministry of Health to collect statistics on the types of contraception being offered to women at the time an abortion is carried out and continue to encourage medical professionals to discuss options with women presenting for abortions.

Adequate and equitable access to contraception helps reduce unwanted pregnancies and should continue to be available without barriers.