



Report of the
**ABORTION
SUPERVISORY
COMMITTEE**

2013

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

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CURRENT MEMBERSHIP OF THE COMMITTEE

Prof Dame Linda Holloway (Chair)

Rev Patricia Allan

Dr Tangimoana Habib

INTRODUCTION

The Abortion Supervisory Committee is encouraged by the further decline in total abortion numbers, ratios and rates in New Zealand. The continuing trend has seen the smallest total number of abortions in New Zealand since 1995.

As required by section 39 of the Contraception, Sterilisation, and Abortion Act 1977 (the Act) this Report summarises our work during the past year. We also include a wide range of graphs and charts that analyse abortion data recently made available for the 2012 calendar year.

Appendix One attached lists the functions and powers of the Committee as per section 14 of the Act while Appendix Two contains further detail of our activity during the 1 July 2012 to 30 June 2013 reporting year.

WORK OF THE COMMITTEE

A primary goal of our work is to improve the quality of abortion services by improving access to certifying consultants, counsellors and licensed abortion clinics throughout the country. We are pleased to report further progress has been made towards training being available for abortion counsellors and that a new licence has been issued, greatly improving availability of services for women in the Bay of Plenty. More detail on these improvements follows later in this Report.

We are also pleased that one important measure of quality abortion services, timeliness, continues to improve especially in smaller centres. A comparison of the box-plot graph at section 7.3 of this Report to previous years shows an improvement in the timeliness of first trimester abortions. We will continue to work towards better understanding factors that contribute to timeliness and to encourage all regions to improve the responsiveness of their services.

In addition to working towards better quality abortion services we spend a large portion of our time responding to requests for information and general correspondence from individual members of the public and groups who have an interest in abortion in New Zealand. Several issues have been raised more than once and so we will address these issues in the next three sections.

LOCAL ACCESS TO SERVICES

As we have said in earlier Reports, we believe it is desirable for women to have access to *local* services. Travelling from smaller regions to access services in main centres can delay consultations with certifying consultants, counselling and abortion procedures. This unnecessarily complicates what is already a stressful time for many people. We believe that requiring a woman to travel for services outside her community adds time and cost pressures creating a non-optimal environment that can hinder a woman's ability to make a careful and considered decision. Travelling can also limit the support a woman needs from her community and whanau.

Another concern raised is that the establishment of new licensed institutions, especially in smaller centres, may result in an increase in abortion numbers for women within these regions. Two relevant examples can address this. In both the Tairāwhiti and Southland regions, where new local licences were issued in recent years, the number of terminations carried out in 2012 was significantly fewer than the number carried out in 2011, not greater. The data show the current declining number of abortions extends nationwide. We have seen no evidence that increasing the number of licensed clinics is likely to increase the number of abortions.

THE REFERRAL SYSTEM

Concern has been raised that almost every woman who is referred will inevitably proceed to have an abortion. After taking into account spontaneous miscarriages, information received from licensed institutions reveals that the reality is that women are choosing to continue with pregnancy at various stages within the abortion decision-making pathway. There is indication that effective counselling and support for women from both health professionals and whanau provide them with the opportunity to discuss and take time to consider their options. As a result, a number of women are opting not to proceed to termination of pregnancy.

We are confident that the referral system is operating effectively throughout New Zealand, providing opportunities for appropriate and fully informed decision-making along the abortion pathway. The information we have received supports this view.

SEX SELECTION ABORTION

In the past we have received correspondence from writers expressing concern about the possibility of sex selection abortion in New Zealand and, to that end we have discussed this with certifying consultants. The feedback received supports our view that requests for abortion on the grounds of sex, which is illegal, is not an issue in New Zealand.

In 2012, 92% of induced abortions were carried out in the first trimester of pregnancy (up to and including 12 weeks gestation). The sex of the foetus is rarely known by the 12th week of pregnancy and therefore cannot be a reason for termination in these cases.

NEW LICENCE

On 22 February 2013, a limited licence to perform medical abortions (where no surgical procedure takes place) was granted to Tauranga Family Planning Clinic, with support from the Bay of Plenty District Health Board. Feedback received since the Clinic began providing abortion services indicates the service is operating well.

Tauranga previously did not have local services available to women seeking abortion. We are pleased that Family Planning responded to the need for a new service in that area and were successful in applying for and expanding their services in the Bay of Plenty.

CERTIFYING CONSULTANTS

Certifying consultants are required to submit renewal applications each year to maintain their certification. We have been pleased with the degree of detail many consultants are providing in these applications, especially itemised lists of publications accessed, continuing professional education courses attended and confirmation of participation within peer group activities.

We continue to request relevant and specific information from consultants, such as changes to the number of consultations and authorisations carried out annually, and where necessary, we ask follow-up questions before granting a renewal. We recognise the importance of monitoring certifying consultant trends, including any changing patterns in certifications.

COUNSELLING TRAINING

We continue to feel strongly that access to professional education for counsellors is critical. We again recommend that adequate funding be appropriated within District Health Board budgets to ensure the ongoing education and training of their staff, especially attendance at counselling training courses. We note in the past few years there has been a lack of training in this area which is of great concern.

This year we have worked with a counselling training provider and opportunities will soon be available at several sites around the country to attend short courses approved by the Committee. Individuals running the courses will be in touch with DHBs in due course with further information. It is essential funding is made available to run these courses and we encourage licensed institutions to send all staff members involved in providing counselling services to these courses.

RESEARCH AND LITERATURE REVIEW

The Committee continues to keep up to date with new and relevant international and local research publications in the field of abortion, including papers on abortion and mental health, emergency contraception and abortion services in high needs areas.

We feel it is important in achieving best practice that those working in this field are aware of research being carried out and of papers being published, particularly in New Zealand and Australia. Where appropriate we will alert certifying consultants to the relevant literature.

It is encouraging to see women's health research being carried out within New Zealand. We hope more researchers will be provided with funding from appropriate bodies for this purpose and we look forward to reading the results of future studies.

HARASSMENT

Harassment of those seeking or providing abortion services remains a significant concern to the Committee, especially as disturbing reports of violence at overseas abortion clinics continue to surface.

We have continued to work proactively with the Police in response to reports of protests near licensed institutions and harassment of abortion clinic staff, other hospital staff and patients. While we recognise the right to peaceful protest, we will take all practicable steps to address any perceived harassment, either separate from or as part of any protest activity.

In addition to ensuring that services are not affected as a result of harassment, the safety and autonomy of medical staff and patients is paramount. Our aim is to ease the concern and vulnerability of staff around the country and we are considering what support and preventative measures can be put in place to prevent further harassment.

COMMENT ON STATISTICS

As mentioned in the Introduction of this Report, the Committee is pleased to see a continued decline in abortion numbers, including ratios and rates, to a near 20 year low. It is especially encouraging that numbers have fallen dramatically in the 11-14 and 15-19 year old age groups.

We believe that increased education and importance placed the use of contraception may provide some explanation for the falling abortion numbers.

Despite the overall positive trend we are still concerned at the number of women, over 50% of those having abortions, who report using no contraception. We are also greatly

concerned with the ongoing lack of any decline in the number of women having three or more abortions. This group now represents more than 1 in every 8 New Zealand women having an abortion.

The Committee now requires every operating surgeon to note on the Statistics New Zealand form information on the type of contraception provided to women at the completion of the procedure. It is hoped that this proactive approach of prompting operating surgeons to discuss contraceptives at the time of a termination will reduce repeat abortion figures. We are pleased to note research is being carried out in New Zealand on the use of post abortion contraception and we look forward to reading the results of this study.

A final observation of interest in the statistics is the continued sharp decline in the abortion ratio in Asian women (see Graph 6.3). We do not yet understand what is causing this but consider it to be a positive trend.

STATISTICAL ANALYSIS AND TRENDS

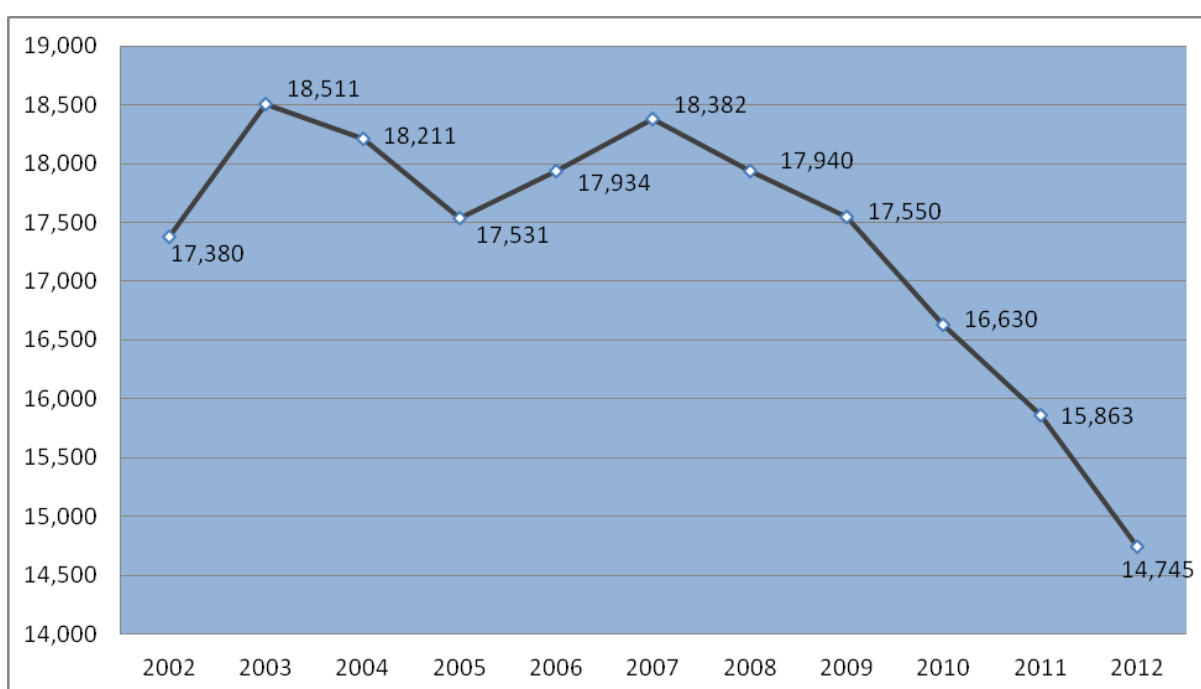
In this section the Committee presents its analysis of the New Zealand abortion statistics for the 2012 calendar year. Further statistics in tabular form are available to view online at the Statistics New Zealand website:

http://www.stats.govt.nz/browse_for_stats/health/abortion.aspx

1. Induced Abortions, Ratios and Rates

Graph 1.1

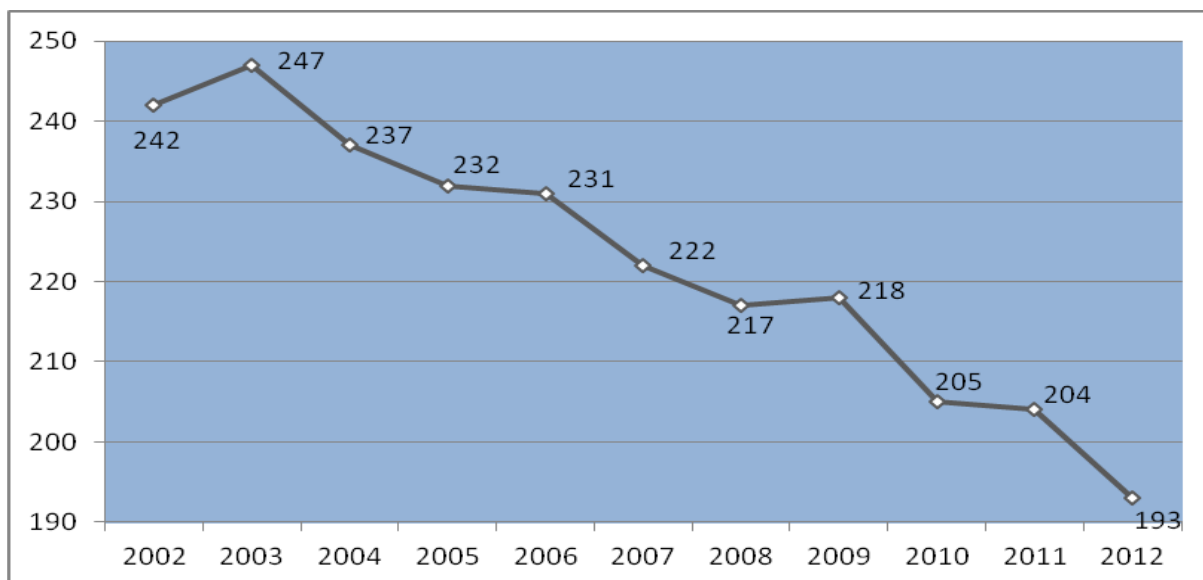
**Number of Induced Abortions
2002-2012**



Induced abortions are those initiated with the intention of terminating a pregnancy. No other form of pregnancy loss is called induced abortion, even if an external cause is involved such as injury or high fever.

Graph 1.2

Abortion Ratio 2002-2012

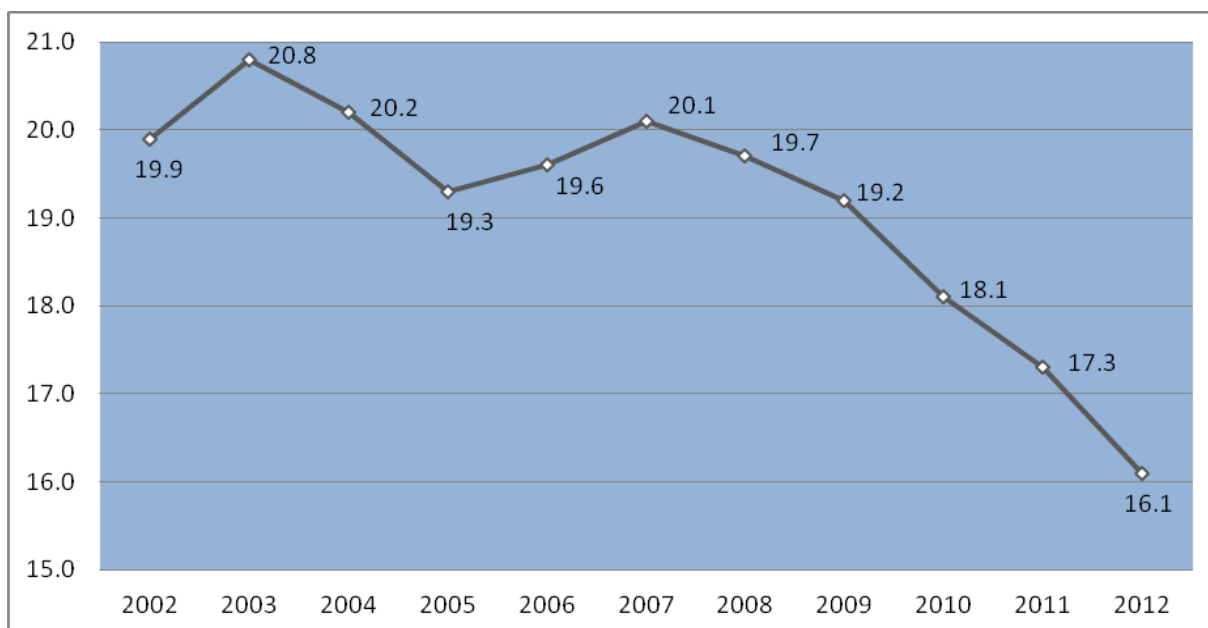


The abortion ratio is the number of abortions per 1,000 known pregnancies. Known pregnancies include live births, stillbirths and induced abortions combined, but does not include miscarriages.

Stillbirth is defined as foetal loss, excluding induced abortions, after the 20th week of pregnancy or where the foetus weighed 400g or more. Miscarriage is defined as foetal loss, excluding induced abortions, before the 21st week of pregnancy and where the foetus weighed less than 400g.

Graph 1.3

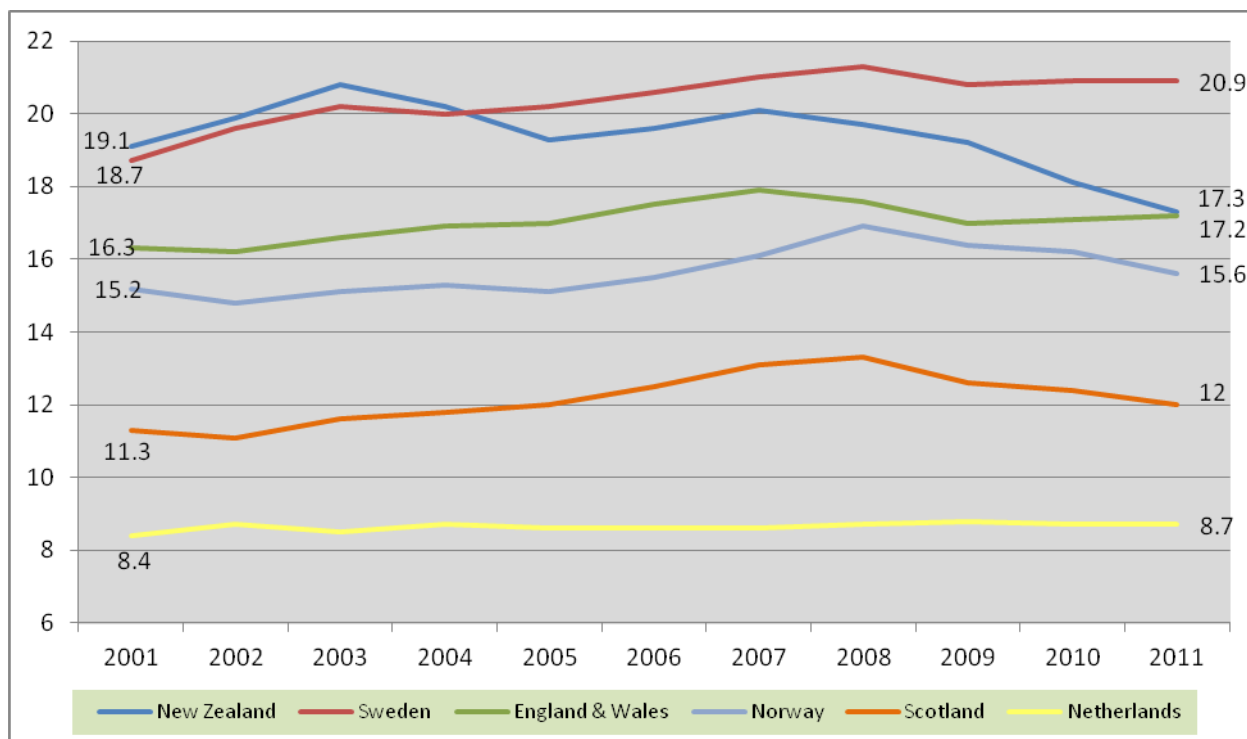
General Abortion Rate 2002-2012



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
2001-2011



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

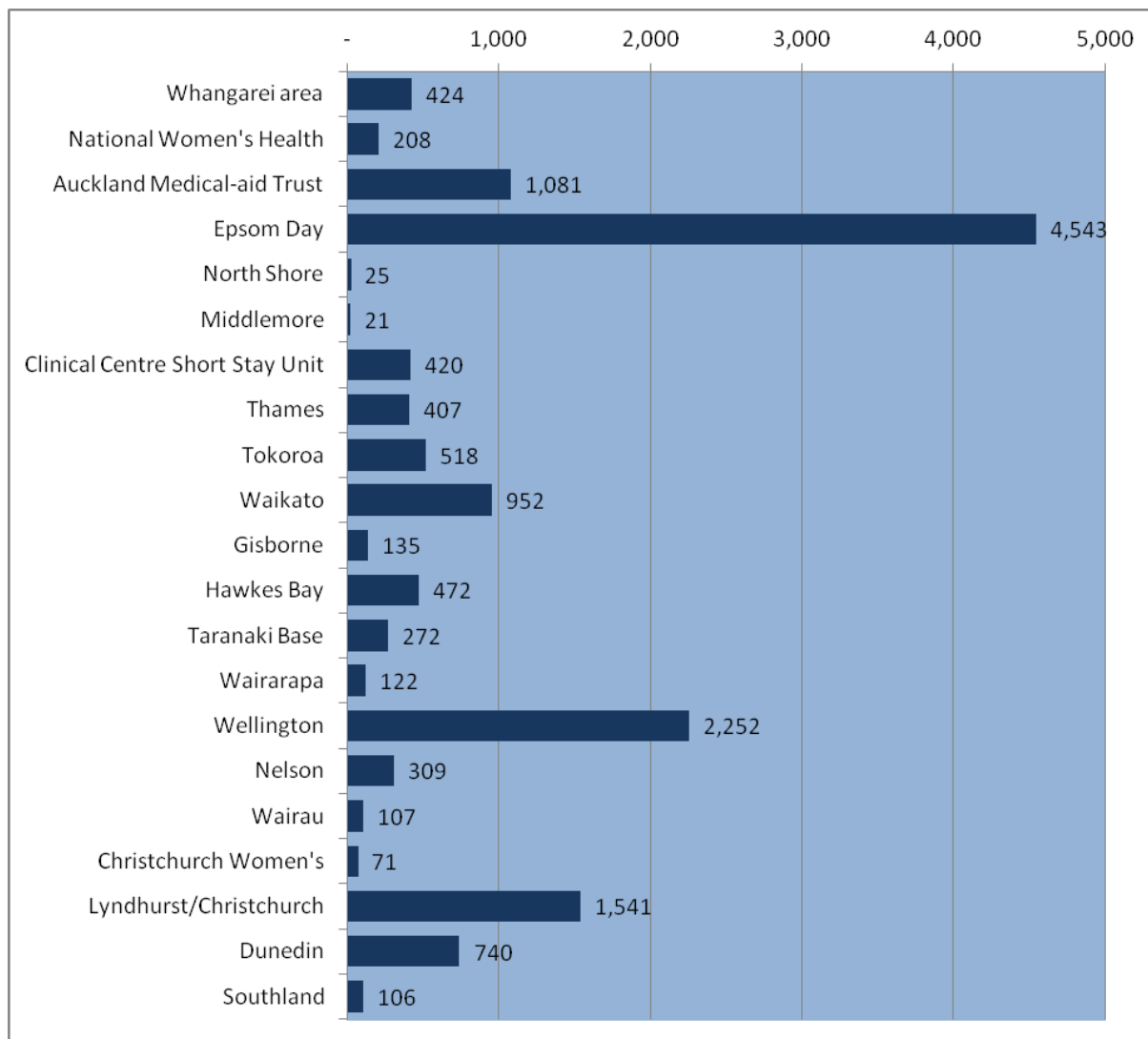
Statistical coverage and laws relating to induced abortion affect international comparisons of abortion statistics. Induced abortions are not a notifiable procedure in many countries and statistics on abortion rates are not available for many countries. Consequently, differences between abortion rates for New Zealand and other countries should be interpreted with care.

International data for 2012 is not available for many countries, so comparisons are made using 2011 data.

2. Hospital and Residence

Graph 2.1

Number of Abortions by Hospital
December Year 2012



Three other hospitals performed a total of 19 abortions:

Palmerston North Hospital
Surgery on Shakespeare
Timaru

Graph 2.2

Number of Abortions by Residence of Woman
Regional Council
December Year 2012

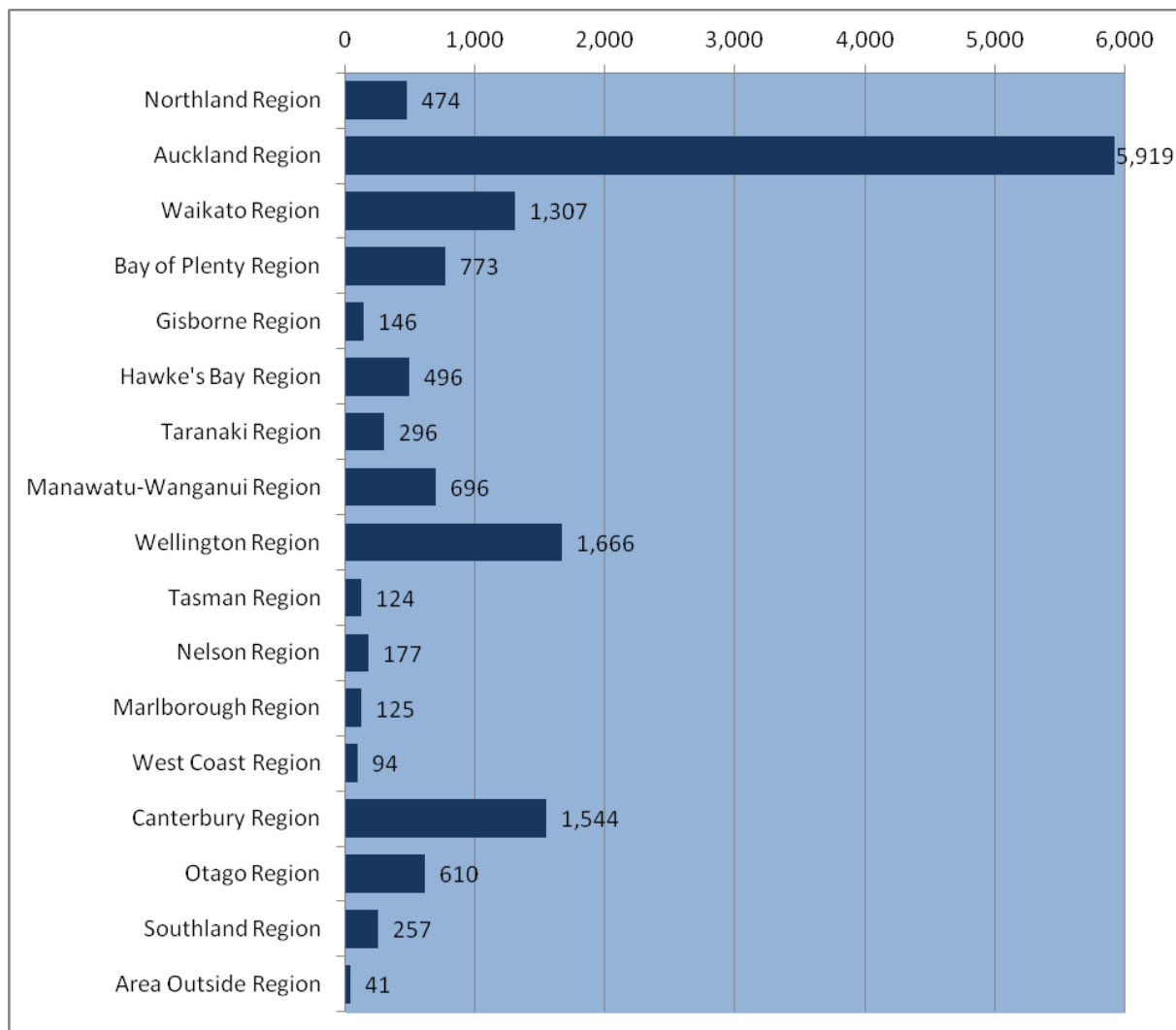


Table 2.3

Induced Abortions by Residential Status of Woman
December Year 2012

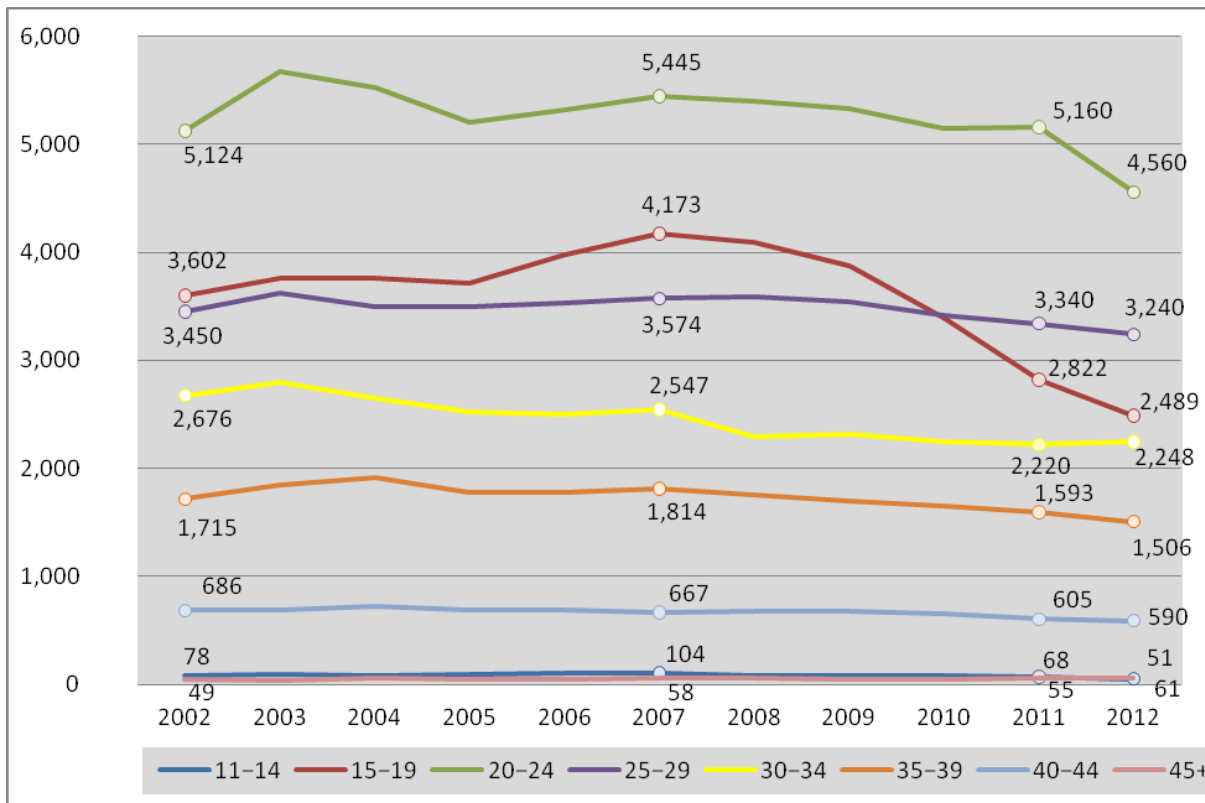
Residential Status ⁽¹⁾	Number
New Zealand Resident	13,625
Non-Resident	979
Not Stated	141
Total	14,745

(1) Residential status is not the same as place of residence.

3. Age of Woman

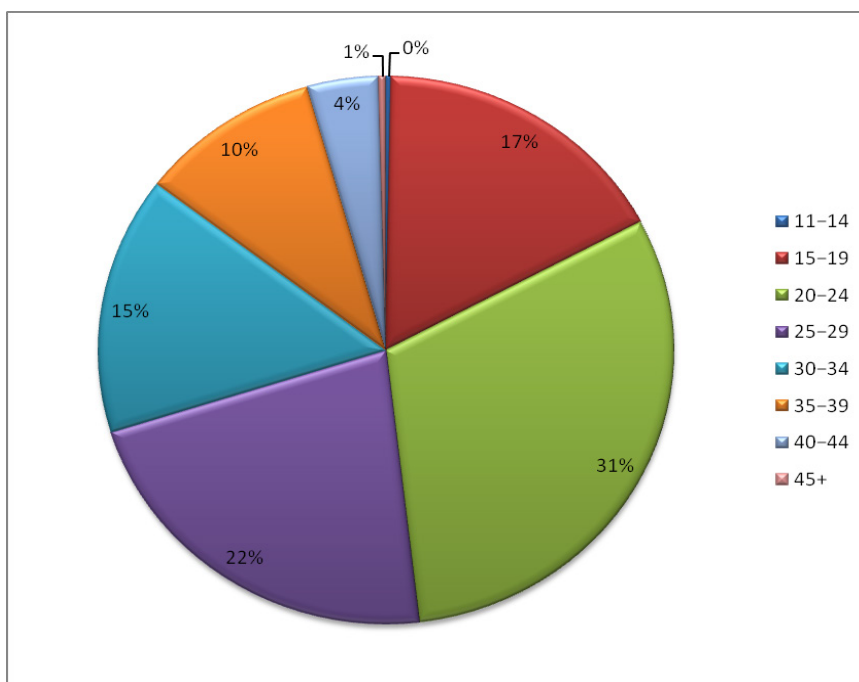
Graph 3.1

Number of Abortions by Age
2002-2012



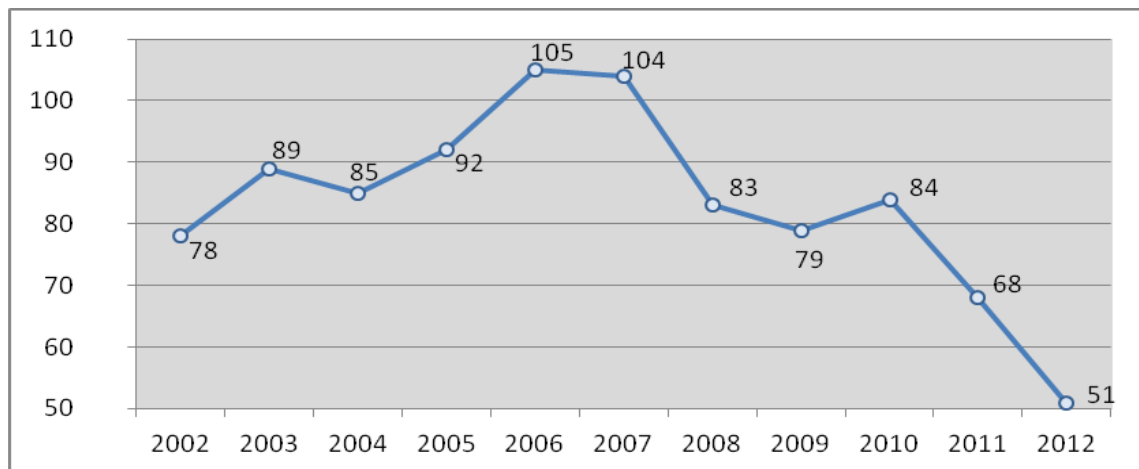
Graph 3.2

Number of Abortions by Age in Percentages
December Year 2012



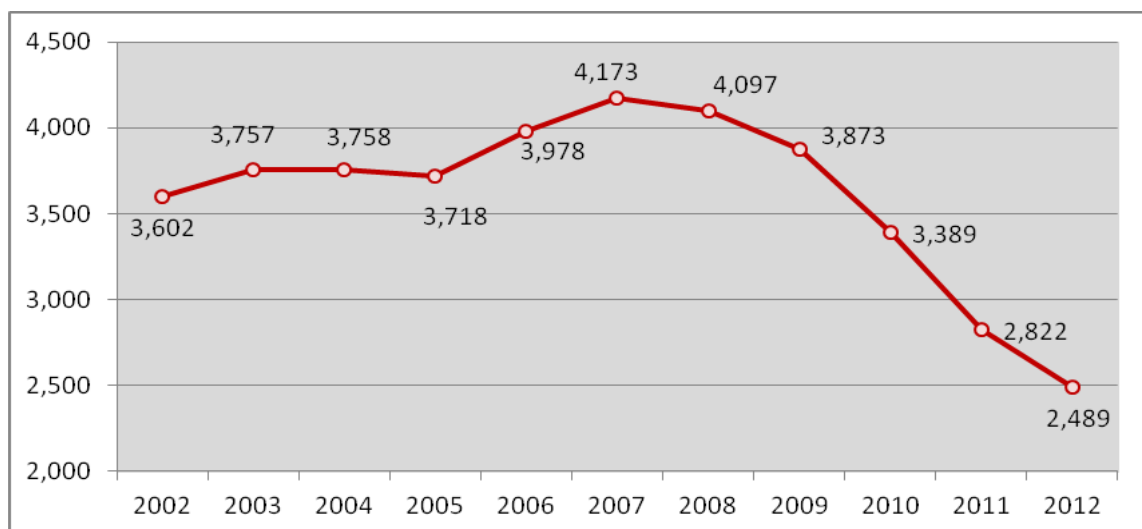
Graph 3.3

**Number of Abortions for Ages 11-14
2002-2012**



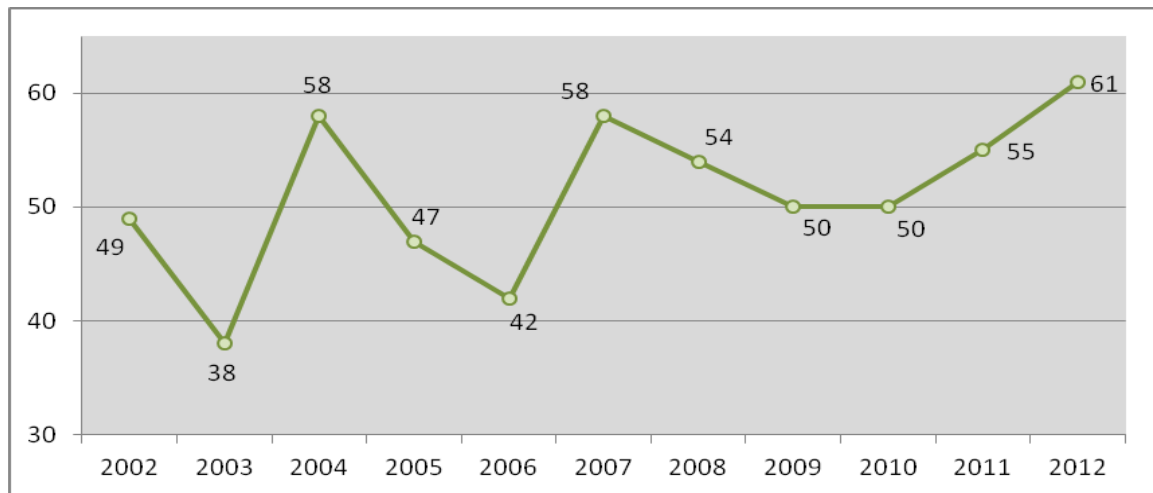
Graph 3.4

**Number of Abortions for Ages 15-19
2002-2012**



Graph 3.5

**Number of Abortions for Age 45+
2002-2012**



4. Previous Live Births

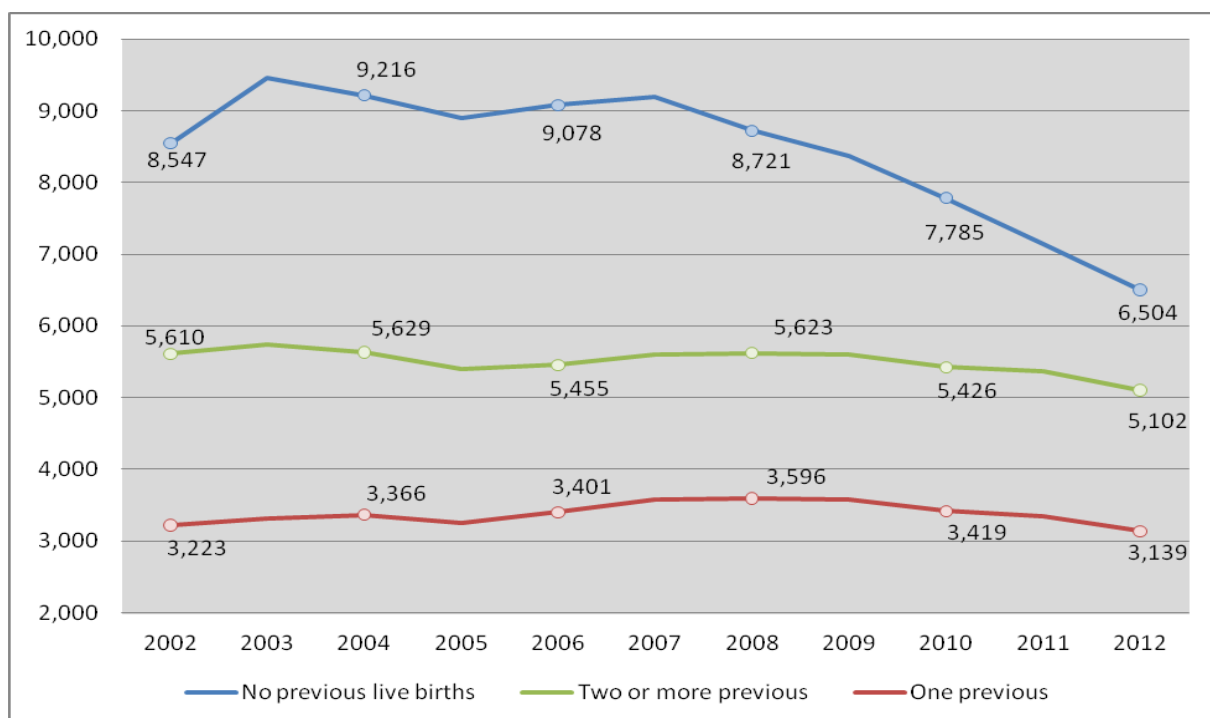
Table 4.1

Induced Abortions by Age and Previous Live Births
December Year 2012

Age (years)	Previous Live Births									
	Total	0	1	2	3	4	5	6	7 or More	6 or More
Number										
All Ages	14,745	6,504	3,139	2,887	1,344	481	224	97	69	166
Under 15	51	50	1	-	-	-	-	-	-	-
15-19	2,489	2,092	338	54	4	1	-	-	-	-
20-24	4,560	2,521	1,212	620	171	28	7	1	-	1
25-29	3,240	1,114	758	772	406	129	42	13	6	19
30-34	2,248	468	463	661	356	155	88	38	19	57
35-39	1,506	202	262	541	268	100	74	32	27	59
40-44	590	48	97	216	130	59	13	12	15	27
45 and over	61	9	8	23	9	9	-	1	2	3

Graph 4.2

Number of Abortions by Previous Live Births
2002-2012



5. Previous Induced Abortions

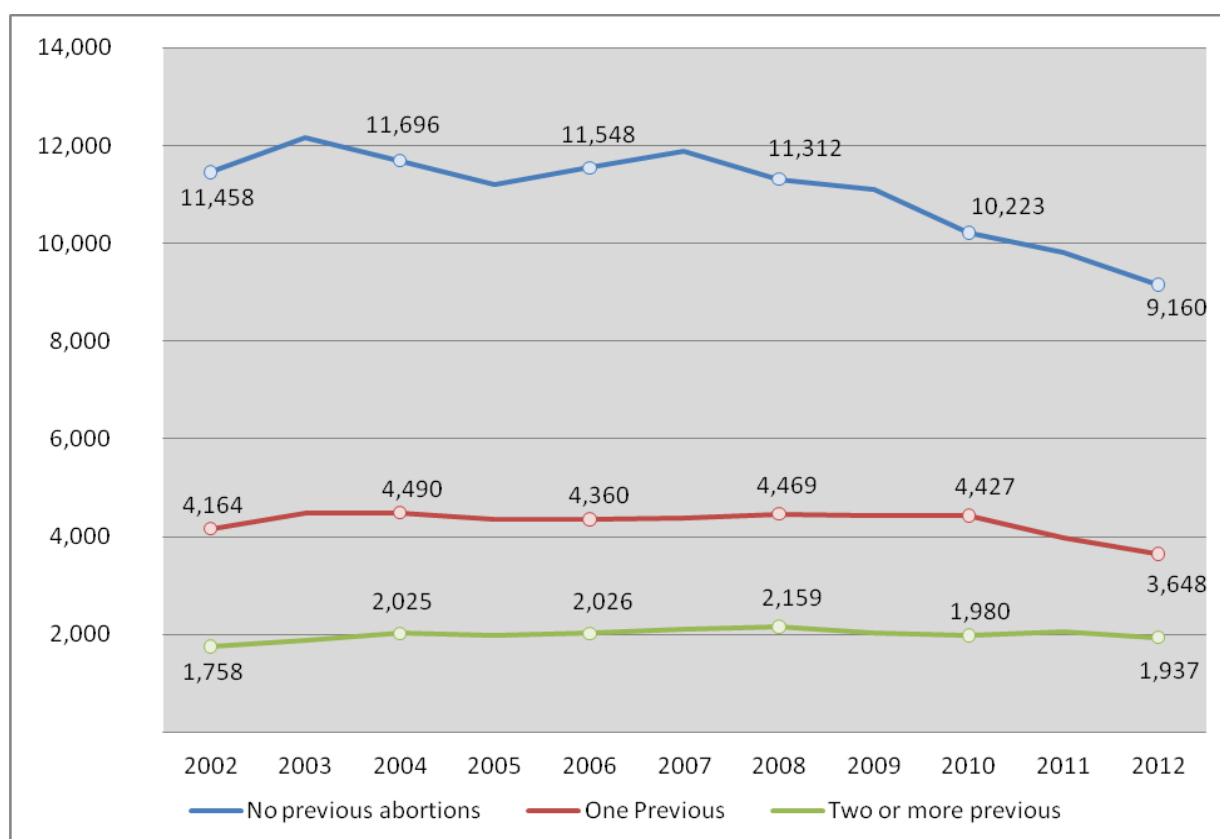
Table 5.1

Induced Abortions by Age and Previous Induced Abortions
December Year 2012

Age (years)	Previous Abortions							
	Total	0	1	2	3	4	5	6 or More
All Ages	14,745	9,160	3,648	1,259	457	156	38	28
Under 15	51	50	1	-	-	-	-	-
15-19	2,489	2,151	302	30	5	1	-	-
20-24	4,560	2,969	1,177	319	76	18	-	1
25-29	3,240	1,729	910	389	146	50	12	4
30-34	2,248	1,143	626	283	123	44	19	10
35-39	1,506	780	430	169	81	31	5	10
40-44	590	305	183	65	24	9	1	3
45 and over	61	33	19	4	2	3	-	-

Graph 5.2

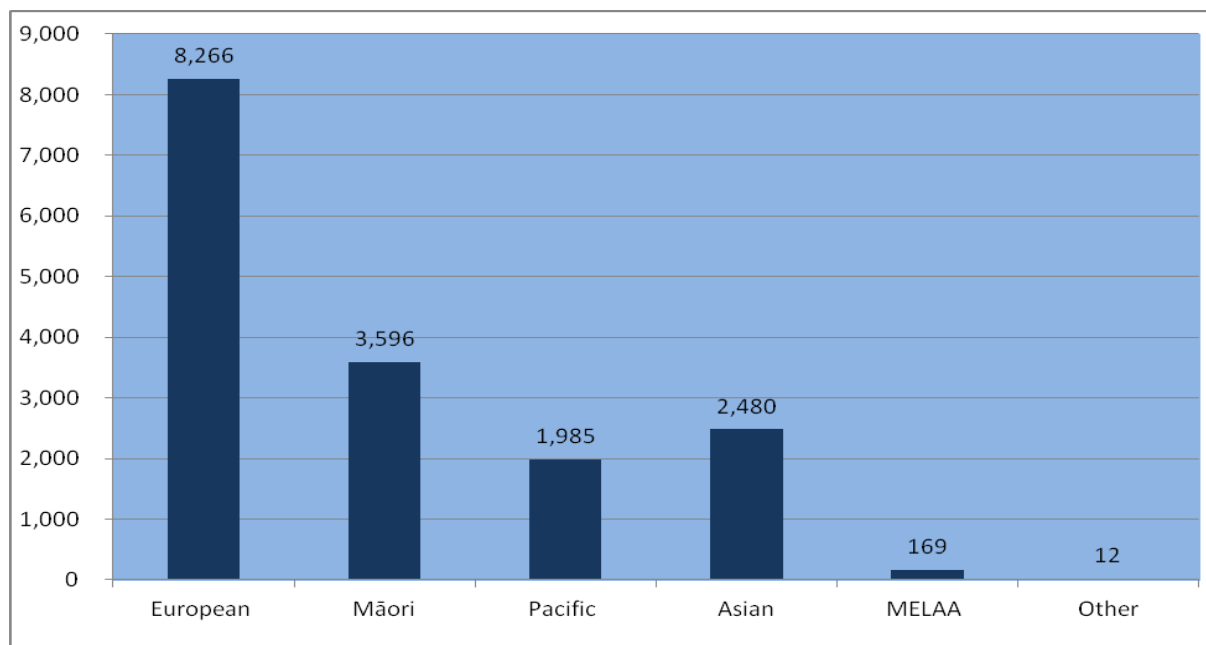
Number of Abortions by Previous Induced Abortions
2002-2012



6. Ethnic Group

Graph 6.1

Number of Abortions by Ethnic Group December Year 2012



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

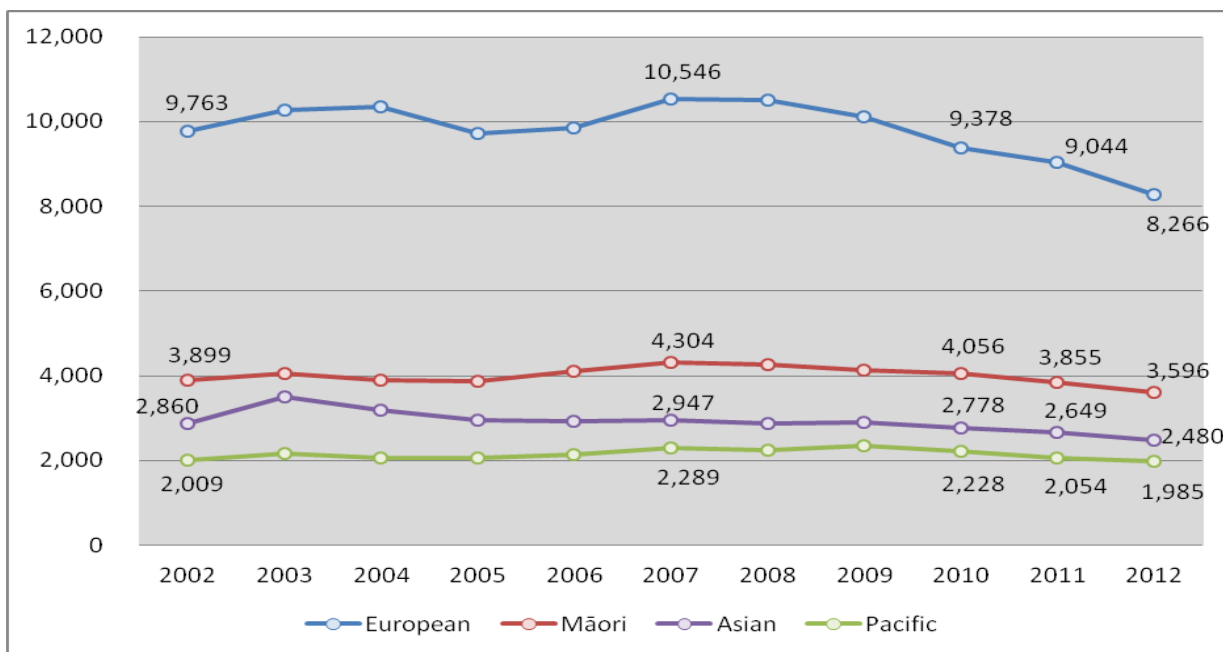
Note:

(a) MELAA = Middle Eastern, Latin American and African

(b) Other includes New Zealander.

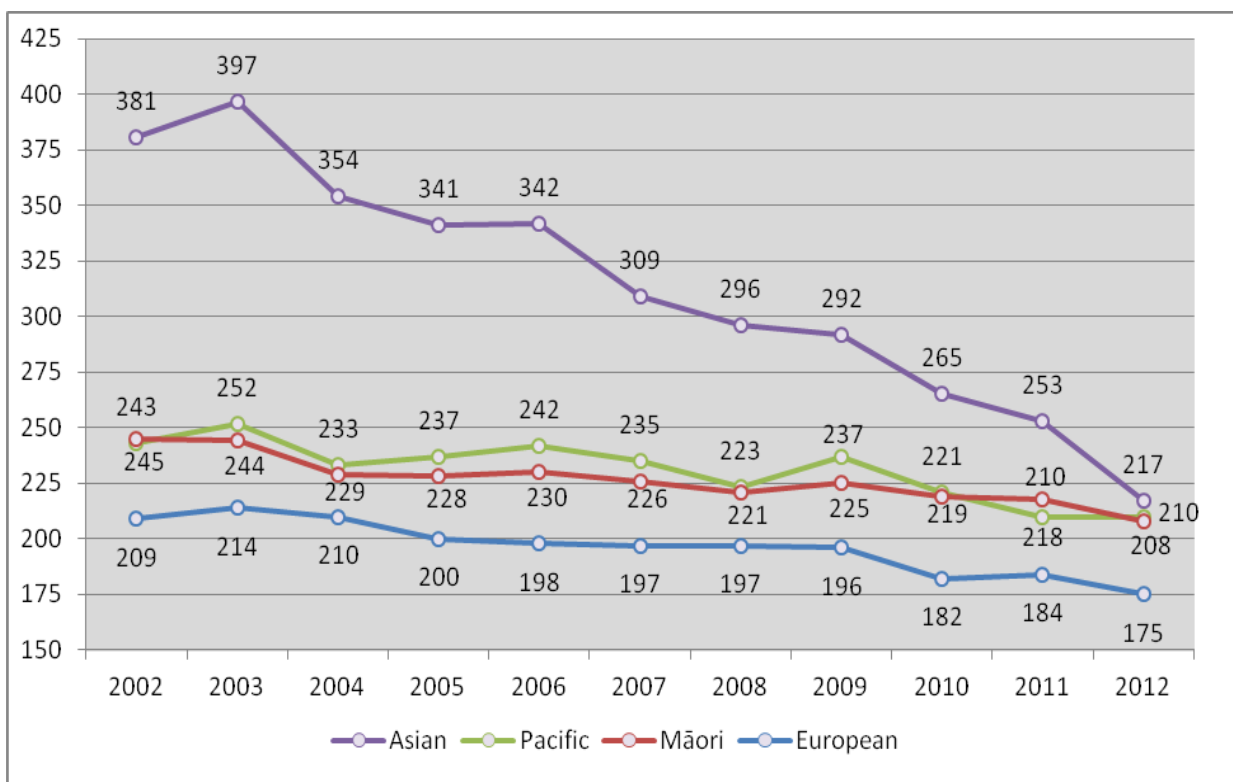
Graph 6.2

Number of Abortions by Ethnic Group (Trend)
2002-2012



Graph 6.3

Induced Abortions by Ethnicity Ratio
2002-2012



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 Abortions by Age and Duration of Pregnancy
December Year 2012**

Age Group	Total	Under 8 weeks	8-12 weeks	13-16 weeks	17-20 weeks	Over 20 weeks
Totals	14,745	2,031	11,462	937	249	66
Under 20	2,540	279	2,009	201	46	5
20-24	4,560	610	3,607	277	56	10
25-29	3,240	490	2,499	190	48	13
30-34	2,248	324	1,735	130	38	21
35-39	1,506	229	1,125	101	39	12
40-44	590	91	439	35	20	5
45 +	61	8	48	3	2	-

Table 7.2

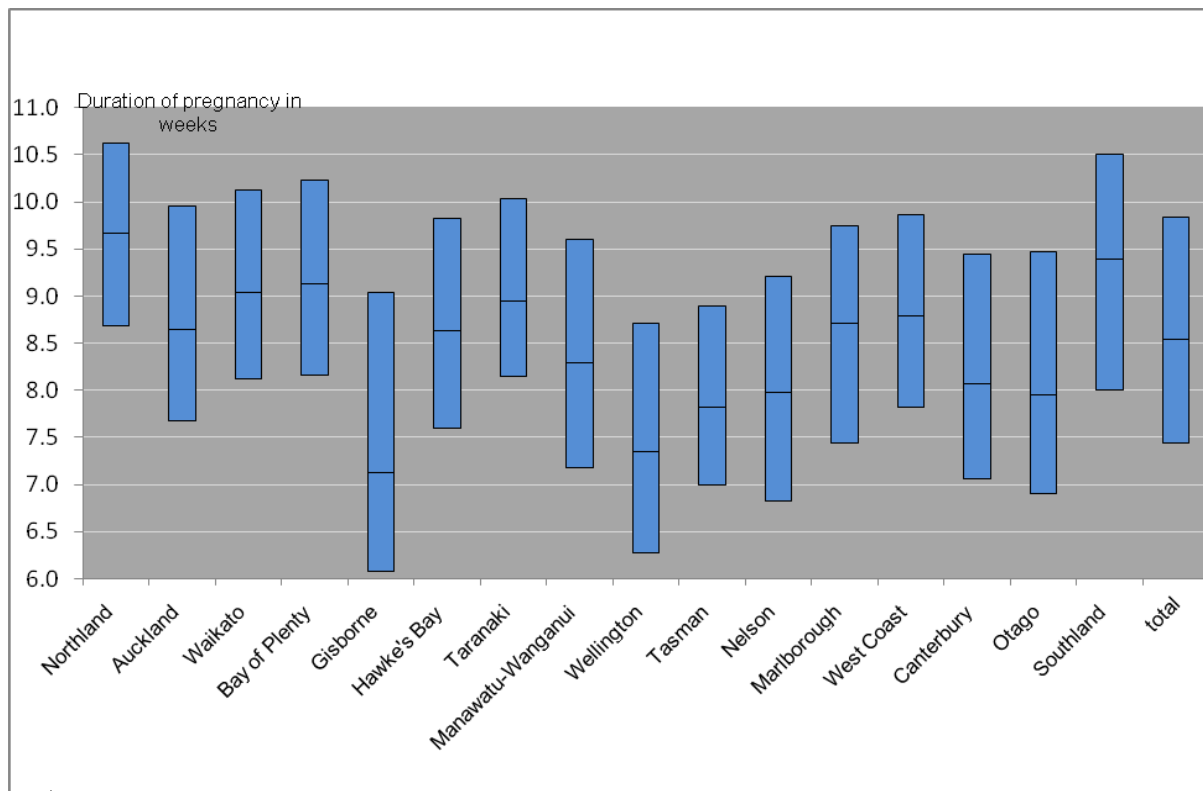
**Induced Abortions by Duration of Pregnancy
2002-2012**

December year	Duration of pregnancy (weeks)								Total abortions
	Under 8	8	9	10	11	12	13	14+	
Number									
2002	1,129	1,751	2,773	3,820	3,019	2,633	1,300	955	17,380
2003	1,281	1,824	2,710	3,882	3,456	2,903	1,494	961	18,511
2004	1,263	1,835	3,505	3,933	3,007	2,613	1,164	891	18,211
2005	1,271	1,782	2,928	3,620	3,011	2,640	1,350	929	17,531
2006	1,526	1,843	3,012	3,729	2,990	2,634	1,259	941	17,934
2007	1,478	2,413	3,558	3,671	3,131	2,631	478	1,022	18,382
2008	1,687	2,875	3,743	3,535	2,655	2,026	438	981	17,940
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
Percent									
2002	6.5	10.1	16.0	22.0	17.4	15.1	7.5	5.5	100.0
2003	6.9	9.9	14.6	21.0	18.7	15.7	8.1	5.2	100.0
2004	6.9	10.1	19.2	21.6	16.5	14.3	6.4	4.9	100.0
2005	7.3	10.2	16.7	20.6	17.2	15.1	7.7	5.3	100.0
2006	8.5	10.3	16.8	20.8	16.7	14.7	7.0	5.2	100.0
2007	8.0	13.1	19.4	20.0	17.0	14.3	2.6	5.6	100.0
2008	9.4	16.0	20.9	19.7	14.8	11.3	2.4	5.5	100.0
2009	11.1	18.8	20.4	17.9	13.7	10.1	2.3	5.7	100.0
2010	13.0	23.1	19.9	15.6	12.0	8.2	2.8	5.3	100.0
2011	11.9	22.2	20.7	16.1	12.2	8.6	2.5	5.7	100.0
2012	13.8	20.8	20.7	15.9	11.7	8.6	2.8	5.7	100.0

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

Table 7.3

First Trimester Abortions⁽¹⁾ by Duration of Pregnancy 2012
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 Abortions by Grounds for Abortion
December Year 2012

Grounds for Abortion	Number	Percent
Total	14,745	100.0
Danger to life	36	0.2
Danger to physical health	15	0.1
Danger to mental health	14,364	97.4
Danger to life and physical health	2	0.0
Danger to life and mental health	6	0.0
Mental and physical health danger	112	0.8
Other physical/mental/health combination	1	0.0
Handicapped child and danger to life	1	0.0
Handicapped child and mental danger	143	1.0
Handicapped child, physical and mental danger	8	0.1
Seriously handicapped child	51	0.3
Incest and other	1	0.0
Criminal offence and danger to mental health	5	0.0

9. Procedure

Table 9.1

Induced Abortions by Procedure December Year 2012

Procedure	Number	Percent
Total	14,745	100.0
Prostaglandin and suction curettage	11,999	81.4
Other surgical and medical combination	1,803	12.2
Medical only	943	6.4

10. Complication

Table 10.1

Induced Abortions by Complication December Year 2012

Complication	Number	Percent
Total	14,745	100.0
None	14,655	99.4
Haemorrhage (500ml or more)	29	0.2
Retained placenta/products	24	0.2
Other	17	0.1
Perforation of uterus	12	0.1
Two or more other complications	4	0.0
Haemorrhage and retained placenta/products	3	0.0
Haemorrhage and other	1	0.0

11. Contraception

Table 11.1

Induced Abortions by Contraception Used
December Year 2012

Contraception Used	Number	Percent
Total	14,745	100.0
None	7,802	52.9
Condoms	4,140	28.1
Combined oral contraceptives	1,551	10.5
Progestrone only contraceptives	438	3.0
Natural family planning	242	1.6
Emergency contraception	207	1.4
Intra-uterine contraceptive device without hormones	169	1.1
Depo provera injections	98	0.7
Intra-uterine contraceptive device with hormones	43	0.3
Other	29	0.2
Long-acting implant	21	0.1
Diaphragm	5	0.0

Graph 11.2

Percentage of Abortions by Contraception Used
December Year 2012

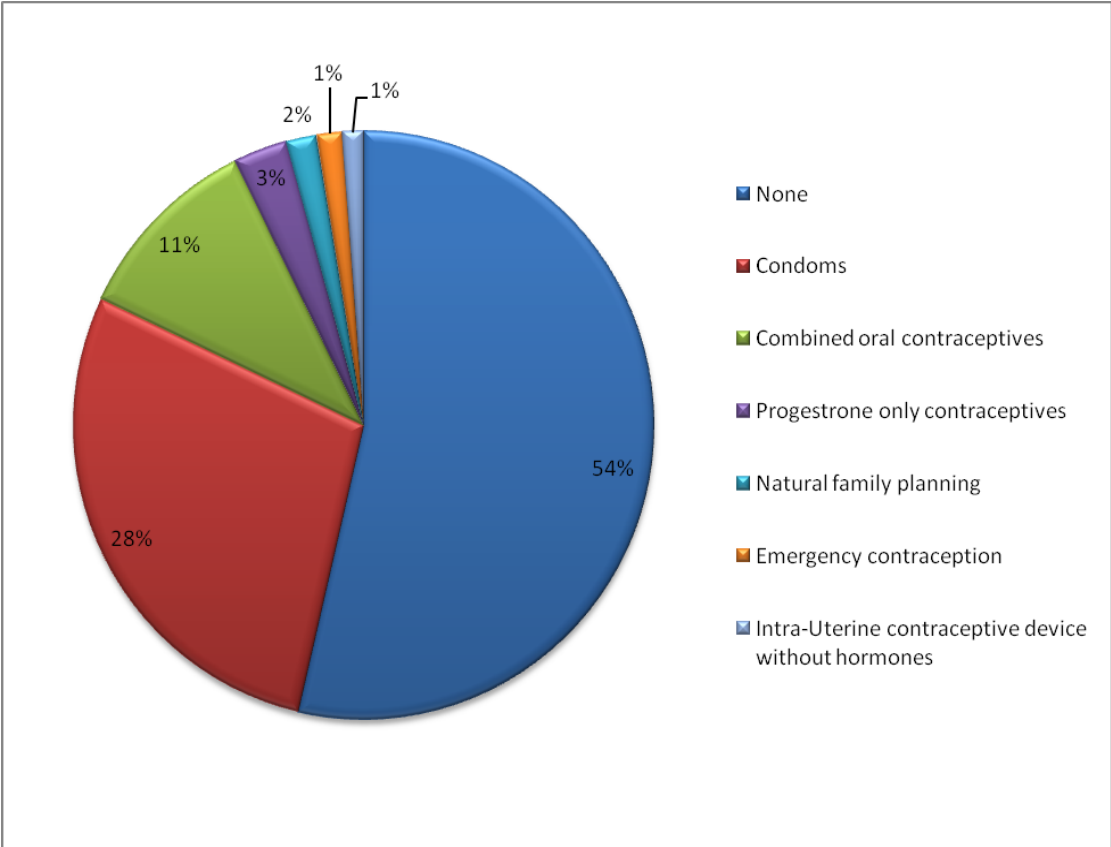


Table 11.3

Induced Abortions by Age and Contraception Use
December Year 2012

Age Group (years)	Total	No Contraception Used	Contraception Used
All Ages	14,745	7,802	6,943
Under 20	2,540	1,449	1,091
20-24	4,560	2,358	2,202
25-29	3,240	1,658	1,582
30-34	2,248	1,192	1,056
35-39	1,506	790	716
40 +	651	355	296

Graph 11.4

No Contraception Used by Age Group
December Year 2012

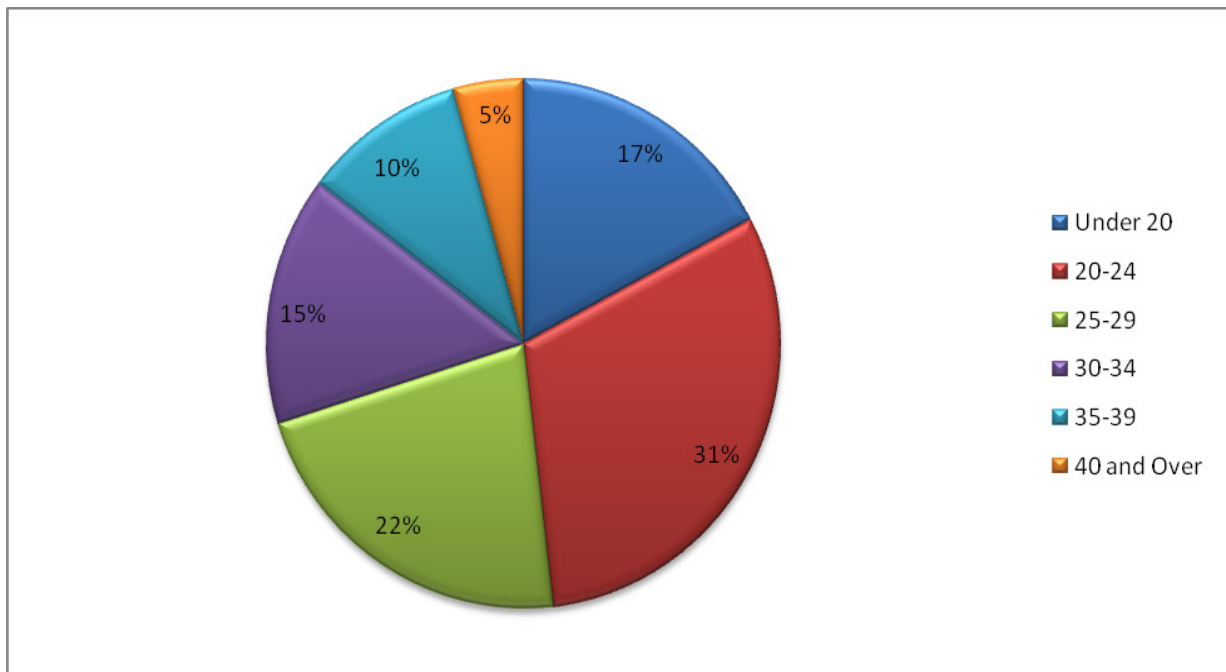


Table 11.5

Contraception Used by Previous Live Births and Previous Abortions
December Year 2012

Number	Previous Live Births			Previous Abortions		
	Total	No Contraception Used	Contraception Used	Total	No Contraception Used	Contraception Used
Total	14,745	7,802	6,943	14,745	7,802	6,943
0	6,504	3,292	3,212	9,160	4,985	4,175
1	3,139	1,692	1,447	3,648	1,820	1,828
2	2,887	1,519	1,368	1,259	634	625
3	1,344	746	598	457	241	216
4 or more	871	553	318	221	122	99

APPENDIX ONE

Functions and powers of the Abortion Supervisory Committee

The functions and powers of the Committee are set out in section 14 of the Contraception, Sterilisation, and Abortion Act 1977.

s14(1)

(a) Keep under review all the provisions of the abortion law, and the operation and effect of those provisions in practice.

(b) Receive, consider, grant, and refuse applications for licences or for the renewal of licences under this Act, and to revoke any such licence

(c) Prescribe standards in respect of facilities to be provided in licensed institutions for the performance of abortions

(d) Take all reasonable and practicable steps to ensure that:

- i. licensed institutions maintain adequate facilities for the performance of abortions; and***
- ii. all staff employed in licensed institutions in connection with the performance of abortions are competent***

(e) Take all reasonable and practicable steps to ensure that sufficient and adequate facilities are available throughout New Zealand for counselling women who may seek advice in relation to abortion

(f) Recommend maximum fees that may be charged by any person in respect of the performance of an abortion in any licensed institution or class of licensed institutions, and maximum fees that may be charged by any licensed institution or class of licensed institutions for the performance of any services or the provision of any facilities in relation to any abortion

(g) Obtain, monitor, analyse, collate, and disseminate information relating to the performance of abortions in New Zealand

(h) Keep under review the procedure, prescribed by sections 32 and 33 of this Act, whereby it is determined in any case whether the performance of an abortion would be justified

(i) Take all reasonable and practicable steps to ensure that the administration of the abortion law is consistent throughout New Zealand, and to ensure the effective operation of this Act and the procedures thereunder

(j) From time to time report to and advise the Minister of Health and any district health board on the establishment of clinics and centres, and the provision of related facilities and services, in respect of contraception and sterilisation

(k) Report annually to Parliament on the operation of the abortion law.

APPENDIX TWO

In the year from 1 July 2012 to 30 June 2013 the Abortion Supervisory Committee held nine meetings.

Visits

Tauranga Family Planning Clinic

Meetings

The Abortion Supervisory Committee met with:

- Officials from Crown Law Office
- Ministry of Justice staff
- Ministry of Health staff
- Statistics New Zealand staff
- Tauranga Family Planning Clinic staff
- Official from Ministry of Women's Affairs
- Official from Wellington District Police
- Massey University staff, Wellington
- Various medical professionals
- Various counselling professionals

Certifying Consultants

As at 30 June 2013 there were 166 certifying consultants (of whom 112 met the Act's specialist category requirements) on the Abortion Supervisory Committee's list.

Fees payable to certifying consultants for consultations with women considering termination of pregnancy totalled \$4,096,464 (GST exclusive) in the year ended 30 June 2013.