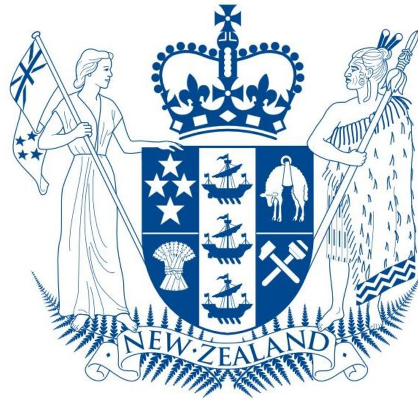

Report of the

ABORTION SUPERVISORY COMMITTEE

2016

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)
Dr Tangimoana Habib
Carolyn McIlraith

INTRODUCTION

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 2015 calendar year.

Appendix One 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 2015 to 30 June 2016 reporting year.

CONTRACEPTION, STERILISATION AND ABORTION ACT 1977 (CSA ACT)

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Some of the wording in the Act is outdated and clumsy.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It is notable that terminology has been repealed and redefined on various occasions in the more recent past, yet the related and consequential provisions have been left intact.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. Some examples include:

Section 32 – Procedure where woman seeks abortion

Throughout various sections, but particularly section 32, medical practitioners (doctors) are referred to as “he”. This is not acceptable in today’s society where women work as medical professionals, doctors and specialists in the field. Women should also be represented in the wording of legislation.

Section 32 also refers to every medical practitioner as the “woman’s own doctor” a term which is not now defined in the Act.

This term “the woman’s own doctor” is inapt, due to the changed nature of doctor/patient relatioships since enactment, the greater availability of specialised services, and the fact that many people (especially migrants) may not have a regular GP. There is also the matter of conscientious objection: if a woman’s usual doctor invokes the right under s 46, the woman would need to be referred by an alternative doctor. It would be beneficial for participants in the referral process to have this matter clarified in the Act.

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.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS CONFERENCE AOTEAROA NEW ZEALAND 2016

The Abortion Supervisory Committee attended the Sexual and Reproductive Health and Rights Conference in Wellington on 10, 11 and 12 November 2016.

We were impressed by the number of abortion providers from throughout the country who attended the conference and showed a commitment to continuing professional education. The conference provided a great opportunity to those who attended to hear from distinguished

international speakers, healthcare workers that provide abortion care and contraception in New Zealand who presented up to date information on healthcare practices in various licensed institutions, and presenters discussing research carried out to date; particularly around contraception uptakes and attitudes of sexual health in teenagers.

There was mention about difficulties understanding the wording of the law as it is currently written and how it is applied in practice. We will continue to look at the potential of having the Contraception, Sterilisation and Abortion Act 1977 reviewed and amended to more clearly set out the abortion pathway for healthcare providers working in the field.

JUSTICE AND ELECTORAL COMMITTEE REPORT
HILARY KIEFT AND 6 OTHERS PETITION

A report by the Justice and Electoral Committee on Petition 2014/11 of Hillary Kieft and 6 others was released in July 2016.

The petitioner requested "That Parliament pass legislation providing that a parent of a woman under the age of 16 years has the right to know if that woman has a pregnancy confirmed before she is referred for any resulting medical procedure, and that any consent sought for the medical procedure be fully informed as to procedure, possible repercussions, and after-effects."

After considering written submissions and oral evidence from the petitioner, various government agencies, organisations and members of the public, the Justice and Electoral Committee decided not to support the petition to require mandatory parental notification of women under the age of 16 years old.

There were, however, a number of recommendations set out in the resulting report, with the majority of these recommendations directed at the Abortion Supervisory Committee. These included:

- Data collection on the uptake of post-procedure care, such as counselling services and the rates of parental notification by young women under 16 who are pregnant;
- Strengthening the regime around post-procedure care and oversight;

- Emphasising the certifying consultant's responsibilities around post-procedure care and the protection of women under 16 who have an abortion procedure and ongoing training being provided to consultants to assist them in recognising the risk and safety issues around parental notification;

- Work with District Health Boards to confirm best-practice guidelines for pre and post-procedure care, mandatory follow-up for women under 16 years old, especially for those who opt not to inform a parent or caregiver.

We have considered the recommendations set out in the report and understand the objectives they seek to achieve. There are a number of actions we intend to take to strengthen pre and post-procedure care in New Zealand, increase data collection and communicate with certifying consultants about the importance of recognising and supporting all vulnerable women, including young women. It is important to understand that there are limitations on the ASC's ability to implement some of the recommendations due to legislative restrictions and resourcing.

Pre and Post Procedure Care

The Standards of Care document was produced in 2009 with the assistance of an appointed Standards Committee and it has become an important guideline for abortion providers and certifying consultants throughout the country. Section 9.9 details the expectation of consultants to provide follow-up aftercare including ensuring a woman is aware that there is access to further counselling after an abortion if she needs it. Certifying consultants are provided with a copy at the time of their appointment. We believe that it is timely for this document to be reviewed in the new year and once completed it will be distributed to all abortion providers and certifying consultants.

It is our intention to add a section to the document that emphasises the importance of recognising the additional needs of some women, including young women under the age of 16 with or without parental support.

In reviewing the Standards of Care document, there may be other areas that could be strengthened in terms of post-procedure care and counselling support. It would be helpful to open up dialogue with the Ministry of Health and relevant District Health Boards to ensure the delivery of abortion care is consistent nationwide. While abortion grounds are set out in the Crimes Act and the administration of this law is overseen by the ASC, patient care and treatment in this context is a core healthcare service that should be managed by District Health Boards, medical professionals and the Ministry of Health, as with other medical procedures.

Data Collection

With the co-operation of Statistics New Zealand, we have made changes to the statistical data collection form (*ASC form 4*) completed by operating doctors when an abortion procedure is performed. These changes will facilitate obtaining figures on the number of young women who have or have not notified a parent of their pregnancy and their intention to seek an abortion. Due to the very low number of young women who may not inform their parents, it is unlikely that we will be able to release these statistics in order to protect the privacy of the young women involved. Statistics NZ cautioned, by way of email to the ASC:

> "*We have concerns about data quality and confidentiality:*
>
> - *Under 16 year olds make up only about 1% of all abortions (around 100)… This means the reporting number is likely to be small. It also relies on the patient being willing to provide accurate information in what could be an anxious and stressful situation.*
>
> - *Most importantly, how can we safely report the results? In rejecting mandatory notification of an abortion to parents, the Select Committee stated concerns that young people may not seek medical help if reporting was mandatory. … how we compile and present the results will need to be very carefully considered to ensure we don't place patients at risk of harm (and to preserve confidentiality). Breakdowns of results below the national level is unlikely. That is, we would not support releasing data with regional, ethnic, or single age breakdowns. "* [sic]

It is difficult to gather information on the number of young women, or any women, who choose to pursue post-procedure counselling or the extent of post-procedural care each woman receives after procuring an abortion. Current abortion statistics available to the ASC are collected on a form completed by operating doctors who perform the abortion procedure. Post-procedure care is carried out by various agencies including the women's own doctor, outpatient clinics, or any number of medical professionals from whom the woman may seek care. Collecting data on the nature of follow-up care sought by women after receiving an abortion and from where these services are obtained is not achievable by the ASC. The ASC does not have the legislative authority to retrieve a woman's medical records or compel private practices to provide it with anonymised statistical data. This is also the case with respect to collecting data on the uptake of counselling services.

INTERPRETING SERVICES

It is vitally important for any person pursuing health services to be able to communicate their needs with healthcare professionals and to understand all the important factors involved when opting to undergo a medical procedure.

In instances where English may not be their first language or where language barriers may present challenges for patients and their healthcare professionals or counsellors, the use of an independent interpreter is often needed. Allowing family members or friends to provide interpreting services for a patient could raise concerns about coercion. There is also risk around untrained or unvetted interpreters holding strong views about abortions that may inappropriately influence the decision-making process.

We believe it is appropriate in these circumstances that only reputable services with suitably trained interpreters be used. The renewal application form sent to all licensed institutions each year has been updated to collect information about the quality of interpreting services used by each District Health Board.

STATISTICS

The total number of abortions performed in New Zealand for the 2015 has remained relatively unchanged from the 2014 year with a difference of 18 abortions. When factoring in population growth we can see that abortion rates are still continuing to trend downward. The abortion rate is the number of abortions per 1,000 women between the ages of 15-44. More information about abortion rates can be seen in graph 1.3 located on page 10 of this report.

There has been a significant decrease in the number of abortions in women under the age of 25. This steady decline has seen abortion rates in the age group 20-24 drop from 41 abortions per 1,000 in 2003 to 23 abortions per 1,000 in 2015. Abortions in 15-19 year olds are down from 27 per 1,000 in 2007 to 11 per 1,000 in 2015.

Abortion ratios (number of abortions per 1,000 known pregnancies including live births, still births and abortions but excluding miscarriages) have also continued to drop. The total ratio for 2015 was 177 per 1,000 known pregnancies, down from 186 in 2014. This is the lowest ratio since 1993.

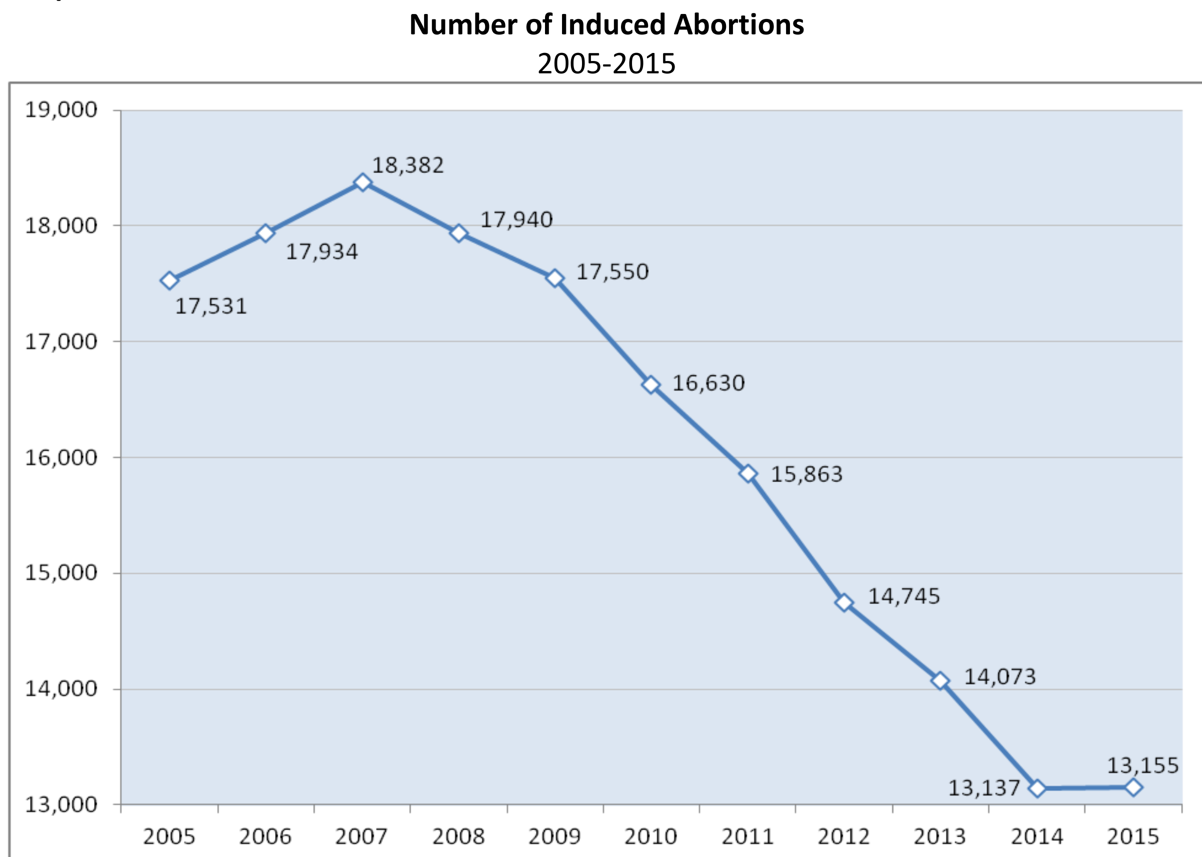
We are pleased to report that 88% of women are provided with contraception at the time an abortion is carried out. This is a positive step to prevent future unintended pregnancies.

STATISTICAL ANALYSIS AND TRENDS

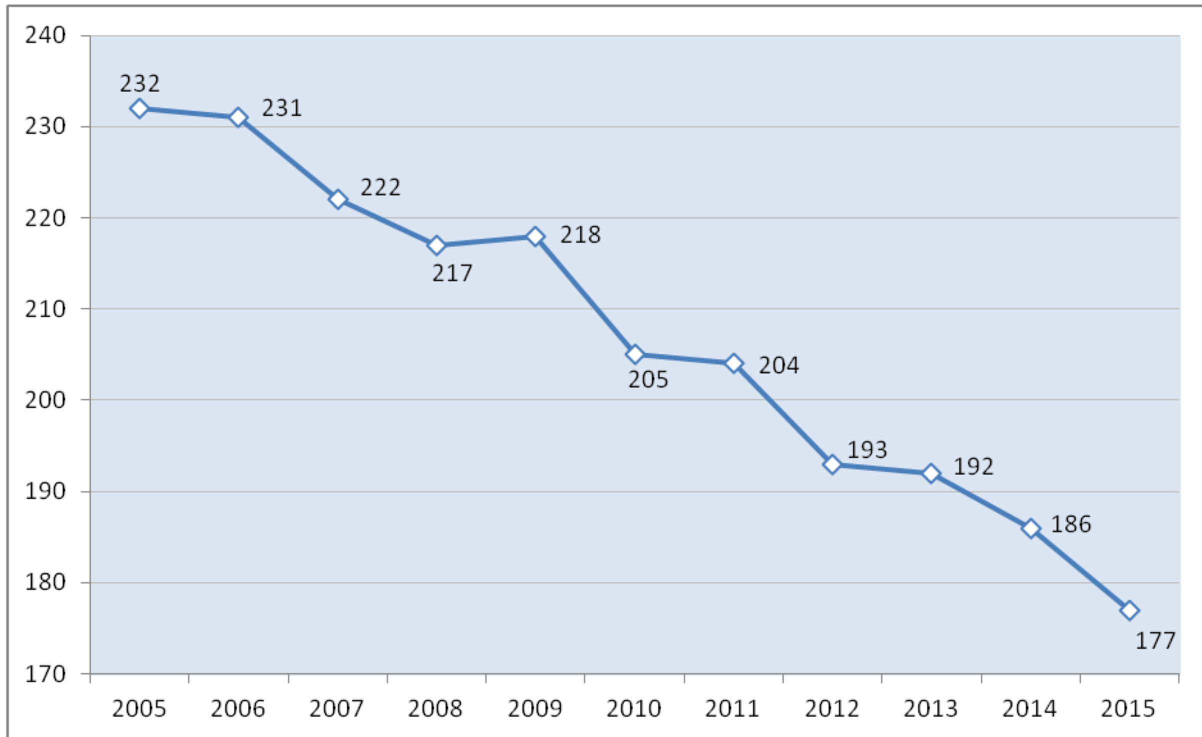
In this section the Committee presents its analysis of the New Zealand abortion statistics for the 2015 calendar year. Further statistics in tabular form are available to view online at Statistics New Zealand website: http://www.stats.govt.nz

1. Induced Abortions, Rates and Ratios

Graph 1.1

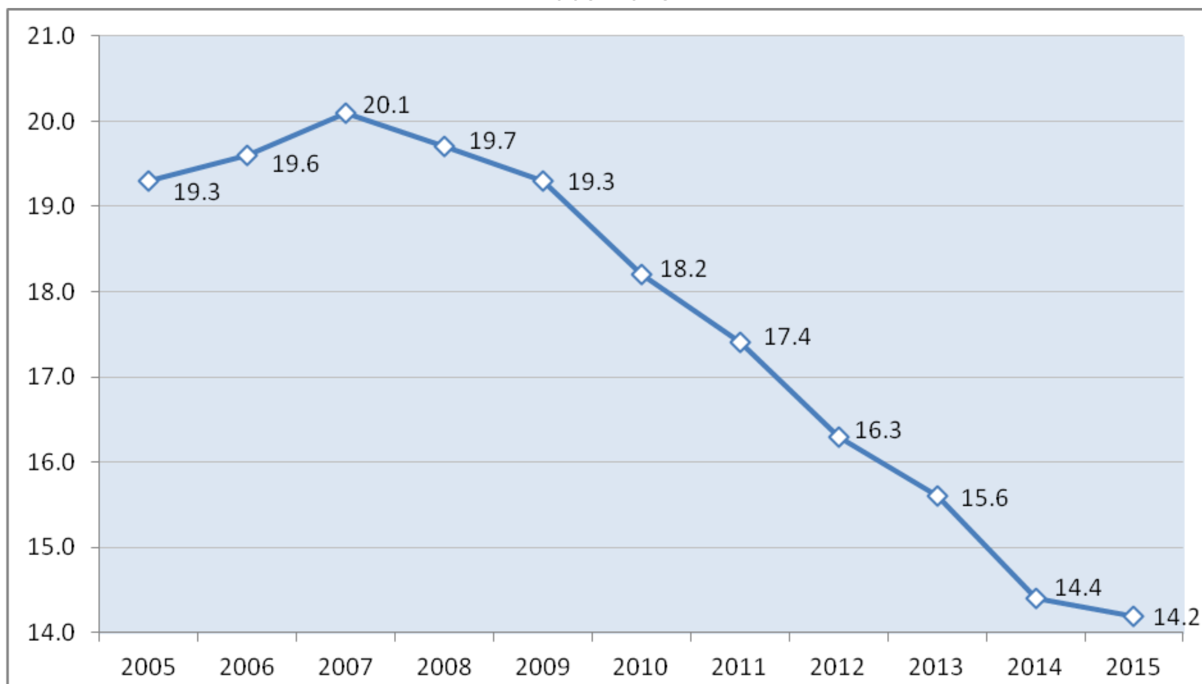


Graph 1.2



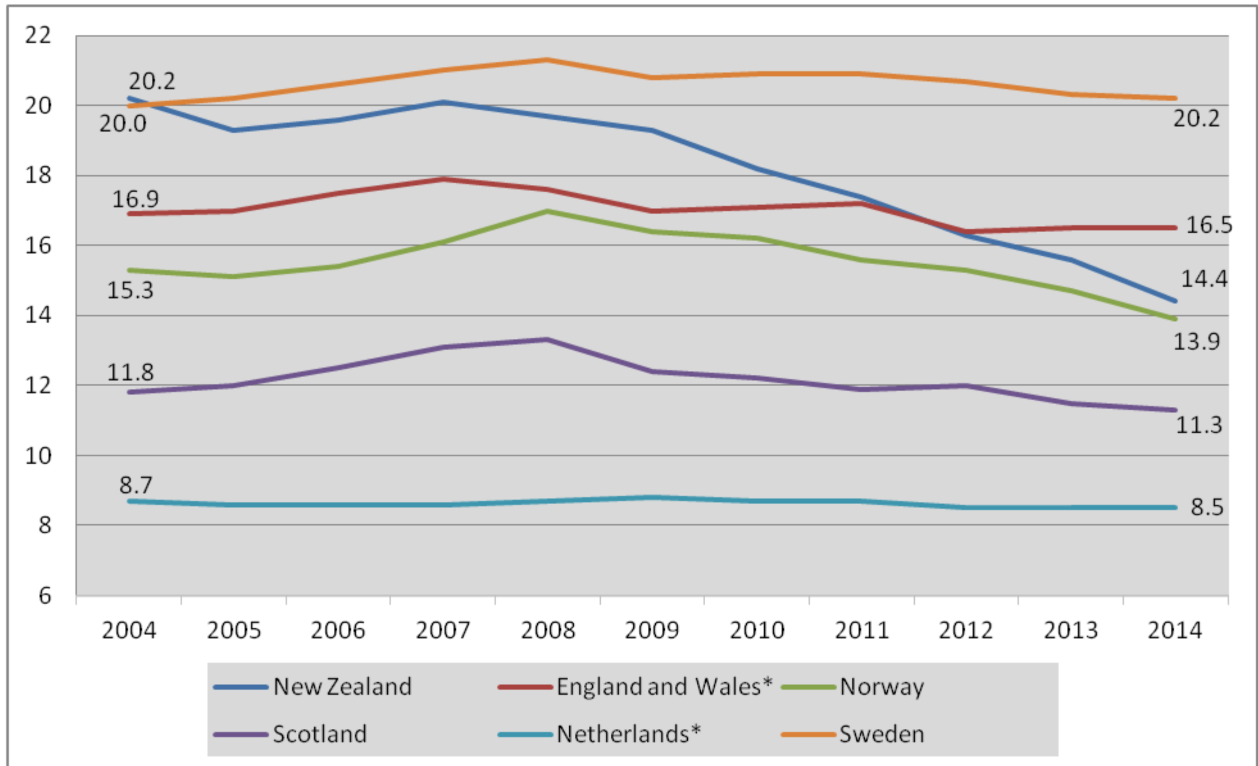
The abortion ratio is the number of abortions per 1,000 known pregnancies. Known pregnancies include live births, stillbirths and induced abortions combined, but does not include miscarriages.

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



*Residents only

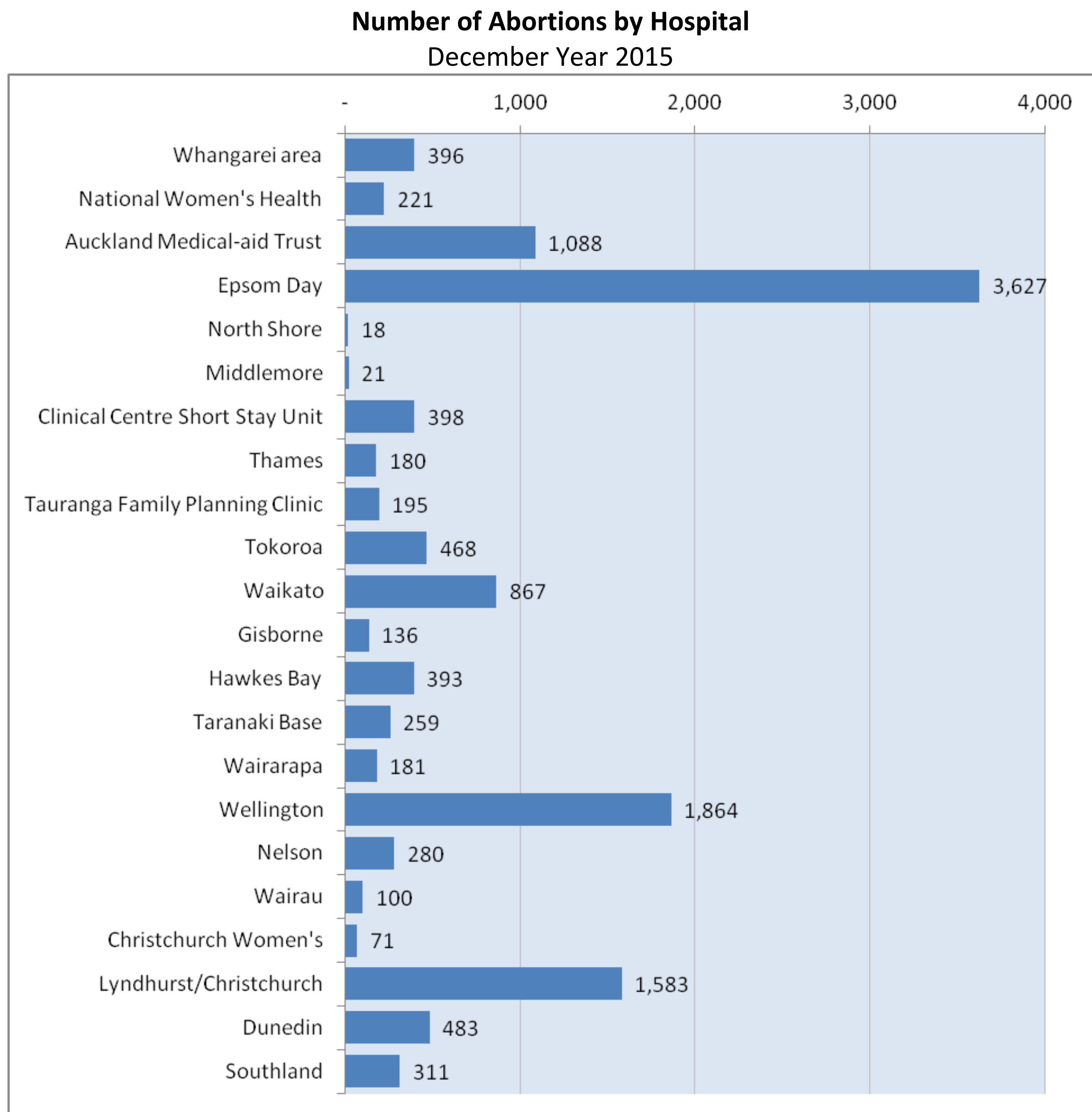
The general abortion rate is the number of abortions per 1,000 of the mean estimated population of women aged 15-44 years. Statistical coverage and laws relating to induced abortion affect international comparisons of abortion statistics.

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 2015 is not available for many countries, so comparisons are made using 2014 data.

2. Hospital and Residence

Graph 2.1



Three other hospitals performed a total of 15 abortions:

Palmerston North
Sugery on Shakespeare
Hutt Hospital

Graph 2.2

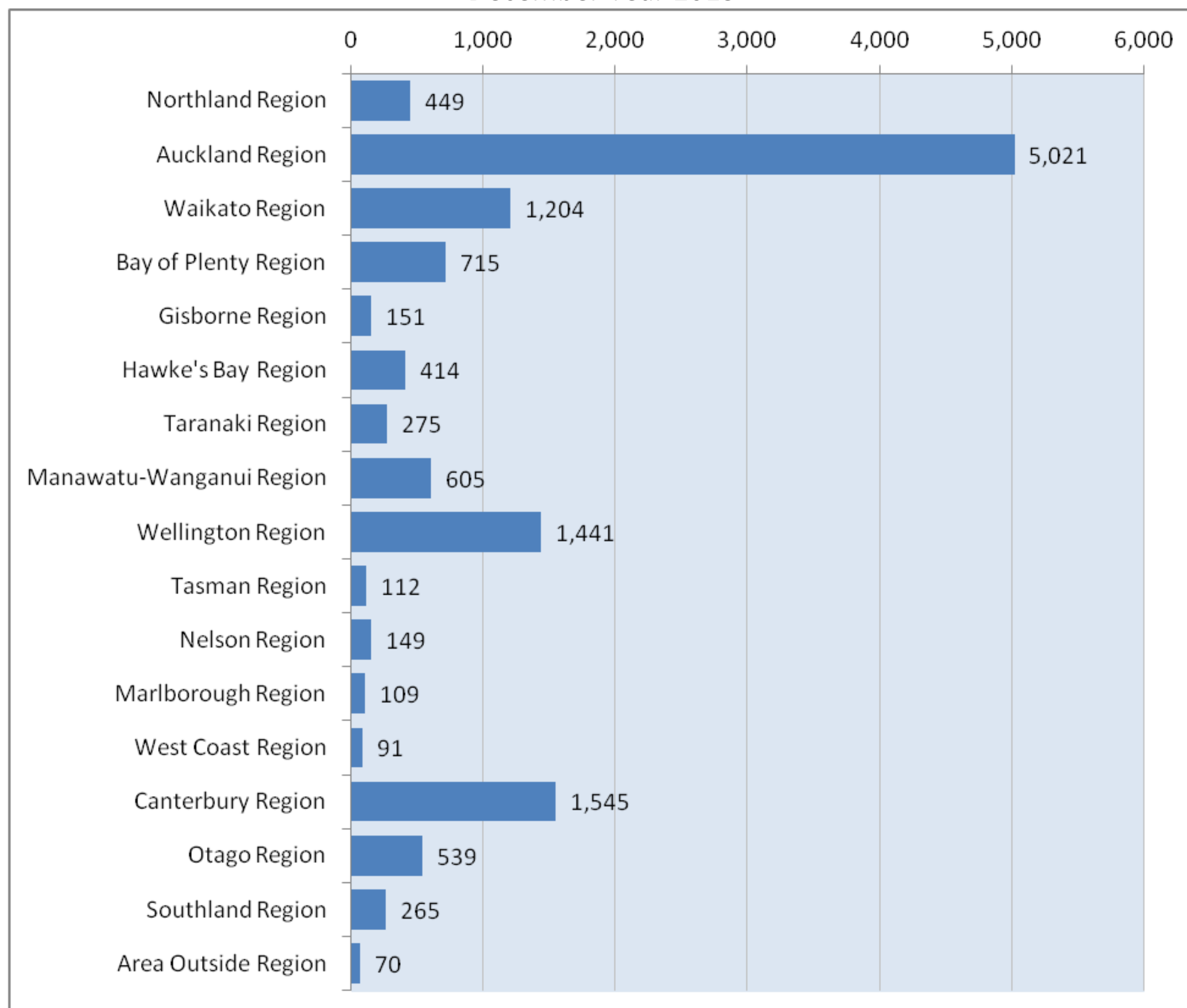


Table 2.3

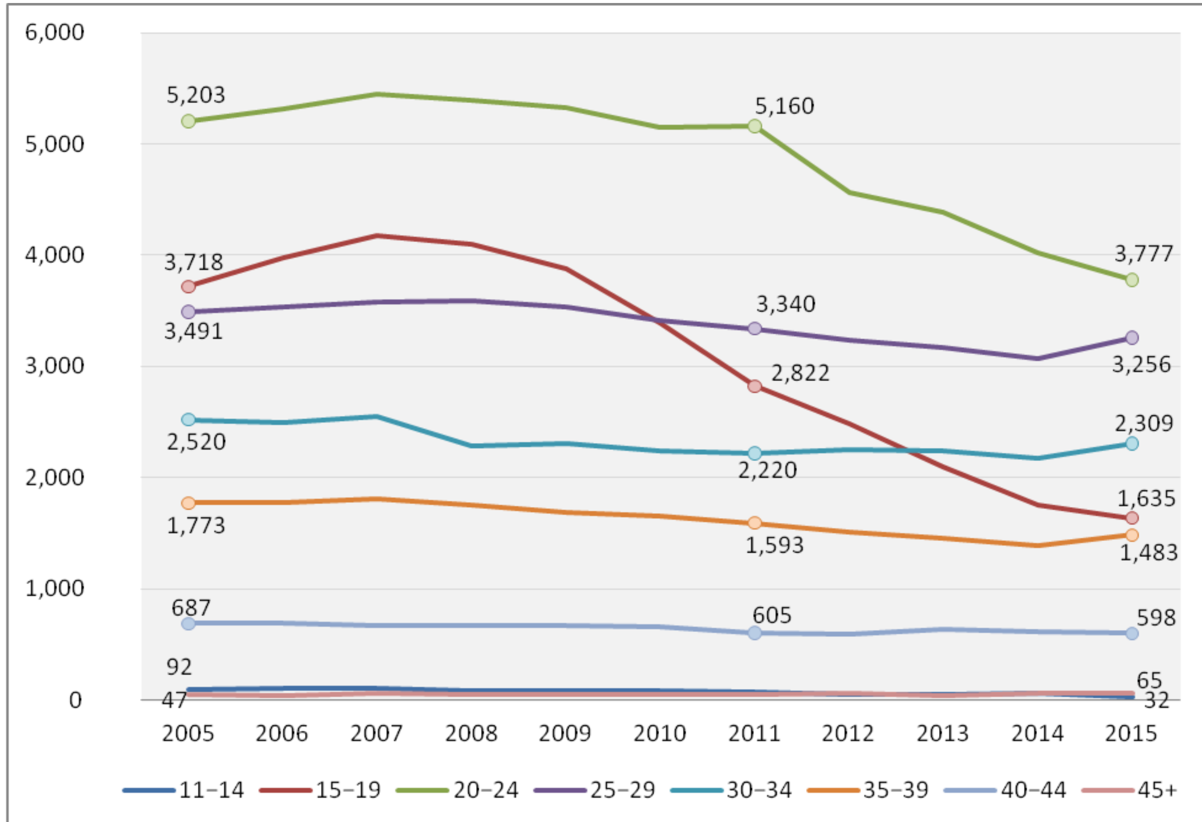
Induced Abortions by Residential Status of Woman
December Year 2015

Residential Status [2]	Number
New Zealand Resident	11,844
Non-Resident	1,032
Not Stated	279
Total	**13,155**

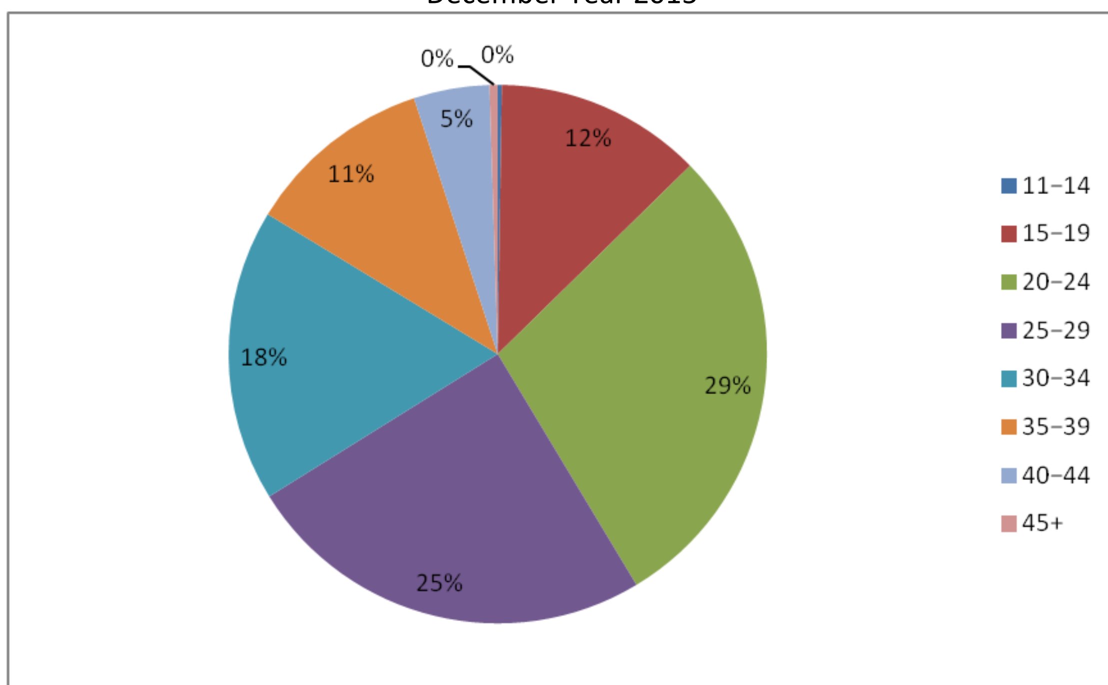
[1] Due to different rates of 'not specified' region across hospitals, regional data should be interpreted with care.
[2] Residential status is not the same as place of residence.

3. Age of Woman

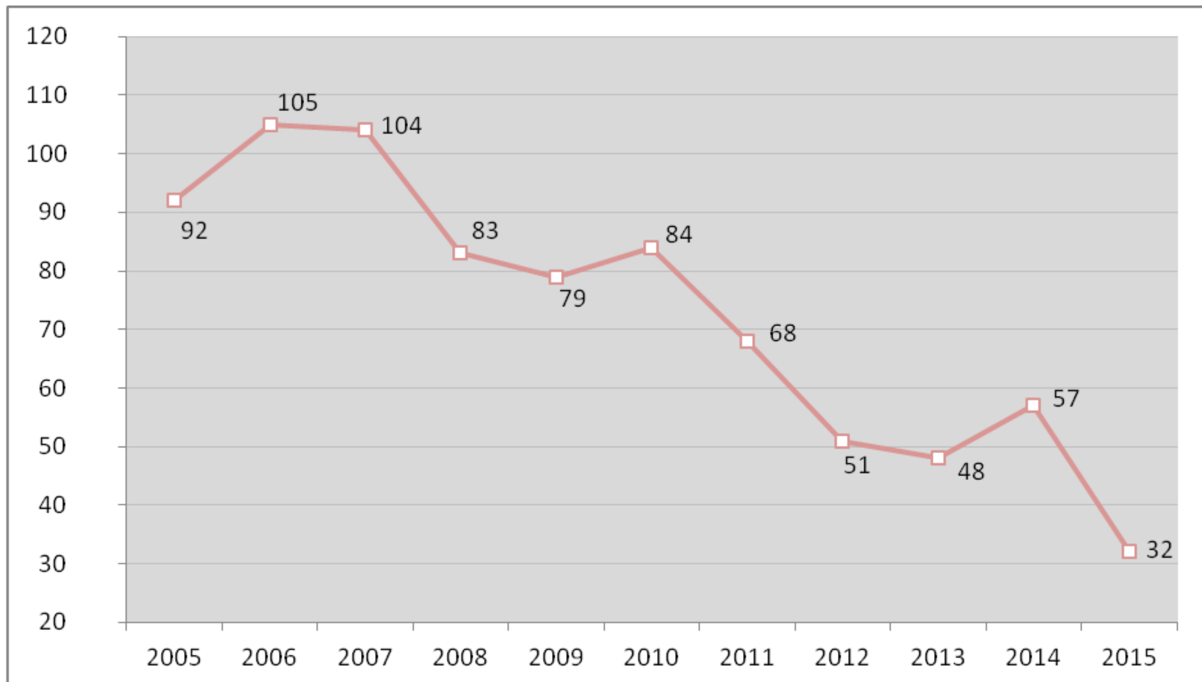
Graph 3.1



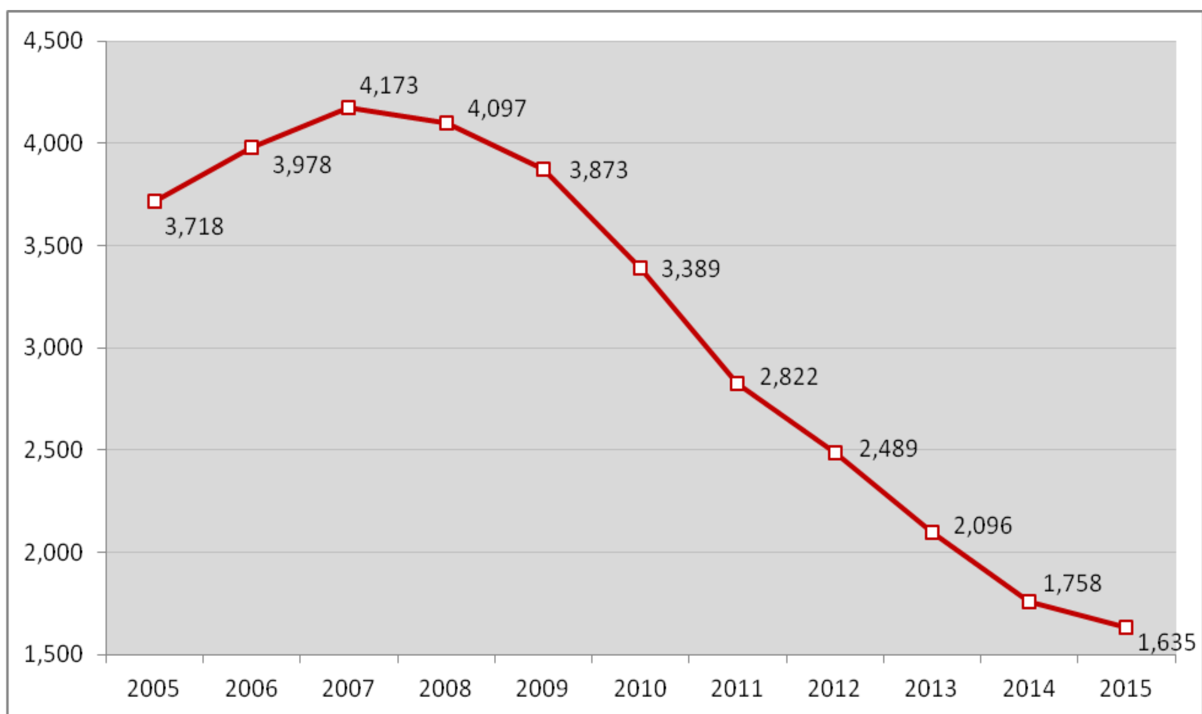
Graph 3.2



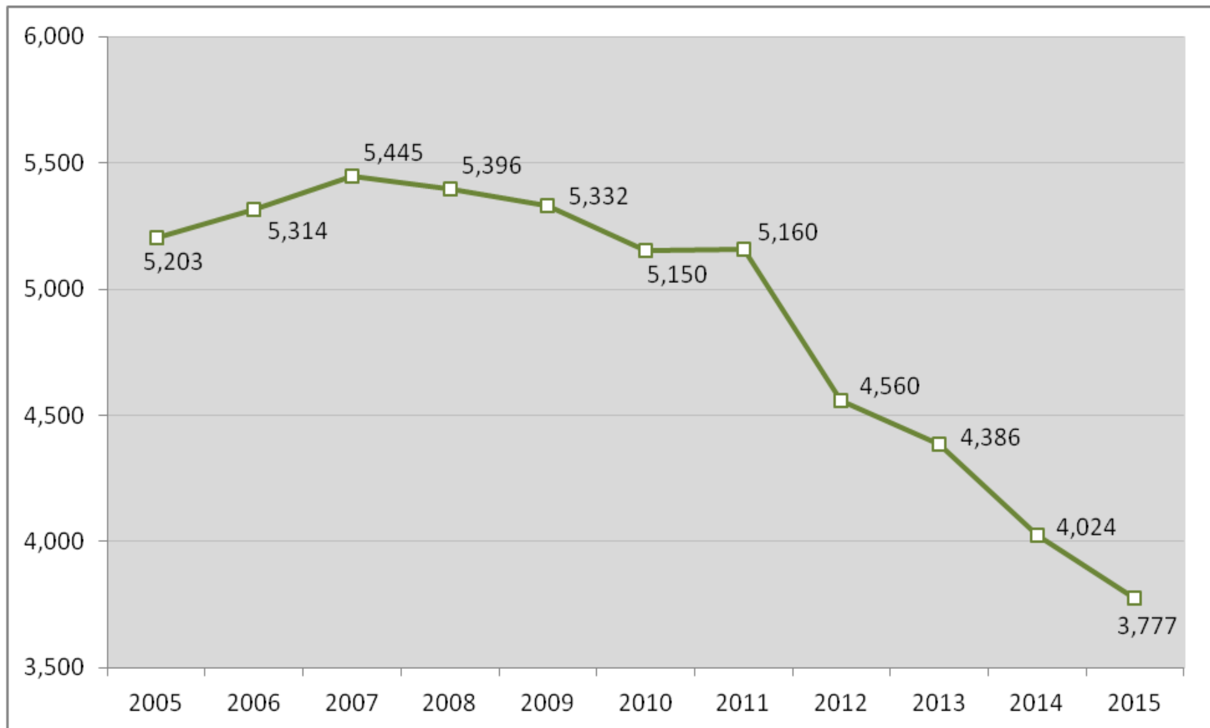
Graph 3.3



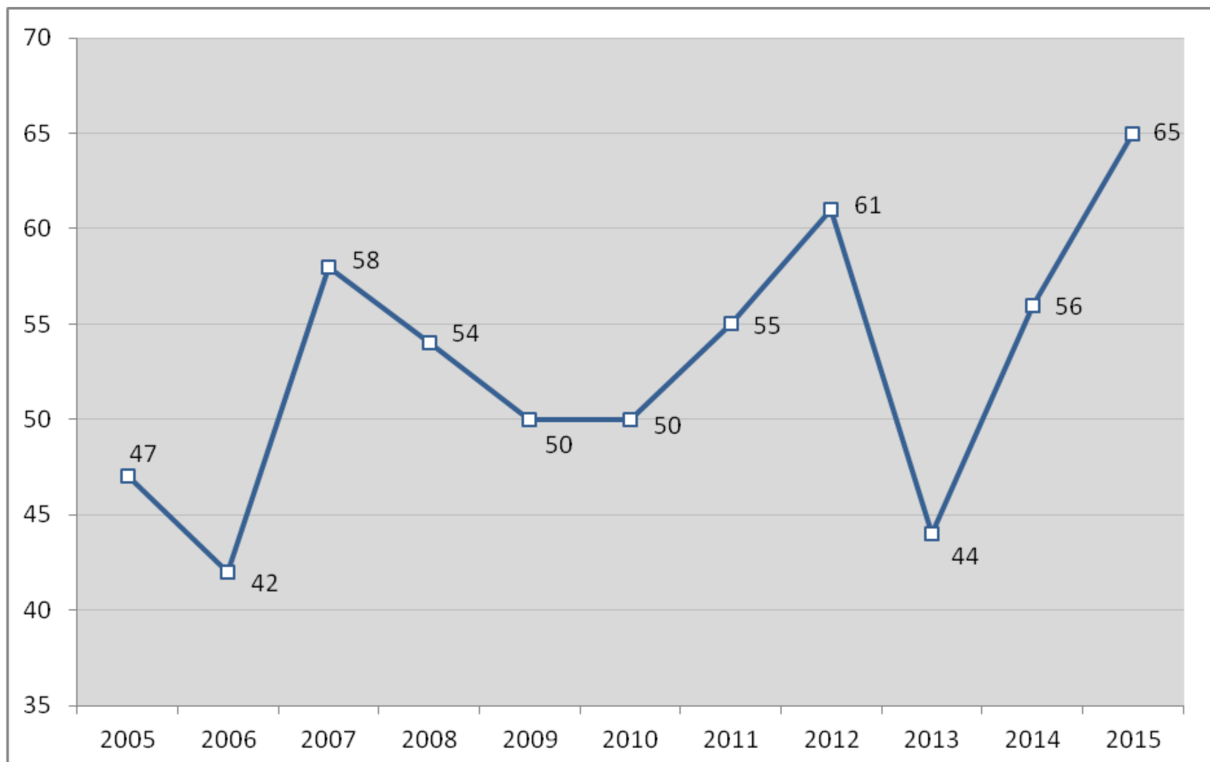
Graph 3.4



Graph 3.5



Graph 3.6



4. Previous Live Births

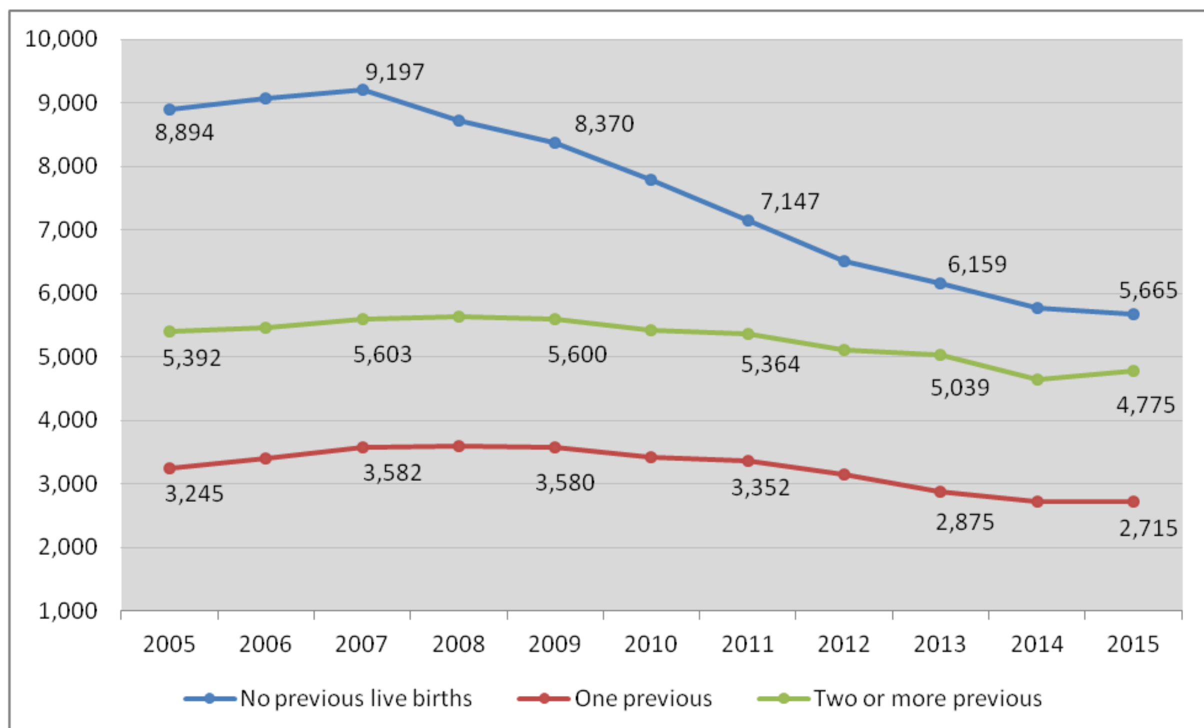
Table 4.1

Induced Abortions by Age and Previous Live Births
December Year 2015

Age (years)	Previous Live Births								
	Total	0	1	2	3	4	5	6	7 or More
All Ages	**13,155**	**5,665**	**2,715**	**2,728**	**1,264**	**473**	**193**	**74**	**43**
Under 15	32	32	-	-	-	-	-	-	-
15-19	1,635	1,393	208	31	3	-	-	-	-
20-24	3,777	2,257	891	470	129	27	3	-	-
25-29	3,256	1,183	764	744	376	129	44	12	4
30-34	2,309	521	483	712	344	149	63	25	12
35-39	1,483	210	261	510	280	117	60	26	19
40-44	598	59	94	238	121	48	21	10	7
45 and Over	65	10	14	23	11	3	2	1	1

Graph 4.2

Number of Abortions by Previous Live Births
2005-2015



5. Previous Induced Abortions

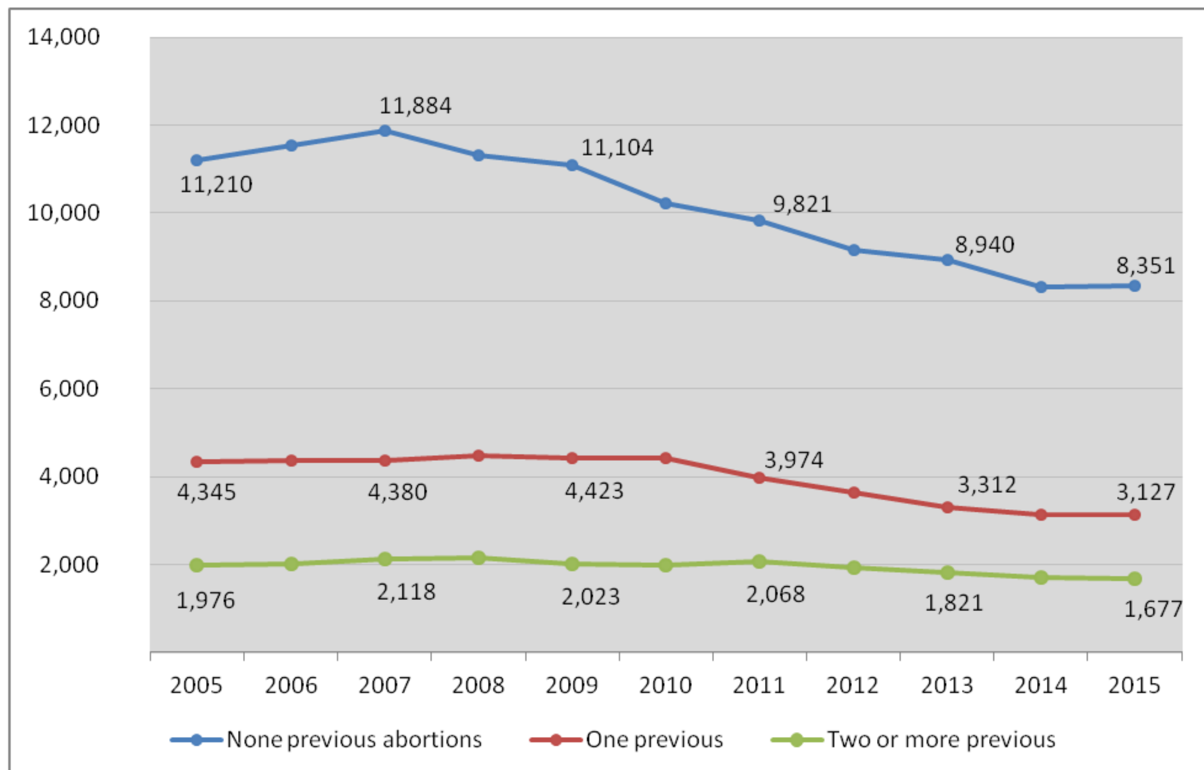
Table 5.1

Induced Abortions by Age and Previous Induced Abortions
December Year 2015

Age (years)	Previous Abortions							
	Total	0	1	2	3	4	5	6 or more
All Ages	**13,155**	**8,351**	**3,127**	**1,097**	**375**	**130**	**44**	**31**
Under 15	32	32	-	-	-	-	-	-
15-19	1,635	1,449	173	12	1	-	-	-
20-24	3,777	2,637	864	234	30	11	1	-
25-29	3,256	1,813	899	353	122	48	13	8
30-34	2,309	1,233	619	274	120	39	18	6
35-39	1,483	815	399	155	69	23	10	12
40-44	598	336	149	67	32	8	2	4
45 and Over	65	36	24	2	1	1	-	1

Graph 5.2

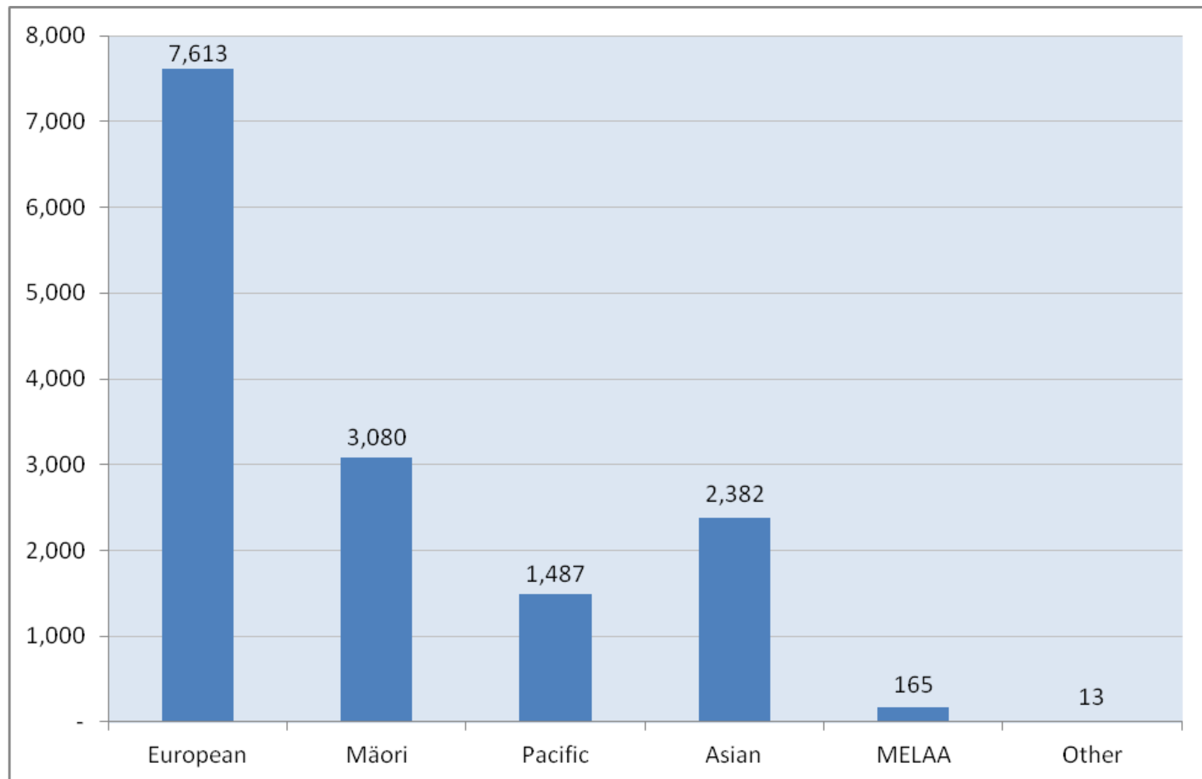
Number of Abortions by Previous Induced Abortions
2005-2015



6. Ethnic Group

Graph 6.1

Number of Abortions by Ethnic Group
December Year 2015



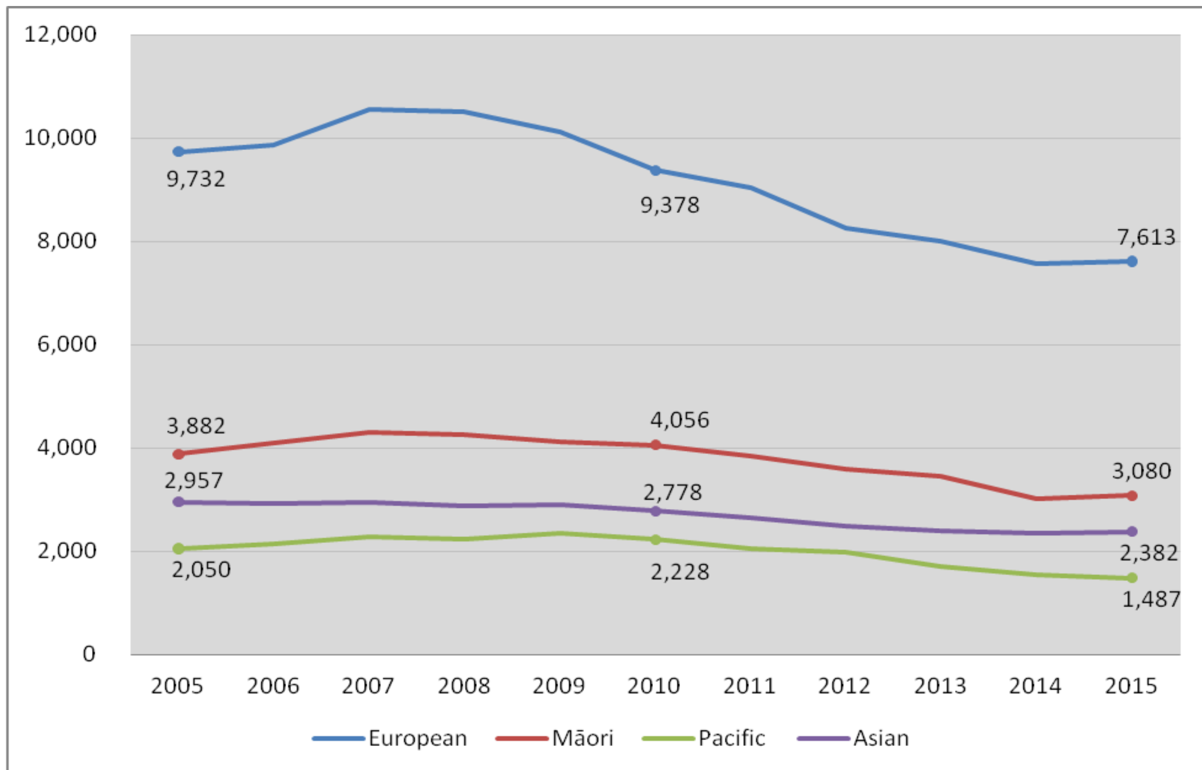
Each abortion has been included in every ethnic group specified. For this reason, some abortions are counted more than once.

Note:

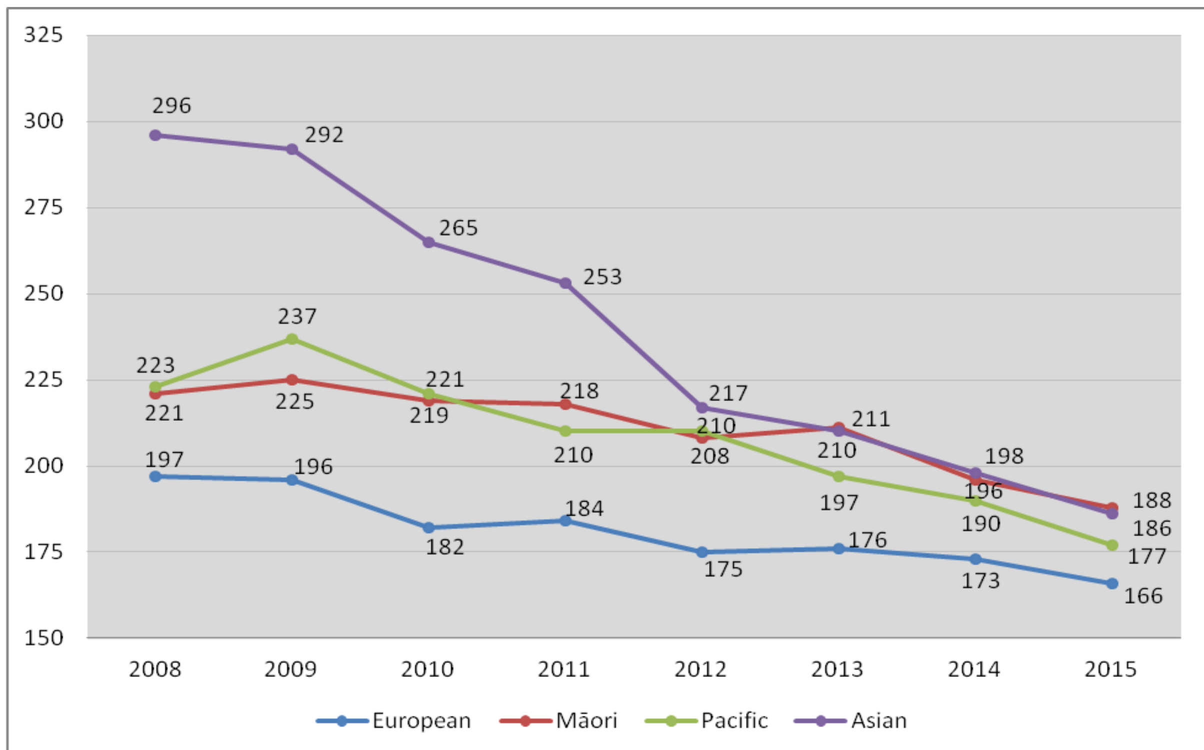
(a) MELAA = Middle Eastern, Latin American and African

(b) Other includes New Zealanders.

Graph 6.2



Graph 6.3



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

December Year 2015

Age (years)	Duration of Pregnancy (weeks)					
	Total	Under 8	8-12	13-16	17-20	Over 20
All Ages	**13,155**	**2,465**	**9,352**	**1,031**	**250**	**57**
Under 20	1,667	230	1,223	163	47	4
20-24	3,777	673	2,754	285	56	9
25-29	3,256	663	2,277	249	55	12
30-34	2,309	476	1,623	144	49	17
35-39	1,483	272	1,037	129	33	12
40-44	598	131	402	53	10	2
45 +	65	20	36	8	-	1

Table 7.2

Induced Abortion by Duration of Pregnancy

2005-2015

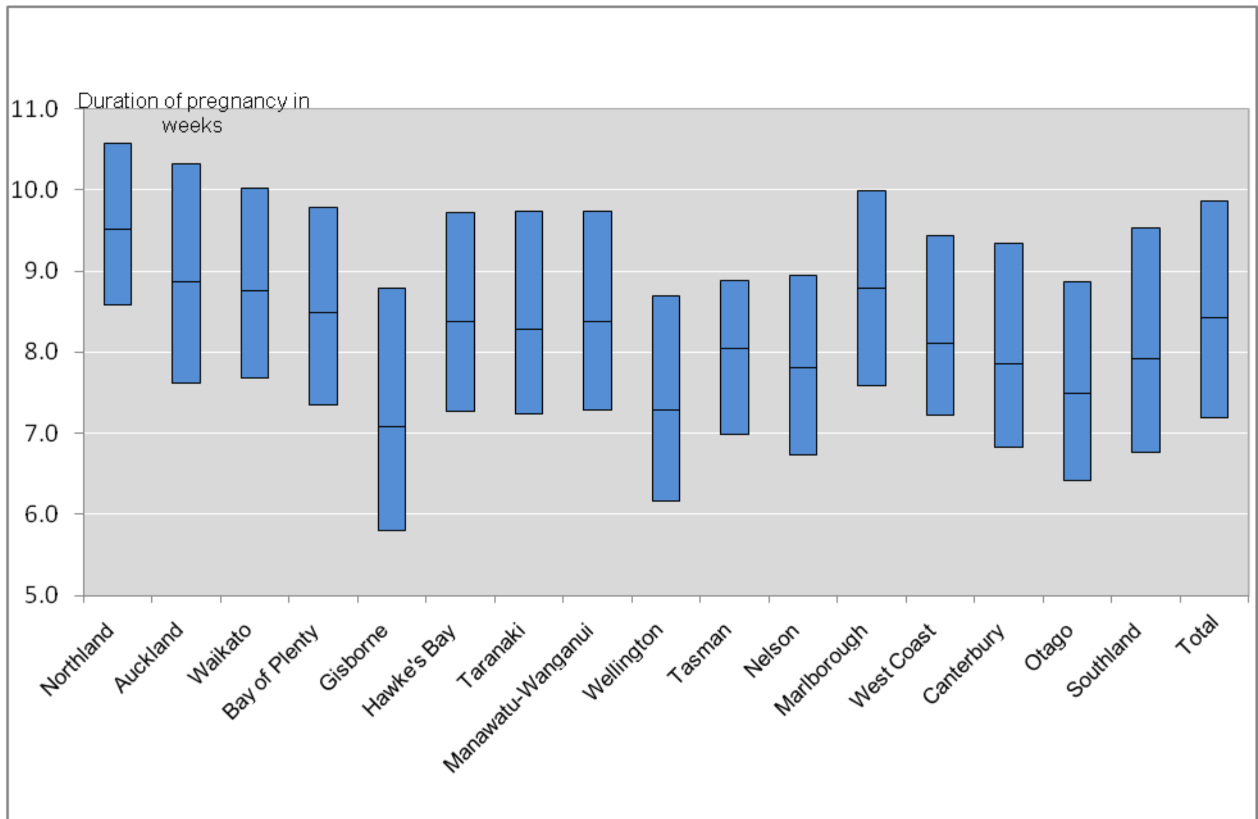
December year	Duration of pregnancy (weeks)								Total abortions
	Under 8	8	9	10	11	12	13	14+	
					Number				
2005	1,271	1,782	2,928	3,620	3,011	2,640	1,350	929	17,531
2006	1,526	1,843	3,012	3,729	2,990	2,634	1,259	941	17,934
2007	1,478	2,413	3,558	3,671	3,131	2,631	478	1,022	18,382
2008	1,687	2,875	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
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
					Percent				
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
2013	17.9	19.4	19.1	16.0	11.2	8.3	2.5	5.6	100.0
2014	19.5	19.5	17.7	14.1	10.8	8.6	3.8	5.9	100.0
2015	18.7	18.6	17.9	13.9	11.5	9.1	4.2	6.0	100.0

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

Table 7.3

First Trimester Abortions [1] by Duration of Pregnancy 2015

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
December Year 2015

Grounds for Abortion	Number	Percent
Total	**13,155**	**100.0**
Danger to Life	32	0.2
Danger to Physical Health	21	0.2
Danger to Mental Health	12,810	97.4
Danger to Life and Physical Health	1	0.0
Danger to Life and Mental Health	1	0.0
Mental and Physical Health Danger	110	0.8
Handicapped Child and Danger to Life	2	0.0
Handicapped Child and Physical Danger	5	0.0
Handicapped Child and Mental Danger	107	0.8
Handicapped Child, Physical and Mental Danger	3	0.0
Seriously Handicapped Child	57	0.4
Criminal Offence and Danger to Mental Health	6	0.0

9. Procedure

Table 9.1

Induced Abortions by Procedure and Duration of Pregnancy

December Year 2015

Procedure	Under 9 weeks	9th week and over	Total
Total	**4,917**	**8,238**	**13,155**
Surgical	3,539	7,813	**11,352**
Medical only (no surgery)	1,365	401	**1,766**
Failed medical only followed by surgical	10	22	**32**
Failed surgical followed by medical	3	0	**3**
Other	0	2	**2**

10. Complication

Table 10.1

Induced Abortions by Complication

December Year 2015

Complication	Number	Percent
Total	**13,155**	**100.0**
None	13,088	99.5
Retained placenta/products	32	0.2
Haemorrhage (500ml or more)	17	0.1
Perforation of Uterus	7	0.1
Haemorrhage and retained placenta/products	6	0.0
Haemorrhage and Other	2	0.0
Other	2	0.0
Haemorrhage and perforation of uterus	1	0.0

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

11. Contraception

Table 11.1

Induced Abortions by Contraception Used
December Year 2015

Contraception Used	Number	Percent
Total	**13,155**	**100.0**
None	7,493	57.0
Condoms	3,220	24.5
Combined oral contraceptives	1,228	9.3
Progesterone only contraceptives	472	3.6
Natural family planning	214	1.6
Emergency contraception	190	1.4
Intra-Uterine contraceptive device without hormones	184	1.4
Depo provera injections	75	0.6
Intra-Uterine contraceptive device with hormones	35	0.3
Other	30	0.2
Long-acting implant	10	0.1
Diaphragm	4	0.0

Graph 11.2

Percentage of Abortions by Contraception Used
December Year 2015

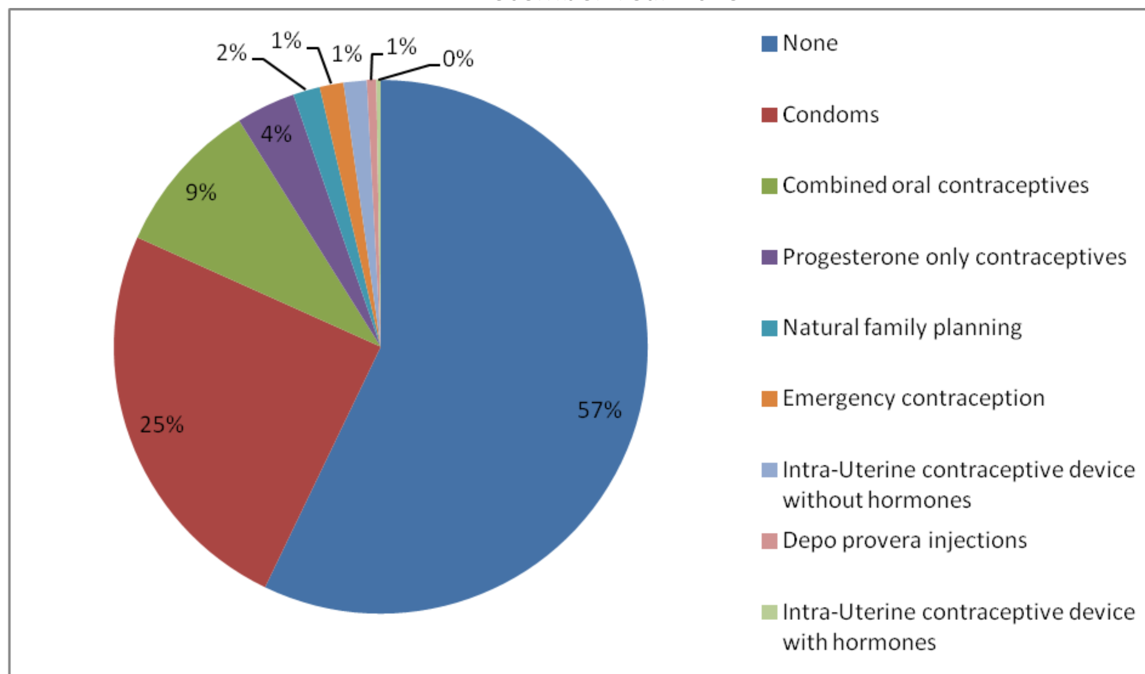


Table 11.3

Induced Abortions by Age and Contraception Use
December Year 2015

Age Group (years)	Total	No Contraception Used	Contraception Used
All Ages	**13,155**	**7,493**	**5,662**
Under 20	1,667	1,053	614
20-24	3,777	2,129	1,648
25-29	3,256	1,793	1,463
30-34	2,309	1,294	1,015
35-39	1,483	829	654
40 +	663	395	268

Graph 11.4

No Contraception Used by Age Group
December Year 2015

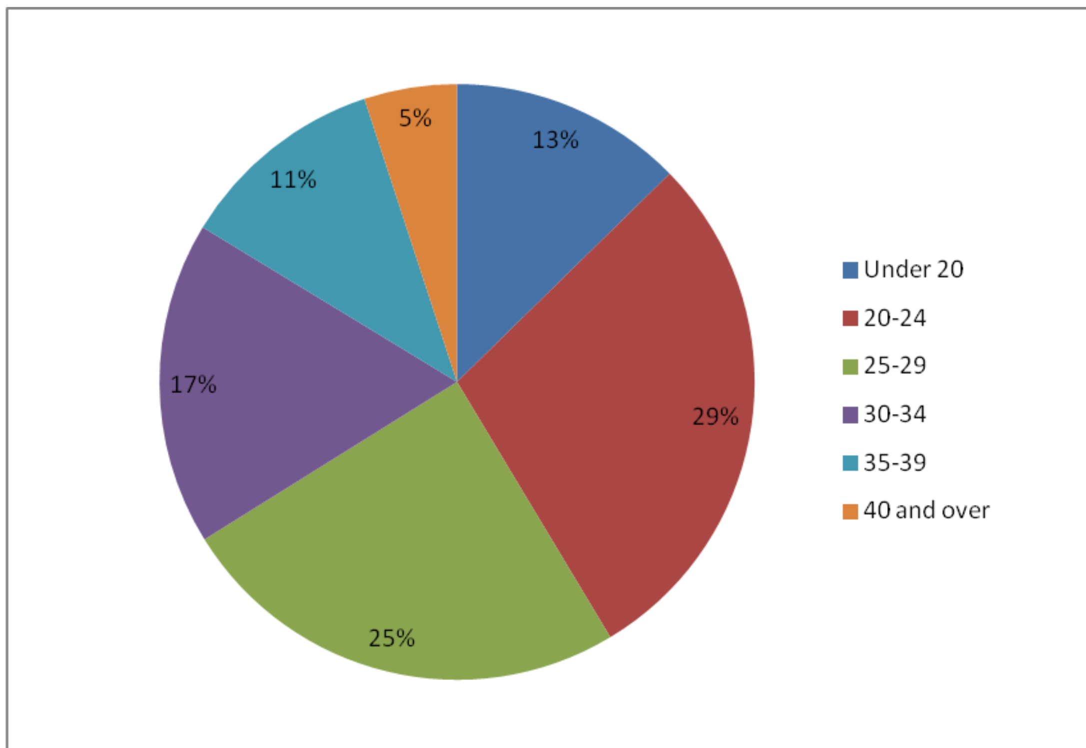


Table 11.5

Contraception Used by Previous Live Births and Previous Abortions
December Year 2015

Number	Previous Live Births			Previous Abortions		
	Total	No Contraception Used	Contraception Used	Total	No Contraception Used	Contraception Used
Total	**13,155**	**7,493**	**5,662**	**13,155**	**7,493**	**5,662**
0	5,665	3,090	2,575	8,351	4,870	3,481
1	2,715	1,615	1,100	3,127	1,693	1,434
2	2,728	1,575	1,153	1,097	592	505
3	1,264	707	557	375	221	154
4 or more	783	506	277	205	117	88

Table 11.6

Contraception Provided at the Time of the Procedure by Previous Abortions
December Year 2015

Previous abortions	Total	Type of contraceptive						
		None	IUCD	Implant	Oral Contraceptives	Depo Provera	Condoms	Other
Total	**13,155**	**1,590**	**4,749**	**1,804**	**2,843**	**1,167**	**1,049**	**268**
0	8,351	1,071	2,777	1,151	1,947	683	758	203
1	3,127	338	1,271	412	620	296	201	40
2 or more	1,677	181	701	241	276	188	90	25

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 progestrone 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

December Year 2015

Contraception Used	Number	Percent
Total	**13,155**	**100.0**
IUCD insertion	4,729	35.9
Combined oral contraceptives	2,316	17.6
Implant insertion	1,799	13.7
None	1,590	12.1
Depo provera injections	1,157	8.8
Condoms	750	5.7
Progesterone only contraceptives	469	3.6
Condoms and emergency contraceptive pill	231	1.8
Progesterone only contraceptives and condoms	26	0.2
Combined oral contraceptives and condoms	24	0.2
Other	22	0.2
IUCD insertion and condoms	9	0.1
IUCD insertion and depo provera injections	5	0.0
Diaphragm	4	0.0
Emergency contraceptive pill	4	0.0
IUCD insertion and combined oral contraceptives	4	0.0
Diaphragm and condoms	3	0.0
Implant insertion and condoms	3	0.0
Condoms and Other	2	0.0
Depo provera injections and condoms	2	0.0
Depo provera injections and other	2	0.0
Implant insertion and combined oral contraceptives	2	0.0
Depo provera injections and combined oral contraceptives	1	0.0
IUCD insertion and progesterone only contraceptives	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

December Year 2015

Regional Council	Total	Type of contraceptive						
		None	IUCD	Implant	Oral Contraceptives	Depo Provera	Condoms	Other
New Zealand	**13,155**	**1,590**	**4,749**	**1,804**	**2,843**	**1,167**	**1,049**	**268**
Northland Region	449	51	188	32	73	85	20	4
Auckland Region	5,021	781	1,860	611	922	303	564	180
Waikato Region	1,204	76	487	196	241	121	107	24
Bay of Plenty Region	715	44	269	87	169	97	58	19
Gisborne Region	151	14	69	24	25	16	2	2
Hawke's Bay Region	414	52	133	56	102	43	26	3
Taranaki Region	275	33	77	63	54	39	9	2
Manawatu-Wanganui	605	50	184	136	137	73	26	1
Wellington Region	1,441	164	519	217	351	104	88	3
Tasman Region	112	21	33	11	32	9	3	3
Nelson Region	149	33	44	11	29	17	11	4
Marlborough Region	109	8	29	20	35	12	5	0
West Coast Region	91	13	25	12	29	8	3	1
Canterbury Region	1,545	174	501	165	449	173	82	6
Otago Region	539	50	203	79	124	45	40	15
Southland Region	265	14	108	73	49	19	3	1
Area Outside Region	70	12	20	11	22	3	2	0

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 progestrone only contraceptives.

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

APPENDIX ONE

Functions and powers of the Supervisory Committee

The functions and powers of the ASC 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:

1. ***licensed institutions maintain adequate facilities for the performance of abortions; and***
2. ***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 2015 to 30 June 2016 the Supervisory Committee held 9 meetings.

Visits

Nelson Hospital, Nelson
Auckland Medical Aid Centre, Auckland
Epsom Day Unit, Greenlane, Auckland
The Women's Clinic, Palmerston North
Sexual and Reproductive Health and Rights Conference Aotearoa New Zealand 2016

Meetings

The Supervisory Committee met with:

- Ministry of Justice Staff
- Various certifying consultants
- Licence holders
- APGANZ – Abortion Providers Group Aotearoa New Zealand
- Nelson/Marlborogh DHB counselling staff
- Ministry of Health staff

Certifying Consultants

As at 30 June 2016 there were 159 certifying consultants (of whom 105 met the Act's specialist category requirements) on the Supervisory Committee's list.

Fees payable to certifying consultants for consultations with women considering termination of pregnancy totalled **$3,716,766** in the year ended 30 June 2016.