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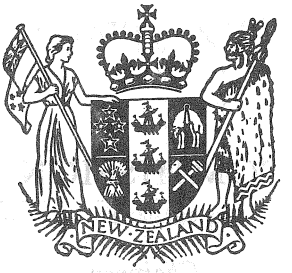

CONTRACEPTION STERILISATION AND ABORTION IN NEW ZEALAND

REPORT OF THE ROYAL COMMISSION OF INQUIRY

Presented to the House of Representatives by Command of His Excellency the Governor-General

BY AUTHORITY:
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Royal Commission to Inquire into and Report upon Contraception, Sterilisation, and Abortion

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ELIZABETH THE SECOND, by the Grace of God, Queen of New Zealand and Her Other Realms and Territories, Head of the Commonwealth, Defender of the Faith:

TO Our Trusty and Well-beloved the Honourable DUNCAN WALLACE MCMULLIN, a Judge of the Supreme Court of New Zealand, GEOFFREY LEONARD BRINKMAN, of Hamilton, medical practitioner, DENESE LETITIA HENARE, of Auckland, barrister and solicitor, MAURICE ROY MCGREGOR, of Christchurch, medical social worker, BARBARA JEANETTE THOMSON, of Wellington, married woman, DOROTHY GERTRUDE WINSTONE, of Auckland, married woman:

GREETING:

KNOW YE that We, reposing trust and confidence in your integrity, knowledge, and ability, do hereby nominate, constitute, and appoint you, the said

The Honourable DUNCAN WALLACE MCMULLIN,
GEOFFREY LEONARD BRINKMAN,
DENESE LETITIA HENARE,
MAURICE ROY MCGREGOR,
BARBARA JEANETTE THOMSON, and
DOROTHY GERTRUDE WINSTONE

to be a Commission to receive representations upon, inquire into, investigate, and report upon the following matters:

1. The legal, social, and moral issues that are raised by the law and practice relating to—

(a) Contraception in all commonly existing and likely forms; and
(b) Voluntary human sterilisation, whether of the male or female:

2. The state of the present law on abortion, its interpretation and its application in practice, and whether it meets the needs of society having regard to the social and moral issues relating to it, including the rights of the pregnant woman and the status of the unborn child:

3. Any changes that should in your opinion be made in the public interest to the law or practice relating to contraception, voluntary human sterilisation, or abortion:

4. The likely effects upon the present health, hospital, and medical services of any changes to such law or practice.

And we hereby appoint you the said

The Honourable DUNCAN WALLACE MCMULLIN

to be Chairman of the said Commission:

And for better enabling you to carry these presents into effect you are hereby authorised and empowered to make and conduct any inquiry or investigation under these presents in such manner and at such time and

place as you think expedient, with power to adjourn from time to time and place to place as you think fit, and so that these presents shall continue in force and any such inquiry may at any time and place be resumed although not regularly adjourned from time to time or from place to place:

And you are hereby strictly charged and directed that you shall not at any time publish or otherwise disclose, save to His Excellency the Governor-General, in pursuance of these presents or by His Excellency's direction, the contents of any report so made or to be made by you, or any evidence or information obtained by you in the exercise of the powers hereby conferred on you, except such evidence or information as is received in the course of a sitting open to the public:

And it is hereby declared that the powers hereby conferred shall be exercisable notwithstanding the absence at any time of any one or any two of the members hereby appointed so long as the Chairman, or a member deputed by the Chairman to act in his stead, and three other members are present and concur in the exercise of the powers:

And We do further ordain that you have liberty to report your proceedings and findings under this Our Commission from time to time if you shall judge it expedient to do so:

And, using all due diligence, you are required to report to His Excellency the Governor-General in writing under your hands, not later than the 30th day of June 1976, your findings and opinions on the matters aforesaid, together with such recommendations as you think fit to make in respect thereof:

And, lastly, it is hereby declared that these presents are issued, under the authority of the Letters Patent of His Late Majesty King George the Fifth, dated the 11th day of May 1917, and under the authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued and the Seal of New Zealand to be hereunto affixed at Wellington this 23rd day of June 1975.

Witness Our Right Trusty and Well-beloved Cousin, Sir Edward Denis Blundell, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of Our Royal Victorian Order, Knight Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

DENIS BLUNDELL, Governor-General.

By His Excellency's Command—

TOM McGUIGAN, Minister of Health.

Approved in Council—

P. G. MILLEN, Clerk of the Executive Council.

Replacement of Member of Royal Commission on Contraception, Sterilisation, and Abortion

ELIZABETH THE SECOND, by the Grace of God, Queen of New Zealand and Her Other Realms and Territories, Head of the Commonwealth, Defender of the Faith:

TO Our Trusty and Well-beloved the Honourable DUNCAN WALLACE MCMULLIN, a Judge of the Supreme Court of New Zealand, GEOFFREY LEONARD BRINKMAN, of Hamilton, medical practitioner, DENESE LETITIA HENARE, of Auckland, barrister and solicitor, MAURICE ROY MCGREGOR, of Christchurch, medical social worker, BARBARA JEANETTE THOMSON, of Wellington, married woman, DOROTHY GERTRUDE WINSTONE, of Auckland, married woman, and MAURICE DOMINIC MATICH, of Dargaville, medical practitioner:

GREETING:

WHEREAS by Our Commission dated the 23rd day of June 1975, We constituted you the said DUNCAN WALLACE MCMULLIN, GEOFFREY LEONARD BRINKMAN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, and DOROTHY GERTRUDE WINSTONE to be a Commission to receive representations upon, inquire into, investigate, and report upon the matters relating to contraception, sterilisation, and abortion referred to therein:

And whereas the said GEOFFREY LEONARD BRINKMAN is no longer able to serve as a member of the said Commission and has asked to be relieved from the duty of so doing, and it is desirable to appoint in his stead you, the said MAURICE DOMINIC MATICH:

Now, Know Ye, that We do hereby discharge you, the said GEOFFREY LEONARD BRINKMAN, from your appointment as a member of the said Commission and, reposing trust and confidence in your integrity, knowledge, and ability, do hereby appoint you, the said MAURICE DOMINIC MATICH, to be a member of the said Commission in the stead of the said GEOFFREY LEONARD BRINKMAN:

And it is hereby declared that all acts and things done and decisions made by the said Commission or any of its members, in the exercise of its powers, before the issuing of these presents, shall be deemed to have been made and done by the said Commission as reconstituted by these presents and as if you, the said MAURICE DOMINIC MATICH had originally been appointed to be a member in the place and stead of the said GEOFFREY LEONARD BRINKMAN:

And We do hereby confirm Our said Commission and the Commission thereby constituted, save as modified by these presents:

And, lastly, it is hereby declared that these presents are issued under the authority of the Letters Patent of His Late Majesty King George the Fifth, dated the 11th day of May 1917, and under the authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued

and the seal of New Zealand to be hereunto affixed at Wellington this 12th day of September 1975.

Witness Our Right Trusty and Well-beloved Cousin, Sir Edward Denis Blundell, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of Our Royal Victorian Order, Knight Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

EDWARD DENIS BLUNDELL, Governor-General,
by His Deputy, RICHARD WILD.

By His Excellency's Command—

TOM McGUIGAN, Minister of Health.

Approved in Council—

A. C. McLEOD, Acting for Clerk of the Executive Council.

Extending the Time Within Which the Royal Commission on Contraception, Sterilisation, and Abortion May Report

---

ELIZABETH THE SECOND, by the Grace of God, Queen of New Zealand and Her Other Realms and Territories, Head of the Commonwealth, Defender of the Faith:

TO Our Trusty and Well-beloved the Honourable DUNCAN WALLACE MCMULLIN, a Judge of the Supreme Court of New Zealand, DENESE LETITIA HENARE, of Auckland, barrister and solicitor, MAURICE ROY MCGREGOR, of Christchurch, medical social worker, BARBARA JEANETTE THOMSON, of Wellington, married woman, DOROTHY GERTRUDE WINSTONE, of Auckland, married woman, and MAURICE DOMINIC MATICH, of Dargaville, medical practitioner:

GREETING:

WHEREAS by our Warrant, dated the 23rd day of June 1975, We constituted you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, and DOROTHY GERTRUDE WINSTONE, together with one GEOFFREY LEONARD BRINKMAN, of Hamilton, medical practitioner, to be a Commission to receive representations upon, inquire into, investigate, and report upon the matters relating to contraception, sterilisation, and abortion referred to therein:

And whereas by Our Warrant, dated the 12th day of September 1975, We constituted the said Commission by appointing you, the said MAURICE DOMINIC MATICH, to be a member of the said Commission in the stead of the said GEOFFREY LEONARD BRINKMAN:

And whereas you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, DOROTHY GERTRUDE WINSTONE, and MAURICE DOMINIC MATICH, the members of the said Commission as so reconstituted, are required by Our Warrant, dated the 23rd day of June 1975, to report, not later than the 30th day of June 1976, your findings and opinions on the matters aforesaid, together with such recommendations as you think fit to make in respect thereof:

And whereas it is expedient that the time for so reporting should be extended as hereinafter provided:

Now, therefore, We do hereby extend until the 30th day of September 1976 the time within which you are so required to report, without prejudice to the liberty conferred on you by Our Said Warrant, dated the 23rd day of June 1975, to report your proceedings and findings from time to time if you should judge it expedient so to do:

And We do hereby confirm Our Said Warrant, dated the 23rd day of June 1975, and the Commission thereby constituted, save as modified by Our Said Warrant dated the 12th day of September 1975 and by these presents:

And, lastly, it is hereby declared that these presents are issued under the authority of the Letters Patent of His Late Majesty King George the

Fifth, dated the 11th day of May 1917, and under the authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued and the Seal of New Zealand to be hereunto affixed at Wellington this 10th day of May 1976.

Witness Our Right Trusty and Well-beloved Sir Edward Denis Blundell, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of Our Royal Victorian Order, Knight Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

DENIS BLUNDELL, Governor-General.

By His Excellency's Command—

FRANK GILL, Minister of Health.

Approved in Council—

P. G. MILLEN, Clerk of the Executive Council.

Further Extending the Time Within Which the Royal Commission on Contraception, Sterilisation, and Abortion May Report

---

ELIZABETH THE SECOND, by the Grace of God, Queen of New Zealand and Her Other Realms and Territories, Head of the Commonwealth, Defender of the Faith:

TO Our Trusty and Well-beloved the Honourable DUNCAN WALLACE MCMULLIN, a Judge of the Supreme Court of New Zealand, DENESE LETITIA HENARE, of Auckland, barrister and solicitor, MAURICE ROY MCGREGOR, of Christchurch, medical social worker, BARBARA JEANETTE THOMSON, of Wellington, married woman, DOROTHY GERTRUDE WINSTONE, of Auckland, married woman, and MAURICE DOMINIC MATICH, of Dargaville, medical practitioner:

GREETING:

WHEREAS by Our Warrant dated the 23rd day of June 1975, We constituted you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, and DOROTHY GERTRUDE WINSTONE, together with one GEOFFREY LEONARD BRINKMAN, of Hamilton, medical practitioner, to be a Commission to receive representations upon, inquire into, investigate, and report upon the matters relating to contraception, sterilisation, and abortion referred to therein:

And whereas by Our Warrant, dated the 12th day of September 1975, We reconstituted the said Commission by appointing you, the said MAURICE DOMINIC MATICH, to be a member of the said Commission in the stead of the said GEOFFREY LEONARD BRINKMAN:

And whereas you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, DOROTHY GERTRUDE WINSTONE, and MAURICE DOMINIC MATICH, the members of the said Commission as so reconstituted, were required by our Warrant, dated the 23rd day of June 1975, to report, not later than the 30th day of June 1976, your findings and opinions on the matters aforesaid, together with such recommendations as you thought fit to make in respect thereof:

And whereas by Our Warrant dated the 10th day of May 1976, the time within which you were so required to report was extended until the 30th day of September 1976:

And whereas it is expedient that the time for so reporting should be further extended as hereinafter provided:

Now, therefore, We do hereby extend until the 31st day of December 1976 the time within which you are so required to report, without prejudice to the liberty conferred on you by Our Said Warrant, dated the 23rd day of June 1975, to report your proceedings and findings from time to time if you should judge it expedient so to do:

And We do hereby confirm Our Said Warrant, dated the 23rd day of June 1975, and the Commission thereby constituted, save as modified by

Our Said Warrant dated the 12th day of September 1975 and by these presents:

And, lastly, it is hereby declared that these presents are issued under the authority of the Letters Patent of His Late Majesty King George the Fifth, dated the 11th day of May 1917, and under the authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued and the Seal of New Zealand to be hereunto affixed at Wellington this 27th day of July 1976.

Witness our Right Trusty and Well-beloved Sir Edward Denis Blundell, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of our Royal Victorian Order, Knight Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

EDWARD DENIS BLUNDELL, Governor-General,
by His Deputy, RICHARD WILD.

By His Excellency's Command—

FRANK GILL, Minister of Health.

Approved in Council—

P. G. MILLEN, Clerk of the Executive Council.

Further Extending the Time Within Which the Royal Commission on Contraception, Sterilisation, and Abortion May Report

---

ELIZABETH THE SECOND, by the Grace of God, Queen of New Zealand and Her Other Realms and Territories, Head of the Commonwealth, Defender of the Faith:

TO Our Trusty and Well-beloved the Honourable DUNCAN WALLACE MCMULLIN, a Judge of the Supreme Court of New Zealand, DENESE LETITIA HENARE, of Auckland, barrister and solicitor, MAURICE ROY MCGREGOR, of Christchurch, medical social worker, BARBARA JEANETTE THOMSON, of Wellington, married woman, DOROTHY GERTRUDE WINSTONE, of Auckland, married woman, and MAURICE DOMINIC MATICH, of Dargaville, medical practitioner:

GREETING:

WHEREAS by Our Warrant, dated the 23rd day of June 1975, We constituted you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON and DOROTHY GERTRUDE WINSTONE, together with one GEOFFREY LEONARD BRINKMAN, of Hamilton, medical practitioner, to be a Commission to receive representations upon, inquire into, investigate, and report upon the matters relating to contraception, sterilisation, and abortion referred to therein:

And whereas by Our Warrant, dated the 12th day of September 1975, We reconstituted the said Commission by appointing you, the said MAURICE DOMINIC MATICH, to be a member of the said Commission in the stead of the said GEOFFREY LEONARD BRINKMAN:

And whereas you the said DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, DOROTHY GERTRUDE WINSTONE, and MAURICE DOMINIC MATICH, the members of the said Commission as so reconstituted, were required by Our Warrant, dated the 23rd day of June 1975, to report, not later than the 30th day of June 1976, your findings and opinions on the matters aforesaid, together with such recommendations as you thought fit to make in respect thereof:

And whereas by Our Warrant dated the 10th day of May 1976, the time within which you were so required to report was extended until the 30th day of September 1976:

And whereas by Our Warrant dated the 27th day of July 1976, the time within which you were so required to report was further extended until the 31st day of December 1976:

And whereas it is expedient that the time for so reporting should be further extended as hereinafter provided:

Now, therefore, We do hereby extend until the 31st day of March 1977 the time within which you are so required to report, without prejudice to the liberty conferred on you by Our Said Warrant, dated the 23rd day of June 1975, to report your proceedings and findings from time to time if you should judge it expedient so to do:

And We do hereby confirm Our Said Warrant, dated the 23rd day of June 1975, and the Commission thereby constituted, save as modified by Our Said Warrant dated the 12th day of September 1975 and by these presents:

And, lastly, it is hereby declared that these presents are issued under the authority of the Letters Patent of His Late Majesty King George the Fifth, dated the 11th day of May 1917, and under the authority of and subject to the provisions of the Commissions of Inquiry Act 1908, and with the advice and consent of the Executive Council of New Zealand.

In witness whereof We have caused this Our Commission to be issued and the Seal of New Zealand to be hereunto affixed at Wellington this 20th day of December 1976.

Witness Our Right Trusty and Well-beloved Sir Edward Denis Blundell, Knight Grand Cross of Our Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of Our Royal Victorian Order, Knight Commander of Our Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

DENIS BLUNDELL, Governor-General.

By His Excellency's Command—

R. D. MULDOON, Prime Minister.

Approved in Council—

P. G. MILLEN, Clerk of the Executive Council.

Letter of Transmittal

To His Excellency Sir Edward Denis Blundell, Knight Grand Cross of the Most Distinguished Order of Saint Michael and Saint George, Knight Grand Cross of the Royal Victorian Order, Knight Commander of the Most Excellent Order of the British Empire, Governor-General and Commander-in-Chief in and over New Zealand.

MAY IT PLEASE YOUR EXCELLENCY

YOUR Excellency by Warrant dated 23 June 1975 appointed us the undersigned DUNCAN WALLACE MCMULLIN, DENESE LETITIA HENARE, MAURICE ROY MCGREGOR, BARBARA JEANETTE THOMSON, and DOROTHY GERTRUDE WINSTONE, to report under the terms of reference stated in the Warrant. GEOFFREY LEONARD BRINKMAN who was appointed by the same Warrant was unable to serve as a member of the Commission and, before our sittings commenced, asked to be relieved from the duty of doing so. By further Warrant dated 12 September 1975 Your Excellency appointed the undersigned MAURICE DOMINIC MATICH in his place.

We were originally required to present our report by 30 June 1976, but your Excellency has extended this date to 31 March 1977.

We now humbly submit our report for Your Excellency's consideration. Your Excellency will see that it is a unanimous report.

We have the honour to be
Your Excellency's most obedient servants,

D. W. MCMULLIN, Chairman.
DENESE L. HENARE, Member.
M. R. MCGREGOR, Member.
M. D. MATICH, Member.
B. J. THOMSON, Member.
DOROTHY G. WINSTONE, Member.

Dated at Auckland this 5th day of March 1977.

SUMMARY OF REPORT

Not the least of the difficulties facing the Commission was the presentation, in a report of reasonable size, of its views on the great mass of information submitted to or researched by it. There was a need, on the one hand, to deal adequately with the medical, scientific, psychiatric, and sociological material raised, not only in the submissions and evidence presented to us, but in the numerous articles and studies to which we were referred, and, on the other, to have regard to the desirability of producing a report that was acceptable in style and length to the many members of the public to whom the issues discussed in the report are of concern. In the various chapters of the report we have endeavoured to deal with the topics discussed in a manner that discharges the duty imposed on us by our terms of reference and, at the same time, provides a book which an interested reader will find not unattractive in style.

To ensure that the reading of the report is not interrupted by references to subject matter which, though of importance and interest, is of less relevance to the inquiry, we have placed some material, although original in content, in the appendices. Appendices 2 to 6 are in this category.

Although the report is not divided into parts, the chapters in it are grouped broadly into the three divisions of contraception, sterilisation, and abortion. Chapters 1 to 5 deal with contraception, chapters 6 to 8 relate to voluntary human sterilisation, chapters 9 to 25 deal with the issue of abortion, and chapter 31 with research on fetuses and fetal material. Chapters 26 to 30 are of more general application.

In chapter 1 we deal with the social and moral issues of contraception, mainly as they affect three groups—the family, the young and unmarried, and the intellectually handicapped.

In chapter 2 we discuss the legal issues raised by contraception. There are, in fact, only a very few provisions of the law bearing on this topic. One of them, however, is of particular importance. We have given it a great deal of consideration. It is the Police Offences Amendment Act 1954 which forbids the supply of contraceptives to persons under 16 and places restrictions on the giving of contraceptive advice to persons under that age. We make recommendations for its amendment.

Chapter 4 deals with the techniques of contraception and their mode of operation. There are those techniques which are regarded by some as contraceptive and by others as abortifacient. For the reasons which we fully discuss in the chapter, we are of the view that pregnancy, the state at which abortion is directed, commences at implantation, and that those techniques which operate to prevent conception or prevent implantation may properly be regarded as contraceptive and those that operate after implantation has occurred as abortifacient. Consistent with this view, we regard the "Morning-after Pill" and the I.U.D. as contraceptive in action, in that they do not interfere with implantation; the practice of menstrual

regulation, the intention of which is to remove from the womb the ova after implantation has occurred, we regard as abortifacient.

The final chapter relating to contraception is chapter 5 in which we examine ways and means of providing more effective services for family planning and contraception.

The social, moral, and legal issues arising from voluntary human sterilisation are discussed in chapters 6 and 7. The doubts which exist in some hospitals in New Zealand with regard to the legality of sterilisation performed for other than therapeutic reasons should be removed and the practice of sterilisation accepted as a means of family planning. We also discuss a number of other matters in these chapters, including the sterilisation of intellectually handicapped persons.

The provision of sterilisation services and criteria upon which sterilisations should be performed are discussed in chapter 8 where a number of recommendations are made.

Chapters 9 and 10 are devoted to a discussion of the law on abortion in New Zealand, its interpretation, its application, and its working. There are, as we there point out, differences of interpretation and application which follow from the uncertain state of the law at present. These have resulted in variations in practice from one district and one hospital to another.

Part and parcel of the working of the abortion law in New Zealand are the estimates of the number of New Zealand women who travel to Australia for abortion. We deal with these matters in chapter 11, and in chapter 12 we discuss the operation of the Auckland Medical Aid Trust, a matter which is also relevant to the working of the abortion law in New Zealand.

There is very little information available in New Zealand on the characteristics of women who seek abortion. Such information as is available has come mainly from the Auckland Medical Aid Centre. We refer to this information in chapter 13.

There are two matters at the heart of the abortion controversy. They are the status of the unborn child and the rights of the pregnant woman. We deal with these two matters in chapters 14 and 15. We are of the view that the unborn child has a status from the time of implantation when pregnancy commences and that this status, although not absolute, should receive protection from the law.

Chapter 16 relates to the morality of abortion, a matter which we are required to consider by our terms of reference.

Individual women who seek abortion do so for a number of reasons which, because of their recurrence in case after case, provide some indication of the factors relating to health, stress, or economic strain which lead women to seek a way out of unwanted pregnancy. These reasons are often referred to as "indications". In chapter 17 we classify, to the extent that they can be classified, the various indications for abortion—medical, psychiatric, socio-economic, fetal defects, rape, incest, and intellectual handicap. Some of these we accept as providing proper grounds for abortion, others we do not. In chapter 24, where we discuss legal policy and make recommendations on what the law should be, we set

out the indications which we think should be accepted as grounds for abortion.

Before any legal code can be formulated, there are other matters which require consideration, such as demographic issues, the particular attitudes of Maoris and Pacific Islanders who together comprise over 300,000 of the population, and polls and surveys which take account of public opinion. These we discuss in chapters 18, 19, and 20.

The techniques of abortion, which have an effect on the health and well-being of the woman and the medical and psychiatric sequelae of abortion, the consequences both to the woman concerned and to any child born to her if abortion is refused, are also of considerable importance. We consider them in chapters 21, 22, and 23.

Chapter 24 is an important chapter. In it we examine the place of the law in the area of abortion and the right of Parliament to intervene in what some say is a matter of a woman's choice. We discuss in this chapter the considerations to which we think any legal policy should have regard and set out in some detail the basis of a suggested legal code which aims to remove the doubts and uncertainties which at present exist in the law and to take account of the many other factors discussed in the report.

Chapter 25 is also of considerable importance because it deals with the means by which the legal code should be implemented and the abortion decision made. We recommend the setting up of a committee which is to have general oversight of the administration of the abortion law in this country. It has been our aim to ensure some uniformity of approach which has hitherto been lacking. The committee would help to attain this object. It would prescribe standards and give general supervision to the working of the abortion law. There is a need for adequate counselling services to be provided before any decision on abortion is made. The setting up of such services would also be the responsibility of the committee. Our recommendation is that the decision should be made by panels established by the statutory committee but, as an alternative, we recommend that the decision should be made by two doctors.

Chapters 26 to 30 are of general application to the issues of contraception, sterilisation, and abortion.

The effect of the recommendations which we make on health, hospital, and medical services is a matter which we discuss in chapter 30. We are unable to estimate the numbers of women who will apply for abortion in the future; nor can we say what percentage of them should be granted or refused an abortion. Whether or not a woman receives an abortion must depend on whether, in the individual circumstances of her case, the necessary criteria have been satisfied. If these are met she will be entitled to an abortion. It is, however, our expectation that if effect is given to all the recommendations made in our report on the matters of contraception, sterilisation, and abortion, the number of abortions performed in this country will be reduced.

Chapter 31 relates to fetal research.

A large number of women and men spoke to us of their personal experiences. What they said related to a variety of matters which do not form part of the general pattern of the report. We have decided to devote

appendix 1 to a consideration of these personal submissions rather than to include them in the report itself.

Many publications and reports which deal with abortion make reference to its place in ancient cultures and societies. Appendix 2 is a review of the extent to which abortion has been practised throughout history, the attitudes of ancient cultures to it, and the considerations which have influenced those attitudes.

Appendices 3, 4, and 5 relate to the abortion laws of the United Kingdom, the United States of America, and Australia. We have selected these countries because of similarities between their culture and our own. Moreover, there have been changes in the abortion laws of the United Kingdom and the United States of America in recent years. In South Australia, too, a more liberal legal code was adopted in 1970. The workings of the United Kingdom legislation and the South Australian legislation, on that account alone, are worthy of discussion.

In the Introduction we set out the reasons why we did not travel overseas. We have, however, at all times been aware of changes which have taken place in the legal codes of many countries throughout the world and have been at pains to ascertain the nature of these changes from authoritative sources. In appendix 6 we set out the abortion laws of many countries in a number of continents.

At the end of each chapter we set out the recommendations which we make in regard to the matters discussed in it. For convenience of reference we have gathered all our recommendations together and set them out immediately following this summary.

To assist the reader we have included a comprehensive bibliography and a glossary of technical terms used in the report.

SUMMARY OF RECOMMENDATIONS APPEARING IN THE REPORT

Chapter 2

CONTRACEPTION: LEGAL ISSUES

1. That section 2(1)(a) of the Police Offences Amendment Act 1954 be amended to exempt from the prohibitions of the subsection certain classes of persons including parents, medical practitioners, accredited representatives of family planning clinics, and other responsible agencies or groups to be named in regulations to be made under the Act.

2. That section 2(1)(b) of the Police Offences Amendment Act 1954 be repealed and replaced by a provision making it an offence:

(1) To direct or persuade or attempt to direct or persuade a child under 16 years of age to use a contraceptive except where such direction or persuasion or attempted direction or persuasion is given by a medical practitioner or other approved person.

(2) To give information or instruction in the use of contraceptives to a child under 16 years of age, except where:

(a) The person giving the information or instruction does so as part of any course on social relationships, biology, or human development approved by the Department of Education or Department of Health; or

(b) Where the person giving the information or instruction is approved by the principal or head teacher of any school.

3. That section 2(3) of the Police Offences Amendment Act 1954 be amended to exempt from the provisions of this subsection every child who procures or attempts to procure any contraceptive from any of the classes or persons defined in section 2(1) (a) as amended above.

4. That up-to-date, reliable, independent information on contraceptives and their use be produced in booklet form by the Department of Health and made available to the public free of charge by general practitioners and through various agencies such as family planning clinics and health clinics.

5. That factual, realistic, up-to-date films on sexually transmitted diseases be provided by the Department of Health and kept under constant review.

6. That parents and other persons having custody of intellectually handicapped women and girls be permitted to administer contraceptives to them and that no legal liability attach to them for such acts.

7. That the superintendent of an institution or any member of the staff directed by him be permitted to administer contraceptives to

intellectually handicapped women and girls as part of their treatment and that no legal liability attach to them for such acts.

8. That section 18(1) of the Food and Drug Act 1969 be amended to permit contraceptive spermicides to be sold with condoms through vending machines.

Chapter 3

HUMAN RELATIONSHIPS AND SEX EDUCATION

1. That courses in human development and relationships be provided in all schools.

2. That such courses aim at inculcating a sense of responsibility towards both the individual and the community, recognising the family as an essential feature of a stable community.

3. That programmes be suited to New Zealand conditions, and be kept as flexible as possible to cater for the special needs of particular areas and differing groups of people.

4. That sex education form a logical part of a carefully integrated programme on human relationships and not be treated as an isolated topic.

5. That basic programmes be prepared by the Department of Education in full consultation with Teachers' Colleges, teachers, and parents whose representatives should come from outside the ranks of the education services.

6. That highly qualified personnel be appointed as lecturers in human relationships in all Teachers' Colleges to:

(1) Conduct basic courses for all students.

(2) Assist with special in-service training courses for those teachers selected to teach human relationships in schools.

7. That regular refresher courses be held for teachers of programmes in human relationships.

8. That the selection of staff to undertake the programmes in human relationships be the responsibility of school principals.

Chapter 5

CONTRACEPTIVE SERVICES

1. That hospital boards be urged to set up family planning clinics if none already exist under their jurisdiction.

2. That all obstetric and gynaecological departments of hospitals give confidential family planning advice to patients attending these departments.

3. That grants be made by the Government to assist with the financing of natural family planning centres, and that increased financial assistance be provided by the Government in order to expand the services of family planning clinics.

4. That mobile family planning clinics be provided to ensure adequate services for rural areas.

5. That special home visiting family planning services be provided for Maori and Pacific Island families.

6. That social workers of the Maori and Pacific Island races be appointed to work with these ethnic groups and to discuss contraceptive practices with them.

7. That counselling services be available at family planning clinics for young people with social and psychological problems.

8. That adequately trained nurses be given responsibility for family planning care in order to release medical practitioners to give more specialised help to patients.

9. That free contraceptives be supplied where there is financial hardship or where there is an approved medical condition.

10. That, in cases of economic need, medical practitioners be permitted to authorise the supply of free contraceptives without reference to the Department of Health.

11. That the general medical services benefit be increased to enable initial contraceptive consultations to be provided free of cost to the patient.

12. That no duty be charged on any contraceptives, contraceptive devices, or pills, provided that they are regarded by the Department of Health as efficient and acceptable.

13. That, if condoms are manufactured in New Zealand, they be made to meet a standard specification no less stringent than that which obtains in the United Kingdom.

14. That all condoms imported from overseas be required to meet a standard equivalent to that required in the United Kingdom.

15. That medical practitioners unwilling to provide contraceptive services on conscientious grounds be required to advise patients requesting such services of their right to apply to another medical practitioner or family planning clinic.

Chapter 6

VOLUNTARY HUMAN STERILISATION: SOCIAL AND MORAL ISSUES

1. That in ante-natal clinics full opportunity be taken to discuss with multiparous women the possibility of sterilisation in the post-partum period. Such discussions should take place in the early stages of pregnancy and deal clearly with all the implications of sterilisation. If possible the woman's spouse or partner should take part.

2. That Polynesian social workers be attached to ante-natal clinics and that these social workers discuss with Pacific Island women the full implications of sterilisation where this is suggested.

3. That information regarding sterilisation, printed in the principal Polynesian languages, be freely available at ante-natal clinics.

Chapter 7
VOLUNTARY HUMAN STERILISATION: LEGAL ISSUES

1. That a clear statutory enactment be made declaring sterilisation of the male or female to be legal provided it is carried out with the consent of the patient.

2. That section 61 of the Crimes Act 1961 be amended by enacting a subsection in the following terms:

> Everyone is protected from criminal responsibility for performing with reasonable care and skill an operation of sterilisation of the male or female with the consent of the patient whether that operation is performed for therapeutic reasons or not.

3. That the Courts be vested with power to make an order for the sterilisation of an intellectually handicapped person.

4. That in the case of an application by a parent for the sterilisation of an intellectually handicapped person, to safeguard the interests of the handicapped person concerned, an appropriate certificate of reference must be forwarded by a medical practitioner, supported by reliable information assessing the social adjustment and intellectual capacity of the person concerned.

5. That if an application is not made by the parents of the intellectually handicapped person, it be permissible for the application for sterilisation to be initiated by the superintendent of any institution or home, a registered medical practitioner, or a social worker.

6. That the cost of instituting any such application to a court and the costs of the persons made party to the application, in the absence of any separate estate on the part of the person to be sterilised, be borne by the State, notwithstanding the result of the application.

Chapter 8
STERILISATION SERVICES

1. That decisions regarding sterilisation operations be taken entirely on medical grounds and not be influenced by considerations of cost.

2. That before an operation is embarked upon, both the person seeking sterilisation and the partner receive adequate counselling so that all the implications of the operation are clearly understood.

3. That wherever possible the partner be a party to the decision regarding sterilisation, but that the consent of the partner be not mandatory.

4. That booklets containing relevant information be provided for all patients after the initial interview.

5. That overnight stay facilities and out-patient services for sterilisation of both the male and female be established by public hospitals.

6. That medical practitioners unwilling to perform sterilisations on conscientious grounds be required to advise patients requesting sterilisations of their right to apply to another practitioner or a family planning clinic.

7. That the necessity for adequate counselling before sterilisation be recognised and that the use by medical practitioners of trained counsellors for this purpose be encouraged.

8. That, once the position regarding the legality of the operation has been clarified, insurance companies be asked to provide coverage for voluntary sterilisation operations.

9. That it be made illegal to offer mortgage finance or accommodation on condition that the applicant produce evidence of sterilisation or an undertaking to undergo sterilisation.

10. That those performing sterilisations be required to report each month on the number and type of sterilisations performed, the reasons for the operation, the age, marital status, race and number of children of each patient, whether the operation has been on a day-care or an in-patient basis, and whether it was post-partum.

Chapter 15

THE RIGHTS OF THE PREGNANT WOMAN

1. That, irrespective of the ultimate decision, a woman seeking an abortion be given, as of right, a careful, attentive, and sympathetic hearing by her doctor.

2. That requests for abortion be considered strictly on their merits and no conditions attached to decisions.

3. That the principle of protection of employment opportunities for pregnant women be supported.

4. That careful consideration be given to the following recommendations of the Select Committee on Women's Rights:

(1) That the Government:

(a) introduce legislation to provide for paid maternity leave for women with the objective of either (i) ratifying by legislative Act I.L.O. Convention 103 concerning maternity protection; or (ii) giving effect to the principles contained in the aforesaid convention, and

(b) consider the desirability of allowing for paid paternity leave in cases of family need.

(2) That the State Services Commission experiment in extending provisions for part-time work and job-sharing in a variety of fields in order to consider whether guidelines can be established for their future development.

(3) That the State Services Commission give early consideration to evolving methods of recruitment which provide for recognition of voluntary work as a job qualification in terms of the grading of women entering the Public Service after a period out of employment for family reasons during which time volunteer service has been actively engaged in.

5. That early pregnancy testing services and contraceptive advice and information be free of cost and be made widely available.

6. That opportunities always be made available for pregnant schoolgirls to continue their education.

7. That greater publicity be given to the various benefits and social agencies available to help unmarried mothers, including single mothers.

8. That counsellors be attached to all public hospitals, social welfare departments, health centres, and voluntary agencies to give contraceptive advice and to discuss the problems of the unmarried mother and the availability of benefit.

Chapter 18

DEMOGRAPHIC ISSUES

That separate statistical information be kept by the Department of Statistics, recording the births and deaths of Pacific Islanders.

Chapter 19

MAORIS AND PACIFIC ISLANDERS

That Maori and Pacific Island social and community workers be encouraged to participate in family planning courses to enable them to assist in hospitals, clinics, and health centres, particularly in areas where there is a concentration of Maori and Pacific Island groups.

Chapter 24

LEGAL POLICY: WHAT SHOULD THE LAW ON ABORTION BE?

1. That abortion and miscarriage be defined in any legal code as the premature expulsion of the fetus or embryo after implantation.

2. That the Crimes Act 1961 be amended by substituting for sections 183 and 184 a section providing that:

(1) Everyone shall be guilty of a crime who, with intent to procure the miscarriage of any woman or girl, whether she is with child or not:

(a) Unlawfully administers to, or causes to be taken by her, any poison or any drug or any noxious thing; or

(b) Unlawfully uses on her any instrument; or

(c) Unlawfully uses on her any means whatsoever, not being means to which (a) and (b) apply.

(2) It shall be unlawful to do any of the acts mentioned in paras. (a), (b), (c) of subsection (1) unless:

(a) The continuance of the pregnancy would result in serious danger to the life of the pregnant woman or girl, such danger not being the normal danger of childbirth itself; or

(b) The continuance of the pregnancy would result in serious danger to the physical or mental health of the woman or girl, such danger not being the normal danger of childbirth itself; or

(c) There is a substantial risk that if the pregnancy were not terminated and the child were to be born, it would have or suffer from such physical or mental abnormality as to be seriously handicapped; or

(d) The pregnancy is the result of sexual intercourse: (i) Which, if a charge were laid, would constitute the crime of incest as defined by section 130(1) of the Crimes Act 1961, or (ii) In such circumstances that, if a charge were laid, it would constitute a crime under section 131 (1) of the Crimes Act 1961; or

(e) The pregnancy is the result of sexual intercourse with a woman or girl who is, or was at the time of the intercourse, "severely subnormal" within the meaning of section 138(2) of the Crimes Act 1961.

(3) The woman or girl shall not be charged as a party to any offence against this section.

Appropriate amendments will be required to sections 185 and 186 to define the word "unlawfully".

3. That the penalty of imprisonment provided by section 185 of the Crimes Act 1961 (female procuring her own abortion) be replaced by a fine or lesser penalty.

4. That the extremes of age of a pregnant woman or girl, while not of themselves grounds for abortion, be regarded as factors to be taken into account when considering whether there is a danger to the physical or mental health of the woman or girl concerned and the extent of that danger.

5. (1) That pregnancy resulting from rape be not of itself a ground for abortion but that the plight of women and girls who are fearful of pregnancy following on rape be met by ensuring that either the "Morning-after Pill" or some form of intra-uterine device such as the "Copper-7" be made available to women and girls complaining of rape.

(2) That where women and girls make complaints of rape, it be mandatory for medical practitioners called by the police to examine them, either to provide the "Morning-after Pill", or, if requested, to fit an appropriate form of I.U.D., or, if they are unwilling to do this, to advise complainants that these methods of treatment are available and that they may, if they wish, obtain them from a medical practitioner of their choice or from a family planning clinic.

6. That socio-economic factors be not of themselves grounds for abortion.

7. That abortion be not carried out after 20 weeks' gestation, except:

(1) Where there is a substantial risk that the child would be born with a serious disability, whether physical or mental; or

(2) Where it is necessary to save the life of the pregnant woman or to prevent serious permanent injury to her physical or mental health.

8. That all abortions carried out after 12 weeks' gestation be carried out only in public or private hospitals where emergency services are available.

9. That, while every effort should be made in counselling before any application for abortion is considered to include both partners in discussions and to ascertain the wishes of the father of the child, his prior consent to abortion be not necessary if proper grounds for abortion are established.

10. That legislation be enacted to provide that the consent of a girl under the age of 20 years shall, notwithstanding the advice of her parents or guardian, have the same effect as if she were of full age, provided that grounds for legal abortion exist, and that, conversely, no abortion shall be carried out on any girl under the age of 20 years without her consent.

11. That the burden of proof in prosecutions against persons charged with carrying out abortions unlawfully remain on the prosecution.

12. That the use of the technique known as "menstrual regulation", "menstrual aspiration", or "menstrual extraction" as a contraceptive technique be discouraged.

Chapter 25
WHO DECIDES?

1. That a committee, referred to as the "statutory committee", be established in New Zealand to discharge the following functions:

(1) The oversight of the working of the abortion laws throughout New Zealand.

(2) The licensing of public and private hospitals and other institutions to carry out abortions.

(3) Ensuring that institutions where abortions are performed have adequate facilities.

(4) Ensuring that staff in such institutions are competent.

(5) Ensuring that adequate facilities exist for the counselling of women before and after abortion decisions are taken.

(6) The collecting of data on the characteristics of women aborted. Classifications would be made giving details of age, marital status, period at which the abortion was carried out, race, number of children, place of residence, grounds for abortion, technique used, place where carried out, and complication rates. Where abortion is refused it will be necessary to record the numbers involved and the grounds for refusal.

(7) The review of the process of decision-making, whether it be by panel or otherwise.

(8) The laying down of standards for the facilities in institutions where abortions are performed.

(9) The setting of maximum fees payable for abortion in private institutions.

(10) The maintenance of consistent standards in the interpretation and administration of the abortion laws.

(11) Advising the Minister of Health and hospital boards on the establishment of clinics and centres for contraceptive and sterilisation services.

(12) Reporting to Parliament on the working of the abortion code.

2. That the carrying out of abortions be permitted in public and private hospitals and day clinics, provided however that abortions performed later than the first trimester be carried out in public and private hospitals only.

3. That provision be made for the regular inspection of hospitals and clinics where abortions are to be carried out to ensure that adequate facilities, equipment, and staff are available and that adequate arrangements have been made with base hospitals for the treatment of complications, if and when they arise.

4. (1) That all public hospitals with full and approved facilities be licensed to carry out abortions and that such private hospitals as have full surgical facilities also be licensed if they desire it.

(2) That the licensing of day clinics in particular areas be dependent, not only on whether they are able to offer satisfactory surgical and medical care, but on whether there is a need for clinics in those areas.

5. That before any decision is made on abortion, the patient be given independent and objective counselling separate from the institution in which abortions are performed and that such counselling be carried out at a counselling service established by the statutory committee or by some counselling agency approved by the statutory committee.

6. That in order to ensure the uniform, impartial, and efficient working of the abortion laws, panels be established under the jurisdiction and oversight of the statutory committee to decide, after considering all relevant information, whether the abortion sought is justified within the law.

7. That such panels consist of three members, two of whom are medical practitioners and the other a social worker, and that the social worker, while not being entitled to vote on any abortion decision, have the right to be present at all meetings of the panel.

8. That, before any decision on abortion is made, the panel have regard to:

(1) A statement from the woman's general practitioner or specialist of the reasons for requesting abortion.

(2) Any further medical reports.

(3) Advice that the woman has been adequately counselled.

9. That, if the application for abortion is granted, the panel refer the woman without delay to the hospital or clinic where she desires the abortion to be performed.

10. That, if the application for abortion is refused, regard be had to the desirability of the counsellor making arrangements for further counselling to be given to the woman and referring her to appropriate supporting services.

11. That it be the duty of each panel to keep full records and to report regularly to the statutory committee on all requests for termination of

pregnancy, all requests which have been granted, the grounds on which they have been granted, together with relevant personal details and any other information which the statutory committee may require.

12. That it be regarded as essential to the working of such a system that particular attention be given to:

(1) The treatment of the patient with care, courtesy, and consideration.

(2) The adequate counselling of the patient.

(3) Speedy assessment of each case.

(4) Prompt referral to hospital or clinic, or supportive services.

13. That in the establishment and operation of a counselling service it be noted that:

(1) Such a service can well be conducted in the same building in which the assessment panel conducts its sittings.

(2) The counselling service should be directed by an experienced, professionally trained social worker who may be a member of the panel.

(3) Counsellors should be thoroughly familiar with all social services and alternatives to abortion such as adoption and solo parenthood.

(4) Where there are no trained counsellors available in a particular area, agencies may be approved to carry out the counselling service.

(5) Consideration should be given to the employment of trained lay counsellors where professional counsellors are not available.

(6) The State should pay for the cost both of the counselling of the pregnant woman and of the assessment by the panel.

(7) The counsellor should be the first person to see the applicant after referral by the medical practitioner to the panel and should obtain her relevant history and counsel her.

(8) The counsellor should be trained to give contraceptive advice. Alternatively, nurses or para-medical staff should be available to do so.

14. That any abortion carried out in a public hospital be free of charge to the patient. If a woman does not wish to have an abortion carried out in a public hospital, the cost should fall on her, as is the case with any other medical treatment, subject to the receipt by the hospital of the customary hospital subsidy.

15. That charitable trusts be permitted to carry out abortions at a direct charge to the patient and that such trusts operating within the abortion area be treated no differently in the matter of tax relief from charitable trusts operating in other areas of business.

16. That the State have the right, on the advice of the statutory committee, to fix maximum fees for abortions.

17. That, as an alternative to the system of decision-making by panels, the decision be made by two doctors under the general framework and supervision of the statutory committee, and that such decision then be made only after the pregnant woman has been

counselled at the counselling service established by the statutory committee or at one approved by it.

In the event of the adoption of this alternative, the two medical practitioners, if they are in private practice, should not be partners; one should not be employed as the assistant of the other or be employed or share a financial interest in the same nursing home or agency; one of them should be of at least 5 years' standing.

18. That the requirement that no abortion shall be performed unless and until a decision to that effect has been made by a panel or two doctors, as the case may be, be waived where one medical practitioner is of the opinion, formed in good faith, that the termination is immediately necessary to save the life of the mother or to prevent grave permanent injury to her physical or mental health.

Chapter 26

SUPPORTIVE SERVICES FOR WOMEN AND FAMILIES

1. That hospital boards expand their existing social services for women attending ante-natal clinics or being treated in women's hospitals.

2. That the professional status of social workers as part of professional teams in women's hospitals be recognised.

3. That church and other social agencies be encouraged, with government financial support, to offer more comprehensive counselling and case work services for mothers and families.

4. That the number of social workers in the Department of Social Welfare be increased so that more will be available to work with mothers and families.

5. That, within all penal and reform institutions dealing with young offenders, provision be made, in terms of the wider recommendations made in chapter 2, for the giving to inmates of contraceptive counselling, and education in matters of human development.

6. That social workers with special training and experience in the field of adoption be available to help with the selection of adopting parents and to assist the mother of the child through the stress of placement.

7. That in order to ensure a closer liaison within existing welfare services, and to ensure the dissemination of information and the better co-ordination of such services, there be regular consultations between government departments and voluntary agencies working in the field of child and maternal welfare.

Chapter 28

THE CONSCIENCE CLAUSE

1. That no medical, surgical, nursing, or para-medical personnel (whether or not self-employed) be under an obligation to assist at, or participate in, any abortion, or sterilisation, or the fitting of any

contraceptive device, or the supply of any contraceptive, or the giving of any contraceptive advice if that person has a conscientious objection based on religious, ethical, or other ground.

2. That no law be enacted or practice established which would make housing, accommodation, the holding of office, or the enjoyment of any benefit dependent upon the participation of any medical, surgical, nursing, or para-medical personnel in any abortion, or sterilisation, or in the fitting of any contraceptive device, or in the supply of any contraceptive, or in the giving of any contraceptive advice.

3. That medical, surgical, nursing, and para-medical personnel holding a conscientious objection be not required to participate in any panel considering applications for abortion.

4. That in public hospitals the obligation of any medical, surgical, nursing, or para-medical personnel to participate in an abortion or sterilisation be not a condition of employment.

5. That a medical practitioner who has conscientious objections to giving advice on contraception or sterilisation advise patients accordingly and refer them to another practitioner or agency.

Chapter 29

EDUCATION OF MEDICAL PERSONNEL

1. That recognition be given by medical schools, medical associations and groups, hospital boards, and medical practitioners to the need to instruct medical students adequately in matters of family planning.

2. That regular refresher courses in developments in contraceptive techniques be provided for medical practitioners and that they be encouraged and assisted to participate in them.

Chapter 30

EFFECTS OF RECOMMENDED CHANGES ON HEALTH, HOSPITAL, AND MEDICAL SERVICES

That adequate finance be made available to the appropriate government departments, including those of Health, Social Welfare, and Education to ensure the ready implementation of recommendations made in this report.

Chapter 31

FETAL RESEARCH

That the Department of Health bring to the notice of all universities, medical associations and groups, and medical practitioners in New Zealand the recommendations made by the Advisory Group (U.K.) in their report entitled *The Use of Fetuses and Fetal Material for Research* and urge its adoption by them.

INTRODUCTION

SCOPE OF INQUIRY

The Warrant constituting the Royal Commission sets out the various matters to which we are to have regard in making this report. The terms of reference are comprehensive, requiring us to examine the subjects of contraception, sterilisation, and abortion. According to evidence which we heard from a witness from the United States of America, who had made a study of abortion legislation and practice throughout the world, this is the first time in which a commission or committee of inquiry in any country has been specifically directed to take account of all of the three subjects—contraception, sterilisation, and abortion, each one of which has profound physical, moral, social, and psychological implications both for the individual and for society.

HISTORY OF ABORTION INQUIRIES IN NEW ZEALAND

The Maternal Mortality Report, 1921

In 1921, a special committee was set up by the Board of Health to consider and report on the question of the deaths of mothers in connection with childbirth. In a brief report, which is printed as Appendix 7, the committee expressed concern about the "abnormally high death rate due to septic conditions following on attempts to procure abortion."

The McMillan Report, 1937

As far as we have been able to ascertain, the only substantial inquiry hitherto made into any of these topics was that made into abortion in New Zealand in 1936, when a special committee was set up by Cabinet with the following order of reference:

> 1. To inquire into and report upon the incidence of abortion in New Zealand, including:
> (1) The incidence among married and single women:
> (2) Whether the rate of incidence has increased during recent years:
> (3) How New Zealand compared with other countries in this respect.
> 2. To inquire into and report upon the underlying causes for occurrence of abortion in New Zealand, including medical, economic, social and any other factors.
> 3. To advise as to the best means of combating and preventing the occurrence of abortion in New Zealand.
> 4. Generally to make any other observations or recommendations that appear appropriate to the committee on the subject.

The committee, under the chairmanship of the late Dr D. G. McMillan, heard evidence from the British Medical Association, obstetricians and gynaecologists, and individuals. In its findings, which became known as

the McMillan Report, the committee stated that it was quite unable to assess the incidence of abortion with complete accuracy but reached the conclusions:

1. That abortion was "exceedingly frequent" in New Zealand.
2. That, as far as it could judge from the evidence, about one in every five pregnancies ended in abortion, and that some 6,000 abortions occurred in New Zealand every year. Of these, it was believed that 4,000, at a conservative estimate, were criminally induced either through the agency of criminal abortionists or by self-induction.
3. That, according to comparative international statistics then available, New Zealand had one of the highest death rates from abortion in the world, such deaths accounting for one quarter of the total maternity mortality for New Zealand. Women dying from sepsis following abortion numbered 176 during the five year period 1931 to 1935.
4. That the main causes for resort to abortion were economic and domestic hardship, changes in social and moral outlook, pregnancy amongst the unmarried and, in a small proportion of cases, fear of childbirth.

In an endeavour to remedy these causes, the committee made recommendations for financial, domestic, and obstetrical help by the State; it recommended that the young be educated in matters of sex, that the advertising and sale of contraceptives to the young be prohibited, and that society take a more tolerant attitude towards unmarried girls and their children. No changes to the law on abortion were recommended.

A Select Committee, 1946

In 1946, a Select Committee of Parliament, referred to as the "Dominion Population Committee", again considered the subject of abortion. By this time a number of the recommendations of the McMillan Committee had been put into effect, namely, the introduction of increased family allowances, maternity benefits and a home aid service, and the institution of an educational programme by the Department of Health. The 1946 committee generally endorsed the report and conclusions of the McMillan Committee and again did not recommend any alteration to the law. The Select Committee found it difficult, from the evidence submitted, to assess the actual extent of abortion, but said that there was general agreement that, despite strenuous endeavours to check the crime of abortion, it still continued to be a "serious evil."

The Crimes Act 1961

The law on abortion was again considered when the Bill, which subsequently became the Crimes Act 1961, was before Parliament. The New Zealand branch of the body, then known as the British Medical Association, made submissions to the Statutes Revision Committee, advancing the view that any provision to legalise therapeutic abortion in specific terms was unnecessary. Further, it could see no reason to make provision for abortion for social or economic reasons, nor for pregnancies resulting from rape or unlawful sexual intercourse. It did, however,

suggest the codification, within the statute, of the defence recognised in the case of *R. v. Bourne* [1939] 1 K.B.687; [1938] 3 All ER615. We will refer to this case at some length in Chapter 9, in which we deal with the law on abortion. The Statutes Revision Committee did not accede to the suggestion for codification and the law remained as it was.

The Abortion Act 1967 (U.K.)

In 1967 the Abortion Act was passed in England. It effected substantial changes to the law on abortion in the United Kingdom (except Northern Ireland.) It is not surprising that the passing of this Act should have attracted some attention in this country and that the enactment of similar legislation here should have been raised.

Parliamentary Question 1967

On 9 November 1967, the then Minister of Justice, the Hon. J. R. Hanan, was asked in the House of Representatives whether he had any plans for introducing legislation to legalise abortion in New Zealand. The Minister said that he did not consider that the time was ripe for legislation on the subject. On being asked whether he was prepared to set up a committee to examine the British legislation and legislation passed in certain American States, the Minister said that he agreed that after the legislation had been in force in the United Kingdom for some time, the results might well be considered by an expert committee in New Zealand. Nothing further seems to have been said in the House upon the matter at that time and, so far as we are aware, it was allowed to rest until 1975 when events to which we will refer caused it to be raised again.

HISTORY OF ABORTION INQUIRIES OVERSEAS

The Lane Committee

The passing of the Abortion Act 1967 (U.K.) was an event of great significance in the debate on abortion. Although the Act permits abortion on liberal grounds, it does not in express terms allow of abortion on demand. A committee, with the Hon. Mrs Justice Lane as chairman, was set up in 1971 to consider the Abortion Act of 1967 and to report on its working. In due course the committee submitted its findings to Parliament in a document now known as the Lane Report. The terms of reference of the Lane Committee were limited and were restricted to a review of the operation of the Abortion Act 1967 on the basis that the statute should remain unaltered. We will refer to the Lane Report from time to time in this report and in Appendix 3. We also examine the English legislation, its operation and some of the troubles with which the administration of it has been beset.

South Australian Legislation

In 1969 the South Australian Parliament passed the Criminal Law Consolidation Act Amendment Act, which liberalised the abortion law in the State of South Australia. In Appendix 5 we examine the South Australian legislation and its working. We have corresponded with Sir

Leonard Mallen, the Chairman of a special statutory committee set up to supervise the working of the abortion law of South Australia. He has made available to us the Annual Reports which that committee is required to make to the Government of South Australia.

The United States Supreme Court Decision

In 1973 the members of the Supreme Court of the United States of America delivered their judgments in the case of *Roe v. Wade*, holding that no state had the right to prohibit any woman from obtaining an abortion in the first trimester of pregnancy. In Appendix 4, we examine these judgments in greater detail.

The changes referred to in the United Kingdom legislation and the South Australian legislation and the United States Supreme Court judgments have given impetus to proposals for changes in the abortion law of New Zealand. Proponents of abortion law reform here have used the experience of these other countries as the basis for their proposals. However, the abortion debate extends beyond the countries mentioned. In France a new law was passed in 1974 and in Italy the controversy continues. The laws of other countries and their working are worthy of note as exercises in comparative jurisprudence. In Appendix 6 we set out the abortion laws of a number of other countries.

RECENT EVENTS IN NEW ZEALAND LEADING TO THE SETTING UP OF THE COMMISSION

An event of more immediate and dramatic significance was the establishment, in May 1974, of the Auckland Medical Aid Trust. In the same month, this organisation opened in Great South Road, Remuera, a centre for the carrying out of abortions. This became known as the Remuera Clinic. On 8 September 1975, as a result of the passing of the Hospitals Amendment Act 1975, it transferred its premises to the Aotea Private Hospital, Ranfurly Road, Epsom, performing the same services there which were formerly carried out at the clinic. We refer to the Auckland Medical Aid Trust in a separate chapter of this report.

On 14 September 1974, a search warrant was issued authorising the police to enter and search the premises of the clinic and to seize anything there which they had reasonable ground to believe would be evidence of the commission of the offence of abortion. On 16 September 1974 the warrant was executed and some 475 files were seized. These were all the files then at the clinic except for some 19 files which were in current use. The validity of the warrant was later tested in legal proceedings, and on 10 January 1975, the Court of Appeal of New Zealand made an order quashing the search warrant, broadly on the ground that it was too general in form. The seizure of the clinic's files received a great deal of publicity in the news media and much was subsequently said on the subject of the confidentiality of medical records and the law on abortion itself. Then, in December 1974, the police laid twelve informations charging Dr James Woolnough, a doctor employed by the Trust, with performing unlawful abortions on twelve women or girls. These charges resulted in Dr Woolnough being tried. We refer to the two trials of Dr

Woolnough in Chapter 9, where we discuss the law on abortion in New Zealand.

In 1975, Cabinet appointed a sub-committee of five to report on the appointment of a Royal Commission to investigate the matters of contraception, sterilisation, and abortion. On 23 June 1975 the members of this commission were appointed and the terms of reference stated.

PROCEDURE OF THE COMMISSION

Reporting Time

By the terms of our warrant we were required to report in writing not later than the thirtieth day of June 1976. However, the volume of submissions which we received made it necessary for us to apply for extensions of time beyond that date. Indeed, it was not until 22 June 1976 that we concluded our public sittings. Initially we applied for an extension until 31 December 1976. We were given an extension until 30 September 1976 only, but further extensions to 31 December 1976 and later to 31 March 1977 were subsequently granted.

Advertisements Calling for Submissions

It was always apparent to us that the matters into which we were directed to inquire were of such interest and so much in issue that it was likely that a large number of submissions would be made. By public notice published on 10 July 1975 in the daily newspapers circulating throughout New Zealand, repeated on 23 August 1975, we set out our terms of reference and invited interested persons and organisations to make representations or present evidence to the Commission on all or any of the matters which formed the subject of the inquiry. While not debarring oral submissions we let it be known that we favoured the making of submissions in writing. It was inevitable that some of those who were to make submissions to us would wish to do so in private so that their representations or evidence would remain confidential. In fact, the Commission heard a large number of women, and some men, in private. Some of those who elected to give evidence at public sittings of the Commission requested that their anonymity be preserved or asked that some restriction be placed upon the publication of certain parts of their evidence. We respected these requests and made any necessary orders to meet them. In addition, a great many organisations and individuals made written submissions to us but did not seek to present them in person at public hearings. The views which we have formed and the recommendations which we have made have been influenced by the confidential submissions and the submissions made in writing as well as by the submissions presented to us at public sittings.

In the public notice which invited the making of submissions, we fixed 19 September 1975 as being the date by which submissions should be forwarded to us but, as a result of further requests, we extended this date to 30 September 1975. In order that no one should be denied the opportunity of giving evidence on matters of such great public concern and interest, we willingly granted requests for further extensions of time where such action seemed reasonable.

First Sitting of Commission

On 10 September 1975, the Commission held its first public sitting in Wellington. On that occasion we heard what might be called "background" papers on the subjects under inquiry. At our request the Solicitor-General made submissions to us on the law as to contraception, sterilisation, and abortion in New Zealand. Dr C. M. Collins, Director of Public Health, tendered a background paper on behalf of the Department of Health, dealing with the subjects of contraception and sterilisation, and Dr K. W. Cochrane, then of the Department of Health but now Superintendent of Wellington Hospital, tendered a background paper on abortion. Mr R. Te Punga, Assistant Director-General (Social Work), delivered a paper on behalf of the Department of Social Welfare. At that sitting, counsel who were to represent various organisations announced their appearance, as did representatives of other organisations which were interested in the work of the Commission.

Confidentiality of Private Submissions

Opportunity was taken at that first sitting to state and discuss the procedures which the Commission would follow. One matter in particular should be mentioned. We were asked to grant to witnesses appearing before the Commission immunity from prosecution for any offences which evidence to be tendered might suggest had been committed by them. We expressed the view that we had no power to grant any such immunity. The terms of our warrant confer no such power and it is doubtful whether, under the terms of the Letters Patent granted to Governors-General on 11 May 1917 and the Royal Instructions of that date, such a general power of immunity can be conferred. However, the position of such witnesses was protected in two ways. First, any witness who was likely to give evidence of participation in an illegal act was invited to speak to the Commission, and the Commission only, in private. Secondly, the Attorney-General, on 10 October 1975, made a statement to the news media that he would give consideration to entering a stay of proceedings which would effectively grant immunity from prosecution to any witness who had evidence to give which was relevant to the matters being considered by the Commission, but which might incriminate him or her. We have no doubt that members of the public felt able to share with us, in confidence, the experiences which they had undergone, and that they were in no way inhibited from doing so through fear of legal proceedings.

Public Sittings

Apart from those occasions when the Commission sat in private to hear submissions or evidence which individuals or organisations wished to give in confidence, all hearings were conducted in public. The Commission allowed any individual or organisation who wished to do so to be represented by counsel. In fact, three organisations which made extensive submissions and called a number of witnesses were represented by counsel. These were the Abortion Law Reform Association, the Guild of St. Luke, Ss. Cosmas and Damian, and the Society for the Protection of the Unborn Child. Other individuals and organisations were, from time to

time, represented by counsel, but the great majority of those who appeared before us did so without assistance of that kind. Before any public hearings took place, Mr H. T. D. Knight of Auckland was appointed as counsel to assist the Commission. At the earlier hearings of the Commission and indeed in all of the hearings which took place in 1975, Mr Knight attended at our request and assisted a number of individuals and organisations who were making submissions or who wished to ask questions of other witnesses who were giving evidence. As it happened, with the progress of the Commission, there was not such a call on Mr Knight's services as we had originally expected, and at later sittings we did not find it necessary to seek his assistance.

Cross-examination of Witnesses

At all sittings of the Commission at which they were present, counsel were allowed to cross-examine those witnesses who were regarded as expert or who represented organisations, and we record our indebtedness to them for the help which they thereby gave us. We also allowed those individuals or organisations who had declared their interest in the inquiry by themselves making submissions in writing, to ask questions of other witnesses. While, for the most part, this right was not exercised, there were times when interested persons cross-examined witnesses themselves. We did not, however, permit cross-examination of witnesses who were expressing some personal view or conviction and not speaking as experts or on behalf of an organisation.

Public Sittings Throughout New Zealand

We have mentioned that our first public sitting was held in Wellington on 10 September 1975. We concluded our public hearings with our last sitting in Auckland on 22 June 1976. Between those dates the Commission conducted public hearings over 79 days in Auckland, Wellington, Christchurch, and Dunedin and heard 317 separate submissions and 379 witnesses. In Appendix 11 we set out the names of those organisations and individuals who made submissions to us and the names of the witnesses who were called to give evidence. We have, of course, made no mention of the names of those who made written submissions to us but asked that they be treated as confidential. Nor do we mention by name those who spoke to us in confidence.

The debate before us for major abortion law reform in New Zealand has largely been carried by the Abortion Law Reform Association and that against such reform by the Society for the Protection of the Unborn Child and the Guild of St. Luke, Ss. Cosmas and Damian. There were, however, many other organisations and individuals who, in giving evidence before us, expressed views for and against abortion law reform and it is not to be thought that the Commission has arrived at its conclusions on the basis of the acceptance of the views of one of these larger groups to the exclusion of any others. The Commission has acted upon the views which it has formed from all the submissions and all the evidence presented to it whether from organisations or individuals.

Reference to Medical, Scientific, Psychiatric and Sociological Studies

Some of the submissions were very long. One numbered nearly 500 pages. The submissions heard at public hearings and the notes of evidence covered 10,513 pages. We were referred to hundreds of articles and studies in books, journals, and periodicals covering medical, scientific, psychiatric, and sociological material. We have had regard to all these, recognising always the differences of culture and outlook existing in the various countries from which the articles and studies emanated. We were mindful, too, that in evaluating studies and surveys, care must always be taken to determine whether the author has done no more than to put his own construction on material available and has thereby sought to demonstrate the correctness of the proposition in which he implicitly believed before he undertook the study or survey.

Inquiries by the Commission

The terms of our warrant authorised us to make inquiries as well as to hear representations and evidence. We have availed ourselves of the opportunity to make our own inquiries on many matters. This we have done by interviewing a number of people and corresponding with many others.

Assessing of Overseas Experience

During the course of the hearing of the submissions and evidence, reference was frequently made to overseas experience, particularly in the field of abortion. There have, of course, been great changes in recent years in the abortion laws and practice in a number of countries, as is demonstrated by Appendix 6. We heard evidence from a number of witnesses from the United Kingdom, the United States, France, and Australia. These witnesses were able to speak, not only of their experience in their own countries, but also of knowledge gained in such places as Scandinavia, Africa, India, Bangladesh, Singapore, and the Pacific.

The Commission gave careful consideration to the advisability of travelling overseas to study the law and practice of other countries, particularly the United Kingdom, the United States of America, and Sweden, but we decided against this course. It seemed to us that it would be better to rely upon evidence as to the situation in those countries given at public hearings in which the position was fully canvassed before us. Had we travelled abroad our visits would of necessity have been brief, with our contact confined to a limited number of institutions and individuals. It might well have been thought that we had substituted hastily gained and somewhat superficial impressions for the well-researched views clearly set out for us in the evidence.

In the past it has also often been the custom for the chairman or a limited number of commissioners to travel overseas and to report back to other commissioners on the information gained. It seemed to us that, in the inquiry on which we were embarked, our report should be based on information which came to the knowledge of and made its impact on us all. In the result we are satisfied that we are as well able to reach

conclusions as to what we consider is right for New Zealand as if we had travelled overseas for what must inevitably have been a hurried visit to a number of places.

Publication of Submissions in Advance

The Commission from the outset asked that copies of the briefs of evidence be given to it in advance so that these could be available together with submissions already heard, at the Commission's offices in Auckland, and at the public libraries in Auckland, Wellington, Christchurch, and Dunedin, for perusal before the date of presentation by those who had an interest in their content. As well, copies were made available under embargo to the news media. Additional copies of all public submissions, copies of the notes of evidence given upon them and the cross-examination on that evidence were also sent to the public libraries mentioned above at the conclusion of each day's hearings. In this way interested persons and organisations were kept aware, not only of what was to be presented to the Commission, but of what was, in fact, finally said in evidence.

Publicity

It was inevitable from the nature of the inquiry that the news media would exhibit a great interest in our hearings. Recognising the interest of the public at large in the work of the Commission, we allowed television crews to film our proceedings and press reporters to attend. The news media as a whole were pleased to take advantage of these privileges, and the sittings of the Commission received a great deal of publicity which has sustained the great measure of public interest in our task. We are grateful to the news media for their co-operation and for their responsible handling of material provided to them in confidence.

QUALITY OF SUBMISSIONS

Throughout our sittings we were impressed again and again with the care and effort which had accompanied the preparation of submissions. Many of these were of an exceptionally high standard and represented months of work and years of study. They were well-documented, responsibly written, and demonstrated a great concern for the individual and for the community. We desire to record our grateful thanks to all those individuals and organisations who assisted in the preparation of submissions and to those who presented them to us. We would especially thank those who at our request provided us with additional information.

THE AUSTRALIAN COMMISSION ON HUMAN RELATIONSHIPS

We were made aware, at an early date, of the appointment in Australia of a Royal Commission on Human Relationships. It is the function of that Commission to inquire into and report, *inter alia*, upon the family, social, educational, legal, and sexual aspects of male and female relationships so far as these matters are relevant to the powers and functions of the Australian Parliament and Government. We have communicated with the chairman of the Commission and know something of the scope and nature

of its inquiries. We have also read a copy of its Interim Report. The terms of reference of the Australian Commission, while making no specific reference to contraception, sterilisation, and abortion, are much wider than our own. Indeed, it would seem that, because of the very breadth of their inquiries, it has been necessary for the Australian Commission to request a number of surveys and reports from other bodies. We have not found it necessary to do this although we have had a great deal of evidence from geneticists, embryologists, biologists, medical practitioners, psychologists, demographers, sociologists, and educationists, on matters which, while in some cases peripheral to our inquiries, are concerned with trends and attitudes in society on family, social, and educational matters. Where we think they have relevance, we refer to them in the report.

ACKNOWLEDGMENTS

We have already recorded our indebtedness to those who made submissions to us in public or private. We also record our indebtedness to those departments, organisations, and individuals who supplied us with information at our request. Necessarily we have had to direct many inquiries to the Director-General of Health and to his department. We have been assisted by the Solicitor-General, Mr R. C. Savage, Q.C., from whom we sought legal opinions, the Department of Social Welfare, the Department of Education, the Police Department, the Department of Maori Affairs, the Department of Justice, the Department of Trade and Industry, the Department of Statistics, the Department of Internal Affairs, the Department of Scientific and Industrial Research, the State Services Commission, the Government Printer and his staff, and the Department of Labour. We wish to make special mention of Mr F. H. Foster, Chief Health Statistician, Wellington. He and his staff, by re-arrangement of their work programme, have given us as much statistical information as can be made available on matters of health. Mr S. Kuzmicich, Assistant Government Statistician, has made the resources of the Department of Statistics available to us and has travelled to Auckland to discuss a number of matters of a statistical nature.

In keeping abreast of developments overseas, we have used the good offices of the Ministry of Foreign Affairs, the New Zealand High Commission, the United States Embassy, and many other Embassies and accredited representatives. They have met our many requests for information and we are grateful to them for their help.

The Medical Superintendent of National Women's Hospital, Auckland, and his staff have gone to some trouble to provide information, at our request, on the characteristics of women seeking abortions at that hospital. Professor G. C. Liggins has met with us at our request, and again and again has filled in gaps in our knowledge and kept us up to date with developments in contraceptive practice. The Chemists' Guild, the Pharmaceutical Society, and a major drug firm have given us information when required, relating to contraceptives and their usage. We extend our thanks to them all.

Our researchers and members of the Commission have necessarily had recourse to information available in the libraries. We express our thanks

to Mrs Elizabeth Darlow, Librarian, Law Society Library, Auckland, and to the librarian and staff of the Philson Library, Auckland Medical School, the Otago Medical School Library, the Victoria University Library, the University of Auckland Library, the Davis Law Library, Dr W. Neville, Department of Geography, University of Auckland, and the Auckland Public Library, for the help they have given us.

We are grateful to publishers, literary representatives, and writers for willingly permitting us to use material from books, pamphlets, articles, and studies.

We have been greatly assisted in our research on the law or on matters of a quasi-legal nature by Mr Robert S. Chambers, LL.B. (Hons.), Auckland, now a Commonwealth Scholar at New College, Oxford, and Mr. Colin Beaven, M.Com., LL.B. (Hons.), Auckland. Mr Chambers is a former Judge's Clerk at the Supreme Court, Auckland, and Mr Beaven now holds that office.

STAFF

Any organisation engaged in dealing with the public and anxious to ascertain the true measure of opinion on all matters relevant to its inquiry, must have an alert, well-organised, objective, and helpful secretariat and administration. We were fortunate at the outset in being able to obtain the services of Dr W. H. Cooper, a man of scholarship and administrative ability, as Secretary of the Commission. He developed a well-organised team of workers and ensured that sittings of the Commission proceeded smoothly. We are also grateful to other members of the staff of the Commission. Mr I. T. Bingham was Assistant Secretary of the Commission until he retired on 23 July 1976. Mr J. W. Young and Mrs D. Brook conducted the day-to-day affairs of the Commission with great efficiency, often working under intense pressure to cope with the continuous hearings and the great volume of evidence. Originally we had two Research Officers, Mr R. H. Shallcrass and Miss B. J. Trotter. Mr Shallcrass, who was stationed in Wellington, resigned at the end of 1975. The work of researching for the Commission was then carried on by Miss Trotter alone. She became a great storehouse of information and was able quickly to locate, when required, almost everything that had been said or written upon the subjects under inquiry.

A word of praise should be given to those who reported our hearings and produced the typewritten record of evidence. Miss H. McInally assisted us in the early stages of our hearings and Mrs K. Burns, Miss M. Coghill, Ms E. Edwards, and Miss D. Stinson were with us during many arduous months. Without demur, they sat through long sittings and often worked into the evenings to produce a record of the evidence given to us each day.

LEGISLATIVE CHANGES AND PROPOSED LEGISLATIVE CHANGES SINCE THE COMMISSION WAS ESTABLISHED

We have already referred to events leading to the establishment of the Commission. We now wish to refer to the Hospitals Amendment Act 1975, and the Health Amendment Bill 1976 — both of which were

introduced into the House of Representatives after the Warrant appointing the Commission had been signed.

The Hospitals Amendment Act Bill 1975, which later became the Hospitals Amendment Act 1975, was a private member's Bill. It duly became law and came into operation on 1 September 1975. The Act purported to limit the exculpatory provisions of section 182(2) of the Crimes Act 1961 (relating to the causing of the death of a child in good faith for the preservation of the life of the mother) to operations carried out in institutions under the control of a hospital board, or in any licensed hospital that might be approved by the Director-General of Health upon his being satisfied that it maintains or uses adequate and independent counselling services. The Act was the subject of a declaratory judgment delivered by Mr Justice Speight in the Supreme Court at Auckland on 24 September 1975 in the case of *The Auckland Medical Aid Trust v. Her Majesty's Attorney-General.* His Honour delivered a judgment which largely nullified the provisions of the statute which he described as an "ill-drafted piece of legislation."

In 1976, the Government introduced into the House the Health Amendment Bill 1976, the effect of which would have been to prohibit the performance of an abortion otherwise than in a public or licensed hospital following counselling of the patient and review of her case by committees established by hospital boards. We will not refer to the bill in detail because it did not become law, the House voting on the second reading on 2 September 1976 to defer consideration of it for twelve months, by which time this report will have become available for study. In view of the publicity which the bill received and some criticism which was directed at it, we think it right to say that we have at all times since our appointment regarded ourselves as separate and independent of Parliament or of the Government of the day. It is the function of the Commission to obtain information on a whole range of relevant issues which would not otherwise be obtainable, and to assess that information in an objective manner, independent of those who press for this view or that. It is the function of Parliament to legislate. It is not our right to tell Parliament what it must do, although we would hope to provide a background of dispassionate and informed advice on which legislation may properly be based. Nor is it the right of Parliament or of the Government to tell us how we should go about our task except to the extent that this is contained in our terms of reference. This much having been said to emphasize our complete and utter independence, we should record that at no time has any attempt been made by the Government in power at the time of our appointment or the present Government to impose any views upon us or to influence our thinking; nor has there been any suggestion to us that we were redundant or that the warrant might be revoked. For these reasons we have been able to pursue our task with the same measure of independence and objectivity which we would have employed had neither the Hospitals Amendment Act 1975 been passed, nor the Health Amendment Bill 1976 been introduced.

This report with its findings and recommendations is based on the evaluation which each one of us has made of the submissions which we

have received, the evidence we have heard, the inquiries we have made, and our assessment of the research material, articles, surveys, and studies to which we have had access. We have at all times been keenly aware of the depth and complexity of the human problems which have given rise to this inquiry. In the recommendations that we make, we have endeavoured to balance human needs and human distress with philosophy and scientific fact.

Chapter 1

CONTRACEPTION: SOCIAL AND MORAL ISSUES

TERMS OF REFERENCE

Our terms of reference require us to inquire into and report upon the legal, social, and moral issues that are raised by the law and practice relating to contraception in all commonly existing and likely forms. In Chapter 2 we deal with the legal issues. The present chapter is confined to a consideration of the social and moral issues involved.

DEFINITION OF "SOCIAL" AND "MORAL"

The terms "social" and "moral" pose problems of definition. To some, social and moral issues, if not indistinguishable, are inseparable. To others, their connotations are quite different. In some matters the dividing line between the two may be clear. In others it is not. The issues may sometimes merge but there is still a distinction between them. It is desirable, therefore, at the outset, to define what we understand by these terms.

Social Issues

A social issue is one which concerns the relationships between men and women living in society. In today's world, people live in communities, large and small, in dependence upon each other. These communities are concerned with the mode of life of the individuals in them, and the effect that life has, not only on the individuals themselves, but on the community as a whole. Issues which affect that mode of life are social issues. They are closely bound up with the survival and welfare of the community and the people within it, as expressed in their health, education, housing, and other standards of living.

Moral Issues

A moral issue is one which concerns right and wrong, and standards of behaviour. Every community has an interest in the standards of behaviour of its members, and there will be a general measure of acceptance within it of what is regarded as acceptable behaviour and what is not. Questions arising within a community as to what is right or wrong are moral issues.

Morality is often equated with religious teachings. Many believe that without religion there can be no morality and that without morality there can be no law. Undoubtedly many of our moral standards find their origin in religion and, notwithstanding the present day decline in religious

affiliations, the part played by religion in providing a basis for present day morality cannot be discounted. Standards of morality which were set in days of stricter religious observance still carry much weight with the community, but it would be unrealistic to relate morality solely to religion or to regard religion as the only source of morals. The morals of a community are the customs and conventions, whatever their origin, to which society, overtly or tacitly, gives its recognition. They are the patterns of behaviour to which society subscribes and by which people live together. They are dictated by the standards of care and responsibility which we accept for each other and for ourselves, and which ensure the ultimate preservation of society itself. Consequently, while it is accepted that morality is often related to religion, to regard it as founded on religion only would be putting too narrow a construction upon the matter.

A number of submissions were directed to us on the morality of contraception. There were those who, out of considerations of conscience or for religious reasons, argued that contraception was immoral even within the marriage relationship, in that it led to the brutalisation of sex, interfered with the process of generation, detracted from the place of the family as a unit in society, and encouraged sex outside a permanent, monogamous relationship. There were others, too, who for similar considerations, argued that artificial contraception was wrong, although they supported natural family planning. It should be said, however, that few, if any, of those who thought that contraception in any form was wrong, suggested that it ought to be made illegal. They conceded, however, that it was a matter of private morality in respect of which the State had no right or duty to legislate. For all that was said to the contrary, the attitudes of society can only be seen as supporting overwhelmingly the morality of contraception within the family group, regarding this as improving the environment for children and helping greatly to enhance the quality of the marriage relationship.

Social and Moral Issues Considered

The social and moral issues raised by the law and practice of contraception may differ as they affect one group in society or another. The submissions made to us have, in the main, been directed to the issues of contraception as they affect three separate groups:

The Family;
The Young and Unmarried;
The Intellectually Handicapped.
We propose to deal with each group separately.

The Family

Undoubtedly effective contraceptive practice on the part of parents can favourably affect the physical, mental, and economic welfare of all members of the family. There are many large families in which children are well cared for in a wholesome environment, but in all too many parts of the world the large family is unfortunately characterised by poor

nutrition, poor housing, overcrowding, and poor education. The report of the World Health Organisation on "Health Aspects of Family Planning" 1970 (W.H.O. Technical Series Report Series No. 442) stated:

> Human reproduction, and thus family planning, is very often associated with the social, economic, and cultural factors in the environment. For example, high parity is commonly associated with low socio-economic status, poor nutrition, poor hygiene, overcrowding, poor education, and resistance to change. These factors are all associated with each other, and in turn tend to be linked with premature or difficult labour, low birth weight, trauma and infection.

Intelligent family planning has been shown to be a major factor in improving the health of both the mother and of the family as a whole. It also has an important bearing on the family's financial circumstances and its quality of life.

The role of parents in these matters was recognised by the United Nations in the Proclamation of Teheran, adopted by the International Conference on Human Rights in Teheran at its 27th Primary Meeting on 13 May 1968. Article 16 of the Proclamation provides:

> The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of their children.

The evidence presented to us in no way conflicted with the spirit of these declarations. Time and again we heard of stable, happy families where parents had responsibly planned the number and spacing of their children. In contrast, we were told of pregnancies which occasioned stresses with which other families could at that time scarcely cope. In some cases women had turned to abortion; in others, the birth of the child had been the "last straw" in an already unstable marriage.

Little more need be said. Without doubt there is widespread acceptance by the community that, within the family and within the *de facto* relationships of a genuinely stable kind, the provision of effective contraceptives and understanding of their use are socially desirable. That the community accepts this is clear from the following:

1. There are no legal restraints on the provision of contraceptives for those 16 years of age and over. Any restraints,under the Food and Drug Act 1969, have been imposed with the object of protecting the consumer from misleading advertising.

2. The State itself provides a measure of financial assistance in family planning within New Zealand and a considerable amount of assistance for family planning overseas. The New Zealand Government supports the United Nations Fund for Population Activities (U.N.F.P.A.). It is also a member of the International Planned Parenthood Federation (I.P.P.F.). For the years 1971 to 1976, it granted sums of $25,000, $40,000, $200,000, $400,000, $700,000 and $600,000 respectively, to be divided between these two organisations. In 1975, it made a grant of $60,000 for the support of family planning in New Zealand. As the Hon. R. J. Tizard, Deputy Prime Minister at the time, explained in a letter dated 30 April 1975, the purpose of this assistance was to make contraceptive advice and services freely available to people who would otherwise not receive them, and to enable new clinics to be established

in areas of special need, to maintain existing services, and to produce pamphlets and educational material. This sum was increased in 1976 to $73,000.

3. While we were not able to obtain accurate figures as to the measure of use of specific kinds of contraceptives, we were informed by the Department of Health that there was a substantial use of both hormonal and mechanical contraceptives in New Zealand. It was estimated that in 1974, 2,316,200 cycle packs of contraceptive pills were used in New Zealand and that approximately 20,000 women received injections of the contraceptive hormone Depo-Provera. In 1973, it was estimated that 22,000 intra-uterine devices (I.U.D.s) were in use. A year later it was estimated that the number increased to 30,000. Information obtained by us from Intercontinental Medical Statistics indicates that, based on the measure of purchases by retail pharmacies in various countries, New Zealand women between the ages of 15 and 45 years, have the second highest rate of usage of contraceptive pills in the world. The percentages of women in that age group using the pill in 1975 were:

Holland	...	44.4
New Zealand	...	35.3
Sweden	...	31.4
Australia	...	30.8
Germany	...	30.8
Belgium	...	27.0
Austria	...	23.0
Switzerland	...	22.4
France...	...	21.2
United States	...	19.3
United Kingdom		18.9

The only information that we have for the use of condoms is that in 1971, the last year for which we have information, 800,000 packs (three per pack) were sold.

4. A family growth survey conducted by the Department of Health in the Hutt Valley in 1975, aimed at finding out about women's pregnancy histories and their preference for the number, sex, and spacing of their children. This showed that women who participated in this survey had a comprehensive knowledge of contraceptives, and, in particular, of the pill. Those conducting the survey concluded that knowledge of contraception was so widespread that non-use appeared to reflect differing attitudes to the timing and number of births rather than ignorance of the availability of different forms of contraceptives. This study provides an insight into contraceptive practice in a limited area and we hope that the department will in future conduct studies of a more comprehensive kind.

It would be hard to deny that effective contraception, which will enable couples to plan their families wisely, is socially desirable and that the State has an interest in helping its citizens to achieve this end.

The Young and Unmarried

Whatever may be said about the social desirability and the morality of contraception within the family, different considerations must be taken into account in considering the social and moral issues involved in contraception in the young. Indeed, these were recognised by Parliament in enacting the Police Offences Amendment Act 1954 to which we make separate reference in Chapter 2 where we deal with the law on contraception and discuss the reasons which moved Parliament at that time to legislate against the provision of contraceptives for children under 16 years of age.

Our attention was repeatedly drawn to the increase in this country in the number of ex-nuptial births, particularly to girls under 16 years of age, during the past ten years. This increase has already been made the subject of research by the Department of Social Welfare and the topic has been discussed in a Social Welfare Research Monograph entitled *Ex-nuptial Children and Their Parents* (1976). It is not our intention to make any independent survey of the situation but we refer in this report to certain basic material which has been assembled in the monograph, and to additional data, not yet published, which we have obtained from the Departments of Statistics and Social Welfare.

The Ex-nuptial Birthrate in New Zealand

There are a number of factors which influence the level of ex-nuptial births. Changes in the composition of the population in terms of age and race structure may influence the level considerably, as may the marital status of the women of child-bearing age. Again, a shift in the attitudes of the population to formal marriage may influence the level, in that children born to stable relationships where there has been no formal marriage will, notwithstanding the stability of the relationship, be classed as "ex-nuptial".

For the purpose of this discussion, we accept the definition of "ex-nuptial" adopted by the Registrar-General of Births, Deaths, and Marriages, in the compilation of birth statistics. Using this classification, a birth is deemed to have been ex-nuptial if the mother and father of the child were not married to each other at the time of conception and had not married each other between the time of conception and the time of birth. Stated in those terms, the definition may have some imperfections but, for our purposes, it will suffice. Various statistical methods may be used to measure the incidence and characteristics of ex-nuptial births. The three most commonly used are:

1. The absolute number of live ex-nuptial births.

2. The number of live ex-nuptial births expressed as a percentage of all live births (nuptial and ex-nuptial). This measure is referred to as the "illegitimacy ratio."

3. The number of live ex-nuptial births expressed as a rate per 1000 single, widowed, and divorced women in a specified age range and within a specified population. This measure is usually referred to as the "illegitimacy rate".

Table 1 shows the incidence of ex-nuptial live births between 1962 and 1975 as measured by the absolute number of live births, the illegitimacy ratio, and the illegitimacy rate.

Table 1—Measures of Illegitimacy: 1962 to 1975

Year	Ex-nuptial Live Births	Illegitimacy Ratio	Illegitimacy Rate
		%	
1962	5,227	8.04	33.6
1963	5,680	8.80	35.2
1964	6,154	9.88	36.8
1965	6,531	10.88	37.8
1966	6,940	11.57	38.8
1967	7,765	12.72	42.9
1968	8,060	12.98	44.0
1969	8,105	13.00	43.8
1970	8,276	13.34	44.2
1971	8,981	13.93	47.4
1972	9,394	14.86	48.1
1973	9,206	15.16	45.7
1974	9,370	15.79	45.0
1975	9,407	16.61	44.0

1. Sources: Numbers of births and the illegitimacy ratio for 1964 to 1974 were extracted from *Monthly Abstract of Statistics*, July 1975; for 1962 and 1963 the information was obtained from the Department of Statistics.

2. The rates presented here are based on all ex-nuptial births as a rate per 1,000 single, widowed, and divorced women aged 15 to 44 years. The estimates of numbers of single, widowed, and divorced women aged 15 to 44 years for the intercensal years were calculated by linear interpolation of the appropriate populations from census results. The population estimates for the years since the last census (1971) were calculated by assuming that the proportion of all women aged 15 to 44 years who were single, widowed, or divorced has remained constant since 1971, and by applying this proportion to age specific population estimates provided by the Department of Statistics.

3. Note that the illegitimacy rates presented in this table differ from those presented in *Vital Statistics*. The differences arise because the rates are based on slightly different populations in that *Vital Statistics* include legally separated women in the population on which the rates are based; because the method of estimating populations in intercensal years in this table differs from that adopted in *Vital Statistics*; because the rates on this table are based on the population aged 15 to 44 years while those in *Vital Statistics* are based on the population aged 16 to 44 years.

The problem of ex-nuptial conceptions is not new. Table 2 gives the illegitimate births and total births within one year after marriage in New Zealand between 1913 and 1921, a period referred to in the report of the Committee of the Board of Health in 1922 on *Venereal Diseases in New Zealand* to which we were referred on another aspect of our inquiries. Ex-nuptial births were then called "illegitimate" births, but, as we have explained, the terms are interchangeable.

Table 2—Illegitimate Births, and Births Within One Year After Marriage, in New Zealand, 1913–21

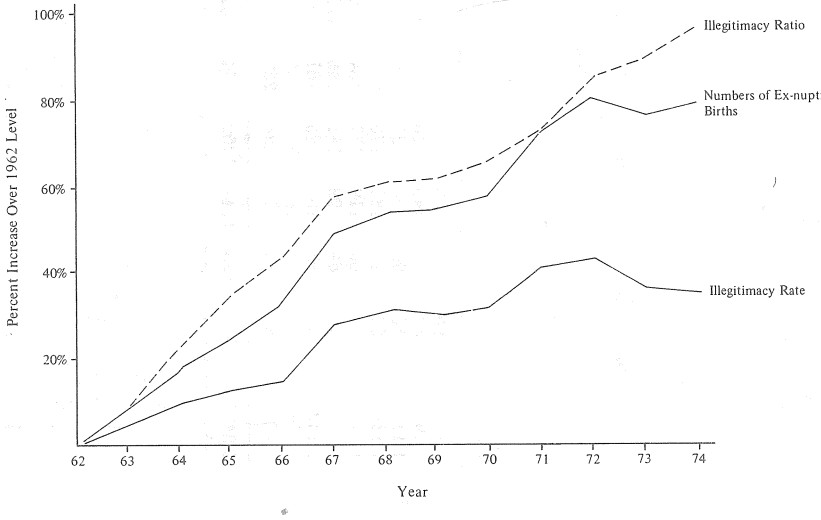
NOTE—The figures refer to accouchements, not to children born, multiple cases being counted once only. (Only live births are included.)

Year	Illegitimate Births	Duration of Marriage (In Complete Months)												Total Legitimate First Births Within One Year After Marriage	Total Registered Births
		0	1	2	3	4	5	6	7	8	9	10	11		
1913	1,173	96	122	145	241	255	350	398	306	327	831	669	462	4,202	27,935
1914	1,291	83	122	146	216	247	354	398	294	335	720	642	487	4,044	28,338
1915	1,137	56	96	158	231	219	288	353	286	336	769	621	457	3,870	27,850
1916	1,139	63	95	135	170	212	269	326	266	343	793	694	512	3,878	28,509
1917	1,141	68	66	119	137	184	216	291	264	250	575	505	449	3,124	28,239
1918	1,169	42	64	99	141	148	215	259	213	212	443	298	279	2,413	25,860
1919	1,132	52	98	101	125	161	202	258	222	238	469	397	314	2,637	24,483
1920	1,414	69	125	167	220	295	347	445	377	407	859	802	575	4,688	29,921
1921	1,245	82	140	177	228	253	341	456	370	382	979	804	670	4,882	28,567
Total	10,841	611	928	1247	1709	1974	2582	3184	2598	2830	6438	5432	4205	33,738	249,702

Table 1 indicates that there has been an increase in the illegitimacy ratio which has risen from 8.04 percent in 1962 to 16.61 percent in 1975. It is to be noted, however, that a contributing factor in this rise is the decline in nuptial births. This point was made in a paper published as a supplement to the monthly Abstract of Statistics, November 1975, entitled *Recent Trends in New Zealand Fertility* by E. A. Harris, Government Statistician, when he said, "The ex-nuptial ratio is valuable in that it indicates the proportion of births that constitute the major social problem for any community. However, as a true indicator of trends in ex-nuptial fertility, it is of limited value because it is influenced by extraneous factors. Ex-nuptial ratios may change, not so much because of changing numbers of ex-nuptial births, but because of a change in nuptial fertility experience as measured by nuptial birth numbers. This situation is well illustrated by experience during the 1962-1973 period when ex-nuptial births increased from 5,227 to 9,206, while nuptial births showed an overall fall from 59,787 to 51,212, resulting in the ex-nuptial ratio exaggerating the 'real' rise in the ex-nuptial fertility level."

The increase recorded in the previous table is clearly demonstrated in Table 3.

Table 3—Increases in Numbers of Ex-nuptial Births, the Illegitimacy Ratio, and the Illegitimacy Rate: 1962–1974



Maori and Non-Maori Births

Before 1962 different systems existed for the registration of Maori and non-Maori births. In that year the registration procedures were standardised and the same information was thereafter collected for the whole population. Table 4 sets out Maori and non-Maori ex-nuptial births.

Table 4—Maori and Non-Maori Illegitimate Births, Illegitimacy Ratios, and Illegitimacy Rates: 1962 to 1975.[1,2]

Year	Maori Population			Non-Maori Population		
	Numbers of Ex-nuptial Births	Illegitimacy Ratio %	Illegitimacy Rate	Numbers of Ex-nuptial Births	Illegitimacy Ratio %	Illegitimacy Rate
1962 ...	1,655	21.75	138.1	3,572	6.22	24.9
1963 ...	1,812	22.56	147.2	3,868	6.85	26.0
1964 ...	1,823	23.13	144.3	4,331	7.96	28.0
1965 ...	1,827	23.50	141.0	4,704	9.00	29.4
1966 ...	1,979	25.56	149.0	4,961	9.49	30.0
1967 ...	2,188	27.36	159.4	5,577	10.52	33.4
1968 ...	2,262	27.96	159.6	5,798	10.73	34.3
1969 ...	2,439	29.89	166.9	5,666	10.45	33.2
1970 ...	2,460	30.03	163.3	5,816	10.80	33.7
1971 ...	2,682	32.07	173.0	6,299	11.23	36.2
1972 ...	2,671	33.94	158.0	6,723	12.15	37.7
1973 ...	2,573	34.85	143.2	6,633	12.43	36.1
1974 ...	2,516	36.30	132.0	6,854	13.08	36.2
1975 ...	2,707	39.94	133.7	6,700	13.44	34.6

[1] Sources: Numbers of births and the illegitimacy ratios for 1964 to 1974 were obtained from *Monthly Abstract of Statistics*, July 1975; for 1962 and 1963 the information was obtained from the Department of Statistics.

[2] The illegitimacy rates presented here are based on all ex-nuptial births as a rate per 1,000 single, widowed, and divorced women aged 15 to 44 years. The method of estimation of the numbers of such women in intercensal years is described in the footnote to Table 1.

Over the past decade the ex-nuptial birth ratio of the non-Maori has increased at a much faster rate than that of the Maori. Even so, the Maori ratio remains substantially higher.

Births to Girls Under 16 Years of Age

The terms of our inquiry are not specifically directed to the numbers of ex-nuptial births as a whole, and we do no more than draw attention to them. However, the numbers of ex-nuptial births to young girls, particularly to those under 16 years are relevant to the matters we are asked to consider. Births to mothers under 16 years of age in relation to total nuptial and ex-nuptial births in other age groups for 1972, 1973, and 1974 (the last years for which the information is available to us) are set out in Tables 5a and 5b.

The increase in the number of ex-nuptial births recorded at four-yearly periods for the years 1962, 1966, and 1970 is demonstrated by Table 6. These increases are matters of considerable concern to many people and formed the basis of a number of submissions made to us on the restrictions imposed by law on the supply of contraceptives to those under 16 years of age.

Table 5a—Numbers of Nuptial and Ex-Nuptial Births Registered During 1972 and 1973, Classified by Age of Mother[1]

Age of Mother (in Years)	Ex-nuptial Births		Nuptial Births		Illegitimacy Ratio	
	1972	1973	1972	1973	1972	1973
					%	%
11 ...	...	1	...	...	...	100.0
12 ...	1	1	...	...	100.0	100.0
13 ...	4	7	...	...	100.0	100.0
14 ...	38	60	...	...	100.0	100.0
15 ...	262	296	...	...	100.0	100.0
16 ...	604	675	292	283	67.4	70.4
17 ...	996	1,041	925	814	51.8	56.1
18 ...	1,099	1,032	1,614	1,435	40.5	41.8
19 ...	1,059	1,024	2,256	2,136	31.9	32.4
20 ...	874	794	2,949	2,865	22.9	21.7
21 ...	721	664	3,641	3,414	16.5	16.3
22 ...	612	588	4,106	3,917	13.0	13.0
23 ...	528	507	4,549	4,291	10.4	10.6
24 ...	411	388	4,915	4,512	7.7	7.9
25 ...	344	341	4,763	4,602	6.7	6.9
26 ...	298	279	4,011	4,263	6.9	6.1
27 ...	242	240	3,532	3,536	6.4	6.3
28 ...	190	194	2,855	2,942	6.2	6.2
29 ...	172	184	2,365	2,376	6.8	7.2
30 ...	143	164	2,188	2,004	6.1	7.6
31 ...	129	124	1,829	1,697	6.6	6.8
32 ...	108	108	1,454	1,409	6.9	7.1
33 ...	103	78	1,169	1,121	8.1	6.5
34 ...	78	81	911	879	7.9	8.4
35 ...	88	68	755	695	10.4	8.9
36 ...	58	74	673	557	7.9	11.7
37 ...	50	36	467	467	9.7	7.2
38 ...	41	46	421	339	8.9	11.9
39 ...	47	41	360	265	11.5	13.4
40 ...	33	23	262	204	11.2	10.1
41 ...	23	16	217	177	9.6	8.3
42 ...	17	16	144	136	10.6	10.5
43 ...	11	9	82	80	11.8	10.1
44 ...	4	4	58	50	6.5	7.4
45 ...	5	...	34	32	12.8	0.0
46 ...	...	2	15	12	0.0	16.6
47 ...	...	...	7	9	0.0	0.0
48 ...	1	...	1	2	50.0	0.0
49 ...	...	...	1	...	0.0	0.0
	9,394	9,206	53,821	51,521	14.9	15.2

[1] Source: *Vital Statistics*, 1972 and 1973.

Table 5b—Numbers of Nuptial and Ex-nuptial Births Registered During 1974 Classified by Age of Mother

Age of Mother (In Years)	Ex-nuptial Births	Nuptial Births	Illegitimacy Ratio %
11	...	...	...
12	1	...	100.0
13	10	...	100.0
14	56	...	100.0
15	330	...	100.0
16	732	255	74.2
17	1,049	744	58.5
18	1,094	1,351	44.7
19	995	1,982	33.4
20	828	2,669	23.7
21	636	3,358	15.9
22	558	3,808	12.8
23	487	4,156	10.5
24	453	4,445	9.2
25	359	4,409	7.5
26	310	4,337	6.7
27	236	3,757	5.9
28	207	2,889	6.7
29	164	2,413	6.4
30	134	1,920	6.5
31	133	1,512	8.1
32	122	1,377	8.1
33	109	1,044	9.5
34	81	814	9.1
35	59	648	8.3
36	50	515	8.8
37	44	405	9.8
38	31	367	7.8
39	27	251	9.7
40	25	185	11.9
41	15	139	9.7
42	16	102	13.6
43	10	52	16.1
44	5	30	14.3
45	2	21	8.7
46	...	10	0.0
47	...	3	0.0
48	2	1	66.7
49	...	1	0.0
Totals ...	9,370	49,966	15.8

Source: *Vital Statistics* 1974.

Table 6—Number of Ex-nuptial Births, Percentage of all Ex-nuptial Births to Mothers in Each Age Group, and Percentage Increase in Number of Births by Age Group for the Years 1962, 1966, and 1970[1]

Age of Mother	Ex-nuptial Births Registered			Percentage of all Ex-nuptial Births			Percentage Increase in Number of Ex-nuptial Births		
	1962	1966	1970	1962	1966	1970	1962-1966	1966-1970	1962-1970
Under 16 years...	138	199	234	2.6	2.9	2.8	44.2	17.6	69.6
16–19 ...	1,537†	2,680	3,165	29.3	38.5	38.1	74.4	18.1	105.9
20–24 ...	1,819	2,378	2,937	34.7	34.2	35.4	30.7	23.5	61.5
25–29 ...	805	903	1,092	15.4	13.0	13.2	12.2	20.9	35.7
30–34 ...	514	433	531	9.8	6.2	6.4	—15.8	22.6	3.3
35–39 ...	307	263	253	5.9	3.8	3.1	—14.3	— 3.8	—17.6
40–44 ...	99	95	78	1.9	1.4	0.9	— 4.0	—17.9	—21.2
45 years and over	11	9	10	0.2	0.1	0.1	—18.2	11.1	— 9.1
All ages ...	5,242*	6,960	8,300	100.0	100.0	100.0	32.8	19.3	58.3

*Includes 12 women not classified by age.
†It is possible that a small number (up to eight) of these cases should have been included in the 20 to 24 age group.

The distribution of illegitimate births by age of mother changed considerably between 1962 and 1970: at the younger ages the absolute number of illegitimate births increased but the rate of increase varied markedly. There was a 70 percent increase in numbers of births to women under 16 years of age, a 106 percent increase in the 16 to 19 year age group, a 61 percent increase in the 20 to 24 year age group, and a 36 percent increase in the 25 to 29 year age group. Numbers of births to mothers in the older age groups have increased marginally (30 to 34 year age group) or decreased substantially (age groups over 35 years). One interesting feature of the table is that with one exception the size of the increase in numbers of births declines with age.

[1]Source: *Vital Statistics*, 1962, 1966, and 1970.

Ex-nuptial Conceptions

So far, we have dealt with ex-nuptial conceptions resulting in ex-nuptial births, but to estimate the total number of such conceptions we must also take account of those which ended in abortion, either spontaneous or induced. We must also include those which resulted in nuptial births by reason of the marriage of the mother after conception but before the birth of the child.

Abortion of Girls Under 16 Years of Age

There is no information available on the incidence of spontaneous abortion in girls under 16 years of age, but the incidence of spontaneous abortion in women generally has been estimated to be between 30 percent and 50 percent of fertilised ova.

There is only limited information available as to the number of induced abortions in girls under 16. Before the Hospitals Amendment Act 1975 came into force, there was no obligation to report induced abortions. This statute, while now making reporting mandatory, does not require the age and marital status of the woman or girl concerned to be recorded. However, there is some information available which indicates that in the past few years an increasing number of girls of 16 years and under have been aborted. According to information which we have received from the National Health Statistics Centre, a number of abortions were induced in public hospitals between 1969 and 1975 on girls in this age group. The information gathered for statistical purposes in age groups 10-14 and 15-19 is set out in Tables 7a and 7b.

Table 7a—Abortions Induced in Public Hospitals by Age, 1969–75

Age in Years	1969	1970	1971	1972	1973	1974	1975
10–14 ...	5	5	11	10	20	37	38
15–19 ...	25	46	58	137	183	196	200
20–24 ...	32	72	105	148	195	195	190
25–29 ...	39	58	86	144	168	177	161
30–34 ...	40	46	88	128	165	170	157
35–39 ...	39	48	77	119	158	151	140
40–44 ...	25	29	38	72	87	69	81
45–49 ...	2	5	7	7	12	13	11
Not stated ...	5	4	...	...	...	...	...
Totals ...	212	313	470	765	988	1,008	978

Table 7b—Abortions Induced in Public Hospitals by Age, 1969–75

(percentages in each age group)

Age in Years	1969	1970	1971	1972	1973	1974	1975
10–14 ...	2.3	1.5	2.3	1.3	2.0	3.6	3.8
15–19 ...	11.7	14.6	12.3	17.9	18.5	19.4	20.4
20–24 ...	15.0	23.0	22.3	19.3	19.7	19.3	19.4
25–29 ...	18.3	18.5	18.2	18.8	17.0	17.5	16.4
30–34 ...	18.8	14.6	18.7	16.7	16.7	16.8	16.0
35–39 ...	18.3	15.3	16.3	15.5	15.9	14.9	14.3
40–44 ...	11.7	9.2	8.0	9.4	8.8	6.8	8.2
45–49 ...	2.3	1.5	1.4	0.9	1.2	1.2	1.1
Under 20 ...	14.0	16.1	14.6	19.2	20.5	23.0	24.2
20–24 ...	15.0	23.0	22.3	19.3	19.7	19.3	19.4

According to evidence tendered to us by the Auckland Medical Aid Trust, abortions were performed on 73 girls under 16, and on 630 girls between 16 and 20 during the first year of its operation. During the second year of its operation, 156 abortions were performed on girls under 16, and 1,127 on girls between 16 and 20. There still remains the question of how many girls 16 years and under have been aborted in Australia or elsewhere. On this point there is no material upon which any valid age classification can be made. Because of differences in methods of age classification, and the periods of time for which the information is available, it is not possible to say by what percentage the total number of ex-nuptial births to girls under 16 would have been increased had these abortions not been carried out.

Ex-nuptial Intercourse

It is not possible to assess with accuracy the ratio of ex-nuptial conceptions to acts of intercourse. Information from some studies would indicate that, in a sexually active, non-contracepting population, about 80 percent of the women of reproductive age will become pregnant. Although information on the measure of contraceptive usage in New Zealand in married women is available, no inferences can be drawn from that to gauge the measure of usage in the unmarried.

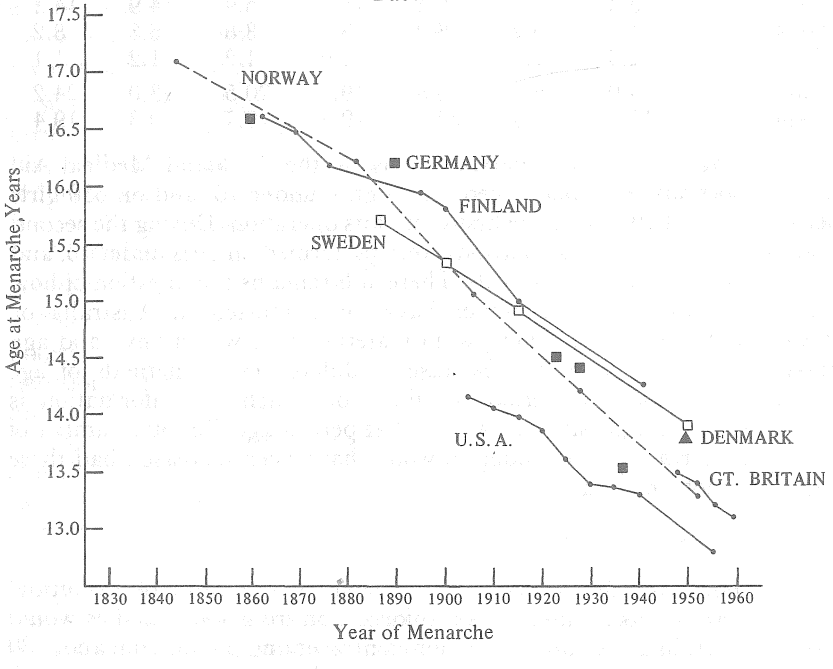
The number of ex-nuptial births to girls 16 years of age and under, the number of abortions performed on girls in this age group, the undoubted, though unquantified, incidence of spontaneous abortions, and the assumption that, for each birth, there would on an average be reckoned to be a number of acts of coitus, combine to indicate considerable sexual activity in those under 20 years of age.

Factors Influencing Sexual Activity in the Young

Biological Changes

It is important to note that, over the last 100 years, the gap between physical development and mental development has widened. It is now well established that over the past 100 years and less, a marked decline has been noted in Europe and North America in the age of menarche. B. V. Short draws attention to this point in an article entitled "Man, the Changing Animal." He maintains that the reasons for the downward trend are almost certainly related to nutrition, menarche being associated with a critical body weight of 47 kilograms. Improved nutrition in childhood and adolescence has enabled individuals to attain this critical body weight at a much younger age. In his work, *Growth at Adolescence,* J. M. Tanner notes lowering of the age of menarche in various European countries and the United States of America between 1830 and 1960. This is illustrated in Table 8.

Table 8



Secular trend in age at menarche 1830–1960. Sources of data as follows:

Finland: 1862–1915, hospital patients Helsinki, from Malmio (1919) and Vara (1943); 1941, medical practice and health visitor inquiries, all Finland, age at interrogation 17 to 27 only, from Simell (1952).

Sweden: 1886–1915 hospital patients, Lund and Stockholm, from Essen-Möller (quoted in Lenner, 1944), Lundh (1925), Samuelson (1942) and Lenner (1944) (hospital data of last two pooled for value at 1915); 1950, schoolchildren, estimated from data of Romanus (1952).

Norway: 1844–81, from Backman (1948); 1907 Oslo hospital patients, from Skerlj (1939); 1928–52 Oslo schoolchildren, data of Schiötz (1930), and Kiil (1953) fitted by probits.

Germany: 1860–1928 hospital patients various towns successively from Schlichting (1880), Heyn (1920) and Schaeffer (1908) pooled, Risopoulos (1936), Scheibner (1938); 1937, schoolchildren S.W. Germany, probits fitted to data of Ley (1938). See also values reported in Backman (1948) and Wallau (1952).

Great Britain: 1948–1960 schoolchildren, probits, successively S. England, from Wilson & Sutherland, (1950b), Edinburgh from Provis & Ellis (1955), Bristol from Wofinden & Smallwood (1958), London From Scott (1961).

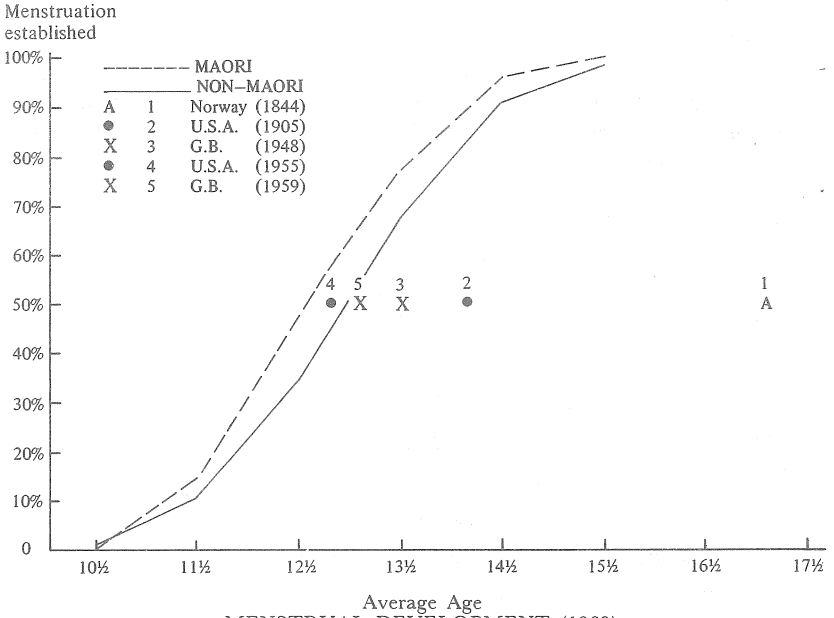
U.S.A.: 1905–1940 University of South Carolina entrants, from Mills (1950), 1960 estimated, see text.

Denmark: 1950, Copenhagen schoolchildren, probits, from Bojlén, Rasch & Weis-Bentzon (1954).

Values are plotted at year in which the average menarche took place, i.e. in 'recollected-age' data if average menarche of 40-year-olds interrogated in 1900 was 15 years, this is plotted at 1875. This places old data on same age scale as modern probit data. Where age of interrogation is not recorded an estimated amount has been subtracted according to nature of population studied (primiparae, etc.). Grouping errors have been corrected where necessary (i.e. '13-year-olds' centred at 13.5 years, not 13, as in some of older literature).

New Zealand figures for the age of menarche show a marked similarity to those of certain European countries and the United States of America. This is illustrated in Table 9 taken from Special Report No.38, "The Physical Development of New Zealand School Children 1969", issued by the Health Services Research Unit, Department of Health, Wellington, September 1971.

Table 9—Physical Development of New Zealand Schoolchildren
(1969 Special Report No. 38)



3*

MENSTRUATION

Girls who were over 10 years of age were asked the question "Have you commenced having periods?", and the answer was recorded. The table shows that a small percentage of girls in both racial groups will have commenced menstruating before reaching 11 years of age; 50 percent of Maori girls will have menstruated by the age of 12 years 7 months, and 50 percent of non-Maori girls will have menstruated by the age of 13 years.

It is interesting to note that this functional sign of sexual maturity together with breast development seems to occur earlier in the Maori, whereas pubic hair growth seems to develop earlier in the non-Maori.

When New Zealand figures for the age of menarche are compared with those of other countries, it is seen that there is little difference in median ages in New Zealand, the United States, and Britain.

Tanner (ref. 2) shows that the age for the onset of menstruation has decreased over the years in all countries for which figures are available. Girls are estimated to begin menstruation 2.5 to 3.3 years earlier than they did a century ago.

In his study, Short points out that a century ago, girls (and boys) were reaching reproductive maturity at the age of 17 or 18, an age at which they were also becoming intellectually mature, but that this is no longer so. Sexual or physical maturity is now attained well in advance of intellectual maturity.

Other Factors

Along with earlier biological maturity, several other factors encourage and influence sexual activity in the young. Among these are:

Greater affluence:

There is now a greater measure of affluence among the young, allowing them freedom to travel and seek a wider range of entertainments and activities.

Greater mobility:

Most young people either own or have access to motor vehicles. They are thereby enabled to move away from the influences of home for reasons of business and pleasure. With affluence and mobility they gain independence of action.

Unsupervised leisure:

Affluence and mobility operate to allow both parents and children alike to go their own ways in the pursuit of pleasure. In consequence leisure time activities of the young are supervised less and less.

Access to liquor (with reduced inhibitions).

Access to drugs (with reduced inhibitions).

The influence of the news media.

Pressures from friends and those of the same age group.

Lessening of influence within the family unit.

Lack of guidance in home, schools, and community.

Availability of contraception.

Factors Influencing the Likelihood of Pregnancy in the Young

The factors encouraging very young girls to engage in intercourse may be different from those which influence those of more mature years. Any division according to age must be arbitrary, but it seems logical to adopt, as does the law, the age of 16 years as a dividing line.

From the many submissions we received regarding sexual activity in the young, we have come to the conclusion that very young girls may often be persuaded to engage in acts of intercourse without giving a full and understanding consent. Physical maturity may have outstripped mental maturity to the point where a young person may be quite unable to cope with powerful emotional pressures. There are times, too, when young girls yield to pressures for intercourse in the belief that they must conform to the standards of others in their own age group.

Social and Moral Issues

Pregnancy in a young girl can only be regarded as socially undesirable, leading as it may to induced abortion or to the experience of birth which is likely to have serious emotional consequences for the girl herself. It may interrupt and possibly mean an end to her further education; it poses the problem of the upbringing of the child, and it may well create stress in the home for the parents; it may require the provision of social assistance both in a personal and financial form. Even with girls between the ages of 16 and 19 years, the problem can still be very real. Some of the factors to which we have made reference may no longer apply but other considerations will be introduced. There may be questions of solo parenthood, questions of maintenance, and questions of the provision of adequate housing for mother and child.

Repeatedly, we were made aware of cases of young people financially insecure, and emotionally totally unequipped to bear the responsibility with which they were suddenly faced. We hope that, through education, young people, amongst whom the practice of pre-marital sex is now increasingly common, can be made more aware that unsatisfactory personal and social situations all too often ensue from sexual intercourse outside of a stable relationship, and that they will responsibly decide against engaging in practices which are likely to lead to consequences beyond their capacity to handle.

Sexually Transmitted Diseases

There is another important social issue which arises from sexual activity among the young. This is the problem of sexually transmitted disease which, although not confined to the young, has its highest incidence in those under 20 years of age.

The problem is not new in this or any other country. In 1922 a Committee of the Board of Health was appointed to inquire into the prevalence of venereal disease in New Zealand. As part of its report, the committee published figures which showed a high incidence of various forms of the disease.

In recent years it has become the practice to use the term "sexually transmitted diseases". These include, not only those diseases which formerly were called "venereal diseases" such as syphilis, gonorrhoea, genital herpes, chancroid, genital or venereal warts, and non-specific urethritis (also referred to as non-gonococcal urethritis), but certain sex-related conditions which are listed as sexually transmitted diseases. These are:

Cystitis (not necessarily sex related)
Candidiasis
Trichomoniasis
Scabies
Pubic Lice

There has been a dramatic rise in sexually transmitted diseases throughout the world. In the United States there were an estimated 2,500,000 new cases of gonorrhoea in 1973. However, in Sweden and Denmark, though the incidence is still high, falls have been recorded in recent years. It is not known whether in these countries this decrease is the result of an extensive campaign advocating the use of the condom, a reduction in the number of travellers, or an awakening sense of responsibility on the part of the young people regarding the transmitting of disease.

Regrettably, New Zealand has one of the highest rates of gonorrhoea in the world. Table 10, compiled by the World Health Organisation, shows the position of New Zealand in relation to a number of other selected countries.

Table 10—Incidence Rate of Gonorrhea, Infectious Syphilis per 100,000 Population of Selected Countries

	1970		1973	
	Inf. Syphilis	Gonorrhoea	Inf. Syphilis	Gonorrhoea
Australia	7.5	77	8.6	88
Japan	63.8	78	...	...
New Zealand ...	2.7	200	1.8	300
United Kingdom ...	3.0	118	...	114
Sweden	4.3	460	4.4	350
Hong Kong ...	21.0	175	2.8	168
Fiji	...	245	8.0	236
U.S.A.	11.6	32	11.9	405

WHO figures. Rates for New Zealand adjusted from clinics' and private patients' laboratory reports.

Statistics on the number of new cases of sexually transmitted diseases occurring in New Zealand each year are difficult to obtain because not all cases are treated at hospital clinics and the diseases are not notifiable. Table 11 is taken from the Annual Report of the Department of Health, 1975. This table clearly shows that, although the numbers of cases of syphilis have not grown, there is a marked increase in the incidence of gonorrhoea.

Table 11—Number of Persons Reporting for the First Time to Venereal Disease Clinics run by Hospital Boards (1974)

	Gonorrhoea			Syphilis			Non-specific Urethritis	
	M.	F.	Total	M.	F.	Total	M.	F.
Auckland ...	644	370	1,014	15	3	18	593	...
Hamilton ...	46	28	74	1	1	2	77	...
Gisborne ...	58	39	97	...	1	1	30	...
Napier ...	126	81	207	5	2	7	46	...
Hastings ...	174	60	234	1	2	3	97	...
Wanganui ...	25	8	33	...	...	...	9	...
Hutt* ...	12	4	16	...	1	1	11	...
Wellington ...	540	400	940	15	3	18	726	...
Christchurch	334	216	550	6	3	9	592	...
Dunedin ...	71	65	136	5	...	5	218	...
Invercargill ...	88	53	141	...	...	...	75	...
Totals—								
1974 ...	2,118	1,324	3,442	48	16	64	2,474	
1973 ...	1,848	1,027	2,875	36	14	50	2,495	
1972 ...	1,727	913	2,640	43	16	59	2,416	
1971 ...	1,578	940	2,518	49	24	73	1,773	
1970 ...	1,377	903	2,280	53	22	75	1,496	

*Hutt figures from May to December.

First Admissions to Public Hospitals for Syphilis and Gonorrhoea Infections

	1967	1968	1969	1970	1971
Syphilis (all forms) ...	40	28	23	27	35
Gonorrhoea	66	88	89	81	94
Total	106	116	112	108	129

Source: Annual report of the Department of Health, 1975.

The increase in the number of new cases of gonorrhoea treated at clinics in Auckland, Wellington, Napier, Christchurch, Dunedin, Invercargill, and Hamilton, is demonstrated by Table 12, compiled by the New Zealand National Health Statistics Centre, Wellington. It should be noted that the figures up to 1964 are given on a quinquennial basis but that after 1965 they are given for single years.

A number of submissions expressed concern at the increasing number of cases of sexually transmitted diseases particularly in younger people, and much was said to us in evidence as to the underlying causes.

Venereologists from various parts of New Zealand spoke to the Commission. Each of them confirmed the increase in the number of persons treated for sexually transmitted diseases at hospital board clinics, and statistics provided by individual hospitals show clearly that this is so.

Our attention has been drawn to the problem of the increase in gonorrhoea of the throat during recent years, particularly in those in the

younger age groups. In some New Zealand hospitals, tests for gonorrhoea of the throat are carried out where patients are known to have engaged in oral sex. In others, the throats of all females suffering from a sexually transmitted disease are swabbed as a routine procedure. We have been made aware of a similar increase in the number of cases of oral gonorrhoea in many countries overseas. Figures given to us in evidence from some overseas studies showed that a third of those having intercourse pre-maritally or extra-maritally engaged in oral sex, and that the incidence of gonorrhoea of the throat in a series of 3,000 cases of genital gonorrhoea was 3.6 percent in men and 5.8 percent in women. The incidence in the third who stated that they had engaged in orogenital intercourse was 7 percent in men and 16 percent in women.

Table 12—Venereal Disease: Cases Seen at Clinics: Numbers

These figures represent the numbers of persons seen for the first time at the clinics at Auckland, Wellington, Napier, Christchurch, Dunedin, Invercargill, and Hamilton, and found to be suffering from syphilis or gonorrhoea. Persons seen by general practitioners (estimated to be a total greater than these figures quoted) are not able to be included since these conditions are not notifiable.

ANNUAL AVERAGE NUMBERS FOR QUINQUENNIAL PERIODS AND ACTUAL NUMBERS FOR SINGLE YEARS

Period or Year	Suffering from Syphilis			Suffering from Gonorrhoea		
	Males	Females	Total	Males	Females	Total
1920–24	274	88	362	808	103	911
1925–29	187	72	259	1,325	212	1,537
1930–34	220	140	360	1,232	400	1,632
1935–39	124	101	225	1,287	427	1,714
1940–44	157	132	289	841	496	1,337
1945–49	128	89	217	1,024	421	1,445
1950–54	42	59	101	835	299	1,134
1955–59	30	19	49	724	200	924
1960–64	43	10	53	915	247	1,162
1965	69	10	79	1,437	385	1,822
1966	127	20	147	1,747	616	2,363
1967	136	10	146	1,695	639	2,334
1968	91	17	108	1,407	718	2,125
1969[1]	55	13	68	1,402	785	2,187
1970	53	22	75	1,377	903	2,280
1971[2]	49	24	73	1,578	940	2,518
1972	43	16	59	1,727	913	2,640
1973	36	14	50	1,848	1,027	2,875
1974	48	16	64	2,118	1,324	3,442

NOTE: Non-specific urethritis cases, a possible form of venereal infection, totalled 1048 (1968), 1142 (1969), 1496 (1970), 1773 (1971), 2416 (1972), and 2495 (1973) all of whom were males.

[1] Includes Napier figures for 9 months.
[2] Includes Hamilton figures for 5 months.

One venereologist of long experience and high standing who appeared before us attributed the incidence of gonorrhoea of the throat in the young to their exposure to material which, while purporting to have therapeutic value in the field of human relationships, is, in fact, plainly pornographic. He saw a definite link between the stimulus provided by the pornographic literature of this type and the increase in gonorrhoea of the throat. Although a causal relationship may be difficult to establish, our view is that it would be difficult to ignore the part played by glossy magazines which, in issue after issue, unduly emphasize oral sex. Fellatio and cunnilingus have always been accepted by some as pleasurable and satisfying forms of sexual expression, but we must question the judgment and sense of responsibility of those who publish material encouraging such practices, material, which evidence shows, is readily accessible to the young.

Overseas studies suggest that a significant proportion of the young girls who contract gonorrhoea are from broken homes and have left school at an early age. Factors which result in the high rate of sexually transmitted diseases are the freedom, mobility and affluence previously mentioned, and the abandonment of traditional values, particularly abstinence from sexual intercourse. Attitudes to sex have changed markedly. Society has offered little to replace the virtues, admittedly somewhat restrictive, of conventional morality.

The Intellectually Handicapped

We were made aware by responsible individuals and organisations of the problems of contraception for intellectually handicapped women and girls. The degree of their disability may range from mild intellectual handicap where women and girls, capable of managing their own affairs, often marry or form semi-permanent relationships, to those more severely handicapped, who have some degree of personal independence but cannot be regarded as capable of managing their own affairs. Some may become pregnant through promiscuity, others through a lack of realisation of the nature of the sexual act and its consequences. With the change in the pattern of treatment now available for the intellectually handicapped, in which they live in the community rather than in large psychiatric institutions, the risk of pregnancy is increased. To these women and girls, pregnancy and childbirth may be a deeply traumatic experience; the child, although likely more often than not to be a normal infant, may be born to a woman quite incapable of providing normal maternal care for it. The parents of the handicapped daughter, too, are never free from anxiety that she may become pregnant.

It is difficult for intellectually handicapped people to comprehend the need for contraception or to understand its functioning. In many cases they will be incapable of observing the routine of oral contraception, and quite unable to use any mechanical device. The Society for the Intellectually Handicapped presented a carefully considered submission on this subject. The Society itself has no official policy on this matter but its submission showed that there is a substantial group within its membership which believes it should be lawful to provide contraception at

the request of the parent or guardian for severely retarded girls and women, not only while they are below the age of 16 years, but throughout their reproductive life. Injections of a hormonal contraceptive such as Depo-Provera are most satisfactory in such cases. The group we have mentioned also believes that there should be a legal obligation upon every person who has oversight, care, or control of any girl or woman in a psychiatric or psychopaedic hospital to provide appropriate sex education and contraceptive advice.

We have been told that, in some psychiatric institutions, hormonal contraceptives are injected to protect handicapped girls and women from pregnancy which may occur despite careful supervision. There are those who believe that it is morally wrong to administer a hormonal injection to patients where they themselves are incapable of giving a full and informed consent. We ourselves can see nothing socially or morally reprehensible in providing protection for those who, because of intellectual infirmity, are unable to provide protection for themselves. For reasons already discussed, we have no doubt that there are enormous advantages in such a course. There are, however, some legal problems which arise from the administration of contraceptives to intellectually handicapped people. These we discuss in Chapter 2.

Chapter 2
CONTRACEPTION: LEGAL ISSUES

The law of New Zealand has little to say on the subject of contraception but legal issues relating to contraception arise under the following heads:

1. Restrictions imposed by the Police Offences Amendment Act 1954 on the distribution of contraceptives to persons under 16 years of age and on instruction in their use.
2. Restrictions in regard to the advertising of contraceptives.
3. The provision of contraceptives to women and girls not of full mental capacity.
4. The regulation of the sale of contraceptives through vending machines.

POLICE OFFENCES AMENDMENT ACT 1954

History of the Legislation

Before the passing of the Police Offences Amendment Act 1954, there was no legislation in New Zealand which placed any restriction on the distribution of contraceptives. When the Indecent Publications Act 1910 was enacted, it contained a provision (section 10) which declared that any document or matter which related to, *inter alia*, the prevention of conception, was deemed to be indecent. This provision was, however, subject to another which required the Court, in finally determining indecency, to take into account a number of matters, including the purpose of the person dealing with the document, and the persons and age groups among whom the document was to be distributed. Section 10 was repealed by the Indecent Publications Act 1963 — the Act which set up the Indecent Publications Tribunal.

It is clear that the Police Offences Amendment Act 1954 was passed as a result of the tabling in Parliament of the Report of the Special Committee on Moral Delinquency in Children and Adolescents, otherwise known as the Mazengarb Report. The Committee was set up under the chairmanship of the late Dr O. C. Mazengarb, Q.C., following upon revelations of sexual immorality in the area of Lower Hutt. It soon became apparent to the committee, however, that the increase in delinquency in young people, which it found to exist, was not confined to any one district or any one country. At page 44 of their report the committee said:

> The Committee has found a strong public demand that contraceptives should not be allowed to get into the hands of children and adolescents.

Whatever views may be held concerning the use of contraceptives by older people (married or unmarried) no responsible father or mother could countenance their possession by their young sons and daughters.

The Committee is unanimous that adolescents should not buy or have contraceptives in their possession.

The report was made on 20 September 1954 and on the following day it was tabled in the House of Representatives. On 27 September 1954 the Police Offences Amendment Act 1954, which put into legislative form the recommendations of the Mazengarb Committee, was introduced into the House and, on 1 October 1954, became law.

The relevant provisions of the Police Offences Amendment Act 1954 are as follows:

2. (1) Every person commits an offence who—

(a) Sells, or gives or otherwise disposes of any contraceptive to any child under the age of 16 years, or offers to sell or give or otherwise dispose of any contraceptive to any child under that age; or

(b) Instructs or persuades or attempts to instruct or persuade any child under the age of 16 years to use any contraceptive.

(2) Every person who commits an offence against subsection (1) of this section is liable on summary conviction—

(a) In the case of a first offence, to a fine not exceeding ($200):

(b) In the case of a second or any subsequent offence, to imprisonment for a term not exceeding 3 months or to a fine not exceeding ($400).

(3) Every child under the age of 16 years who procures or attempts to procure any contraceptive, knowing its purpose, commits an offence and is liable on summary conviction—

(a) In the case of a first offence, to have a conviction recorded against him:

(b) In the case of a second or any subsequent offence, to a fine not exceeding ($4).

The effect of the amendment is as follows:

Section 2(1)(a) prohibits the selling, giving, or otherwise disposing of any contraceptive to any child under the age of 16 years. Section 2(1)(b) prohibits the instructing or persuading of any child under the age of 16 to use a contraceptive. Section 2(2) prescribes the penalties to be imposed for a breach of section 2(1). Section 2(3) prohibits a child under the age of 16 years from procuring or attempting to procure a contraceptive, and prescribes penalties for such breaches.

The provisions of section 2(2) and 2(3) do not call for any particular comment except to say that, thirteen years later, in the passing of the Police Offences Amendment Act 1967, Parliament doubled the maximum penalty which might be imposed for breaches of section 2(1).

There have been very few prosecutions under the Police Offences Amendment Act 1954, as the following statistics supplied by the Commissioner of Police, and representing all types of prosecution under the amendment, demonstrate:

Year	Offences Reported	Offences Prosecuted
1964	3	1
1965	8	3
1966	3	1
1967	1	0
1968	8	1
1969	3	0
1970	0	0
1971	1	0
1972	3	0
1973	2	0
1974	Statistics not kept	

Although very few apparent breaches of the statute have been the subject of prosecution, the very existence of the law may have operated as a sanction against the sale or distribution of contraceptives to children under 16 years and their purchase by those under that age. The ambiguity of interpretation of some of its provisions has, undoubtedly, had an inhibiting effect in discouraging some teachers and health workers from discussing matters of contraception with their pupils or patients.

The provisions of sections 2(1) which create that ambiguity require closer scrutiny. It is not clear whether section 2(1)(b) was intended to prohibit, not only the giving of instruction or direction in the use of contraceptives, but also the dissemination of contraceptive information to persons under 16 years of age.

The ambiguity arises because section 2(1)(b) is directed against instructing or persuading any child under the age of 16 to use a contraceptive and not against the mere giving of information in the use of contraceptives. There is, therefore, in section 2(1)(b) a distinction, perhaps fine, between "instructing to use" and "giving information as to the use of." The Police Department, which has the responsibility of administering the Act, has interpreted the word "instructing", where it is used in section 2(1)(b), as referring to a command, so that an offence is not considered by that department to have been committed unless there is an instruction in the form of a command to use a contraceptive. The department takes the view that there is no offence where all that has been given is information regarding contraceptives. In adopting this view, the department has taken account of the fact that the word "instructs" is associated in section 2(1)(b) with "persuades" and that it does not specifically prohibit instruction in the use of any contraceptive. This opinion was first given by the department in 1972 and repeated in a memorandum issued by Police Headquarters to all police districts in December 1975. The department conveyed that view to the Statutes Revision Committee which undertook in 1973, on the instructions of Parliament, a review of the Police Offences Act 1927. It then said:

> There has been only one prosecution under this section in the last four years and the Police do not regard the section as prohibiting advice in the use of contraceptives.

Submissions to Statutes Revision Committee

The Statutes Revision Committee was asked to report to the House of Representatives on the changes it considered should be made to the law in the light of present day attitudes and social conditions. It received a great many submissions from Government departments, organisations, and individuals. We have obtained and considered copies of these submissions. For the most part they advocated the repeal or amendment of the Act, although a few advocated that it should be left in its present form.

Those submissions which were directed to total repeal or amendment of section 2 drew attention to the large number of births in New Zealand to mothers under the age of 17 years, which indicated the degree of sexual activity among those under 16 years. Within this group there was a considerable body of opinion which thought that these births could best be prevented by adequate sex education, together with the ready availability of contraceptives and contraceptive advice. It was also asserted that the strong "public demand" that contraceptives should not get into the hands of children and adolescents, which the Mazengarb Committee had found to exist, was no longer present. It was claimed that legislation, which attempted to prevent sexual intercourse by persons under 16 years of age, in fact deprived young girls of the means of preventing conception.

It is fair to say that the bulk of the submissions made to the Statutes Revision Committee in favour of repeal or amendment did not condone sexual activity among the young but rather deplored the occurrence of pregnancy in young girls who were often unable to provide satisfactory parenthood for the children born to them.

Those submissions to the Statutes Revision Committee which sought the retention of section 2 claimed that the present law was a deterrent to sexual relations between younger teenagers, that repeal would inevitably cause increased promiscuity, and that repeal would be tantamount to facilitating or condoning intercourse between those under 16.

The Statutes Revision Committee was of the view that the Police Offences Amendment Act did not prohibit dissemination of contraceptive information to young persons and that it should not do so. It pointed out that, even if information about the use of contraceptives could lawfully be given, the distinction between the mere provision of information and counselling in the use of contraceptives would sometimes be a fine one. It agreed with such groups as the New Zealand Association of Social Workers that its members should be permitted, without breaking the law, to advise on the use of contraceptives in cases where they thought it desirable, for example, in cases where exhortations to abstinence would be unrealistic and unwanted pregnancies seemed likely to ensue. The committee, therefore, recommended the repeal of section 2(1)(b) of the Police Offences Amendment Act 1954.

The committee considered that, once it was accepted that section 2(1)(b) should be repealed, section 2(1)(a) also should be repealed. It felt that, where young people were clearly determined to indulge in intercourse, there was little point in educating them about the need for

protection against conception and venereal disease or in counselling them to use contraceptives if these could not legally be obtained.

It considered that the Police Offences Amendment Act 1954 should be repealed and that its repeal would have a considerable measure of support throughout the country. It acknowledged that some controls might in due course have to be placed upon the location of contraceptive vending machines.

The recommendations of the Statutes Revision Committee have not been acted on by Parliament, and the Police Offences Amendment Act 1954 remains in force.

Submissions to the Royal Commission

Submissions on this topic were made to us by educationists, medical practitioners, social workers, and a variety of groups and organisations. In fact, more submissions were directed to the supply of contraceptives and the giving of contraceptive advice to the young than to any other topic to which our inquiries were directed. A great number of these advocated the complete repeal of the Police Offences Amendment Act 1954, advancing much the same points as had been made to the Statutes Revision Committee. They saw the legislation as having failed in its aim to prevent sexual intercourse in children under the age of 16 years. They saw it as failing to take account of a changing social climate in which children under 16 are in fact engaging in sexual intercourse and in which young girls are being exposed to the risk of pregnancy. In addition they regarded as undesirable an Act which prohibited the giving of help to many young people for whom moral injunctions to abstinence carried no weight. They argued that education in sexual and contraceptive matters should be encouraged, that spermicides and condoms should be available from such retail outlets as dairies, supermarkets, garages, hairdressers, and chemists, and that condom dispensing machines should be installed in suitable private areas.

They considered the risk of some loss of innocence by the majority of school children was justified to protect a minority who were at risk of pregnancy, misery, and disease through ignorance. They were confident that young people whose parents and moral teachers had already given them proper attitudes and values would not be harmed either by information on contraception or by the availability of contraceptives.

Those who favoured a modification, as distinct from repeal, of the law, regarded its provisions as restricting the giving of help to many young people in need of it, as preventing medical practitioners, teachers, social workers, and indeed, parents themselves, from supplying contraceptives, or giving advice to children under 16 known to be at risk. Those in this group generally favoured the exemption of certain categories of responsible adults from the provisions of the Police Offences Amendment Act 1954.

The third class, comprising those who favoured retention of the law in its existing form, argued that, regrettable though the numbers of ex-nuptial pregnancies to girls under 16 might be, the incidence of ex-nuptial pregnancy among schoolgirls was very small compared with the total

number of that age at risk. It was their view that this risk was greatly outweighed by the dangers involved in teaching contraception to the young and advising them of specific techniques. In an attempt to demonstrate this point, one group holding this view compared, in one particular year, the numbers of ex-nuptial births to girls under 16 with the total number of schoolgirls. Their statistics showed that in 1974 there were 899 girls aged 16 and under who gave birth to children. In that year it was estimated that there were 134,299 girls in forms 1 to 7. They claimed that, even if it were assumed that all of the 899 girls had conceived while they were under the age of 16, and were in fact still at school, the proportion of all schoolgirls in forms 1 to 7 who became pregnant and bore ex-nuptial children was under one percent.

Those who put forward this view recognised that among the girls in forms 1 to 7 there would have been some girls over 16 years of age. They maintained that, even after making due allowance for this, the proportion of all girls, who became pregnant and bore ex-nuptial children while under the age of 16, was still no more than one percent.

They argued further that a policy, which made contraception available and provided instruction in contraceptive techniques to those under 16, would encourage young people in the belief that intercourse outside the marriage relationship was socially and morally acceptable to the community so long as pregnancy did not result.

They foresaw other dangers in such a policy: a rapid increase in the already high incidence of sexually transmitted diseases; serious emotional and psychological disturbances in the young; a further breakdown in family life; a debasing of the sanctity of the sexual act.

We were referred to overseas experience, and, in particular, to that of Sweden where compulsory sex education for all school grades was introduced in the mid 1950s. It was said that the experience of Sweden showed that, far from reducing ex-nuptial pregnancies, education in contraceptive practice actually caused an increase. The Swedish programme of education is directed to methods of contraception and to all aspects of venereal disease. According to statistics obtained from Swedish Statistical Year Books, the number of cases of gonorrhoea increased from 13,810 in 1956 to 39,360 in 1970. The same statistics, however, show a decrease in the number of cases of gonorrhoea from 39,360 in 1970 to 24,035 in 1974. This decrease has been attributed to a campaign in which the use of the condom has been encouraged.

Again, the Swedish Statistical Year Books show that illegitimate births increased from 11,050 in 1956 to 34,451 in 1976. Expressed as percentages of the total births, these figures represent an increase from 10.2 percent in 1956 to 31.3 percent in 1974.

Here, too, care must be taken in interpreting the figures. The overall birth rate in Sweden has been decreasing steadily in recent years, and in that time the ex-nuptial birth rate has increased. According to information provided by the Central Bureau of Statistics, Sweden, to those who prepared the Department of Social Welfare Monograph, *Ex-nuptial Children and Their Parents,* there are indications, although no appropriate supporting statistics are available, that the number of new

families being established is relatively constant from year to year. Fewer couples, however, are giving recognition to their liaison by formal marriage. The increase in ex-nuptial births in Sweden may not therefore be necessarily indicative of a diminishing number of stable liaisons.

We have had regard to these figures but are of the opinion that great care must be taken in drawing inferences from statistics of another country. There will be a variety of social factors, the individual weight of which it is not always possible to determine.

The Commission has given much thought to these matters but we feel bound to say that, on the evidence presented to us, we are not convinced that the provision of contraceptives or instruction in contraceptive techniques away from a background of teaching in human relationships will be the panacea that some would claim it to be. We do not feel that any significant reduction in the numbers of ex-nuptial pregnancies will necessarily result and agree that there is a danger that the very young may be led to assume that intercourse on their part is acceptable conduct provided that pregnancy does not occur. We are reinforced in this view by thoughtful evidence from doctors, social workers, and other concerned people who maintain that many ex-nuptial pregnancies in young people are not attributable to promiscuity.

We think that the giving of specific contraceptive advice and access to contraceptives is not warranted, except where some special provision must be made for certain girls under 16. In our view the total repeal of the Police Offences Amendment Act 1954 is not justified.

The rising incidence of sexually transmitted diseases among young people has already been discussed. There is plenty of evidence to suggest that the contraceptive pill, in offering protection from the consequences of sexual activity, has undoubtedly been a factor in bringing about this increase. Some have advocated that the provision of condoms to young people will reduce the number of cases of certain forms of sexually transmitted diseases—gonorrhoea in particular. People of 16 years and over already have access to them but we have been told that many who receive treatment at clinics do not use them and regard them as unacceptable. We would not expect there to be any significant reduction in the number of cases of sexually transmitted diseases by the removal of any prohibition against the supply of contraceptives to those under 16 years. The rising trend in the incidence of sexually transmitted disease and in the numbers of ex-nuptial births is apparent also in the statistics for those over 16 years of age.

However, the Commission is of the view that the Police Offences Amendment Act 1954, in its present form, is altogether too restrictive. On the face of it, the Act would prevent a parent from giving specific sexual instruction to a child, and a medical practitioner from prescribing contraceptives to a young person under 16 years of age who, notwithstanding advice to the contrary, intends to have intercourse and is thereby exposed to risk of pregnancy. There are other responsible members of society, too, who, because their work requires them to deal with young people at risk, ought to receive a measure of exemption from

the provisions of the Act. The Commission therefore proposes to make recommendations for amendment to the Act.

Notwithstanding the recommendations of the Statutes Revision Committee, we think that any law controlling the supply of contraceptives to young persons should be formulated with due regard to the basic principles of setting and helping to maintain standards of behaviour acceptable to the community at large and of helping to promote the stability of the family.

In our view, amendments to the Police Offences Amendment Act 1954 should proceed along the following lines and take account of the following matters:

Section 2(1)(a) at present forbids the supply of contraceptives by parents, registered medical practitioners, and family planning clinics to those under 16. Despite this, the provision is often broken, and contraceptives are prescribed by both doctors and clinics. The subsection should therefore be amended to allow contraceptives to be legally prescribed in cases where responsible persons are convinced that the young people with whom they are dealing will not be dissuaded from sexual activity.

There may be others such as social workers or counsellors to whom these rights should be extended. For that reason we suggest that section 2(1)(a) might be amended by exempting from the prohibitions of the subsection certain classes of persons including parents, medical practitioners, accredited representatives of family planning clinics, and other responsible agencies or groups to be named in regulations to be made under the Act.

Section 2(1)(b) should be amended to make it clear that the interpretation at present placed upon the subsection by the Police Department has the full approval of the Legislature. This is of particular importance in safeguarding the position of the teacher who is engaged in a programme of human relationships or biology in which human reproduction is discussed.

It seems to us that three factors must be balanced. The first is the need to protect the teacher who, as part of a programme on social relationships, biology, or human development, has to deal with family planning and contraception. The second is the need to protect the parent and child against those persons who, in or out of the school, would, under the guise of teaching programmes of the kind mentioned above, and contrary to parental wishes, give lessons in contraceptive techniques and urge the use of contraceptives. The third is the need to provide a measure of assistance for children under 16 years of age who are believed, on good grounds, to be at risk.

One cannot legislate for every case and a perfect solution to a much debated, and often misunderstood, problem is not possible. It is our view that these competing needs and interests can best be met by repealing section 2(1)(b) and replacing it with a provision making it an offence:

1. To direct or persuade or attempt to direct or persuade a child under 16 years of age to use a contraceptive except where such direction or persuasion or attempted direction or persuasion is given by

a parent, medical practitioner, family planning clinic, or other approved person.

2. To give information or instruction in the use of contraceptives to a child under 16 years of age except where:

(1) The person giving the information or instruction does so as part of any course on social relationships, biology, or human development approved by the Department of Education or Department of Health; or

(2) Where the person giving the information or instruction is approved by the principal or head teacher of any school.

The adoption and implementation of these recommendations would place responsibility on principals for selecting persons best suited to teach on these matters. We believe that trust must be reposed in the principal to make wise appointments, having due regard to the views of parents.

Only section 2(3) remains. This subsection has been rarely, if ever, invoked, and the argument can be advanced that any child under 16 years of age who purchases or attempts to purchase a contraceptive in spite of a statutory prohibition will be likely to do so only as an act of bravado, for which the invocation of a penal statute is hardly appropriate. We do not overlook this argument but on balance take the view that, if it is to remain an offence for a person to supply contraceptives to children under 16 years whose age may be difficult to determine, it should also remain an offence for a child to obtain them. Amendments would, however, have to be made to section 2(3) in line with those suggested for section 2(1)(a) to except those cases where contraceptives are supplied by parents, medical practitioners, family planning clinics, or other approved persons.

The Law on the Advertising of Contraceptives

We know of no prohibition against the advertising of contraceptives. Certain restrictions on the advertising of contraceptives do, however, obtain for the protection of the consumer. These are contained in the Food and Drug Act 1969 which regulates the sale of food, drugs, and medical devices. The definition of "drug" in section 2 of that Act includes:

> (c) any substance or mixture of substances used or represented for use for the purposes of influencing, inhibiting, or modifying any physiological process in human beings, or the desires or emotions connected with any physiological process;
>
> (d) any chemical contraceptive.

Section 2 of the Act further defines "medical device" as:

> any device, instrument, apparatus, or contrivance, including component parts and accessories thereof, used or represented for use for any of the purposes specified in paragraph (c) of the definition of "drug" mentioned above.

It is clear from a review of these definitions that a mechanical contraceptive (as distinct from a chemical contraceptive) is a medical device within the Food and Drug Act 1969 and that a chemical contraceptive is a drug within the meaning of the Act because it is specifically said to be so. Sections 8, 9, 10, and 11 of the Act impose certain restrictions on the advertising of drugs. For this reason,

appropriate restrictions are placed on the informational content of medical advertisements.

In practice there seems to be very little advertising of contraceptives in New Zealand. Our attention has been directed to one advertisement which represents that a certain chemical contraceptive is more effective than the evidence given to us would show it to be. If this is the case, we believe that the existing provisions of the Food and Drug Act 1969 are sufficient to warrant a prosecution being brought, the onus always resting on the prosecution to establish that in fact the drug does not measure up to the claims made for it and that those claims are falsely made.

We have made inquiries of the Broadcasting Council of New Zealand and of the two television channels as to the existence of rules regulating the advertising of contraceptives on the radio or on television. The Broadcasting Council of New Zealand has informed us that it has no rule which refers specifically to the advertising of contraceptives but that there are several general rules which can be considered to have some relevance to the subject. These are:

> 1.1 The Council shall ensure that nothing is included in programmes which offends against good taste and decency or is likely to be offensive to public feeling.
>
> 3.1 No station shall broadcast any advertisement which directly or by implication:
>
> (a) Fails to observe high standards of ethics, propriety and good taste.
>
> (b) Is likely to endanger the physical, mental or moral welfare of the audience in general and children in particular.
>
> 3.2 Advertisements shall not, directly or indirectly, advertise any of the following products, services or activities:
>
> (c) Products associated with intimate personal hygiene or medication.

We are informed that, while it is unlikely that the Council could permit the advertising of contraceptives on radio or television, such a rule could be reviewed and rewritten to meet and reflect any change in public attitudes and standards.

We see no need for any changes in the law relating to the advertising of contraceptives. Nor do we consider that any expansion of programmes of advertising brands or types of contraceptives by television, radio or by newspaper should be undertaken. Advertising of certain types or brands of contraceptives has the disadvantage that individual manufacturers or distributors tend to promote their own products and proclaim their efficacy. There is, however, a place for the promotion of independent, reliable information on contraceptives. The booklet published by the Consumers' Institute of New Zealand, entitled *How to Cope with Contraception*, which describes various contraceptives and their use, is an illustration of information of this kind. It appears to us to be well researched and objective. In describing a variety of contraceptive techniques, it leaves the choice of a particular technique to the individual couple, rightly recognising that the decision as to which technique is used is largely a personal one. We think that up-to-date information of the same kind should from time to time be published by the Department of Health and that this information should be made available to the public by general practitioners and through various agencies such as family

planning clinics and health clinics. We emphasize that the information should be kept up to date.

Although the cost of preparing and circulating information of this kind would fall on the State, there is ample justification for the expenditure being met from public funds. The immediate cost would be more than offset by the subsequent saving in state funds from which family benefit and other social services are met.

The use of advertising by radio, television, booklets, and films to combat the increase in the number of cases of sexually transmitted diseases has been suggested to us. Films of this kind are already available in the libraries of the Departments of Health and Education. There is a definite place for such films provided they are factual, realistic but not exaggerated, and that they are up to date. We have viewed two educational films on sexually transmitted diseases. For a number of reasons they did not impress us as films which would make much impact on the audience to whom they were directed. Not only were the dress, language, and hair styles of the actors who appeared in them many years out of date, but the message lacked force and conviction. When the approach and presentation of such films is completely out of date they should be discarded and replaced.

The purpose of information, however it is disseminated, should be to advise both young and old of the symptoms of these diseases and their effects upon those who contract them. They should also be told where treatment is available and how it can be obtained. Above all, they should be told how these diseases can be avoided. One venereologist, with whom we spoke, expressed the view that there was a good deal to be said for what were sometimes called "old fashioned values" in sexual behaviour. However, it would be less than realistic to presume that injunctions of this kind would meet with universal acceptance, and the need to stress, to young and old alike, the risks involved in casual acts of intercourse must be recognised.

The Law Regulating the Sale of Contraceptives Through Vending Machines

Some of those who made submissions to us on contraceptive issues advocated that greater use be made of vending machines. These are already in use in a number of places. The only statutory provision which restricts the use of vending machines in the distribution of contraceptives is the Food and Drug Act 1969, section 18(1), which provides:

> Every person commits an offence against this Act who sells any therapeutic drug by means of a vending machine or by auctioning the drug.

The definition given to the term "therapeutic drug" by the Act is sufficiently wide to cover chemical contraceptives of all kinds, including hormonal contraceptives and jellies. However, it is apparent that while chemical contraceptives are within the ambit of section 18(1), mechanical contraceptives (not being drugs) may be sold by vending machines. Our attention has been drawn to the desirability of marketing condoms in conjunction with contraceptive creams or jellies. The latter fall within the definition of "therapeutic drugs", the sale of which by a vending machine is prohibited by section 18(1). The need for limiting the sale of drugs of

any kind is apparent, but contraceptive creams which may themselves be purchased across the counter can scarcely be said to be dangerous. In the United Kingdom a dual pack containing both condoms and spermicide is marketed. Submissions advocating that these should be made available here have been made to us. According to information supplied to us by the Chemists' Guild, there is a high degree of demand for both these items although they must at present be purchased separately. The use of both the condom and a spermicide together would provide a more effective contraceptive method. However, in view of the prohibition on the sale of spermicides as chemical contraceptives through vending machines, twin packs containing condoms and spermicides cannot at present be sold through this means. We recommend that section 18(1) of the Food and Drug Act 1969 be amended to permit contraceptive spermicides to be sold with condoms through vending machines.

The Provision of Contraceptives to Women and Girls Not of Full Mental Capacity

The moral and social issues arising from administering contraceptives to intellectually handicapped women and girls have already been discussed.

At present there is a possible legal impediment to administering contraceptives to such persons, particularly in giving injections of hormonal contraceptive, in that this practice could constitute an assault in law. An assault is defined by section 2 of the Crimes Act 1961 as being the act of intentionally applying force to the person of another, directly or indirectly. Consent may constitute a defence to a charge of assault, a point which we make in Chapter 7, but it is at least doubtful whether the purported consent of an intellectually handicapped woman or girl, who does not fully understand what is being done to her, is a consent for this purpose. As a present justification for the practice of administering injectable contraceptives to intellectually handicapped women and girls, a practice which already obtains in some institutions, it could be argued that it represents part of the medical treatment provided for them. We think, however, that the matter should be put beyond doubt, and that the Mental Health Act should be amended to provide that the superintendent of a psychiatric institution or any member of the staff of that institution directed by him should be able to administer contraceptives to intellectually handicapped women and girls as part of their treatment, and that no legal liability should attach to them for such acts. The same exemption should be given to parents and other persons or institutions having the custody of such women and girls.

RECOMMENDATIONS

1. That section 2(1)(a) of the Police Offences Amendment Act 1954 be amended to exempt from the prohibitions of the subsection certain classes of persons including parents, medical practitioners, accredited representatives of family planning clinics, and other responsible

agencies or groups to be named in regulations to be made under the Act.

2. That section 2(1)(b) of the Police Offences Amendment Act 1954 be repealed and replaced by a provision making it an offence:

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(2) To give information or instruction in the use of contraceptives to a child under 16 years of age, except where:
where:

(a) The person giving the information or instruction does so as part of any course on social relationships, biology, or human development approved by the Department of Education or Department of Health; or

(b) Where the person giving the information or instruction is approved by the principal or head teacher of any school.

3. That section 2(3) of the Police Offences Amendment Act 1954 be amended to exempt from the provisions of this subsection every child who procures or attempts to procure any contraceptive from any of the classes or persons defined in section 2(1)(a) as amended above.

4. That up-to-date, reliable, independent information on contraceptives and their use be produced in booklet form by the Department of Health and made available to the public free of charge by general practitioners and through various agencies such as family planning clinics and health clinics.

5. That factual, realistic, up-to-date films on sexually transmitted diseases be provided by the Department of Health and kept under constant review.

6. That parents and other persons having custody of intellectually handicapped women and girls be permitted to administer contraceptives to them, and that no legal liability attach to them for such acts.

7. That the superintendent of an institution or any member of the staff directed by him be permitted to administer contraceptives to intellectually handicapped women and girls as part of their treatment, and that no legal liability attach to them for such acts.

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8. That section 18(1) of the Food and Drug Act 1969 be amended to permit contraceptive spermicides to be sold with condoms through vending machines.

Chapter 3

HUMAN RELATIONSHIPS AND SEX EDUCATION

The Commission received many submissions stressing the desirability of some form of sex education in the school curriculum. Most of those who advocated this saw it as part of a continuing course dealing with moral education in its widest aspects. Not a few submissions pointed out the dangers inherent in sex education programmes when taught by people with no generally acceptable set of values or when handled in a clumsy, insensitive way. Some submissions were completely opposed to such programmes, seeing them as an unwarranted intrusion upon the rights and responsibilities of parents.

In addition to this evidence, presented by a wide variety of organisations and individuals, the Commission has studied programmes on sex education, family life, and human relationships currently being conducted in parts of the United Kingdom, Australia, the United States, and Europe. It has also had access to programmes being carried out at the present time in various schools in New Zealand. It notes that, for over fifty years, as evidenced in the Board of Health Report of 1922, the McMillan Report of 1937, the Thomas Report of 1943, the Mazengarb Report of 1954, the "Currie" Commission on Education Report of 1962, and the Education Development Conference Report of 1974, mention has been made of the important role schools should play in character training and moral education.

The Commission sets great store by stability in society and sees the family as the essential feature of such a society. The overwhelming weight of evidence presented to it confirms it in this view. It freely acknowledges that it is the fundamental right and duty of parents to instruct their children in attitudes and responsibilities with regard to sex and morality in general. Quite clearly, however, contemporary life brings far more problems to such instruction than was the case in the past. Until comparatively recently, moral standards were largely set by the family which, in its turn, was strongly influenced by the organised churches with their uncomplicated teaching that "right is right and wrong is wrong", and, in matters pertaining to sex, their insistence on the virtues of chastity. It would be foolish to pretend that there were not frequent deviations from the strict moral principles thus laid down, but society was less tolerant of such deviations, and social penalties could be much more severe.

Many parents still receive much support and assistance from churches and associated youth groups. The Commission regards the work of these organisations as most valuable and worthy of every encouragement from the community. However, it recognises that, in recent years, there has

been a marked falling-off in church attendance and traditional religious observance. In consequence, many families are no longer under pastoral oversight. Many have abandoned altogether any religious allegiance. Many are without any firmly held principles. All too often, family life has undergone such changes that it can hardly be said to exist at all. Divorce, broken homes, strained marital relationships, solo-parenthood, endless social engagements, mothers wearied by the day's work made necessary to meet financial commitments, television, which can so easily stifle any useful and sustained interchange of ideas, all compound the problem. Fortunately, there still exist a great many homes where children can grow up in a caring, responsible atmosphere. A united family unit can face and cope with most of the problems that are part and parcel of the process of growing up. A divided family may be unaware, until it is too late, that serious problems exist. Even in a stable home environment, parents frequently feel ignorant and inadequate or are emotionally incapable of imparting knowledge which is essential for the balanced physical, emotional, and moral development of young people.

The Commission sees the school as the one institution which reaches every child and therefore is in a unique position to influence the kind of society we will have. In this regard it notes the following comment from the Roman Catholic Archbishop of Liverpool in a letter in 1970 to the Heads of Catholic Schools:

> The education of children in sexual matters is primarily the right and duty of parents. In not a few cases, however, parents through inability or neglect, fail to carry out their responsibilities in this field. In such cases, the school may have a positive duty to supply as far as possible, the deficiencies of the home. Such a task when prudently undertaken will not be opposed by those people who have accepted and fulfilled their responsibilities in these matters.

For these reasons the Commission is firmly of the opinion that a carefully thought out school programme in the field of human relationships will, in some cases, complement what the stable, caring home achieves and, in others, will provide the only responsible information and instruction which children are likely to receive. It fully realises the delicate nature of much of the subject matter of such a programme and the many difficulties in providing material suited to the needs of children from varied backgrounds, with varied experiences, and at varied stages of physical or mental development. It is also well aware of the difficulty of sustaining a programme of this nature week by week and making it satisfying to pupils both individually and in class groups. It realises, too, the additional problems facing the school. The earlier onset of puberty with its attendant emotional stresses and at the same time, the higher age to which pupils now remain at school make it difficult for many to balance the restrictions of school life with the freedom apparent outside.

The Commission fully appreciates that the school is not the only means by which responsibility in individuals is developed and recognises the danger of regarding it as being able to provide a solution to all the problems of childhood and adolescence.

During its hearings throughout New Zealand, the Commission was concerned, both in evidence presented in public sessions and in many

private and confidential submissions, to come face to face with a large number of most distressing cases. Some of these appeared to result from an almost complete ignorance of the simple facts of life, some from the lack of even the most rudimentary guidance in moral principles, others again from an outlook with little, if any, appreciation of responsibility. Some, at least, of this distress might well have been avoided by dealing with these problems at source in courses such as the Commission has in mind.

In supporting the many requests for a place in the curriculum for these courses, the Commission feels that, provided certain principles are clearly established and laid down, the content and method of implementation of the programmes should be kept as flexible as possible and should be allowed to vary to suit the needs of particular areas and particular schools. It feels strongly that the programmes should be constructed with New Zealand conditions in mind and commends much of what is already being done in many localities. It emphasizes that sex education, the most sensitive and most controversial area of all, should not be treated as an isolated topic but should be regarded as a logical part of a total, carefully-integrated programme stressing the importance of responsible and understanding relationships between girls and boys, men and women, parents and children, teachers and pupils, old and young, individuals and races of different ethnic origins, and people of different religious persuasions or with no firm religious beliefs.

Full discussions between teachers, parents, and school authorities will facilitate the provision of programmes best suited to the particular needs of the schools and of the ethnic groups to which the pupils belong.

The Commission believes that the teacher is the key person in the success or failure of any programme. It is well aware that no school can be isolated from the society of which it is a part and which it seeks to serve. The current customs of the community are mirrored not only in the pupils and their parents but also in the staffs of the schools. Those teachers who have the responsibility for carrying out the human relationships programme must have a philosophy of living allowing them to deal with it with complete conviction. Their personal standards and their integrity are all-important. The Commission sees the school, too, as having a positive duty to set values and standards which depend, not on restriction and suppression, but on a sense of responsibility within a civilised group. By "values" it understands those qualities which are not the prerogative of any one class or any one age, but are unchanging—truth and integrity, justice, respect for others, tolerance, sympathy, responsibility, compassion. A school which expects these virtues at all times of staff and pupils alike, which insists on honest effort and a willingness on the part of all to do to the best of their ability the task that comes to hand, will produce an atmosphere of mutual respect and confidence where sympathetic instruction and advice, given with the authority that comes from experience, will be far more welcome and far more acceptable than is generally admitted. In such an atmosphere the whole area of sex education can be treated in the light of the individual's responsibility to himself, to others, and to the welfare of society.

The Commission is aware that this approach differs in concept, in certain aspects at least, from courses now in vogue in some areas overseas. It stresses again that teachers with maturity of outlook working in a favourable school atmosphere are the key figures in making such an approach worth while, and sees the adequate training of such teachers as of the greatest importance. In an endeavour to devise prescriptions that will meet the needs of pupils and parents alike and as part of a total programme aimed at the mental, physical, emotional, and moral development of children, the Commission stresses the desirability of basic courses in human relationships being provided for all teacher trainees. Although relatively few will specialise in this field, it is necessary that all teachers have an appreciation of the content of and the approach to an agreed programme. We attach great importance to the selection of mature teachers, by school principals, for specialist in-service training courses prepared by the Education Department, in consultation with practising teachers, Teachers' Colleges, and parents who are not themselves directly involved in the education services. This we see as an important first step in producing a greater awareness of the problems being faced by young people and an appreciation of what schools can accomplish in finding solutions, at least in part, for many of them.

RECOMMENDATIONS

1. That courses in human development and relationships be provided in all schools.

2. That such courses aim at inculcating a sense of responsibility towards both the individual and the community, recognising the family as an essential feature of a stable community.

3. That programmes be suited to New Zealand conditions and be kept as flexible as possible to cater for the special needs of particular areas and differing groups of pupils.

4. That sex education form a logical part of a carefully integrated programme on human relationships and not be treated as an isolated topic.

5. That basic programmes be prepared by the Department of Education in full consultation with Teachers' Colleges, teachers, and parents whose representatives should come from outside the ranks of the education services.

6. That highly qualified personnel be appointed as lecturers in human relationships in all Teachers' Colleges to:

(1) Conduct basic courses for all students.

(2) Assist with special in-service training courses for those teachers selected to teach human relationships in schools.

7. That regular refresher courses be held for teachers of programmes in human relationships.

8. That the selection of staff to undertake the programmes in human relationships be the responsibility of school principals.

Chapter 4

TECHNIQUES OF CONTRACEPTION

The techniques of contraception are relevant to this report so far as they bear on the legal, social and moral issues involved in "contraception in all commonly existing and likely forms."

It is not our purpose to provide a contraceptive manual nor to give a scientific evaluation of the effectiveness of one technique of contraception compared with another, and although we will deal in passing with health risks associated with the use of certain forms of contraception, our comments are not intended as an authoritative assessment of them. The selection of a contraceptive technique which is most effective and most suited to the needs of a particular couple is best left for discussion between that couple and either their medical practitioner or a family planning clinic. Moreover, it should be borne in mind that the efficacy of a specific contraceptive or technique depends not only on the effectiveness of the contraceptive itself, but also on its proper use. This point may be demonstrated by reference to the hormonal pill where it is necessary for a daily routine to be observed by the woman herself in order to ensure the high degree of effectiveness which its correct use makes possible.

CONTRACEPTIVE OR ABORTIFACIENT?

It is apparent from the submissions made to us that a doubt exists as to whether certain devices and techniques are contraceptive or abortifacient. By its own definition, contraception is the avoidance of conception, i.e., the prevention by any means of conception as a result of intercourse. By the same considerations an abortifacient is a mechanical, chemical or pharmaceutical agent which causes abortion. Abortion is the expulsion of the embryo or fetus from the uterus before it has proceeded to term. Some techniques or devices, said by some to be merely contraceptive and by others to be abortifacient, raise questions of a moral and legal nature, but these questions can only be answered after the mode of operation of the technique or device has been considered. That mode of operation itself requires a consideration of the processes of ovulation, fertilisation and implantation, at various stages of which the contraceptive device or technique will operate.

The adoption of the definition of contraception mentioned above would restrict the area of inquiry and would prevent us from embarking on a discussion of those techniques such as the intra-uterine device (I.U.D.), Morning-after Pill, and menstrual extraction, the legality of which have been questioned. For the purposes of this discussion, contraception includes all temporary and permanent measures designed to prevent

coitus from resulting in pregnancy whether by prevention of ovulation, fertilisation, or implantation.

PROCESSES OF OVULATION, FERTILISATION, AND IMPLANTATION

Process of Ovulation

The release of the ovum from the female ovary in each month is controlled by the hypothalamus which is that portion of the brain adjacent to the pituitary gland. The latter gland secretes two hormones; the first of these, a follicle-stimulating hormone, stimulates the ripening of follicles (structures in the ovary that contain eggs), and with the aid of the second hormone, a luteinising-hormone, causes one of the follicles to rupture and release the ovum. The ruptured follicle is then transformed into a yellow body called the corpus luteum which continues to produce estrogen and progesterone. The estrogen promotes the building of the membrane lining the uterus (endometrium) after each menstrual bleeding. Progesterone from the corpus luteum starts the secretion from the glands which prepare the superficial layers of the endometrium for the implantation of the fertilised ovum. If fertilisation does not occur, the corpus luteum ceases to produce this hormone and dies. The mucous membrane also dies and must be discarded. This is done by the passage of blood through this tissue, now in decay, and the uterine lining is shed in the menstrual bleeding. If, however, fertilisation does occur, the resulting conceptus produces a hormone called chorionic gonadotrophin. This is present in the urine in early pregnancy and forms the basis of pregnancy detection tests. Chorionic gonadotrophin maintains the life of the corpus luteum. It is only this complicated inter-relationship between the hypothalamus and the ovary which stimulates or inhibits the production of hormones as the case may be, and controls the process of ovulation, regulating it and making it cyclic.

Process of Fertilisation

When the ovum is released from the follicle it travels down the Fallopian tube where it may encounter the male sperm. For fertilisation to occur, the ovum must unite with the sperm within 48 hours of release. When the ovum is released, it is surrounded by a shiny skin called the "zona pellucida." To fertilise the ovum it is necessary for the sperm to penetrate this skin and this it does within the tube. The product of conception, now called the "zygote", travels down the Fallopian tube within which it is held for three to five days by a valve at the junction of the tube and the entrance to the uterus. The arrest of the zygote at the valve for this period of time is necessary to allow cell division to take place and for the zona pellucida to be shed. Unless the zona pellucida is shed, the zygote will not be able to implant itself in the lining of the uterus. The timing is important. If the period of time for which the zygote is held at the valve is altered, as it can be by various means, then the likelihood of successful implantation will be reduced. If it is held for too long, it may

implant in the Fallopian tube, causing an ectopic pregnancy. But if it is held for an insufficient length of time, it will be released into the uterus in a state where it is not sufficiently developed to implant.

Process of Implantation

Not every zygote that enters the uterus will implant because there are substantial losses of fertilised ova which are flushed from the uterus before implantation. But if it does implant, it will, as it passes through the stages of implantation, be called first a "blastula", and later an "embryo". As a blastula it will penetrate the mucous membrane lining the uterus and attach itself to the uterine wall by a network of roots. Implantation of the blastula in the uterine wall occurs about five to seven days after fertilisation and takes about four days. By the eleventh day following upon fertilisation, implantation is complete. Once implanted, the blastula becomes known as the embryo.

With an understanding of these processes, the techniques of contraception can now be better appreciated and examined.

COMMONLY EXISTING FORMS OF CONTRACEPTIVE TECHNIQUES

FOR FEMALES

The Hormonal Pill

In the last fifty years the processes by which ovulation is initiated and regulated and the influence of the hypothalamus in the menstrual cycle and its response to the feedback of material to it have become understood. The understanding of the inter-relationship between the hypothalamus and the ovaries has resulted in the exploration of the development of a hormone pill to control conception. For a time the lack of a source of cheap hormones impeded the control of conception, but the discovery that certain plants were rich sources of steroids from which oral ingestions could be synthesised inexpensively provided the impetus to the development and marketing of the pill. The combined estrogen-progesterone product became the subject of a trial in the 1950s and its efficacy in suppressing ovulation in women was then recognised. Since that time it has been found that lower doses of synthetic estrogens and progesterones can be used without any loss of efficiency in suppressing ovulation and, from 1970, only low dose oral contraceptives have been prescribed.

Mode of Operation

Hormonal pills are synthetic preparations consisting of the hormones estrogen and progesterone. The proportions in which these two hormones are combined determine their mode of operation. Hormonal pills may act in any of the following ways. First, they may act upon the pituitary gland

and the hypothalamus, inhibiting ovulation; secondly, they may act upon the cervix, altering the cervical mucus and making it hostile to sperm and interfering with their passage into the Fallopian tube for fertilisation; thirdly, they may act upon the endometrium and the fluid in the uterus and tubes, making the endometrium an unfavourable environment for implantation of the fertilised egg.

Types of Hormonal Pill

The Combined Pill

The Combined Pill is most commonly used. It is sold in many brands and contains both estrogen and progesterone. Pills containing these two hormones are taken from the fifth to the twenty-fifth day of the menstrual cycle. A break of a week then follows, when the pill-taking cycle begins again. Some brands of the Combined Pill contain a sufficient number of dummy pills to be taken during the period from the twenty-sixth day of one cycle to the fourth day of the next, in order to establish a routine of pill taking. The mode of operation of the Combined Pill is that it prevents the ova being released by the ovary but, even if an egg is released, conception is prevented by two other factors: (i) changes in the consistency of the mucus in the cervical canal, making it more difficult for the sperm to make its way through it to the Fallopian tube, and (ii) alterations in the endometrium, making the implantation of the fertilised egg less likely.

The Continuous, or Mini-Pill

This type of pill, of which brands are more limited, contains only a low dose of progesterone. Pills are taken daily throughout the month. Their mode of operation is to change the character of the lining of the womb and of the cervical mucus, although they may also inhibit ovulation.

The Sequential Pill

The contraceptive action of this pill depends entirely on estrogen. Progesterone is included in the latter part of the cycle merely to ensure normal menstrual loss. This pill was entirely withdrawn from the market in 1975 because of health risks.

Degree of Use of the Hormonal Pill

Oral contraceptives are among the most effective and the most widely used methods of family planning. According to information which we have received from the Department of Health, the use of contraceptive pills in 1974 in New Zealand was estimated to be as follows:

Combined Pill	2,057,800 cycle packs
Continuous or Mini-Pill	73,800 cycle packs
Sequential Pill (since withdrawn) ...	184,600 cycle packs
Total	2,316,200 cycle packs

It is estimated that over 20,000,000 women throughout the world take the contraceptive pill on any one day. (Derek Llewellyn-Jones, *Human Reproduction and Society*). New Zealand women between the ages of 15 and

45 years are said to have the second highest user rate in the world, a factor to which we have made reference earlier in this report.

Effectiveness of the Hormonal Pill

The Combined Pill, taken daily as prescribed, is considered to be 99.9 percent effective in preventing unwanted pregnancy. The Continuous Pill is less reliable than the Combined Pill but from various trials which have been conducted it can be said to be somewhere in excess of 95 percent effective. The Sequential Pill is also less effective than the Combined Pill, but its success rate has been estimated to be about 99 percent.

Health Risks

The biochemical alterations caused by the Pill affect the physiology of women and side effects may follow. There are health risks which must also be taken into account. It is not our intention, nor would it be within our competence on the evidence given to us, to assess the extent of these side effects, transient or long-term. Their evaluation would be a scientific study in itself. The Royal College of General Practitioners in England is currently carrying out a study of the health of 23,000 women who are using the Pill together with that of an equal number of non-users in a control group matched for age and marital status. It is the purpose of this study to try and assess the good and bad effects of the Pill and to see how far the one offsets the other. It seems to be accepted that the great majority of women will obtain a high degree of protection against unwanted pregnancies with only minimal side effects and that the health risks attached to the taking of the Pill will be far outweighed by its beneficial effects. A separate study, commenced in 1968, in which over 17,000 women in the United Kingdom are under observation, lends general support to this viewpoint. (*Journal of Biosocial Science,* Vol. 8, No. 4, Oct. 1976, pp.373–427).

The view was once held that the Pill was harmful to girls under 16 years of age and that it resulted in the stunting of growth through the premature closing of the bone ends. It is now established that once menstruation has commenced this is most unlikely to occur and the Pill has become medically acceptable as a contraceptive for a girl of this age.

Long-acting Injectable Progestogen (Depo-Provera 150)

This technique involves the intramuscular injection of a single dose of progesterone. This has a depot effect where the medication is stored and is slowly released into the system of the patient. It is effective as a contraceptive measure for three to six months and has the advantage that it obviates the need for the continuous decision-making required of women taking the Hormonal Pill. It can also be used during breast feeding as injectable progesterones do not affect milk secretions and may even improve them. Long-acting injectable progesterones are suitable for those women who have tried and abandoned for various reasons other methods of birth control and are prepared to have injections at three-monthly intervals.

Degree of Use and Efficacy

According to information given to us by the Department of Health, approximately 20,000 women now receive injectable contraception. It is over 99 percent effective.

Intra-uterine Contraceptive Device or Intra-uterine Device: (I.U.C.D. or I.U.D.)

This is a small coiled device which is inserted into the uterus. The idea that a foreign body placed in the womb prevents pregnancy is not new. It is reported that, at least 500 years ago, the Arabs introduced small pea-sized stones into the uterus of female camels which then repulsed the advances of male camels as if they were pregnant. This enabled beasts of burden to be used for long journeys without the intervention of pregnancy.

Various types of I.U.D. have been in use since the 19th century but, because of high complication rates, little interest in them was displayed until the 1960s. Since then considerable research and experimentation have resulted in their acceptance as effective and safe methods of contraception.

There are various shapes and sizes of I.U.D. They are usually made of plastic and occasionally impregnated with some chemical substance such as copper or progesterone which increases their efficacy. They are inserted into the uterus by means of a narrow "introducer" and spring back into their normal shape once released. They may be left in place for several years. The small size of modern I.U.Ds enables them to be used by women and girls who have never had children.

Mode of Operation

The working of the I.U.D. is still not fully understood. Because of this, doubts were expressed to us as to whether the I.U.D. may achieve its anti-fertility action by causing detachment of the implanted blastula (abortion). The Commission has, therefore, been at pains to gain the most recent medical information, and this is reflected in our comments in these paragraphs.

There is general medical agreement that the I.U.D. does not interfere with the woman's ovulatory cycle or with fertilisation, but rather appears to exert its main contraceptive action on the uterus itself by inhibiting the process of implantation.

Various theories of its mode of action have been suggested: mechanical interference through the physical presence of the device itself; a combination of foreign body reaction with low grade inflammation in the uterus; and destruction of the sperm and fertilised ova by toxic substances. So far none of these actions, either singly or in combination, has provided a complete explanation of the working of the device or at any rate an explanation applicable to all kinds of such devices which have been studied up to the present.

The indications of more recent research are that the various anti-fertility actions which have been attributed to I.U.Ds are linked to the release, in their presence, of a hormone called "prostaglandin". It is

believed that prostaglandins cause an alteration in the rate of transport of the fertilised egg down the Fallopian tube. The crucial element in implantation is timing, the stage of development of the fertilised egg and the lining of the uterus being critical. An alteration of this process brought about by the release of prostaglandins makes implantation impossible.

The efficiency of the I.U.D. may be increased by the addition of hormones such as progesterone or trace elements such as copper. This renders the uterine lining hostile to implantation.

Whatever views about the mode of action of I.U.Ds in women ultimately emerge, it is fair to say, in the light of present day scientific knowledge, that their action is complete before the stage of implantation is reached. They can therefore be considered as contraceptive and not abortifacient.

Effectiveness of I.U.Ds

The effectiveness of the I.U.D. as a contraceptive agent depends on the particular kind of I.U.D. employed. It has been reckoned to be in the vicinity of 98 percent. The I.U.D. must be properly inserted. There is a slight risk that, once fitted, it may be expelled.

Health Risks

There are health risks associated with the use of the I.U.D. It may cause an infection in the womb or aggravate an already existing condition. The risk of ectopic pregnancy (implantation in the Fallopian tube) is higher in women using I.U.Ds. It may cause pain and excessive bleeding during menstruation. There is a possibility that the I.U.D. may penetrate the wall of the uterus and enter the abdominal cavity, but this is not to be regarded as a significant risk. The I.U.D. is useful for women who dislike the idea of oral contraceptives or are medically unsuited to them. Its cost is low, and once inserted it will remain *in situ* indefinitely unless deliberately removed or accidentally expelled.

Caps

These are thin rubber domes that fit over the cervix or mouth of the womb and prevent the sperm moving into the Fallopian tubes via the uterus. They are of three kinds: diaphragm, cervical, and vault. They must be inserted before intercourse and should be left in place for six or eight hours afterwards. They should initially be fitted by a doctor or other suitably trained person. They should be used in combination with a vaginal jelly or cream.

Diaphragm or Dutch Cap

Prior to the introduction of oral contraceptives, the diaphragm was the contraceptive method most recommended by doctors for women. It is the largest of the caps. The perimeter of the dome contains either a coiled spring or a flat metal spring.

Cervical Cap

This is much smaller than the diaphragm. Its construction is similar although it has no spring. It fits over the cervix.

Effectiveness of Caps

The cap is more effective when used with a spermicidal jelly or cream and its effectiveness depends on its correct fitting and conscientious use. It has been estimated that, used with a spermicide, it is 95 percent effective. There are few health risks associated with its use.

Chemical Contraceptives

Chemical contraceptives are creams and jellies, soluble pessaries, foaming tablets, and foam-producing aerosols. Each type of chemical contraceptive contains an ingredient which kills or renders inactive the sperm ejaculated. They may also form a barrier over the neck of the womb against the entry of the sperm into it. Chemical creams and jellies should be used in conjunction with a cap.

Health Risks

There are no health risks associated with chemical spermicides, although irritation or inflammatory changes of the mucous membrane have been reported in a few cases.

Effectiveness of Chemical Contraceptives

Spermicides used alone appear to be less effective than when used with a diaphragm. Clinical trials in the United States have shown that vaginal foams are more effective than other types of spermicides.

The Douche

This method involves the washing out of the vagina after intercourse with water or a douching agent. It is not recognised as an effective method of contraception.

The Morning-after Pill

This term is in fact a misnomer, in that the Morning-after Pill is not just one pill but usually a five-day course of pills containing high doses of estrogen which are taken within 72 hours of unprotected intercourse during the time a woman is ovulating.

Mode of Operation

The large doses of estrogen prevent implantation of any ovum that has been fertilised during the act of unprotected coitus. Fertilisation is not impeded and an established implantation is not interrupted. The success rate is high if the treatment is given at the right time and at the correct dosage. The Morning-after Pill has side effects which are more unpleasant than dangerous. These are vomiting, nausea, headache and dizziness. It is to be looked on as an emergency measure only. If implantation is taken as

marking the beginning of pregnancy, the Morning-after Pill is a contraceptive and not an abortifacient.

Menstrual Regulation

Menstrual regulation is also called menstrual extraction, menstrual induction, menstrual planning, menstrual interruption and endometrial aspiration.

It involves the aspiration of the contents of the uterus within a few weeks of a late menstrual period, usually not more than 14 days after the expected onset of the menstrual period. A Karman cannula of small dimensions is inserted through the cervix into the uterus after the cervix has been dilated, if that is necessary. A negative pressure is applied and the contents of the uterus are sucked out. The technique is widely used in some parts of America and in several Asian countries, where it has become routine.

Because the menstrual period of a woman is suppressed only after implantation of the fertilised ovum in the uterine lining, the carrying out of a menstrual extraction may be expected, in the majority of cases, to terminate a pregnancy of which the stopping of the menstrual cycle is some evidence. In a study, entitled *Very Early Termination of Pregnancy (Menstrual Extraction)* by Stringer, Anderson, Beard, Fairweather and Steele, the cases of 424 women in three London teaching hospitals were considered. Of these women, 90 percent were no more than 14 days overdue. Of these, 67 percent had histological evidence of pregnancy. The process of menstrual regulation differs little in technique from abortion carried out in the first trimester of pregnancy, and has a similar incidence of complications. It is not, however, referred to as abortion or termination because no pregnancy diagnosis is made before the technique is employed. The operation cannot, therefore, be said in a specific case to be intended to procure the miscarriage of the woman concerned because, apart from the lateness of her period, the technician will have no knowledge that the woman may be pregnant and in some cases there will be no subsequent histological evidence. The procedure has not, so far as we are aware, been established in New Zealand. If implantation is taken as marking the beginning of pregnancy, the technique is abortifacient and not contraceptive.

Health Risks

Menstrual regulation is unpleasant for the patient. A local anaesthetic is desirable, though not strictly necessary. There are gynaecological dangers inherent in the procedure as it involves interference with the uterine cavity and lining.

We were told of, and shown, a portable kit containing an instrument which could, it was said, be used by a woman for regulating her own menstruation. On the medical evidence we have heard, the use of such an instrument by the woman herself can only be described as hazardous.

Natural Family Planning

Under this heading there can be grouped three methods of natural family planning. They are:

1. The Ovulation, or Mucus Method.
2. The Safe Period, or Rhythm Method.
3. The Temperature Method.

These methods are all called "natural" because they avoid the use of artificial means of contraception and are based on the biological fact that a woman is infertile on the majority of the days of the menstrual cycle. The days of infertility, when it is impossible for an act of intercourse to cause conception, are more numerous than the days of fertility when conception is possible. Therefore abstinence from sexual contact during the days of possible fertility is required in all "natural" methods of contraception.

The Ovulation, or Mucus Method

It is the occurrence of ovulation that determines which are the fertile days within the menstrual cycle. It is now well established that the occurrence of fertility in a woman is always accompanied by the secretion of a particular type of mucus from the glands of the cervix or the uterus. The mucus develops ahead of ovulation and warns of its approach. Unless the mucus is present in a quantity and of a consistency which will preserve the sperm cells in a virile state and aid their transport to the Fallopian tube, fertilisation will not take place. A change in the character of the mucus about the time of ovulation, and in the days preceding it, can be detected by the woman herself provided she is first trained to recognise the symptoms. The partners at this time must avoid all sexual contact.

The Safe Period, or Rhythm Method

Unlike the Ovulation Method, the Safe Period, Calendar or Rhythm Method of contraception is dependent upon a woman having regular cycles. It has, because of the variation in cycles of the average woman, sometimes been proved to be unreliable and so has fallen into some disrepute. This doubt as to its reliability has hindered the acceptance of the Ovulation Method with which it has been sometimes confused. The Ovulation Method does not depend for its efficacy on regular cycles but is applicable to all variations of reproductive physiology in the female, including irregular cycles and anovular cycles, lactation, the approach to menopause and low fertility.

The Temperature Method

The Temperature Method is an improvement on the Calendar or Rhythm Method. Its working turns on the fact that following ovulation the basal body temperature rises about 0.3°C and remains elevated until the next menstrual period. Knowledge of this fact can be used

either to avoid pregnancy or to improve the chance of pregnancy by selecting the optimum time for intercourse for those planning pregnancy. Unfortunately infection or illness may cause elevation of temperature and thus confuse the user.

Effectiveness of Natural Family Planning

Of the three natural methods referred to, the Ovulation Method is the most effective. It requires to be properly taught, and the symptoms of ovulation carefully observed if it is to be effective. It also requires the partners to accept the discipline of refraining from intercourse during the time that the woman may most desire it. But if the method is properly observed, it provides a safe method of contraception.

Prolonged Lactation

Since time immemorial, women have known that they are less likely to become pregnant if they breast feed their babies. This has led to the deliberate extension of lactation in order to reduce the likelihood of conception. Breast feeding prolongs post-partum amenorrhoea but it is impossible to predict the extent of the prolongation. Ovulation may return at any time and even precede the first post-partum menstrual period. If this happens, conception may occur while the woman is amenorrhoeic.

FOR MALES

The Condom

The Condom is a sheath of fine latex or plastic, sometimes prelubricated with silicone. Its purpose is to prevent semen entering the vagina.

Effectiveness of the Condom

The reliability of condoms is difficult to evaluate. According to a publication of the Consumers' Institute of New Zealand, *How to Cope With Contraception*, tests conducted by the Consumers' Association in the United Kingdom in 1963 showed that they were poorly made. In 1964 a British Standard (B.S.3704) was fixed. This resulted in an improvement in the efficacy of the condom. Additional tests carried out by the Consumers' Association in 1966 and further tests in 1970 showed marked improvement. The British Standard allows only 0.5 percent of condoms to fail.

The pregnancy rate following the use of the condom or diaphragm is difficult to evaluate because much depends on the motivation to use the method properly. Condoms are reckoned to be about 90 percent effective, if properly used. They are best used with spermicidal creams or pessaries.

According to information which we have received from the Department of Health, 800,000 packs of condoms (packs of three) were sold in 1971. Condoms are more frequently used in acts of casual sex and by younger persons than by married couples who prefer other methods of contraception.

Health Risks

There are no health hazards attaching to the use of the condom. In fact, the condom will assist in preventing the spread of sexually transmitted diseases.

Washable Sheath

This is a type of condom which is designed for continuous use. The rubber is thicker, and on that account the enjoyment of the sexual act may be impaired. Washable sheaths are little used.

Coitus Interruptus

Coitus Interruptus is said to be probably the oldest method of birth control, and to have played an important part in the transition from a high to a low birth rate which occurred in many European nations between 1820 and 1890.

Effectiveness of Coitus Interruptus

The effectiveness of coitus interruptus as a method of birth control depends on the ability of the male to recognise impending ejaculation and to withdraw before ejaculation occurs. It may be more effective than has been previously recognised. It requires no preparation and the cost is nil. It has been claimed that coitus interruptus is physically and psychologically injurious to both partners, but this claim cannot be substantiated. A woman may fail to reach orgasm and may become sexually frustrated unless her partner brings her to orgasm by other means.

OTHER METHODS

Throughout history, various other methods of fertility control have been tried. These have included sexual abstinence, celibacy, late marriage, isolation of women, and taboos associated with menstruation and childbirth. We do not propose to discuss further these methods, some of which, though they have their origins in folk lore, are still used in various countries and societies.

LIKELY FUTURE METHODS OF CONTRACEPTION

In addition to the better known methods of contraception outlined in this chapter, significant developments in the field of fertility control have been made recently, resulting in many promising new methods.

As the terms of reference of the Commission refer not only to present but also likely forms of contraception in the future, some of these research findings are presented below. It must be noted, however, that several methods which were considered to have much potential in recent years have not fulfilled their promise and, according to medical opinion, will not be of any great importance.

The possibility of drug control of male fertility has evoked interest and much research effort, but for various reasons, probably related to

apprehension regarding alterations in libido and psychological resistance, little research has been done on man himself. It is considered that although preparations have been developed to reduce sperm counts, these do not hold out much promise at present.

Other methods for women, such as injectables and implants have also not lived up to expectations and research is continuing into their use.

However, from the various areas of research it is possible to compile a list of potential methods of regulating fertility which, in the light of present day knowledge, appear likely to meet with success.

Medicated I.U.Ds

Research has shown that the addition of bioactive ingredients such as trace metals and hormones to I.U.Ds increases their efficiency.

Copper was the first substance to be added to the conventional I.U.D.; the Copper-7 and the Copper-T are now distributed worldwide.

Another bioactive substance, progesterone, has recently been added to the I.U.D. Progesterones are known to alter the lining of the uterus in such a way as to prevent implantation and may also reduce cramping and pain caused by the I.U.D. because they have a tranquilizing effect on the uterus. A progesterone-bearing I.U.D. has been available in New Zealand since 1 February 1977. This is a flexible device with a hollow stem containing progesterone which is released gradually into the uterus. It must be replaced at the end of one year when the active ingredient is exhausted.

Implants

The progesterone device described above at present holds more promise than an implant under the skin which has various disadvantages, an obvious one being the need to remove the capsule after the medication has been exhausted.

However, research is continuing into the manufacture of a biodegradable form of capsule for implantation.

Vaccine Against Pregnancy

The first clinical trials of a vaccine against pregnancy hold sufficient promise to warrant further assessment. The vaccine produces antibodies to chorionic gonadotrophin, so destroying the hormone which plays a critical role in maintaining pregnancy. This gives immunity to pregnancy in much the same way as a smallpox injection gives immunity to smallpox. The vaccine is claimed to be long-lasting in effect (from 11 to 16 months); it can be boosted by a second injection and shows every sign of being reversible.

Extensive testing must still be carried out but immunisation of women against pregnancy is considered a realistic prospect for the future, and will probably play an important role in the next five years or so.

Prostaglandins

Prostaglandins are a group of hormones which produce uterine contractions and also alter the speed of transport of the egg down the tube, thus preventing implantation. Work on the use of tampons impregnated with prostaglandin is well advanced. The tampon is inserted into the vagina and will bring on menstrual bleeding whether or not the cycle has been fertile. We understand that this method will be in use overseas in the next year or so.

Contra-progestational Pill

This is a pill to be taken once a month at the time of expected menstruation. It interferes with the preparation of the uterine lining for implantation and causes bleeding whether or not the cycle has been fertile. Several compounds with a potential for this action are available and may hold promise for the future.

Many other lines of investigation are at present being followed and open up a diverse range of possibilities, such as sex determination at will by immunisation with Y sperm antigen, the release of premature eggs, and immunisation with sperm antigens. None of these is as yet sufficiently developed to be regarded as a serious practical possibility in the foreseeable future.

Chapter 5
CONTRACEPTIVE SERVICES

BENEFITS OF FAMILY PLANNING

The beneficial effects of family planning on the physical, mental, and social health of the mother, the child, and the family group have already been discussed in Chapter 1.

Many submissions were made to us in which the belief was expressed that, with more adequate family planning, there would be an improvement in the quality of family life and less need to consider abortion as an alternative for unwanted births. It was suggested that an extension of facilities for contraception was most desirable and that such an extension could be brought about in one or more of the following ways:

1. By establishing family planning clinics in areas deficient in such services.
2. By making the services provided by family planning clinics more readily available to people who do not make use of such services.
3. By making greater use of para-medical staff in family planning clinics.
4. By providing contraceptives free of charge.
5. By providing free contraceptive advice.
6. By taking the Pill off prescription and allowing more retail outlets for the sale of contraceptives.
7. By extending educational programmes already provided for secondary schools and the public and by increasing the training given in this area to all health professionals.
8. By mounting a promotional campaign for contraception.
9. By encouraging the advertising of contraceptives.
10. By repealing the Police Offences Amendment Act 1954, thus legalising the distribution of contraceptives to those under 16 years of age and the giving of instruction in contraception to persons in this same age group.

ORGANISATION OF FAMILY PLANNING SERVICES

At present there are a number of facilities for the provision of contraceptive advice. Advice can be obtained from general practitioners, from private specialists, from any one of the 32 clinics of the Family Planning Association which function in various parts of the country, or from any of the eight clinics conducted by hospital boards. There are also 67 Natural Family Planning Centres, established in hospitals, halls, and private homes, which give instruction in the techniques of natural family planning, to which reference has already been made. Appendix 9 lists the geographical locations of the clinics in New Zealand.

General Practitioners and Family Planning

In most cases the family doctor is in the best position to provide confidential contraceptive advice. He is able to give continuing care and ensure that the contraceptive method used will be compatible with any other health or social problems that the patient may have. Although we will later discuss the areas in which the training of medical students in matters of family planning is deficient, there seems to be a growing measure of acceptance on the part of general practitioners that the control of human fertility is an important part of their responsibility to patients and their families.

Evidence was presented to the Commission which indicated that, for a number of reasons, the close and personal ties once regarded as commonly existing in the relationship of doctor and patient have been eroded. In group practices, which are becoming established as part of the system of medical services in New Zealand, patients are not always able to consult the doctor of their choice. In what are known as "lock up" practices, where the doctor can be seen only in a city or suburban surgery during specified hours of the day, the patients who require medical advice must, outside those hours, seek it elsewhere, and the doctor and patient relationship is for that time severed. Today people do not always live, as they once did, in the same locality during a substantial period of their lives but move from one community to another. Young people, in particular, are no longer restricted by geographical limits. Then, as has been drawn to our notice, some doctors, because of their religious and other personal beliefs, do not provide contraceptive advice or services. Others again do not give contraceptive counselling but limit their service to the mere prescription of contraceptives.

Although many complaints were made to us about the inadequacy of family planning advice provided by general practitioners, the Commission is of the view that doctors who offer no services or only limited services of this kind are few in number and that the patients affected are not greatly inconvenienced by having to seek out another doctor or attend a clinic.

Any general criticism directed against the general practitioner as the first and best source of contraceptive advice would not be justified, but it would be idle to pretend that the family doctor is to be regarded as the only source of contraceptive advice or, where more than one source is available, always the best source of that advice.

New Zealand Family Planning Association Clinics

Together with the clinics conducted by the hospital boards, and natural family planning centres, the New Zealand Family Planning Association offers a valuable alternative source of consultation to that provided by general practitioners and specialists. Doctors, nurses, and receptionists employed at the clinics receive specialised training and have a particular interest in the problems of patients seeking advice about contraception, infertility, and sexual relationships. The commitment of the staff of such clinics to family planning services enables them to give more time to those patients who, because of embarrassment, respond better to the female

doctors who form a large percentage of the medical personnel in this area. A high proportion of the patients seen at family planning clinics are those with problems which are time-consuming, and this, in addition to the provision of free services for those who are unable to pay either for the contraceptive advice or the contraceptives themselves, places a severe financial strain on the Association. Donations and membership fees are received from individuals, but the Association is dependent upon the Government grant which for the 1975/1976 year amounted to $73,000. The Association made it clear to us that it needs the additional finance in order to reduce its waiting list, establish new clinics, and expand its educational programme.

Hospital Board Clinics

It is within the powers of hospital boards to set up family planning clinics, but not all have done so. The reason for this apparent tardiness is that clinics are given a low rating in the claims made on the limited funds available to hospital boards. Yet these clinics can play an important part in the teaching of skills in family planning to medical and nursing students, and the provision of clinics by more hospital boards on that ground alone is justified.

Natural Family Planning Centres

In 1975, over 1,000 couples attended at one or other of the 67 clinics established by the New Zealand Association of Natural Family Planning Centres. Two-thirds of those attending were Catholics; the remainder had other religious beliefs or were of no religious persuasion. These clinics are staffed by 120 tutor teachers who have a detailed knowledge of natural family planning techniques and are experienced in interviewing and counselling. In 1976, a full time co-ordinator was appointed to train tutors, to visit local areas, to encourage the setting up of clinics, and to ensure that existing clinics are reaching an adequate standard. Although the teachers are not paid, the New Zealand Association of Natural Family Planning Centres does incur expenses in their training. Patients are asked to pay for the charts used, and expenses have been kept down by churches and voluntary organisations giving the use of their premises free of charge. The Commission recognises the contribution made by natural family planning centres to developing responsible parenthood and supports strongly the granting of financial aid by the Government to centres of this kind.

We are happy to note that the New Zealand Family Planning Association and the New Zealand Association of Natural Family Planning Centres appear to work in well with each other and we see no reason why financial help should be given to one association to the exclusion of the other.

Hospital Obstetric and Gynaecological Departments

It is standard practice in some New Zealand obstetric and gynaecological departments to give family planning advice to all patients in their reproductive years. This advice is given to patients attending post-

natal clinics and to those who have had a termination of pregnancy. The Commission considers that patients should be made aware of the wisdom of inquiring about contraception from their doctors or midwives when they are attending these departments. When such advice is sought, it should be given with the same confidentiality and respect for the rights of the patient as is the custom in family planning clinics. If the initiative for discussion is taken by hospital staff, it is important that interviews be conducted with equal sensitivity and that equal respect be shown for the attitude and opinions of the individual patient.

EXTENSION OF FAMILY PLANNING SERVICES

Increased financial assistance to clinics is required in order that they may expand. The Commission is impressed by the services given by them and considers that more government finance should be provided. Support should be given to voluntary agencies, not only for their clinical services but also for their educational programmes, their research undertakings, and the training of their staff. We note that at the present time the New Zealand Government provides less support for New Zealand agencies than for overseas family planning activities. It is pertinent to observe that, in 1975, $700,000 was set aside by the New Zealand Government to support the United Nations Fund for Population Activity and the International Planned Parenthood Federation, an action which we endorse. From this grant the Federation will return to the New Zealand Family Planning Association $10,000 together with contraceptives to the value of $4,500. We appreciate that family planning is not to be looked at in isolation from the problems of world population growth, but adequate provision should be made to meet the need, which we believe has been clearly demonstrated, for further aid in this country.

The Commission has been made aware of the importance of sufficient numbers of trained staff being available to ensure that people at greatest risk are motivated to seek out and utilize contraceptive services at places readily accessible to them. It was recommended to us that mobile clinics should be provided to ensure better services for some rural areas, that special services such as the home-visiting of Maoris and Pacific Islanders should be considered, and that, in urban areas, neighbourhood clinics with community involvement should be established. We consider that social workers from the same ethnic groups may well provide a more acceptable and more effective service for both Maori and Pacific Island families. We think, too, that clinics attended by young people should have counselling available for those who have social and psychological problems arising from their personal relationships.

We recognise that nurses are able to give a closer and more continuous supervision of family planning care than busy medical practitioners can possibly provide. If more responsibility were given to nurses in these matters, medical practitioners would be enabled to give adequate time to initial consultations and specialised care to those patients referred to them because of well-defined signs of abnormality.

DISPENSING OF CONTRACEPTIVES

From the evidence given to the Commission, it seems that the contraceptive Pill and the I.U.D. have a small but significant complication rate. For that reason these two forms of contraception should be available only on prescription from a medical practitioner as is the case at present.

On the evidence before us, we do not favour an extension of the outlets for the distribution of condoms and spermicides to include dairies, supermarkets, and other agencies as recommended in some submissions.

FREE CONTRACEPTIVES AND FREE CONTRACEPTIVE ADVICE

Over forty submissions were made to the Commission containing recommendations that all contraceptives should be made available free of charge. The range of support for these views came from individual doctors, from medical groups, from numerous women's groups, and from a variety of other individuals and organisations. The Royal College of Obstetricians and Gynaecologists of New Zealand, in a survey of 98 of its members, reported that half the members surveyed considered contraceptives should be free on prescription. The findings of a Heylen poll conducted in 1975 revealed that 46 percent of the sample of the population who were the subject of the poll considered that contraception should be available free under social security. There was also evidence given to the Commission that the most disadvantaged people could be deterred from seeking contraceptive advice and supplies because of the costs involved. It was maintained that for these reasons great social and personal benefits would ensue if contraceptives were provided free of charge.

We have considered the submissions made to us which maintain that effective fertility control results in a favourable cost benefit to the community. Studies to this effect, in which overseas experience has been analysed, were produced, including one undertaken into the birth control campaign in Aberdeen between 1946 and 1970. In a review of the study entitled *Birth Control Campaign: The Benefits of Birth Control; Aberdeen's Experience 1946-1970* by A. Service, it is claimed that the benefits of the service had included notable reductions in the birth rate, fertility rate, high risk pregnancies, illegitimate birth rate, and unwanted pregnancies in large families. Expenditure on contraceptive services was claimed to have been more than offset by the savings to the ratepayer on maternity services, care of deprived children, support of persons with mental or physical handicap of genetic origin, and a multitude of services for problem families. It is to be noted that the institution of the scheme has met with criticism as well as praise. In another study by B. Thompson and J. Aitken-Swan, *Pregnancy Outcome and Fertility Control in Aberdeen*, it was said that the objectives of Aberdeen's programme of "every pregnancy a wanted pregnancy" was not achieved in that the rate of therapeutic abortions among some groups of single women continued to rise.

A matter to which we would make reference was the institution in April 1974 in England of free contraceptive services from family planning clinics

to all who need them. In 1975 this service was extended to permit general practitioners to supply contraceptives free of charge. When this scheme is fully developed, it is expected that three million women will receive free contraceptives at a total cost to the State of £27 million per year.

Estimates of contraceptive usage in New Zealand given to us by the Department of Health are set out in Chapter l. From figures provided for us by the New Zealand Family Planning Association and confirmed by the Department of Health, it is estimated that to provide these contraceptives free of charge would involve an expenditure of $4 million annually. If all the women in New Zealand between 15 and 44 years of age were supplied with hormonal contraceptives for a year, the total annual cost at retail pharmacy rates would be $8.4 million.

On the evidence placed before us, we do not think that it has been clearly established that contraceptives would be more widely used if they were made available free of charge. There is no doubt that New Zealand women are already high users of contraceptives. In our opinion, the non-use of contraceptives by some people is based on psychological reasons or moral attitudes rather than on economic factors. The Commission, therefore, does not agree that contraceptives should be made available free of charge. It is aware that already too many calls are made on the public purse and it has found no evidence to show that, if contraceptives were available without cost, their use would be extended to those who are most in need of them. It is reinforced in this opinion by evidence pointing out that people, as a whole, tend to make full use only of those things which they have paid for. Nevertheless, there are those cases where the limitations in the family budget have resulted in couples finding themselves unable to pay either for contraceptives or for advice. Several women who spoke to us stressed the risks they had run of having unwanted pregnancies through their inability to pay for a supply of the Pill at some particular time. Some had, in fact, become pregnant and had felt compelled to seek an abortion. At the present time, when contraceptives are considered by a medical practitioner to be necessary on medical grounds for a patient who cannot reasonably be expected to meet the cost involved, these may be supplied free of charge if the doctor obtains the permission of the Department of Health by means of a letter setting out the special circumstances. There have been only 362 such applications since 1971, and the procedure for obtaining approval appears to us to be cumbersome and time-consuming for doctors. However, many more contraceptives are obtained free of charge by being prescribed by a medical practitioner for an "approved condition". One example of an "approved condition" would be a menstrual irregularity. We note that in 1972 the New Zealand Family Planning Association, supported by the Department of Health, submitted to the Royal Commission on Social Security that "contraceptives should be available under benefit for family planning purposes in those cases where the medical need and financial hardship were substantiated by a doctor" (*Social Security in New Zealand*, Report of the Royal Commission of Inquiry, March 1972, page 449). We are of the view that a case exists for the provision of free contraceptives where there is financial hardship as well as for approved medical

conditions. The Commission considers that the prescribing doctor should be entitled to authorise the supply of free contraceptives in these cases without reference to the Department of Health.

A delay occasioned by the difficulty in securing prompt financial approval may prevent a patient from obtaining contraceptive advice, particularly initial advice. The result may well be an unwanted pregnancy. We think that every encouragement should be given to patients to seek prompt advice and recommend that the general medical services benefit payable to doctors for consultation regarding contraception should be increased and that no fee be payable by the patient. We would expect that, in these circumstances, a full consultation would be provided with a complete physical examination, including a vaginal examination and cervical smear in addition to contraceptive counselling.

The Department of Trade and Industry and the Department of Customs have at our request supplied to us information as to the duty and sales tax charged on contraceptives. No sales tax is charged on contraceptives although certain contraceptives are subject to duty. We recognise that trade and tariff arrangements may require duty to be charged on some contraceptives. Subject to the observance of such arrangements, it is our view that no duty should be otherwise charged on any contraceptives, contraceptive devices, or pills, provided that they are regarded by the Department of Health as efficient and acceptable.

STANDARDS FOR CONDOMS

In the United Kingdom, where there is a standard by which condoms may be tested, there are at least 52 brands of condoms which comply with it. In New Zealand there are no separate standards laid down for condoms although the appropriate British Standard, B.S.3704, 1972, is endorsed for use in New Zealand, as is also the appropriate standard for diaphragms, B.S.4028, 1966. When a British Standard is endorsed for use in New Zealand, articles which meet the standard are considered by the relevant Standards Association as suitable for use in this country. However, it is not mandatory to comply with the standard. A standard becomes mandatory in this country only after it has been declared as such. Alternatively, a separate New Zealand standard can be drafted.

Condoms are not manufactured in New Zealand. The standard, B.S.3704, endorsed in this country, relates to condoms manufactured in Great Britain which supplies at least 95 percent of those sold here. Only a very few brands of condoms sold in New Zealand bear the KITE mark which is the sign of compliance with the British standard. We recommend that, if condoms are to be manufactured in this country, the manufacturer should be required to meet a standard specification no less stringent than that which obtains in the United Kingdom. Condoms imported from other countries should be subject to the same requirement.

INFORMATION AND EDUCATION

Elsewhere the Commission has given at some length its views on sex education as one part of a carefully integrated programme in the field of

human relationships. It sees contraception and family planning with all their implications both for the individual and for society as a logical and, indeed, an essential feature of this aspect of the wider programme. In line with its recommended approach, the Commission does not approve of the mere handing-out of factual information but believes all information must be related to the moral, emotional, and social aspects of sexual development and treated with a view to producing stable and happy family relationships. Economic and demographic factors relevant to fertility control may be dealt with naturally in the same context. The Commission recognises that schools have a particular problem in dealing with the topic in a manner suited to the ages of the pupils while, at the same time, ensuring that vital information presented in a responsible manner is made available to early leavers. Numerous submissions emphasized the particular needs of young people in this category. To provide for them, there appears to be an important place for responsible groups and organisations such as family planning associations, who are able to provide information on contraception and family planning against a background of personal responsibility and caring concern for others.

The Commission is well aware, however, and this was stressed in numerous submissions, that recent years have witnessed great changes in the attitude of many to sexual relationships. While its whole educational policy is aimed at encouraging stable family homes, and while it refuses to adopt the defeatist attitude that nothing can be done to stem the tide of permissiveness, the Commission cannot shut its eyes to the fact that large numbers do not at present accept the necessity for pre-marital chastity. For these, as well as for others, information on contraception is seen as essential to prevent large numbers of unwanted children being irresponsibly brought into the world.

The Commission does not feel that a responsible approach to contraception and family planning should in any way run counter to a person's moral or religious beliefs. It feels strongly that there should be no legal sanctions against those who are sincerely engaged in implementing programmes within the broad framework that has been indicated.

RECOMMENDATIONS

1. That hospital boards be urged to set up family planning clinics if none already exist under their jurisdiction.
2. That all obstetric and gynaecological departments of hospitals give confidential family planning advice to patients attending these departments.
3. That grants be made by the Government to assist with the financing of natural family planning centres, and that increased financial assistance be provided by the Government in order to expand the services of family planning clinics.
4. That mobile family planning clinics be provided to ensure adequate services for rural areas.
5. That special home visiting family planning services be provided for Maori and Pacific Island families.

6. That social workers of the Maori and Pacific Island races be appointed to work with these ethnic groups and to discuss contraceptive practices with them.

7. That counselling services be available at family planning clinics for young people with social and psychological problems.

8. That adequately trained nurses be given responsibility for family planning care in order to release medical practitioners to give more specialised help to patients.

9. That free contraceptives be supplied where there is financial hardship or where there is an approved medical condition.

10. That, in cases of economic need, medical practitioners be permitted to authorise the supply of free contraceptives without reference to the Department of Health.

11. That the general medical services benefit be increased to enable initial contraceptive consultations to be provided free of cost to the patient.

12. That no duty be charged on any contraceptives, contraceptive devices, or pills, provided that they are regarded by the Department of Health as efficient and acceptable.

13. That, if condoms are manufactured in New Zealand, they be made to meet a standard specification no less stringent than that which obtains in the United Kingdom.

14. That all condoms imported from overseas be required to meet a standard equivalent to that required in the United Kingdom.

15. That medical practitioners unwilling to provide contraceptive services on conscientious grounds be required to advise patients requesting such services of their right to apply to another medical practitioner or family planning clinic.

Chapter 6

VOLUNTARY HUMAN STERILISATION: SOCIAL AND MORAL ISSUES

STERILISATION DEFINED

Sterilisation is a surgical procedure, performed on either male or female, in which the patient's ability to procreate is terminated. The nature of the operation is sometimes misunderstood. Sterilisation in no way interferes with the physiological performance of the sexual act, nor does it, as is sometimes thought, desex or castrate the individual. Sex drive, potential and capacity for orgasm still remain.

Voluntary Sterilisation

Sterilisation may be performed for a number of reasons. It is the motivation behind the operation which determines whether the sterilisation is to be properly referred to as "voluntary", "eugenic", or "punitive". Our terms of reference do not require us to consider any form of human sterilisation other than "voluntary" sterilisation, but a brief reference to other forms of human sterilisation will better define voluntary sterilisation and avoid a confusion in terminology.

Voluntary sterilisation is sterilisation undertaken by a patient willingly, whatever the patient's motivation. Sterilisation may be voluntary:

1. Where the patient is motivated by personal, family, or socio-economic considerations.
2. Where it is performed for medical reasons in the interests of protecting the physical or mental health of the patient. Medical reasons may include:
   (1) Diseases such as severe cardiac or kidney disorders which would make pregnancy dangerous to the health or life of the mother.
   (2) Diseases of a congenital or hereditary nature which make it probable that pregnancy would result in deformed or stillborn children.
   (3) Grand multiparity which increases the probability of complications with future pregnancies.

Sterilisations performed for any of the above reasons are properly termed "voluntary" if the free consent of the patient is forthcoming. However, where it is necessary in this report to distinguish them, we will refer to the first as "social" and the second as "therapeutic".

Other Kinds of Sterilisation

Two other kinds of sterilisation should be mentioned although they do not fall within the concept of voluntary sterilisation. They are eugenic sterilisation and punitive sterilisation. Eugenic sterilisation is a sterilisation performed to prevent the transmission of certain undesirable hereditary traits, such as feeble-mindedness and insanity. Punitive sterilisation is that performed as a punishment for sex crimes and certain other criminal offences. Punitive sterilisation is not part of the criminal law of New Zealand.

TECHNIQUES OF STERILISATION

Sterilisation of the Male

The operation for sterilisation in the male, known as vasectomy, is best carried out in a surgically-equipped hospital, but is frequently performed in a doctor's surgery. It is a relatively simple procedure in which each vas deferens is cut and tied. The vas deferens is the tube through which sperm is transported from the testis, where it is manufactured, to the back of the penis from which, mixed with secretions of the accessory glands, it is discharged in an orgasm. There are two such tubes. The surgical practice is to excise a small length of vas on each side and to have this sent to a laboratory for microscopic examination for confirmation of the tissue removed. The patient is usually discharged home on the same day with medication for pain relief. The sutures are subsequently removed. Hospitalisation overnight is not necessary. Either a general anaesthetic or a local anaesthetic is administered.

Sterilisation is not complete until the already stored sperm in the seminal vesicles is removed by further intercourse and this may take some months. The patient should have tests subsequent to the operation to establish whether sperm cells are present before accepting that he is infertile.

Sterilisation of the Female

Sterilisation of the female may be performed in a number of ways but its purpose, whatever technique may be adopted, is to prevent the fertilisation by the male sperm of the ovum released from the ovary.

Medical journals furnish an extensive body of literature on the suitability of techniques. We are satisfied that there is available within New Zealand a sufficient range of techniques to ensure that female sterilisation can be successfully and safely carried out. There are risks involved in each technique and the operation is not to be lightly undertaken. The risks can only be assessed in the circumstances of each case. The particular techniques of female sterilisation have no bearing on the social or moral issues and, for that reason, we do not propose to discuss them further. It is sufficient to say that operative techniques differ according to the method adopted to gain access to the Fallopian tubes and the methods used to secure their occlusion.

Permanency of Sterilisation

Sterilisation both of the male and of the female should be considered as being irreversible. Further research and the adoption of new surgical techniques may enable the vas in the male and the tubes in the female to be reconstructed, but in the light of present medical knowledge, the patient upon whom the operation is to be performed should be advised that it is irreversible.

SOCIAL ISSUES

In considering the social and moral issues involved in contraception, we defined as social issues those with particular bearing on matters of health, education, housing, and standards of living which affect the welfare and mode of living of men and women in society. We adopt the same definition in considering the social and moral issues involved in voluntary human sterilisation.

Whatever attitudes were once adopted towards sterilisation, there has been a tremendous increase in the number of sterilisations of both males and females in the past decade throughout the world. Sterilisations performed in New Zealand have increased to the point where it can be said that they now receive a large measure of public acceptance. In this connection the Commission notes the increasing acceptance of male responsibility in family planning.

The increase in vasectomies performed in public hospitals in New Zealand in the five years ended 30 June 1975 is shown in the following figures:

1970-1971	...	244
1971-1972	...	368
1972-1973	...	497
1973-1974	...	494
1974-1975	...	522

a total of 2,125 vasectomies in five years. No figures are available from doctors' surgeries or private hospitals where the majority of vasectomies are performed.

The figures set out below (made available to us by the National Health Statistics Centre) for female sterilisations performed in public hospitals in New Zealand in the post-partum period for the five years ended 30 June 1975 reflect this increase:

1970-1971	...	672
1971-1972	...	1,018
1972-1973	...	1,384
1973-1974	...	1,879
1974-1975	...	2,607

a total of 7,560 female sterilisations in five years. The responses to the Hutt Valley survey, to which we have already made reference in Chapter 1, indicate that the persons questioned had a good knowledge of the use of sterilisation as a contraceptive measure. Of the women in the sample, 22

percent stated that either they or their partners had had a sterilisation operation. More than half of these operations were male sterilisations. Of the women sterilised, three-quarters had undergone tubal ligation.

A number of women told us in evidence of difficulties which they had encountered in obtaining sterilisation operations. Some who were refused sterilisations at public hospitals and could not afford operations in private hospitals had become pregnant and later had sought abortion. If society accepts the right of a couple to plan their family size, then sterilisation as the most effective method of birth control and family planning should be accepted. If the decision for sterilisation is responsibly made after mature reflection, there are no social reasons why the operation should not be performed.

It is important, however, that the decision should be carefully considered by the couple concerned. In some hospitals it is the practice to suggest sterilisation to multiparous women in the post-partum period. There are some advantages in sterilisation at this time. The tubes can be more easily reached and a further admission to hospital is not necessary. As against this, there is a danger that a woman who has not previously discussed sterilisation with her partner and accepted it as the ultimate contraceptive step may, in the emotional and physical aftermath of childbirth, consent to an operation which she will subsequently regret. This danger will be removed if in ante-natal clinics the implications of sterilisation are pointed out to her and she has the opportunity to discuss the matter with her partner.

Sterilisation of Pacific Islanders

On a number of occasions during both public and private hearings we were told of cases where sterilisations had been carried out on Pacific Island women without their full understanding of the finality of the operation. It was said that these women had not understood the irreversibility of the operation and that great unhappiness had resulted when its permanent effect was finally appreciated. Such unfortunate occurrences will usually be avoided if the nature of the operation is fully discussed with the women in the ante-natal clinic with the assistance of a social worker able to converse with them in their own language. Information on sterilisation should also be printed in Polynesian languages and made readily available to patients. This will ensure that any consent given is with the full understanding of the irreversibility of the operation. Husbands of patients should take part in the discussions so that they, too, understand what is involved.

MORAL ISSUES

There are some who see voluntary sterilisation as morally wrong. They regard it as promoting gratification rather than responsibility in sex; as a mutilation of the body and, to that extent, dehumanising; as likely to promote promiscuity and infidelity in marriage; as a potentially dangerous threat to ethnic and religious groups; and as a forerunner of compulsory sterilisation as a means of social engineering. Some of these

objections are arguable but, whatever their validity, they cannot be viewed without due regard being paid to the advantages, social and otherwise, which often accompany sterilisation. There are those cases in which we are satisfied that sterilisation of one or other of the partners to a marriage has stabilised the marriage by freeing the parties from concern for unwanted pregnancy.

The morality of sterilisation must be considered against the morality of abortion. Those who argue against sterilisation for moral reasons still accept it as being less immoral than abortion. We respect the opinions of those who oppose sterilisation on moral grounds but see great advantages to society in voluntary sterilisations for which the decisions have been responsibly taken.

Sterilisation of the Intellectually Handicapped

The social and moral aspects of the sterilisation of the intellectually handicapped are best considered together with any legal issues that arise. They are discussed in Chapter 7.

RECOMMENDATIONS

1. That in ante-natal clinics full opportunity be taken to discuss with multiparous women the possibility of sterilisation in the post-partum period. Such discussions should take place in the early stages of pregnancy and deal clearly with all the implications of sterilisation. If possible the woman's spouse or partner should take part.

2. That Polynesian social workers be attached to ante-natal clinics and that these social workers discuss with Pacific Island women the full implications of sterilisation where this is suggested.

3. That information regarding sterilisation, printed in the principal Polynesian languages, be freely available at ante-natal clinics.

Chapter 7

VOLUNTARY HUMAN STERILISATION: LEGAL ISSUES

THE LAW OF VOLUNTARY HUMAN STERILISATION IN NEW ZEALAND

There is no statutory provision in New Zealand which makes it an offence for a person to undergo an operation for sterilisation or for another to perform that operation. In New Zealand the sole source of the criminal law is statute. There are no common law offences as there are in England, where, in the highly controversial decision of *Shaw v. Director of Public Prosecutions* (1962) A.C.220, it was laid down that as *custodes morum*, the courts possess a residual power to superintend offences prejudicial to the public welfare. This much is clear from section 9 of the Crimes Act 1961 which provides that no one shall be convicted of any common law offence. Unless, therefore, a person can be shown to have been in breach of a statute or a statutory regulation, he or she cannot be said to have been guilty of a criminal offence.

To our knowledge there is no case on record of any person in New Zealand having been prosecuted for performing a sterilisation upon another with the patient's consent. Despite this, there is still a measure of uncertainty about the criminal liability of a person who performs such a sterilisation operation in this country. It is not surprising, therefore, that there is no consensus of medical opinion as to the legality of sterilisation. Uncertainty exists because of its nature as a surgical operation. It is unusual as a surgical procedure in that it may not always be performed for reasons of medical necessity and in that it involves the permanent destruction of a basic bodily function.

By its very nature, any surgical operation constitutes an assault upon the patient. An assault is defined by section 2 of the Crimes Act 1961 as "intentionally applying force to the person of another, directly or indirectly". However, the criminal law of this country recognises as a defence to a charge of assault an operation performed for the benefit of the patient's health. Section 61 of the Crimes Act 1961 provides:

> Everyone is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit, if the performance of the operation was reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

The purpose behind the enactment of section 61 was discussed by the late Sir Francis Adams in *Criminal Law and Practice in New Zealand* 2nd edition. It need only be said here that, whatever the limits of section 61, it is doubtful whether it would apply to a voluntary sterilisation performed for considerations of social convenience only, rather than for

"therapeutic" reasons. It would still be open to a person performing a voluntary sterilisation operation for social reasons to raise the defence of consent on the part of the patient, even if he were unable to invoke section 61. Although we consider that the defence of consent would be likely to succeed in such a case, it is here that the element of uncertainty creeps into the law. For this reason, we think it advisable to explain why we believe this area of the law has given rise to a measure of uncertainty.

The criminal law of New Zealand, as contained in the Crimes Act 1961 and other statutes, does not specifically provide for a defence of consent to an act which otherwise would be criminal. The defence of consent is preserved, however, by section 20(1) of the Crimes Act 1961 which provides that all rules and principles of the common law which render any circumstances a justification or excuse for any act or omission, or a defence to any charge, shall remain in force and apply in respect of a charge of any offence under the Crimes Act 1961 or any other enactment, except so far as they are altered by or are inconsistent with the Act or any other enactment. The question now to be answered is whether the common law of England recognises a defence of consent to a charge of assault. The view now prevailing in England is that consent does provide a defence to charges of assault, of a lesser grade at least.

The Common Law of England

In England prior to 1960, the British Medical Association had received the opinion of its counsel to the effect that therapeutic sterilisation was lawful but that eugenic or other sterilisations were not. In 1960 two further opinions were sought. The opinions expressed were to the effect that whether performed for therapeutic, eugenic, or other reasons, sterilisation was lawful. But the opinions led the Secretary of the English Medical Defence Union to state, "In view of this opinion, we now have no hesitation in advising members of the medical profession in Britain that sterilisation carried out merely on the grounds of personal convenience, in other words as a convenient method of birth control, is a legitimate legal undertaking." (*The Human Body and the Law* by D. W. Meyers.) The two opinions obtained by the Medical Defence Union are discussed in the *British Medical Journal* 1960, p.1510 and p.1516. In 1966 the Secretary of the Medical Defence Union reaffirmed the opinion expressed by counsel earlier but reminded the profession that this opinion was not based on any statute or judicial authority, as it had never been tested in the courts. However, he guaranteed the full support of the Union if any member became involved in medico-legal difficulties.

In the "Lloyd Reports" lecture to the Medical Society in London in 1960, reported in *Samples of Lawmaking*, Lord Devlin, an eminent English law lord, seems to have accepted the opinion of the English Medical Defence Union in that he there said, "Voluntary non-therapeutic sterilisation is lawful if proper consent is given and the operation is performed for a purpose not otherwise criminal."

Legal opinion in Scotland seems to have been to the same effect. In 1960 the Medical and Dental Defence Union of Scotland, in a report, stated: ". . . if a sterilisation operation were performed with the full

consent of the patient by a responsible surgeon and the reason for doing it was substantial and not obviously immoral by present day standards, it is exceedingly improbable that the court would hold the act to be criminal." *British Medical Journal* 2,15,16 (1960)

While the view in England seems now to be that consent does provide a defence at common law to a charge of assault where that assault takes the form of an operation for sterilisation, there have been some statements there to the opposite effect. It is these which have caused doubts in New Zealand as to the legality of sterilisation carried out for reasons of social convenience.

The first of these statements is contained in judicial *dicta* in *R. v. Coney* (1882) 8 Q.B.D.534. At page 549, Mr. Justice Stephens, an eminent English judge, said: "The principle as to consent seems to me to be this: When one person is indicted for inflicting a personal injury upon another, the consent of the person who sustains the injury is no defence to the person who inflicts the injury, if the injury is of such a nature or is inflicted under such circumstances, that its infliction is injurious to the public as well as to the person injured." This case, and that of *R. v. Donovan* (1934) 2 K.B.498, in which a somewhat similar view was expressed, have been regarded by some writers as cases of historical interest having no relevance to the law of sterilisation. Indeed, the first case concerned a prize fight and the second an assault by a man upon a young girl for motives of sexual gratification of himself. But the cases have received a wider construction. In *Bravery v. Bravery* (1954) 3 All E R 59, Mr. Justice Denning, as he then was, rekindled the doubts as to the legality of sterilisation for motives of convenience. He said, "An ordinary surgical operation, which is done for the sake of a man's health, with his consent, is, of course, perfectly lawful because there is just cause for it. If, however, there is no just cause or excuse for an operation, it is unlawful even though the man consents to it." (page 67). He continued, "Likewise with the sterilisation operation. When it is done with the man's consent for a just cause, it is quite lawful, as, for instance, when it is done to prevent the transmission of an hereditary disease; but when it is done without just cause or excuse, it is unlawful even though the man consents to it. Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it. The operation then is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and to any woman whom he may marry, to say nothing of the way it opens to licentiousness; and, unlike contraceptives, it allows no room for a change of mind on either side. It is illegal, even though the man consents to it for it comes within the principle stated by Stephens, J. (who was a great authority on criminal law), in *R. v. Coney* 8 Q.B.D.549." It is to be noted, however, that Lord Denning was only one of three judges who constituted the court in Bravery's case and that the other two, Sir Raymond Evershed, the Master of the Rolls, and Lord Justice Hodson, who were in the majority, did not share the views of Lord Denning and declined to hold that sterilisation operations must be regarded as injurious to the public interest. They said: "We also feel bound to disassociate ourselves

from the more general observations of Denning, L.J. at the end of his judgment, in which he has expressed his view (as we understand it) that the performance on a man of an operation for sterilisation, in the absence of some "just cause or excuse" (as was not, in his view, shown to exist in the present case) is an unlawful assault, an act criminal *per se*, to which consent provides no answer or defence." (page 63). "In our view, these observations are wholly inapplicable to operations for sterilisation as such, and we are not prepared to hold in the present case that such operations must be regarded as injurious to the public interest." (page 64).

Operation of the Law in New Zealand

The statistical material to which we have referred in the previous chapter provides an indication as to the extent to which sterilisations of both males and females are carried out in public hospitals in this country. It is apparent, however, that the performance of sterilisations on males in public hospitals in some areas has been inhibited by doubts existing as to the law. In the Auckland Hospital Board area, vasectomies for socio-economic reasons or to safeguard the health of the patient's wife are not carried out because of doubts as to the legality of the act. In institutions under control of the Auckland Hospital Board, sterilisation of the male will be undertaken only where there is a clinical condition from which the male partner is suffering and which makes the operation clinically desirable. Representations from the Board asked that the legality or otherwise of vasectomies being carried out in hospital board institutions throughout the country for socio-economic reasons or to safeguard the health of the wife be resolved by suitable changes in legislation. There have been other submissions to this effect and it is apparent that attitudes to the legality of vasectomies vary and that this variation has reflected itself in the practice throughout the public hospitals of the country.

Section 77A of the Hospitals Act 1956, as inserted by section 10 of the Hospitals Amendment Act 1966, authorised a hospital board to provide treatment free of charge to any person, *inter alia*, prepared to undergo a medical or surgical procedure or operation for the purpose of assisting the relief and medical or surgical treatment of some other person or the advancement of medical knowledge, education, or research. It was amended by section 13 of the Hospitals Amendment Act 1973 to permit of the provision of such a service "for any other lawful purpose."

In the submission of the Department of Health, it was claimed that the purpose of the 1973 Amendment was to remove any doubt that any operation which was otherwise lawful could be performed in a hospital controlled by a hospital board and criticism was directed at the Auckland Hospital Board for not taking advantage of this amendment and permitting vasectomies to be performed in the Board's institutions. If the purpose of the amendment was to authorise hospital boards to perform vasectomies free of charge in institutions under their control, then its wording would appear to beg the question in that it did not say that vasectomies or, indeed, any other operations were lawful. It merely stated that operations "for any lawful purpose" could be carried out in a public

hospital. Legislation intended to remove doubts as to the legality of sterilisations should be clear in its import and the declaration of Parliament to that end should be free from all ambiguity. For its part the Commission is still in some doubt as to whether it was the purpose of the Hospitals Amendment Act 1973 to declare vasectomies to be legal.

The Hon. R. J. Tizard, Minister of Health at the time, in moving the reading of the Bill for the second time, said (*New Zealand Parliamentary Debates* Vol.387, pp.4607/8):

> The important point to be covered by this clause is the legality of the operation known as vasectomy. There is little doubt that under the existing law a challenge could be made on the grounds that an operation was being carried out that was not specifically for the improvement of the health of the person on whom it was being performed. This operation affects the wife of the person undergoing the operation, and clearly persons opposed to the operation could challenge the legality of performing the operation in a public hospital. But on socio-economic grounds it is very clear that the people whose family responsibilities and whose income limitations must call for the operation to be done free in a public hospital are the ones who will be most affected if any such appeal or objection is allowed. In present practice no challenge is likely if the operation is done in a private hospital and a fee is paid, but the present law appears to prevent our meeting a social need. Therefore this clause makes it clear that if an operation—and this covers vasectomy, but is not limited to that one operation—is in itself legal it shall be legal for that operation to be performed in a public hospital. Then it is only a matter for decision whether the operation is legal in all the circumstances of the particular case.

Whatever the intention of the legislation, it seems clear that it did not declare vasectomies to be lawful. Doubts as to the legality of the operation still exist and these can only be removed by a clear statutory enactment that sterilisation of the male or female is lawful and no criminal liability will be incurred where such an operation is carried out competently, always provided it is carried out with the consent of the patient. It seems to us that the position could be clarified by an amendment to section 61 of the Crimes Act 1961 by enacting a subsection to that section in the following terms:

> Everyone is protected from criminal responsibility for performing with reasonable care and skill any operation of sterilisation of the male or female with the consent of the patient whether that operation is performed for therapeutic reasons or not.

The Practice of Sterilisation

The doubts which we have mentioned are reflected in the practice of sterilisation, and the differences in viewpoint between one board and another are reflected in Table 13.

It will be noted that in the Auckland Hospital Board area, the largest in the country, only ten vasectomies were performed in the five years ended 30 June 1975 but that in the much less populous area of the Ashburton Hospital Board, 295 vasectomies were carried out in the same period. The figures for female sterilisations carried out in the post-partum period in the various public hospitals throughout the country do not seem to be

influenced by any doubts as to the legality of the operation although they may well reflect different medical attitudes.

Table 13—Vasectomies Performed in Public Hospitals in New Zealand in the 5 Years Ended 30 June 1975

Hospital Board	1970–71	1971–72	1972–73	1973–74	1974–75	Total
Ashburton... ...	9	26	79	85	96	295
Auckland	2	1	1	2	4	10
Bay of Plenty ...	...	...	...	...	...	...
Cook*	...	...	...	2	7	9
Dannevirke ...	...	23	6	2	3	34
Hawkes Bay ...	...	1	4	3	3	11
Maniototo* ...	2	3	7	6	4	22
Marlborough ...	22	13	15	10	9	69
Nelson	...	3	2	6	8	19
North Canterbury ...	2	...	1	...	...	3
Northland... ...	...	...	1	1	...	2
Otago*	2	2	3	6	7	20
Palmerston North* ...	8	20	14	6	5	53
South Canterbury* ...	16	15	11	12	11	65
Southland* ...	7	7	5	4	5	28
South Otago ...	1	1	...	1	...	3
Taranaki	8	9	9	12	5	43
Taumarunui ...	19	26	75	75	64	259
Tauranga	1	2	4	4	6	17
Thames	...	2	4	3	4	13
Vincent	...	...	...	...	...	...
Waiapu	...	...	...	...	...	...
Waikato	51	74	83	77	74	359
Waipawa	1	5	...	...	1	7
Wairarapa ...	13	30	48	47	50	188
Waitaki	1	...	...	...	1	2
Wanganui* ...	1	1	1	...	...	3
Wellington* ...	35	34	42	48	69	228
West Coast ...	43	70	82	62	86	343
Total	244	368	497	474	522	2,105

*Performed as an inpatient service only.

Sterilisation of the Intellectually Handicapped

Our terms of reference require us to report upon "voluntary" human sterilisation only. We are not, therefore, called upon to investigate and report upon sterilisation of any other kind. However, a number of submissions were made to us concerning the sterilisation of the intellectually handicapped.

There are in the community a number of intellectually handicapped persons who are unable to cope with the problems of their own sexuality. The problem is more serious in the case of intellectually handicapped females. Some of these may be promiscuous; others, who are not and show no interest in sexual activity, are still capable of being used by males in society for sexual gratification, and on this account may become pregnant.

While women and girls suffering from mental handicap are confined in institutions, the problem is not so real although it may still exist. But with the growing movement toward the treatment of such persons outside institutions and within the community itself, the problem may become more serious. There may be those for whom oral contraception or intramuscular hormonal injection may be suitable but there are problems occasioned for some women and girls in the taking of the oral pill or injectable hormone which make it desirable for some more permanent form of contraception to be used.

It may be impossible for people in a severely handicapped state to give a full and informed consent to an operation for sterilisation. If the performance of an operation for sterilisation is to depend upon such people giving a full and voluntary consent, no such operation will ever be carried out, and the risk of pregnancy will always be present. We do not overlook the fact that objection can be taken to the sterilisation of persons incapable of giving a full and free consent on the ground that this would be an infringement of the rights of the individual amounting to compulsory sterilisation, and that the operation itself involves a deprivation of what might be considered to be a basic human right, namely, the right to reproduce. This is a moral consideration. It is not to be put aside lightly but it must be weighed against the moral issues which are involved in the possibility of the birth of a child to a woman or girl whose mental handicap places her at risk.

We think that when these views are placed in balance against the rights of the individual patient, who, in the majority of cases, will be incapable of asserting such rights, a case for sterilisation is established.

It may be suggested that there is no need for any legislation of this kind and that the courts have the power, in the case of wardship, to make decisions which are ultimately for the benefit of the minor. A case of this kind was considered in England in 1976. This was *In re D.* (a minor) (1976) 1 All E R 326. The case concerned an 11-year-old girl who was suffering from a condition which was diagnosed as Sotos Syndrome, the symptoms of which included accelerated growth during infancy, epilepsy, generalised clumsiness, and unusual facial appearance and behaviour problems, including emotional instability, certain aggressive tendencies, and some impairment of mental function which could result in dull intelligence or possibly more serious mental retardation. She was not, however, considered to be as seriously retarded as some children suffering from mental handicap and she was sent to an appropriate school which specialised in children with learning difficulties and associated behaviour problems. The move was a success. She had an intelligence quotient of about 80, indicating a dull normal intelligence, and she had the understanding of a girl of about 9 or 9½ years of age. The mother, acting on medical advice, was convinced that the girl was seriously retarded mentally. She was concerned that the girl might become pregnant and decided that she should be sterilised. Arrangements were made for the operation to be carried out. Other professional people concerned with her challenged the social and behavioural reasons for performing such an operation which would be irreversible and permanent. An application was

made to the High Court by an educational psychologist attached to an educational department to have the child made a ward of court and to continue the wardship in order to delay or prevent the proposed operation from being carried out. It was held by Mrs Justice Heilbron that the operation proposed was one which involved the deprivation of a basic human right, i.e., the right of the woman to reproduce, and that if it were performed on a woman for non-therapeutic reasons without her consent, it would be a violation of that right. Since she could not give an informed consent at that time but since there was a strong likelihood that she would understand the implications of the operation when she reached the age of 18, the case was one in which the court should exercise its protective powers. The wardship was therefore continued. It was held it would not be in the best interests of the child for the sterilisation to be performed.

The case would suggest that it was within the inherent jurisdiction of the court to approve of the sterilisation if the circumstances had warranted that course being taken. The decision not to allow the sterilisation to proceed was based upon evidence, which the judge accepted, that the child's mental and physical condition and attainments had already improved, that her future prospects were unpredictable, and that she was as yet unable to understand or appreciate the implications of the operation, whereas it was likely that in later years she would be able to make her own choice.

Whether there is any jurisdiction at present within the courts of New Zealand to make an order approving of a sterilisation is arguable, but we think it desirable that they should have power to make an order for the sterilisation of an intellectually handicapped person. It has been suggested to us that a statutory board might be established and that the power to make decisions for the sterilisation of intellectually handicapped persons should be vested in this board. We think it may be quite unnecessary to set up such a board and that it would be sufficient to vest any decision-making process within the existing court structure. If that were to be the case, the decision would be one to be made after careful consideration of all the circumstances. It is the Commission's view that if the consent of the parent or guardian is forthcoming, whatever the age of the intellectually handicapped person, there will be no need for any application to an outside tribunal provided that adequate safeguards are taken. By adequate safeguards we include the furnishing of an appropriate certificate or reference from a medical practitioner, supported by reliable information assessing the social adjustment and intellectual capacity of the person concerned. While we are of the view that the refusal of the parent to consent should be a strong factor to be taken into account, such refusal should not be an absolute bar to the making of an order by some outside agency.

We have in mind the case of those parents who may display very little interest in their intellectually handicapped children and who ignore the dangers to which they are exposed. It should be permissible for an application for the sterilisation of an intellectually handicapped person to be initiated by the superintendent of any institution or home, a registered medical practitioner, or a social worker. On the making of such an

application, the court could then direct the service of the application, with the relevant supporting affidavits on various parties, including the parent. The application could then be determined on its merits. Those who in our view would be entitled to service of the proceedings would include the superintendent of the institution in which the person was resident and the parent or other legal guardian. We would also recommend that the cost of the persons made party to the application should, in the absence of any separate estate on the part of the person to be sterilised, be borne by the State, notwithstanding the result of the application.

RECOMMENDATIONS

1. That a clear statutory enactment be made declaring sterilisation of the male or female to be legal provided it is carried out with the consent of the patient.

2. That section 61 of the Crimes Act 1961 be amended by enacting a subsection in the following terms:

> Everyone is protected from criminal responsibility for performing with reasonable care and skill an operation of sterilisation of the male or female with the consent of the patient whether that operation is performed for therapeutic reasons or not.

3. That the Courts be vested with power to make an order for the sterilisation of an intellectually handicapped person.

4. That in the case of an application by a parent for the sterilisation of an intellectually handicapped person, to safeguard the interests of the handicapped person concerned, an appropriate certificate of reference must be forwarded by a medical practitioner, supported by reliable information assessing the social adjustment and intellectual capacity of the person concerned.

5. That if an application is not made by the parents of the intellectually handicapped person, it be permissible for the application for sterilisation to be initiated by the superintendent of any institution or home, a registered medical practitioner, or a social worker.

6. That the cost of instituting any such application to a court and the costs of the persons made party to the application, in the absence of any separate estate on the part of the person to be sterilised, be borne by the State, notwithstanding the result of the application.

Chapter 8
STERILISATION SERVICES

If, as we suggest, any doubts as to the legality of sterilisation are removed by statutory enactment, it is likely that many men and women, particularly those in the lower income groups, will wish to have the operation carried out in a public hospital. The number of female sterilisations carried out in public hospitals is already high and the growing awareness that vasectomy is simple, quick and effective and has negligible side effects will increase the demand on existing hospital services. This will be particularly evident in those hospitals which at present do not perform vasectomies because of doubts held as to the legality of the operation and in others where, in respect of both male and female sterilisations, restrictive criteria have been applied, effectively limiting sterilisation to those who have some medical condition, or have at least a specified number of children, or, again, have reached a certain age.

In the survey conducted in the Hutt Valley by the Department of Health, it was found that 80 percent of the female sterilisations, compared with only 15 percent of the male sterilisations, were carried out in public hospitals. Of the men who had sterilisations, 25 percent had the operation carried out in private hospitals and the remaining 60 percent were treated in doctors' surgeries. As the authors of the Hutt Valley report say, "Sterilisation appears, for the most part, to be sought because couples have decided they have enough or too many children, and the high proportion of sterilised couples among the lower income groups probably reflects the degree of financial embarrassment these people could face as the result of an unwanted birth. Knowledge of sterilisation is widespread and the demand for the service appears to be strong. We could not assess, on the basis of the information obtained from the survey, whether apparent variations in the availability of facilities for the operation affect this demand. On the other hand, questions do arise about the extent to which health services are adapting to meet what appears to be a rapidly growing demand for sterilisation."

Terry Buddin, in *The Elusive Right of Voluntary Sterilisation; a Statutory Panacea*, has also referred to the significantly increasing demand for sterilisation in Australia, and has pointed out that the ratio there between tubal ligation performed in the female and vasectomy performed in the male is rapidly diminishing. It is now about two to one.

EXISTING SERVICES

Public Hospital

There is at present a lack of uniformity in the conditions which a patient must fulfil before becoming eligible for a sterilisation operation. Some doctors apply extremely restrictive criteria. For the very reason that

sterilisation of the male or female should be regarded as irreversible, it is to be expected that the decision to undergo the operation will not be lightly taken, and that the surgeon will approach it with a full sense of responsibility, having regard to the age and status of the patient. The criteria which are usually applied are:

1. The patient must have attained the age of 30 years.
2. The patient must have two children or more.
3. The patient must be married and must have obtained his/her spouse's consent.

From the evidence before it, the Commission feels that these criteria, and others even more stringent, have at times been applied too rigidly and that too little attention has been paid to individual factors, particularly the patient's mental health and emotional or economic capacity for assuming responsibility for children.

The difficulties encountered by patients have sometimes been compounded by delays which have preceded the carrying out of the operation. In the main centres, female patients are usually obliged to wait for a period varying from three months to one year for a sterilisation to be performed. The Commission was informed that these delays are caused by lack of staff, pressure on operating facilities, and a shortage of beds. If sterilisation is to be regarded as a means of birth control, with resultant benefits both to the couple concerned and to the State, hospital boards must accept the responsibility for providing sterilisation services with the minimum of delay. The Commission appreciates that requests for sterilisation operations must be measured alongside the demand for treatment of patients with other gynaecological problems and that sensible priorities must be established.

There are ways and means by which delay can be minimised. For instance, a woman is often given a sterilisation in the post-partum period, that is, during the 48 hours following the birth of her child. There are obvious advantages in carrying out a sterilisation at this time. The pressures on the hospital services are not much more than those occasioned by admission of the woman to the hospital for confinement. A subsequent admission of the same patient with the added problems of family adjustment and possible economic difficulties are avoided. The evidence which we have heard would suggest that there is some risk of a thrombo-embolic accident when sterilisation is done at this time, but the advantages to the woman concerned in achieving a permanent method of birth control without subsequent admission to hospital would seem to outweigh the risks.

Another important factor in the matter under discussion is the development of techniques for sterilisation of both males and females which require no more than outpatient facilities, or at the most, an overnight stay in hospital. Sterilisation by laparoscopy under local anaesthesia performed by experienced surgeons has greatly simplified the operative procedure and reduced the period of convalescence for women seeking sterilisation at a time other than the post-partum period.

Vasectomy, too, is essentially a procedure suitable for outpatient surgery. For these reasons the Commission believes that overnight stay

facilities and outpatient services for sterilisation of both the male and female can be readily and easily established by public hospitals without undue pressure being placed on hospital staff and the use of hospital beds.

Private Treatment

In the course of our hearings we spoke to many men and women who had sought sterilisations. Some were completely satisfied with the treatment they had received. We were told of other cases where patients had been refused sterilisation in public hospitals or had felt compelled to seek this service elsewhere because of their concern over the long wait entailed. We learned of other patients again who, after consulting their general practitioner, were not referred to public hospitals. In the case of some patients, vasectomies were performed by a general practitioner in his rooms. The majority of patients who had been refused sterilisation in public hospitals or who had been discouraged by the prospect of a long wait before they could be accommodated were operated on at considerable cost to themselves by specialists in private hospitals. The cost of a vasectomy appears to range from $60 to $100, and of a female sterilisation from $100 to $250. According to the Hutt Valley survey to which we have already made reference, the average cost of a sterilisation in 1975 was $147.50 for a woman and $90 for a man.

The burden of meeting these costs can sometimes cause a financial problem and result in a sterilisation being performed upon the wrong one of two partners who are considering this method of birth control. Concern was expressed to the Commission more than once about the likelihood of this taking place. There are usually circumstances indicating which one should more fittingly undergo sterilisation and when the couple decide after counselling that one or other of them is to be sterilised, the decision regarding the operation should be taken on medical grounds and not be influenced by considerations of cost.

If public hospital services are expanded to meet a growing demand for male and female sterilisations, and if the fees for private treatment, where that is preferred, are kept at a reasonable level, patients will not be subjected to pressure to accept a form of sterilisation other than the one most suitable for them and their individual circumstances.

Mention should be made of medical insurance schemes. Some companies at present decline to recognise a claim for a vasectomy on the grounds that the legality of that operation is in question. The Commission has no power to control insurance schemes but expresses the hope that once the legal position regarding sterilisation has been made clear, the medical insurance companies will be moved to provide a coverage for voluntary sterilisation operations performed either on therapeutic or social grounds.

Conscientious Objection by Medical Staff to Sterilisation

Some medical practitioners may be unwilling to perform or participate in sterilisations because of their own moral attitudes. Nothing should be done to interfere with conscientious objections of that kind although we

would hope that a doctor holding such views would refer the patient to another practitioner or to a family planning clinic. Instances have been brought to the notice of the Commission where patients have been caused great distress by the manner in which a refusal to perform a sterilisation has been conveyed to them.

Counselling and Assessment

Before any operation is embarked upon, it is essential that both the person seeking sterilisation and the partner should receive adequate counselling. This should be given sufficiently in advance of the date set down for the operation to give the couple proper time for reflection. In particular, the patient should be made to understand what is involved in the procedures: the permanency of the operation, the period of hospitalisation (if hospitalisation is necessary), and the cost involved if private treatment is being sought. Some hospitals have developed procedures designed to bring home to the patient what is involved in the operation. In some, booklets containing relevant information are given out after the initial interview. These booklets reinforce what will have been said in the counselling session. We are of the view that the following considerations need to be dealt with in the preliminary interview to ensure that a couple who do not wish to have any more children have clearly understood all the implications of sterilisation and have then made a realistic and responsible decision:

1. The couple must appreciate the irreversibility of the operation.
2. The previous contraceptive history of the couple should be reviewed in order to ascertain that this is the right method of birth control for this particular case.
3. The stability of the marriage or union should be established.
4. The patient's attitude to the possibility of future remarriage or a future wish to increase the family size, or the possibility of existing children dying, should be explored.
5. Consideration should be given as to whether sterilisation of the woman or vasectomy of the man is the more appropriate in the circumstances.

The final decision should be that of the couple only and it should not be made under pressure from other sources.

We have been made aware, however, of a number of cases where a spouse who had not previously displayed any noticeable interest in preserving the stability of the marriage has stubbornly refused to give consent and, on this account, the operation has been refused. For this reason we are of the view that while it is highly desirable that the other partner or spouse should be a party to any decision regarding sterilisation, the consent of that person should not be mandatory.

Factors to be Borne in Mind in the Sterilisation Decision

The factors which have led to the decision of the patient to request sterilisation must be first assessed. In some cases it will be shown during counselling that a patient has not fully understood the irreversibility of the

operation or has distorted or irrational ideas about the social outcome of the operation, e.g., providing a solution for a marital problem. Patients will sometimes be found who are experiencing a period of emotional or psychological instability. In such circumstances a request for sterilisation may justifiably be refused. When a sterilisation is requested by a person under thirty years of age, care should be taken to ensure that the patient appreciates the finality of the operation and will not regret it. This may best be done by obtaining an independent assessment.

At the present time, counselling for sterilisation and the assessment of whether sterilisation should be carried out is done by a medical practitioner or a specialist. We have no reason to believe that such counselling is not responsibly carried out. However, if the use of sterilisation as a contraceptive method is recommended, there is, in our view, a need for more people with counselling skill to work with doctors who, through pressure of work, may be unable to devote sufficient time to a patient during a period of considerable stress.

Conditional Sterilisation

It was brought to our notice that sterilisation is sometimes offered on a conditional basis. Several women with whom we spoke stated that they had obtained abortions on condition that they agreed to sterilisation. In our view the imposition of such a condition is quite wrong. We also heard evidence that in some countries overseas, offers of mortgage finance and accommodation had been made conditional upon the applicant producing evidence of sterilisation or an undertaking to undergo sterilisation. We have no evidence that this has ever taken place in New Zealand nor would we wish to see the practice develop here. We would recommend that it be made illegal to offer mortgage finance or accommodation under such conditions as this is an undue interference with the rights of the individual.

Cost of Sterilisation

Among the many suggestions which we received were a number which recommended that sterilisation should be provided free of charge. This could be achieved in practice by increasing the number of sterilisations performed in public hospitals or by providing special benefits to cover the cost of the operation when performed in a private hospital or a clinic by a specialist or a general practitioner.

There is no accurate information as to the number of sterilisations, male or female, presently being performed in New Zealand. Hence it is impossible to estimate the cost which would be involved in the provision of this service.

The arguments in favour of sterilisation at no cost to the patient were:

1. Sterilisation is usually a completely effective contraceptive measure.
2. Sterilisation is a "once only" cost.
3. Because of the finality of the operation, sterilisation is likely to be considered only by couples genuinely concerned about family birth control.

4. Sterilisation will reduce the amount of money spent on family benefits and child allowances.

5. The demand on social services can be heavy if sterilisation is refused and unwanted children result.

We accept that there is much validity in these arguments. However, in the situation where calls on hospital services are many, those which are most urgent must take precedence. Those cases where sterilisation is responsibly sought because of the size of the family, or state of health of the patient, or pressing socio-economic considerations, are likely to be granted urgency at public hospitals and provided free. However, those cases where sterilisation is sought as a matter of convenience rather than because of family size, state of health, or economic difficulties, may well have to wait. We expect that the rather cautious stand at present adopted by some hospitals and their staff on sterilisation will be modified and that those boards which take that stand will examine the possibility of providing outpatient services. This should provide a free service for all couples unable to meet the cost of a sterilisation operation in a private hospital.

Notification

We have already commented on the inadequacy of statistical information as to the number of sterilisations performed each year in New Zealand. Statistics of this kind are important in assessing future population trends, and for this reason we recommend that sterilisation be made a notifiable procedure. We recommend that all those performing sterilisations be required to report each month to the Department of Health on the number and type of sterilisations performed, the reasons for the operation, the age, marital status, race, and number of children of each patient, whether the operation has been on a day-care or in-patient basis, and whether the operation is post-partum.

RECOMMENDATIONS

1. That decisions regarding sterilisation operations be taken entirely on medical grounds and not be influenced by considerations of cost.

2. That before an operation is embarked upon, both the person seeking sterilisation and the partner receive adequate counselling so that all the implications of the operation are clearly understood.

3. That wherever possible the partner be a party to the decision regarding sterilisation, but that the consent of the partner be not mandatory.

4. That booklets containing relevant information be provided for all patients after the initial interview.

5. That overnight stay facilities and out-patient services for sterilisation of both the male and female be established by public hospitals.

6. That medical practitioners unwilling to perform sterilisations on conscientious grounds be required to advise patients requesting sterilisations of their right to apply to another practitioner or a family planning clinic.

7. That the necessity for adequate counselling before sterilisation be recognised. That the use by medical practitioners of trained counsellors for this purpose be encouraged.

8. That, once the position regarding the legality of the operation has been clarified, insurance companies be asked to provide coverage for voluntary sterilisation operations.

9. That it be made illegal to offer mortgage finance or accommodation on condition that the applicant produce evidence of sterilisation or an undertaking to undergo sterilisation.

10. That those performing sterilisations be required to report each month on the number and type of sterilisations performed, the reasons for the operation, the age, marital status, race and number of children of each patient, whether the operation has been on a day-care or an in-patient basis, and whether it was post-partum.

Chapter 9

THE LAW ON ABORTION IN NEW ZEALAND, ITS INTERPRETATION AND ITS APPLICATION IN PRACTICE

HISTORY OF THE LAW

Some of those who made submissions to us on the law on abortion in New Zealand considered that the present law was satisfactory both in its definition and application; others again were critical of the variation in its application from one locality and one hospital board to another. We are grateful to those who took great pains to research all aspects of the law and to report objectively on it. In this chapter we set out as best we are able the law on abortion in New Zealand as it has been stated "with a lack of precision" in the statutes and subsequently interpreted by the courts.

The law of New Zealand on abortion is contained in the Crimes Act 1961, sections 182 to 187. Whether section 182 was intended to affect the law on abortion, or whether it was intended to cover a gap which would otherwise have existed in the law of homicide, is itself a matter for debate. An examination of the history of the section, made later in this chapter, would suggest that the second view is the more likely.

Sections 182 to 187 inclusive are as follows:

182. KILLING UNBORN CHILD—(1) Every one is liable to imprisonment for a term not exceeding fourteen years who causes the death of any child that has not become a human being in such a manner that he would have been guilty of murder if the child had become a human being.

(2) No one is guilty of any crime who before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother.

183. PROCURING ABORTION BY DRUG OR INSTRUMENT—(1) Every one is liable to imprisonment for a term not exceeding fourteen years who, with intent to procure the miscarriage of any woman or girl, whether she is with child or not,—

(a) Unlawfully administers to or causes to be taken by her any poison or any drug or any noxious thing; or

(b) Unlawfully uses on her any instrument.

(2) The woman or girl shall not be charged as a party to an offence against this section.

184. PROCURING ABORTION BY OTHER MEANS—(1) Every one is liable to imprisonment for a term not exceeding ten years who, with intent to procure the miscarriage of any woman or girl, whether she is with child or not, unlawfully uses on her any means whatsoever, not being means to which section 183 of this Act applies.

(2) The woman or girl shall not be charged as a party to an offence against this section.

185. FEMALE PROCURING HER OWN MISCARRIAGE—Every woman or girl is liable to imprisonment for a term not exceeding seven years who with intent to procure miscarriage, whether she is with child or not,—

(a) Unlawfully administers to herself, or permits to be administered to her, any poison or any drug or any noxious thing; or

(b) Unlawfully uses on herself, or permits to be used on her, any instrument; or

(c) Unlawfully uses on herself, or permits to be used on her, any other means whatsoever.

186. SUPPLYING MEANS OF PROCURING ABORTION—Every one is liable to imprisonment for a term not exceeding seven years who unlawfully supplies or procures any poison or any drug or any noxious thing, or any instrument or other thing, whether of a like nature or not, believing that it is intended to be unlawfully used to procure miscarriage.

187. EFFECTIVENESS OF MEANS USED IMMATERIAL—The provisions of sections 183 to 186 of this Act shall apply whether or not the poison, drug, thing, instrument, or means administered, taken, used, supplied, or procured was in fact capable of procuring miscarriage.

The provisions set out above have appeared in the statute law of New Zealand since legislation on abortion was first enacted in this country in the Offences Against the Person Act 1867 (N.Z.). This statute substantially reproduced sections 58 and 59 of the English statute, the Offences Against the Person Act 1861. The latter, which was one of several abortion statutes passed in England in the 19th century, made it an offence, *inter alia*, for a person to use any instrument unlawfully or any means whatsoever with intent to procure the miscarriage of any woman. The statute, with some amendments effected by statutes passed in England in 1892 and 1893, and with the more substantial amendments effected by the Abortion Act 1967 (U.K.), remains in force in England today.

The Offences Against the Person Act 1867 (N.Z.) was repealed by the enactment of the Criminal Code Act in 1893. The Criminal Code Act 1893 was in turn repealed by the Crimes Act 1908. The Crimes Act 1961, which remains in force today, repealed the Crimes Act 1908. Except as to penalty, sections 182 and 183 of the Crimes Act 1961 are in the same terms as sections 200 and 201 of the Criminal Code Act 1893 and sections 220 and 221 of the Crimes Act 1908. Although the interpretation of the law in New Zealand has changed with the passage of the years, in fact no alterations of any consequence have been brought about by any changes in the wording of the legislation.

Sections 58 and 59 of the Offences Against the Person Act 1861 (U.K.) made it an offence to procure an abortion "unlawfully". But the statute did not define the word "unlawful" nor did it lay down in what circumstances the procuring of an abortion would be unlawful. The New Zealand legislation, throughout its history, has suffered from that same omission. It is an omission, both in England and New Zealand, which the courts have been called upon to make good, as best they have been able, in a number of cases which commenced with the prosecution of Mr Alec Bourne, an English obstetrician and gynaecologist, in 1938. Because Bourne's case has had a strong influence on the New Zealand law, it may be taken as a convenient starting point for a discussion on abortion law and the meaning of the word "unlawfully".

The facts of Bourne's case, as taken from the law reports, are as follows:

A girl, aged 15 years at the time of the assault upon her, was raped with great violence in circumstances which would have been most terrifying to any woman, let alone a child of 15 years, by a man who was in due course convicted of the crime. In consequence of the rape she became pregnant. Her case was brought to the attention of Mr Bourne, then an obstetrical surgeon at St. Mary's Hospital. With the consent of her parents, he performed an abortion on the girl. He was charged under section 58 of the Offences Against the Person Act 1861 with unlawfully procuring her abortion. At his trial he gave evidence on his own behalf. He stated that after he had made a careful examination of the girl and had informed himself of all the relevant facts of the case, he had come to the conclusion that it was his duty to perform the operation. He said that in his opinion the continuance of the pregnancy would probably have caused injury to the girl so serious as to justify aborting her. It appears from a perusal of the reports of the case that the Attorney-General, who prosecuted for the Crown, accepted Mr Bourne's evidence as a frank statement of what actually passed through his mind, namely, that, in view of the age and character of the girl and the fact that she had been raped with great violence, she should be aborted. The evidence of Mr Bourne was supported and confirmed by Lord Horder, a physician of great repute, and also by a Dr J. R. Rees, a specialist in medical psychology. Dr Rees expressed the view that if the girl had been allowed to give birth to the child, she would have been likely to become a mental wreck. Because Mr Bourne had admitted in his evidence to having aborted the girl, the principal inquiry required to be made by the court trying him was whether it had been proved that Mr Bourne had acted "unlawfully" in so doing.

Section 58 of the Offences Against the Person Act 1861, under which Mr Bourne was charged, did not lay down the circumstances in which the performance of an abortion was unlawful, so no indication as to the law could be obtained from it, but in directing the jury as to the meaning to be given to "unlawfully", the trial judge, Mr. Justice Macnaghten, invoked the provisions of the Infant Life (Preservation) Act 1929 (U.K.). This statute, which is still in force in England, is not an abortion statute. It was enacted in 1929 to fill a gap in the law on homicide. Its relevant provisions are as follows:

> Section 1(1) Subject as hereinafter in this subsection provided, any person who with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.
>
> 2(1) Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.
>
> 2(2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of 28 weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.

Mr Justice Macnaghten in Bourne's case referred to the provisions of this statute and said:

It is true . . . that this enactment provides for the case where a child is killed by a wilful act at the time when it is being delivered in the ordinary course of nature, but in my view the proviso that it is necessary for the Crown to prove that the act was not done in good faith for the purpose only of preserving the life of the mother is in accordance with what has always been the common law of England with regard to the killing of an unborn child. No such proviso was in fact set out in section 58 of the Offences Against the Person Act 1861, but the words of that section are that any person who "unlawfully" uses an instrument with intent to procure a miscarriage shall be guilty of felony. In my opinion the word "unlawfully" is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in section 1, subsection 1 of the Infant Life (Preservation) Act 1929, and that section 58 of the Offences Against the Person Act 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso . . .

In this case, therefore, my direction to you in law is this—that the burden rests on the Crown to satisfy you beyond all reasonable doubt that the defendant did not procure the miscarriage of the girl in good faith for the purpose only of preserving her life. If the Crown fails to satisfy you of that, the defendant is entitled by the law of this land to a verdict of acquittal. If, on the other hand, you are satisfied that what the defendant did was not done by him in good faith for the purpose only of preserving the life of the girl, it is your duty to find him guilty.

The expression "for the purposes of preserving the life of the mother" as used in the Infant Life (Preservation) Act 1929, was also discussed by Mr Justice Macnaghten. He said:

There has been much discussion in this case as to the difference between danger to life and danger to health. It may be that you are more fortunate than I am, but I confess that I have found it difficult to understand what the discussion really meant, since life depends upon health, and it may be that health is so gravely impaired that death results.

The judge continued:

It is not contended that those words mean merely for the purpose of saving the mother from instant death. There are cases, we are told, where it is reasonably certain that a pregnant woman will not be able to deliver the child which is in her womb and survive. In such a case where the doctor anticipates that the child cannot be delivered without the death of the mother, it is obvious that the sooner the operation is performed the better. The law does not require the doctor to wait until the unfortunate woman is in peril of immediate death. In such a case he is not only entitled, but it is his duty to perform the operation with a view to saving her life.

Until the prosecution in 1975 of Dr J. Woolnough, a case to which reference is shortly to be made, Bourne's case was followed by the courts in New Zealand and accepted as being declaratory of the law of abortion, in particular, of the meaning to be given to the word "unlawfully" where used in sections 183 and 184 of the Crimes Act 1961. Bourne's case was referred to by Mr Justice F. B. Adams in *R. v. Anderson* (1951) N.Z.L.R.443. There, speaking of section 221 of the Crimes Act 1908, (now section 183 of the Crimes Act 1961), the judge said:

It is incumbent on the Crown to prove the intent specified in section 221, namely, the intent to procure a miscarriage, but the word "unlawfully" imposes on the Crown the burden of disproving another intent. According to *R. v. Bourne* the meaning is that the Crown must prove that the act was not done in good faith with the purpose only of preserving the life of the woman or girl, a formula which, as that case shows, may be satisfied even where there is no imminent danger of death.

The same judge, writing twenty years later as editor of the standard work, *Criminal Law and Practice in New Zealand*, said (2nd edition, page 377, para. 1389):

> In the context of sections 183 to 186, it is obvious that "unlawfully" requires something more than that the act should have been done with the specified intent to procure a miscarriage. That intent, and such acts as are referred to, are not necessarily unlawful. The act must be proved to have been done otherwise than in good faith for the purpose of preserving the life or health, physical or mental, of the woman or girl. This formula seems adequate.

Two further English cases should be mentioned. The first is *R. v. Bergmann and Ferguson*, a case tried at the Central Criminal Court in London in May 1948. It is mentioned by Dr Glanville Williams in his work, *The Sanctity of Life and the Criminal Law*, at page 154. There Dr Williams says that the case "seems to indicate that where serious injury to health is feared the court will not look too narrowly into the question of danger to life." The case is also referred to in Smith and Hogan's *Criminal Law*, 3rd edition, pages 273-274, where the learned authors state that the trial judge, Mr Justice Morris (as he then was), "is reported to have said that the Court will not look too narrowly into the question of danger to life where danger to health is anticipated."

The second case is *R. v. Newton and Stungo*, which is reported only in [1958] Crim.L.R.469, and discussed in an article "Therapeutic Abortion", by Mr J. D. J. Harvard at page 600 of the same volume. The trial judge, in that case, Mr Justice Ashworth, is reported as directing the jury in the following way:

> The law about the use of instruments to procure miscarriage is this: "Such use of an instrument is unlawful unless the use is made in good faith for the purposes of preserving the life or health of the woman." When I say health I mean not only her physical health but also her mental health.

The direction of Mr Justice Ashworth seems to have extended the direction of Mr Justice Macnaghten in Bourne's case by accepting the preservation of the health of the mother, physical or mental, as an alternative justification to the preservation of the life of the mother.

Reference should also be made to the Australian case of *R. v. Davidson* [1969] V.R.667, where a Victorian Supreme Court judge, Mr Justice Menhennitt, was called upon to give a direction on the meaning to be attributed to the word "unlawfully". This word was used in a statute of the State of Victoria which made it an offence to use an instrument or other means unlawfully to procure the miscarriage of a woman. The relevant section of the Victorian statute under which Davidson was charged was similar in its essential wording both to the section in the English statute under which Mr Bourne was charged and to section 183 of the Crimes Act 1961 (N.Z.). It did not say when an abortion was unlawful. There is in the Victorian legislation no provision similar to section 182 of the Crimes Act 1961 (N.Z.) or the proviso to section 1(1) of the Infant Life (Preservation) Act 1929 (U.K.) to which Mr Justice Macnaghten had recourse in Bourne's case. Speaking of the word "unlawfully" Mr Justice Menhennitt said this:

> The use of the word "unlawfully" in the section implies that in certain circumstances the use of an instrument or other means to procure a miscarriage may be lawful. The word "unlawfully" is nowhere statutorily defined.

He decided that in Victoria "for therapeutic abortion to be lawful I think that the accused must have honestly believed on reasonable grounds that the act done by him was necessary to preserve the woman from some serious danger. As to this element of danger, it appears to be in principle that it should not be confined to danger to life but should apply equally to danger to physical or mental health provided that it is a serious danger not being merely the normal dangers of pregnancy and childbirth."

All the cases to which reference has been made were referred to in the judgments of the Court of Appeal in *Queen v. James Woolnough* (C.A.14/76) to which we now refer.

THE WOOLNOUGH CASE

In 1975 Dr James Woolnough was tried in the Supreme Court at Auckland on twelve counts of using an instrument with intent to procure a miscarriage. In directing the jury as to the test to be applied in deciding whether an abortion was lawful, the trial judge at the first trial, Mr Justice Speight, said that the test was whether the abortion was necessary to preserve the woman or girl from serious danger to her life or her physical or mental health, not merely being the normal dangers of pregnancy and childbirth.

The jury at that trial were unable to reach a unanimous verdict and a new trial was ordered. The retrial took place in the Supreme Court of Auckland before Mr Justice Chilwell. Mr Justice Chilwell adopted the same approach as had been adopted by Mr Justice Speight. Because Mr Justice Chilwell's direction was later the subject of an appeal to the Court of Appeal in which the summing up was examined, we set out in detail the direction he gave to the jury. Mr Justice Chilwell said:

> The test for whether or not the use of an instrument is unlawful is whether it is necessary to preserve the woman from serious danger to her life or to her physical or mental health, not being the normal dangers of pregnancy and childbirth.

and

> As to whether there existed in any of the twelve instances under consideration here a serious danger to life or a serious danger to physical health, or a serious danger to mental health, this is entirely a question of fact for you. Pregnancy and childbirth must always and have from time immemorial always carried certain risks. Most women are probably healthier if they are not pregnant and they are probably in less risk to health if they are not pregnant. Unmarried women who are pregnant are probably under greater emotional and mental strain than if they are not pregnant. Hence the qualification in the legal formula which I have given you, the words "not being the normal dangers of pregnancy and childbirth".
>
> Now I do not know that I can help you a great deal with the words "serious danger". They are common enough English words in everyday use. It must always be a matter of degree as to whether the condition of a person involves a serious danger to life or serious danger to physical health or a serious danger to mental health. There will be some conditions where one can say, "Of course that is a serious danger", and there are other conditions where one can say, "Well, that is only a slight risk", but then there are conditions in between where some degree of judgment is called for. Now one could use many other

adjectives such as "substantial danger to life", or "substantial danger to physical health", or "substantial danger to mental health". The adjective "substantial" was preferred to "serious" by a judge in Australia in a case which was very similar to this one. But that is just a matter of words as I see it. Again one could adopt what I think Mr Williams said in opening, "a real risk to life" or "a real risk to physical health", or "a real risk to mental health". They are just different ways of expressing the same thing—"a serious danger".

The jury found Dr Woolnough not guilty of the offences charged and Dr Woolnough was discharged subject to the stating of a case at the request of the Crown for the opinion of the Court of Appeal on the question of whether the judge's direction to the jury on the meaning of the word "unlawfully" in section 183(1) of the Crimes Act 1961, was correct in law. The appeal by way of case stated was argued on 12 April 1976. The Crown argued that the test as propounded by Mr Justice Chilwell was not in accordance with Bourne's case. The judgments of the three members of the Court of Appeal were delivered on 22 July 1976. They were divided in their opinions as to the law. Mr Justice Richmond and Mr Justice Woodhouse were of the view that the appeal by the Crown should be dismissed. They thought that the summing up and direction to the jury by Mr Justice Chilwell at the trial had not been too benevolent to the accused. The Chief Justice, Sir Richard Wild, thought that the direction to the jury was wrong. The following points can be noted in the judgment of Mr Justice Richmond:

1. As a matter of common sense it must have been intended by the legislature that a bona fide intention to preserve the life of the mother would prevent an abortion from being unlawful under section 183.
2. Necessity is too vague a defence in English criminal law, but to the extent that it existed, it was preserved by virtue of section 20 of the Crimes Act 1961. (Section 20 preserves all common law defences.)
3. Because of the way in which section 183 was worded (in the use of the word "unlawfully") it was a matter of necessary inference that the legislature had entrusted to the courts the task of drawing a line between those abortions which are, and those which are not, unlawful.
4. Section 182 would seem to have no application to the case because its purpose seems to have been to fill in apparent gaps between the law as to homicide and the law as to abortion.
5. The purpose of section 182 seems to be twofold: one purpose is to protect the life or potential for life of the unborn child, and the second is to protect the life and health of the mother, having regard to the grave dangers that are attendant upon induced abortions.
6. It is impossible to lay down any general principle in the matter. All that the courts can do is to consider the circumstances of alleged justification when they are submitted for decision.
7. Support for the summing-up can be drawn from the shift in emphasis detected in the judgments of Mr Justice Morris and Mr Justice Ashworth in the cases of *R. v. Bergmann and Ferguson*[1948] and *R. v. Newton and Stungo*[1958] respectively.
8. When Parliament passed the Crimes Act 1961, it did so after lengthy preliminary consideration by a committee and then by Sir George Finlay, a retired judge of the Supreme Court of New Zealand.

It is to be presumed that Parliament has been content to accept the developing views of the English judges.

9. There is no warrant for adopting the words "not being the normal dangers of pregnancy and childbirth" laid down in Davidson's case as part of the test.

10. The law is uncertain, and unless more definite guidelines are given, judges will be called upon to determine difficult factual questions without real help.

Mr Justice Woodhouse agreed with Mr Justice Richmond in the result at which he arrived, but declined to express any final opinion on what might be the unlawful limits, for every purpose and in all circumstances, of a procured miscarriage. In the result he thought that it was undesirable to regard the formula used in the Woolnough case as finally determining the limits within which any therapeutic abortion might ever lawfully be performed.

The following points may be noted from the dissenting judgment of the Chief Justice:

1. The legislature has never stated what was lawful and what was unlawful in enacting abortion legislation. It has abdicated this function to the Courts.

2. When Bourne's case was decided, the direction given by Mr Justice Macnaghten was generally regarded as sound and had been so regarded on both sides of the Atlantic. It had later been accepted as expressing the law in New Zealand.

3. When the Crimes Act 1961 was enacted, as it was, only after it had received the close scrutiny in the form of a Bill, section 183 was re-enacted in the same form as it had appeared in the Crimes Act 1908. It is to be inferred that Parliament thereby approved of the construction placed upon the word "unlawfully" in Bourne's case.

4. If the test is to be enlarged, it is the function of Parliament, and not the Courts, to enlarge it.

It is to be noted that all three judgments make the common point that the Courts have gone as far as they can go in law making and that Parliament, and not the Courts, must now define "unlawfully".

As a result of the judgments declined in the Woolnough case, the law of New Zealand on abortion cannot now be stated with certainty. Although the majority view of Mr Justice Richmond and Mr Justice Woodhouse dismissed the appeal by the Crown, they did not define the limits to be placed upon the word "unlawfully". Only Parliament, as all three judges said, can now do that by legislation. Until it is done, the law on abortion will continue to merit the criticism that it is undefined and lacking in certainty.

SECTION 182: CRIMES ACT 1961

The proviso to section 1(1) of the Infant Life (Preservation) Act 1929 (U.K.) has influenced the development of the law of abortion in England where in Bourne's case its provisions were invoked in interpreting the word "unlawfully". The equivalent statutory provision in New Zealand is section 182 of the Crimes Act 1961.

Section 182 is as follows:

182. (1) Every one is liable to imprisonment for a term not exceeding fourteen years who causes the death of any child that has not become a human being in such a manner that he would have been guilty of murder if the child had become a human being.

(2) No one is guilty of any crime who before or during the birth of any child causes its death by means employed in good faith for the preservation of the life of the mother.

The section first appeared in the criminal law of New Zealand as section 200 of the Criminal Code Act 1893. It was replaced by section 220 of the Crimes Act 1908 and now appears as section 182 of the Crimes Act 1961.

Its enactment as section 200 of the Criminal Code Act 1893 represented the culmination of efforts made over the previous fifty years towards the codification of the criminal law in England. In 1878 a Royal Commission was appointed in England to consider a draft criminal code and to suggest alterations and amendments to the existing criminal law. After a number of reports and draft codes had been prepared, the Criminal Code Commission produced a new draft code which was prepared for introduction into the Imperial Parliament in 1879. It was not fully adopted, but in 1880 a Bill was submitted to the Criminal Code Commission by the Attorney-General who was authorised by the Commissioners to state that it set out substantially their earlier proposals. The Bill never became law in England but it was the basis upon which the New Zealand Criminal Code Bill 1882 was prepared by Mr Justice Johnston and Mr W. S. Reid, the then Solicitor-General. The code was first introduced into the New Zealand Parliament in 1883 but ten years passed before it finally became law with the passing of the Criminal Code Act 1893.

Section 155 of the Criminal Code Act 1893 made provision, as does section 159 of the Crimes Act 1961, defining when a child becomes a human being within the meaning of the statute. The definition then given, and still retained in the present statute, is that a child becomes a human being within the meaning of the statute when it has completely proceeded in the living state from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not. The killing of such a child is homicide if it dies in consequence of injuries received before, during or after birth.

At common law a child was not deemed to have been born alive unless it had an independent circulation. The killing of a child before it had completely proceeded in the living state did not amount to murder. If, therefore, a mother or anyone else inflicted a mortal wound on a child during birth, and, as a result, the child died before it had completely proceeded from the body of the mother, it was not murder. Nor was it made murder by the Criminal Code Act 1893 (section 155) which now appears as section 159 of the Crimes Act 1961. The purpose of section 200 of the Criminal Code Act 1893 (now section 182 of the Crimes Act 1961) was to make it so. As the Commissioners said: "We may, however, observe that we provide by section 200 for the offence of killing a child in the act of birth and before it is fully born. This seems not to be an offence by the present law."

Although the report of the English Commissioners was acted on in New Zealand in 1893, it was not acted on in England to legislate against the killing of a child during the process of birth until 1929 when the Infant Life (Preservation) Act was passed. The provisions of the statute have already been discussed in connection with Bourne's case.

Section 182 seems to have been intended to fill the apparent gap between the law on abortion and the law as to homicide by making it an offence to kill a child in the course of birth. However, it has been regarded as wide enough in its language to cover the killing of a child who dies in the course of abortion by hysterotomy. There would be little point in invoking section 182 in such a case, and we cannot readily conceive of a case where a prosecution in such circumstances would succeed under section 182 which would not succeed under section 183. Moreover, it seems hardly likely that section 182 was ever intended to be invoked in prosecutions for abortion when, in England and New Zealand, abortion legislation had already been enacted years before section 182 or its English equivalent had come into force.

In Woolnough's case Mr Justice Richmond expressed strong doubts as to its application in abortion cases. In the wide construction which the wording of section 182 invites, the purpose behind its original enactment may have been overlooked. The Hospitals Amendment Act 1975 was passed upon the basis that section 182 was one of wide import. Its use there posed serious problems of interpretation.

The Hospitals Amendment Act 1975, a copy of which forms Appendix 10, came into force on 1 September 1975. Its operative provision was section 2 which provided as follows:

> 140A (1) Nothing in section 182(2) of the Crimes Act 1961 (which relates to the causing of the death of a child in good faith for the preservation of the life of the mother) shall apply unless the operation is performed in an institution under the control of a hospital board under this Act or in any licensed hospital that may be approved for the purpose by the Director-General of Health upon his being satisfied that it maintains or uses adequate and independent counselling services and also procedures to ensure that all operations authorised are within the law and that the facilities for operation and after-care are satisfactory:
>
> Provided that nothing in this section shall apply in any case where by reason of the urgency of the case the life of the mother is likely to be prejudiced by the time occupied in conveying her to such an institution or licensed hospital.
>
> (2) Whenever any therapeutic abortion, or other operation that could lead to or effect an abortion or subsequent unnatural miscarriage, is performed, a record of that operation and the reason for it, but without the patient's name, shall be made and forwarded within 1 month to the Director-General of Health.

The statute became the subject of a judgment in the Supreme Court at Auckland when the Auckland Medical Aid Trust as plaintiff sought a declaration as to its interpretation against the Attorney-General as defendant (A.1156/75). Originally the Trust sought the ruling of the court on two questions:

1. Is a non-viable fetus "a child that has not become a human being" within the meaning of section 182 (1) of the Crimes Act 1961?
2. What effect, if any, does section 140A of the Hospitals Act 1957 have upon section 183 of the Crimes Act 1961?

At the hearing, the first question was not proceeded with and the Court was not required to answer it. The second question was answered as follows:

> (a) Persons charged with an offence under section 183 of the Crimes Act 1961 have the same defences as have always existed under that Act and their position is not affected by the provisions of section 140A(1) of the Hospitals Act 1957 as amended.
>
> (b) Section 140A(2) may cover a wide variety of circumstances which cannot be exhaustively listed under the present proceedings but for the plaintiff's purposes this much at least is clear, miscarriages which occur as a result of medical treatment applied for that purpose must be reported. So, too, must manual or instrumental procedures recognised by medicine and likely to cause miscarriages, whether that was the purpose or not, provided the woman or girl was in fact pregnant. This liability arises whether the event occurs in a public hospital, in a hospital licensed under section 140A or elsewhere.

Mr Justice Speight, in his judgment, said that he had no doubt that the conclusions he had reached as to the meaning of the Act were far removed from the intentions of the author.

Although submissions have been made to us which would suggest that the judgment is wrong in law, we note that the judgment was not made the subject of an appeal by the Attorney-General who was a party to the action, nor would it be within the province of the Commission, which is not a court of law, to do other than accept the judgment as being a proper interpretation of the Hospitals Amendment Act 1975.

Chapter 10

THE WORKING OF THE ABORTION LAW IN NEW ZEALAND

It is not surprising that the vagueness of the law on abortion has resulted in uncertainty in its application.

Evidence as to the working of the abortion law in New Zealand came to us from five main sources:

1. Evidence regarding abortions carried out in certain public hospitals in New Zealand, and the principles by which applications for abortions are considered in these institutions.
2. Evidence of gynaecologists and general practitioners as to what tests are applied in particular localities and hospitals.
3. Evidence from the Government Statistician, the National Health Statistics Centre, and the Department of Health as to the number of abortions carried out in particular hospitals.
4. Evidence from the Auckland Medical Aid Trust as to the number of abortions carried out at the Auckland Medical Aid Centre since it was established in May 1974.
5. Evidence of women who told us of their own experience of the application of the abortion laws in various parts of New Zealand.

It is apparent from this evidence that widely differing interpretations of the law have been adopted throughout New Zealand. Whether a woman or girl has been able to obtain an abortion has, to some extent, depended on the particular geographical location in which she has lived and the view of the law held by the medical practitioners in the area.

The very uncertainty of the law has not made it easy for medical practitioners to decide in particular cases whether or not an abortion should be performed. It is not surprising, therefore, that medical practitioners should be uncertain in their approach, if the courts, through the failure of Parliament to say when an abortion is unlawful, have themselves had difficulty in defining what meaning should be given to the word "unlawful" where it is used in abortion legislation.

There is a diversity of medical views on the legality of abortion. This was revealed in a survey of 1,726 medical practitioners in New Zealand conducted in 1969 and 1970 by Professor Gregson and Dr Irwin (N.Z. Medical Journal 1971, p.267). One of the features of this survey was that it revealed that medical practitioners assumed a knowledge as to the existing law on abortion which, in the view of those conducting the research, was not correct. They found that, of those who responded to the survey, 62.4 percent saw themselves as being sufficiently well informed as to the law, although in fact, only 35 percent were able to state it correctly.

Danger to the mother's life was recognised as a legal ground by only 90.9 percent, danger to the mother's physical health by 64 percent, and danger to the mother's mental health by 63.4 percent of the respondents. In the opinion of 29.1 percent, pregnancy resulting from rape or incest (in the case of a girl under 16 years of age) constituted a legal ground. It was believed by 27.9 percent that a significant risk of there being a mentally or physically defective child born as a result of the pregnancy was a legally acceptable ground for termination. Without examining whether the law would permit abortion in specific cases where circumstances such as these exist, it is apparent that, if this survey is taken as an indication of the measure of understanding of medical practitioners in this country of the legal position, there is a wide divergence of opinion as to when abortion is permissible.

Three points in particular may be mentioned as illustrating the different views which have been taken in interpreting the law. The first relates to the meaning to be given to the word "health" where the preservation of the life or health of the woman is concerned (as in Bourne's case) or where dangers to physical or mental health arise (as in *R. v. Newton and Stungo*). The definition of "health" given in the *Shorter Oxford English Dictionary* is, "soundness of body, that condition in which its functions are duly discharged." This definition has been adopted by many medical practitioners as being a proper definition but others have regarded it as being too narrow. They have accepted the definition of "health" adopted by the World Health Organisation in 1946. On many occasions it was suggested to us that we should adopt this definition in formulating any policy on abortion law, but it is apparent to us that the definition has already been adopted by some practitioners as a basis upon which the present abortion law is to be interpreted and applied.

"Health" is defined by the World Health Organisation as "a state of complete mental, physical and social well-being, not merely the absence of disease or infirmity". In one hospital board area in which this definition has been adopted, a gynaecologist carrying out abortions described it as warranting abortion on request. Certainly it can be said that adoption of the World Health Organisation's definition will result in the application of an abortion law much more liberal than would flow from the adoption of the more orthodox definition of health because, by some standards, not much more than a small dent or tear in the social fabric represents a danger to a woman's health. The second point relates to the meaning to be given to the words "for the preservation of the life of the mother" where used in the Bourne formula. These words have traditionally been interpreted to mean "life" in contra-distinction to "death", but in more recent years have been interpreted to mean "life" in the sense of the "quality of life". A much more liberal approach to abortion can be justified in this way because factors which cannot be said to be dangers to physical life may be dangers to the quality of life. The third point concerns the use made of the phrase "in good faith". In any prosecution, the onus of proving lack of good faith on the part of the doctor concerned rests on the Crown. Undoubtedly some doctors have been very mindful of this fact and have used it to justify abortions which would not have been accepted

if the application for abortion had been decided by a more objective tribunal.

OPERATION OF THE LAW IN SPECIFIC HOSPITAL BOARD AREAS

The differences of viewpoint between one hospital board area and another, and the changes in outlook over the years in particular areas, are best illustrated by reference to specific institutions:

National Women's Hospital, Auckland

Between 23 April 1963 and 31 March 1969, National Women's Hospital accepted 34 percent of patients by whom applications for abortions were made. In the period 1 April 1970 to 31 March 1976, it accepted 50 percent. The increase in percentage suggests that a more liberal view is now being adopted.

Cook Hospital, Gisborne

Since the end of 1973, the procedure for determining applications for abortions followed at Cook Hospital has been changed and it is clear, from the number of abortions performed since 1974, that a liberal view has been taken of the law. In the years 1969 to 1973 inclusive, three abortions on the average were performed each year. In 1974, following the adoption of a different approach, 58 abortions were performed, and in 1975 the number of abortions was 100. We were told that of 182 women who had made application for abortion since the institution of the new system, no woman had been denied termination on legal grounds.

Christchurch Women's Hospital

No abortions are performed at Christchurch by gynaecologists and obstetricians except in a public hospital. This practice was adopted following the passing of a resolution by the members of the Royal College of Obstetricians and Gynaecologists in 1971 that abortions should be performed only in public hospitals. Nonetheless, the statistics show the number of abortions performed at Christchurch Women's Hospital has risen from 71 in 1972 to 163 in 1975. We have no information on what percentage this represents of the total number who applied.

Dunedin Public Hospital

There has been a marked increase in the number of abortions performed per annum between the years 1967 and 1975. Table 14 sets out the numbers of abortions performed at Dunedin Public Hospital between 1967 and 1975.

The Auckland Medical Aid Centre

The Centre opened on 17 May 1974. In its first year of operation it carried out a total of 1,874 abortions. This represented 81.9 percent of the patients referred. Abortions were not carried out on the remaining 18.1

percent for a number of reasons. Of the 414 referrals on whom abortions were not carried out, 104 or 4.6 percent, were refused because of insufficient legal grounds. In the second year of its operation, the Centre carried out 3,269 abortions. Of 746 referrals on whom abortions were not carried out, 81, or 2.0 percent, were refused because of insufficient legal grounds.

Lack of a definition of the circumstances in which an abortion is unlawful and the varying interpretations which have been given to the law in practice have resulted in a state of affairs where it can be said that the law on abortion in New Zealand is undefined, lacking in certainty, varied in practice and unfair in its incidence. Clearly there is a need for restatement.

Table 14—Abortions Carried Out at Dunedin Public Hospital

Year	No. of Abortions
1962	3
1963	2
1964	7
1965	6
1966	13
1967	20
1968	11
1969	48
1970	49
1971	97
1972	119
1973	160
1974	130
1975	104

ABORTION STATISTICS IN NEW ZEALAND

Before the passing of the Hospitals Amendment Act 1975, abortion was not a notifiable operation. Nevertheless, a reliable estimate of the numbers of abortions performed in both public and private hospitals can be obtained from figures which have been made available to the National Health Statistics Centre in Wellington. The number performed in private hospitals is probably conservatively stated because operations which were in fact abortions may have been listed under other names such as Dilatation and Curettage or Hysterotomy. Table 15 sets out the number of therapeutic abortions performed in individual public hospitals in New Zealand in the years 1969 to 1975 inclusive.

Figures for abortions performed in private hospitals from 1969 to 1975 inclusive are not available but abortions carried out in 1974 in private hospitals (excluding the Auckland Medical Aid Centre) totalled 1,366.

Until the opening of the Auckland Medical Aid Centre in May 1974, with the exception of illegal abortions and those carried out on New Zealand women in Australia, all abortions in New Zealand were performed in public or private hospitals.

Table 15—Therapeutic Abortions in Public Hospitals 1969–75

	1969	1970	1971	1972	1973	1974	1975
Ashburton	...	...	...	8	22	31	25
Auckland	...	...	1	...	...	...	...
Balclutha	...	...	...	1	1	5	2
Buller	...	...	...	...	1	...	...
Christchurch	...	...	1	...	...	...	...
Christchurch Women's ...	16	81	114	162	161	153	163
Cook	3	5	1	2	4	58	100
Dannevirke	2	...	...	...	1	...	...
Dargaville	...	...	...	...	...	1	...
Dunedin...	48	49	97	119	160	130	104
Green Lane	1	...	...	...	...	...	...
Grey	...	...	6	6	7	8	1
Hastings	7	11	8	31	24	29	29
Hawera	...	...	...	3	3	11	11
Hilljack	...	...	...	...	3	...	1
Lower Hutt	7	13	22	21	36	29	22
Kawakawa	2	...	3	1	6	10	6
Masterton	...	5	3	4	2	1	1
Middlemore	...	...	...	...	...	1	...
Napier	5	4	5	7	10	14	14
National Women's ...	23	48	74	157	210	198	161
Nelson	6	9	15	30	40	44	45
New Plymouth	6	8	11	12	...	...	...
Oamaru...	...	...	...	...	...	1	...
Palmerston North... ...	4	2	4	12	5	13	10
Princess Margaret ...	16	...	...	...	...	...	...
Riverholm	...	1	...	...	...	1	...
Rotorua	6	9	7	23	25	25	35
Seddon Memorial... ...	...	...	...	...	1	6	3
Southland	3	4	1	11	5	6	16
Stratford	...	1	3	3	2	1	...
Taihape...	...	2	...	...	...	...	...
Taranaki Base	...	...	...	2	18	21	30
Taumarunui	...	1	2	3	...	...	1
Taupo General	...	...	...	...	...	1	4
Tauranga	2	1	5	5	6	5	12
Te Kuiti...	...	4	1	5	7	3	...
Te Puia	4	2	2	1	...	2	2
Thames	...	...	...	1	...	...	1
Timaru	4	3	4	14	46	17	22
Tokoroa...	...	...	1	1	1	1	...
Waikato...	24	24	34	56	89	75	62
Waimarino	1	...	...	1	...	...	...
Wairau	4	3	3	12	12	10	6
Wakari	...	1	...	...	...	...	...
Wanganui	1	1	1	...	10	12	14
Wellington	13	13	30	44	49	66	60
Westown	...	1	...	...	...	...	...
Whakatane	...	1	4	3	1	2	...
Whangarei	4	6	7	4	21	13	15
Total	212	313	470	765	988	1,008	978

Table 16, compiled from the Termination of Pregnancy forms received by the National Health Statistics Centre, shows the number of abortions performed in public and private hospitals in New Zealand between 1 October 1975 and 30 September 1976.

It should be borne in mind that the figures are provisional only and are liable to amendment on receipt of late notifications.

Table 16—Abortions Performed in Public and Private Hospitals in New Zealand 1 October 1975–30 September 1976

		Performed for Psychiatric Reasons	
	Numbers	Numbers	Percent
Public hospitals	719	582	81
Auckland Medical Aid Centre ...	3,602	3,584	99
Other private hospitals	21		
All hospitals	4,342	4,166	96

Chapter 11
ILLEGAL ABORTIONS

One of the grounds on which the case for abortion law reform is frequently based is that liberalisation of the laws will result in a major reduction in the numbers of abortions carried out by non-medical persons, outside of hospitals, with unsuitable instruments, and under unhygienic conditions. Such abortions commonly give rise to serious medical complications and may even cause death. If, under restrictive laws, large numbers of women are quite resolved to have such abortions which are fraught with hazards to their health, it is argued that there is a strong case for changing the law, and, in the process, doing away with a serious social evil.

The incidence of illegal abortions, whether under a restrictive or liberal legal code, has other implications relevant to medical, social and demographic issues with which this inquiry is concerned. It is said that women "vote" with their behaviour, regardless of laws, religious injunctions, or opinion polls, and that those who have abortions, legal or illegal, thereby declare their acceptance of the practice as a necessary social measure. Proof of a large number of women falling into the illegal category would highlight this acceptance.

A reliable estimate of the numbers of illegal abortions is important when the effect that any liberalisation of the law would have on health and hospital services is being considered. It would seem logical to assume that liberalisation of the law would result in both public and private hospitals being requested to carry out most of the abortions previously performed illegally elsewhere.

Definition of "Illegal" Abortion

The term "illegal" abortion is open to a number of interpretations. In its own terms, an illegal abortion is one which is performed other than in accordance with the law. Such a definition could include an abortion performed by a registered medical practitioner in a hospital or surgery, as well as one carried out by a non-medical person outside such an institution. It would also include a self-induced abortion.

While we have no doubt, from the evidence submitted to us, that medical practitioners have performed illegal abortions within hospitals under the guise, sometimes of dilatation and curettage, sometimes of hysterotomy, it is difficult to prove that they were not acting in good faith. Because of our inability to determine whether an operation performed by a medical practitioner in a hospital or surgery is legal or otherwise, we propose to confine our definition of an "illegal" abortion to one which is performed by a non-medical person outside a hospital. Nevertheless, those

operations of doubtful legality to which we have referred must be taken into account as being relevant to the issues which we have discussed.

In considering the various surveys and estimates of the incidence of illegal abortion in New Zealand, it is important to look critically at the interpretation given in each instance to the term, and the use which is made of it in producing figures for statistical purposes.

Illegal Abortions in the Past

The problem of illegal abortion has long been recognised in New Zealand, and the incidence of death from septic abortion has caused much concern. Mention has been made in the Introduction of the special committee set up by the Board of Health in 1921 to consider and report on the question of the deaths of mothers in childbirth. The report appears as Appendix 7.

The lengthier report of the 1936 McMillan Committee which was set up to inquire into the incidence of abortion because of the rise in the death rate from septic abortion, arrived at an estimate of 4,000 cases of criminally induced abortions in the year ended 31 March 1936. The McMillan Committee considered its estimate of 4,000 abortions to be conservative. Bearing in mind that the committee heard evidence from numerous witnesses, the weight of whose testimonies it alone could assess, and that, forty years later no useful re-assessment of this evidence can possibly be made, we must accept its estimate.

Two points relative to the findings of the McMillan Committee appear to bear upon the validity of its conclusions when taken as a basis for comparison with the situation today:

1. Medical research since 1936 has shown that the proportion of spontaneous abortions to live births is much higher than it was once believed to be. Inferences, therefore, as to the number of illegal abortions, which are drawn from the number of hospital admissions for all abortions, must be considered with caution.
2. Estimates made by the committee were based largely on projections for the whole country made from the total number of cases for abortion treated in public hospitals in one urban district.

On the evidence we have heard, we would be loath to arrive at an estimate of abortions for the whole of New Zealand from the figures giving the number of abortions carried out in a single urban area. Attitudes towards abortion can differ greatly from one area to another. Women from a predominantly rural area may not necessarily have the same attitudes as women living in an urban community. However this may be, it cannot be denied that the number of illegal abortions resulting either in death or in serious impairment of health must have been very large both in 1921 and 1936. It is recognised that both mortality and morbidity figures would have been much lower had there been access to the modern drugs which play an important part in preventing sepsis.

Present Estimates of Illegal Abortion in New Zealand

For a number of reasons, it is difficult to estimate the incidence of illegal abortion. The debate in the House of Commons in England before the

passing of the Abortion Act 1967 demonstrated the variety of opinions as to the number of illegal abortions carried out in that country. Before the passing of the British act, the figure was frequently suggested as being 100,000 per year, but the Lane Committee could find no satisfactory justification for this estimate. (Lane Report para. 505).

The Lane Committee (para. 506) referred to some seven estimates of illegal abortions before the passing of the Abortion Act 1967. These varied from 15,000 to 250,000 per annum. Many of the difficulties in obtaining reliable figures on illegal abortion arise from the secrecy attached to it. Women on whom illegal abortions have been carried out will be reluctant to co-operate with the police who are likely to obtain information about abortion only if death or injury eventuates and the matter is reported to health authorities. These difficulties are reflected in the estimates made which must be regarded as being as much the product of conjecture as of calculation.

Table 17 sets out the total number of charges and the total number of persons convicted and sentenced for offences of abortion since 1954.

Table 17—Prosecutions for Abortions in New Zealand, 1954–75

Year	Total Charges	Distinct Cases	Persons Convicted and Sentenced		
			Males	Females	Total
1954 ...	13	...	2	3	5
1955 ...	1	...	...	2	2
1956 ...	...	8	3	3	6
1957 ...	10	3	1	2	3
1958 ...	8	3	2	1	3
1959 ...	1	1	1	...	1
1960 ...	20	16	1	4	5
1961 ...	16	9	5	2	7
1962 ...	47	16	2	2	4
1963 ...	12	9	6	3	9
1964 ...	12	5	2	1	3
1965 ...	31	13	6	5	11
1966 ...	27	12	5	2	7
1967 ...	26	13	3	2	5
1968 ...	5	4	5	...	5
1969 ...	3	2	...	1	1
1970 ...	7	2	2	1	3
1971 ...	7	3	1	1	2
1972 ...	8	5	2	1	3
1973 ...	26	9	5	3	8
1974*					
1975*					

*No offences recorded.

An independent inquiry made by officers of the Department of Scientific and Industrial Research in Auckland has provided some information of cases from 1934 onwards in which the resources of the department were used to investigate aspects of cases of alleged abortion by instrument or drugs where, for the most part, death or injury to the woman's health had occurred. This information is set out in Appendix 8.

We note four comments made by the department in connection with the information:

1. Many of the prosecutions were brought against people who made abortion a lucrative business. Some were charged several times over a period of five years.
2. No cases have been referred to the Department of Scientific and Industrial Research in Auckland since 1973.
3. All the cases brought to the courts involved either the death of a woman or a serious danger to her health.
4. During the war years, 1941-1945, the work done by the laboratory for the police was limited to matters other than abortion.

Other Methods of Estimating Numbers of Illegal Abortions

Estimates of the number of illegal abortions in New Zealand are made in several studies and surveys which have been brought to our notice and to which we refer. Apart from factors peculiar to the individual studies or surveys, certain other matters should be borne in mind in making an assessment of them:

1. There is no uniform definition of illegal abortion in the surveys and studies. In the public mind an "illegal" abortion is likely to connote an abortion carried out in a "back street" and accompanied by much physical and psychological misery. Many such abortions have been performed in the past and the experience of overseas countries shows that no law, however liberal, has entirely eliminated them. A number of women spoke to us who had had "back street" abortions, often in degrading and unhygienic conditions. Some of the incidents of which we heard had occurred as far back as the 1930s.
2. In estimating the number of illegal abortions, some studies include not only "back street" abortions, but also those which are self-induced and those which have been performed by doctors under relatively safe conditions in hospitals or surgeries.
3. Some studies include statistics of women travelling to Australia for abortions, which appear to have been performed there legally, even though, in some cases, they might well have been performed legally in this country. We deal separately with abortions performed on New Zealand women in Australia.
4. There is no statistical information making a clear distinction between cases of spontaneous and induced abortion admitted to hospitals for treatment. Probably over 90 percent of these cases are genuine spontaneous abortions. For this reason, the number of abortion cases admitted to hospital cannot be taken as an index of a large incidence of illegal abortions requiring subsequent hospital treatment.

SURVEYS AND PROJECTIONS

National Research Bureau

In 1971 the National Research Bureau conducted a nationwide survey of abortion opinion on behalf of the Abortion Law Reform Association. It

addressed questions to a national random sample of 1,200 females and 1,200 males, 15 years of age and over. The sample was selected by a multi-stage random probability method, and was spread through New Zealand proportionately to the spread of population. Questions dealing indirectly with the incidence of abortion were:

Q.18. "Have you ever had a natural miscarriage?"
1. (Yes) 2. (No)

Q.19. "Have you ever done anything to yourself or to anyone else to try to bring on an overdue period?"
1. (Yes, 1 year ago)
2. (Yes, 2 years ago)
3. (Yes, 3 years ago)
4. (Yes, 4 years ago)
5. (Yes, 5 years ago)
6. (Yes, more than 5 years)
7. (No, never)

Q.20. "Have you ever done anything to yourself or to anyone else which successfully terminated a pregnancy?"
1. (Yes, 1 year ago)
2. (Yes, 2 years ago)
3. (Yes, 3 years ago)
4. (Yes, 4 years ago)
5. (Yes, 5 years ago)
6. (Yes, more than 5 years)
7. (No, never)

From the answers to the questions, two sets of results were drawn up. One related to overall experience, and the other to experiences in the last two years which were averaged out to give yearly proportions. Of the women questioned, 5.8 percent answered that they had had abortion attempts at some time in the past; 2.2 percent said that they had attempted abortion in the last two years.

Those conducting the survey concluded that if these percentages for abortion attempts were projected on to the estimated 997,000 women and girls 16 years of age and over in New Zealand at the time of the survey, an average of 11,000 abortion attempts could be reckoned to have occurred in each of the last two years.

With regard to successful abortions, 2.4 percent of the women questioned claimed to have had experience of a successful abortion at some time in the past and 1.3 percent claimed a successful abortion during the previous two years. By the same method of projection, it was concluded that an average of 6,500 successful abortions could be reckoned to have occurred in each of the last two years of the survey.

Although the sampling and methodology of the survey appear reliable, the form of the question is open to criticism. It is doubtful whether affirmative answers to Q.19: "Have you ever done anything to yourself or to anyone else to try to bring on an overdue period?" can be validly regarded as genuine abortion attempts or indicating that abortion was socially and morally acceptable to the women who responded in this way.

Some drugs prescribed for women to bring on a period may not, in fact, do so, and will not interfere with an implanted embryo. They can hardly be described as abortifacients nor their use as abortion attempts. Many women who endeavour to bring on a late period do so with no thought of attempting abortion, or attempting in any way to interfere with a pregnancy. Although, therefore, attempts to bring on periods are in some cases undoubtedly abortion attempts, it is misleading to present all affirmative replies to the question in this light.

Q.20 leaves open the possibility that both the person having the abortion performed and the person carrying it out may report the same instance.

Other criticisms may be made. In order to obtain a valid estimate of annual illegal abortions from projections made from samples in the two years preceding the survey, it is theoretically necessary to obtain data on abortion experiences in the year concerned. Neither sample error possibilities nor reporting errors of the respondent are allowed for in the calculations. On the grounds of the possibility of errors in the sample alone, the total of abortion attempts could be anywhere in the range 11,000 plus or minus 2,600, i.e., between 8,400 and 13,600.

Gemming and Crighton Survey 1972

In 1972 a survey was conducted throughout Auckland among a random probability sample of 578 women aged 16 to 55 years. No attempt was made to determine whether the abortions obtained were legal or illegal. The questions asked of respondents in the survey relevant to their abortion experience were:

1. "Have you ever seriously considered doing anything to yourself, or considered having something done to terminate a pregnancy of yours?"

To this question 19.3 percent replied in the affirmative.

2. "What action did you take after you considered an abortion (abortions)?"

For this question the options were: "None"; "Made enquiries but went no further"; "Attempted an abortion".

To this question 9.6 percent replied that they had attempted an abortion.

3. "When did you have a successful abortion?"

To this question 5.2 percent of the respondents replied.

Of the women reporting a successful abortion, 16.6 percent had their pregnancies terminated in hospital, 43.4 percent had them terminated outside of the hospital (although some of these terminations might have been carried out by a medical practitioner), 13.3 percent were aborted by non-medical personnel, and 26.7 percent of the abortions were self-induced. We note that these questions and others relating to abortion were preceded by another question which asked: "Have you ever done anything to yourself, or had anything done to bring on an overdue period?" The respondents were asked to indicate whether anything had been done in any of the previous five years, or more than five years before,

or never. The same criticisms are to be made of this question as have been made of a similar question in the National Research Bureau Survey.

Note also that the Gemming and Crighton Survey failed to record any successful abortions in the year prior to the survey (1972). This is a strange result and raises serious doubts as to the reliability of the reporting. Because of this anomaly, those conducting the survey made two estimates of the number of abortions carried out in Auckland per year. One was based on the five years prior to 1972, and the other on the six years including 1972. By projecting the answers from the survey on to the total female population of Greater Auckland, the authors estimated that in each of the six years 1967-1972, 2,600 women plus or minus 1,680 seriously considered abortion, 1,130 attempted abortion, and 650 had successful abortions, and that in each of the five years 1967-1971, 810 women had successful abortions.

The Greater Auckland area corresponds to the Auckland statistical area, which contains about one-quarter of all females in the given age range in New Zealand. When answers are projected on to the total New Zealand population, the figure of 2,600 to 3,240 abortions per annum, both legal and illegal, is reached.

Apart from the criticism as to the form of the questions and as to the absence of any statistics prior to 1972, another criticism is to be made of the survey method. There are some limitations on the reliability of information gained from personal interviews. These include the differences in the ability of women to recall abortions and to admit to abortion behaviour, and in the capability of research interviewers to elicit answers on such a personal topic.

Extrapolation from Maternal Deaths

At least one attempt has been made in New Zealand to assess the number of illegal abortions by extrapolation from the number of maternal deaths directly attributable to abortion. The adoption of this technique does not purport to arrive at a specific number of illegal abortions, but rather to suggest some reasonably acceptable figures within which upper and lower limits are to be found. This method proceeds on the basis that between 1958 and 1967 an average of five deaths per year directly attributable to induced abortion occurred in New Zealand. The process of extrapolation depends on the use of the multiplier, in this case known mortality rates from legal abortions in several other countries during the same period of time.

In Northern Europe (Sweden, Denmark, England and Wales), the maternal mortality rate from abortion was 33 per 100,000 during the 1960s. If this rate is applied to the five New Zealand abortion deaths, a corresponding annual rate of 15,000 abortions would be obtained. However, if the experience of Eastern European countries is taken as the criterion and their mortality rate of about three per 100,000 abortions is applied to the corresponding five New Zealand abortion deaths, the annual rate of abortions in New Zealand rises to 166,000. Criticisms to be made of this method are obvious:

1. The selection of the multiplier is crucial to this kind of calculation.

2. The estimate of 15,000 is based on mortality figures from 1958 to 1967, and could at best apply to the situation prevailing at that time. The number of abortion deaths in New Zealand in recent years has been minimal. They were as follows:

1969 (2)	1973 (0)
1970 (1)	1974 (0)
1971 (1)	1975 (0)
1972 (0)	

If the same basis of projection is used, the number of illegal abortions arrived at would be under 2,000.

3. The propriety of using deaths resulting from legal abortions as a multiplier in the situation relating to deaths from an unknown proportion of legal and illegal abortions is questionable. In Northern Europe, where more liberal standards prevail, abortion would be subject to some measure of control from health authorities. The deaths referred to in New Zealand would probably have resulted from abortions carried out in unhygienic conditions.

Estimates Based on Fertility Levels

Another method suggested by a demographer for estimating the number of abortions in New Zealand is based on fertility levels. The author's propositions are:

> The uncontrolled fertility of the human population may be conservatively represented at 7.0 live births per woman during her reproductive life. To reduce this rate to the level needed for a stationary population (2.2 children) by the use of abortion alone, without contraception, one would need an average of 9.6 abortions per woman's reproductive span.
>
> If contraception is practised with 95 percent effectiveness, and abortion is used only as a backstop to contraceptive failure, a stationary population would eventually be achieved, with an abortion rate of 0.7 per woman. This corresponds to a ratio of 318 abortions per 1000 live births. During the assumed logistic transition from high to low fertility, a point is reached which corresponds to the total fertility rate of 3.0 which applied in New Zealand in recent years. The total fertility rate is defined as the average number of children a woman might expect to have if current age specific fertility rates continue through her productive life. This implied an abortion rate of 30 per 1000 women aged between 15 and 44 years, and an abortion ratio of 300 per 1000 live births. This would imply an annual number of abortions in New Zealand in the region of 15,000 to 18,000.

It is proper to recognise that in an area in which there is little factual information, this method does provide another basis of estimate but one which is open to criticism on the grounds that its assumptions, to say the least, are speculative and the inferences to be drawn from them in consequence, unreliable. There is no evidence that the uncontrolled fertility of New Zealand females can be taken as seven live births per person, and the assumption of a transition from the high fertility level (which is not defined) to a level consistent with a stationary population can lead to estimates which are not well-founded.

Estimates Based on Hospital Admission

Table 18 gives details of the number of cases treated for abortions in public hospitals in New Zealand during the years 1950-1975.

Table 18—Abortions in New Zealand

PUBLIC HOSPITAL CASES ONLY, 1950–75

(Numbers and Rates Per 1,000 Total Births (Live Plus Still))

Year	(I.C.D.) 643–644 Spontaneous or Unspecified		640–641 Induced for Medical or Legal Indications		642 Induced for Other Reasons		645 Other Abortion (e.g., Carneous Mole)		Total Abortions	
	Numbers	Rates	Numbers	Rates	Numbers	Rates	Numbers	Rates	Numbers	Rates
1950 ...	3,661	72.7	96	1.9	47	0.9	106	2.1	3,910	77.6
1951 ...	3,758	74.0	74	1.5	40	0.8	119	2.3	3,991	78.6
1952 ...	3,870	73.2	83	1.6	32	0.6	126	2.4	4,111	77.7
1953 ...	4,028	76.1	48	0.9	38	0.7	129	2.4	4,243	80.1
1954 ...	4,090	74.2	61	1.1	30	0.5	128	2.3	4,309	78.2
1955 ...	4,179	73.9	77	1.4	20	0.4	100	1.8	4,376	77.4
1956 ...	4,206	73.1	73	1.3	14	0.2	106	1.8	4,399	76.4
1957 ...	4,138	69.6	72	1.2	10	0.2	99	1.7	4,319	72.7
1958 ...	4,500	73.1	45	0.7	16	0.3	141	2.3	4,702	76.4
1959 ...	4,597	73.2	54	0.9	9	0.1	134	2.1	4,794	76.3
1960 ...	4,891	76.7	74	1.2	11	0.2	177	2.8	5,153	80.8
1961 ...	4,847	73.0	40	0.6	11	0.2	181	2.7	5,079	76.5
1962 ...	4,592	69.6	38	0.6	10	0.2	193	2.9	4,833	73.3
1963 ...	4,689	71.6	45	0.7	5	0.1	134	2.0	4,873	74.4
1964 ...	4,531	71.6	76	1.2	4	0.1	104	1.6	4,715	74.5
1965 ...	4,209	69.1	60	1.0	7	0.1	154	2.5	4,430	72.7
1966 ...	4,164	68.4	70	1.2	6	0.1	157	2.6	4,397	72.3
1967 ...	4,164	67.3	95	1.5	3	0.0	99	1.6	4,361	70.4
1968 ...	4,343	68.9	128	2.0	7	0.1	63	1.0	4,541	72.0
1969 ...	4,183	66.2	211	3.3	13	0.2	107	1.7	4,514	71.5
1970 ...	4,446	70.7	313	5.0	21	0.3	86	1.4	4,866	77.4
1971 ...	4,471	68.4	470	7.2	23	0.4	103	1.6	5,067	77.5
1972 ...	4,589	71.9	765	12.0	19	0.3	99	1.6	5,472	85.7
1973 ...	4,464	72.8	988	16.1	18	0.3	76	1.2	5,546	90.5
1974 ...	4,186	70.5	1,008	17.0	16	0.3	144	2.4	5,354	90.2
1975 ...	4,215	74.4	978	17.3	1	...	131	2.3	5,325	94.0

Source: National Health Statistics Centre.

Some estimates of illegal abortions have been made on the assumption that a large proportion of abortions listed under the category "spontaneous" or "unspecified" could be patients seeking or requiring treatment after procuring an illegal abortion. Various estimates of the proportions admitted to hospital following upon illegal abortion attempts have been made, but none can be substantiated. A British gynaecologist, Diggory, in 1966, estimated on the basis of his hospital experience that two-thirds of abortion admissions were due to criminal interference. If a similar situation obtained in New Zealand, and was applied to the experience of 1968/1969, an estimate could be made that about 3,000 hospital admissions in that period were the direct result of illegal abortions.

Again there are criticisms to be made:

1. There is no information as to what percentage of women require hospitalisation for spontaneous abortions or what percentage require it after attempted or successful illegal abortions. Some of those upon whom illegal abortions have been performed might seek private medical aid; others again would require no hospital treatment because of the availability of modern antibiotics which have greatly reduced the number of complications attendant upon attempts at illegal abortion in the past.

Contrary to Diggory's opinion, we note that it was the impression of the authors of a report adopted unanimously by the Council of the Royal College of Obstetricians and Gynaecologists on 26 March 1966 that not more than one out of five abortions treated in hospitals in the United Kingdom was other than spontaneous in onset.

2. Reference is made in Table 18 to abortions which have been induced "for other reasons". We are informed that this is the official category under which criminal abortion attempts are classified. We note that there is a wide fluctuation in the numbers, and that between the years 1962 and 1968 they fell markedly. However, the numbers of spontaneous or unspecified abortions remained fairly constant in these years. **This would suggest that the number of cases admitted to public hospitals in New Zealand for spontaneous or unspecified abortions is not a reliable indication of the number of illegal abortions.**

The evidence which the Commission has heard at the various sittings which it has conducted throughout New Zealand suggests that the traditional "back street" concept of illegal abortion is not prevalent in New Zealand. A number of gynaecologists throughout the country told us that cases of women admitted to hospital suffering from complications of "back street" abortion were almost unknown and that deaths and complications from septic abortions which gave rise to the McMillan Report in 1935 were a thing of the past. Only in Auckland did we hear evidence of admissions to hospital in recent years because of illegal abortion. This evidence concerned two young girls who were admitted to hospital in Auckland in 1976 suffering from the complications of abortion performed by a "back street" operator.

The New Zealand Medical Maternal Death Assessment Committee has reported that, from 1969 to 1972 inclusive, there were two specific cases of death from septicaemia associated with illegal abortion. There was another case which on review was thought to be the result of illegal abortion. Some criticism has been made of the medical statistics. It has been suggested that the cause of mortality has sometimes been disguised and that unsatisfactory medical statistics may mask a higher number of deaths following illegal abortion than is reported. Whatever substance there may be in this criticism, we do not think that even if it were accepted and a different system of tabulating causes of mortality introduced, there would be any significant change in the estimated number of abortions carried out annually.

After a careful study of all available statistics, surveys and methods of assessment, we are unable to arrive at any reliable formula to enable us to form an accurate assessment of illegal abortions performed in New Zealand in a particular year. Our impression is that the estimates in the survey data which we have studied are unduly high.

Estimates of New Zealand Women Obtaining Abortions in Australia

A number of attempts have been made to estimate the number of New Zealand women who have sought abortion in Australia. It is common knowledge that for some years women and girls from New Zealand have travelled to Australia, particularly to Sydney and Melbourne, to take advantage of the more liberal construction placed upon the laws of abortion there. The traffic across the Tasman to Australia has been referred to in a number of submissions made to us, and various estimates have been given as to the numbers involved. We are aware, too, that at least two Australian doctors have actively canvassed doctors in New Zealand, advertising that they are willing to carry out abortions in Australia on New Zealand women and girls.

The estimates differ widely. We refer to two of these in particular:

Survey by Rogers and Lenthall

In an article entitled, "Characteristics of New Zealand Women Seeking Abortion in Melbourne, Australia", published in the *New Zealand Medical Journal*, March 26, 1975, A. F. C. Rogers and Judith F. Lenthall examined the characteristics of New Zealand women seeking abortion in Melbourne. In that article they stated, "Some 4,000 New Zealanders are estimated to fly in to Australia annually because of less restrictive abortion laws in some Australian states." Again, "Various estimates suggest that about 4,000 New Zealand women travel to Australia annually to seek abortion. The accuracy of this number arrived at by the popular press, e.g., the *Australian* 7 June 1974, is difficult to verify."

The newspaper has been referred to in other evidence before us. We have endeavoured, by correspondence with Australia, to ascertain the basis upon which the estimate was made. No information which we would regard as satisfactory has been forthcoming and we know of no information by which the estimate can be verified or, indeed, upon which

it is based. For these reasons we regard it as being no more than speculation and scientifically unreliable.

The Rogers and Lenthall article should not therefore be taken as a basis for estimating the number of New Zealand women going to Australia for abortions.

Survey by Mrs J. Steincamp

Evidence was given to the Commission by Mrs Jacqueline Steincamp of Christchurch. She set out to arrive at an assessment of the numbers of New Zealand women who had been seen in all the clinics and hospitals and by individual doctors in Melbourne and Sydney from July 1974 to the end of June 1975. For this purpose she wrote to all those clinics, hospitals and doctors which were known to the Christchurch branch of the Abortion Law Reform Association, and to referral agencies. They were asked to give the numbers of New Zealand women they had seen over the period of twelve months referred to. The responses varied greatly in detail. Some operators kept no records; some clinics, on the other hand, kept extremely detailed records. One large Sydney clinic had had most of its records destroyed in a fire. For all these limitations, the survey seems to have been well organised and carried out with a high degree of thoroughness. Mrs Steincamp arrived at the conclusion that, for the twelve month period stated, the number of New Zealand women and girls who travelled to Australia for abortion was in the region of 900. The total number of patients actually seen in Sydney was 770 and in Melbourne, 195. Of the various estimates made, Mrs Steincamp's assessment seems to us to be a genuine attempt to arrive at a proper assessment of the numbers travelling to Australia and, in the absence of better information, we are inclined to the view that this is the most accurate figure available for the period under consideration.

The point should be noted that during the period covered by Mrs Steincamp's survey, the Auckland Medical Aid Centre was operating, but it would not have been possible for some of the women in her survey to have had their pregnancies terminated there because their abortions were performed in the mid-trimester of pregnancy, whereas the Centre limits its operations to pregnancies of not more than 12 weeks' duration.

There is no evidence upon which we can assess the number of women travelling to Australia before the opening of the Clinic.

The Commission has heard evidence, mainly from doctors in private practice, from gynaecologists attached to hospitals and from family planning clinics, from which it feels justified in concluding that there has been a marked decline in the number of women referred to Australia for abortion since the opening of the Auckland Medical Aid Centre. We give three examples of the type of evidence which led us to arrive at this conclusion:

1. A doctor in private practice informed us that, between February 1973 and May 1974, she had referred 36 patients to Australia and 2 to hospitals in New Zealand for abortions, but that for the period May 1974 to August 1975, she had referred 43 for abortions within New Zealand and only 10 to Australia. Of those referred to Australia, some

had been reluctant to be involved within the Medical Aid Centre during the trial of Dr Woolnough, others were too advanced in pregnancy and others again had personal reasons.

2. A gynaecologist, between February 1973 and May 1974, referred two women for abortion to hospitals in New Zealand and 36 to Australia, but between May 1974 and August 1975, referred 43 for abortion within New Zealand and 19 to Australia.

3. A family planning clinic, during the three months February to April 1974, referred 39 patients out of a total of 64 to Australia, but during the corresponding period in 1975, referred 8 to Australia and 74 within New Zealand.

CONCLUSION

It is impossible to assess the number of women travelling to Australia for abortion before or after the opening of the Auckland Medical Aid Clinic, but since the opening of the Clinic the numbers have dropped. All the estimates made are speculative with the exception of that made by Mrs Steincamp which was obtained from a vigorous and well organised attempt to make an objective and accurate assessment of the position.

Chapter 12

THE AUCKLAND MEDICAL AID TRUST

TERMS OF REFERENCE

The Auckland Medical Aid Trust which we refer to as the "Trust" is not specifically mentioned in our terms of reference. Its constitution and its workings are, however, relevant for a number of reasons:

1. We are required to investigate and report upon the likely effects upon the present health, hospital and medical services of any changes to the law or practice of abortion in New Zealand. Among the recommendations made to us were some which advocated the use of free-standing day clinics as places in which abortions might be performed in the private sector. Since May 1974, the Trust has conducted the only institution of this kind in New Zealand and its workings may well serve as a guide to the operation of such enterprises.
2. The Auckland Medical Aid Centre, administered by the Trust, carries out more abortions in New Zealand than all other public and private hospitals together. An examination of its workings and administration are therefore relevant to the interpretation and application of the present law on abortion.
3. The Trust was mentioned in many submissions made to us and itself made a submission of its own volition. In this the Trustees expressed their views on the present abortion laws, emphasized the place of counselling in abortion and furnished important information as to the workings of the Auckland Medical Aid Centre. In addition, the Trust supplied us with information, of which in this country there is a dearth, on the characteristics of women seeking abortion.

Constitution of the Trust

The Trust, which is registered as a Charitable Trust under the Charitable Trusts Act 1957, was established on 17 May 1974. It aimed to provide, to quote the words of its manual, "a comprehensive service with regard to the lawful termination of pregnancies of less than ten weeks' gestation". This period has since been extended to twelve weeks. It opened a centre, known as the Remuera Clinic, at 182 Great South Road, Remuera, on 17 May 1974. On 8 September 1975, as a result of the passing of the Hospitals Amendment Act 1975, it moved its premises to Aotea Private Hospital, Ranfurly Road, Epsom, where it now provides the same services as were previously available at the clinic. Both the clinic and the hospital can be conveniently referred to as the "Centre".

Submissions

A lengthy written submission was made on behalf of the Trust and was presented at public hearings of the Commission. Those who appeared before the Commission for this purpose comprised a member of the Trust Board and former Director of the Centre, a second member of the Trust Board, and a chartered accountant, also a member of the Trust Board, who presented the financial accounts of the Trust.

The submission by the Trust, and the evidence tendered in support of it, described the workings of the Centre and criticised the present law on abortion and its workings as being vague and variable.

The submission also contained a great deal of useful statistical information regarding the number of women and girls who had applied for and had been granted abortions at the Centre. At the time that its submissions were heard, information on only the first year of the Trust's workings was available. Information on the second year of operation was supplied to us later.

The Auckland Medical Aid Centre

The Auckland Medical Aid Centre provides services for counselling, assessment and early pregnancy termination. It is approved to perform abortions by the Director-General of Health, pursuant to the Hospitals Amendment Act 1975. The Centre operates on a day-stay basis, and on the information given to us, accepts patients only on referral from general practitioners.

The Trust is of the view that the performance of abortions in the first trimester of pregnancy should not be confined to private and public hospitals, but should also be available in clinics licensed by the Department of Health. It considers that the performance of abortions after the first trimester of pregnancy should be confined to licensed public and private hospitals. It supports a concept of first trimester abortion on a day-stay basis in free-standing clinics with adequate counselling and concern for the woman, and adequate follow-up services.

Counselling

The Centre provides a service of medical assessment together with counselling before, during and following the operation. Its counsellors and its medical and surgical staff are employed and paid by the Trust. The decision whether or not an abortion should be performed is made within the Centre.

An invitation was extended to us to attend at the Centre. The basis of that invitation should be stated. We were not asked to be present at the counselling of a patient before an abortion. Our presence might have inhibited both the counsellor and the patient, and would have amounted to a breach of privacy. We were not asked to be present when an abortion was performed. Again our presence would have amounted to a breach of the patient's privacy. By witnessing one, or even several abortions, we would not have been able to form an opinion as to the competence of the doctor performing the operations, or the safety of the procedure. Our view on these points was shared by representatives of the Centre.

We were invited, however, to attend in order to observe the "friendly and relaxed" atmosphere at the Centre. Ultimately we did not accept the invitation, but preferred to form our opinions from oral and written evidence presented to us. However, we have no reason to believe that the atmosphere at the Centre is not "friendly and relaxed."

Complication Rates

Our conclusions concerning the techniques of abortion and complication rates following various methods of abortion are dealt with in Chapter 22.

The medical evidence given to us indicates that the complication rates following abortions performed at the Centre are low, although it is only fair to record that the technique used at the Clinic is the vacuum aspiration technique performed up to, but not beyond, the twelfth week following conception. This is the technique least likely to cause complications. Moreover, because it functions on a day-stay basis, any complications occurring after the patient has departed may not always be known to the Centre, or to the patient's own practitioner as they would be if the patient remained in hospital as an in-patient after the abortion had been carried out. A number of women have required admission to National Women's Hospital, and some few have been admitted to Middlemore Hospital or other hospitals in the Auckland Province, but the number is no more than would be expected, remembering that abortion is a surgical operation.

The Working of the Abortion Law at the Medical Aid Centre

In the first year of its operations, which ended on 15 May 1975, 2,288 women were referred for abortion at the Centre. Of these, 1,874 were aborted. Of the 414 women who were not, 184 were considered to be too far advanced in their pregnancy for the technique available at the Centre, 81 changed their minds before the abortion was to take place, 11 had medical contra-indications; 32 were not pregnant, and 106 were declined for insufficient legal grounds.

Although on the face of it, the number of women who did not obtain abortions is 18.1 percent of the total referrals, only a very small percentage were declined for insufficient legal grounds. Out of the total of 414, it was not possible to carry out abortions at the Centre on 308 women because they were either too far advanced in their pregnancy, had medical contra-indications, were not pregnant or had changed their minds. Only 4.6 percent of the total of 2,288 women referred for abortion were declined for legal reasons.

During the second year of operation which ended on 17 May 1976, 4,015 women were referred to the Centre. Of these, 3,269 obtained abortions. Of the 746 on whom the Centre did not carry out abortions, 665 were refused because they were too far advanced in pregnancy, had medical contra-indications, were not pregnant, had earlier miscarried, or had changed their minds. Only 2.0 percent were refused because of insufficient legal grounds.

Table 19 sets out the reasons for which patients were denied abortions in the two years of the Centre's operations.

Table 19—Patients Denied Abortions at the Auckland Medical Aid Centre

	1974–75		1975–76	
	No.	Percentage	No.	Percentage
Pregnancy too advanced ...	184	8.0	117	2.9
Insufficient legal grounds ...	106	4.6	81	2.0
Changed mind	81	3.5	459	11.5
Medical contra-indications ...	11	0.5	17	0.4
Not pregnant	32	1.3	50	1.2
Miscarried	...	...	22	0.6
Total	414	18.1	746	18.6

In pointing out the change in distribution of the reasons for which abortion had been declined in the second year of operation, the Trust made these points:

1. The percentage refused on the grounds that the pregnancy was too far advanced had fallen from 8 percent to 2.9 percent. It was stated that one of the main factors for this decline is that women and their doctors are now more aware of the need to attend the Centre early in pregnancy. We think that this is probably so.

2. Patients declined abortion on insufficient legal grounds had fallen from 4.6 percent of those referred to 2 percent. The explanation suggested was that medical practitioners who refer patients to the Centre are now more aware of the legal requirements for abortion, and that more patients are changing their minds about abortion at the Centre before being seen by the assessing doctor. While there may be some substance in the second of these suggestions, no evidence was presented to us to support the first. On the contrary, it seemed to us that knowledge of the comparatively small percentage of patients refused abortion on insufficient legal grounds in the first year would be likely to encourage doctors to refer even more patients to the Centre. It could be argued that the reduced percentage of refusals is consistent with the Centre taking an even more relaxed view of the law than it did in the first year of its existence. On the whole we think the explanation offered by the Trust is somewhat ingenuous.

3. More patients are changing their minds about abortion at the Centre before being seen by the assessing doctors, i.e., after counselling. While the increase in percentage may provide some evidence of the value of the counselling before the abortion decision is made, it may also indicate that some medical practitioners are referring patients to the clinic without first discussing with them the implications of and alternatives to abortion.

Finance

The Trust is a non-profit making organisation, registered under the Charitable Trusts Act 1957. The nature of this Act and the benefits which it confers on any organisation which may be registered as a charitable trust under its provisions should be clearly understood.

Section 8 of the Charitable Trusts Act 1957 provides that any society which exists exclusively or principally for charitable purposes may apply to the Registrar of Charitable Trusts for incorporation of the society as a Board under the Act. "Charitable purpose" is defined by the Charitable Trusts Act 1957 as "every purpose which in accordance with the law of New Zealand is charitable; and, for the purposes of Parts 1 and 2 of this Act, includes every purpose that is religious or educational, whether or not it is charitable according to the law of New Zealand." The Auckland Medical Aid Trust is registered as a charitable trust under the provisions of this statute.

Section 61 of the Income Tax Act 1976 exempts from taxation the non-business income derived by Trustees in trust for charitable purposes. Section 2 of this statute defines "charitable purpose" as including every charitable purpose, whether it relates to the relief of poverty, advancement of education, or religion, or any other matter beneficial to the community. In order to obtain exemption from income tax it is required that the society or institution shall have been established exclusively for charitable purposes, i.e., that it shall not be carried on for the private pecuniary profit of any individual, and the Commissioner of Inland Revenue must be satisfied that the corpus of the Trust is held for the benefit of the charitable trust or purpose.

There are other advantages to be obtained from registration as a charitable trust. The Land Tax Act 1976 exempts the land owned by any charitable trust, or seven hectares thereof if the site exceeds this area, held by, or in trust for, any body established exclusively for charitable purposes, not carried on for the private pecuniary profit of any individual, provided the land is used as a site for the purposes of that body.

Accordingly, once the Commissioner of Inland Revenue finds that the trust has been legally registered, he is unable to attack for tax purposes any part of the earnings of the trust, unless it can be shown that the trust is in reality being carried out for the private pecuniary profit of an individual.

For the 11 months of its operations ended 31 March 1975, the Trust received $119,515 from counselling and operating fees, $3,598 from a general medical subsidy, and $403 from donations. Its total income in that period was therefore $123,516. After meeting all outgoings, including operating expenses, salaries and consultants' fees, it had a surplus of income over expenditure of $31,532.

In the year ended 31 March 1976, the Trust received $300,345 for counselling and operating fees, $14,553 from general medical subsidies, $41,844 from hospital bed subsidy, and $7,554 from donations. Its total income was therefore $364,296. After meeting all outgoings, including operating expenses, salaries and consultants' fees, the excess of income over expenditure in that year was $120,281.

The hospital bed subsidy of $41,844 paid during the year ended 31 March 1976, was paid at the rate of $18.00 per patient until 30 September 1975, and at the rate of $24.00 per patient on and after 1 October 1975. The payment was made in terms of the Social Security (Hospital Benefits) Regulations 1964 (S.R.1964/17 as amended by S.R.1971/266).

Regulation 3 (1) (a) (i) provides that, where hospital treatment has been afforded on not more than two days, a subsidy is payable in respect of that treatment to private hospitals in which the treatment has been carried out. In respect of surgical procedures it is generally reckoned that the patient will require hospitalisation for at least part of two days, and for that reason a benefit of $24.00, being $12.00 per day, has been paid since 1 October 1975. The need for patients to stay in hospital overnight for certain surgical operations has decreased. Patients at the Centre have never remained overnight, and have been day-care patients only. However, because surgical treatments have been traditionally associated with a minimum of a two day stay in hospital, the full benefit of $24.00 has been paid to the Trust, abortion being regarded for the purposes of the regulations as a surgical procedure.

When the Clinic was first opened, the cost of an abortion was $80.00, made up of $10.00 counselling fee, and $70.00 operating fee. When it moved to the Aotea Hospital, the fee was increased to $100.00, but from 1 March 1976, it has been reduced to $90.00, made up of $20.00 counselling fee and $70.00 operating fee.

Assessment of the Auckland Medical Aid Centre

Much was said both in favour of, and against, the operations of the Trust. We think it desirable that we should set out our view of the operations of the Trust and the Centre based on an objective appraisal of all the evidence which we have heard. We are of the opinion that:

1. The surgical and medical facilities provided at the Centre are adequate for the performance of first trimester abortion, using the vacuum aspiration method. They have been commended by some gynaecologists. Satisfactory arrangements have been made so that patients in whom complications develop may be referred to National Women's Hospital for necessary treatment.
2. The performance of the operating doctors, once trained, seems to be satisfactory, and complication rates appear to be below those generally reckoned to be acceptable in many hospitals.
3. Women presenting for an abortion are treated with every consideration.
4. The refusal of only 4.6 percent of women referred for abortion in the first year and 2 percent in the second year on the basis of insufficient legal grounds indicates that virtually any woman, not more than twelve weeks advanced in pregnancy, is able to obtain an abortion by making a request and not deviating from her attitude through counselling.
5. The vagueness of the law on abortion has been exploited to the fullest extent by the Centre by providing what is virtually an "abortion on request" service.
6. Those at the Centre carrying out pre-abortion counselling and performing the abortions are generally abortion-orientated, and in favour of liberalisation of the abortion laws.

7. The counselling service provided by the Centre has not the appearance of independence, in that counsellors are employed and paid by the Trust, the profitability of which is directly related to the number of abortions performed.

Chapter 13

CHARACTERISTICS OF WOMEN SEEKING ABORTION

An analysis of the characteristics of women seeking abortion is of importance, not only in assessing the need for medical support services and welfare agencies, but also in seeking alternatives to abortion, and in formulating abortion legislation. Some few studies have been carried out overseas in an endeavour to identify these characteristics but in the main they suffer from sampling deficiencies. Only in recent years has any attempt been made to make an analysis of this nature in New Zealand.

There are two main sources in New Zealand from which information useful for analysis has been provided. The first is statistical information compiled by the Auckland Medical Aid Trust covering its two years of operation from May 1974 to May 1976. The second is information compiled for us from the records of National Women's Hospital, Auckland, between September 1975 and July 1976. However, the information made available from these two sources has been supplemented by several smaller studies brought to our attention and discussed with us during the course of our hearings and by knowledge gleaned from interviews with a number of women and girls who have themselves obtained abortions. The statistical material made available to us has been studied from the following viewpoints: age, marital status, parity (number of children), gravidity (number of pregnancies), period of gestation at which abortion is sought, contraceptive usage at the time of conception, race, religion, education and occupation. Such information as is available on the putative father has also been considered.

CLASSIFICATION

Age

Information available overseas and in New Zealand indicates that abortion applicants are concentrated in the younger age groups and that the percentage of younger girls aborted is on the increase. Statistics available with reference to age, for abortions induced in New Zealand public hospitals between 1969 and 1975, reflect an increase in the number of those in the under 20 age groups. The percentage of those under 20 years of age who obtained abortions in 1969 was 14 percent, but by 1975 this figure had increased to 24.2 percent.

Table 20 shows abortions induced in public hospitals (by reference to age) between 1969 and 1975.

Table 20—Abortions Induced in Public Hospitals by Age, 1969–75

Age in Years	1969	1970	1971	1972	1973	1974	1975
10–14 ...	5	5	11	10	20	37	38
15–19 ...	25	46	58	137	183	196	200
20–24 ...	32	72	105	148	195	195	190
25–29 ...	39	58	86	144	168	177	161
30–34 ...	40	46	88	128	165	170	157
35–39 ...	39	48	77	119	158	151	140
40–44 ...	25	29	38	72	87	69	81
45–49 ...	2	5	7	7	12	13	11
Not stated ...	5	4	...	...	...	...	...
Totals ...	212	313	470	765	988	1,008	978

The figures, by reference to age, for abortions performed in public hospitals in New Zealand correspond with age groupings in overseas countries. In 1974 in England and Wales the number of those under 20 years of age who were aborted accounted for 23 percent of the total number of abortions.

In 1974 in the United States, the figure for this age group was 33 percent, and in 1975 in South Australia, it was 27.4 percent. A similar trend, though not so marked, can be seen in the figures supplied to us by the Auckland Medical Aid Trust.

Table 21 shows a small percentage increase in the number of abortions performed on girls under 16, and on girls between 16 and 20 years, in relation to the total number of abortions performed on patients at the Auckland Medical Aid Centre in the two years of its operation.

Table 21—Abortions Performed at Auckland Medical Aid Centre by Age, 1974–76

	1974–75		1975–76	
	No.	Percentage	No.	Percentage
Under 16	73	3.9	156	4.8
16–20	630	33.6	1,127	34.5
21–25	508	27.1	816	25.0
26–30	313	16.7	521	15.9
31–35	192	10.2	372	11.4
36–40	114	6.1	186	5.6
More than 40	39	2.1	81	2.5
Not known	5	0.3	10	0.3
Total	1,874	100.0	3,269	100.0

We have noted from our comparison of the statistics provided by National Women's Hospital and the Auckland Medical Aid Trust that a smaller proportion of younger women and girls are accepted for abortion at National Women's Hospital than at the Auckland Medical Aid Centre. In the periods under examination only 22 percent of those seeking

abortion at National Women's Hospital were under 20 years of age while at the Auckland Medical Aid Centre, 40 percent were under 20.

From the information available, the inference can be drawn that the absolute numbers of abortions are highest at the peak of the reproductive years of women (20-25 years) when they are sexually most active and most likely to conceive, but the ratios of abortions performed to live births are higher in the younger and older age groups, where pregnancy is less acceptable.

Marital Status

Single pregnant women are more likely to seek abortions than married women. There are no official New Zealand hospital statistics showing the marital status of aborted women but figures for the total number of women seeking abortion at National Women's Hospital between September 1975 and July 1976 show that 49.7 percent were married, 32.9 percent were single, and 17.3 percent were separated, widowed or divorced. Of those accepted for abortion, 59 percent were single. Statistics from the Auckland Medical Aid Centre reveal that a different group of women sought abortion there; 58.9 percent were single, 27.8 percent were married, and 12.7 percent had previously been married. Such information as is available therefore indicates that more single or previously married women and girls than currently married women are seeking abortions in New Zealand. This trend is also apparent in other countries with cultural backgrounds similar to that of New Zealand. In 1975 in South Australia, 50.3 percent of women aborted were single, 38.2 percent were married, and 11.3 percent had previously been married.

In 1974 in England and Wales the corresponding figures were 48.7 percent, 41.2 percent and 10 percent respectively. The figures from the United States of America more closely resembled those of the Auckland Medical Aid Centre and contained a higher proportion of single women.

Parity and Gravidity

First pregnancy abortions are in the majority in New Zealand, although this is not the situation in a number of overseas countries where the more children a woman has had previously, the more likely she is to seek an abortion. There may be a number of reasons for this difference. Single women in this country may have a greater desire to complete their formal education or follow a career; they may engage in greater sexual activity than is the case elsewhere; in the very young, it may be conjectured that poor access to contraceptives is a contributing factor, although on the evidence which we have heard, the premeditated use of contraceptives is not in keeping with the spontaneity of the sexual act for girls in this category.

Period of Gestation

The majority of women (over 95 percent) seen at National Women's Hospital for abortion had a gestation period of over eight weeks from the last menstrual period. Of those accepted for abortion, 41 percent were in

fact over ten weeks' pregnant. Of those refused abortion, 62.1 percent were over ten weeks' pregnant. At the Auckland Medical Aid Centre, women were aborted at an earlier stage in pregnancy, the greatest number, 39.8 percent, at eight weeks, though 63 percent presented at this stage or earlier. It must be noted, however, that the Auckland Medical Aid Centre does not accept women for abortion with a gestation period greater than 12 weeks from the last menstrual period, and this fact is reflected in the statistics.

Contraceptive Usage

Most studies on the characteristics of women presenting for abortion contain information on contraceptive usage. These commonly show that the majority of unwanted pregnancies result from failure to use contraceptives, the use of inefficient methods of contraception, or haphazard and incorrect usage. Of women seeking abortion at National Women's Hospital, 58.5 percent admitted to using no contraception and 17.7 percent said that they had used methods which were often ineffective (condom, withdrawal, etc.). In 11.6 percent of cases, it was claimed that effective methods had been used (the Pill, I.U.D.).

At the Auckland Medical Aid Centre, the corresponding figures on contraceptive usage were 48.9 percent, 34 percent, and 17.1 percent respectively. Overseas studies reveal, as do the two Auckland studies, that a high proportion of women fail to use any contraceptive measures. There is material from which the following inferences may be drawn:

1. Young unmarried women are less likely to use contraception than married women or women with stable relationships.
2. In the case of married women, unwanted pregnancies are more likely to result either from a temporary lapse in contraceptive use or a failure of contraceptive method.
3. In the case of single women, failure to use contraceptives is more frequent as the deliberate decision to use contraceptives, a decision involving the sexual partner and a doctor or pharmacist, appears to be more difficult to make.

It was often urged upon us that an intensive contraceptive and educational programme would result in a drastic reduction in the demand for abortion. Certainly we believe that such a programme would result in better contraceptive usage and fewer unwanted pregnancies but the results are unlikely to be as dramatic as may be commonly supposed.

Race

The information provided by the Auckland Medical Aid Trust gives a classification for abortions performed according to race. Of the abortions performed, 85.2 percent were on Europeans and 11.4 percent on Maoris and Pacific Islanders. These figures in fact approximate to the proportion of these races in the overall population of Auckland. Abortions performed at National Women's Hospital and classified by race reveal that a higher proportion of Maoris and Pacific Islanders were aborted than are represented in the general population. There, Maoris and Pacific

Islanders comprised 17 percent and 19 percent respectively of the women aborted. The higher proportion of Maoris and Pacific Islanders aborted at National Women's Hospital may illustrate a greater dependence displayed by these races on the public hospital system as a whole.

A study from the Gisborne area given to us in evidence showed that the proportion of Maoris seeking and obtaining abortion there was smaller than the proportion of Maoris in the general population. Reasons advanced for this included poor education, lack of knowledge of the working of the medical system, the attitude of the Maori male and a greater willingness to enter into a *de facto* relationship.

Religion

Figures provided by the Auckland Medical Aid Trust, the only figures which give a classification according to religion, suggest, on analysis, that the religions of abortion patients are consistent with their proportions in the community. The religious denominations given by persons seeking abortion were:

Protestants: 58.8 percent
Catholics: 15.5 percent
Others: 25.7 percent

These percentages show a close correlation with those for religious professions in New Zealand which are:

Protestants: 63.7 percent
Catholics: 15.7 percent
Others: 20.76 percent

Education

Again, the only statistics available are from the Auckland Medical Aid Trust. There, over 50 percent of the patients aborted claimed to have attained a level of education equivalent to School Certificate and above, a level slightly higher than the national level.

Occupation

Of those aborted at the Auckland Medical Aid Centre, 52.9 percent of patients were in full-time employment, 14.5 percent were students, and 30.6 percent were housewives or part-time workers. In contrast, of the women referred for abortion at National Women's Hospital, 55.8 percent were housewives, 36.7 percent were in full-time employment, and 7.3 percent were students.

Residential Origins

Information on this topic is available only from the Auckland Medical Aid Trust. The places of residence of women referred to the Auckland Medical Aid Centre in the two years ended 17 May 1976 are set out in Table 22.

Table 22—Residential Origins of Patients Referred to Auckland Medical Aid Centre 1974–76

	1974–75		1975–76	
	No.	Percentage	No.	Percentage
Auckland	1,274	55.7	1,893	47.1
Wellington	312	13.6	415	10.3
Christchurch	105	4.6	247	6.2
Dunedin	48	2.1	76	1.9
Other	549	24.0	1,384	34.5
North of North Island ...	...	...	723	18.0
South of North Island ...	...	...	504	12.6
North of South Island ...	...	...	61	1.5
South of South Island ...	...	...	87	2.2
Unknown	...	...	9	0.2
Total	2,288	100.0	4,015	100.0

The Emotional and Psychological Characteristics of Women Seeking Abortion

Very little investigation has been carried out into this matter in New Zealand, and most overseas studies deal with the sequelae of abortion rather than noting any of the prior characteristics of the women concerned.

Putative Father

There is very little information available in New Zealand on the characteristics of the father of the unborn child. There is some information available from the Auckland Medical Aid Trust, where the statistics show that the larger number, 38.5 percent, were employed in the technical, commercial, or manual fields. Unskilled workers accounted for 20.5 percent, 18.4 percent were engaged in managerial, sales or clerical work, 8.7 percent were engaged in the professions, 7.8 percent were students, and 6 percent fell into other categories. Overseas studies show that the majority of pregnancies result from a semi-permanent or permanent relationship.

Characteristics of Women Seeking Abortion in Australia

There is very little detailed information regarding women seeking abortion in Australia. Rogers and Lenthall have endeavoured to analyse them in a study, "Characteristics of New Zealand Women Seeking Abortion in Melbourne, Australia", reported in *New Zealand Medical Journal*, 1973, 81:282-286. They would appear to share the same characteristics as women seeking abortion in New Zealand, although the time at which abortion is sought shows a greater variation since the Australian hospitals and clinics operate beyond twelve weeks gestation.

Characteristics of Women Seeking a Repeat Abortion

There are a number of overseas studies on this topic, but information in New Zealand is scarce. It has been suggested that women seeking repeat abortions have emotional and psychological problems, but the evidence is not conclusive. We were told by the Auckland Medical Aid Centre that 13 of the 17 women seeking repeat abortions at the Centre could have prevented their second pregnancy with better contraceptives.

The only other relevant information relates to age and race. The average age of repeat abortion patients seen at the Auckland Medical Aid Centre was 23.5 years, though the range was from 16 to 34 years. The women concerned comprised 14 Europeans, 2 Pacific Islanders, and 1 Maori. Three were married, 8 were separated or divorced, and 6 were single. No definite conclusions can be reached regarding these women, but it appears likely that women having repeat abortions come from three main groups:

1. Those women whose contraception fails because of imperfections in the technique, device or medication.
2. Those women who experience contraceptive failure because social and personal factors, interacting with the method used, result in an ineffective contraceptive regime.
3. Those women who make little or no attempt to practise any contraception.

CONCLUSION

An analysis of the information available and the evidence we have heard suggests that, while race and religion have little bearing on the decision to terminate a pregnancy, the factors of age, marital status, parity, social class and education may influence a woman's response to a particular pregnancy. For older women, age alone may be the greatest motivating force, while for the very young woman it may only be one of a number of factors. Marital status is still important in the evaluation of a particular pregnancy and single women use abortion to delay their anticipated child-bearing. The number of children a woman has may influence her decision. Two general types of abortion patients emerge and these are reflected in the statistics of both private clinics and the public hospital system:

1. The young, unmarried woman who does not want a family.
2. The older, previously or presently married woman who has completed the family she desires.

We have found no conclusive evidence that abortion patients as a class share specific personality traits. It seems that women with varying characteristics evaluate the circumstances of their particular pregnancies in quite different ways.

Chapter 14

THE STATUS OF THE UNBORN CHILD

Our terms of reference require us to have regard to a number of issues, including the rights of the pregnant woman and the status of the unborn child. We do not overlook the rights of the pregnant woman when we say that the status of the unborn child is the cornerstone of the abortion argument. If the child has no status, other issues resolve themselves. Certainly, no question concerning the rights of the pregnant woman will arise, in that if the unborn child has no rights, no obstacle will lie in the path of the mother's rights other than consideration of her health.

If, however, the unborn child has a status, the nature of that status, and whether it changes according to the duration of the pregnancy, must be considered. Questions which then arise for consideration are whether the status of the unborn child is such that its rights completely yield to the mother's wishes, or whether the rights of the unborn child and the rights of the pregnant woman each yield to the other according to circumstances affecting them.

Legislation on abortion is usually regarded as being liberal, moderate, or restrictive, according to the status given to the unborn child. The only need for legislative interference in the sphere of abortion where no status is given to the unborn child would be to protect the health of the pregnant woman. In that case, what is regarded as a liberal code will result. Legislative interference which recognises that the unborn child has some status, but that the pregnant woman has rights, which may at times take precedence over the unborn child, will result in a moderate code. But where the purpose of legislative action is to confer on the unborn child a status which at least equals the rights of the pregnant woman, a restrictive code of abortion will result.

"Unborn Child" Defined

Some people dislike the use of the term "unborn child" and prefer to call it an "embryo" or "fetus". They read into the use of the expression "unborn child" an implication of status. Whatever status is to be attached to the unborn child, a matter which we discuss in this chapter, we use the term "unborn child" as being appropriate to the embryo or fetus from the time of implantation to the time of birth. We have no doubt that those who framed our terms of reference adopted the expression as a neutral term to distinguish it from a "born child" which it would ultimately be if it proceeded to term and live birth.

"Status" Defined

Status is defined as a social position, rank, relationship to others, or position as fixed by the law, or legal standing.

BIOLOGICAL APPROACH

It is essential, in dealing with the matter of status, to give careful consideration to the unborn child from the biological standpoint. In Chapter 4, the processes of ovulation, fertilisation and implantation were examined as a basis for the study of the workings of certain contraceptive measures. It will be necessary in this chapter to examine and emphasize some aspects of these processes again as they are fundamental to any consideration of the origins of human life.

Origin of Life

The Process of Ovulation

The ovaries of the woman contain follicles in which ova are held. Each month the hypothalamus, which is that portion of the brain adjacent to the pituitary gland, secretes a hormone which stimulates the ripening of the follicles, and this hormone, with the aid of the second hormone, a luteinising hormone, causes one of the follicles to rupture and release the ovum.

The Process of Fertilisation

On its release from the follicle, the ovum travels down the Fallopian tube which links the ovary to the uterus. It may encounter the male sperm within the tube. In order that fertilisation may occur, the ovum must unite with the sperm within 48 hours of release. When it does, the product of conception, now called the zygote, travels down the Fallopian tube within which it is held for three to five days by a valve at the junction of the tube and the entrance to the uterus. It is necessary for the zygote to be held for this period of time to allow the necessary cell divisions to take place, and for the zona pellucida (the shiny skin surrounding the ovum) to be shed. So long as the zona pellucida remains in position around the ovum, the zygote is not able to implant itself in the lining of the uterus. The period of time for which the zygote is held at the valve is important to its chances of successfully implanting itself in the uterine lining.

The Process of Implantation

The fertilised ovum, on entering the uterus, may implant itself in the uterine wall. There are substantial losses of fertilised ova which are flushed from the uterus before implantation. Various estimates of this loss have been made and these vary widely. Probably between 15 and 30 percent of all fertilised ova will not survive the stage of implantation, and even after implantation a further 20 to 25 percent will not survive, or will be stillborn, or spontaneously aborted. There is reason to believe that these losses are beneficial to the human species as a whole, as the fertilised ova which do not implant largely consist of genetically abnormal and

malformed babies. The fertilised ovum, now known as the zygote, which does implant in the lining of the uterus, passes through a number of phases in the process of implantation, and is called at first a blastula, and later an embryo. As a blastula it will penetrate the mucous membrane lining the uterus and attach itself to the uterine wall by a network of roots. The implantation of the blastula in the uterine wall takes place about five to seven days after fertilisation of the ovum, and itself occupies a period of about four days. Implantation is complete by the eleventh day following upon fertilisation. In the initial stages of implantation, the survival of the blastula is precarious but, with the growth of the placental tissue, the uterus seems to accept it.

Had the ovum not been fertilised, the uterine lining, the maintenance of which would be no longer necessary, would be shed with the woman's menstrual bleeding. With the implantation of the blastula it must be encouraged to stay, until the delivery of the child some 37 weeks later. This encouragement is provided by the cells within the placental villi (the network of roots put out by the blastula) which secrete chorionic gonadotrophin and relay it to the corpus luteum via the maternal blood. The corpus luteum is thereby enabled to secrete estrogen and progesterone to maintain the uterine lining in place. The presence of chorionic gonadotrophin can now be detected in the urine of the woman and the woman's pregnancy confirmed.

As a result of the release of these two hormones and the resultant maintenance of the uterine lining, the menstrual bleeding which usually takes place on the twenty-eighth day of the cycle does not occur.

Stages of Development of the Unborn Child

There is often confusion in measuring the duration of a pregnancy. Pregnancy is normally retrospectively reckoned as commencing on the first day of the last menstrual bleeding, although the ovum is normally fertilised within a day of ovulation, i.e., around the fourteenth day of the cycle. Implantation occurs about eight to eleven days after fertilisation, i.e., about the twenty-first day of the cycle. At this stage, when a week remains before the next menstrual bleeding is due, the implanted embryo is a week old.

However, in referring to the stages of development of the unborn child, as we now do, we speak not of the stage of pregnancy, but of the number of weeks which have elapsed from conception.

By the third week the embryo is well established under the surface of the uterine lining. The outer cell layers continue to grow and, as they do, they erode more blood vessels in the uterine glands in the mother to obtain nourishment. During this third week the embryo, which was formerly a two-layered disc growing mainly longitudinally, begins to take on a more discernible body shape.

In the fourth week, menstruation is now one week overdue. The body now consists of three layers. The outer layer will ultimately form the epidermis with hair, sebaceous and sweat glands, and the nervous system. The middle layer will become muscle, skeletal bone, blood vessels, kidneys, genital glands, and connective tissue. From the inner layer there

will develop the digestive tract with lining and glands, the urinary system, and the lungs.

In the fourth week the spinal cord and vertebrae begin to form, a rudimentary heart starts beating, although it will be some weeks before the beating of the heart can be observed with technological assistance.

By the fifth week the embryo is about one-fifth of an inch long. From this point on the rate of development will accelerate.

In the sixth week the embryo undergoes a period of design, during which the arms, legs, body, and face take shape according to the genetic imprinting of the cells.

In the seventh week the skeleton of the unborn child is complete in cartilage, but not in bone. The buds of the milk teeth appear, and the unborn child makes the first movements of its body and new-grown limbs.

By the end of the eighth week the chorionic sac formed around the unborn child and attached to the mother is 20-30 millimetres (about one inch) in size. It is at about this point that it is no longer referred to as an embryo but as a fetus. The embryo itself is about five millimetres long (slightly less than a quarter of an inch). The umbilical cord, which attaches the unborn child in a free-floating way to the placenta, has already begun to form. All the organs of a full term baby are present, although in rudimentary form. Electrical activity is discernible in the brain, but it is far from fully developed. The brain stem is the most developed part, but it has not initiated the breathing movements which are a feature of fetal life.

The area which will become the cerebral cortex is rudimentary. This organ is then only nine percent of the brain weight, as against 90 percent of the brain weight at 28 weeks. The nerves of the skin receptors and nerve/muscle junctions are not fully formed. The fetus may react to pain, but the stimuli would have to be gross for it to do so and the reflex responses may be sluggish.

At nine to ten weeks the fetus measures 22-24 millimetres. The head is large as is usual in embryonic forms. The fingers and toes are formed, and the external ears are present.

In the tenth week spontaneous movement occurs. This movement is associated with the development of bones and joints.

In the twelfth week the bone structure is complete, and a fetal electro-encephalogram may be made. There is, however, at this stage, no element of consciousness in the fullest sense of the term; that does not develop until later. The fetus is now about 30 millimetres in length. All major structures of the body are now formed.

At the end of the fourteenth week the unborn child is 79 millimetres in length. External genitals are obvious.

Between the end of the fourteenth week and twenty weeks the rate of growth of the fetus is accelerated. During this time the movements of the fetus, known as "quickening" can be felt. Quickening is a state in which the mother is able to feel the movement of the unborn child within her. However, the fetus has been moving since the development of arms and legs, i.e., about 42-47 days from conception, but because the uterus is totally insensitive to any stimulus except stretch, it is not possible for these

movements to be felt. It is only when the movements are strong that they are felt by the mother through the buffer of the womb. There are a number of factors which influence the time at which quickening is first felt. It may be felt as early as thirteen weeks, and it may be felt as late as twenty-four weeks. Quickening is a subjective experience, and a mother who has felt it in a previous pregnancy will be likely to notice it at an earlier date in a subsequent pregnancy.

In the fifth month the fetus grows from nine centimetres in length, which it was at the end of three and a half months, to approximately twenty-two centimetres, and then weighs 300 grams. It has been established that the fetus responds to sound as early as the twenty-third week. Between the twenty-sixth and twenty-eighth week it is possible that the fetus, if born prematurely, will live, although there have been cases recorded of fetuses surviving from as early as twenty weeks.

At twenty-eight weeks two characteristics may be noticed. One is the alertness or awareness of the fetus, which causes it to respond by movement to pressure placed upon it. The other is the appearance of a cyclic variation in behaviour. The fetus appears profoundly asleep, but shows wakefulness at times. Prior to 28 weeks any electro-encephalogram tracings which are detectable are thought to originate in the sub-cortex and do not show any clear discrimination between the waking and sleep states, or the different phases of sleep. Between 28 and 32 weeks, patterns of cortical origin appear, similar to the sleep states of adults.

At 37 weeks the electro-encephalogram records reveal a difference between the waking and sleeping states of the unborn child, and indicate that there is a functional interaction between brain stem and cortex. Apart from these developments in the fetal brain from 24 weeks to birth, there are no further significant stages in fetal development which from that stage on is largely one of growth. Development of the fetal brain still proceeds after the fetus has reached the point where it is capable of extra-uterine life, and even after birth the function of the brain continues to be polished.

Research has taken place in recent times as to the extent to which fetuses breathe in the uterus. It is now thought that breathing movements first begin in the uterus at about three months. Their purpose is not to obtain oxygen but to exercise bodily functions and to allow for development and co-ordination of fine movements. The breathing is quite powerful but only a very small quantity of fluid is inhaled because of flow resistance. When the child is born some fluid runs out of the lungs, but the rest is absorbed. By the time the unborn child reaches term, it has taken over nine million breaths.

WHEN DOES HUMAN LIFE BEGIN?

This question has been a fruitful ground for discussion by philosophers, sociologists, psychologists and theologians. From a biological point of view there is no argument as to when life begins. Evidence was given to us by eminent scientists from all over the world. None of them suggested that human life begins at any time other than at conception. Although the process of conception may not be momentary, and it may not be possible

to say whether it takes minutes or hours, by the time the fertilised ovum has reached the uterus, conception can be said to be complete.

The real point to which the arguments have been addressed is not as to when life begins, but as to the value which is to be attributed to that life, particularly in its incipient stages. In short, if it is accepted that life begins at fertilisation of the ovum, how should that life be regarded while it remains in the womb? Is the life of the unborn child to be regarded as being of the same value right throughout the duration of its development and pregnancy, and does its status differ from the status it has when it becomes a born child?

A wide range of views have been expressed to us on these points. To some, the fertilised ovum, at least from implantation, is a human being whose status is no less than that of the pregnant woman. To some, the unborn child has a status, the significance of which depends on its stage of development. Those who hold this view would consider a fetus late in development as a living, human individual both in form and function, but in the earlier stages of development as no more than an incipient human being. To others the status of the unborn child depends on the standing which society agrees to accord it.

It was apparent that many of the views which were expressed to us had been influenced by the writings of Daniel Callahan, in his book, *Abortion: Law, Choice and Morality*. Indeed, a number of those who made submissions to us cited this text in support of their views. Some of those who did so expressed their view of the status of the unborn child as they saw it, either from the point of view of the Genetic School, the Developmental School, or the Social Consequences School, these being the viewpoints examined by Callahan in his book. Others who made submissions did not adopt this classification, but, by and large, their views can be examined in the light of Callahan's approach. Since many of those making submissions adopted Callahan's approach, we find it convenient to adopt these three broad classifications in examining the evidence and submissions made to us. That is not to say, however, that we accept Callahan's views or regard him as the authority on this issue.

The Genetic School

The main views of the Genetic School, as canvassed before us, were:

1. At the moment of conception all the characteristics of the human being are determined genetically. From that point on, there is a new human being, a separate individual, a man in miniature. From the moment of conception the child is an independent person, for the time being included inside the body of the mother.

2. The life is never part of the mother but it is a distinct individual human life. The unborn child, like any other person, can be ill and require treatment before birth, just as it does after birth.

3. The unborn child asserts a command over the pregnancy. The conceptus initiates the process by which the corpus luteum maintains the uterine lining by suppressing menstruation. It initiates the development of the amniotic sac and the placenta for its survival; and it

is from the pituitary gland of the fetus that the processes of labour are initiated.

4. The conceptus has the ability to satisfy the two qualities of an individual: unity and uniqueness. Exceptions to unity and uniqueness, for example, twinning and chromosomal disorders, occur extremely precociously and do not alter the humanity of the being. Abnormalities and diseases such as the hydatidiform mole may kill a conceptus but do not alter its humanity. It is then still a human being, but a diseased one.

5. The fact that a fetus under 20 weeks has never been capable of extra-uterine life, and that it is unlikely to survive if born before 24 weeks, does not make it any the less an independent being. Viability depends on the appropriate environment, not on the subject in that environment. After the child reaches full term and is born, it lives in the environment which is most suited to its survival but until birth it lives in the environment which is most suitable to its survival at that stage.

6. Terms such as zygote, embryo, and fetus, do no more than indicate the stages of development within the uterus, and should not be confused with the fact of the existence of human life. Life is already present from conception. Between conception and death, life does not develop; it is already there. What does change and mature is a morphological structure, in which, as growth continues, behaviour traits, personality, ethical awareness and an appreciation of social responsibilities develop.

Advantages and Criticisms of the Genetic School

Callahan himself accepts that strong arguments can be advanced for the acceptance of the genetic test. In particular it excludes the employment of arbitrary norms, and it offers the possibility of a prudently safe moral policy.

However, various criticisms have been made of the genetic approach, and Callahan queries whether the adoption of its criterion for humanity is really necessary for the abortion decision, in which society is not asking whether a decision to abort is a decision for or against the attribute of humanity, but whether it is a decision for or against a particular human being. He considers that the definition of "human" adopted by some philosophers of the genetic school is too narrow. It is not sufficient in making this determination to depend on genetic individuality alone, and to ignore the way in which a particular fertilised ovum will develop. One must also take account of the interaction of the genotype with its environment.

The Developmental School

Within this school are those who hold that, while conception establishes the genetic basis for an individual human being, some degree of development is required before one can legitimately speak of the life of an individual human being as being an issue in the abortion decision. The Developmental School does not accept that the establishment of the genetic basis of itself will constitute an "individual human being." Some

degree of development of the embryo is required before full human status is assigned to it. Those who are persuaded to this line of thinking believe that life is a continual process with growing stages of significance deserving different degrees of moral concern. On this view the fetus late in development is recognised as a living human individual both in form and function. But this status is not given to the single cell stage, early in biological development. In short, the view is taken that the human individual develops biologically in a continuous fashion and the possibility is advanced that the rights of a human person might develop in the same way.

On the basis that this view is accepted, a moral policy is put forward which proceeds upon the footing that the developing embryo is not yet a human being, and that, under some circumstances, the welfare of the actually existing person might supersede the welfare of the developing embryo.

The main views of those who subscribe to this philosophy, as canvassed before us, were as follows:

1. While conception establishes a genetic basis, some degree of development is required before full human status can be assigned.
2. Presence of the full genetic code from the time of conception proves nothing because after fertilisation two or more human existences (twins) can develop with the same genetic code.
3. Although the fetus is a potential human being, it should not be regarded as acquiring human status until later stages in development.

Three stages in particular are suggested. These are:

(1) Brain development. The fetus does not have the characteristically human cerebral substratum for thought until the twenty-eighth to thirty-second week of pregnancy. It is suggested that this stage of development is one at which the fetus can be regarded as achieving full human status.

(2) Viability. Until the fetus is capable of a continuous, independent, extra-uterine existence, it is said that it is parasitic upon the mother. Therefore, up to that stage the fate of such a fetus should be vested in the mother alone.

(3) Quickening. Quickening is the stage at which the movements of the fetus can be felt within the mother. It is suggested as a stage when the fetus can be recognised as an individual human being.

4. Sacredness of life is a value judgment capable of varying interpretations.
5. The enormous wastage associated with human reproduction, including spontaneous abortion, is seen as evidence that life is not regarded by nature as being sacred.
6. There is a difference between a neurologically undifferentiated organism and a socially and mentally integrated organism with complex rights and needs.
7. People feel and react differently to different stages of fetal development.

Advantages and Criticisms of the Developmental School

The advantage claimed for this viewpoint is that it takes account of the whole range of human attributes, and places concern on individual persons at progressive stages of development, rather than on the protection of the human body. However, a number of criticisms can be made of it. The principal general criticism is that the choice of the time at which the fetus is given human status is subjective and arbitrary. It is open to people to vary their norms. The stages of development at which humanity is accorded, such as quickening or viability, are themselves variable in individuals, and may be conditioned by the state of medical technology. Moreover, if an unborn child is given a status according to its stage of development in the uterus at the beginning of life, it may be difficult to resist a claim that a human being at the end of life should be accorded a status equivalent to the declining stage which he has reached. These points make the developmental theory a somewhat hazardous one to adopt. Some particular criticisms made of it are as follows:

1. While there is no way of determining the precise time of conception, the event is complete by the time the ovum reaches the uterus, and certainly by the time when implantation occurs.

2. Insofar as quickening is suggested as being a stage at which the fetus can be recognised as being human, that process must be recognised as being entirely subjective. Moreover, it does not mark any stage of development of the fetus, but rather a point at which the individual mother is able to discern the movements of the unborn child within her.

3. Insofar as viability is advanced as being the point at which human status should be attributed to the unborn child, two points can be made:

(1) Viability is usually reckoned as being reached between 25 and 28 weeks, but children have been born at a lesser age and have survived.

(2) Viability is a stage at which it is recognised that the child can survive outside the uterus. It is, however, only a stage of development of the unborn child who is better preserved within the environment of the uterus until the point of viability is reached.

4. Insofar as the attainment of a level of consciousness reached is accepted as being the point at which human status is achieved, the criticism can be made that the brain continues to develop after that point, and if a child is born prematurely before the twenty-eighth week, it will still attain the level of consciousness, and will probably be a normal child.

5. If some stage of physical or mental development has to be accepted as indicating whether or not a human life is in being, so a stage may be reached at the other end of life where a person who has become senile or lost consciousness may be disposed of.

The Social Consequences School

This school of thought has gained strength from the writings of Dr Glanville Williams, and Dr Garret Hardin. According to the former, in the "Legalisation of Medical Abortion", the decision to call the conceptus a human being is to be made on the basis of the social consequences of the decision. For his part, Dr Williams would accept viability, which he thinks to be socially acceptable, as the dividing line, and the beginning of brain waves as a possible compromise solution. Garret Hardin, in "Abortion—Or Compulsory Pregnancy?" says: "Whether the fetus is or is not a human being is a matter of definition, not fact; and we can define it in any way we wish. In terms of the human problem involved, it would be unwise to define the fetus as human (hence tactically unwise ever to refer to the fetus as an 'unborn child')". The main views of this school as dealt with in the submissions made to us were:

1. Biological facts do not directly dictate the definition of "human".
2. The decision to call the conceptus a human being is to be made on the basis of the social consequences of the decision.
3. People do not feel the same emotional response to the zygote and the embryo as they do to the unborn child in the later stages of pregnancy.
4. Society has never regarded the fetus as a human being, and no nation requires that a dead fetus be treated in the same way as a dead person.

Criticism of the Social Consequences School

The arguments of the Social Consequences School are open to serious objections which are:

1. The adoption of its viewpoint would make much of the biological information irrelevant. Indeed, if it is possible to define the human being in any way we wish, guided only by the social consequences of our definition, there is no reason why biological information should be considered at all.
2. To make the definition of "human" fit a desired moral policy is arbitrary. If it is possible to define "human" in any way we wish when referring to pre-natal life, there is no logical reason why we should not be able to define "human" in any way we wish when we are dealing with post-natal life. In this way society could justify the disposal of the chronically ill, the senile, and the elderly as "non-human", and attempt to justify the taking of their lives on the grounds of the social good to be obtained.

Value of New Human Life

Some of the arguments on what is human and the quality of humanness in human beings are semantic only. One can debate at great length, but to no profit, whether an unborn child is a human being or a potential human being. The social, philosophical and theological debate on these matters has to date produced no acceptable solution, nor is it likely to do so in the future. There are some areas, however, where as a result of developments

in scientific medical knowledge, room for debate has been eliminated. In our view it is established that:

1. While life begins at conception, external proof of pregnancy dates only from implantation. (It is only after implantation when the hormone, chorionic gonadotrophin, has been released, that a reliable test as to the pregnancy of the woman can be made.) Moreover it is only after implantation has occurred that menstruation is suppressed and the woman herself will know that she is pregnant.
2. From implantation to birth, changes which take place in the unborn child are of a developmental nature only. There are no changes of a qualitative nature. The three events suggested as being of significance, namely, quickening, viability and brain development, are no more than stages in that development and are not indicative of any qualitative changes in the developing fetus which would make it non-human at one point of time and human at another.
3. There is no point between implantation and birth of a biological kind which enables a particular point of time between implantation and birth to be accepted as the one at which the status of the unborn child is changed. The terms "embryo" and "fetus" do no more than mark those stages in a progressive development.

Existing Status of the Unborn Child

English and New Zealand law have long given some recognition to the unborn child. For obvious reasons, that recognition has been made subject to the subsequent live birth of the child. The unborn child is recognised as having a status in the following branches of the law:

The Criminal Law

In New Zealand, since the passing of the first criminal law statute, the law has provided a protection for the unborn child by legislating against abortion. It cannot be said that the only purpose of that statute or of subsequent legislation was to provide protection for the woman's health. Even if that argument was available in respect of the English Statute of 1803 (Lord Ellenborough's Act), the preamble of which would suggest that the Parliament of 1803 was not solely motivated by concern for the rights of the unborn child, the fact that the passing of the subsequent English statute of 1837 made abortion an offence, not merely from quickening, but at any time, would suggest that one of the purposes of the legislation has been the protection of the unborn child.

The Property Law

An unborn child can own property as a successor to a settled estate, or as a beneficiary under a trust. The law is clear that for these purposes a child *en ventre sa mere* can succeed to an estate which has been settled, and, in the absence of a contrary indication in the will or testamentary document, a gift to children will include a child conceived but yet unborn at the date of coming into operation of the trust instrument.

The Law of Tort

The law also recognises the position of the unborn child as a person upon whom a tort or civil wrong may be done.

In *Watt v. Rama* [1972] V.R.353, the Full Court of Victoria considered the case of a mother who had been made a quadraplegic in a traffic accident on 15 May 1967, and that of her child born on 4 January 1968, who suffered from brain damage and epilepsy. It was alleged that the injuries to the child were the result either of the damage suffered by the child in its embryonic state in the traffic accident, or the mother's inability to carry the child, or to go into labour or deliver in a normal way. In proceedings brought on behalf of the child against the negligent driver, it was contended that he was under no liability to the child because he had no duty of care to a non-existent person, or because he owed no duty of care to an infant not to injure the infant's parent, or because the damage was too remote to be foreseeable. It was held by the Victorian Court that the child was entitled to succeed in his claim. As one judge put it:

> It is obvious that "the person" who is conceived and develops in the mother's body is biologically the same "person" who survives birth, lives, and finally, dies.

A similar view was taken in the case of *Montreal Tramways v. Leveille* [1933] 4 D.L.R.357, where it was alleged that the cause of the infant plaintiff being born with a physical defect was the fact that the child's mother, through the negligence of the motorman, had been thrown to the ground when getting off a tram. A verdict awarding damages to the child was upheld by the Supreme Court of Canada. Mr Justice Lamont at page 345, said: "If a child after birth has no right of action for pre-natal injuries, we have a wrong inflicted for which there is no remedy . . . . To my mind it is but natural justice that a child, if born alive and viable, should be allowed to maintain an action in the courts for injuries wrongfully committed upon its person while in the womb of its mother."

The Courts of the United States, until 1960, did not usually afford a right of action to a child who had sustained an injury while in the womb, on the ground that no duty of care was owed by a person to another of whose existence he did not know. But in that year, in the case of *Smith v. Brennan* [1960] 31 N.J.353, the rule that no duty of care was owed to an unborn child of whose existence a defendant could not be aware was reversed. A judge in that case said: "The semantic argument whether an unborn child is a person in being seems to us to be beside the point. There is no question that conception sets in motion biological processes which if undisturbed will produce what everyone will concede to be a person in being. If, in the meanwhile, those processes can be disrupted resulting in harm to the child when born, it is immaterial whether before birth the child is considered a person in being."

Dean Prosser in *The Law of Torts* (4th Edition 1971), page 336, described the new trend as ". . . the most spectacular abrupt reversal of a well-settled law in the whole history of the law of torts."

In England, as long ago as 1942, Sir Percy Winfield, Professor of Law at the University of Cambridge, said: "I can see no good reason why any

action should not lie for pre-natal injury which results in post-natal harm."

In the thalidomide cases, large sums of money were paid out for injuries caused to children whose mothers had taken thalidomide during pregnancy. Liability was not strictly admitted in those cases, but the actions instituted on behalf of the children did not have to be litigated in court because of the settlements made.

While there is no New Zealand case upon the subject, there seems no doubt that the Australian, Canadian, and American decisions would be recognised here as conferring upon a child a right of action to damages sustained in its pre-natal state.

It is to be noted, however, that no claim has yet been recognised for harm caused to an unborn child. The child is recognised by the law before birth, but its capacity to sue does not come into being until it is born alive. Moreover, the Law Commission set up in the United Kingdom in its Report on Injuries to Unborn Children in 1974, recommended as follows:

1. Legislation should deal with the rights of a living person, and no rights should be given to the fetus.
2. The general principle should be that whenever pre-natal injury is caused intentionally, negligently or by breach of statutory duty, there should be liability for that injury.
3. As a general rule, whenever there is liability of common law to a parent for an act or omission which causes pre-natal injury, a child should be entitled to recover damages.
4. As a general rule, whenever a breach of statutory duty owed to a parent causes pre-natal injury to his or her child, that child should be entitled to recover damages for his disability.
5. Where liability for a breach of statutory duty is regarded as contractual, no action should lie at the suit of a child in respect of the pre-natal injury.

CONCLUSIONS

On a review of the essential biological evidence which has already been discussed in this chapter, it is our view that:

1. The fetus has a status from implantation which entitles it to preservation and protection.
2. This status does not confer upon it an absolute right to life. If it did, then human life with full conscious development would have to yield to it, and a greater value might be placed on fetal life with its potential still unformed than on human life with full conscious development.
3. The unborn child, as one of the weakest, the most vulnerable, and most defenceless forms of humanity, should receive protection.
4. That protection should not be absolute but should yield in the face of compelling competing interests.
5. The measure of that protection can only be decided after the nature of those competing rights has been examined.

Chapter 15

THE RIGHTS OF THE PREGNANT WOMAN

The Changing Role of Woman

In recent years social changes of tremendous significance have occurred. Many of these have affected the status of women. Women expect and increasingly receive equal pay and employment opportunities and with them the removal of discrimination based on sex. Changes have been made to matrimonial laws to ensure that on the breakdown of a marriage, a woman receives a share of matrimonial property which is just and equitable, having regard to all her contributions to that property. Legislative changes in other fields have given recognition to and influenced social changes. Women are now less willing to accept many conditions which they once would have regarded as their lot, particularly where the resultant unhappiness is avoidable. But if one single factor can be said to have been responsible for bringing about the emancipation of women, it is their increasing ability to control their fertility.

This factor and others related to it have brought about a change in attitude towards the role of women. Many women will no longer accept the responsibility, and sometimes the burden, of frequent childbearing and child rearing. They seek and expect an independence and freedom of choice that once would not have been possible. They may spend time in voluntary work, creative pursuits or paid employment. There are economic pressures, too, which cause many women to enter the work force. In some cases the standards of living which they and their families enjoy depend upon the maintenance of two incomes.

The Right to Control Her Fertility

The claim is sometimes made that the State has no place in the decision of the woman to control her own fertility. It is put in a number of ways. It is variously said that abortion is a woman's choice; a woman's right to abortion is an absolute right; a woman has the right to control her own body; and a woman's sexuality is her affair only.

Few would now deny the right of a woman to decide whether or not she will marry, whether she will have children, and, if she does, how many children she will have. It is important, however, to understand what these assertions involve. A right may exist because there is no interest or other right against which it must be weighed or be asserted. Where, therefore, it is said that an individual has a right, that right will not generally be questioned if there is no other competing personal interest. But the existence of a right may be questioned where there are other interests against which it must be balanced and weighed. It is one thing to assert

that it is a woman's right to marry or not to marry, or to have children or not to have children. It is another matter altogether to assert that a pregnant woman has the right to abortion. There is another interest against which that assertion must be weighed. Most submissions made to us recognised that there was some stage during the pregnancy when the rights of the pregnant woman had to be considered against the status of the unborn child and modified. Even the judgments of the majority in the Supreme Court of the United States of America in *Roe v. Wade*, a decision welcomed by the advocates of abortion law reform, recognised this.

Once it is recognised that the unborn child has a status, the rights of the pregnant woman cannot be regarded as absolute, because any rights she then has must be measured against the existence of the fetus. Any legal code must give weight to that consideration.

We therefore conclude that while a woman has a right to control her fertility, she cannot, once she is pregnant, any longer assert that right as an absolute right and it must be considered against the status of the unborn child. The counter-balancing of the status of the unborn child and the rights of the pregnant woman are considered in a subsequent chapter.

There are, however, other rights belonging to the pregnant woman to which regard should be paid.

The Right to Have Her Case for Abortion Considered

A number of women complained to us that doctors with whom they had sought to discuss the subject of abortion had treated them in a perfunctory manner and had never considered their circumstances on their merits. We are satisfied that there are those cases where, both in private practice and in public hospitals, doctors, by words and conduct, have displayed an indifference approaching arrogance towards women seeking to discuss abortion and have failed to entertain their cases on their merits. It seems to us that, in the weighing of the woman's claims to abortion, care should be taken to give the woman a sympathetic and attentive hearing even though the doctor may be obliged ultimately to advise against abortion or to indicate that it is not legally justifiable.

Then there are those cases where, within New Zealand, doctors have made abortion conditional upon the acceptance of sterilisation even though, in at least one of the cases to which our attention was called, the condition of sterilisation was not acceptable. We note that the Lane Committee in its report (para.534) expressed concern at comments to the effect that a large number of young unmarried women were sterilised as a condition of obtaining an abortion. The grafting of any such condition on to an abortion decision is, in our view, totally wrong and an infringement of the woman's right to have her case considered on its merits.

The Right to Employment

Several women's organisations drew our attention to the disadvantages suffered by women whose education or employment are interrupted by pregnancy. In the State Services there are regulations covering maternity leave. Employers in other sectors also make provision for leave entitlement for pregnant employees. Some hospital employees have been

granted leave entitlements which are similar to those obtaining in the State Services. The Select Committee on Women's Rights made a number of recommendations regarding pregnancy leave. We draw attention to and commend three of them in particular:

> The Government (a) introduce legislation to provide for paid maternity leave for employed women with the objective of either (i) ratifying by legislative act I.L.O. Convention 103 concerning maternity protection, or (ii) giving effect to the principles contained in aforesaid convention; and (b) consider the desirability of allowing for paid paternity leave in cases of family need.
>
> The State Services Commission experiment in extending provisions for part-time work and job-sharing in a variety of fields in order to consider whether guidelines can be established for their future development.
>
> The State Services Commission give early consideration to evolving methods of recruitment which provide for recognition of voluntary work as a job qualification in terms of the grading of women entering the Public Service after a period out of employment for family reasons during which time volunteer service has been actively engaged in.

It is important that, if women are to be encouraged to be mothers, and if society is to recognise that parenthood is a valuable function, the need to ensure that job opportunities are protected and that women do not suffer financially because of child-rearing should be recognised. We do not overlook the fact that the implementing of maternity leave is not without difficulties and that the absence of an employee on pregnancy leave in small businesses may cause serious interruption.

The Right to Medical Services and Information

Many submissions urged that early pregnancy testing and contraceptive advice and information should be free and widely available. The Lane Committee (para. 538) recommended: "That all hospital obstetric and gynaecological departments should either give or arrange for contraceptive advice and prescription for all maternity and abortion patients and for any other patients who might benefit thereby, whether in-patients or out-patients".

The Right to Education

At present it seems certain that a great many minors who become pregnant and continue with their pregnancy discontinue their schooling or vocational training, often never to resume it. Although accurate statistics covering all such cases throughout the country are impossible to obtain, some indication of the position can be gained from figures provided by the Correspondence School. Enrolments of pregnant schoolgirls at this school during the years 1973, 1974 and 1975 were 412, 394 and 382 respectively. Of these approximately 75 percent were in the 15 to 17 age bracket. Statistics for confinements in this age group are not available for the three years mentioned, but in 1972 the total was 1,852. It is unlikely that this figure would show a decrease in ensuing years and it would thus appear that a considerable number of girls cease schooling altogether on becoming pregnant. Inferences with regard to drop-out rates must be drawn with some caution as there are no statistics showing how many schoolgirls are represented in this total of 1,852 and there is no

detailed information concerning other arrangements made by secondary schools to enable pregnant girls to carry on with their education.

The Commission commends the educational facilities provided by the Education Department through the Correspondence School and recommends that much more use should be made of the excellent service made readily available from this source. It believes that a great deal could be done by the family doctor in giving information of the opportunities available by enrolling at the Correspondence School. This would ensure that doors are not closed through lack of information to those girls who do not return to school after pregnancy has been diagnosed. A recent survey by the Headmaster gives an encouraging picture of what is being done to help these girls in a period of great stress and uncertainty. It is apparent that the girls not only benefit educationally but find some solace in corresponding with their teachers. They welcome the normality offered to them by the School and benefit greatly from the routine of familiar schoolwork and the posting and receiving of mail. Those at the fifth and sixth form stage gain much motivation by being given the opportunity and being encouraged to sit external examinations. Single subject passes in these examinations have opened the door to girls who would not have been equal to meeting the previous four subject pass requirement. In the three years 1973 to 1975, passes in one or more School Certificate subjects were gained by 58, 69, and 60 girls respectively and in the same period 45 girls qualified for University Entrance.

Whether a schoolgirl is to be allowed to continue with her education at the school at which she is enrolled at the time of her pregnancy is a decision which must remain with the Principal, who must have regard to the interests both of the girl concerned and of other pupils in the school. The Commission appreciates the care and concern shown by most principals in their endeavour to find the best possible solution for these distressing cases. If, in particular circumstances, a decision is taken to suspend a pupil, it is of the utmost importance that every assistance be given to make alternative arrangements for her education. Even though some do not avail themselves of the opportunity, none should be denied it through lack of information.

The Right to Know of Available Social Services

Under section 10 of the Children and Young Persons Act 1974, there is a statutory obligation for a social worker of the Department of Social Welfare to investigate the circumstances surrounding each ex-nuptial birth and "to make such inquiries as may be necessary to ascertain the condition of the child and its mother and to take such steps, if any, as in the circumstances he considers necessary." The majority of mothers of ex-nuptial children are in fact visited by a departmental social worker soon after the birth of the child. We have no reason to doubt that, having regard to the many burdens already placed upon it, the Department of Social Welfare discharges this duty as best it can. However, many single mothers, before the birth of their children, are quite unaware of the various benefits and social agencies available for their help. There is a need, not only to make those who are pregnant aware of any monetary

benefits to which they may be entitled, but also to provide counselling services for them by persons trained in social work. The function of such counsellors, who should be attached to public hospitals, social welfare departments and health centres, and private practitioners and voluntary agencies, should be to give counselling on adoption, to give contraceptive advice, and to discuss the problems of the unmarried mother and the availability of benefits.

RECOMMENDATIONS

1. That irrespective of the ultimate decision, a woman seeking an abortion be given, as of right, a careful, attentive and sympathetic hearing by her doctor.

2. That requests for abortion be considered strictly on their merits and no conditions attached to decisions.

3. That the principle of protection of employment opportunities for pregnant women be supported.

4. That careful consideration be given to the following recommendations of the Select Committee on Women's Rights:

(1) That the Government: (a) introduce legislation to provide for paid maternity leave for women with the objective of either: (i) ratifying by legislative act I.L.O. Convention 103 concerning maternity protection; or (ii) giving effect to the principles contained in the aforesaid convention, and (b) consider the desirability of allowing for paid paternity leave in cases of family need.

(2) That the State Services Commission experiment in extending provisions for part-time work and job-sharing in a variety of fields in order to consider whether guidelines can be established for their future development.

(3) That the State Services Commission give early consideration to evolving methods of recruitment which provide for recognition of voluntary work as a job qualification in terms of the grading of women entering the Public Service after a period out of employment for family reasons during which time volunteer service has been actively engaged in.

5. That early pregnancy testing services and contraceptive advice and information be free of cost and be made widely available.

6. That opportunities always be made available for pregnant schoolgirls to continue their education.

7. That greater publicity be given to the various benefits and social agencies available to help unmarried mothers, including single mothers.

8. That counsellors be attached to all public hospitals, social welfare departments, health centres, and voluntary agencies to give contraceptive advice and to discuss the problems of the unmarried mother and the availability of benefits.

Chapter 16
THE MORALITY OF ABORTION

Much has been written upon the morality of abortion, a topic closely linked with the status of the unborn child. The early writings upon it are closely linked to the teachings of the Roman Catholic Church and the writings of its moral theologians. In the *Didache* (c. 80 A.D.), an authoritative source of Christian law, abortion was regarded as a grievous sin. That is still the viewpoint of the Catholic Church.

While the Catholic Church maintained that induced abortion is morally evil in all circumstances because it involves the taking of human life, the submissions of some Protestant churches were less emphatic and did not attach the same absolute value to fetal life.

There would be little point in discussing in detail all the viewpoints placed before us. Many of them find their origin in the particular religious denomination to which the proponents subscribe. We cannot base any opinion on the morality of abortion solely on a particular religious belief. But that is not to say that a moral viewpoint is to be rejected merely because it finds its source in a particular religious denomination. The influences of religion in the formation of responsible attitudes in society are too well recognised to be doubted. But views as to the morality of abortion may also be held by those in the community who do not subscribe to any particular religious view. Here again, the viewpoints are not uniform. One strongly held view on the morality of abortion is that which holds that abortion is morally wrong because it involves the taking of human life. Another places weight upon the principle of the sanctity of life but regards incipient life as not being of absolute worth. Another takes the view that morality requires that a pregnant woman should have the right to her own opinion and the responsibility of choice. Yet another places stress upon the position of the child to be born into circumstances in which it is unwanted or seriously handicapped.

In our view, any consideration of the moral issues of abortion must hinge primarily on the value which society places on unborn life and that which it attaches to the life and health of the pregnant woman.

Is it morally right to destroy a living fetus? There is a universal tradition concerning the absolute worth of any living human person. That tradition finds its expression in the laws of many governments and in declarations of the United Nations and related bodies. The right to life is a sacred principle of civilisation. It is an indispensable guarantee of the individual worth of the persons within it. Its universal denial would threaten civilisation and would fail to recognise the dignity of man. A similar tradition, primarily Christian in origin, exists with regard to the unborn child. Although this tradition has been eroded, we think it to be still accepted that unborn life is entitled to a measure of protection and

that it is wrong, except for good reasons, to terminate it. This same tradition finds expression in the declarations of the United Nations. On 20 November 1959 the General Assembly of the United Nations adopted the Declaration of the Rights of the Child. The preamble to that declaration states that "The child, by reason of his physical and mental immaturity needs special safeguards and care including appropriate legal protection, before as well as after birth." In September 1948 the World Medical Association adopted the International Code of Medical Ethics contained in the Declaration of Geneva. This provided: "I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity."

The International Code of Medical Ethics published in October 1949 states: "A doctor must always bear in mind the importance of preserving human life from the time of conception until death."

The need to preserve human life from conception was still recognised in 1970 by the World Medical Association in the Declaration of Oslo. It recalled the assertion in the Declaration of Geneva that the doctor would maintain the utmost respect for human life from the time of conception, but said that sometimes the vital interests of the mother would clash with those of the fetus. Therefore, where the local law permitted abortion, or where legislation was contemplated and where the legislators "desire or will accept" the guidance of the medical profession, the following principles were approved:

1. Abortion should be performed only as a therapeutic measure.

2. A decision to terminate pregnancy should normally be approved in writing by at least two doctors chosen for their professional competence.

3. The procedure should be performed by a doctor competent to do so in premises approved by the appropriate authority.

We think that any moral code should accept:

(1) That society recognises a duty of protection towards the unborn child.

(2) That the standard of protection does not accord absolute protection to the child.

(3) That society recognises a duty of protection of the life and health of the pregnant woman.

(4) That society recognises the undesirability of children being born into a deprived state, but that the life of the child should not be terminated in its unborn state merely because ideal conditions for its upbringing in its born state may not be attainable. Many well-adjusted people have been born and reared in circumstances of social deprivation. History itself is a record of the success of people of poor circumstances.

(5) It is not immoral to terminate a pregnancy where the fetus is likely to be born with a severe physical or mental handicap, because the burden of the handicapped person to himself and to his parents may be greater than the sum total of their happiness.

(6) The termination of unborn life for reasons of social convenience is morally wrong.

Chapter 17
INDICATIONS FOR ABORTION

In New Zealand no authoritative study has ever been made of the reasons why women seek abortions. Overseas studies on the subject are limited by bounds of location, time and number. It is, however, possible to catalogue a variety of reasons why individual women, discovering themselves to be pregnant, have contemplated, and in some cases obtained, abortions. Reasons, which recur in case after case, provide some indication of the factors relating to health, stress, or economic strain, which lead women to seek a way out of unwanted pregnancy.

The reasons themselves are referred to as "indications" and may broadly be classed as life-threatening, medical, psychiatric, or socio-economic. There are also some special cases which admit of no easy classification. While the adoption of this terminology will provide a useful method of approach, it is to be remembered that one category of indications is not necessarily exclusive of another, and that they sometimes overlap.

Life-threatening and Medical Indications

Up until the 1940s there were a variety of life-threatening illnesses and pathological conditions which were recognised as justifying abortion. These included cardio-vascular disease, gastro-intestinal diseases, renal diseases, neurological diseases, and diabetes, but it is not necessary to catalogue all the conditions which at some time or other in the past would have been accepted in medical circles as being in this category.

With the advancement of medical science, successful treatments have been discovered for some conditions which previously could have been remedied only by the termination of pregnancy. It is now recognised that if appropriate treatment is given, the life of a patient is seldom jeopardised by pregnancy. Cancer of the bowel, cancer of the uterus and cancer of the ovary are exceptions to this general principle. The percentage of abortions performed for medical conditions has declined steadily over recent years.

There are, however, those cases where a disease, while no longer life-threatening, will manifest itself in frequent pain and in periodic disablement, and the patient will have to subject herself to bedrest. In some cases she may require hospitalisation or home aid. Her ability to perform normal tasks will be seriously impaired. Diseases of this order are rheumatoid arthritis, multiple sclerosis, poliomyelitis, paralysis and epilepsy, though this list is not intended to be exhaustive. There may also be accident cases where the patient has been left disabled. Whatever the cause of disablement, a great deal of fortitude is required at all times by the patient. It may be difficult enough for her to withstand the pain and periodic disablement and to accept the hospitalisation and bedrest which

normally accompany such infirmities, but all these problems may be exacerbated by pregnancy to the point where, in some cases, continuation of the pregnancy becomes a serious hardship. While, therefore, it can be said that life-threatening indications for abortion are now almost non-existent, the inter-relationship of the symptoms of serious, but not life-threatening, disease and pregnancy must be considered. It is necessary, too, to examine carefully the kind and degree of hospitalisation which would be necessary if the pregnancy were to continue.

Psychiatric Indications

A great deal has been written in the past ten years on the subject of psychiatry as it relates to pregnancy and abortion. The literature on the subject is difficult to evaluate and provides no consensus of opinion. One would hardly expect it to be otherwise. In interpreting the numerous studies made overseas by psychiatrists and other writers, the differences in legal standards, social conditions, cultural backgrounds, and psychiatric services must be taken into account, and comparisons with the New Zealand conditions must be made with caution.

The limitations of psychiatry as the least well established of the medical sciences becomes apparent when psychiatric indications for abortion are considered. It is difficult to grapple with a subject on which opinions, in the literature, are often vaguely expressed and for which reliable material is not readily available.

Few references to the subject are to be found in textbooks written more than ten years ago. The monumental 1,628-page textbook entitled *Comprehensive Psychiatry*, edited by Freedman and Kaplan (1967) devotes less than one page to the subject of induced abortion. However, in the past ten years a good deal has been written on the topic, and despite the brevity of the association between psychiatry and abortion, in several countries psychiatric grounds have provided the principal justification on which abortions have been performed. In the United Kingdom under the provisions of the Abortion Act 1967, abortion is permitted if the continuation of the pregnancy would involve risk of injury to the mental health of the pregnant woman greater than if the pregnancy were terminated. In the first 18 months after the passing of the Act, the number of abortions performed on the grounds of mental health represented 72 percent of all abortions notified. The percentage has increased steadily in subsequent years. In South Australia, the same trend has been noted, the percentage of abortions carried out for psychiatric reasons increasing from 83.9 percent of the total in 1970 to 94.7 percent in 1975.

In all countries where abortion is permitted on grounds of mental health, a similar pattern is evident. The same position prevails in New Zealand. Of all abortions induced in New Zealand in the period between 1 October 1975 and 30 September 1976, 96 percent were performed on psychiatric grounds.

With life-threatening conditions almost disappearing and risk to the physical health of the pregnant woman reduced by new methods of treatment, an increase in the percentage of abortions performed on the grounds of mental health was to be expected. However, the extent of this

increase, together with the increase in the overall number of abortions performed, is to be explained, not by a dramatic decline in the mental health of pregnant women but by a change in the criteria for abortion. These changed criteria reflect, in part, a change in community attitudes and, even more, an acceptance by society that the emotional well-being of women and children is of great importance to family life.

Psychiatric Indications Defined

There is no single definition of psychiatry which would meet with universal approval. By its very nature, psychiatry is not a function in which the psychiatrist's role is closely defined. A *Standard Medical Dictionary*, Dorland, defines psychiatry as "that branch of medicine which deals with mental disorders; the recognition and treatment of mental disorders." Many psychiatrists would consider this definition to be too narrow. Psychiatrists also deal with emotional and psycho-social problems. Psychiatry is concerned with the effects that man's environment has upon him. It is because the sphere of inquiry of psychiatry is wide-ranging and a sharp line cannot always be drawn between social factors and mental disorders, that the listing of psychiatric indications for abortion is difficult. Where physical illness or disability is present, the indications for treatment will be clear. Certain conditions, it is agreed, may be remedied or relieved by surgical treatment. So, an acute appendicitis will be recognised as an indication for surgery. Where there is a psychiatric disorder, it will be difficult to find agreement that abortion is the only, or indeed, the proper, treatment for pregnancy. The point may be made by reference to some writings upon the subject. Slater E. and Roth R. (1969) say that the majority of patients presenting for abortion do not suffer from severe mental illness and that "the correct course is to provide psychiatric treatment and support and help the patient to accept the pregnancy." But they recognise that there are those who, notwithstanding the offers of support and help, will be unable to accept their pregnancy and for them the risk of marital discord, further breakdown, or even suicide, must be recognised as genuine complications and assessed accordingly. Bolter (1962) suggests that the only genuine psychiatric indication for abortion is the risk of suicide. Sim (1974) flatly states that there are no psychiatric grounds for abortion and that even severe mental illness during pregnancy or following a previous pregnancy is not a bar to conservative and supportive treatment.

Certainly there has been a measure of agreement among some writers that the role of the psychiatrist has fallen into disrepute in the abortion issue and that some psychiatrists use the science as an instrument of law reform. Eisenberg (1970) states: "I write letters recommending abortion that are frankly fraudulent, because I am satisfied to be used so that someone may obtain what our society would otherwise deny to her. I doubt if the psychiatric indications, as are usually discussed, are difficult to elicit. Would an abortion prevent, or lessen, the possibility of psychosis, for instance? One can of course extract from a co-operative patient a statement about contemplation of suicide. But issues we deal with here are issues of humanity, of the role of physicians and of women in society. If

psychiatrists are to be missionaries, to make this change, I am delighted to co-operate, but when I do, I am using the term "psychiatry" in the sense not ordinarily used in medical circles."

This point was made by a number of psychiatrists themselves who complained that the use of psychiatrists in the abortion issue has been suspect on that account. In New Zealand, Werry (1971) says that there is little doubt that most abortions are performed "on compassionate grounds masquerading as psychiatric."

An analysis of the approach made to the problem by various psychiatrists indicates that while, in recommending abortion for psychiatric reasons, there are those who are prepared to justify abortion in pseudo-psychiatric terms, there are others who genuinely take the view that there are some psychiatric conditions for abortion. At times the psychiatrist is in the best position to assess the full significance of a psychological illness on a woman's life. We sympathise with the difficult situation conscientious psychiatrists have been placed in by generalisations made by some of their medical colleagues.

These problems do not admit of any easy solution. We stress again that it is clearly impossible to list the psychiatric conditions which may be recognised by a code which allows abortion on the grounds of danger to mental health. Some, such as suicide, are life-threatening, and may be accepted. At the other end of the scale, there are the transient interferences with the well-being of the pregnant woman, which some would regard as indications for abortion. In between there are those who find a variety of conditions, some short in duration but sharp in impact, and others continuing over a long term, which could be regarded as making a woman into a mental wreck. One instance of such a condition is puerperal psychosis, a mental illness affecting women after they have given birth to a child. This is often unpredictable but it may occur again and again in some women. The severity of the illness and the resulting disability are variable, but, if the illness is untreated, it can be most serious in its effect.

Medical practitioners from a number of specialties have sought to justify abortions performed on the grounds of mental health by pointing to the definition of "health" approved by the World Health Organisation in 1946. The definition of "health" then adopted was "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity." We subscribe to the ideal which is represented in this definition but its use as a justification of abortion on socio-economic grounds has led in many cases to the development of a policy of abortion on request. The World Health Organisation definition represents a state of health which is seldom attained.

Undoubtedly there are factors such as housing, lack of finance, lack of home help, drunken husband, and other family difficulties which must weigh heavily upon the mind of a pregnant woman, but we have not found that large family size, lack of adequate housing, financial hardship or other difficulties of this kind have necessarily compelled women to seek abortions. Many women faced with these conditions have proved quite capable of dealing satisfactorily with them. For others, these additional

factors have proved altogether too much and have created a state of psychological stress of considerable intensity, often long continued, to the point where a breakdown in mental health has occurred.

Because of the vagueness in the whole area of psychiatric indications, caution is needed in making judgments. Lack of clear definition does not provide a sound basis for ignoring the whole problem or ruling it out of consideration in decision making.

Socio-economic Considerations

We have pointed out that socio-economic factors have often influenced the decision for abortion. In some legislative codes, account is taken of factors which affect the environment in which the pregnant woman and her family live or are likely to live. These factors are often regarded as providing "socio-economic" grounds or indications for abortion. Although the term "socio-economic" is used in a collective sense, the factors may be exclusively social or exclusively economic. Social factors by themselves are those which cover such matters as family size, social position in the community, age, and family relationships. Economic factors, in isolation, are those which relate to the financial state or ability of the pregnant woman to deal with the cost of living, to provide housing and to support a family.

We have been urged by some groups to recognise socio-economic factors as sufficient grounds for abortion. The principal factors are:

Housing

The birth of a child can cause serious housing problems. A further bedroom may be required. If this cannot be added to existing premises, a move to other accommodation is obviously desirable. If this is not possible, living conditions may be highly unsatisfactory. This problem may exist for both married and single mothers.

Finance

Many families live on incomes which barely meet the necessities of life. In some cases both partners have to work to provide even a modest standard of living.

Home Help

Without outside help to assist in performing housework, in the preparation of meals, and in the minding of children, some women are unable to face up to the ordinary tasks involved in rearing a family. We have heard a surprising amount of evidence about cases of this kind. Some women with large families on limited incomes seem to manage very well and the prospect of the birth of further children is regarded by them as a joyous, rather than a daunting experience. The spreading of the family income, the sharing of existing facilities and the extra burdens of motherhood are accepted without demur. There are others for whom the birth of a further child is the "last straw". These differences in reaction suggest that socio-economic factors of themselves are not an indication for

abortion. Whether a woman will thrive or sink under the weight of such circumstances is not determined by the circumstances themselves, but by her personal reaction to them. Pregnancy for the woman who reacts badly to the conditions described above may cause such a severe strain on her physical or mental health that she is quite unable to cope with them.

Aged Mothers

An impending birth may bring joy to an older woman whose children will welcome another child within the home. In contrast there may be little but unhappiness for another whose ability to support and educate her existing family may be impaired as she is faced with demands which she is no longer able to bear. Again socio-economic difficulties which would be accepted by a young, childless couple may have disastrous consequences for an older woman with a large family. The birth itself may result in a higher incidence of medical problems or in medical problems of greater severity. There may be a risk, too, of a fetal defect, a matter to which we give special attention later in this chapter.

The Very Young

In Chapter 1 we discussed the undesirability of pregnancy in girls under 16 years. For some of these, as we have made clear, pregnancy has resulted from ignorance, from pressure from those of a similar age, and, in some cases, from conditions not far removed from duress. Even if childbirth of itself does not create severe strain on these girls, the pressures of deciding what is to be done about the upbringing of the child may produce a severe and continuing state of stress for them. Given a stable background, care, and support from parents, some young girls are able to bear a child and accept responsibility for future consequences. Indeed, some girls, who have become pregnant to fulfil a psychological need, may find some therapy in the rearing of a child. There are others, the whole course of whose lives may be altered by the effect which the birth of a child may have upon them. For many young girls under 16 the case for abortion may be strong, but the selection of a particular age level as an indication for abortion itself poses very great problems, not least of which is the fact that some girls under that age are relatively mature and may wish in any case to keep their babies, while some above that age may be relatively immature. Each case requires assessment on its own merits. We think that age should be a factor to be taken into account in considering the effect which the pregnancy will have upon the mother, but that it should not of itself be an indication for abortion.

Fetal Defects

Although the present law on abortion in New Zealand does not make provision for abortion on the grounds of fetal defects of themselves, abortions on those grounds have in fact been carried out in both public and private hospitals. The justification for such abortions may have been that, while fetal defect alone would not be enough, the danger to the health of the mother caused by the birth of a child with a physical or mental handicap would create sufficient additional grounds.

In the development of the conceptus from zygote to born child, defects of varying origins may be present. Almost 2,000 genetic defects have been catalogued. The proportion in which they occur is difficult to estimate but it is now accepted that the relatively high loss of fertilised ova, either before or after implantation (a subject to which reference is made in Chapter 14), occurs chiefly in genetically abnormal and malformed babies. Not every malformed or abnormal fetus will be spontaneously aborted. A proportion will proceed to term and will be born with a wide variety of defects, ranging from those of relative insignificance to those which will result in a severe degree of intellectual or physical disability or even in early death.

Other fetal abnormalities, not genetic in origin, may be acquired after conception. Abnormalities of this kind may be viral in origin as is the case with Rubella. They may be drug-induced or they may be the result of environmental factors such as exposure to radiation.

It may be possible to correct some defects with which children are born by surgery and other forms of treatment. Some defects, however, will not respond to any form of treatment. Whether, on birth, children with disabilities are accepted into the community depends mainly on parental attitudes.

Some congenital defects occur comparatively frequently; some are extremely rare. It is not within the ambit of this report to list all kinds of genetic disorder nor to examine their aetiology. How they occur is not of moment to the discussion in this chapter except to the extent that their avoidance, diagnosis and treatment may be relevant.

There are those cases in which existing family histories may indicate the likelihood of the occurrence of a disability. The possible recurrence of a genetic disorder may be averted by adequate contraceptive measures or by sterilisation of the spouse from whom the genetic disorder is likely to be inherited. In some disorders there are conditions in which a genetically affected person may pass on a disease to half the children of a union. In some there is no previous history of genetic disorder but the birth of a handicapped child may indicate an increased risk of the birth of another suffering from a similar disability. Down's Syndrome, or Mongolism, is a well-known illustration. The incidence of children born with this disease to all mothers within their childbearing years is 1 in 600, but where a mother has already borne a Mongol child, the risk of bearing another with the same disorder is reckoned to be 1 in 100. In other kinds of disorder there may be nothing in the genetic history of a couple which will alert them to knowledge of any risk.

We believe that it is important to identify those cases in which family histories indicate that a particular condition is likely to occur. It is now possible for an ante-natal diagnosis to be made of a small, but increasing, number of fetal abnormalities and, as scientific research continues and medical knowledge expands, an increase in this number can be expected. Various methods of diagnosis are at present used, the best known and most common of which is amniocentesis. This is a process whereby, under local anaesthesia, a sample of the fluid in the amnion (a membrane containing the fluid in which the fetus floats inside the uterus) is obtained

by inserting a needle through the abdominal and uterine walls. The fluid is then examined for the presence or absence of abnormal metabolites and the biochemical properties of fetal cells grown from the amniotic fluid are determined. In this way it is possible to establish, in the case of certain diseases, an absolute identification of a fetus affected with a serious disorder, inconsistent with normal physical or mental development, and with no prospect of responding to rational treatment. Lesser known techniques used in the ante-natal diagnosis of fetal abnormalities are diagnostic ultra-sound scanning and trans-abdominal fetoscopy. The first of these has been used to detect fetal anencephaly, and the second in the direct examination of the fetus to detect gross external abnormalities such as spina bifida. The use of these processes in the actual determination of fetal abnormalities in utero, or in establishing that the fetus is normal, may be illustrated by reference to a number of diseases which are genetic in origin.

Anencephaly

This is a malformation of the central nervous system. After the sample of amniotic fluid has been removed by amniocentesis, the level of the alpha-feto-protein in the fluid can be examined and a prognosis can be made as to whether the fetus is anencephalic, and possibly also as to whether it is affected by spina bifida.

Tay-Sachs Disease

A baby born with this disease, for which no treatment is available, appears normal, but, by its first birthday, degeneration of the nervous system sets in and the baby dies before the age of four. The disease is inherited through a recessive gene. The incidence of the disease is generally rare, i.e., about 1 in 30/40,000, though it has a higher incidence than this among some Jewish communities. The disease can be detected by amniocentesis.

Spina Bifida

This condition occurs when the spinal area of the unborn child fails to fuse. It may occur in varying degrees of severity. It can be detected in utero by measuring the levels of alpha-feto-protein in the amniotic fluid extracted by amniocentesis.

Down's Syndrome (Mongolism)

This is a chromosomal disorder which it is possible to diagnose in utero by the tissue culture of fetal cells in the amniotic fluid after extraction by amniocentesis. It is well known that the risk of a Down's Syndrome conceptus increases with the maternal age, reaching a probability of approximately 1 in 50 when the mother is in her mid-forties. One estimate of the incidence, according to age group, is as follows:

Age 25 years 1 in 2,000 or 2,500
Age 35 years 1 in 250
Age 40 years 1 in 100
Age 45 years 1 in 50

Even though the risk is much lower when the mother is aged between 20 and 30 years, a significant number of Down's Syndrome cases are born to mothers in this age group owing to their greater reproductive activity at this stage.

An important, though less common form of Down's Syndrome, arises through the translocation of chromosomes which are unbalanced in the child, although they are balanced in one of the parents. Such parents have a high risk of producing a Down's Syndrome child. When the mother is the carrier the risk may be as high as 20 percent, but this drops to approximately 5 percent when the carrier is the father. One very rare form of unbalanced translocation carries 100 percent risk that all children will suffer from Down's Syndrome, whether the carrier is the father or the mother.

Children born with Down's Syndrome have a much diminished life expectancy with an increased incidence of congenital heart defects and other congenital faults, and a twentyfold increase in the risk of dying from leukemia in childhood. They seem especially prone to all the common ailments of childhood, particularly respiratory infections. They are all mentally retarded. The Down's Syndrome children and adults present in the community are mainly those, who, by virtue of their lesser degree of mental retardation, have achieved some social adaptability. More-severely affected cases are generally to be found in institutions.

Muscular Dystrophy

There are a number of forms of muscular dystrophy. The most common is known as Duchennes. This disease, which affects boys only, is serious and leads to death before the age of 20 years. The disease cannot itself be detected in utero, but the sex of the child can be determined by amniocentesis. If the unborn child is female, the possibility of muscular dystrophy can be discounted and the mother reassured.

Haemophilia

Haemophilia is inherited only by men, and transmitted only by women. A female carrier has a chance of giving birth to a normal daughter, a carrier daughter, a normal boy or an affected boy. The chances of giving birth to an affected boy are therefore 1 in 4. Amniocentesis does not indicate the presence of the disease, but the sex of the child can be detected and the chances of the child being affected can be ruled out if it is a girl.

There are great advantages from the use of amniocentesis and the risks to mother and child are small. An analysis of 114 cases in which amniocentesis was carried out at National Women's Hospital revealed one case in which the unborn child was found to be suffering from Down's Syndrome, and two suffering from neural tube defects (spina bifida). As a result it was possible to reassure the pregnant woman, in all except those three cases, that her child would be normal. It is thought that the subsequent and apparently spontaneous abortion of one patient was the result of amniocentesis. The ratio of one fetal loss for 114 cases of

amniocentesis in the hospital concerned is considered to be a fair representation of the risks involved.

Not all pregnant women who entertain fear about the birth of defective children are screened by amniocentesis. The technique should not be used as a means of reassuring women in whose unborn children there is no reason to suspect any fetal abnormality. On the other hand the technique should be available for those who can be identified as running the risk of giving birth to children with severe genetic disorders and would consider abortion if a seriously affected fetus were identified. Those for whom amniocentesis may be considered as appropriate include:

(1) Women who previously have had a child with a severe genetic defect which can be recognised in utero.
(2) Women who have been identified as carriers of a chromosomal aberration, or whose husbands have been recognised as such.
(3) Women who have been identified as carriers of a severe metabolic disorder and whose husbands may be carriers.
(4) Women who have been exposed to infection diseases, drugs or radiation, which might be harmful to the fetus.
(5) Women who are beyond a certain age level and, on that account, run a greatly increased risk of having a child with Down's Syndrome.

Acquired Fetal Abnormalities

Of those abnormalities of a serious kind which are acquired after conception and before birth, the most important are caused by maternal Rubella. Outbreaks of Rubella have occurred periodically throughout the world and in some countries in the past have achieved epidemic levels. In recent times a vaccine has been discovered which may result in a level of control of the disease which has not been possible in the past.

Rubella which occurs in some cases without the presence of visible symptoms, may result in the birth of a child with serious defects such as deafness, cataracts of the eyes, heart disease and mental deficiency. These defects may occur singly or in combination with each other. It is not possible to detect whether the woman who has contracted Rubella will give birth to a child with substantial physical or mental defects, although tests indicating the presence of certain antibodies in the mother's blood will indicate that she has been infected by the disease. One of the problems in assessing the likelihood of abnormality caused by maternal Rubella is that fetal defects occur in only a small proportion of the children, and the effect of the maternal disease on the child depends on the stage in the pregnancy at which the illness was contracted. After fetal life has developed to 12 weeks, maternal Rubella will not affect the child at all.

Morality of Abortion for Fetal Defects

Those who adopt the absolutist position and argue that abortion is morally indefensible in any circumstances, express concern that abortion for fetal defects should be permitted. They see no logical difference

between permitting abortion for a fetal defect and terminating the life of a born child, young or old, whose physical and mental capacities are seriously impaired.

We appreciate the concern expressed by such people and are aware that there are those who regard abortion for fetal defect and euthanasia as being closely allied. Nevertheless, in the minds of most people, there is a clear line of distinction between abortion for fetal defect and the practice of euthanasia.

Within the past 25 years, it has been rightly recognised that intellectually handicapped persons can make a contribution to society, both in their own right, and in the attitudes which they engender in those who work with them. Societies, such as the New Zealand Society for the Intellectually Handicapped Inc. (formerly the Intellectually Handicapped Children's Society), include in their goals, not only the health and care, understanding, training and education of intellectually handicapped persons, but also the development of the self-esteem of such persons and their integration into the community. In a period of 25 years the intellectually handicapped child has been rescued from neglect. Nothing that we say is intended to detract from the belief that these persons should be looked upon simply as fellow-citizens who are unfortunate enough to suffer from disabilities which in different ways and to different degrees restrict independence and limit choice of action.

A number of people gave evidence before us on the effect which handicapped children had made on their lives. To some the rearing of a handicapped child had been regarded as a privilege, enriching their family life and developing the social conscience of the community at large. On the other hand, we received distressing but clear evidence that there are many mothers who are neither physically, mentally or emotionally equipped to rear an intellectually handicapped child, and who would be entirely willing to consent to an abortion where ante-natal tests reveal a strong probability that the child will be born with a substantial degree of physical or mental impairment. We are of the view that mothers in this situation should be given this choice.

We have given much thought to the matter, and are only too aware that difficulties arise as to the formula which should be adopted in such cases. It is not for every defect that the abortion of the unborn child should be considered. No community can hope to produce a race of genetically perfect children, nor is abortion to be entertained because there is a mere statistical possibility that a pregnant woman will give birth to a child suffering from some rare disease. For abortion to be entertained, the risk that the child will have an abnormality when born must be more than a remote risk, and the abnormality from which it will suffer must be of a serious kind. We can find no better formula than that which was adopted in the British Abortion Act 1967, which permits abortion if there is a substantial risk that if a child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Before leaving this theme, we draw attention to submissions made to us as to a financial strain placed on the parents of handicapped children who remain at home. We understand that no social welfare benefit is payable

in respect of these children although, quite apart from the cost of their upbringing, the wear and tear which they impose on clothing and furniture is considerable. We think the devotion of these parents and the saving of state funds effected by their remaining at home should be recognised by the payment of an appropriate benefit.

Rape as an Indication for Abortion

Pregnancy resulting from rape is frequently advanced as a ground which most people would accept as a justification for abortion. The law of New Zealand is that rape is not, of itself, a ground for abortion, although since Bourne's case it has been recognised that the effect on the pregnant woman's health of a pregnancy resulting from rape may be such as to justify such a view being taken.

The subject of rape can be counted upon to stir the emotions when it is raised both within and outside of the abortion debate. Only those who attach an absolute value to the unborn child would claim that a pregnancy resulting from rape is inviolable and entitled to the same protection as a pregnancy resulting from voluntary intercourse. Arguments against the morality of abortion in respect of a pregnancy resulting from rape are not likely to find general acceptance. Most people would regard it as quite unreasonable that a woman should be compelled to bear the child of someone who has made a violent sexual assault upon her against her will. We share that view.

The number of pregnancies resulting from rape is fortunately very small. Statistical information assembled in a number of large police areas in America reveals a very low incidence of pregnancy among a considerable number of rape victims. The evidence which we have heard from gynaecologists and women themselves supports that experience. Only a few cases of pregnancy resulting from rape have been disclosed to us. Bourne's case was one. At our request a senior officer of the Police Department conducted extensive inquiries among experienced police officers within New Zealand as to their knowledge of pregnancies resulting from rape cases reported to them. These inquiries revealed only three cases between the years 1970 to 1973 inclusive where complainants had become pregnant as a result of the alleged rape. In none of these cases was the accused person convicted of rape, although, in two of the cases where pregnancy had resulted from the act of intercourse, the accused were found guilty of some sexual offence of which lack of consent was not an element.

One of the elements of rape, as defined by section 128 of the Crimes Act 1961, is sexual intercourse. Section 127 of this Act provides that, for the purposes of that part of the Act which relates to sexual crimes, sexual intercourse is complete upon penetration. The courts, in interpreting this legislation, have held that it is not necessary for the Crown to prove full penetration. Any degree of penetration will suffice. Much less is it necessary to prove in a charge of rape that there has been an emission of semen. Consequently, in many acts of rape there will neither be full penetration nor emission of semen. Even if full intercourse does take place,

pregnancy will result only if the attack takes place within the limited time in the menstrual cycle in which the woman is fertile.

While there can be no valid argument against allowing abortion in the case of a pregnancy resulting from a proven rape, there are serious difficulties which stand in the way of the administration of any code which includes rape as a ground for abortion. One difficulty which arises results from the time at which the decision to abort is made. If the making of that decision is delayed until a conviction for rape is obtained, it is likely that the pregnancy will have advanced too far for the abortion to be performed.

It might in any case be unfair to the woman to make the abortion decision dependent on the conviction of the offender. A conviction can be entered only if the members of the trial jury are satisfied beyond reasonable doubt of the guilt of the accused. An acquittal would not therefore necessarily mean that the trial jury completely rejected the evidence of the complainant. If, however, the abortion decision is not to depend on the conviction of the offender, it is difficult to find other criteria which are not subject to criticism. If it rests only on the complaint, a number of women who for reasons of embarrassment have not made complaints of rape, will be automatically excluded. Many cases may not be reported at all. Some which are reported are not genuine. If the decision is to rest on the claim of the complainant herself that she has been raped, it may fairly be expected that complaints of rape will readily be made.

In *Abortion and Social Justice*, edited by Thomas W. Hilgers and Dennis J. Horan, reference is made to a personal communication from J. E. Archibald, Counsellor and Attorney at Law, Denver, Colorado, regarding the experience of the State of Colorado in which, on 25 April 1967, the law was altered to permit of rape as a ground for abortion. Although, in that State, abortions for rape between 25 April 1967 and November 1971 totalled 290, it was reported that during this period of time no rapist was charged with the crime of rape, much less convicted of it.

We note that neither under the Abortion Act 1967 (U.K.) nor under the South Australian legislation is pregnancy resulting from rape a specific ground for abortion. This does not mean that, in countries where these codes apply, rape cannot be taken into account in making the abortion decision. It has long been recognised that pregnancy resulting from rape may cause a state of severe psychological stress affecting a woman's mental health. It has, on this basis, been taken into account when considering whether abortion is justifiable on legal grounds. We see no reason why it should not be taken into account in the same way under the legal code which we propose.

It is our opinion, however, that the inclusion in any legal code where pregnancy resulting from rape is a ground in itself for abortion would, for the very few women which it would benefit, be the subject of abuse. The plight of women who are fearful of pregnancy following on rape can be better met by ensuring that either the "Morning-after Pill" or some form of intra-uterine device, such as the "Copper-7", is made available to women and girls who complain of recent rape. Both are effective means of

preventing pregnancy if administered within 72 hours of intercourse. Both may be provided for younger girls as well as women.

Accordingly, where women and girls make complaints of rape, we think that it should be mandatory for medical practitioners called by the police to examine them, either to provide the "Morning-after Pill" or, if requested, to fit an appropriate form of I.U.D. If they are unwilling to do this, they should be required to advise complainants that these methods of treatment are available and that they may, if they wish, obtain them from a medical practitioner of their choice or from a family planning clinic. We do not regard the provision of such a service by a medical practitioner called by the police as an act in which he would be called upon to express his views upon the genuineness of the complaint. He would be doing no more than to advise the woman or girl concerned of forms of treatment which we regard as medically, morally and legally acceptable.

Incest as an Indication for Abortion

Incest is defined by section 130 of the Crimes Act 1961, as "Sexual intercourse between—(a) parent and child; or (b) brother and sister, whether of the whole blood or the half blood; . . . or (c) grandparent and grandchild—where the person charged knows the relationship between the parties."

Incest is not a ground for abortion in New Zealand. Very few persons in fact are charged with the crime, although it is likely that there are many more cases than those reported. Most cases of incest are undetected because of the reluctance of the members of the family involved to report the offence. Sometimes a child born of an incestuous relationship is cared for as part of the family. But, given the existence of an incestuous relationship, where acts of intercourse are in all probability frequent, pregnancy is much more likely to result from incest than where the acts of intercourse are isolated.

Information supplied to us by the Police Department after inquiries had been made of senior experienced police officers reveals that between 1958 and 1976 there were 13 cases where there were grounds for believing that pregnancies had resulted from incestuous relationships. Most of these were between fathers and daughters under 16 years of age. Other evidence of incestuous relationships between fathers and daughters was given to us by school teachers, social workers, and medical practitioners. On the medical evidence which we have heard, it seems that genetic abnormalities which may appear as a result of incest are not likely to be any more serious than genetic abnormalities occurring in non-incestuous relationships, but the chances of their occurrence are greater. Quite apart from the serious risk of genetic disorders recurring, we do not think that any sanctity can be attached to a pregnancy which has resulted from a father taking advantage of his daughter.

Unjustified complaints of incest are not likely to be made. The opposite is more likely to be the case, with the closing of the family ranks ensuring that any such relationship remains secret.

The definition of incest in section 130 is limited to ties of blood. It takes no account of intercourse between a man and those, outside blood

relationship, who are under his care. However, section 131 of the Crimes Act 1961 makes it an offence for a man "to have sexual intercourse with any girl, not being his wife, who is under the age of 20 years, and who, being his stepdaughter, foster-daughter, or ward, is at the time of the intercourse, or attempted intercourse, living with him as a member of his family, or not being his stepdaughter, foster-daughter or ward, and not being a person living with him as his wife, is at the time of intercourse or attempted intercourse, living with him as a member of his family, and is under his care or protection". If, on the view which we take of the matter, a pregnancy resulting from an incestuous relationship within section 130 is not protected, then we think that pregnancies resulting from relationships between a man and his stepdaughter, his foster-daughter, or ward, living with him as a member of his family, and under his care or protection, should not be protected.

Intellectual Handicap as an Indication for Abortion

Section 138 of the Crimes Act 1961 makes it an offence for a person to have sexual intercourse with any woman or girl who is severely subnormal, if he knows or has good reason to believe that she is subnormal. For the purposes of this section, a woman or girl is "severely subnormal" if she is mentally subnormal, within the meaning of the Mental Health Act 1959, to the extent that she is incapable of living an independent life or of guarding herself against exploitation or common physical dangers.

It is our view that there is little, if any, status attached to a pregnancy resulting from an act of intercourse with a girl who is mentally handicapped or subnormal, and that a pregnancy in such a girl ought to be recognised as an indication for abortion.

RECOMMENDATIONS

Chapter 17 is to be read with Chapter 24. For that reason, recommendations from the text of Chapter 17 are included in the recommendations set out at the end of Chapter 24.

Chapter 18

DEMOGRAPHIC ISSUES

In a number of submissions, it was suggested that there was a need for increased access to contraception, sterilisation, and abortion to ensure that New Zealand played its part in restricting the growth of world population, in conserving the existing resources of this country, and in making for a better environment.

Although, on the views which we have formed, there are moral reasons why demographic considerations should not influence the policy of law-making on abortion, we propose to examine some of the points made in the submissions because such matters are taken into account in many countries and, in our view, they may be important in considering population trends in the future.

INFLUENCE OF ABORTION LAWS ON POPULATION AND BIRTH RATES

There are those countries where liberalisation of the abortion laws has influenced birth rates and brought about marked changes in population growth. In some, liberalisation of the abortion laws has been effected for that very purpose. The U.S.S.R., countries in Eastern Europe, and Japan are frequently cited as illustrations of the effect that removal of restrictions on abortion can have on birth rates and population numbers in countries where there is either limited contraceptive practice or no contraception at all. The U.S.S.R., which liberalised its abortion laws in 1920, introduced restrictive legislation in 1936 because of falling birth rates. This was repealed in 1955. In Hungary, Bulgaria, and Romania an almost total prohibition against abortion was removed, and abortion became legal at the request of the pregnant woman, resulting in a spectacular increase in the abortion rate in those countries. Official alarm at rising abortion rates and declining birth rates resulted in the imposition of restrictions in Romania in 1966, in Bulgaria in 1968, 1972, 1973, and in Hungary in 1974.

In Japan, according to official reports, the number of abortions following legalisation rose from 246,000 in 1949 to 1.17 million in 1955, representing a legal abortion rate of 13.1 compared with the birth rate of 19.4 per 1,000 head of population in that year. In considering these figures, it is to be remembered that abortion rates in a particular country must be looked at in the light of whether, in that same country, effective contraception is practised. In most Eastern European countries and in Japan, contraceptive techniques have been poor and so abortion has become the only effective means of fertility control. It is not possible, on that account to make any valid comparison between the abortion rate in

the countries referred to and that in New Zealand where reliable methods of contraception are widely used.

WORLD POPULATION

The present world population is estimated to be in the vicinity of 4,000 million and has been expected to double in about the next 35 years. A recent estimate published by the World Watch Institute of Washington suggests that the annual increase in population has slowed from the 1970 growth rate of 1.9 percent, representing an annual increase in population of 69 million, to 1.64 percent in 1975, representing an annual increase in population of 64 million. This represents a decline in the birth rate per 1,000 mean population from 32 to 28. However, even if lower growth rates are achieved, many years will pass before the growth potential of young persons now entering the reproductive age (16-44 years) is spent.

The problems of world population growth are compounded by the fact that increases in world population are not evenly distributed. In the less developed regions of Asia, Africa, and Latin America, which contain seven-tenths of the world's people, population increases continue, whereas the developed regions of Eastern and Western Europe, North America, Australia, New Zealand, and Japan are characterised by comparatively stable population conditions. According to the report of the Inter-Departmental Committee on Population Questions entitled "Population Policy Guidelines" (1975), the fertility trends then evident in this country will lead to replacement fertility in the next decade. Before zero growth (a population where births equal deaths and long term immigration equals long term emigration over some defined period of time) is reached, the growth potential of those in the reproductive age group will contribute to increases in population for several decades. We have referred in Chapter 1 to the contribution made by New Zealand to family planning programmes overseas. Table 23 sets out the estimates and conjectures of past and present population of the world for more developed and less developed regions.

Table 23—Estimates and Conjectures of Past and Present Population of the World and Current More-developed and Less-developed Regions

	More Developed Percent	Less Developed Percent
1970	30.0	70.0
1750	25.7	74.3
1800	25.6	74.4
1850	27.7	72.3
1900	34.7	65.3
1950	34.5	65.5
2000	22.4	77.6
2050	18.2	81.8

Source: Department of Economic and Social Affairs, Population Studies No. 49; The World Population Situation in 1970, U.N. 1971.

NEW ZEALAND POPULATION

Although, by world standards, the population of New Zealand is small (estimated at 3,094,600 at 30 June 1976), the rate of growth has been high compared with that of other developed countries because of large increases in the population brought about by immigration. In the year ended 30 June 1976, the pattern of immigration previously apparent altered substantially, and there was an excess of persons emigrating over persons immigrating. The numbers of migrants to this country in the year ended 30 June 1974 was 28,406, in the year ended 30 June 1975, 27,118, and in the year ended 30 June 1976 there was a net deficit of 2,514. Information from which the population growth of New Zealand may be compared with that of other countries is available only for the years 1970 to 1973. Table 24 sets out the average annual rate of population growth in selected countries for the years 1970-1973.

Table 24—Selected Countries, Average Annual Rates of Population Growth, 1970–73

Country	Average Annual Growth Rate (Percent)	Country	Average Annual Growth Rate (Percent)
Australia	1.6	New Zealand ...	1.8
Canada	1.2	Norway	0.7
China	1.7	Singapore	1.7
Denmark	0.7	South Africa ...	2.8
Egypt	2.2	Sweden	0.4
France	0.9	Switzerland ...	1.3
Germany, West ...	0.7	Thailand	3.2
India	2.1	United Kingdom ...	0.3
Ireland	0.9	United States ...	0.9
Japan	1.3	U.S.S.R.	1.0
Netherlands ...	1.0	Western Samoa ...	2.1

Source: United Nations "Demographic Yearbook, 1973".

Table 25 sets out the growth in the total population of New Zealand between 1945 and 1976.

Table 25—New Zealand Growth of Total Population, 1945–76

Census Date	Population at Census	Intercensal Increase	Average Annual Increase (Percent)
September 1945 ...	1,702,298	...	...
April 1951	1,939,472	237,174	2.4
April 1956	2,174,062	234,590	2.3
April 1961	2,414,984	240,922	2.1
March 1966 ...	2,676,919	261,935	2.1
March 1971 ...	2,862,631	185,712	1.4
March 1976* ...	3,130,083	267,452	1.8

*Provisional

Source: Department of Statistics

Table 26 sets out the proportions in which natural increase and increase due to net immigration contributed to the total increase in the population of New Zealand.

Table 26—New Zealand Total Population Increase, Natural Increase and Increase Due to Net Immigration, 1970–75

Calendar Year	Total Population at End of Year (Thousands)	Total Population Increase During Year (Thousands)	Natural Increase During Year[1] (Thousands)	Total Net Immigration During Year[2] (Thousands)	Proportion of Population Increase Attributable to: Natural Increase	Net Migration
1970	2,852.1	48.1	37.4	10.7	77.7	22.3
1971	2,896.1[3]	44.0	40.4	3.6	91.8	8.2
1972	2,954.1[3]	58.0	38.7	19.3	66.7	33.3
1973	3,016.2[3]	62.1	35.4	26.7	57.0	43.0
1974	3,080.1[3]	63.9	34.1	29.8	53.4	46.6
1975	3,128.7[3]	48.6	31.5	17.1	64.8	35.2

[1]Excess of births over deaths.
[2]These are not official migration figures but are estimated.
[3]Revised in terms of provisional total population count from the 1976 Census of Population and Dwellings.

Source: Department of Statistics.

It is to be noted, however, that, because of the age structure of the population (in 1975, 29.7 percent were under 15 years of age), the potential for growth is still considerable. Table 27 sets out the proportion of the total population in specified age groups between the years 1945 and 1971.

Table 27—New Zealand Proportion of Total Population in Specified Age Groups, 1945–75

Age-group (Years)	Proportion of Total Population in Age-group at Census						
	1945	1951	1956	1961	1966	1971	1975*
0–4	10.5	12.1	11.8	12.1	11.5	10.4	9.7
5–14	16.5	17.3	19.6	21.0	21.1	21.4	20.0
15–19	8.1	6.7	7.2	7.7	9.2	9.1	9.7
20–44	35.6	35.6	33.4	31.6	31.0	31.5	33.3
45–64	20.6	19.1	18.8	19.0	18.9	19.1	18.5
65 and over	8.7	9.2	9.1	8.6	8.3	8.5	8.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Provisionally estimated age distribution as at 31 December 1975.

Source: Department of Statistics.

The Department of Statistics has compiled tables of population projections on recent fertility trends which predict populations in New

Zealand over the next 25 years. Table 28 sets out population projections for New Zealand, assuming "low" fertility and a specified net annual immigration gain.

*Table 28—Population Projections, 1976–2001**

As at 31 March	Projected New Zealand Population Assuming "low" fertility and net annual immigration of:					
	10,000			15,000		
	Males	Females	Total	Males	Females	Total
			(thousands)			
1971 (base)	1,430	1,431	2,861	1,430	1,431	2,861
1976	1,550	1,549	3,099	1,565	1,560	3,125
1981	1,667	1,664	3,332	1,697	1,689	3,385
1986	1,781	1,776	3,557	1,826	1,814	3,640
1991	1,889	1,883	3,773	1,950	1,934	3,884
1996	1,996	1,989	3,985	2,073	2,054	4,127
2001	2,101	2,092	4,193	2,195	2,171	4,366

*These projections assume a net annual gain from migration of 10,000 and 15,000 per annum, that 1965–67 Life Table Mortality Rates (Total Population) apply throughout the projection period, and "low" fertility. The "low" fertility assumption is considered to be most appropriate in terms of recent fertility trends. It is relative to the "medium" assumption (not shown here) and is based on age-of-mother specific total birth rates which were considered, at the time the projections were prepared, to represent minima in the light of the assessed reasonably expected range of values which might eventuate.

Source: Department of Statistics.

The "low" fertility assumption made in the last table assumes that the fertility trend apparent between 1962 and 1973 will continue between 1974 and 1979, with a further extension of this trend, somewhat flattened, until 1989. On an assumed immigration level of 10,000 persons per annum, it has been estimated that New Zealand's population will be 4,193,000 in the year 2001. An estimate based on an annual immigration rate of 15,000 persons per annum is that New Zealand's population will be 4,366,000 persons by the year 2001. Table 29 shows the projected net reproduction rates between 1976 and 1981.

Table 29—New Zealand Projected Net Reproduction Rates (Total Population), 1976–81

Year Ending 31 March	Projected Net Reproduction Rates Assuming Age-of-Mother-Specific Birthrates Change in Accordance with:		
	"High" Fertility Assumption	"Medium" Fertility Assumption	"Low" Fertility Assumption
1975* (Actual)	1.13	1.13	1.13
1977	1.10	1.08	1.06
1978	1.09	1.04	1.00
1979	1.07	1.01	0.94
1980	1.06	0.97	0.88
1981	1.05	0.93	0.82

*Provisional net reproduction rate for 1975 calendar year.

Source: Department of Statistics.

Estimates have also been made of the projected proportion of the total population of New Zealand according to specified age groups in the years 1981 to 2001. Table 30 sets out these projections.

Table 30—New Zealand Projected Proportion of Total Population in Specified Age Groups, 1981–2001

Age-group (Years)	Estimated Proportion of Total Population in Age-group at 31 March 1974 (Base)	Projected Proportion of Total Population in Age-group at 31 March					
		Assuming "Medium" Fertility [1]			Assuming "Low" Fertility [1]		
		1981	1991	2001	1981	1991	2001
		(Percent)					
		Assuming Zero Net Annual Immigration					
0– 4 ...	10.1	9.3	8.7	8.0	8.5	7.4	6.6
5–14 ...	20.6	18.6	17.0	16.0	18.6	15.5	13.9
15–19 ...	9.5	9.6	8.4	7.9	9.7	8.6	7.3
20–44 ...	32.4	35.7	38.9	38.5	36.0	40.4	40.5
45–64 ...	18.7	17.7	17.5	10.4	17.9	18.2	21.8
65 and over ...	8.6	9.1	9.5	9.2	9.2	9.9	9.9
Total ...	100.0	100.0	100.0	100.0	100.0	100.0	100.0
		Assuming 10,000 Net Annual Immigration					
0– 4 ...	10.1	9.3	8.6	7.9	8.5	7.3	6.6
5–14 ...	20.6	18.5	16.9	15.9	18.6	15.5	13.8
15–19 ...	9.5	9.5	8.4	7.9	9.6	8.6	7.2
20–44 ...	32.4	36.0	39.2	38.8	36.3	40.7	40.7
45–64 ...	18.7	17.6	17.5	20.5	17.8	18.1	21.9
65 and over ...	8.6	9.1	9.4	9.1	9.2	9.7	9.7
Total ...	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] The method of derivation of the fertility assumptions is described in section 2.5.2 of the publication *New Zealand Population Policy Guidelines.*

Source: Department of Statistics.

The high potential for growth in the population has been noted by some who have made submissions to us. They have suggested that New Zealand will have problems with increases in population in the future, and, on that account, they have recommended that birth rates should be further decreased. We note, however, that the birth rate per 1,000 mean population has already declined from 20.14 in 1974, to 18.77 in 1975 and 17.87 in 1976. Natural increases (excess of births over deaths) contributed 30,077 to the population gain in the year ended 30 June 1976 compared with 32,727 in the year ended 30 June 1975 and 35,149 in the year ended 30 June 1974.

Among the factors influencing the decline in fertility rates in New Zealand is better contraceptive usage. This has been brought about by

such factors as rising levels of education, increasing urbanisation, and the growing trend for married women to work following marriage and to enter the work force again later. Family sizes have diminished. There has been a reduction in the average number of children per woman from 4.15 in 1962 to 2.38 in 1975.

Maori fertility rates have been substantially higher than non-Maori rates, but have not had a major effect on the population size as they represent only about 13 percent of births in any year. Although there were approximately 79,000 Pacific Islanders in New Zealand on 31 March 1976, there is no information available to us as to their fertility rates. Separate records are not kept in respect of births and deaths for Pacific Islanders. In our view there are now a sufficient number of Pacific Islanders residing in New Zealand to warrant the keeping of separate statistical information in respect of them. The keeping of such records would be of material assistance in analysing population trends and in determining social needs in the future.

POPULATION DISTRIBUTION IN NEW ZEALAND

Even if demographic considerations were morally acceptable as valid grounds for abortion within New Zealand, the opinion that we have formed, on the information made available to us, is that the size of the population of this country would not warrant action to influence population numbers. We were presented with widely differing estimates of the number of people New Zealand could support. The figures, which are based on different assumptions, are so widely divergent that they cannot readily be reconciled. We are, however, able to say from the information available to us that, even having regard to the world population increase, New Zealand neither has, nor is likely, on its present rate of natural increase, to have problems of excess population. Such problems as exist are problems caused by the uneven distribution of the population, over 70 percent of the population living in the North Island, 40 percent of whom live in the north of the North Island.

STATISTICAL INFORMATION

During the course of its hearings and its deliberations, the Commission has been at pains to obtain the most recent statistical information available which would assist it in the making of findings and the formulation of recommendations. Departmental officers have given us great assistance in our search for this information. In the Introduction we paid tribute to the staff of the National Health Statistics Centre and to the Department of Statistics for the help which they have given us. We feel obliged to record, however, that there were times when we were appalled that the statistical information initially available was very much out of date and that more recent information was made available to us only after the appropriate department had been obliged to give it special priority. It seems to us that, if statistical data is to be used as primary material from which legitimate inferences are to be drawn and upon which forecasts for the future are to be made, it must be both accurate and up to date. As an

example of the level of availability of recent statistical information we note that much of the material relating to ex-nuptial births contained in the Department of Social Welfare monograph, "Ex-nuptial Children and Their Parents", is no more recent than 1971 or 1972.

Many other examples of out-of-date information could be mentioned. It is fortunate that we have not had to rely on this and that more recent figures have been made available to us.

RECOMMENDATION

That separate statistical information be kept by the Department of Statistics, recording the births and deaths of Pacific Islanders.

Chapter 19

MAORIS AND PACIFIC ISLANDERS

POPULATION FIGURES FOR MAORIS AND PACIFIC ISLANDERS

In December 1973 (the last date for which information is available to us) there were 244,794 Maoris living in New Zealand. The number of Pacific Islanders living in New Zealand at 31 March 1976 was estimated to be 79,000. Because Maoris and Pacific Islanders combined comprise more than 10 percent of the population of New Zealand it seemed to us that we should take care not to overlook their cultural attitudes and that we should take account of any special needs that they may have.

We received some submissions from Maoris and Pacific Islanders but regret to say that the number was small despite repeated invitations to various groups and organisations, both orally and in writing, and indications that we were prepared to extend the time for the making of submissions by them. Those Maoris who did make submissions as part of a group or association did so at our public sittings. Those who expressed personal views spoke to us in private.

HISTORICAL BACKGROUND OF THE MAORI

It is difficult to ascertain, with any degree of certainty, the attitudes of Maoris in earlier times on matters such as pre-marital sex, abortion, and infanticide. Maori history is not well documented. The earliest visitors to New Zealand were explorers, sealers, whalers, and traders whose dealings with the Maoris were fragmentary. Those who ventured inland remained for only short periods of time and were handicapped by their limited knowledge of the language. The missionaries came to spread the Christian gospel rather than to depict the society of the day in a written record. Those Europeans who recorded Maori attitudes did so from the knowledge which they gained of the tribe with which they lived or as they interpreted the life style of the Maori people from impressions they formed in reliance on the memories of elders. These difficulties of recording traditional attitudes are reflected in the writings of modern historians who differ widely in the opinions which they express.

THE FAMILY IN HISTORICAL TIMES

Most writers are in agreement that sexual freedom was allowed to both men and women until marriage when strict fidelity was demanded. Little value was placed on virginity. Sexual intercourse was not regarded as being wrong but, once a woman was married, adultery was regarded as a social offence, punished sometimes by the death of the woman concerned. One historian records that a great stigma attached to the children of an adulterous union.

Practices Relating to Children

Adoption

Maori adoptions were the result of Maori custom and were made to ensure the retention of children in the family group to preserve their tribal identity, their succession to land, and the handing down of tribal rites.

Abortion and Infanticide

There is a range of views expressed on the practices of abortion and infanticide in pre-European times. The majority of writers agree that abortion and infanticide were carried out, but the extent or degree of these practices gives rise to much speculation.

Early historical and medical writings of Pollock (1838 and 1840), Deiffenbach (1843), Thomson (1859), Tuke (1863), Bell (1890), Goldie (1899 and 1904), Best (1906 and 1924), and Buck (1955) maintain that abortion and infanticide were practised in pre-European and early European times. Rout (1925) holds that abortion was considered sinful and that sacred legend strictly forbade the practice and decreed that destruction of new life must never occur. Gluckman (1971) expresses the view that there were anthropological reasons which acted as a powerful deterrent against induced abortion so that it was only rarely practised in early New Zealand.

THE FAMILY IN CONTEMPORARY SOCIETY

The Maori Purposes Act 1951 requires that every marriage to which a Maori is a party shall be solemnised in the same manner, and that its validity shall be determined by the same law, as if each of the parties was a non-Maori. The most comprehensive and recent studies of Maori families were carried out in the 1960s.

The Effects of Urbanisation

The traditional structure of the Maori family has altered in recent years. The major factor which has influenced this change is urban migration. This started with the movement of Maori women to the cities and towns during World War II to work in factories while the men went to war. By the time of the 1971 census, 70.2 percent of the Maori population had moved into urban areas. Urbanisation has promoted greater social contact for the Maori and has led to the adoption of many of the social attitudes of the European. In the cities the nuclear family is the most common type of household. Households may consist of the immediate family group or even a three generation family, including parents of the householder or his wife or one or more married children with spouse(s) and children.

The Role of the Extended Family

The extended family, once a feature of Maori life, ensured that no child in the Maori community was ever unwanted. It was spoken for before birth and treated with the same love within the family of adoption as were

the natural children. Urbanisation has affected the role of the extended family. It is still widely regarded as the ideal but, at least in the cities, it is no longer the reality that it once was. We were asked by the New Zealand Association of Social Workers to accept with caution any submission that there are not, or are not likely to be, any unwanted and therefore neglected, Maori or Pacific Island children in the community. It was the experience of many of the members of the Association that, in city families especially, parents in lower income groups were becoming more reluctant to assume responsibility for the children of unmarried daughters. The same trend, it was said, may become evident with the passage of time with Pacific Island families.

MAORI FERTILITY PATTERNS

Over the past twenty years there have been considerable changes in Maori population patterns. Between the years 1945 and 1966 the Maori population has more than doubled. The relevant figures are: 1945 census 98,744; 1956 census 137,151; 1961 census 167,086; 1966 census 201,159.

The average annual increase in the Maori population up until 1961 was 4.0 percent. The increase declined to 3.8 percent in 1966 and 2.5 percent in 1971. Maori family size also dropped from an average of 6.19 in 1962 to 3.55 in 1975. Various reasons have been advanced for this decline in the size of the Maori family:

1. Urbanisation, with consequent exposure to non-Maori influences, has resulted in a change in traditional attitudes and values.
2. Contraceptive advice available through the opening of family planning clinics in areas with a high proportion of Maori and Polynesian residents is now more readily accepted.

Contraception

The attitudes of Maoris and Pacific Islanders towards contraception is not easy to assess. Many are reticent about expressing an opinion on such a topic, especially if that opinion appears different from traditional concepts of family size and male and female roles in society.

We were told that some Maoris regard family planning as unnatural in that the Maori male, believing that he is threatened by social and economic changes, feels a need to prove his dominance by having a large family which he regards as wealth and a symbol of his authority in the home. There was also reference to Pacific Island women who encounter strong opposition to the use of contraceptives, it being the husband's belief that the wife's most important role is to bear children. Both Maori and Pacific Island women have in the past been less inclined than Europeans to plan their pregnancies or to discuss contraception with their husbands or medical practitioners. We heard evidence that some Maori and Pacific Island women bitterly resent having contraceptive advice offered to them in obstetric hospitals. It is fair to say, however, that the weight of the evidence tendered to us suggested that an increasing number of Maori and Pacific Island women are anxious to learn about contraception to enable them to space their families and to offer their children better

opportunities. There is now a greater attendance by Maoris at hospital and family planning clinics although this attendance differs according to the location of the clinic. Women attend in greater numbers at the outer suburban clinics than at those in the inner city and the choice may well be determined by transport facilities. Information leaflets in Island languages are becoming available on all forms of contraception including natural family planning. More single Maori girls now seek contraceptive advice.

Sterilisation

The attitudes of Maoris and Pacific Islanders towards sterilisation are consistent with their attitudes towards contraception. They have less knowledge of sterilisation procedures than European women, and resentment has been felt towards the European staff of hospitals who have invaded the privacy of maternity patients with unwanted contraceptive advice and advice about sterilisation. This criticism was levelled more sharply against those who pressured women into sterilisation without displaying an awareness that these women might not fully understand the nature of the procedure. As we have previously stated, this criticism would be largely overcome if obstetric clinics, to which a significant proportion of Maori and Pacific Island patients are admitted, were to employ Maori or Island social workers to discuss sterilisation and contraception with the patients.

Abortion

Submissions were made to us by several church leaders that abortion runs counter to Maori and Pacific Island philosophy and holds no solution to their physical, financial, or social problems. On the evidence available to us it would seem that there has been little open discussion on abortion by men or women although figures supplied by the Auckland Medical Aid Trust classify, in the first year of operation of the Centre, 11.4 percent of the patients presenting for abortion as either Maoris or Pacific Islanders. In the second year of operation the percentage had increased to 12.4. It would seem that, as Maoris become urbanised, the sophistication of European society is accepted by them, and although their attitudes to abortion are more conservative than those of Europeans, they are becoming more closely identified with them. The attitudes of Pacific Islanders are more conservative, and there is no evidence available to us which would suggest that there has been any measurable change.

WELFARE SERVICES FOR MAORIS AND PACIFIC ISLANDERS

Welfare services are available to all New Zealanders through the Department of Social Welfare, the Department of Health, and the Department of Education. In addition to these services, there exists a general welfare programme provided by the Department of Maori and Island Affairs. The Maori Affairs Department, through the activities of its Social Services Division, helps individuals and families who are experiencing difficulties in their social and economic environment.

However, welfare officers do not concern themselves particularly with the subject of family planning nor do they receive special training in this subject. Welfare officers in the Pacific Island section are male and on this account may tend to be reticent about the matter. If requests for assistance in this area are made, the officers will refer them on for consideration. The Maori and Island Affairs Department provides counselling but does not provide financial assistance to unmarried pregnant women whom it refers to the Department of Social Welfare or voluntary agencies.

Adoption

There are now no restrictions on adoptions by race. Maoris may now adopt European children and Europeans may adopt Maori children. The Maori and Island Affairs Department has jurisdiction in matters of adoption where all concerned are Maoris in accordance with the statutory definition, where the child and one of the intending adoptive parents of the child concerned are Maoris, and in other cases referred to the Department by Registrars of the Magistrate's Court.

We are unable to obtain from the Department of Social Welfare or the Department of Maori and Island Affairs figures as to the numbers of adoptions handled by the Department of Maori and Island Affairs. Apparently comprehensive statistics on the racial background of adopted children are not kept in New Zealand, and the official adoption statistics do not classify children by race. It is known, however, that Maori children born ex-nuptially are much less likely to be placed for adoption than European ex-nuptial children. Table 31 gives details of the percentages of children born ex-nuptially placed for adoption in 1970.

Table 31—Placement Arrangement Made For Ex-nuptial Children Born in 1970

Placement Arrangement	Race of Child			
	European %	Maori %	Other %	Total %
Placed for Adoption ...	43	10	18	32
Living with Mother ...	30	31	37	31
Living with both parents (Co-habiting)	18	44	32	25
Living in other situation ...	9	15	13	12
Totals	100	100	100	100

Source: Department of Social Welfare.

This table reveals that 10 percent of Maori ex-nuptial children were placed for adoption compared with more than 40 percent of European children. The Department of Social Welfare reports that, since 1970, there have been changes in the pattern of placement arrangements made for ex-nuptial children. Of all ex-nuptial children, 32 percent were placed for adoption in 1970 but by 1975 this figure had fallen to 17 percent.

PACIFIC ISLANDERS

The census figures between 1961 and 1971 show that the Pacific Island population in New Zealand rose from 14,340 to 45,413. It is estimated that at 31 March 1976 there were 79,000 Pacific Islanders living in New Zealand. Of these, approximately 45 to 50 percent live in the Auckland area. Very few Pacific Islanders made submissions to us. Some who did so suggested that in New Zealand, where Islanders are exposed to entirely different cultural, social, and economic values, the concept of the extended family is most important, ex-nuptial children being welcomed into the group and solo mothers cared for. The church remains a focal point for many Island families and its moral guidance is appreciated. There, young people are taught that sex before marriage is wrong, that sons are expected to treat girls with the respect they would afford their sisters, and abortion is rejected.

We have in the course of other chapters referred to the special position of Maori and Pacific Island women and the need to take account of their particular circumstances.

RECOMMENDATION

That Maori and Pacific Island social and community workers be encouraged to participate in family planning courses to enable them to assist in hospitals, clinics, and health centres, particularly in areas where there is a concentration of Maori and Pacific Island groups.

Chapter 20
OPINION POLLS AND SURVEYS

During the course of its hearings, the Commission was referred to many surveys and opinion polls conducted since the late 1960s in an endeavour to ascertain the attitudes to abortion of various professional groups and of the public and to gauge public opinion on the desirability of amending the abortion laws. It is difficult to analyse these surveys and to interpret their findings correctly. The news media have sometimes compounded this difficulty by only partially reporting the results of a particular survey. It is not possible, within the compass of this report, to discuss in detail each one of the polls or surveys mentioned to us in evidence. Those which we have studied but do not review in this chapter include those conducted by the following organisations:

Association of Anglican Women, Christchurch.
Dunedin Collective for Women, 1975.
Eden Electorate Survey, 1975.
General Practitioner Society, 1974-1975.
Levine Survey, Massey University, 1975.
New Plymouth Women's Action Group, 1975.
Nurses Reform Association, 1974.
N.Z. Federation of Business and Professional Women's Clubs, 1975.
N.Z. Federation of University Women, 1974.
N.Z. Medical Students, 1975.
N.Z. Medical Women, 1975.
Rotaract, 1975.
Society for Research on Women, 1975.
United Nations Association of New Zealand, Christchurch Branch, 1971.
Y.W.C.A., 1975.

We propose to discuss within this chapter the results of some surveys which we consider give an indication of both public and medical opinion. Where information which we considered to be necessary for the proper evaluation of a particular survey was not apparent from the submissions or evidence we took steps to obtain it from those who had conducted the survey. We also obtained expert advice to enable us to assess both the methodology used in the surveys and the validity of any conclusions reached.

The responses made to surveys and polls have commonly been advanced as an indication either of the measure of public support for existing laws or for suggested reforms to those laws. In our opinion, however, their value has been limited in some cases by faults in methodology or in interpreting the responses made to the questions asked.

t is to be remembered that even where the methodology is sound and the esponses to the questions are correctly interpreted a survey or opinion oll cannot express in any exact way what public opinion is upon a articular matter. Results can be expressed only in terms of a probability ased on the responses of the random sample of the public whose opinions re sought. It is difficult to know whether the opinions expressed on these ssues are based on an adequate knowledge of the relevant facts or a full ppreciation of the issues involved.

The surveys and polls which we propose to examine in this chapter are s follows:

PUBLIC OPINION POLLS

Nationwide

1. National Research Bureau Surveys, 1972, 1974, 1976.
2. Heylen Polls, 1970, 1973, 1975, 1976.
3. Political Research Bureau, 1974.

Local

1. Gemming and Crighton Survey, Auckland, 1972-1973.
2. University of Waikato Opinion Survey, Tokoroa, 1975.
3. National Organisation of Women Survey, Porirua, 1972.

National Organisations

National Council of Women Survey, 1975.

MEDICAL OPINION POLLS

1. Veale Survey, Department of Community Medicine, Auckland, 1975.
2. Gregson and Irwin, 1971.
3. Royal College of Obstetricians and Gynaecologists, 1975.
4. Australian and New Zealand College of Psychiatrists, 1975.
5. Auckland Faculty of the New Zealand College of General Practitioners, 1975.

PUBLIC OPINION POLLS

NATIONWIDE

1. National Research Bureau Surveys, 1972, 1974, 1976

In 1972 and 1974, the research division of the National Research Bureau Consulting Group Ltd conducted surveys of a sample of 1,200 males and 1,200 females, 15 years of age and over, selected throughout New Zealand by a multi-stage random probability method. A similar survey was conducted in May 1976 of 2,400 New Zealanders, 15 years of age and over, selected by a multi-stage random probability method and spread throughout the country proportionately to the spread of

population. Table 32 sets out the answers obtained in each of the three years in which the surveys were conducted to the question: "Under which of the following circumstances, if any, do you think an abortion should be legally allowed?"

Table 32—National Research Bureau Surveys—1972, 1974, 1976

	1976 %	1974 %	1972 %
Life of mother endangered by pregnancy ...	82.4	80.0	79.0
Pregnancy result of a criminal act	76.4	74.0	n.a.
Mother's physical health endangered by pregnancy	71.6	70.6	71.5
Birth would probably result in a seriously deformed child...	71.6	69.4	70.8
Mother's living conditions would not support another child	40.4	38.5	41.8
Mother's mental health endangered by pregnancy	64.9	64.6	65.2
Pregnancy result of contraceptive failure ...	27.1	25.9	n.a.
Woman and her doctor agree within first 12 weeks of pregnancy	60.7	n.a.	n.a.
Woman and her doctor decide it would be advisable not to continue pregnancy ...	53.6	61.8	65.0
Mother under 16 years of age	45.7	39.1	43.2
Husband gives his consent	28.3	26.7	35.8
Always legal within the first 12 weeks of pregnancy	31.5	n.a.	n.a.
Always legal under any circumstances ...	18.2	15.6	24.9
Never legal under any circumstances ...	7.2	10.5	13.9

The maximum statistical sampling error on any result is±2%.

The main points to be made from this survey are:

1. In each of the three years the least support shown for each of the three circumstances now recognised as legal grounds for abortion (threat to the life of the mother, danger to physical health, and danger to mental health) was 64 percent of the respondents.

2. In each of the three years, support for abortion on particular grounds was as follows:

(1) "Pregnancy result of a criminal act" (1974 and 1976 only)—not less than 74 percent.

(2) "Birth would probably result in a seriously deformed child"—not less than 69 percent.

(3) "Woman and her doctor decide that it would be advisable not to continue pregnancy"—decline from 65 percent in 1972 to 53.6 percent in 1976.

3. Only a minority accepted as grounds for legal abortion the mother's living conditions, her youth, pregnancy arising from contraceptive failure, and husband giving his consent.

4. There was a decline between 1972 and 1976 in the proportions holding extremist views either for or against legal abortion under any circumstances.

In 1976 a new ground was added to the questionnaire, namely, "Woman and her doctor agree within first 12 weeks of pregnancy" Abortion on this ground was supported by 60.7 percent of respondents. It should be noted, however, in assessing the weight to be given to the response to this question that, in the same year, only 53.6 percent of respondents supported the ground "Woman and her doctor decide it would be advisable not to continue pregnancy", and even fewer (31.5 percent) supported the ground "Always legal within the first 12 weeks of pregnancy". The low percentage of support for this last ground would suggest that a high proportion of the 60.7 percent who supported abortion on the basis "Woman and her doctor agree within first 12 weeks of pregnancy" treated the ground as containing some medical factor. Only this interpretation would explain the substantial differences in levels of response.

Sub-groups

There were differences in the responses by various groups within the survey. It was found that males and young respondents (under 35 years of age) tended to be more liberal than females and older respondents (55 years of age and over). Those with no religious affiliations were the strongest supporters of liberalisation while, among the various denominations, the most liberal were the Anglicans, and the most conservative the Roman Catholics. Residents in the North Island (and Auckland City in particular) were found to be more liberal than the South Island residents (especially those in Dunedin City)

Methodology

Response rates to the 1972 and 1974 surveys were high. The samples employed would appear to be genuine national samples and the selection procedure to have been satisfactory.

2. The Heylen Polls

In 1970, 1973, 1975, and 1976, polls were conducted by the Heylen Research Centre, an independent agency conducting social and opinion research. The polls were conducted on the basis of a nationwide random probability sample of 1,000 persons in 1970 and 1976 and 2,000 persons in the polls of 1973 and 1975. Table 33 sets out the question asked in the poll with responses in the respective years.

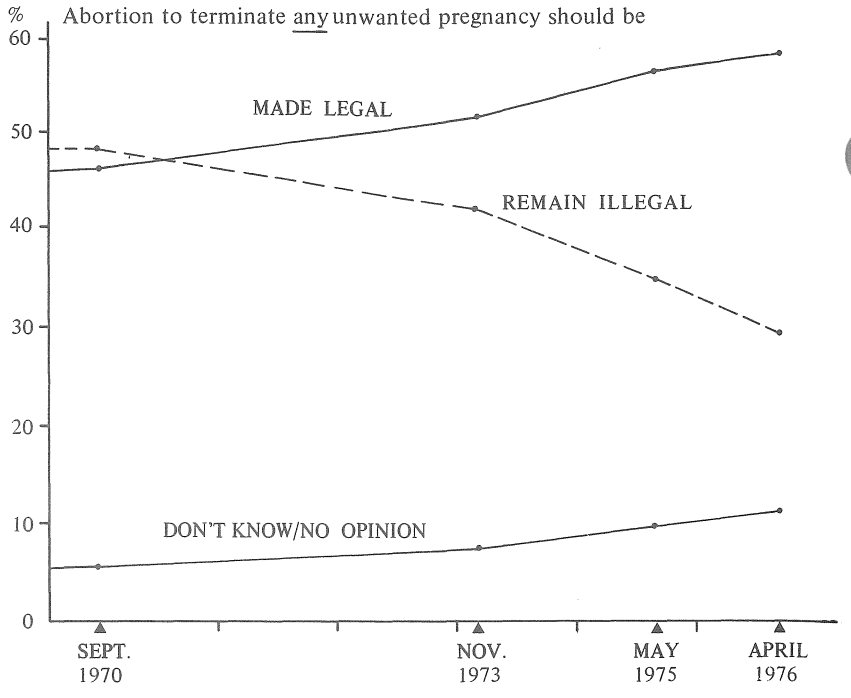
Table 33—Heylen Research Centre Polls—1970, 1973, 1975, 1976

Question: In your opinion, should abortion to terminate *any* unwanted pregnancy be made legal, or should it remain illegal?

	September 1970	November 1973	May 1975	April 1976
Made legal	46.8	50.9	55.9	60.5
Remain illegal ...	47.7	41.8	34.3	29.0
Don't know/No opinion	5.5	7.3	9.8	10.5

Table 34 is a pictorial representation of the responses to the poll over the respective years.

Table 34—Heylen Research Centre Polls—1970, 1973, 1975, 1976



The responses to the poll indicate:

1. The percentage favouring legalisation of abortion moved upward between 1970 and 1976.

2. Those in the "Don't know/No opinion" category increased from 5.5 percent in 1972 to 10.5 percent in 1976.

3. The poll revealed differences in attitudes to abortion within subgroups. The population of the northern North Island appeared to be more liberal than the population of the South Island; younger people (15-39 years) appeared more liberal than older people (over 40 years); younger females appeared to be slightly more liberal than younger males; among older people, men appeared to be more liberal in their attitude than women.

We have had some difficulty in ascertaining the exact methodology which was employed by those conducting the poll. The poll itself is subject to the criticism that, in a single and somewhat imprecisely worded question, it sought to ascertain public opinion on a complicated matter of great sensitivity. The form of the question, "In your opinion, should abortion to terminate any unwanted pregnancy be made legal, or should it remain illegal?", may have conveyed to respondents the impression that

abortion for any unwanted pregnancy at all was at present illegal whereas this is not the case.

3. Political Research Bureau, 1973

The Political Research Bureau, between February and September 1973, surveyed 21 Parliamentary electorates from Henderson to Invercargill. One hundred volunteers were engaged to carry out the survey. The electorates were chosen on a deliberate basis to reflect the political and social composition of the country. Within each electorate, sample blocks were balanced to reflect as closely as possible the social composition of the electorate. The selection of the final points of delivery to households was left uncontrolled in the hands of the caller to whom each block was allocated. Within each block the choice of respondents was left at random. We are told that callers generally operated outside of the areas personally known to them. Of the 6,994 response forms handed out, 6,516 (85.54 percent) were recovered.

The results of the survey were that 59.72 percent of respondents felt that the present law on abortion met the needs of the community. To a different question, 57.35 percent replied that restrictions should not be abolished.

There are a number of criticisms to be made of this survey. It does not reveal the precise criteria for selection of electorates and sample blocks, and the interviewers, who may well have had committed views to the issues under the survey, were left entirely free to make their own selection of households, thus introducing the possibility of bias. There is, in fact, a heavy bias in the responses towards women (67.9 percent of the respondents). In addition, the statements as to the existing law contained in some of the questions were somewhat loosely phrased and may, on that account, have been misleading. These factors seriously detract from the survey as a valid scientific inquiry into public attitudes.

LOCAL

1. Gemming and Crighton Survey, Auckland, 1972-1973

This survey, which is reported in the *New Zealand Medical Journal*, April 24, 1974, at pp. 857-862, was made of a random probability sample of 578 women, aged 16 to 55 years, throughout Greater Auckland. It was conducted between November 1972 and February 1973. Table 35 sets out the responses to the various grounds suggested as a basis for legal abortion.

The results of the survey were that a substantial majority supported legal abortion for danger to the life of the mother, for danger to her physical health, for danger to her mental health, for incest, and for fetal defect. Abortion was supported by 68.7 percent "Where the woman and her doctor decide it to be advisable not to continue with the pregnancy". It would appear, however, from the degree of support indicated for other grounds, that some of those comprising the 68.7 percent who favoured abortion where the woman and her doctor decided it to be advisable not to continue with the pregnancy did so on some medical basis.

Table 35—Gemming and Crighton Survey 1972–1973

Supported grounds for legal abortion

Circumstances	% (N = 574)
1. Always legal under any circumstances	31.5
2. Never legal under any circumstances	8.1
3. The life of the mother is endangered by the pregnancy* ...	83.1
4. Pregnancy is the result of incest	64.9
5. The mother's physical health is endangered by the pregnancy*	75.6
6. Birth would probably result in a seriously deformed child	75.8
7. The mother's living conditions would not support another child	53.6
8. The mother is unmarried	40.4
9. The mother's mental health is endangered by the pregnancy*	73.0
10. Pregnancy is a result of rape	76.9
11. Where the woman and her doctor decide it to be advisable not to continue the pregnancy	68.7
12. The mother is under 16 years of age	53.3
13. Husband gives his consent	41.6

*Ground considered permissible for legal abortion under New Zealand law.

Sub-groups

The responses to the survey revealed differences of viewpoint between various groups of respondents. Those holding the most conservative views were the women (a) over 34 years of age, (b) of Polynesian racial stock, (c) of the Roman Catholic religion and other respondents who considered that their religious beliefs had a major bearing on their attitudes.

Methodology

The sample selection appears to be sound and the age and religious affiliation of the sample members matches the general Central Auckland population fairly well. However, the percentage estimates for individual groups of ethnic origin and religious affiliation are subject to large sampling errors in many cases and cannot be considered as reliable. Otherwise the survey appears to be of a generally satisfactory standard although a possible bias through non-response should be taken into account.

2. University of Waikato Opinion Survey, Tokoroa, 1975

In April and May 1975, the School of Social Sciences, University of Waikato, supervised a survey in Tokoroa of 293 persons of whom 63 percent were female. This was conducted on a multiple random choice basis. The survey was organised by three local women and the surveyors were members of political groups. Table 36 sets out the questions relating to the grounds of abortion.

Table 36—University of Waikato Opinion Survey, Tokoroa, 1975

1. Under which of the following circumstances, if any, do you think an abortion should be legally allowed?

	Yes		No		No Response	
	N	%	N	%	N	%
A. The life of the mother is endangered by pregnancy	263	89.76	26	8.87	4	1.37
B. The pregnancy was the result of a criminal act (e.g., rape, incest) ...	232	79.18	47	16.04	14	4.78
C. The mother's physical health is endangered by the pregnancy ...	237	80.89	48	16.38	8	2.73
D. Birth would probably result in a seriously deformed child	232	79.18	44	15.02	17	5.80
E. The mother's living conditions would not support another child	114	38.91	159	54.27	20	6.83
F. The mother's mental health is endangered by the pregnancy ...	220	75.09	64	21.84	9	3.07
G. The pregnancy was the result of contraceptive failure	86	29.35	189	64.51	18	6.14
H. Where a woman and her doctor decide that it would be advisable not to continue the pregnancy	187	63.82	92	31.40	14	4.78
I. The mother is under 16 years of age	120	40.96	153	52.22	20	6.83
J. If the husband gives his consent	100	34.13	169	57.68	24	8.19
K. Always legal under any circumstances	61	20.82	214	73.04	18	6.14
L. Never legal under any circumstances	60	20.48	192	65.53	41	13.99

While 63.82 percent of the respondents thought that abortion should be lawful "Where a woman and her doctor decided that it would be advisable not to continue with the pregnancy", we note that only 20.82 percent were in favour of abortion being "Always legal under any circumstances"

Methodology

No provision was made in the questionnaire for those who were uncertain in their attitude. The use of members of three political parties as interviewers in a survey which included a question relating to the result of the 1975 election is unsatisfactory.

3. National Organisation of Women Survey, Porirua, 1972

In 1972, the National Organisation of Women conducted a survey in the Porirua electorate of 643 female voters chosen by random selection of the houses in which they lived. Fourteen questions were asked of respondents. The survey revealed that 83 percent of the women interviewed agreed that abortion should be legal if the woman and her doctor agreed and that 80 percent were in favour of social conditions being taken into account in the making of the abortion decision. The sample size is relatively small and, in view of this and the lack of methodological data, it would be unsafe to interpret the results as being true of all New Zealand women.

National Council of Women Survey, 1975

In 1975 the National Council of Women conducted a survey of Council delegates and of societies affiliated to the Council. Replies were received from 666 delegates. The questions asked of delegates and the numbers who responded to each question are set out in Table 37.

Table 37—National Council of Women Survey, 1975 (666 Replies)

GROUNDS ON WHICH ABORTION SHOULD BE LEGALLY PERMITTED

(a) In no circumstances	105
(b) If there is serious threat to the health of the pregnant woman (e.g., heart disease, asthma, kidney disease, high blood pressure)	555
(c) If there is a serious threat to the psychological health of the pregnant woman	481
(d) In the case of a mentally retarded pregnant woman ...	509
(e) In the case of an insane pregnant woman	507
(f) If there is a serious threat to the health of the foetus (e.g., Downs Syndrome, German Measles, use of drugs) ...	499
(g) If the pregnancy is the result of rape	515
(h) If the pregnancy is the result of incest	500
(i) If the stability of the family is threatened because of:	
(1) the number of other children	278
(2) serious financial problems	231
(3) family psychological problems	291
(4) age of pregnant woman	257
(5) others—please specify Few answered this part of the question, and where they did so, numbers were not given. However the most commonly suggested grounds, supplied by the few who did answer, were: failed contraception, marriage instability or marriage breakdown, and hereditary factors. (Other reasons, none of which was cited more than twice, were unwanted pregnancy, drunkenness or drug addiction, previous child bashing, criminal conviction, and unsatisfactory obstetrical history.)	
(j) Very young pregnant girl—please specify age ... ... (The ages specified ranged from "under 18" to "under 11", with the one occurring most frequently being "under 16")	329
(k) Pregnant girl or woman without husband	131
(l) On request...	88

The results of this survey show that a large majority supported abortion on medical grounds, including health, rape, incest, and defective fetus, but that less than one-half supported abortion for socio-economic grounds. Only 88 (12 percent) considered abortion should be legal on request.

MEDICAL OPINION POLLS

1. Veale Survey, Department of Community Medicine, Auckland, 1975

In 1975 a postal survey of all registered medical practitioners registered in New Zealand was conducted by Professor A. M. O. Veale of Auckland. Replies were received from 3,064 (78 percent) of those to whom questionnaire forms were sent. Table 38 sets out the questions which were asked in the survey.

Table 38—Veale Survey, Department of Community Medicine, Auckland, 1975

Question 1: Have you ever had a patient for whom you felt termination of pregnancy was desirable, but not legally allowed under the present law?

Question 2: Have you ever referred a patient for assessment for termination of pregnancy to:

(a) Public hospital.
(b) Private hospital or specialist.
(c) Australian doctor or clinic.
(d) Auckland Medical Aid Centre.

Question 3: Do you feel the present law pertaining to abortion (as set out in clauses 182–187 of the Crimes Act 1961) is clear?

Question 4: Do you think abortion should be illegal no matter what the circumstances (physical, mental, social etc.)?

Question 5: Do you think that the "Termination Committee" system of public hospitals is a satisfactory way of making decisions concerning patients requesting pregnancy termination?

Question 6: Do you believe that abortions should be performed only in public hospitals?

Question 7: Do you think abortion should be legally allowed:

(a) When there is an increased risk that the child at birth would be physically or mentally abnormal.
(b) When the woman's physical health is endangered.
(c) When the woman's mental health is endangered.
(d) When the pregnancy is the result of a criminal act, e.g., rape or incest.
(e) When the continuing pregnancy would cause extreme social or economic hardship.
(f) When the woman and two doctors consider it desirable.
(g) When the woman and her doctor consider it desirable.
(h) When the woman requests it.

Table 39 sets out the answers to each of the questions asked.

This survey revealed high levels of support for (a) fetal abnormality, (b) woman's physical health, (c) woman's mental health, (d) where pregnancy was the result of a criminal act. Of the doctors replying to the questionnaire, 53.5 percent considered it undesirable for the abortion decision to be made solely by the woman and her doctor; 72.9 percent of all doctors (75.1 percent of general practitioners only) considered that the decision should be made by two doctors; 77.3 percent were against abortion on request.

Table 39—Veale Survey, Department of Community Medicine, Auckland, 1975

Question	All Medical Practitioners			General Practitioners Only		
	Yes	No	NA*	Yes	No	NA*
I ...	57.9	37.3	4.8	76.6	21.5	1.9
II (a) ...	52.3	39.7	8.0	74.3	20.6	5.1
(b) ...	45.0	44.3	10.7	71.7	20.7	7.1
(c) ...	20.5	64.8	14.7	36.9	50.7	12.4
(d) ...	20.4	65.0	14.6	39.4	49.7	10.8
III ...	28.9	59.5	11.6	31.7	60.3	7.9
IV ...	3.8	93.6	2.6	4.0	94.4	1.1
V ...	22.9	53.5	23.7	21.5	58.9	19.6
VI ...	18.2	74.9	6.9	17.5	77.3	5.2
VII (a) ...	81.8	10.7	7.5	83.5	11.3	5.1
(b) ...	91.4	2.2	6.4	92.2	3.2	4.7
(c) ...	86.2	6.7	7.2	88.0	6.5	5.5
(d) ...	87.8	5.7	6.4	89.4	5.8	4.8
(e) ...	68.8	24.1	7.2	71.3	23.6	5.1
(f) ...	72.9	19.2	7.9	75.1	18.8	6.1
(g) ...	38.6	53.5	7.9	41.4	52.1	6.5
(h) ...	15.1	77.3	7.6	15.0	79.3	5.8

*No answer, incorrectly answered or not sure of answer.

2. Gregson and Irwin, 1971

In late 1969 and early 1970, a postal survey was conducted in New Zealand by Professor R. A. M. Gregson and Dr Janet Irwin. Replies were received from 1,726 medical practitioners. Table 40 sets out the questions relating to the grounds on which abortion should be legal, together with the percentages of answers.

In addition to the grounds of preservation of life, serious danger to physical health, and serious danger to mental health, the majority of those replying to the survey were in favour of abortion where the pregnancy was (a) the result of incest, (b) where there was a significant probability of a mentally or physically defective child, (c) where the mother was intellectually handicapped. Less than 40 percent supported each of the two grounds relating to abortion on request.

3. Royal College of Obstetricians and Gynaecologists, 1975

In August 1975, a survey of the members of the Royal College of Obstetricians and Gynaecologists was conducted, and the results were analysed by the Department of Health. Of the 130 members of the College, 91 replied, giving a response rate of 76 percent. Over 60 percent of respondents had no strong objections to the termination of pregnancy on religious or other grounds. The overwhelming majority (over 90 percent) did not favour abortion on request; 83.7 percent accepted abortion on the grounds of malformation of the fetus; 81.8 percent for rape; 81.8 percent for incest; 52.6 percent for under-age pregnancy; 38.3 percent on socio-economic grounds.

Table 40—Gregson and Irwin Survey, 1971

Frequency of answers, as percentages, to each possible ground for therapeutic termination as worded in the questionnaire

Grounds as Stated	Y.	Q.Y.	N.	Q.N.	Believed Legal
1. When the life of the mother is in danger?	88.6	6.3	3.5	0.9	90.9
2. When the physical health of the mother might be impaired?	64.0	21.5	11.4	2.5	64.0
3. When there is a significant risk that the mental or emotional health of the mother might be jeopardised?	60.4	22.6	12.5	3.6	63.4
4. When there is a significant risk that the child would be born mentally or physically defective?	59.7	17.9	17.3	4.2	27.9
5. When pregnancy results from rape or incest of a girl under 16 years of age?	73.6	12.9	9.9	2.7	29.1
6. When pregnancy results from rape or incest of a girl over 16 years of age?	60.4	20.4	13.7	4.6	15.4
7. When requested by a single woman?	12.3	21.9	54.1	10.9	2.0
8. When requested by a married woman?	11.8	25.2	51.4	10.2	1.6
9. When the economic circumstances of the mother's home life make a limit on her family size desirable?	23.7	20.6	45.8	8.8	2.8
10. When the mother is intellectually handicapped?	43.2	26.5	21.7	7.6	10.4
11. Only with the consent of the husband in the case of a married woman?	38.7	21.3	30.9	6.0	8.1

Y. means "Yes"; Q.Y. means "Qualified Yes"; N. means "No"; etc.

4. The Australian and New Zealand College of Psychiatrists, 1975

In 1975 a survey of the opinions of members of the College of Psychiatrists was conducted. Fifty-three (56.9 percent) of the total of 93 members replied.

The results reveal that the majority of psychiatrists who replied to the questionnaire (94 percent) considered that doctors should be free to exercise their professional judgment on the abortion decision and 72

percent agreed that abortion was important for the prevention of mental ill-health; 94 percent were in agreement with abortion where the woman was unable to cope with more children; 80 percent thought that abortion should be legal within the first twelve weeks provided that adequate counselling was carried out.

5. Auckland Faculty of New Zealand College of General Practitioners, 1975

In August 1975 a survey of the opinions of 140 members of the College was conducted, and 112 (80 percent) replied. Of the respondents, 71 (62.3 percent) had no religious or moral objection to abortion, contraception, or sterilisation; 41 (35.6 percent) had objections.

The results indicated that the majority were not in favour of abortion on demand but favoured a modification of the law for a more liberal interpretation on the grounds of the health of the mother. Lack of methodological data makes the validity of this survey difficult to determine.

Chapter 21
TECHNIQUES OF ABORTION

METHODS

There are a number of methods by which abortions can be induced. Some of them are now of historical interest only. In the course of this chapter we discuss only those techniques that are recognised as being medically acceptable and make no comment on the many other methods which have been used by criminal abortionists.

It will be convenient to list methods currently used for the termination of pregnancy under the following headings:

FIRST TRIMESTER METHODS (UP TO 12 WEEKS' GESTATION)

(1) Dilatation and Curettage
(2) Vacuum Aspiration
(3) Menstrual Regulation

SECOND TRIMESTER METHODS (OVER 12 WEEKS' GESTATION)

(1) Stimulation of Uterine Contractions; by
    (a) Hypertonic Solutions
    (b) Intra-uterine paste, saline, or dye
    (c) Laminaria Tents
    (d) Prostaglandins
(2) Major Surgical Procedures
    (a) Hysterotomy
    (b) Hysterectomy

THIRD TRIMESTER METHODS (OVER 24 WEEKS' GESTATION)

(a) Prostaglandins
(b) Hysterotomy
(c) Hysterectomy

FIRST TRIMESTER METHODS

Dilatation and Curettage (D. and C.)

After the cervical canal has been dilated under general anaesthesia by the insertion of a series of metal dilators of gradually increasing size, an

instrument is passed into the uterus to remove the embryo or fetus. Any material then remaining is removed from the uterine cavity by a curette. The degree of dilatation becomes greater as the pregnancy advances. After 12 weeks the technical difficulties and risks accompanying the adoption of this procedure are such that most gynaecologists use other methods.

Vacuum Aspiration (Suction or Uterine Aspiration)

This method was first described in China in January 1958 and was accepted in the United Kingdom and the United States of America in 1966. After the cervical canal has been dilated, the contents of the uterus are evacuated through a hollow plastic or metal cannula to which a pump has been attached. The method is quicker than dilatation and curettage, and blood loss is reduced. This technique is used at the Auckland Medical Aid Centre. It has the advantage over other techniques that patients may be treated on a day care basis and may be allowed home within a few hours of the operation.

Menstrual Regulation

This technique is closely allied to vacuum aspiration but differs from it in two main respects:

(a) It is performed within two weeks after a missed menstrual period.

(b) It is performed before a test confirming pregnancy has been carried out.

In chapter 4 we discuss this technique as a possible contraceptive measure and in chapter 23 we comment adversely on its use as such.

SECOND TRIMESTER METHODS

Stimulation of uterine contractions

Hypertonic Solutions

When this technique is used, a needle is inserted under local anaesthesia through the abdominal wall, the uterine wall, and then into the amniotic fluid surrounding the fetus. The fluid is aspirated and replaced by a solution of salt or urea. This causes the death of the fetus within a matter of a few hours although the fetus is not expelled until 24 to 30 hours after the injection of the solution. The process can be accelerated by an injection of oxytocin (a hormone which produces uterine contractions). The mechanism by which the abortion is produced is not fully understood but the action is thought to be twofold. The uterus is stimulated into contractions and the placenta is damaged. Some form of pain relief is necessary. The technique is usually limited to the sixteenth week of pregnancy and onwards but is not always successful. Where it fails, the method may be attempted again, or abortion may be procured either by the administration of prostaglandins or by hysterotomy.

Intra-uterine Paste, Saline, or Dye

Under these methods, an intra-uterine paste, saline, or a dye called Rivanol is injected into the uterus by means of a cannula inserted through the cervical canal. It enters the area between the decidual tissue lining the inner surface of the uterine muscle and the fetal membranes. Abortion is thought to be induced partly by the stimulation of the uterine muscle and partly by damage to the placenta.

Laminaria Tents

Laminaria is a marine plant the dried stems of which expand in the presence of moisture. It is used to procure abortion after the fourteenth week of pregnancy. Several "tents" are inserted into the cervical canal under general anaesthetic and left for 24 hours. As they expand they gradually dilate the cervix. Under a subsequent general anaesthetic, when further dilatation may be performed, the products of conception are removed by forceps and curette. In Japan a variation of this technique is practised but it is not in use in New Zealand.

Prostaglandins

Although the first report on the action of prostaglandins was published in 1930, it was not until 1972 that they were used to induce abortion. Prostaglandins are compounds found in the tissues of many species, including man, which have a stimulating effect on smooth muscles causing them to contract. They can be administered in the form of an intra-amniotic injection without the prior withdrawal of amniotic fluid. They cause powerful contractions of the uterus and the ultimate expulsion of the fetus and placenta. Prostaglandins have now begun to replace hypertonic saline solution for the termination of second trimester pregnancy because they have fewer side effects. However, vomiting and diarrhoea may follow this procedure, and, despite their efficacy, their use is not without complications. The fetus is usually born dead.

Major Surgical Procedures

Hysterotomy

Hysterotomy is in essence a caesarian section performed before the fetus is viable. An entry is made through a lower abdominal incision under general anaesthesia. The pregnant uterus is opened and its contents removed. Major complications may follow the use of this method in that, although the wound heals, the area tends subsequently to be weaker than the rest of the uterus and may rupture if there is a further pregnancy.

Hysterectomy

Hysterectomy is a procedure which involves the removal of the uterus, including the fetus, but not the ovaries. It will be more likely to be selected as a technique of abortion when the object of the operation is to remove the uterus because of fibroid tumours or other pathological conditions in addition to the termination of the pregnancy. Hysterectomy may be performed vaginally although this is most unusual.

THIRD TRIMESTER METHODS

Prostaglandins

While prostaglandins may be used to induce abortion at any stage of pregnancy, including the third trimester, in practice they are used only in the second trimester.

Hysterotomy

This method may be used in the third trimester.

Hysterectomy

This method may be used in the third trimester.

Chapter 22

MEDICAL AND PSYCHIATRIC SEQUELAE OF ABORTION

With the development of new techniques and the use of modern drugs, medical and psychiatric complications and deaths resulting from induced abortion have declined in the past thirty years to the point where, in the majority of cases, abortions carried out by medical personnel in a hospital are no longer fraught with grave risks to life or health. Notwithstanding these advances, however, complications still occur and sometimes prove fatal.

Abortion may also have an effect on the mental health of the woman concerned, causing depression, anxiety, distress, and regret. These sequelae may be transient or long lasting. In this chapter we consider the effects of abortion on the physical and mental health of women.

NEED FOR CAUTION IN CONSIDERING STATISTICAL MATERIAL

It is important to adopt a cautious approach when considering statistical material relevant to the consequences of abortion, particularly those statistics relating to rates of morbidity. There are good reasons for this:

1. Induced abortions, even when carried out in hospitals, have so often been surrounded by secrecy that their associated complications have not always been recorded.

2. There is no yardstick against which the severity of complications can be measured. Indeed, it is fair to say that whether a complication is regarded as minor or otherwise may often depend on the doctor concerned. Whether he chooses to record or report a classification is a matter very largely for him.

This point has been made in the annual reports of the Mallen Committee in South Australia. The committee on several occasions has complained that medical practitioners have not reported complications resulting from abortion even though the patients concerned were known to have been admitted to teaching hospitals suffering from significant complications.

3. Complication rates may vary according to whether the abortion is performed in or out of hospital and whether it is performed legally or illegally. Other factors are the skill of the person performing the operation, the duration of the pregnancy, the number of prior pregnancies and abortions, the age of the woman, the presence or absence of concurrent sterilisation, and the state of medical care in the country in which the abortion is carried out.

In examining the sequelae of abortion we propose to examine the

mortality rate, morbidity (rates of complications, short and long-term), and the likelihood of psychological effects.

MORTALITY RATES

Every surgical procedure and every interference with the processes of nature involves some risk to life or health. Abortion is no exception. The risks associated with it depend on the particular procedure adopted and other factors which we will discuss.

Table 41 sets out the number of deaths resulting from abortion in a number of developed countries, expressed per 100,000 legal abortions performed.

Table 41—Mortality Ratios Per 100,000 Abortions in Selected Countries

Country	Years	Rate
Canada	1970–73	4.8
U.S.A.	1972–73	3.4
England and Wales	1973	9.1 (maximum estimate)
Czechoslovakia	1967–72	1.9
Denmark	1967–74	4.2
Hungary	1968–73	0.8
Sweden	1964–74	5.1

Source: Induced Abortion: 1975 Fact Book (Tietze and Murstein).

Because of the size of the population, abortions in New Zealand have not been carried out in numbers sufficient to provide a valid basis of comparison with the countries mentioned in this table. Between 1968 and 1974 only six deaths resulting from abortion were reported in New Zealand. Two of these occurred in 1968 and one in each of the years 1969, 1970, 1972, and 1974. The live births in each of these years were as follows: 1968, 62,112; 1969, 62,360; 1970, 62,050; 1971, 64,460; 1972, 63,215; 1973, 60,727; 1974, 59,336.

Factors Influencing Mortality Ratios

Gestation

One of the difficulties in comparing the ratio of abortion deaths to abortions performed in different countries is caused by the differences in the stage of gestation at which abortions are carried out. The later in pregnancy an abortion is performed, the greater is the risk to life. The small number of deaths in New Zealand makes it impossible to assess the significance of gestation in relation to mortality ratios, but regard may be had to information available from overseas.

In England and Wales, between 1968 and 1973, the mortality ratio per 100,000 abortions carried out at 12 weeks' gestation or less was 7.2, as against 24 where the abortion was carried out at 13 weeks' gestation or more. In the United States of America in 1972 and 1973, the mortality ratio for abortions carried out at 8 weeks' gestation or less was 0.4 per 100,000 abortions, increasing to 1.5 at 9-10 weeks' gestation, 3.8 at 11-12 weeks, 6.2 at 13-15 weeks, and 17 at 16 weeks or more.

Age

The risk to life is also associated with the age of the woman whose abortion is induced. In England and Wales between 1968 and 1973, the mortality ratio for 100,000 abortions carried out on women 29 years of age and under was 6.5, but for those 30 years of age and over, it was 21.

Sterilisation

Sterilisation is sometimes carried out at the same time as abortion. Where this is done the risk to life is increased. In England and Wales, between 1968 and 1973, the mortality ratio per 100,000 abortions carried out at under 12 weeks' gestation where sterilisation was not concurrently performed was 2.75; where sterilisation was performed at the same time, the mortality ratio increased to 4.7. The mortality ratio per 100,000 abortions performed in excess of 12 weeks' gestation was 25 where sterilisation was not concurrently performed and 61 when it was.

Technique

The method used to induce abortion is another factor of which account must be taken in comparing ratios of abortion mortality. The choice of an appropriate technique may itself depend on the stage of gestation at which the abortion is performed. In England and Wales, between 1968 and 1973, the mortality ratios per 100,000 women on whom abortions were performed, classified according to the technique adopted, were as follows:

Suction	12 weeks or less	2.5
Suction	13 weeks or more	11.0
Surgical Curettage	12 weeks or less	3.4
Surgical Curettage	13 weeks or more	5.7
Abdominal Hysterotomy (without sterilisation)		20.0
Abdominal Hysterotomy (with sterilisation)		63.0
Saline		60.0
Pastes		80.0
Hysterectomy		100.0

Statistics available from the United States of America for the years 1972 to 1973 do not differentiate between the stages of gestation at which abortions were performed, but the mortality rates per 100,000 abortions are as follows: Surgical Curettage 1.5; Suction 1.5; Saline 16.0; Hysterotomy and Hysterectomy 53.0.

We have been informed by the New Zealand Maternal Deaths Assessment Committee that the two deaths which occurred in 1972 and 1974 in New Zealand following upon abortions here were the result of hysterotomy operations performed late in pregnancy and at a stage involving far more risk than would have been the case if they had been carried out earlier.

If any generalisation is to be made from a consideration of the material referred to above, it is that, although the risks to life from abortion carried out in a hospital may in all the circumstances be minimal, these risks should not be discounted. They should not, therefore, be regarded lightly.

Comparison with Maternal Mortality Rates

It is sometimes said that there is less risk to the life of a pregnant woman from induced abortion than from a pregnancy carried to term. Where abortions are performed by competent operators in sterile surroundings during the first trimester, this is true as the figures available from England and Wales indicate. In 1973, in those countries, the maternal mortality rate per 100,000 abortions was 9.1. The corresponding mortality rate per 100,000 live births was 11 *(Induced Abortion: 1975 Fact Book)*. The same comparison would appear to be valid in the United States. In that country in 1973, the mortality ratio per 100,000 abortions performed was 3.2 for all stages of gestation, but the maternal mortality rate per 100,000 live births was 15.2, made up of 10.7 for whites, 34.6 for negroes and others (American Information Service 1976).

For the reasons already given, it is not possible to make a comparison with the New Zealand figures per 100,000 abortions. It is possible, however, to make a comparison with the maternal mortality rates of other countries. The maternal mortality rate per 1,000 live births in New Zealand was 0.24 in 1973, 0.17 in 1974, and 0.23 in 1975. Projected to a level of 100,000 live births, the figures in those years would be 24, 17, and 23.

MORBIDITY

Apart from the risk to life from induced abortion, there are a number of risks to health from complications of varying severity which may result. These are of two kinds, early and late. Early complications are those which occur within a month after induced abortion. Late complications are those occurring after that time. Early complications may again be further divided into those which are immediate in the sense of occurring either during the procedure or within a few hours following it, and delayed complications which develop after that time.

Early Complications

Immediate Complications

Immediate complications of a serious nature include perforation of the uterus or injury to other organs caused by one of the instruments used to induce the abortion; major haemorrhage (defined as blood loss necessitating blood transfusion of more than 500 mls, or as blood loss causing significant anaemia); laceration of the cervix; severe disturbances of blood clotting, or excessive amounts of salt in the blood (resulting from saline induced abortion); water intoxication resulting from the use of high doses of oxytocin; and untoward effects of general or local anaesthesia. Fortunately complications of this kind are not common.

Delayed Complications

The most common types of delayed complications include retention of fragments of the placenta (resulting in bleeding continuing after abortion); infection, which may be localised as mild inflammation of the lining of the uterus, or widespread, extending to the tubes (salpingitis), or ovaries (oophoritis), or, most seriously, may cause peritonitis (infection of the abdominal walls), or septicaemia (blood poisoning). Thrombophlebitis (inflammation of the wall of a vein) may also occur. This may lead to a blood clot in the lungs with a possible fatal outcome.

Milder forms of infection can be successfully treated by antibiotics, though these are less effective if septicaemia is more extensive.

Late Complications

1. Known late complications include sensitisation of women with the blood type Rh negative to a fetus with Rh positive blood. This complication may occur when some of the blood of the fetus passes into the mother during an induced abortion causing her to produce antibodies by way of defence against the fetal blood. As a result, should the woman become pregnant in the future, her body will reject a fetus with Rh positive blood. This result may, however, be prevented by the injection of Rh immune globulin, provided that the condition is first recognised.

2. Scar tissue may form in the wall of the uterus following hysterotomy, resulting in tearing or bursting of the uterus in future pregnancies.

3. Some investigators think that there may be an increase in the risk of premature birth and early death of an infant and of spontaneous abortion in the second trimester in subsequent pregnancies due to a combination of damage to the cervix at dilatation and a weakening of the uterine wall through over-vigorous curettage in an early pregnancy. This is, however, challenged by other investigators. The World Health Organisation is at present conducting research into these complications, but to date no definitive conclusions have been reached.

Relative Risks of Abortion Techniques

There are a number of factors which make the assessment of the risks attaching to the various techniques of abortion a difficult task. Some techniques are used mainly or exclusively during the early months of gestation when the fetus and surrounding tissue are very small in size. Where the fetus is small the risks are much less than in later pregnancy when the fetus and related tissue are much bigger. Even where similar techniques are used at similar stages of gestation, it may be difficult to make comparisons between rates of complication assessed in one area or institution and those assessed in another, because of the absence of any uniform criteria by which complications are measured and recorded.

The lack of consistent criteria for the measurement of complications, compounded by the effects of bias on the part of the individual investigator, make certain studies difficult to evaluate. A further difficulty

arises in the assessment of long-term complications because some women who were part of an original survey become lost to the investigators and the full assessment of long-term complications is thereby made difficult, if not impossible.

In our endeavour to assess the complications of abortion we have studied many research papers from overseas countries as well as the very small amount of information that is available within New Zealand. From these the following comments may be made:

1. Complication rates following upon abortion increase steadily at about 15 weeks' gestation and onward.
2. Complication rates during the second trimester of pregnancy are three to four times as high as corresponding rates during the first trimester.
3. Complication rates are lowest for abortions carried out by the suction aspiration technique, followed in ascending order by surgical curettage, injection of hypertonic saline solution, hysterotomy, and hysterectomy.
4. Total complication rates for suction aspiration increase with the period of gestation and are about twice as high at fifteen weeks or more as at 7-8 weeks.
5. The risk of complications is considerably increased when abortion is combined with tubal sterilisation by surgical incision. It is not known whether the combined complication rates for abortion and tubal sterilisation performed separately with an interval of several weeks are lower or higher than those following concurrent operations.
6. Total complication rates increase with age and parity in the second trimester. In the first trimester there is no association with parity, and there is a slight downward trend with age.
7. The risk of post-abortion complications, particularly major complications, is higher for women with known pre-existing complications than for apparently healthy women.

Within New Zealand, as we have already pointed out, statistical information on the rates of complications following upon abortion is limited. The Commission has, however, had access to information made available by the Auckland Medical Aid Trust, a study by Dr M. H. A. Baird entitled "Morbidity of Therapeutic Abortion in Auckland" (N.Z.M.J., 9 June 1976, p. 395) and some information made available to us from the Christchurch Women's Hospital.

Complications at Auckland Medical Aid Centre

The Trust supplied us with the figures on complication rates following upon abortions performed at the Auckland Medical Aid Centre. These rates were assessed after an analysis was made of the first 567 patients on whom abortions were performed at the Centre between 17 May 1974 and 1 October 1974.

In order to assess the rates of complications, the Trust sent to all doctors who had referred patients to the Centre a questionnaire seeking

information as to whether patients had had any one of a number of specified complications often associated with abortion. We are informed that all the referring doctors to whom this questionnaire was sent replied to it, some by telephone. Each doctor was asked:

(1) Have you seen or heard about your patient post-operatively—yes/no?
(2) Indicate and comment if your patient has had any of the above listed complications.
(3) Are you satisfied with the services provided by the Centre for your patient—yes/no?
(4) Any general comments?

Table 42 sets out details of the replies received.

Table 42—Medical Practitioner Replies on Complications: Auckland Medical Aid Centre

	Number Of Patients	Doctor Satisfied re Patient Treatment			Doctor's Comments	
		Yes	No	No Answer	Positive	Negative
Not seen	64	42	...	22	3	...
Complications ...	34	27	3	4	6	2
No complications ...	469	449	...	20	134	6
Total	567	518	3	46	143	8

The Trust states that complications were reported in some 34 cases, or in 5.8 percent of the 567 women aborted. Table 43 sets out details of the specific complications as reported by the Trust.

Table 43—Complications Reported Following Abortions, Auckland Medical Aid Centre

	Number	Percentage	Admitted Hospital	Treated by GP
Perforated uterus ...	3	0.5	3	...
Other injury	...	...	...	...
Haemorrhage	4	0.7	1	3
Pelvic infection	17	3.0	5	12
Haemorrhage and infection	5	0.9	3	2
Fever only	2	0.3	1	1
Psychiatric	2	0.3	...	2
Other	1*	...	...	1
Total	34	5.8	13	21

* Deep vein thrombosis.

We note that the complication rate for first trimester abortions reported by the Joint Programme for the Study of Abortion, mentioned by Tietze, C., and Dawson, *Induced Abortion: A Fact Book*, Reports on Population/Family Planning, 14 December 1973, was 7.8 percent. Complications arising from abortions carried out at the Auckland

Medical Aid Centre on 26 women who were subsequently admitted to National Women's Hospital were reviewed by Dr M. A. H. Baird, Tutor Specialist, National Women's Hospital, in the *New Zealand Medical Journal*, 9 June 1976, pp. 395-399. The number of admissions represents 1.4 percent of the total number of 1,874 women whose pregnancies were terminated at the Centre in the first year of its operation. Two further women were admitted to Middlemore Hospital. Dr Baird records that no women were admitted to any other Auckland Hospital Board institution. There is no information available as to whether patients whose pregnancies had been terminated at the Centre were admitted to other hospitals in New Zealand but an inquiry made by us reveals that about fifteen women suffering from complications following abortion were admitted to one hospital elsewhere in New Zealand in the year ended 24 June 1976. It is impossible to say how many of these had been patients at the Centre.

Dr Baird has compared the 26 cases of women admitted with complications following on abortions performed at the Centre with the cases of 17 women who had similar complications following on abortions at National Women's Hospital. As Dr Baird has pointed out, the results are not comparable because of the number of second trimester abortions carried out at National Women's Hospital. However, he concludes that vacuum aspiration under paracervical block, as practised at the Centre, carries a low complication rate and the practice at the Centre appears to be satisfactory by world standards.

Before leaving this topic, we note that it is often said that the earlier an abortion is performed, the less the likelihood of complications arising, and that an abortion performed in the first trimester may be accompanied by fewer risks to the pregnant woman than childbirth. While this is true, it should also be said that there are some who have been inclined to minimise the risks. It was this fact which resulted in the publication of an article entitled, "Legal Abortion: Critical Assessment of its Risks", the *Lancet*, 4 December 1971, pp. 1245-1249, by Sir John Stallworthy, Professor of Obstetrics and Gynaecology, University of Oxford, and Drs A. S. Moolgaoker and J. J. Walsh, two registrars at the United Oxford Hospitals. In the article they wrote:

> The morbidity and fatal potential of criminal abortion is accepted widely, while at the same time the public is misled into believing that legal abortion is a trivial incident, even a lunch-hour procedure, which can be used as a mere extension of contraceptive practice. There has been almost a conspiracy of silence in declaring its risks.

Professor Stallworthy and his two colleagues, in the article referred to, examined the cases of 1,182 patients whose pregnancies were terminated at varying stages of gestation at Oxford under the National Health Service. They record a higher rate of complication than the other rates recorded earlier in this chapter. We are not in a position to evaluate the various studies but, in view of the eminence of Sir John and the very comprehensive nature of the study which led to the article in the *Lancet*, we set out in Table 44 the complications recorded in this particular piece of research.

Table 44—Immediate and Early Complications Following Legal Abortion in 1182 Patients

	D & C: vac. asp.*		Pharmacological		Hysterotomy		Hysterectomy		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
No. of Patients	812		194		70		106		1182	
Complications:										
Haemorrhage 500 ml ...	141	17.0	36	18.6	10	14.5	10	9.4	197	16.7
Blood-Transfusion ...	69	8.5	13	6.7	13	18.8	17	16.0	112	9.5
Cervical laceration ...	39	4.8	3	1.5	...	...	...	...	42	4.2
Uterine perforation ...	14	1.7	...	...	...	...	...	...	14	1.2
Laparotomy	6	0.7	...	...	...	...	...	...	6	0.5
Further evacuation ...	42	5.0	86	44.3	2	2.8	...	...	130	11.0
Pyrexia	124	15.0	68	35.0	30	43.0	89	84.0	321	27.0
Peritonitis	6	0.7	4	2.1	1	1.4	2	1.9	14	1.2
Septicaemia	3	0.37	...	...	2	2.9	1	0.9	6	0.5
Pelvic Inflammatory Disease	20	2.5	3	1.5	1	1.4	...	...	24	2.0
Urinary Tract infection...	12	1.5	...	...	4	5.7	16	15.1	32	2.7
Deep-vein Thrombosis ...	8	1.0	...	...	...	...	4	3.8	12	1.0
Continuous bleeding ...	78	9.6	15	7.7	3	4.3	...	...	96	9.0
Readmission to hospital	27	3.3	13	6.7	2	2.9	3	2.8	45	4.0

* Dilatation and curettage, vacuum aspiration.

Source: *Legal Abortion—A Critical Assessment of its Risks—1971,* by Stallworthy, Moolgaoker and Walsh.

PSYCHIATRIC SEQUELAE OF INDUCED ABORTION

A great deal has been said and written upon the psychiatric effects of induced abortion. In spite of a number of overseas studies on the topic conducted mainly in England, the United States of America, and Sweden, little comparable research appears to have been undertaken in New Zealand, and there is a general inadequacy of objective information on the subject.

Some writers claim that the majority of women experience few or no emotionally adverse results following upon induced abortion. There are others who maintain that severe mental consequences to the woman concerned are, if not frequent, certainly not uncommon. Pare and Raven (U.K. 1970), in a follow-up of patients referred for termination of pregnancy, reported that, of 128 women whose pregnancies were terminated on psychiatric grounds, only two regretted the operation, although 17 experienced mild guilt for longer than three months. On the other hand M. Sim, *Guide to Psychiatry*, 1974, reported that of those who did have an adverse result the outlook was far worse than would have been the case if they had carried the pregnancy to term.

Main Reasons for Psychiatric Sequelae

In view of reservations which we have expressed in this report regarding the purpose, methodology, and validity of the inferences drawn from various studies, we think it advisable to outline the main points for which there appears to be a preponderance of evidence rather than to rely on individual studies. These are:

1. There appears to be general agreement among most writers that women with pre-existing psychiatric histories are more likely to experience difficulties following upon induced abortion than those without psychiatric disturbance.
2. There is general agreement that those pressured into abortion by families and social factors, those who are not firmly decided in favour of abortion, and those whose pregnancies have been terminated for strictly medical indications are more likely to manifest psychiatric problems after induced abortion than others.
3. Whether a woman experiences relief or regret following upon abortion will depend upon the stage of gestation, the type of operation, and social factors of the kind referred to later in this chapter.
4. The psychological sequelae may be less in the woman whose pregnancy is terminated in the early weeks. If hysterotomy is used or some other procedure adopted in later pregnancy, a different degree of stress may be expected, probably because as pregnancy progresses the unborn child has a greater significance to the pregnant woman than it would have in the very early stages of pregnancy.

Social Climate in the Community

Whether a pregnant woman feels guilt following upon an abortion may depend to some extent upon whether abortion is regarded with disfavour in the community at large.

Marital Status

Married and unmarried women may differ in their reaction to abortion. Some studies would indicate that single girls who are aborted following promiscuity rarely show regret, but a girl who conceives a child to a man whom she loves is more likely to suffer remorse after abortion. Women whose marriages are stable may experience feelings of regret more than those who are involved in marital disharmony.

Support

Whether a woman or girl has support following upon an induced abortion or whether she is left alone may determine the extent to which she feels regret and feelings of self-punishment.

Attitudes of Hospital and Medical Personnel

Whether a woman receives sympathy and kindness or suffers hostility from doctors and other hospital personnel at the time the abortion is induced may determine whether or not she feels guilt.

CONCLUSION

Although the majority of women whose pregnancies are terminated may suffer some emotional reaction, in general they do not experience clinically adverse results, and only a minority suffer severe disturbance. Where there is a history of psychiatric illness there is a greater likelihood that severe disturbance may follow the abortion.

Chapter 23
CONSEQUENCES OF ABORTION REFUSED

There is little information available in New Zealand either of the subsequent histories of women who have been refused abortions or of children who may be born to them, and it is not possible to assess the number of women who, in fact, are refused in any one year. Some hospitals keep no records of women whose applications have been refused. Of those institutions where records are kept, only the Auckland Medical Aid Centre has attempted a follow-up of the women who have been refused abortion. In this chapter we examine the effects of the refusal of abortion on the pregnant woman and on any child subsequently born to her.

CONSEQUENCES FOR THE WOMAN

There are several ways in which a woman who has been refused an abortion may act. She may seek to obtain an abortion at another institution; she may seek an illegal abortion (from non-medical persons outside a hospital) or attempt to abort herself; she may travel to Australia in an endeavour to have her pregnancy terminated there; or she may continue with the pregnancy, in which event she may elect to keep the child or to have it adopted.

We have not been made aware of whether women refused abortion in one geographical area have sought or been able to obtain abortions in another area, or whether, having been declined in one hospital, they have been able to obtain abortions in another. We think it probable, however, that some women who have been declined in an institution which for technical reasons cannot perform abortions either at a particular stage in pregnancy or where there are certain medical contra-indications have sought and obtained abortions in hospitals which can provide a full range of services. There is no information available from which an inference can be drawn as to the number of women who, having been refused, have subsequently obtained illegal abortions.

The Auckland Medical Aid Trust has given us information on a follow-up of 253 women living in the Auckland area who were refused abortion at the Auckland Medical Aid Centre in its first year of operation.

Table 45 sets out the reasons for which these women were refused abortion at the Auckland Medical Aid Centre and details of what happened to them afterwards.

Table 45—Patients Denied Abortion—Auckland Medical Aid Centre, 1974–75

Reason for Denial	Number	Abortion Public Hospital	Abortion NZ Private Hospital	Abortion Australia	Kept Infant	Infant Adopted	Miscarried	Not Traced
Pregnancy too far advanced ...	106	4	30	36	22	4	...	10
Insufficient legal grounds ...	66	2	18	16	13	4	2	11
Changed mind	54	...	4	4	26	...	8	12
Medical contra-indications ...	'9	2	2	...	...	...	3	2
Not pregnant	18	...	...	...	...	...	...	...
Total	253	8 (3.1%)	54 (21.3%)	56 (22.1%)	61 (24.1%)	8 (3.2%)	13 (5.1%)	35 (13.8%)

It is clear from the table that not all of the 118 who obtained abortion either in public and private hospitals or in Australia had been denied abortion at the Centre for insufficient legal grounds, because, of the 253 refused abortion there, only 66 were refused on that basis. Of the total of 253 women refused, 18 were not pregnant and 54 changed their minds. It was not possible to perform abortions at the Auckland Medical Aid Centre on 115 of the other 181, either because they were beyond 12 weeks' gestation, or because there were medical contra-indications. It was possible to perform abortions on some of them at public hospitals where second trimester methods were in use or medical skills which could cope with the medical contra-indications were available. It can, however, be said that, of the 66 women who are recorded as having been refused abortion at the Auckland Medical Aid Centre on the basis of insufficient legal grounds, 36 demonstrated a determination to obtain one subsequently at a public or private hospital or in Australia.

From the submissions made to us and the evidence which we have heard, it would seem that a woman who is determined to obtain an abortion will pursue her purpose, particularly where she is unmarried or not living in a stable relationship.

Abortions in Australia

In chapter 11 we refer to the difficulties of estimating the number of women travelling to Australia for abortions and point out that some who travel there may do so for reasons other than their inability for legal reasons to obtain abortions in this country, e.g., a desire to preserve complete confidentiality.

Suicide

Women who are refused abortion sometimes threaten suicide. The evidence would, however, suggest that few ever resort to it. There is virtually no evidence in New Zealand as to the risk of suicide following upon the refusal of abortion. There are studies in Sweden which suggest that suicide following upon the refusal of abortion is rare, and in Australia, Whitlock and Edwards have pointed out that suicides which follow the refusal of abortion are usually the result of other factors. The most comprehensive survey carried out was that of Barno in Minnesota (1967) where, at the time of the study, there was a suicide rate among females of the same order as that of New Zealand. Barno found that there was one suicide for 93,000 live births; that 75 percent of these suicides occurred during the post-partum state; that 100 percent of the women who died had been seriously psychiatrically ill, but that only 30 percent had seen a psychiatrist and none had requested abortion. In Australia, Whitlock and Edwards (1968), after an extensive epidemiological investigation of suicide, were unable to find a pregnant woman who had taken her life.

Suicide during pregnancy therefore appears to be extremely rare. The instances of suicide after induced abortion appears to be low, but reliable figures from which comparisons may be made with the incidence of suicide following abortion or refusal of abortion are unavailable.

Continuation with Pregnancy

There are so many factors, some very personal, which cause the individual to react in varying ways that it is quite impossible to be precise when considering what effects, if any, the refusal of an abortion will have on a pregnant woman. The matter is one which has been the subject of many studies made overseas. Hook (Sweden 1963) studied the cases of 249 women who had been refused abortions in 1948. Of these, 86 percent went to term and 14 percent did not. Eleven percent of the 249 women were known to have had illegal abortions. Of the 86 percent who went to term, 60 percent had originally kept the children, but some years later when the second follow-up was conducted, only 59 percent still had their children with them. A few of the children had died. At a follow-up, twelve years after refusal, it was found that 73 percent were satisfied with their situation and that about a quarter had adjusted poorly to refusal.

Aren and Amark (Sweden 1961) examined the cases of 195 women whose application for legal abortion had actually been granted although the operation had not been carried out, the procedure having been refused either by the woman (in 50 percent of the cases) or by the gynaecologist. Of the 142 who kept their babies, 131 (94 percent) were satisfied with having given birth to the child and appeared to have a positive maternal attitude toward it.

In a follow-up study of 321 patients who had been referred for termination of pregnancy, Pare and Raven (U.K. 1970) found that termination of pregnancy caused little psychiatric disturbance provided the patient wanted an abortion but that continuation of the pregnancy occasionally led to serious psychiatric disability and a third of the mothers who kept their babies showed signs of resenting them.

Emery and Lavin (U.K. 1973) studied the cases of 203 pregnant women who had been referred for a psychiatric opinion regarding termination. They reported that the overall results after a termination were significantly better than those after completion of a pregnancy but that obsessional women, and to a lesser degree women who had been predisposed to mental illness, were most likely to develop sequelae of a serious kind after either outcome.

A study by Horobin (1973) of 370 Aberdeen women suggested that the actual number who suffered severe distress from either abortion or from continuing with an unwanted pregnancy was small and that the incidence of depression in their series did not differ significantly between aborted and non-aborted groups although regrets about continuing the pregnancy were more common than regrets about abortion.

It would appear that the majority of women who are unsuccessful in obtaining abortions do not suffer from clinically adverse results although the condition of a significant minority is worse. The risks of unhappiness and continued resentment are present. A great deal seems to rest on whether a woman refused abortion receives support, help, and comfort following on the refusal. If this is not forthcoming the symptoms of stress which are present may increase and she may develop a long-standing resentment.

CONSEQUENCES FOR THE CHILD

The argument for liberalisation of the abortion laws is often advanced upon the ground that it is undesirable to bring into the world the child of an unwanted pregnancy who will be the victim of neglect and abuse and will drift into delinquency. A number of submissions to this effect were made to us.

It is important to define at the outset what is meant by an unwanted pregnancy. We understand an unwanted pregnancy to be one where the pregnant woman did not desire, at the time she conceived, to have a child. An unplanned pregnancy may result in an unwanted pregnancy, but this is not necessarily so. Some women who have not planned a pregnancy will accept it willingly, particularly as it advances towards term. It is to be remembered, too, that an unwanted pregnancy does not inevitably result in an unwanted child. Having initially regarded the birth of a child with some disfavour, a pregnant woman may, as she proceeds to term, often come to accept the birth and treat the child, when born, with love and affection. A married woman living in a harmonious relationship is more likely than an unmarried woman to accept the child of her pregnancy which was originally unwanted. We heard evidence from a number of women who had been refused abortion. Some expressed unfeigned relief at having been refused and gave every indication of leading contented lives. In sharp contrast, others who had been refused told us that they continued to entertain regrets and feelings of resentment towards children they had not wished to bear.

Where abortion is refused, the child who is subsequently born may become a member of a family, may be adopted, or may be brought up by a solo mother. Those who strongly advocated abortion claimed that the unwanted child faced the prospect of becoming the subject of abuse and that adoption was an unsatisfactory procedure.

Child Abuse

The term "child abuse" is a general one referring to all forms of maltreatment of children. It may take the form of passive neglect or "baby-battering", a term coined by an American paediatrician, Henry Kempe, in 1962. It is a matter of regret that cases of battered children both in this country and overseas are not uncommon. The Department of Social Welfare was unable to provide us with any information as to the number of battered children who had been placed under its care. A special survey would be necessary to determine such numbers and the circumstances which gave rise to their being placed within departmental institutions or foster homes.

In an endeavour to ascertain whether any link can be established between unwantedness and child abuse, we have examined a number of studies in which the causes of child abuse have been considered. The literature is inconclusive on the point. Fontana (U.S.A. 1971) found that 88 percent of physically abused children were either the first or the last in the family, suggesting that the child was an unwanted addition to existing family numbers. A study by S. M. Smith *et al.* (Birmingham

1975) suggested that the following factors were likely to increase the incidence of child abuse:

1. The youth of the parents at the time of pregnancy.
2. The fact that the child had been conceived premaritally.
3. The unhappy childhood of the parents, contributing to their current social isolation and marital disharmony.
4. The existence of an attitude of rejection of the child by the parents preceding the battering.

Further studies which suggest a link between unwantedness and battering are those of Zalba (1966), Wasserman (1967), Bennie *et al.* (U.S.A. 1969). There are, however, studies which suggest that there is no relationship between unwantedness and child abuse. Kempe has suggested that parents who abuse their children can be shown frequently to have had some kind of disastrous rearing experience when they themselves were small. Jobling has also supported this view, and has found that battered babies themselves grow up to batter their own babies.

Lenoski (U.S.A.), after examining 712 cases of child abuse between April 1966 and January 1973, concluded that 91 percent of the child abusers had themselves wanted the child and that this was so in 63 percent of 500 families whose children had not been abused. In reaching his conclusions, Lenoski had adopted, as indications of wantedness, the time in pregnancy at which the mother first wore maternity clothes and the frequency with which the child was named after one or other parent. Helfar (U.S.A. 1968) also reported a high degree of wantedness of the children as an integral part of the setting for child abuse.

Experience in England, where the Abortion Act 1967 provided for liberalisation of the abortion laws, does not suggest that the introduction of more permissive abortion laws will necessarily result in a reduction in child abuse. Linklater, in an article in the *Spectator*, 10 August 1974, wrote: "In 1964, 420 babies in Britain were deliberately and severely injured by their parents. Last year this figure had risen to 4,600 over 12 months, of whom 580 died and 400 suffered permanent brain damage."

The number of abortions performed in Britain in 1964 can only be the subject of an estimate but it is known that between 1969 and 1973 the number of abortions performed in England and Wales rose from approximately 55,000 to 166,000.

We are unable to reconcile the various studies. We consider, however, that there is no warrant for the inference that a pregnancy which, in the first trimester, is regarded as unwanted by the pregnant woman will always result in the birth of a child who will be the subject of neglect and abuse.

Adoption

Throughout the early and mid-1960s, 40 percent of all children born ex-nuptially in New Zealand were placed for adoption. From 1967 a steady decline in the number of children placed for adoption occurred, and, by 1970, the proportion of children born ex-nuptially who were placed for

adoption had declined to 34 percent. By 1972 it had further declined to 30 percent and, by 1974, to 22 percent. There has been a gradual decline in the proportion of children adopted by strangers but a steady increase in the number of children adopted by a natural parent, the parent's partner, and by relatives and friends.

The demand for babies for adoption has increased over the past decade. According to information which we have received from the Department of Social Welfare, there are at present about 3,000 couples in New Zealand waiting to adopt babies. In 1975, 2,106 babies who were born ex-nuptially were made available for adoption. The demand for babies for adoption should be kept in perspective when considering the abortion problem. In commenting on a similar situation in the United Kingdom, the Lane Committee (para.166) said: "We do not subscribe to the view that the present shortage of babies for adoption is a valid reason for refusing abortion: in our view this should not have any bearing on the working of the Abortion Act. If a woman has grounds for the abortion she desires, she ought not be debarred from obtaining it in order that other people may benefit from her child bearing. There is of course no reason why her attention should not be drawn to the fact that if she does not wish to keep the child, suitable adoption arrangements may be made."

We entirely agree. We propose, however, to make some comments on adoption, more particularly because several submissions dealt with it as the likely outcome for the child whose mother had been refused abortion. As we have mentioned, some claimed that it was a far from satisfactory solution which resulted in a great deal of unhappiness for the natural mother, for the child, and even for the adopting parents.

There can be little doubt that almost every woman who gives up a child for adoption suffers a great deal of emotional stress which may continue well after the adoption arrangements have been finalised. In the light of the evidence presented to us, it seems that the emotional stress has at times been increased by an apparent lack of consideration for the mother on the part of the hospital authorities and others arranging the adoption. Clearly, stress cannot be entirely avoided, but it may be reduced by a more conscious attempt to treat the mother with sympathy and understanding.

Some evidence which we have heard has suggested that adoption is not a satisfactory outcome in that adopted children are over-represented in psychiatric institutions. While statistically this is probably true, it was said in one submission that we received that there are a number of reasons why adoption of itself should not be regarded as the cause of this over-representation. These include:

1. There is a higher rate of prematurity associated with unmarried status with the result that more babies who are candidates for adoption are likely to have been exposed to the hazards of prematurity.
2. Delays in placement for adoption for over three months still occur.
3. Adopting parents are more likely to have come from middle or upper class backgrounds and, on that account, will be more inclined than the parents of natural children to avail themselves of special child guidance facilities when any behavioural problems in the child occur.

A report of the Research Unit to the Joint Committee on Young Offenders (1969) in New Zealand reveals that, in general, children who have been adopted have come to the notice of the Department of Social Welfare less frequently than would be expected on the basis of the overall composition of the child population. The research also revealed:

1. Adopted girls are more likely to appear in the Children's Court charged with offences or on complaints of misdemeanour than would be expected on the basis of the composition of the child population, but the same is not true of adopted boys who are slightly less likely to appear in Court charged with offences than other boys in the population.
2. Adopted children (both boys and girls) are markedly unrepresented in populations of children appearing in the Children's Courts on complaints of neglect, indigence, and parental inadequacy.
3. The proportion of state wards who are adopted is somewhat lower than would be expected on the basis of estimates of numbers of adopted children in the overall child population.

It seems to us that there is a great need for careful assessment of adopting parents and instruction as to what is required of them to bring up children successfully. Family counselling services deal with problems arising out of the place of the adoptive child within the family. Some of these problems might not have arisen if more time had been spent with the adopting parents by the officers arranging the adoption when placements were initially considered. At present the responsibility for counselling adopting parents falls on officers of the Department of Social Welfare whose work load in other areas is such that they may be unable to give as much time as is desirable to it. We recognise that the Adoption Act 1955 places certain duties on these officers in the adoption field. We do not suggest that they should not continue to discharge them but we are of the view that the department should make increased use of, and give greater recognition to, specialised private agencies already operating in counselling the mothers of adoptive children and the adopting parents.

The Unmarried Mother

In its monograph entitled *Ex-nuptial Children and their Parents*, the Department of Social Welfare uses the term "Solo Parents" to refer to all parents who for a variety of reasons are bringing up a dependent child or dependent children without the support of a marriage partner or the father of the child. The term in that context includes widows, widowers, and deserted, separated, divorced, and unmarried parents. We are not concerned in this report with some of these categories and prefer to use the term "unmarried mother" or "single mother" so that it is clear that we are referring to children born to unmarried women who elect to rear them.

In recent years there has been a marked increase in the number of unmarried women who have elected to keep and rear their children. In 1962, 19 percent of children born ex-nuptially were retained by their mothers, but, by 1968, this had increased to 25 percent, and, by 1974, to 35 percent. The reasons for this increase are examined in the monograph and we do not propose to discuss them here.

While it is recognised that many mothers have, without the help of a husband, successfully reared children who have grown into excellent citizens, there is material which suggests that to be born ex-nuptially is to be born at a risk which may largely be reduced by subsequent adoption. Some of this material is referred to in the Social Welfare monograph. The most significant study is that conducted by Crellin, Pringle, and West (U.K. 1971) in which it was found that in almost all levels of home conditions the attainment, ability, and social and emotional adjustments of ex-nuptial children kept by their mothers were less satisfactory than those of legitimate children or ex-nuptial children who had been placed for adoption. The report also showed that the proportion of young offenders not living with both natural parents generally increased with the age of the offenders.

J. E. Jansen of the Department of Social Welfare (N.Z.) in an unpublished report entitled *Illegitimacy and Adoption related to appearance in the Children's Court and committed to the care of the Superintendent of Child Welfare* also supports the view that children from solo parent situations have a high risk of coming to the notice of the department. This study examined the incidence of children coming to the notice of the department according to whether they had been born nuptially or ex-nuptially. The main findings of the research may be summarised as follows:

1. Ex-nuptial children were over-represented in populations of both boys and girls coming before the Children's Court either charged with an offence or a complaint involving the child's behaviour. Adopted girls (but not boys) were also over-represented in such populations.

2. Ex-nuptial children were vastly over-represented in populations of both males and females appearing in the Children's Court on care and protection complaints. By contrast, adopted children (both boys and girls) were markedly under-represented in populations coming under notice for these reasons.

Research conducted by the Department of Social Welfare, based on all cases of child abuse brought to its notice, has revealed that ex-nuptial children are two or three times more likely than nuptial children to come to the notice of the department because of child abuse. The results of research in the United States and in England are to the same effect.

It is not the purpose of this report to espouse the cause of children reared in one particular situation as compared with another. But in considering the consequences of abortion refused and examining the outcomes for children born, we must comment on information which has been made available to us. It is against this background only that we have discussed the advantages and disadvantages that may ensue from adoption or the rearing of children by solo parents. The evidence that we have heard has left us with a concern for the kind of society and relationships which will best secure a stable and wholesome upbringing for children.

Chapter 24

LEGAL POLICY: WHAT SHOULD THE LAW ON ABORTION BE?

THE PLACE OF LEGISLATION IN ABORTION

Although in England since the passing of Lord Ellenborough's Act in 1803 and in New Zealand since the passing of the Offences Against the Person Act 1867 there have been laws making abortion a criminal offence, some now dispute the right of Parliament to legislate in any way against abortion except in so far as such legislation is designed to protect the health of the pregnant woman. For them abortion is at the most a moral issue in which the law has no rightful place.

In our view the law has a legitimate interest in abortion because abortion affects not only the pregnant mother whose well-being the law should safeguard, but also the unborn child for whom it should provide a measure of protection. It is clearly the right of any ordered society which places a value on human life to legislate to this end. To what extent it legislates and to what extent its legislation proscribes abortion depends on the status which it confers on the unborn child. It is that factor which will largely determine whether the legislative code is to be restrictive, moderate, or liberal. We do not consider that the right of Parliament to legislate arises only if the fetus is said to be a full human being. It exists whether the fetus is considered to be a full human being or an incipient human being. "Whether the fetus is considered to be a full human being or an incipient human being, it is 'live enough' not to be dead, not yet mature enough to be an infant, yet a human being enough to deserve protection." ("The Ethics of Fetal Research", Yale University Press).

We stress again that Parliament has the right to legislate to protect the health of the citizens of whom pregnant women are an important section.

OF WHAT MATTERS SHOULD LEGISLATION TAKE ACCOUNT?

In our view good legislation should endeavour to take account of the following factors:

1. Existing scientific and biological knowledge from which true assessments can be made of the status to be attributed to the unborn child and the dangers to the health of the mother consequent on pregnancy.
2. The views of the community to the extent that they can be ascertained. Laws which totally disregard the views of the community are likely to fall into disrepute.
3. The need to lay down in clear terms what conduct is unlawful so that those who administer the laws and those who are affected by them may know the metes and bounds of lawful conduct.

4. The desirability of encouraging people to behave responsibly.

By way of amplifying each of these factors we draw attention to the following points:

(1) In the last hundred years, mankind's knowledge of the processes by which human life begins, develops, and ends has increased enormously. It was not until the mid-nineteenth century that the sperm and ovum were identified as true cells, and it was not until the 1890s that the foundations of ante-natal care were laid. Only in the past twenty years has intra-uterine therapy of the fetus been established. The genetic uniqueness and individuality of the unborn child and the control it exerts over its environment are now accepted as scientific facts. It seems to us that it would be somewhat ironic if the protection which the law afforded to the fetus when the genesis of life was only partly understood were now to be removed or reduced.

(2) The place of public opinion polls and surveys and the weight to be accorded to them in determining the views of the public on the law of abortion have been discussed in another chapter. It will be sufficient if, at this stage, we merely draw attention to the need to treat the findings of some polls and surveys with circumspection. Where, however, it is possible to detect a clear consensus of responsible opinion, an endeavour should be made to give effect to it in legal form. We need not labour the point that a law which accords with public opinion is more likely to be observed than one which does not. There is a sharp division between the extremes of public opinion on the issue of abortion but we consider that the majority of people would support a code which lay between these extremes. The absence of agreement in the community is not, however, a factor which should dissuade Parliament from legislating. Agreement on social issues is rarely to be attained. Issues such as the sale of liquor, the sale and use of drugs, the display and sale of pornographic material may be sharply debated and widely varying opinions upon them may be held. But for all the disagreement, the law has never hesitated to legislate on these matters. Laws should not be so rigorous that only a minority of citizens willingly obey them in their entirety, nor should they be geared to the level of conduct of those whose moral standards leave much to be desired.

(3) The law should be clear. In *Murphy v. Gregory* (1959) N.Z.L.R. 868 at 871, Mr Justice Henry, in speaking of the offence of "unlawful conversion" of a motor vehicle created by section 32 of the Police Offences Act 1927, said, "It is the business of the Legislature to let its citizens know what conversions are unlawful and not to enact in effect that 'unlawful conversions' are unlawful". Those comments apply equally well to sections 183 to 186 of the Crimes Act 1961. The very fact that abortion is a crime only when it is done "unlawfully" presupposes that there are circumstances where the law recognises that

abortions may be done lawfully. The legislature should let its citizens know what acts are unlawful.

(4) In legislating for responsible behaviour, the State is faced with the problem of striking an appropriate balance between, on the one hand encouraging people to behave responsibly and accept the consequences of their own actions, and, on the other, providing a safety net for the unfortunate.

THE CODE

We move now to the specific provisions of the legislative code which we propose. In doing so we make the point that such a code should reflect the status which should be accorded to the unborn child and the points at which the rights of the unborn child must yield to the rights of the mother. It cannot be gainsaid that the decision to abort a fetus, on the least view which can be taken of the matter, extinguishes the potentiality of life and for this reason must be regarded as a most serious step. It is difficult, in some circumstances, to balance the importance of preserving that life against the health and well-being of the mother, and no perfect formula can be evolved. It is proper, however, to give greater weight to an existing life than to a potential one.

Abortion Defined

Abortion is not defined in the Crimes Act 1961 but it is referred to in sections 183 to 187 of the Crimes Act 1961 as an act done with intent to procure a miscarriage. Abortion and miscarriage are defined in most dictionaries, both ordinary and medical, as the premature expulsion of the fetus or embryo. The use of these terms presupposes implantation because it is only after that stage has been reached that the terms "embryo" and "fetus" are used. In only one dictionary, of which we are aware, namely, the *American Illustrated Medical Dictionary*, by W. A. N. Dorland, 19th Ed., is miscarriage defined as "the loss of the products of conception" from the uterus. This definition is wide enough to include the loss of the fertilised ovum after it has left the Fallopian tube and before it has implanted. It is a cardinal rule of statutory interpretation that where a criminal statute has two meanings, one of which is more favourable to the subject than the other, that meaning which is more favourable to the subject should be accepted. We think that to be consonant both with the existing law and with scientific fact the law should give its attention to any conduct which is directed at the termination of pregnancy. Such a view would be entirely consistent with the one which we have formed, as a result of the scientific evidence presented to us, and on which the opinions expressed in Chapter 20 have been formed. Only when the fertilised ovum has implanted itself as a blastula in the uterine wall does a woman's menstrual cycle cease and pregnancy commence. Before that stage is reached, it would be virtually impossible in any prosecution to prove that an act was done with intent to procure a miscarriage unless there was some evidence that there was something to miscarry.

Life-threatening Conditions

With the advances in medicine, there are now few medical conditions remaining where the continuance of the pregnancy would threaten or shorten the life of the mother. However, since Bourne's case, abortion has been accepted as lawful where the continuation of the pregnancy would threaten the actual life of the mother. It has not been suggested to us that life-threatening conditions should no longer be accepted as lawful grounds, rare though their occurrence may be. Where, therefore, there are life-threatening considerations attendant upon the continuation of the pregnancy, the unborn child should yield to the life of the mother, and abortion should be permitted as it now is.

Physical Health

We have already discussed those physical diseases which, although not life-threatening, are exacerbated by the continuance of the pregnancy. It is not for every disease or disablement that abortion should be permitted, but, in the opinion of the Commission, it should be lawful whenever the continuance of the pregnancy would result in a serious danger to the health of the pregnant woman. In this connection, reference should be made to the word "health" which is susceptible of several meanings. The traditional meaning is "soundness of body; a condition in which the functions of the body are discharged." The World Health Organisation definition, to which we have already referred, is wider. We see no real justification for adopting this definition as part of any legislative code on abortion. Very few people ever enjoy health which produces a state of physical, mental, and social well-being and the attainment of such a state is seldom present throughout pregnancy. Where a state of physical or mental health is to be recognised as a ground for abortion, health should be defined as "a condition of physical and mental soundness." We do, however, stress that it is not for every physical disease or disablement that abortion should be allowed. In our view abortion should be lawful where the continuance of the pregnancy would result in a "serious" danger to the physical health of the mother.

Mental Health

Danger to mental health has been recognised as grounds for abortion since Bourne's case. That recognition was continued in the case of *R. v. Newton and Stungo.* It is well accepted medically that in the first trimester of pregnancy women undergo biological changes as a result of which some suffer from anxiety, insomnia, and emotional outbursts. Others may not be affected in this way. It would be wrong, on the view which we have taken of the status of the unborn child, to terminate a pregnancy because of some psychological stress which was relatively short in duration or of relatively mild intensity. We would recommend that abortion should be lawful only where the continuance of the pregnancy would result in serious danger to the mental health of the woman.

We should record that, in examining various formulas to give expression to our acceptance of serious dangers to physical and mental

health as grounds for abortion, we have examined that laid down in the Abortion Act 1967 (U.K.) section 1(1) which provides that an abortion is lawful if the "continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated". A similar provision is to be found in the South Australian legislation where abortion is not unlawful if "the continuance of the pregnancy would involve greater risk to the life of the pregnant woman or greater risk of injury to the physical or mental health of the pregnant woman, or any existing children of her family, than if the pregnancy were terminated." The danger in adopting a formula of this kind was pointed out by Dr P. H. Tooley, Consultant Psychiatrist to the London Hospital, in an address entitled "If All Abortions are Legal, which are Desirable?", given on 7 February 1969 at a Symposium held by the Medical Protection Society, in collaboration with the Royal College of General Practitioners, at the Royal College of Obstetricians and Gynaecologists. He said, "I am quite sure that the legislators had no idea when they passed the Act in its present form that there could be any question of it being interpreted as providing for abortion on demand. But you must realise that the dangers associated with any pregnancy which is allowed to go to term are in fact greater than the dangers of aborting the woman in the first twelve weeks of her pregnancy. If this is the case, then the words 'the continuance of pregnancy would involve the risk to the life of the mother greater than if termination takes place', could apply to any pregnancy. In Japan a series of 15 million abortions had a mortality of between three and four per 100,000. If we could get our maternal mortality down to this figure, I am sure people would be extremely pleased and satisfied. Even our own figures in this country, which are still of course small, suggest that it is at least twice as dangerous to have a perfectly normal pregnancy as it is to have what I might call a perfectly normal abortion. So it does seem to me, willynilly, the legislature has provided grounds on which I could—legally—abort any woman who asked me, because in my view it is more dangerous for her to continue with her pregnancy than it is to have an abortion now." It is likely that considerations of this kind prompted Mr Justice Menhennitt in the Victorian case of *R. v. Davidson*, to which we have made reference, to include the words "not being the dangers of childbirth" in the modified form of the formula in Bourne's case which he there proposed as being the test for lawful abortion. In Dr Woolnough's case, both Mr Justice Richmond and Mr Justice Woodhouse said that there was no warrant for including these words as part of the formula which had been evolved from Bourne's case. However, in the light of advances in medical practice made since the test in Bourne's case was formulated, it would be wise to recognise that without the addition of some such check, abortion on request could be justified. For this reason we think that any legislative formula should exclude the dangers attendant upon normal childbirth.

The socio-economic and social and economic factors for which abortion is sometimes sought have already been discussed in Chapter 17. There are four reasons for which, in our opinion, abortion for purely socio-economic

grounds or social and economic grounds on their own should not be allowed. They are:

1. On the scale of values we have given to the unborn child, socio-economic reasons of themselves should not be sufficient to justify an abortion.
2. When socio-economic reasons are taken into account individually or collectively, a situation of abortion on demand or request is likely to develop. All the evidence which we have heard would confirm this.
3. The evaluation of socio-economic factors is difficult.
4. Some women cope with socio-economic difficulties and some do not, demonstrating that these factors are not in themselves indications for abortion. Where women are unable to cope in spite of sympathetic help and support, their difficulties may manifest themselves in severe conditions of psychological stress which can be considered serious because of their duration or intensity. In these situations abortion would be justified on the grounds of a serious danger to mental health.

Fetal Defect

We refer now to fetal indications as grounds for abortion. There are difficulties in prescribing a formula which will completely cover every case. As we have pointed out in Chapter 17, in some cases both the existence of the fetal defect and its severity can be forecast with relative accuracy. In others there may be only a slight risk that the child will be born with a physical or mental handicap although it is known that if it suffers this misfortune the defect will be a serious one.

In our view the test is best stated that abortion should be lawful if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Rape

For the reasons discussed earlier in this report, we reject rape as a ground for abortion.

Incest

We would accept as a ground for abortion a pregnancy resulting from sexual intercourse within the relationship recognised as incestuous by section 130(1) of the Crimes Act 1961. We would also accept as a ground for abortion a pregnancy resulting from sexual intercourse within the relationships recognised as unlawful by section 131 of the Crimes Act 1961.

Mentally Retarded Women and Girls

For the reasons which we have outlined in Chapter 1, we would recommend that the pregnancy of a mentally retarded woman or girl be regarded as a ground for abortion.

Young Girls and Older Women

The position of young girls at the beginning of their child-bearing years and of older women who are at the end of theirs, is difficult. Although we

think that extreme youth and older age are factors to be taken into account in making the abortion decision, we reject them as grounds in themselves for abortion. The point can be made that if the girl is under the age of 16, the act of having intercourse with her is a criminal offence, although a defence will be open to the man concerned that he honestly believed that she was over the age of 16 years and that he had reasonable grounds for that belief. The fact that pregnancy in young girls under 16 is prima facie evidence of a criminal offence may seem to provide some warrant for abortion. But it should not be overlooked that some precocious girls are as willing to engage in intercourse as the man or boy involved, and on this account they may have no better claim to abortion than less mature girls over the age of 16. We consider, therefore, that extremes of age are factors which ought to be taken into account when considering whether serious danger to physical or mental health can be established but that they should not operate as grounds for abortion in themselves.

Grounds for Abortion Suggested to the Commission

It is proper that we should declare our views on various formulas suggested to us as grounds for abortion although we do not recommend their acceptance as such. They are:

Abortion on Request

This is often referred to as "abortion as a woman's choice", or "abortion as of a woman's right", and sometimes as "abortion on demand". Abortion on request and abortion on demand are often treated as being synonymous but there is, in theory at least, a difference between them. Abortion on request is a phrase used to describe an abortion to which a woman is entitled without the necessity for medical or legal justification. No doctor is bound to perform such an abortion if, either through the dictates of his conscience, or on his view of medical practice, the abortion is not justified. Abortion on demand is a phrase used to describe an abortion upon which a woman is entitled to insist without the necessity for medical or legal justification and regardless of the doctor's professional opinion. The phrase "abortion on demand" is often used to denote "abortion on request" and may be sometimes a more emphatic way of expressing abortion on request.

We ourselves would not recommend abortion "on request" or "as of right", or "as of choice" To allow abortion on that basis would be to deny to the unborn child any status whatever. We reject abortion on demand for the same reasons as we reject abortion on request and for the additional reason that we consider that no doctor should be obliged to provide medical care or treatment for a woman contrary to the dictates of his conscience or the professional view which he takes of the case.

Abortion up to Twelve Weeks

It was urged upon us that abortion should be made lawful up to twelve weeks. It seems to us that this is no more than saying that abortion should be permissible on request up to the time of twelve weeks from conception.

This formula does not commend itself to us because it accords no status whatever to the unborn child. The view of the development of the child *in utero* in Chapter 14 does not indicate that the twelfth week from conception is notable for any change in the growth of the fetus. The twelfth week is significant in the abortion decision, if at all, for one reason only, and that is that it marks the end of the period of time in which the technique of vacuum aspiration can be safely used. After that time other techniques more injurious to the health of the pregnant woman must be used. Therefore, until the twelfth week, the dangers of abortion are less than they are at subsequent stages of pregnancy. Again we would point out that while a formula which permits of abortion on request up to twelve weeks is aimed to protect the health of the pregnant woman, it entirely ignores the status of the unborn child. The point may also be made that, if abortion is restricted as of right to twelve weeks only because the health risks to the pregnant woman within that time are minimal, it would be hard to resist the logic of the claim of a pregnant woman without dependants who, at some time after the twelfth week, requested an abortion and agreed to run the additional health risks involved. It might well be argued that, with no dependants involved, her claim to abortion should be met.

Abortion as a Decision Between a Woman and Her Doctor

Some opinion polls and surveys sought to ascertain the measure of support available for abortion where it is decided between a woman and her doctor. On a first and superficial consideration, the formula appears to have some attraction. It suggests that there are medical criteria to be observed. On more mature reflection, the dangers in the adoption of the formula become obvious and what was an initially attractive formula becomes a meaningless phrase. Does the phrase mean that a woman is entitled to an abortion if her doctor considers that the interests of her health would be better served by that abortion, or does it mean that she is entitled to an abortion if he thinks that there are no contra-medical indications? The phrase provides no solution to these questions. There are further objections to it. It accords to the unborn child only that status which the individual doctor and the woman herself choose to give it. They may, in fact, be unable to agree on the matter. Medical opinion may also differ. One doctor may think that a woman should be aborted and another may not. In this respect alone the formula is quite unsatisfactory and gives no direction to the individual doctor as to the principles upon which he should proceed nor to the woman an indication as to the grounds upon which she may be refused. It may leave her in the position where she has to go from doctor to doctor before she finds one who will agree to abort her. It would import more uncertainty into the operation of the law than at present exists.

Upper Time Limit

Complication rates resulting from induced abortion have already been considered. It is clear that those resulting from abortion under twelve weeks are much less than those resulting from abortions carried out subsequently. For these considerations alone, abortions are best

performed within the first twelve weeks from conception. Most abortions are in fact carried out during this time. There are several reasons why this is so:

1. Most women who have reached the twelfth week of pregnancy have already made a decision to carry the child to term.

2. Any emotional instability which accompanies the biological changes of pregnancy in the first trimester has gone.

3. As the pregnancy advances the abortion is less likely to be justified as a medical procedure because of the increasing danger to the woman's health.

If, however, abortion can be justified on one of the grounds which we have already mentioned, there seems to us to be no reason why, subject to one point to which we will shortly refer, abortion should not be available in appropriate cases after twelve weeks. Indeed, if this period were adopted as the point beyond which abortions were not allowed, there would be cases where abortion which was otherwise legally justified would have to be denied. Two examples will suffice to make this point. A young girl may be reluctant to admit pregnancy until after the twelfth week has passed. It would be wrong to refuse abortion for considerations of time if her abortion were otherwise justified. Amniocentesis is not usually carried out until after the fourteenth week of pregnancy and the results of it are not generally available till after the sixteenth week. Fetal defects cannot therefore be detected in most cases until the second trimester. For these reasons we think that abortions should be permitted after twelve weeks if legal grounds exist but such abortions should be performed in public and private hospitals where emergency services are readily available. The exception we have mentioned is the upper time limit which should be placed on abortion. Although the Abortion Act 1967 (U.K.) places no limit of time on the performance of abortions, the Lane Committee make the following recommendations in its report (paras. 280 and 283):

1. That the Abortion Act 1967 (U.K.) should be amended to authorise abortions up to the twenty-fourth week of pregnancy and not thereafter.

2. In order to preserve the life or health of the mother or the child, termination of a pregnancy may be medically necessary in some cases after the twenty-fourth week of gestation and up to or beyond the normal date for delivery of the child. In this event, the Committee concluded, termination should be treated as induction of labour and every effort should be made to preserve the life of the child.

The Select Committee set up in the United Kingdom in the circumstances set out in Appendix 3 of this report has recommended at page 22 para. 8 of its report that "legislation should be introduced to provide an upper time limit of twenty weeks' gestation on treatment of termination of pregnancy but provision should be made allowing such treatment where the child would be born with a major disability, whether physical or mental, or where it is necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman" (First Report from the Select Committee on Abortion, Vol. 1 page 22). Viability is now recognised as a possibility after twenty-four

weeks. However, fetuses have been born alive after twenty weeks, and it is conceivable that with the development of medical science fetuses born before twenty weeks may be capable of extra-uterine life. We find ourselves in agreement with the recommendations of the Select Committee in England and consider there should be an upper time limit on abortions, restricting them to twenty weeks' gestation, subject only to, the provision that abortions should still be allowed after that time only where there is a substantial risk that the child would be born with a serious disability, whether physical or mental, or where it is necessary to save the life of the pregnant woman, or to prevent serious permanent injury to her physical or mental health.

Consent of Father of the Child

The decision to abort is a decision to be arrived at only after the matter has been given the most careful consideration. Where a woman is married we would expect that the husband should be consulted. The decision to interfere with the continuing life of the unborn child is one in which the father of the child has an interest and responsibility. In those cases where a woman, contrary to her partner's wishes, seeks an abortion, and the abortion is justified on legal grounds, it is likely that the couple are not living in harmony. It would not be proper in our view to refuse abortion to a woman in those circumstances if sound legal grounds can be established. No restriction of that kind exists in law at present. We would expect, of course, that in pre-abortion counselling the matter would be explored with both partners.

Consent of the Parent

A girl under 20 years of age may often be under strong parental and other pressures to have an abortion although she herself may wish to keep the child. On the other hand, such a girl may wish to have an abortion in the face of parental opposition. In both these situations the question arises as to whose decision should prevail.

The legal position is not entirely free from doubt. According to advice which we have received, until the enactment of the Guardianship Act 1968, the better view of the law was that all minors were incapable of giving a legally effective consent to any operation upon themselves. In accordance with that view it has been the practice in New Zealand for hospitals to require the consent of a parent or of a legal guardian before undertaking any surgical procedure on a minor. A material alteration to the legal position was made by section 25 of the Guardianship Act 1968 (which came into force on 1 January 1970). The relevant part of that section is as follows:

> (1) Subject to subsection (6) of this section, the consent of a child of or over the age of sixteen years to any donation of blood by him, or to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on him for his benefit by a person professionally qualified to carry it out, shall have the same effect as if he were of full age.
>
> (2) The consent of or refusal to consent by a child to any donation of blood or to any medical, surgical, or dental procedure (including a blood trans-

fusion) whether to be carried out on him or on any other person, shall if the child is or has been married have the same effect as if he were of full age.

(5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances:

(a) No consent or no express consent is necessary; or

(b) The consent of the child in addition to that of any other person is necessary; or

(c) Subject to subsection (2) of this section the consent of any other person instead of the consent of the child is sufficient.

These provisions appear to draw a distinction between minors who are or have been married and those who are unmarried but are of or over the age of 16 years. Under present law a minor under the age of 16 years cannot marry even with parental consent. In the former case, the minor is treated as an adult and may give a valid consent. In the latter case, the consent of the minor would appear to be effective only where the particular procedure concerned is to be carried out for the minor's benefit by a person professionally qualified to carry it out. It is in this area that difficulties will arise in the case of girls of or over the age of 16 but under 20 whose wish to have an abortion is contrary to the wishes of their parents.

The words "any medical (or) surgical . . . procedure" where used in section 25(1) of the Guardianship Act 1968 are wide enough to include an abortion and, provided it is carried out for the benefit of the girl concerned by a professionally qualified person, her consent would appear to be effective for the purposes of the section. The resolution of the question of whether a particular abortion is for the benefit of the girl still remains. Where legally permissible abortion is restricted to grounds which are broadly therapeutic (a description which can be applied to the grounds which we have recommended), we can foresee no difficulties in the administration of the abortion law, and a girl of or over 16 years but under 20, would, on the wording of section 25(1) of the Guardianship Act 1968 be able, notwithstanding the absence of parental consent and, indeed, in the face of parental opposition, to give a valid consent to the procedure.

Where the right to an abortion is not tied to grounds which can be said to be for a girl's benefit, as may be the case where the legal code allows abortion on request, difficulties could arise and the efficacy of the girl's consent might, in some circumstances, be doubted. The point will, however, remain academic if the recommendations which we have made as to the grounds for legal abortion are adopted and such grounds are accepted by the legislature as being for the benefit of the girl.

The case of girls under 16 years of age is more difficult. We think it better to assume that in the case of girls under 16, to whom section 25 of the Guardianship Act 1968 has no application, the common law prevails and parental consent to the carrying out of an abortion, even if it is legally permissible, is still necessary in law. In the event, therefore, of a division of opinion between a girl under 16 who desires to keep her child and her parents who think that she should have an abortion, the wishes of the latter prevail in law. Such a position raises the question of whose decision should be accepted. In particular, should a girl under 16 who is sufficiently mature to make a rational and responsible decision herself be forced to undergo an abortion because her parents are of a contrary view?

Although we recognise the place of parents as the head of the family, an institution the place of which should be upheld in society, we are of the opinion that the dilemma should be resolved by the decision of the girl herself so that, if after proper counselling she wishes to continue with her pregnancy, an abortion should not be forced on her against her will.

There remains the further question of the girl under 16 who desires an abortion in face of the wishes of her parents that she continue with the pregnancy. Again we think, on balance, that the girl's wishes should prevail if proper grounds for her abortion have been established on the procedures we have recommended. It seems to us that, if it can be shown that an abortion is legally permissible on one of the grounds which we have recommended, it would be harsh as well as illogical to deny it to her because of her age.

We would not expect situations of the kind that we have discussed here to arise other than infrequently, particularly where there has been counselling of parents and child, but they may from time to time occur. To cover those cases in which they do occur, we recommend that legislation should be enacted to provide that the consent of a girl under the age of 20 years to an abortion on herself shall, notwithstanding the absence of the consent of her parents or guardian, have the same effect as if she were of full age, provided that grounds for legal abortion exist, and that, conversely, no abortion shall be carried out on any girl under the age of 20 years without her consent.

The Burden of Proof

It was suggested to us that in prosecutions against persons who are carrying out unlawful abortions, the onus should rest on the persons charged to prove that what was done was in accordance with the law and that they acted in good faith. There are some limited areas of law in which the onus is placed by statute on the accused persons to prove their innocence or to establish the existence of certain facts consistent with that innocence. For example section 23(1) of the Crimes Act 1961 provides that everyone shall be presumed to be sane at the time of doing or committing any act until the contrary is proved.

Section 244(2) of the Crimes Act 1961 provides a defence for a person charged with having in his possession by night any instrument, being an instrument capable of being used for burglary, in circumstances that prima facie show an intention to use it for burglary, if he proves that he had lawful excuse for having the instrument in his possession.

Sections 5(6) and 17 of the Narcotics Act 1965 provide that where narcotics are found in the possession of a person in certain circumstances, the burden of proof of innocent user or possession rests on him.

The justification advanced for placing on the shoulders of an accused person the burden of proof of innocence is said to be that the particular facts which are an element of the crime are peculiarly within the knowledge of the person charged but not within the ability of the prosecution to prove. It was said to us that persons charged with abortion should be required to prove their good faith rather than that the Crown should be required to prove its absence. It is almost certainly true that if the burden of proof of good faith were placed upon the accused, medical

practitioners and others who contemplated performing abortions would be particularly careful to ensure that there were adequate legal grounds before they proceeded and, on this account, we have given careful consideration to the suggestion. We are moved, however, to reject it on two main grounds:

1. It is quite contrary to the mainstream of jurisprudence and the policy of the criminal law. Those cases where the burden of proof of innocence has been made to rest on the accused can be justified as exceptions to the general rule.
2. If this reversal of the burden of proof were to be adopted in the abortion legislation, it could result in doctors being deterred, through fear of prosecution, from performing abortions in cases which might properly be carried out within the criminal law.

Section 182 of the Crimes Act 1961

The place of section 182 of the Crimes Act 1961 in the abortion legislation requires to be considered. We see no reason for suggesting its deletion from the criminal law when the purpose behind its introduction was to fill a gap between the law of homicide and the law of abortion. Section 182 should be left to fill that gap but any legislation intended to alter the existing law on abortion should be framed in terms of section 183 to 187 of the Crimes Act 1961 only. It now appears that the legal definition of human being in section 159 of the Crimes Act no longer coincides with medical opinion. Section 159 provides that a child becomes a human being within the meaning of the Act when it has completely proceeded in a living state from the body of its mother, whether it has an independent circulation or not, and whether the navel string is severed or not. It may be now said that it is inaccurate to speak of the child having an independent circulation only after birth, when in fact it is firmly established that a child has an independent circulation while still within the womb and that the severing of the navel cord separates the child from the placenta, not the body of its mother. The import of section 159 has not been the subject of our inquiry and we only comment on its provisions in passing. If, however, amendments were made to section 159, then consequential amendments would require to be made to section 182. So long as section 159 remains in its present form, we do not think that section 182 requires further amendment. We note that the equivalent English section, namely, section 1 of the Infant Life (Preservation) Act 1929, creates the offence of child destruction, if, with intent to destroy the life of a child capable of being born alive, a person by a wilful act causes the child to die before it has an existence independent of its mother. It further provides that, for the purposes of the Act, evidence that a woman has at any material time been pregnant for a period of 28 weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive. If the recommendations of the Select Committee in England are adopted, it is likely that that period will be reduced to twenty weeks. Section 182 makes no reference to the duration of the pregnancy. It merely refers to "unborn child".

Specific Amendments

It is our recommendation that an appropriate code for abortion in New Zealand would be achieved by repealing sections 183 and 184 and replacing them with a section providing that:

1. Everyone shall be guilty of a crime who, with intent to procure the miscarriage of any woman or girl, whether she is with child or not:

(1) Unlawfully administers to, or causes to be taken by her, any poison or any drug or any noxious thing; or

(2) Unlawfully uses on her any instrument; or

(3) Unlawfully uses on her any means whatsoever, not being means to which (1) and (2) apply.

2. It shall be unlawful to do any of the acts mentioned in paras. (1), (2), (3) of subsection 1, unless:

(1) The continuance of the pregnancy would result in serious danger to the life of the pregnant woman or girl, such danger not being the normal danger of childbirth itself; or

(2) The continuance of the pregnancy would result in serious danger to the physical or mental health of the woman or girl, such danger not being the normal danger of childbirth itself; or

(3) There is a substantial risk that, if the pregnancy were not terminated and the child were to be born, it would have or suffer from such physical or mental abnormality as to be seriously handicapped; or

(4) The pregnancy is the result of sexual intercourse:

(a) Which, if a charge were laid, would constitute the crime of incest as defined by section 130(1) of the Crimes Act 1961; or

(b) In such circumstances that, if a charge were laid, it would constitute a crime under section 131(1) of the Crimes Act 1961; or

(5) The pregnancy is the result of sexual intercourse with a woman or girl who is, or was at the time of the intercourse, "severely subnormal" within the meaning of section 138(2) of the Crimes Act 1961.

3. The woman or girl shall not be charged as a party to any offence against this section.

We have considered the position of abortion induced by the woman or girl herself. This is at present a crime under section 183 of the Crimes Act 1961. Whether it should remain a crime for a woman or girl to abort or attempt abortion of herself has troubled us considerably. We note, in particular, that the offence at present carries with it a maximum of seven years' imprisonment. Any woman or girl who attempts an abortion upon herself must be in desperate straits and a sentence of seven years' imprisonment seems savage. Even under the present legislation the penalty which may be imposed seems quite unrealistic, it being unlikely that the courts would impose more than a fine or an order to come up for sentence if called upon. After anxious consideration we think that a

provision similar to section 185, but with drastic modification of the penalty, should remain. We are moved to the retention of section 185 by two main considerations, which are:

1. If the unborn child has some status then it seems to us that that status is unaffected by the identity of the person performing or attempting to perform the abortion.

2. If the criminal law is to take account of the acts of third persons who may sometimes be motivated by considerations of pity, then it ought to take account of the acts of the woman or girl herself. It is true that the woman or girl is not liable to be charged as a party to offences under sections 183 and 184 of the Crimes Act 1961 but the exemption from prosecution conferred by these sections is an exemption not dictated by considerations of principle but rather for practical reasons. If such an exemption did not exist then it might be impossible to prove that an illegal abortion had taken place in that the woman or girl whose evidence was necessary as proof of the crime might decline to give evidence at the trial of another person on the ground that her evidence might incriminate her.

Section 186 should remain with a proviso that for the purpose of that section, the term "unlawfully" should have the same meaning as that contained in section 183.

Section 187 should remain.

"Life" Defined

In discussing the working of the Abortion Law in New Zealand, we mentioned that one of the difficulties that has been encountered arises from the varying interpretations given to the word "life" in the phrase used in Bourne's case, "the preservation of the life of the woman." We were asked by one hospital board to clarify whether the term "life" means "physical life of the woman" or the "quality of life". We think that the term "life" should be defined in terms of actual, physical life and not in terms of the quality of life, of which adequate account can be taken in the code which we have already enunciated.

Menstrual Extraction

In discussing the techniques of contraception, reference was made to the technique variously known as "menstrual extraction", "menstrual regulation", or "endometrial aspiration". The legality of this procedure requires consideration. Although the procedures are very similar, menstrual regulation differs from vacuum aspiration (an acknowledged technique of abortion) only in that it is carried out before a diagnosis of pregnancy has been made, although the woman's period will have been overdue for some days. In the majority of cases, where the technique has been used, it has been found from an examination of the contents of the uterus extracted by menstrual regulation that the woman in fact was pregnant.

For several reasons we do not think that the use of this technique should be encouraged:

1. If, in fact, the woman is not pregnant, the procedure will have been carried out unnecessarily. There are a number of conditions other than pregnancy which may delay the onset of a period, and many women have fears of pregnancy which are dispelled without the need for such drastic surgical intervention.

2. It may come to be regarded as being an adequate contraceptive measure.

3. It is a surgical procedure which, because it interferes with the uterine lining, is accompanied by complications. Each insertion of the cannula into the cervix involves a potential risk of infection where there is a pre-existing vaginal cervical infection and a risk of perforation. Damage to the endometrium, with consequent morbidity and infertility, may result.

If, in fact, the process of menstrual regulation is carried out on a woman or girl with intent to procure her miscarriage, the act would plainly be within the existing abortion law, whether or not she subsequently proved to be pregnant. If it cannot be proved that that was its purpose, then it would not. Unless, however, some curbs are placed on the use of this technique, it could become a means of circumventing the operation of the law. Those who recommend its use and carry it out could employ the technique on any woman or girl whose period was overdue, being careful not to have a pregnancy test made first. There would be nothing to prevent the setting up of clinics in which menstrual extraction could be carried out on women and girls who believed they were pregnant. Such clinics could operate within the law by advising women and girls to seek menstrual extraction before having a pregnancy test. While it would be likely that the majority would in fact be pregnant, it would be impossible to prove that the operator knew that an individual woman had been pregnant.

For these reasons we consider that provision should be made legislating against the use of the technique of menstrual regulation unless a pregnancy test has first been carried out. If then the woman concerned is not pregnant, there will be no need for the technique to be used, but if pregnancy is confirmed, the criteria for abortion must be satisfied.

RECOMMENDATIONS

1. That abortion and miscarriage be defined in any legal code as the premature expulsion of the fetus or embryo after implantation.

2. That the Crimes Act 1961 be amended by substituting for section 183 and 184 a section providing that:

(1) Everyone shall be guilty of a crime who, with intent to procure the miscarriage of any woman or girl, whether she is with child or not:

(a) Unlawfully administers to, or causes to be taken by her, any poison or any drug or any noxious thing; or

(b) Unlawfully uses on her any instrument; or

(c) Unlawfully uses on her any means whatsoever, not being means to which (a) and (b) apply.

(2) It shall be unlawful to do any of the acts mentioned in paras. (a), (b), (c) of subsection (1) unless:

(a) The continuance of the pregnancy would result in serious danger to the life of the pregnant woman or girl, such danger not being the normal danger of childbirth itself, or

(b) The continuance of the pregnancy would result in serious danger to the physical or mental health of the woman or girl, such danger not being the normal danger of childbirth itself; or

(c) There is a substantial risk that if the pregnancy were not terminated and the child were to be born, it would have or suffer from such physical or mental abnormality as to be seriously handicapped; or

(d) The pregnancy is the result of sexual intercourse:
(i) Which, if a charge were laid, would constitute the crime of incest as defined by section 130 (1) of the Crimes Act 1961, or
(ii) In such circumstances that, if a charge were laid, it would constitute a crime under section 131 (1) of the Crimes Act 1961; or

(e) The pregnancy is the result of sexual intercourse with a woman or girl who is, or was at the time of the intercourse, "severely subnormal" within the meaning of section 138 (2) of the Crimes Act 1961.

(3) The woman or girl shall not be charged as a party to any offence against this section.

Appropriate amendments will be required to sections 185 and 186 to define the word "unlawfully".

3. That the penalty of imprisonment provided by section 185 of the Crimes Act 1961 (female procuring her own abortion) be replaced by a fine or lesser penalty.

4. That the extremes of age of a pregnant woman or girl, while not of themselves grounds for abortion, be regarded as factors to be taken into account when considering whether there is a danger to the physical or mental health of the woman or girl concerned and the extent of that danger.

5. (1) That pregnancy resulting from rape be not of itself a ground for abortion but that the plight of women and girls who are fearful of pregnancy following on rape be met by ensuring that either the "Morning-after Pill" or some form of intra-uterine device such as the "Copper-7" be made available to women and girls complaining of rape.

(2) That where women and girls make complaints of rape, it be mandatory for medical practitioners called by the police to examine them, either to provide the "Morning-after Pill", or, if requested, to fit an appropriate form of I.U.D., or, if they are unwilling to do this, to advise complainants that these methods of treatment are available and that they may, if they wish, obtain them from a medical practitioner of their choice or from a family planning clinic.

6. That socio-economic factors be not of themselves grounds for abortion.

7. That abortion be not carried out after 20 weeks' gestation except:

(1) Where there is a substantial risk that the child would be born with a serious disability, whether physical or mental; or

(2) Where it is necessary to save the life of the pregnant woman or to prevent serious permanent injury to her physical or mental health.

8. That all abortions carried out after twelve weeks' gestation be carried out only in public or private hospitals where emergency services are available.

9. That, while every effort should be made in counselling, before any application for abortion is considered, to include both partners in discussions and to ascertain the wishes of the father of the child, his prior consent to abortion be not necessary if proper grounds for abortion are established.

10. That legislation be enacted to provide that the consent of a girl under the age of 20 years shall, notwithstanding the advice of her parents or guardian, have the same effect as if she were of full age, provided that grounds for legal abortion exist, and that, conversely, no abortion be carried out on any girl under the age of 20 years without her consent.

11. That the burden of proof in prosecutions against persons charged with carrying out abortions unlawfully remain on the prosecution.

12. That the use of the technique known as "menstrual regulation", "menstrual aspiration", or "menstrual extraction" as a contraceptive technique be discouraged.

Chapter 25
WHO DECIDES?

CRITICISM OF EXISTING ABORTION PRACTICE

Most of the criticism heard by the Commission during discussion on the legal aspects of abortion was levelled at the vagueness and uncertainty of the abortion law which have resulted in widely differing interpretations being given to it in practice. We believe that much of this criticism will disappear if the law is amended to include in the statute a clear statement as to when abortion is unlawful. Serious criticism, however, has also been directed at the procedures leading to the making of decisions on abortions. These vary substantially from place to place and between one doctor or one committee and another. This is a matter fundamental to the whole abortion issue, and every endeavour must be made to rectify conditions which at present cause dissatisfaction and concern.

THE APPLICATION OF CRITERIA

The implementation of any law on abortion which does not rest entirely on rigid and unyielding criteria requires the application of both legal principles and medical tests to the circumstances of each case. Any code laying down criteria which require account to be taken of the individual merits of each case will require those making the decision to decide questions of degree. Such questions will include, for instance, whether the danger to the woman from the pregnancy is such as to be a serious danger to her life or a serious danger to her physical or mental health.

In requiring that account be taken of the circumstances of each case, abortion is not in a unique position either medically or legally. The practice of medicine requires decisions, sometimes of a serious kind, to be made in the treatment of a patient. The practice of the law requires the application of principles and legal tests to individual circumstances. The decision may often be difficult but the impossibility of laying down a set of conditions against which the decision can be measured with computer-like efficiency in each case does not mean that criteria should be abandoned or the legal code vacated in the making of decisions on abortion or in any other area. It is necessary, however, to reduce the differences of interpretation to a minimum by ensuring that the law does not vary in its application and practice from one place to another, from one hospital to another, and from one doctor to another.

Before we examine the various means by which the decision should be made, it is desirable that we discuss a number of matters which have their part in the decision-making process.

A Statutory Committee

The administration of the abortion law in New Zealand is not at present the responsibility of any single body or department. There is, however,

reason to think that the oversight of this administration could well be vested in a single body. The working of the abortion law in one locality may highlight social issues peculiar to that area, or it may indicate the application of different medical standards and demonstrate a different interpretation of the law between one district and another. The issues raised may come within the oversight of a number of departments. They may involve vital statistics relating to age, race, and marital status, all of which are relevant to the consideration of demographic issues. Questions of health may arise. The State has an interest in maintaining the standards of health of its citizens, in ascertaining the complications attendant on abortion, and in seeing that abortions for which approval is given are carried out in proper conditions and by competent people. Whether consent to abortion is given or refused, it must ensure that women are properly counselled both before and after the decision is made.

In Appendix 5 we refer to the operation of a committee headed by Sir Leonard Mallen which reports each year to the Parliament of South Australia on the working of the abortion laws in that state. We have been impressed by the type of material set out in the reports of this committee. We recommend the establishment of such a committee in New Zealand and consider that it would be better suited to the general oversight of the administration of the abortion law than the Department of Health which is already heavily charged with health care in so many other areas. We envisage a committee of three members, two of whom should be experienced medical practitioners. In order to preserve some consistency of approach and outlook, the chairman of such a committee should hold office for a term of years, particularly at the outset. The committee should have the following powers and duties:

1. The oversight of the working of the abortion laws throughout New Zealand.
2. The licensing of public and private hospitals and other institutions to carry out abortions.
3. Ensuring that institutions where abortions are performed have adequate facilities.
4. Ensuring that staff in such institutions are competent.
5. Ensuring that adequate facilities exist for the counselling of women before and after abortion decisions are taken.
6. The collecting of data on the characteristics of women aborted. Classifications would be made giving details of age, marital status, period at which the abortion was carried out, race, number of children, place of residence, grounds for abortion, technique used, place where carried out, and complication rates. Where abortion is refused it will be necessary to record the numbers involved and the grounds for refusal.
7. The review of the process of decision-making, whether it be by panel or otherwise.
8. The laying down of standards for the facilities in institutions where abortions are performed.
9. The setting of maximum fees payable for abortion in private institutions.

10. The maintenance of consistent standards in the interpretation and administration of the abortion laws.

11. Advising the Minister of Health and hospital boards on the establishment of clinics and centres for contraceptive and sterilisation services.

12. Reporting to Parliament on the working of the abortion code.

Where Should Abortions be Carried Out?

Subject to adequate safeguards on decision-making, we think that facilities for the carrying out of abortions could be provided in public hospitals, private hospitals, and day clinics. We would make the proviso that abortions performed later than the first trimester should be carried out only in public or private hospitals as distinct from day clinics. It is essential that proper provision be made for the regular inspection of hospitals and clinics where abortions are to be carried out to ensure that adequate facilities, equipment, and staff are available and that adequate arrangements have been made with base hospitals for the treatment of complications if and when they arise.

We consider that all public hospitals with full and approved facilities should be licensed and that private hospitals with full surgical facilities should also be licensed if they so desire. The licensing of a day clinic in a particular area should depend, not only on whether it is able to offer satisfactory surgical and medical care, but on whether there is a need for a clinic in that area. We do not favour a proliferation of clinics, although the statutory committee, whose establishment we recommend, may feel it necessary to establish clinics where there is a need.

COUNSELLORS

The place of counselling before decisions on abortion are made has been increasingly recognised in the last few years. Section 2 of the Hospitals Amendment Act 1975 makes specific provision for independent counselling to be provided before any abortion is undertaken.

What is Meant by Counselling?

We have heard a great number of submissions on what is meant by counselling. They have been notable for the sharply divergent views advanced as to what is involved. We note that the Lane Committee encountered a similar confusion and lack of clarity regarding the objectives to be sought from counselling and made some pertinent comments (para. 292): "A woman considering abortion should be able to discuss and explore her difficulties and anxieties in an informal and unhurried manner. She should be told of the nature of the operation and of the likelihood of complete recovery from it, or the possible resultant morbidity. She should also be informed of any appropriate help which may be available to her, either if abortion is performed or if it is not. She should thus become more fully aware of the implications of the continuation, or alternatively the termination, of her pregnancy, and be helped to arrive at a wise and independent decision as to what her real

wishes are. Further, when her personal and social circumstances are discussed, it may be possible to identify problems which would be appropriately dealt with by others, e.g., a psychiatrist or a social work agency."

We, too, are convinced that counselling should provide opportunities for discussion between counsellor and patient and for the giving of information, explanation, and advice.

The Independence of Counselling

Counselling should be independent in a twofold sense. It should be: (1) independent of the hospital, institution or clinic in which the abortion is to be carried out, and (2) independent in the sense of being objective and removed from any particular philosophy. Independence itself and the appearance of independence are both important. Where a monetary payment is received for the carrying out of an abortion, or where facilities are provided in furtherance of some philosophy on abortion, the need to ensure that the counselling is independent is even more important. In public hospitals, as distinct from private, the criticism can scarcely be made that the successful running of the institution is dependent upon or related to the numbers of abortions performed. On the other hand, this criticism may be valid in the case of private hospitals or clinics where patients make payments to those conducting the institution or carrying out the abortions. In such cases the independence of counselling may be open to question. The independence of counselling is best ensured when it is carried out by a person or persons who are separate from any institution, be it private hospital or clinic, where abortions are performed.

The Role of the Counsellor

We think that the functions of a counsellor are to assist a woman who is requesting abortion, by helping her in a friendly, relaxed atmosphere to evaluate her own particular circumstances and to explore all possible alternatives. As we have said, counselling should be objective and should not be given by anyone who strongly espouses any particular philosophy on abortion. Strongly-held views will almost inevitably influence the attitude of the counsellor. In the end it will be for the counsellor to advise the woman counselled and to discuss her situation and the alternatives with her; it will be for the woman to decide whether she wishes to proceed with an abortion; it will be for the decision-making body to decide whether, on the application of the law to the facts, abortion is permissible.

WHO SHOULD DECIDE?

It is important to decide which system will best ensure the uniform, impartial, and efficient working of the abortion laws. We have given a great deal of thought to this question. Several systems of decision-making have been suggested:

1. By a Hospital Committee

The degree of satisfaction with this system, where it operates in New Zealand, varies greatly. Much depends on the individuals who comprise

the committee. There is, of course, no provision in the Crimes Act 1961 or in any other statute for the setting up of a committee of this nature. It was evolved in an endeavour to impart some uniformity into the decision-making process, and works on the assumption that two heads are better than one. Despite some obvious advantages, the system also has its drawbacks:

(1) It can be unwieldy and beset with administrative difficulties.

(2) It requires that those holding strong views should be excluded from the committee. In some institutions this is hardly possible.

(3) Where more than one committee functions in a particular hospital, the varying personal views of the committee members may lead to widely different interpretations of the law. (The Commission heard evidence of one hospital with two committees, one of which regularly approved approximately 85 percent of requests for abortion, whereas the other granted only about 15 percent. This wide variation of standard in decision-making under such a committee system demonstrates how haphazard and unsatisfactory conditions have been in some instances in the past.)

(4) Abortions represent only a small part of the huge work load with which hospitals must cope and, in consequence, they must take their place along with the rest in the timetabling of work to be carried out. For the woman concerned, undue delay will almost certainly cause great anguish and may cause serious complications.

(5) There is little evidence of adequate counselling before decisions have been taken or of any supportive counselling if an abortion has been refused.

2. By a Medical Practitioner

In Chapter 24 we discussed and rejected the possibility of abortion being decided between a woman and her doctor. It has, however, been suggested that, once the law has been defined and indications for abortion specifically laid down, the interpretation and application of that law should be left to a single doctor. In our view this is not an acceptable situation. It places too much onus on the doctor concerned whose decision may be unduly influenced by his own personal views whether they be conservative or liberal. While we have no doubt that there are many doctors who would responsibly and objectively assess all the circumstances before arriving at a decision, we feel obliged to say that there are also those in whose hands we would not be happy to leave the decision.

We note that, in the survey of members of the Royal College of Obstetricians and Gynaecologists in 1975, over 95 percent of the members of the College who replied thought that the decision should not rest with any one medical practitioner.

OUR RECOMMENDATIONS

What system will best ensure uniform, objective, and efficient working of the abortion laws in which counselling is given a proper place? We are of the view that these conditions would be best satisfied by setting up panels under the jurisdiction and oversight of the statutory committee, the establishment of which we have already recommended. We see a need for some twelve to fourteen of these panels throughout New Zealand. The number of assessment panels should not be too great because of the difficulty of finding suitable staff, but they must be sufficiently numerous to ensure that women do not have to travel long distances to consult them.

Referral Panels

The constitution of these panels is important. Obviously they must contain at least two members. We favour a panel of three, two of whom should be medical practitioners, at least one with obstetrical and gynaecological qualifications or experience, and the third a social worker. In larger centres a larger panel may be necessary according to work load and availability of staff. Appointments to the panels should be the function of the statutory committee. In making appointments the committee should have regard to the following matters:

(1) The need to appoint persons impartial in outlook.
(2) The desirability of having a woman doctor on each panel. (A pregnant woman will often be more at ease with a woman doctor.)

The decision should be made by the doctors on the clinical evidence put before them. This would include a report from the social worker who would be present during the deliberations and have the right to bring in the individual woman's counsellor. There will be a need, of course, to have a sufficient number of doctors available to provide for recourse to be made to a third doctor if there is a disagreement between the two who are on the panel when the matter is first considered.

The panel should, in its deliberations, have a written application from the referring doctor giving the following information:

(1) A statement from the general practitioner or specialist of the reasons for requesting abortion, e.g., physical or mental health, fetal defect etc., together with a diagnosis of pregnancy.
(2) Any further medical reports.
(3) Advice that the woman has been adequately counselled. Such counselling should be carried out by a counsellor employed by the statutory committee, or by an agency or person approved for counselling by the committee.

The woman should, as a rule, be interviewed by the panel. There may be some few cases in which it will not be necessary for the panel to see the woman concerned. For example, if a woman has been a patient in a psychiatric institution for some length of time, there would be little point in requiring her to appear before the panel if her condition could be as well documented by evidence from objective sources.

We have debated whether the woman should have direct access to the panel. On balance we think it preferable that she be referred to the panel by her general practitioner or by a family planning clinic.

When the abortion decision has been made, whether it be to grant or refuse the request, it should be conveyed to the patient, counsellor, and referring doctor immediately.

If the application is refused, it may be necessary for the counsellor to make arrangements for further counselling to be given to the woman and for her to be referred to appropriate supportive services.

If the request is granted, the panel should refer the woman, without delay, to a public hospital, private hospital, or clinic to have the abortion performed.

It would be the duty of each panel to keep full records and to report regularly to the statutory committee on all requests for termination of pregnancy, all requests which have been granted, the grounds on which they have been granted, together with relevant personal details and any other information which the board may require.

We emphasize that it is essential to the working of such a system that particular attention be given to:

(1) The treatment of the patient with care, courtesy, and consideration.
(2) The adequate counselling of the patient.
(3) Speedy assessment of each case.
(4) Prompt referral to hospital or clinic, or supportive services.

Counselling Service

In the setting up and operation of a counselling service, the following points may be noted:

(1) A counselling service can quite well be conducted in the same building in which the assessment panel conducts its sittings.
(2) The counselling service should be directed by an experienced, professionally trained social worker who may be a member of the panel.
(3) Counsellors should be thoroughly familiar with all social services and alternatives to abortion such as adoption and solo parenthood.
(4) Where there are no trained counsellors available in a particular area, agencies may be approved to carry out the counselling service.
(5) Consideration should be given to the employment of trained lay counsellors where professional counsellors are not available.
(6) The State should pay for the cost both of the counselling and of the assessment.
(7) The counsellor should be the first person to see the applicant after referral by the medical practitioner to the panel and should obtain her relevant history and counsel her.
(8) The counsellor should be trained to give contraceptive advice. Alternatively, nurses or para-medical staff could be available to do so.

Cost of Abortion

If a woman is entitled to an abortion on grounds which are legally justified, then she should, as is the case with all other treatment given to any patient in a public hospital, be able to obtain it free of charge. The costs incurred by the State in performing abortions in public hospitals can be reduced if abortions are performed in the first trimester on a day stay basis. If hospital boards can be persuaded to provide preventative medicine in the family planning area in clinics, women are more likely to be encouraged to attend at these clinics. If a woman does not wish to have the operation in a public hospital, a choice which she has in respect of other forms of treatment, there is no reason why she should not be called upon to meet the cost, including hospitalisation, subject to receipt by the hospital concerned of the customary subsidy.

We think that there is a place for the charitable trust controlling a clinic (such as the Auckland Medical Aid Centre) whose function will be restricted to carrying out first trimester terminations. Such a trust would make a direct charge to the patient as though it were a profit-making institution.

Fees

The question arises as to whether fees chargeable for abortions should be controlled by the State. Outside of surgical or medical services provided by a doctor in a public hospital, a doctor is entitled to charge for his services such fee as is agreed upon with the patient or, in the absence of an agreement, a reasonable fee. Likewise, private hospitals and clinics are free to charge such fees as they wish for hospital, surgical, and medical treatment given. It has been the experience both in the United Kingdom and in the United States of America that large sums of money are to be made by performing abortions. Indeed, in New Zealand, cases have been brought to our notice where abortions have been performed in private hospitals at fees which were quite extravagantly high. On this account we think that there is a case for the State, on the advice of the statutory committee, to fix maximum fees at a reasonable level.

Charitable Trusts

We have already recommended that clinics such as the Auckland Medical Aid Centre should be allowed to perform terminations in the first trimester. This clinic is registered as a charitable trust—a non-profit making institution. Accordingly, it is not liable to pay income tax and it is entitled to substantial relief from land tax. It is a prerequisite to the registration of any body as a charitable trust that its rules should contain a provision that, when its objects have been fulfilled or it is wound up, the assets which it possesses should be paid to some charitable agency and not distributed to private persons. The rules of the Auckland Medical Aid Trust contain such a provision. The Trust now has substantial assets, and at its present rate of charge is likely to acquire further assets or to increase its equity in the Aotea Hospital. The question is whether the State should intervene in the case of a charitable trust operating in the abortion area to remove or reduce the measure of relief from taxation at present afforded to it by legislation. We have no recommendations to make in this area.

Charitable trusts operate in a number of areas of business in competition with other commercial enterprises which pay tax. For this reason we think that it would be unfair for charitable trusts controlling clinics performing abortions to be made the subject of any treatment differing from that extended to charitable trusts operating in other fields of enterprise. If an unfair advantage is obtained by way of relief from taxation by the operation of a charitable trust, that matter should be the subject of an overall fiscal policy.

If an objection to the use of panels in the abortion area were to be made on the ground that they destroyed or interfered with the doctor and patient relationship, we would record that we think the objection is without substance. As we have stated at some length in Chapter 5, doctors themselves have already made substantial inroads into this relationship. The setting up of group and lock-up practices has in many instances already destroyed the traditional relationship of doctor and patient. The patient can no longer count on seeing the doctor of her choice within a group practice. Whenever a general practitioner refers a patient to a public hospital he foregoes the right to prescribe the treatment to be given to his patient while in hospital. We note, too, that doctors have not hesitated to delegate to the Auckland Medical Aid Centre the right to counsel their patients and to make for them the decision on abortion. We are left with the impression that many doctors have been pleased to have been able to rid themselves of what, in many cases, was a difficult decision.

We are aware that the Lane Committee did not accept that the decision on abortion should be made by referral panels. We would point out, however, that by the time the Lane Committee had been established, the network of agencies operating in the public and private sector on abortion in the United Kingdom was already well established. In making our recommendations, we are conscious that no system of decision-making is likely to be free from criticism. Even where, within a professional body, there is strong support for one system in preference to others, there will be some whose opposition to that system is strong. We do not suggest that the panel system which we propose will meet with the approval of all those whose submissions to us recognised the need for some persons or body to decide whether specific criteria had been met in individual cases. It is our view, however, that the system which we propose will best ensure the fair and objective working of the abortion law, and for that reason we recommend its adoption.

An Alternative System—Two Doctors

We think it proper to express our opinion on another system of decision-making which may be considered as an alternative to the panel system. In putting it forward as an alternative, we wish to make it clear that we do not regard it as equally acceptable. We mention it because it is our function to set out in an objective way the various systems suggested and to give them a place in the scale of preferences. The alternative which seems best able to ensure a measure of objectivity in the operation of the abortion law is a system under which, within the general framework and

supervision of the statutory committee, the decision is made by two doctors after the pregnant woman has been counselled at the counselling service set up by the statutory committee or at one approved by it.

There are criticisms which can be made of the placing of the abortion decision in the hands of two doctors. There is the risk that they will give effect to their own personal views in deciding whether the criteria have been met, and that a decision made by two doctors in one locality may differ from that made in similar circumstances in another. The chances of variations of this kind occurring will, however, be much less than if the matter is left to the decision of one doctor. The risk will be further reduced by the supervision and oversight which the statutory committee would give to the working of the abortion laws in New Zealand.

Section 1 of the Abortion Act 1967 (U.K.) provides, in effect, for the abortion decision to be made by two registered medical practitioners. The Select Committee on Abortion, in reporting to the House of Commons, recommended the amendment of that section by providing that the two registered medical practitioners, if they are in private practice, should not be partners, and that one should not be employed as the assistant of the other or be employed or share a financial interest in the same nursing home or agency, and that one of them should be of at least five years standing.

In our view the recommendations of the Select Committee on Abortion in the United Kingdom should be adopted if the decision in New Zealand is to be left to two doctors.

Abortion in Cases of Emergency

Sometimes, though not very often, an abortion may have to be performed in an emergency. It may be quite impossible to obtain a second opinion. The existence of this situation is recognised in the Abortion Act 1967 (U.K.) where it is provided that the requirement that two medical practitioners shall certify to the abortion has no application to the termination of pregnancy if one medical practitioner is of the opinion, formed in good faith, that the termination is immediately necessary to save the life of the mother or to prevent grave permanent injury to her physical or mental health.

A similar provision is contained in the South Australian legislation although it is to be noted that the Mallen Committee has, in more than one annual report, drawn attention to the over-use of this provision. Whether the decision is to be made by a panel or by two doctors, any legislation should contain such an emergency provision.

Fetal Advocate

It was suggested to us both in submissions and in evidence that, whatever system of decision-making was adopted, provision should be made for a fetal advocate whose role would be to argue before the panel or committee the case for the unborn child. We can fully understand the reasons for such a submission but do not consider that there is any need for such a person. The legal code which we recommend has been formulated to give proper weight to the status of the unborn child.

RECOMMENDATIONS

1. That a committee, referred to as the "statutory committee", be established in New Zealand to discharge the following functions:

(1) The oversight of the working of the abortion laws throughout New Zealand.

(2) The licensing of public and private hospitals and other institutions to carry out abortions.

(3) Ensuring that institutions where abortions are performed have adequate facilities.

(4) Ensuring that staff in such institutions are competent.

(5) Ensuring that adequate facilities exist for the counselling of women before and after abortion decisions are taken.

(6) The collecting of data on the characteristics of women aborted. Classifications would be made giving details of age, marital status, period at which the abortion was carried out, race, number of children, place of residence, grounds for abortion, technique used, place where carried out, and complication rates. Where abortion is refused it will be necessary to record the numbers involved and the grounds for refusal.

(7) The review of the process of decision-making, whether it be by panel or otherwise.

(8) The laying down of standards for the facilities in institutions where abortions are performed.

(9) The setting of maximum fees payable for abortion in private institutions.

(10) The maintenance of consistent standards in the interpretation and administration of the abortion laws.

(11) Advising the Minister of Health and hospital boards on the establishment of clinics and centres for contraceptive and sterilisation services.

(12) Reporting to Parliament on the working of the abortion code.

2. That the carrying out of abortions be permitted in public and private hospitals and day clinics, provided however that abortions performed later than the first trimester be carried out in public and private hospitals only.

3. That provision be made for the regular inspection of hospitals and clinics where abortions are to be carried out to ensure that adequate facilities, equipment, and staff are available and that adequate arrangements have been made with base hospitals for the treatment of complications, if and when they arise.

4. (1) That all public hospitals with full and approved facilities be licensed to carry out abortions and that such private hospitals as have full surgical facilities also be licensed if they desire it.

(2) That the licensing of day clinics in particular areas should be dependent, not only on whether they are able to offer satisfactory surgical and medical care, but on whether there is a need for clinics in those areas.

5. That before any decision is made on abortion, the patient be given independent and objective counselling separate from the institution in

which abortions are performed and that such counselling be carried out at a counselling service established by the statutory committee or by some counselling agency approved by the statutory committee.

6. That in order to ensure the uniform, impartial, and efficient working of the abortion laws, panels be established under the jurisdiction and oversight of the statutory committee to decide, after considering all relevant information, whether the abortion sought is justified within the law.

7. That such panels consist of three members, two of whom are medical practitioners and the other a social worker, and that the social worker, while not being entitled to vote on any abortion decision, have the right to be present at all meetings of the panel.

8. That, before any decision on abortion is made, the panel have regard to:

(1) A statement from the woman's general practitioner or specialist of the reasons for requesting abortion.

(2) Any further medical reports.

(3) Advice that the woman has been adequately counselled.

9. That, if the application for abortion is granted, the panel refer the woman without delay to the hospital or clinic where she desires the abortion to be performed.

10. That, if the application for abortion is refused, regard be had to the desirability of the counsellor making arrangements for further counselling to be given to the woman and referring her to appropriate supporting services.

11. That it be the duty of each panel to keep full records and to report regularly to the statutory committee on all requests for termination of pregnancy, all requests which have been granted, the grounds on which they have been granted, together with relevant personal details and any other information which the statutory committee may require.

12. That it be regarded as essential to the working of such a system that particular attention be given to:

(1) The treatment of the patient with care, courtesy, and consideration.

(2) The adequate counselling of the patient.

(3) Speedy assessment of each case.

(4) Prompt referral to hospital or clinic, or supportive services.

13. That in the establishment and operation of a counselling service it be noted that:

(1) Such a service can well be conducted in the same building in which the assessment panel conducts its sittings.

(2) The counselling service should be directed by an experienced, professionally trained social worker who may be a member of the panel.

(3) Counsellors should be thoroughly familiar with all social services and alternatives to abortion such as adoption and solo parenthood.

(4) Where there are no trained counsellors available in a particular area, agencies may be approved to carry out the counselling service.

(5) Consideration should be given to the employment of trained lay counsellors where professional counsellors are not available.
(6) The State should pay for the cost both of the counselling of the pregnant woman and of the assessment by the panel.
(7) The counsellor should be the first person to see the applicant after referral by the medical practitioner to the panel and should obtain her relevant history and counsel her.
(8) The counsellor should be trained to give contraceptive advice. Alternatively, nurses or para-medical staff should be available to do so.

14. That any abortion carried out in a public hospital be free of charge to the patient. If a woman does not wish to have an abortion carried out in a public hospital, the cost should fall on her, as is the case with any other medical treatment, subject to the receipt by the hospital of the customary hospital subsidy.

15. That charitable trusts be permitted to carry out abortions at a direct charge to the patient and that such trusts operating within the abortion area be treated no differently in the matter of tax relief from charitable trusts operating in other areas of business.

16. That the State have the right, on the advice of the statutory committee, to fix maximum fees for abortions.

17. That, as an alternative to the system of decision-making by panels, the decision be made by two doctors under the general framework and supervision of the statutory committee, and that such decision then be made only after the pregnant woman has been counselled at the counselling service established by the statutory committee or at one approved by it.

In the event of the adoption of this alternative, the two medical practitioners, if they are in private practice, should not be partners; one should not be employed as the assistant of the other or be employed or share a financial interest in the same nursing home or agency; one of them should be of at least five years' standing.

18. That the requirement that no abortion shall be performed unless and until a decision to that effect has been made by a panel or two doctors, as the case may be, be waived where one medical practitioner is of the opinion, formed in good faith, that the termination is immediately necessary to save the life of the mother or to prevent grave permanent injury to her physical or mental health.

Chapter 26

SUPPORTIVE SERVICES FOR WOMEN AND FAMILIES

The Commission is of the view, on the evidence given to it, that there are considerable deficiencies in the support services available to mothers and families in New Zealand. In this chapter we evaluate the support services at present available for pregnant women and mothers who have difficulty in raising children and point out the areas in which we believe that inadequacies in the existing services should be remedied.

There is a good deal of truth in the statement that abortion represents a failure on the part of society. Women who seek abortion may do so either because of socio-economic failures resulting from a lack of social or financial services, the availability of which would help during pregnancy, or after the birth of a child, or because of the lack of knowledge that such services exist. There is, too, a tendency to underestimate the special needs of mothers in the contribution they make to society. As the report of the Select Committee on Women's Rights stated: "In a society overtly concerned with money, power, position, and prestige, the universal qualities of mature motherhood can easily be unrecognised, devalued, and pushed aside."

There are a number of ways in which the special needs of women may arise. In particular, mothers with young children may at times find the important task of caring for young children to be too burdensome. Women with physical, psychological, or intellectual disabilities may require practical help in the home as well as adequate medical treatment. Some may require help to assist in looking after a member of the family who is unwell.

If these needs are not met by relatives, friends, or social agencies, some women, unable without that help to function adequately as mothers, may seek abortion for reasons which are no more than social or economic in origin.

Within the community itself there are a number of organisations which aim to provide services for women with particular needs. Family doctors may sometimes be approached on problems of a social as well as of a medical nature. Social welfare agencies may provide individual and family counselling and give financial and material assistance to those in need. With the expansion by central government of social welfare programmes, more voluntary agencies have been set up, and there are increased opportunities for truining in social work. These are important as

there is a limit to the amount of help that central government can provide for the needs of citizens.

SUPPORT SERVICES AVAILABLE DURING PREGNANCY AND CONFINEMENT

Although pregnant women may seek help from the family doctor or a family planning association regarding their own future and that of the child, there are cases where medical practitioners have no real knowledge of the social background of the patients and their family or have no special experience in counselling. However sincere their interest, they may have insufficient time to listen to what will be essentially a narrative of social and economic factors. In that situation a woman may not receive proper counselling, yet the need for adequate counselling services is clear. In a large number of submissions the need for the provision of these services for women seeking help was stressed. Their place is to provide an objective sounding-board for discussion and to inform the woman of the help that is available to her if she continues with her pregnancy. Quite apart from the setting up of the independent counselling service to which we have made reference in Chapter 25, we are of the view that there is a need for hospital boards to expand their existing social services for women attending antenatal clinics or being treated in women's hospitals. Social workers attached to gynaecological and obstetric departments of public hospitals are in a very good position to help unmarried mothers, to give care to solo mothers, and to help those under stress. Social work services in these areas do not appear to have received as much attention or to have developed as quickly as services for medical, psychiatric, and geriatric patients. The Commission believes that in some women's hospitals social workers have not been accepted by medical staff as being members of the hospital professional team and that, until this recognition is given, an important part of the overall service provided for women in those departments will be lacking.

The attention of the Commission was drawn to the work undertaken by church and other social work agencies which offer counselling and case work services for mothers and families. Such agencies may have a more personal influence in that they are not restricted by institutional requirements as is the case with hospital social workers and social workers employed by the Department of Social Welfare. Within the limits of their financial resources, these agencies provide a counselling and welfare service which complements the medical treatment given by general practitioners. It is our view that, with additional government financial support for staffing, more comprehensive counselling could be provided by them in the field of preventative health services.

We were made aware of the work of those organisations which give practical help for women and girls during pregnancy. Their aim is to provide counselling in times of crisis, accommodation, and other assistance for women during pregnancy and confinement and for a short period after the birth of the child. Where there are continuing problems concerned with child management or strained marital relationships, other agencies more particularly concerned with these issues are asked to assist.

In the view of the Commission, the independent counselling service mentioned in Chapter 25 might well refer some women to organisations of this kind.

Financial Provision for Unmarried Mothers

The financial independence of the unmarried mother has been ensured, in part at least, by the Domestic Purposes Benefit which was introduced in 1973. This provides for a weekly payment to an unmarried mother over the age of 16 years who is caring for a dependent child or children and is inadequately maintained by the father. The allowances are $52.32 for one child, $55.32 for two children, together with $1.25 for each additional child. In order to qualify for this benefit, an unmarried mother must initiate maintenance proceedings against the father of the child but does not herself have to enforce the maintenance order. An additional benefit of up to $15 per week is payable, depending on outgoings, if there is financial hardship for the mother. The Domestic Purposes Benefit is payable to the following classes of persons:

(1) Unsupported male and female parents over 16 years of age. These include divorced, separated, and unmarried persons, those whose spouse has been continually in a psychiatric hospital for not less than six months, and those whose spouse has been in prison.
(2) Women without dependent children under certain circumstances.
(3) Male or female applicants over the age of 16 years who are required to give full time care and attention to a person (other than the husband or wife of the applicant) who would otherwise have to be admitted to a hospital.

Those applicants who do not qualify for the Domestic Purposes Benefit (mainly solo parents who have not yet taken, or who failed to take, maintenance proceedings, and those who are unable to meet the residential qualifications) are, in appropriate cases, granted an emergency benefit analogous to the Domestic Purposes Benefit. If the criteria for the statutory benefit are eventually fulfilled, the beneficiaries are transferred to the statutory benefit.

From the sixth month of their pregnancy, single pregnant women are entitled to sickness benefit based on their loss of earnings, and emergency benefits are available for those women not eligible for a sickness benefit. As at 31 March 1976, a sickness benefit for an unmarried person 18 years and over was $33.20 and for a girl under 18 without dependants was $23.35 per week.

In the year ending 31 March 1976, there were 23,047 benefits paid, of which 472 were paid to males. The number of persons receiving the Domestic Purposes Benefit or the related emergency benefit has continued to rise since it was first introduced. In the year ended 31 March 1976, the sum of $48,903,061 was paid in Domestic Purposes Benefits compared with $30,156,109 in the previous year. Some recovery of the amounts paid is effected by the Department of Social Welfare from maintenance payable

by the husband or wife of the beneficiary or by the father or mother of the child in respect of which the benefit is paid. During the year ended 31 March 1976, the Department of Social Welfare recovered $6,113,483 in maintenance payments for persons receiving the Domestic Purposes Benefit.

In alleviating the hardship to solo parents who wish to keep their children, the Domestic Purposes Benefit has undoubtedly achieved one of its objectives. Some consider that it has gone much further than this. On a number of occasions the view was expressed to us that it had not only succeeded in this object but had influenced mothers to keep their children when in fact it would have been better for both mother and child if the latter had been adopted. It may be that some young mothers have elected to keep their children only to find subsequently that there are some real difficulties in the adoption of such a course. It is not for us to express an opinion on this issue, and as the matter is only peripheral to our inquiry we refrain from doing so. While, therefore, the Domestic Purposes Benefit may have encouraged some unmarried mothers to keep their children rather than have them adopted which, both for their own good and the good of the children, would have been the wiser course, the need to ensure that a child's upbringing is not impeded by the lack of reasonable finance must be recognised. The reduction of the benefit could place a mother, particularly if she genuinely wishes and has the capacity to bring up the child, in an invidious position.

Case Work

Under section 10 of the Children and Young Persons Act 1974, social workers employed by the Department of Social Welfare have a statutory duty to investigate the circumstances surrounding each ex-nuptial birth and "to make such enquiries as may be necessary to ascertain the condition of the child and its mother and to take such steps, if any, in the circumstances" as may be necessary. The majority of mothers of ex-nuptial children are in fact visited by representatives of the Department of Social Welfare soon after the birth of their children. The number of mothers requiring help has grown with the increasing number who have decided to keep their babies. In 1975, inquiries made by social workers investigating ex-nuptial births showed that a total of 2,942 infants remained with their mothers (representing 34 percent of all inquiries) while another 2,758 remained with their mothers while they were cohabiting with the infants' fathers. Considerable help can be given to such mothers by social workers provided that those social workers are accessible and not overburdened with other activities.

The Commission was told that the ability of the officers of the Department of Social Welfare to offer any form of comprehensive case work service in furtherance of the statutory duty was greatly reduced by the burden of work which social workers were carrying. The Commission considers that the time given to the counselling of unmarried mothers is well spent and that there is a need, both to increase the number of social workers in the Department of Social Welfare so that more will be available

there for this work, and to make increased finance available to other agencies so that they, too, may be able to provide social workers.

The Putative Father

The putative or unmarried father has a responsibility to accept some of the consequences of a pregnancy. He should provide financial support for the unmarried mother. He can play an important part in helping an unmarried mother come to the best decision for herself and her baby by supporting her in the crisis period when the outcome of the pregnancy is being discussed.

It was brought to our notice that a pregnancy also poses problems for the putative father. He, too, may need counselling help to resolve them.

Child Care

There is a need for day care services to be provided for the children of those solo mothers who are compelled to go to work. Frequently this care is entrusted to relatives but they may not always be available to undertake the work.

The Department of Social Welfare in its annual report notes that concern has been expressed by various groups in the community that there is a need for greater provision of all-day care facilities. Centres which are primarily a temporary substitute for the care of children by parents are conducted by day nurseries, by universities for the children of staff and students, by factories for the children of employees, and by registered children's homes. A few day nurseries provide overnight care. At present there is room for 4,312 children in centres offering day care. This is an increase of 22 percent on the number available in 1974.

The costs involved in leaving children to be cared for in these centres is met by the parents whose children attend although the Department of Social Welfare gives financial assistance for those children whose parents cannot afford to pay the full cost.

There has been an increasing involvement of local bodies, directly or indirectly, in providing day care centres for pre-school children. Experimental courses for training staff for child care centres have been established at Technical Institutes and Polytechnics. Some solo parents have had to resort to the use of "backyarding" or other informal arrangements in which children are gathered together, unfortunately not always with satisfactory supervision. The Commission considers that there is a need for continued expansion of day care centres of a suitable kind, particularly for the children of solo parents.

Girls in Care

Sexually active girls sometimes come under the supervision of a social worker employed by the Department of Social Welfare or a Probation Officer or, if severely disturbed or delinquent, they may be placed in a training centre or penal institution. Some of these girls may be pregnant at the time of their admission to such centres or institutions and others may

have or have had venereal infections. Girls placed in institutions because of particular difficulties relating to their social or emotional backgrounds or coming under supervision run a considerable risk of becoming pregnant. In the case of such girls, changes in sexual attitudes and behaviour would be hard to achieve. Education in these matters may well be to little avail. Nevertheless, in the view of the Commission, it is important that they be provided with individual and professional counselling and advice on contraception. Indeed, in all reform institutions, there may be a need to ensure that some inmates are given contraceptive advice and education. It is important that their position should not be overlooked. The Commission would expect that, if the law regarding the giving of contraceptive information and the provision of contraceptives is altered in line with its recommendations, both the Department of Social Welfare and the Department of Justice will be able to ensure that education and counselling services on contraception will be fully implemented in their institutions.

Adoption

In Chapter 23 we refer to trends which have become apparent in the number of children being adopted each year in New Zealand. There are a number of reasons for these trends. There is probably less pressure now placed on the girls to consider adoption in view of the more tolerant attitude of society towards solo parenthood. The Domestic Purposes Benefits now paid have also made it economically possible for a girl to keep her child. Adoption will, however, always have its place in society. There is much to commend it. It is imperative that social workers with special experience in the field of adoption should be available for the selection of adopting parents suitable for the child and to assist the mother of the child through the stress of placement.

Services for Mothers with Special Needs

A number of submissions were made to the Commission concerning the position of mothers who face special difficulties in caring for their children, particularly very young children, when there is sickness in the home or when the mother herself requires hospitalisation. There have been a great number of cases of relatives, friends, and neighbours who are able to help women in such situations, but there are occasions when home aid help can be obtained only if it can be paid for. There appear to be limits to the extent to which subsidised home help is available in New Zealand. Some hospital boards give home aid help for people who are receiving district nursing care, namely, the disabled, the aged, and mothers after they have been discharged from hospital. The Department of Social Welfare also has a system of home aid help. In some centres the services of these aids are paid by the department although priority is given to people who are on a social welfare benefit. Some financial help is available from the department for mothers in certain cases to engage the services of a Karitane nurse or other suitable help. The Commission is advised that the home help scheme conducted by the Department of Social Welfare and

the home aid scheme administered by the Department of Health through the hospital boards were reviewed in 1975 and that recommendations following upon this review are still under consideration. The Commission is hopeful that, when the new scheme is announced, more subsidised home aids will be available.

Evidence was given to the Commission by individual mothers and by welfare agencies that some mothers face great difficulties in caring for physically or mentally handicapped children at home. For these children help is hard to obtain, and there is a lack of institutions which can accommodate them temporarily so that mothers can obtain respite for short periods. Parents of these children face exceptionally high expenditure. Under the terms of the Disabled Persons Community Welfare Act which was passed in October 1975, the Department of Social Welfare may meet the costs of providing alternative care for a seriously disabled child or adult for up to four weeks in each year. By June of this year some 85 persons had applied for assistance under the scheme. The Commission is of the view that if the provisions of this Act are made more widely known more persons will avail themselves of its benefits.

Legal Services

Mothers, particularly unmarried mothers, likely to require legal advice on matters relating to paternity, maintenance, separation, custody, and property may apply for legal aid under the Legal Aid Act 1969. An applicant may, according to her financial resources, be requested to make some contribution to the cost of the anticipated action. It was suggested to us that there are two main reasons why the public do not consult the legal profession. The first of these is the inability of people to meet costs and the second is the fact that legal offices are situated in the centres of big cities and are therefore out of the reach of a great many members of the public. The legal profession has itself recognised these factors in helping to implement the Legal Aid Act and in establishing law centres in some areas where there is a concentration of Maori and Island families often falling into low income groups and therefore less likely to seek legal help from large city offices.

Organisation of Family Social Welfare Services

Although, as this chapter indicates, there is in fact a proliferation of services available within the community, we were concerned to learn that many young mothers and pregnant girls are unaware of their existence or do not know to which body they should turn for help. With the emergence and growth of new services there is a need for a closer liaison within existing welfare services. For these reasons the Commission recommends that there should be regular consultation between government departments and voluntary agencies working in the field of child and maternal welfare for the dissemination of information and the better co-ordination and advertising of all services. It seems advisable, too, that welfare services should be named in such a way that the name is truly representative of the services they offer otherwise there is a danger that members of the public may be misled as to the kind of activity which they undertake.

RECOMMENDATIONS

1. That hospital boards expand their existing social services for women attending ante-natal clinics or being treated in women's hospitals.

2. That the status of social workers as part of professional teams in women's hospitals be recognised.

3. That church and other social agencies be encouraged, with government financial support, to offer more comprehensive counselling and case work services for mothers and families.

4. That the number of social workers in the Department of Social Welfare be increased so that more will be available to work with mothers and families.

5. That, within all penal and reform institutions dealing with young offenders, provision be made, in terms of the wider recommendations made in Chapter 2, for the giving to inmates of contraceptive counselling and education in matters of human development.

6. That social workers with special training and experience in the field of adoption be available to help with the selection of adopting parents and to assist the mother of the child through the stress of placement.

7. That in order to ensure a closer liaison within existing welfare services, and to ensure the dissemination of information and the better co-ordination of such services, there be regular consultations between Government departments and voluntary agencies working in the field of child and maternal welfare.

Chapter 27
THE FAMILY

Although we are not, by our terms of reference, required to comment on the family, a number of individuals and organisations who made submissions to us on contraception, sterilisation, and abortion stressed the importance of the place of the family in society. Undoubtedly the family has been the basic unit of society. It has been the centre of religious, educational, and recreational activity. Its importance has been stressed in Judaeo-Christian teaching, although it is fair to say that its influences have transcended religious boundaries.

"FAMILY" DEFINED

The word "family" may have different meanings according to the context in which it is used. We are aware that a Cabinet Committee on family affairs has been established and that, for its purposes, the family has been defined as a group of people including the very young and the elderly who live in a close association which produces interdependence and a moral obligation to support one another. This definition would include, not only the family as we understand that term, but persons, quite unrelated by ties of blood, who are living in association with each other for the time being. In our discussion we regard the family as referring primarily to parent or parents and the child or children living with them in one household.

The great majority of those who made submissions to us supported the family as the central unit in society and subscribed to the principle embodied in Article 16 of the Universal Declaration of Rights: "The family is a natural and fundamental group unit of society and is entitled to protection by society and the State".

THE CHANGING FAMILY

The family is still the basic unit in which children are reared and housing, food, and clothing are provided. The law, both in the United Kingdom and New Zealand, still upholds the place of the family and the rights and responsibilities of parents. We are bound to recognise, however, the powerful influences now exercised on the organisation and role of the traditional family by industrialisation and urbanisation. As a result, children now spend less time in the family home. They may find their education and recreation away from the family. Improved transport and increased affluence have given both parents and children wider horizons. Children, on achieving financial independence, may leave the family home and establish, with others of the same age, independent households. Fewer remain at home until marriage.

There are other factors that have affected the stability of the family, the duration of its influence, and its size. The rate of divorce has increased in

the past decade. Table 46 shows the decline in the total number of marriages since 1971 and the increase in the percentage of marriages ending in divorce between the years 1965 and 1974 inclusive.

Table 46—New Zealand Marriage and Divorce Rates 1965–73

Year	Number of Marriages	Rate per 1,000 of Population	Divorces Decrees Absolute	Divorces as Percentage of Marriages	Total Population
1965	21,702	8.23	1,814	8.4	2,635,000
1966	22,949	8.55	2,064	8.9	2,682,000
1967	23,515	8.62	2,047	8.7	2,727,000
1968	24,057	8.74	2,172	9.0	2,753,000
1969	24,971	8.98	2,996	11.9	2,780,000
1970	25,953	9.20	3,136	12.0	2,819,000
1971	27,199	9.50	3,347	12.3	2,864,000
1972	26,868	9.21	3,471	12.9	2,916,000
1973	26,274	8.82	3,616	13.7	2,978,000

Source: *New Zealand Official Yearbook.*

A decree of divorce in a marriage in which there are still young children affects the stability of the family unit and the lives of the children within it. There has been a decrease in family size. The average number of children in the New Zealand family decreased from 4.15 in 1962 to 2.58 in 1974. According to the Hutt Valley survey to which we refer in Chapters 2 and 6, 60 percent of the women questioned saw a two or three child family as ideal. Those conducting the survey reported:

"The two or three child family is seen as ideal by nearly 60 percent of women in the survey. The reasons given by these respondents for their ideal family size preferences are mainly related to the economic and psychological strain of bringing up larger families in the New Zealand urban environment. Few of these respondents justified their choice as being beneficial for the child, in comparison with a number of respondents who favoured larger ideal family sizes for this reason. Hardly any of them perceived the world population problem as having any reference to their own family size preferences. Only 13 percent of the respondents holding this two or three child ideal justified the choice on the grounds that this made for a 'complete' family unit or corresponded in any way with an accepted family size norm. In contrast nearly half the respondents favouring an ideal family size of four children felt that this size reflected some community concept of the 'family unit'. These findings suggest that while the concept of the two child family is receiving increasing support for practical reasons, it has become established as a social norm only to a limited extent. The four child family remains to many people 'the ideal' family in the sense of the ideal number of children who will appear in 'ideal' conditions."

We do not see any particular family size as being "ideal". It is for parents to make their own decisions in the light of their own responsibilities and resources. Some parents enjoy their large families and are well able to love and care for them; others find themselves less able to

meet the demands, both personal and economic, which the rearing of a number of children imposes. These factors emphasize the need to allow parents to decide their own family size. Decisions on such matters should not be affected either by legislation or social pressures.

DECLINE IN THE RATE OF MARRIAGE

We have referred elsewhere in this report to the increasing number of children reared by solo parents. Some part of the increase in the number of ex-nuptial births has been caused by a decrease in the number of marriages. In 1971 there were 95 marriages per 10,000 of population but by 1976 the number had declined to 77 per 10,000. There are now a greater number of couples who are living in de facto relationships. Such relationships have been given an increasing measure of recognition by society and by the law itself. Two instances will suffice to demonstrate this:

The Status of Children Act 1969 has removed the stigma attached to ex-nuptial status by abolishing reference to "illegitimate" births. The Domestic Proceedings Act 1969 empowered the court to take into account the existence of de facto relationships in determining the amount of maintenance payable by one spouse to another. Such legislation reflects the recognition given by society to relationships outside of traditional marriage, and the trends to which we have referred will no doubt continue. Yet, for all that may be said of the changes in the traditional role of the family, no substitute has been found for it. Although young people now leave home at an earlier age and enjoy work and travel opportunities not previously known to those of the same age, thereby lessening the intensity and duration of the family influence, the importance of the traditional family as the central unit around which society is built and as the foundation-stone for standards of conduct cannot be overstressed.

We do not overlook that social changes have given rise to a need for adjustment of roles within the family. Women have assumed vocations in the community in addition to their responsibility as wives and mothers within the home. Adjustments in some of the traditional roles of husband and wife have, on that account, been required. In recognition of these changes, there is a need for a greater willingness on the part of husbands to discharge many tasks within the home, including the upbringing of young children which in the past has been largely left to women.

We do not purport to offer, within the framework of a report in which we are not called upon to make recommendations relating to the family, specific suggestions whereby the family and its sphere of influence within the community may be preserved. The study of family relationships is a subject in itself. We reiterate, however, the need to maintain its place. The state itself has a powerful interest in the maintenance of the family. There is no better place than the family for the inculcation of a proper respect for life, for other people, and for truth, from the adoption of which all within the community must benefit. In our view, legislation bearing on human relationships should take this into account.

Chapter 28
THE CONSCIENCE CLAUSE

THE POSITION IN NEW ZEALAND

The provisions of the Crimes Act 1961 relating to abortion make no reference to the position of a medical practitioner or of a nurse who, because of the dictates of conscience, does not desire to take part in a therapeutic abortion or in an operation for sterilisation. It is, however, well established that medical practitioners and nurses do not incur any sanction either of the criminal law or their professional bodies for refusing on the grounds of conscience to take part in such operations.

In larger hospitals where staffing is adequate, problems of conscientious objection, if they arise, are usually capable of resolution by rearranging the rosters of professional staff. In smaller hospitals an added responsibility may be placed upon the medical and nursing staff, but the increased volume of work is seldom made unduly burdensome to those who assume it.

In other countries difficulties have arisen, and in the legislation of some there is provision in the form of what is known as a "conscience clause" to cover the case of medical practitioners and nurses who have a conscientious objection to participation in an abortion. Two such places are the United Kingdom and South Australia.

STATUTORY PROVISIONS IN THE UNITED KINGDOM AND SOUTH AUSTRALIA

When the Abortion Act 1967 (U.K.) was enacted, provision was made to cover the case of those who had conscientious objection to participating in abortions. Section 4 of the Act provides:

Conscientious objection to participation in treatment

4.—(1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

In South Australia, section 82 (a) (1) of the Criminal Law Consolidation Amendment Act 1969 sets out the grounds upon which abortion may lawfully be performed:

> 82a. (1) Notwithstanding anything contained in section 81 or section 82 of this Act, but subject to this section, a person shall not be guilty of a felony or misdemeanour under either of those sections—
>
> (a) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman—
>
> (i) that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman or greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; or
>
> (ii) that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped, and where the treatment for the termination of the pregnancy is carried out in a hospital or a hospital of a class declared by regulation to be a prescribed hospital or a hospital of a prescribed class for the purposes of this section; or
>
> (b) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave injury to the physical or mental health of the pregnant woman.
>
> (2) Paragraph (a) of subsection (1) of this section does not refer or apply to any woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy.

The position of those who have conscientious objections to performing or participating in abortions is covered by section 82 (a) (5) which provides:

> (5) Subject to subsection (6) of this section, no person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by virtue of the provisions of this section to which he has a conscientious objection: But in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it.

SUBMISSIONS MADE TO THE COMMISSION

Submissions were made to us on the effect which any liberalisation of the abortion laws would have on the medical profession, medical students, and nursing staff. Some of these submissions were also directed to sterilisation and contraception where views of conscience may also be held. It was said to us that liberalisation of the laws on abortion would be likely to have an adverse effect on recruitment to the specialties of obstetrics and gynaecology which have been traditionally directed to the saving of life rather than to its destruction. It was also said by some nursing groups that recruitment to the nursing profession would likewise be affected because some would be deterred from entering it through fear of having to participate in abortions. These groups maintained that senior nurses were able, at present, to excuse themselves from participating in abortions while some younger or junior nurses were not. Other nursing groups, however, did not share this view, holding that there was no evidence to support the contention that liberalisation of the law would

adversely affect the recruitment of nurses and their retention in the service or lessen their morale and satisfaction with their vocation.

While we strongly support the right of any medical practitioner or nurse to refuse, on the grounds of conscience, to take part in any operation for abortion or sterilisation or to prescribe contraceptives or give contraceptive advice, we do not consider that recruitment to the medical profession or the nursing profession will be adversely affected by any of the changes which we have recommended to the law.

THE WORKING OF THE "CONSCIENCE CLAUSE" IN THE UNITED KINGDOM

The operation of the "conscience clause" in the Abortion Act 1967 is referred to in the report of the Lane Committee to whom submissions were made on the problems which abortion posed for nurses and midwives in particular. In paras. 371-374, the Lane Committee said:

(a) Nurses and Midwives

371. In the N.H.S., the Abortion Act has brought unhappiness to many hospital nurses. The nursing profession, by long tradition, is a caring one dedicated to the prolongation and the saving of life. Whilst the doctor has the heavy burden of decision concerning an abortion, the nurse is the person most constantly in attendance on the patient and frequently becomes her confidante. Young nurses may find that they are ill-equipped emotionally to cope with the stresses which abortion work occasions, whilst the more experienced nurses often find it difficult to accept the accelerating demand for the destruction of intra-uterine life, which in other patients they have tried to preserve. For nurses there may be an increasing work-load and few, if any, additional staff. Also for some the very nature of the work offends their deepest feelings or religious convictions. Practising midwives in particular are accustomed to providing total care for mothers and their babies but find it very difficult to reconcile their training and resultant attitudes with caring for patients undergoing termination of pregnancy.

372. From the professional nursing organisations there is evidence that the Act has had little or no effect on nurse recruitment, but there has also been evidence from other sources to the effect that trained staff have resigned from their posts because of it. We have heard of how distressing it has been for some theatre nurses who have had to assist at operations for termination of pregnancy, especially when they have had to dispose of the fetus, and for ward nurses who have had to care for patients having mid-trimester abortions with the distress caused by a miniature labour, possibly resulting in a living fetus.

373. While in theory section 4 of the Abortion Act entitles those with a conscientious objection to opt out of abortion work, many nurses are loath to do so. This may be either because they are reluctant to place an extra work-load on their colleagues or because they fear that as a result of opting out adverse comments may be made in their personal records and their promotion prospects thereby affected. A survey carried out for the Society for the Protection of Unborn Children showed that 7 per cent of nurses would refuse to attend an abortion and 8 per cent had considered withdrawing their services on ethical grounds.

374. In some instances an effort is made to involve nurses and midwives in the discussions and consultations which take place both in the community and in hospital as to abortion. This enables those working in the community to see for themselves the patient and family environment and enables those working in hospital to have a greater understanding of the problems involved and to appreciate the difficulty of the medical profession in keeping a balance between abortion work and other gynaecological procedures. The importance of mutual trust and confidence being built up and maintained between doctors and nurses and midwives undertaking abortion work cannot be over-emphasised.

In the United Kingdom, difficulties in the operation of the "conscience clause" have affected the employment of doctors. There have been claims that some medical practitioners have been discriminated against because of their unwillingness to take part in abortions. Some of these complaints appear to be well-founded.

The minutes of the meeting of the Council of the Royal College of Obstetricians and Gynaecologists on 25 May 1973 record: "Difficulties have arisen at Advisory Appointments Committee when candidates have been asked without warning whether they would be willing to undertake work under the Abortion Act. At the request of the Joint Consultants Committee, the Department of Health attempted to devise a warning phrase for inclusion in advertisements. However, the view of Council is that it would be wrong to exclude any candidate who was judged to be the most capable and experienced applicant, just because he held particular opinions on the single matter of termination of pregnancy. It was accepted that the decision by the Advisory Committee might be influenced by local needs, that no candidate should be 'warned' off. The Department has accepted this view."

On 8 February 1975 the Chairman of the Council stated: "It is the general wish of Council that the requirement to perform terminations of pregnancy should not appear in advertisements for consultant posts, although it is accepted that this may be included in the job description on the specific advice of local consultants if this requirement is essential for the work of a particular hospital in which the other consultants are unwilling to terminate pregnancy.

"While it is easy to criticise this compromise, it does at least prevent this requirement being written into every advertisement by administrators, and we intend to keep a close watch on the working of this scheme."

In 1975 the Chief Medical Officer in the Department of Health and Social Security in England issued a memorandum, the effect of which was that doctors who objected to performing operations on the grounds of conscience should not be appointed to certain posts. The memorandum, which was directed to persons who made appointments in the National Health Service, made it clear that this fact was not to be referred to when posts were advertised and nothing was to be said at interviews relative to the personal beliefs of a candidate.

The departmental memorandum of the Chief Medical Officer of Health prompted the late Cardinal Heenan to write to the then Prime Minister of the United Kingdom a strongly worded letter of protest which included this passage: "This memorandum effectively serves notice on gynaecologists, anaesthetists and psychiatrists that they have no future in the National Health Service. I write on behalf of Catholics, but of course, there are many others who have conscientious objection to taking life. It must further be said that although the memorandum talks only of consultants, its message may eventually affect general practitioners, and still more, the thousands of hospital nurses who refuse to take part in abortion."

The Prime Minister replied at length. In his letter he said:

There had for some time been a clear need for guidance to be given to health authorities and to advisory appointments committees (upon whose recommendations alone appointments to consultant vacancies are made) on filling consultant vacancies in areas where abortion services were needed; and specifically on whether applicants should be informed of this and of what questions they might properly be asked about their preparedness—solely on professional as opposed to religious grounds—to provide such services. If guidance had not been available it would, I believe, have been all too easy for applicants to have been misled and committees drawn into unsuitable lines of questioning.

You will see that the procedures advised are only to be followed where it has first been properly established in each local instance that adequate facilities for termination of pregnancy in the circumstances provided for by Parliament would not be available to the detriment of patient care, if the consultant appointed was unwilling to be involved in this work. This situation arises in some localities because some of the consultants there have, quite properly, exercised their legal right, to which I have referred, not to perform abortions. The procedures have been designed as much to help those who have objections to the termination of pregnancy on grounds of religious belief or conviction of conscience, so that when they apply for posts in localities where adequate facilities for termination already exist there will be no need to question them, as to assist health authorities in fulfilling the twin duties laid upon them by the 1967 Act. Neither the Secretary of State nor I would accept for one moment that the chief medical officer's advice, which will in fact help those applying for posts, means that there is no future in the N.H.S. for some doctors. There is every future for them. Moreover, the chief medical officer's letter, written after full consultation with the representatives of the medical profession, is solely to assist over consultant posts in the situation for which Parliament has made express provision; the advice does not apply to nurses, nor to general practitioners.

I do of course understand the anxieties which prompted your letter, and I hope that this explanation of the responsibilities of the National Health Service will allay them.

You also refer in your letter to the possibility of the legislation of "killing of the old and incurably sick." Such a policy of euthanasia would be wholly abhorrent and there is absolutely no question of this government—or I believe of any government—ever giving it support.

In commenting on the Prime Minister's letter, Cardinal Heenan said: "The Prime Minister says that candidates would be questioned on their preparedness to assist in abortions 'solely on professional as opposed to religious grounds'. I believe this to be a false dichotomy. Whether or not they practise any religion, many doctors have a professional objection to taking life. I believe that the advance of these doctors in the N.H.S. will be impeded."

REPORT OF SELECT COMMITTEE OF HOUSE OF COMMONS

We note that the Select Committee established by the House of Commons to consider the Abortion (Amendment) Bill also considered the "conscience clause" of the Abortion Act 1967. It considered that the burden of proof of conscientious objection, whether it be made on religious, ethical, or other grounds, should not be made to rest, as section 4 of the Abortion Act 1967 provides, on the person claiming it. It recommended that section 4 be amended accordingly. The Committee said of section 4: "This provision is made to deter frivolous claims and to prevent anyone falsely calling in aid conscientious objection to excuse

negligence. In the opinion of your Committee, this exception to the general rule of burden of proof is not justified. We have received no evidence of frivolous and false claims having been made. We recognise the difficulties of those whose objections do not depend on religious grounds."

ATTITUDE OF THE COMMISSION

We think that no medical practitioner or member of the nursing staff of any institution who objects on sincere conscientious grounds should be obliged to take part in any operation for abortion or sterilisation or be required to fit contraceptive devices, supply contraceptives, or give contraceptive advice. In our opinion:

1. No medical, surgical, nursing, or paramedical personnel should be under any obligation to assist at, or participate in, any abortion or sterilisation, or the fitting of any contraceptive device, or supply of any contraceptive, or the giving of any contraceptive advice if that person has conscientious objection based on religious, ethical, or other ground.
2. No provision of law or practice should exist which would make housing, accommodation, the holding of office, or the enjoyment of any benefit dependent upon the participation of any medical, surgical, nursing, or paramedical personnel in any abortion, sterilisation, or the fitting of any contraceptive device, or supply of any contraceptive, or the giving of any contraceptive advice.
3. Medical, surgical, nursing, and paramedical personnel holding such a conscientious objection should not be required to participate in any panel considering applications for abortion.
4. In public hospitals the obligation of any medical, surgical, nursing, or paramedical personnel to participate in either an abortion or a sterilisation should not be made a condition of employment.

The protection of personnel from participation in activities on the basis of their conscientious objection, in our opinion, carries with it an obligation on the part of such personnel not to allow their views to influence them whenever they may be in a position to exercise a medical judgment. In particular, no one who holds strong views of conscience against abortion or sterilisation should offer to serve on any panel which is called upon to make decisions on applications for these services. A general practitioner holding such views should make it clear to patients whether objections to their requests for abortions or sterilisations or prescriptions of contraceptives are based on views of conscience or on the merits of the individual case. The patient should not be given the impression that an objective medical judgment is being made by the practitioner who, in fact, is doing no more than recording a blanket objection on the score of conscience. It was suggested to us that practitioners who have conscientious objections of this kind should display a suitable notice in their waiting rooms. While this is a matter to which general practitioners might well give consideration, we are not prepared to make any recommendations, the effect of which would be to compel practitioners to display notes of this kind. We do, however, consider that a medical practitioner who declines to let patients know in advance that he has

conscientious objections on these matters might be hard put to justify claiming a fee from a patient for whom, on other than medical grounds, he has declined to provide a service.

RECOMMENDATIONS

1. That no medical, surgical, nursing, or paramedical personnel (whether or not self-employed) be under an obligation to assist at, or participate in, any abortion, or sterilisation, or the fitting of any contraceptive device, or the supply of any contraceptive, or the giving of any contraceptive advice if that person has a conscientious objection based on religious, ethical, or other ground.

2. That no law be enacted or practice established which would make housing, accommodation, the holding of office, or the enjoyment of any benefit dependent upon the participation of any medical, surgical, nursing, or paramedical personnel in any abortion, or sterilisation, or in the fitting of any contraceptive device, or in the supply of any contraceptive, or in the giving of any contraceptive advice.

3. That medical, surgical, nursing, and paramedical personnel holding a conscientious objection be not required to participate in any panel considering applications for abortion.

4. That in public hospitals the obligation of any medical, surgical, nursing, or paramedical personnel to participate in either an abortion or a sterilisation be not a condition of employment.

5. That a medical practitioner who has conscientious objections to giving advice on contraception or sterilisation advise patients accordingly and refer them to another practitioner or agency.

Chapter 29

EDUCATION OF MEDICAL PERSONNEL

COMPLAINTS TO THE COMMISSION

A number of women who spoke to the Commission complained not only of the attitudes of medical practitioners from whom they sought advice on contraception and sterilisation but also of advice or treatment which, in the light of subsequent events, they claimed to have been incorrect. The Commission fully appreciates that women who have suffered emotional stress may not be objective in giving details of their personal experiences and that some complaints of this nature may have little foundation in fact. We appreciate that it would be quite unfair to pass judgment in any particular instance without obtaining a full knowledge of all the relevant circumstances and giving the particular medical practitioner concerned an opportunity to be heard. It is to be remembered that general practitioners often have a heavy case load with numerous calls upon their time. Many give outstanding service to the community and no complaint can be made of the standard of advice and treatment provided by the majority.

However, there seemed to be too many cases where, had the time been taken to discuss with the woman concerned her contraceptive problems or had sterilisation been recommended and performed, the need to consider abortion would never have arisen.

We are somewhat reinforced in this view by the evidence given to us by an associate-professor of obstetrics and gynaecology who expressed the view that many doctors are "ill informed of recent developments in contraception, and some are poorly educated, particularly in the insertion of intra-uterine devices." He believed that many of the failures attributed to the more efficient intra-uterine devices can be blamed on doctors who do not know how to insert the devices and have never been trained in these techniques. Many contraceptive techniques have been introduced in recent years, and since their introduction there have been developments in intra-uterine devices and hormonal contraceptives. Unfortunately some members of the medical profession have acquired their only knowledge of these from information disseminated by the drug companies.

We have communicated with the medical schools to obtain details of the training given to medical students on the subjects of contraception and sterilisation. We are aware that in giving consideration to the content of courses for medical students a number of factors must be borne in mind, including the limited time available in each of the subjects which form part of the course of study.

It has been suggested to us that lectures in contraception and family planning represent a somewhat theoretical approach to matters which are

better dealt with by practical instruction. Where consideration is given to practical training, it is to be remembered that women usually prefer to discuss their contraceptive problems in private with one doctor and that the opportunity for carrying out practical instruction with groups of students is very limited.

It would be presumptuous of us to endeavour to prescribe what should be the content of any medical course except to say that there may be a need to place a greater emphasis on education in matters of family planning. We can do no more than bring to the notice of the medical schools and the medical profession the complaints which have been made to us and express our view that there is a need not only to instruct medical students adequately in matters of family planning, including contraception and sterilisation, but also to provide refresher courses for medical practitioners in which instruction on developments in contraceptive techniques can be given and to encourage and assist medical practitioners to take part in them.

In the case of courses for medical practitioners who are already qualified, it is impossible to compel attendance by the imposition of sanctions as is the case with students, and there is little that can be done other than to encourage them to attend. If they do not keep abreast of technological advances in these fields, they may be hard put to resist the claims of trained paramedical personnel for a greater share in this work.

RECOMMENDATIONS

1. That recognition be given by medical schools, medical associations and groups, hospital boards, and medical practitioners to the need to instruct medical students adequately in matters of family planning.

2. That regular refresher courses in developments in contraceptive techniques be provided for medical practitioners and that they be encouraged and assisted to participate in them.

Chapter 30

EFFECTS OF RECOMMENDED CHANGES ON HEALTH, HOSPITAL, AND MEDICAL SERVICES

TERMS OF REFERENCE

We are required by our terms of reference to report upon the likely effects upon the present health, hospital, and medical services of any changes to the law or practice of contraception, sterilisation, and abortion which should, in our opinion, be made. Very few submissions made to us touched upon this point and only one hospital board made any submissions to us on the specific topic.

CONTRACEPTION AND STERILISATION

In Chapter 5, in discussing contraceptive services, we made recommendations in some detail, the implementation of which would have financial and other effects on present health, hospital, and medical services. Similarly, in Chapter 8 we made certain recommendations aimed at providing or improving sterilisation services throughout New Zealand. They, too, if adopted, would have financial and other effects upon existing services.

Specific Contraceptive Services

Recommendations made in Chapter 5 which are likely to affect existing contraceptive services bear upon the following matters:

1. The setting up by hospital boards of family planning clinics or the improvement of those clinics where they already exist.
2. The offering of family planning advice to all patients attending obstetric and gynaecological departments of hospitals.
3. The provision of increased financial assistance to family planning clinics.
4. The provision of mobile family planning clinics in rural areas.
5. The provision of special home-visiting family planning services for Maoris and Pacific Islanders.
6. The appointment of social workers to work with Maoris and Pacific Islanders.
7. The provision of counselling services at family planning clinics for young people with social and psychological problems.
8. The greater use of trained nursing staff in family planning.
9. The provision of free contraceptives in cases of financial hardship or for approved medical conditions and the provision of increased

financial assistance to enable the initial contraceptive consultation to be undertaken without cost to the patient.

Specific Sterilisation Services

Recommendations relating to sterilisation services are directed to:

1. The establishment at public hospitals of overnight stay facilities and outpatient services for sterilisation of both males and females together with the provision of modern surgical equipment for sterilisation.
2. The provision of counselling services before sterilisation is undertaken and the use by medical practitioners of counsellors trained in this field.

It is difficult to estimate the number of people who would take advantage of the services recommended in the fields of contraception and sterilisation if these were provided, but we anticipate an increase in numbers if these services become readily available. It is, of course, the essence of some of the recommendations that the costs that the consumer would normally bear should be reduced, if not removed. It is difficult to estimate the extra cost involved but we have no reason to think that an insuperable burden would be placed on the State. It has been estimated that the cost of providing contraceptives free of charge in New Zealand at the present rate of use would involve an annual expenditure of $4 million and that, if all the women in New Zealand between the ages of 15 and 44 years were to be supplied with hormonal contraceptives, the total annual cost at retail pharmacy rates would be $8.4 million. We do not go to the length of recommending the provision of free contraceptives to all women of child-bearing age but note that the cost of the services which we have recommended would be less than either of the two figures mentioned. It is plain, however, that the costs involved in the provision of free contraceptives (where a case is made out for them) may well be offset by a reduction in the number of unwanted pregnancies and in the cost of providing social services to mothers and children. The provision of family planning clinics within hospitals where contraceptive advice can be given, contraceptive devices fitted, and sterilisations of both male and female carried out will require either a greater allocation of funds to hospital boards within New Zealand or re-allocation within those boards of funds presently available. It is to be remembered that, if sterilisations can be carried out on a day-care or overnight basis, hospital boards will not be troubled with providing beds on a longer term basis and the health services should be saved the cost of providing facilities at a later stage should an abortion be sought and granted.

ABORTION

The effect of any alterations in the law of abortion and its practice is hard to measure in terms of costs or hospital involvement. We do not think that it is for us to attempt to estimate the numbers of women who will apply for abortion in the future nor is it for us to say what percentage of women should be granted or refused abortion. Whether or not a woman

receives an abortion must depend on whether, in the individual circumstances of her case, the necessary criteria have been satisfied. If these are met she will be entitled to an abortion. It is, however, our expectation that, if effect is given to all the recommendations made in this report on the matters of contraception, sterilisation, and abortion, the number of abortions performed in this country will be reduced.

On the basis of the recommendations which we have made, the State would have to accept the expense of setting up the statutory committee and the provision of the free independent counselling service and of the panels, all of which we have recommended. Indeed, it is our view that, except where we suggest otherwise, the costs of implementing the recommendations which we have made in this report and of providing the necessary health, social, and educational services should be borne by the State. Where applications for abortion are granted, the abortions may continue to be performed at public hospitals, private hospitals, and at clinics. We do not anticipate that, on the code which we have proposed, hospitals, either public or private, or clinics will be inundated with applications for abortion. We see a place for all three types of institution in providing abortion facilities, in accordance with the law, for those women who have received counselling from the independent counselling service and whose applications have been granted after consideration in the manner recommended.

At present it is usual for patients on whom abortions are carried out in public or private hospitals to remain in hospital at least overnight and in some cases for some days. If abortions are to be performed within the first trimester, the most appropriate time from a medical point of view, they can be carried out on a day basis at clinics and hospitals, and the degree of bed occupancy required should not be great.

We are informed by the Auckland Hospital Board, the only hospital board which made submissions to us, that, if the existing practice at National Women's Hospital were followed, the following extra staff would be required for every 1,000 extra cases referred for abortion each year: Medical Officers 2.2; Medical Officer (Welfare) 0.5; Registered Nursing Staff 3.0; Medical Social Workers 2.0. The Auckland Hospital Board estimates that two hospital beds, either day-care or in-patient, would be required for each 1,000 extra cases referred for abortion, assuming that of these 550 (55 percent) would be recommended for termination of pregnancy.

In the absence of any further information, we are unable to report further upon the likely effects of the changes which we have recommended upon existing health, hospital, and medical services except to reiterate that we do not think that they will be in any way beyond the resources of any hospital board or health service.

RECOMMENDATION

That adequate finance be made available to the appropriate Government departments, including those of Health, Social Welfare, and Education to ensure the ready implementation of recommendations made in this report.

Chapter 31
FETAL RESEARCH

IMPORTANCE OF FETAL RESEARCH

Research on fetuses and fetal material has an important contribution to make in the isolation and treatment of diseases in man. Fetal tissues may be used in a number of ways, particularly in preventative medicine.

There appears to be no provision in the law of New Zealand which places restrictions on fetal research. The Human Tissue Act 1964, as amended by the Human Tissue Amendment Act 1968, applies to a "dead human body" but not the "body of a stillborn child" which by section 2 of the Births and Deaths Registration Act 1951 is defined as "a child which has issued from its mother after the expiration of the 28th week of pregnancy and which was not alive at the time of issue." Dead fetuses of less than 28 weeks may, therefore, be used without restriction. Research on dead human fetuses is not, however, completely free from control since most hospitals have ethical committees before which plans for medical research must be laid before approval can be given to a particular programme of research.

REPORT OF ADVISORY GROUP IN THE UNITED KINGDOM

The law in the United Kingdom appears to be similar to that of New Zealand, and there is no restriction on the use of fetuses for research. Some concern has been expressed over this fact, and in May 1970 an Advisory Group was appointed by the Secretary of State for Social Services and the Secretaries of State for Scotland and Wales "to consider the ethical, medical, social, and legal implications of using fetuses and fetal material for research." A report of the Group entitled *The Use of Fetuses and Fetal Material for Research* has been published. We set out below its principal findings and recommendations:

1. Definition of Terms Used

The Fetus: the human embryo from conception to delivery (and therefore including what is normally termed the embryonic state).

A Viable Fetus: one which has reached the stage of maintaining the co-ordinated operation of its component parts so that it is capable of functioning as a self-sustaining whole independently of any connection with the mother.

A Pre-Viable Fetus: one which, although it may show some but not all signs of life, has not yet reached the stage at which it is able, and is incapable of being made able, to function as a self-sustaining whole independently of any connection with the mother.

Fetal Death: the state in which the fetus shows none of the signs of life and is incapable of being made to function as a self-sustaining whole.

Fetal Tissue: a part or organ of the fetus, e.g., the lungs or liver.
Fetal Material: any or all of the contents of the uterus resulting from pregnancy excluding the fetus, i.e, placenta, fluids and membranes.

2. Existing Research on Fetuses and Fetal Material

(1) Fetal tissues may be used in the field of virology and research into cancer, arterial degenerative disease, immunology, and congenital deformities.
(2) Fetuses *in utero* have been used to estimate growth, to study their responses to sensory stimuli, and to investigate changes in heart rate, variations in blood composition during labour, and circulatory and respiratory changes during and after birth.
(3) Research on pre-viable fetuses has been carried out in some countries to increase knowledge of perinatal physiology and pathology especially in regard to steroid metabolism.

3. Legal Background

The law in the United Kingdom relevant to fetal research is:

Criminal Law

The criminal law was developed before recent scientific advances and the passing of the Abortion Act 1967. For these reasons, authoritative statements of the law do not provide clear guidance at the present although the law does regard as criminal the following acts:

(1) Deliberate or reckless injury to the fetus at any time between conception and delivery, except in terms of the Abortion Act 1967.
(2) Deliberate or reckless injury to the fetus which has become a child born alive or capable of being born alive.

Civil Law

A medical practitioner who undertakes the treatment of a patient undertakes to do so with the exercise of reasonable skill and care and his failure to exercise that skill and care may result in an action for negligence, be it in diagnosis or treatment. If the fetus survives negligent treatment, an action for damages lies against the medical practitioner, notwithstanding that his conduct is neither criminal nor unethical.

Administrative Law

The requirement to register a birth applies only to live births and to stillbirths, and the delivery of a dead fetus before that stage is not registrable.

Disciplinary Law

The Disciplinary Committee of the General Medical Council is empowered by statute to erase a doctor's name from the register of medical practitioners or to suspend his registration if satisfied that his behaviour constitutes "serious professional misconduct."

4. Research on Fetus *in Utero*

It is unethical to administer drugs or to carry out any procedures on the mother with the deliberate intent of ascertaining the harm that this might do to the fetus, notwithstanding that arrangements may have been made to terminate the pregnancy and even if the mother is willing to give her consent to such an experiment.

5. Research on Viable Fetus

For ethical, medical, and social reasons, evidence that a fetus has reached gestation of 20 weeks (140 days, corresponding to a weight of approximately 400-500 grams), should be regarded as a prima facie proof of viability of the the fetus at the present time. This date should be reviewed regularly to take account of the rapid changes taking place in medical knowledge.

6. Research on Pre-Viable Fetus

Research on pre-viable fetuses has already contributed significantly to the understanding of vital physiological and biochemical processes before birth on which the development of a fetus into a normal child eventually depends and offers the most hopeful approach to understanding certain failures of the human brain to develop properly and the influence such factors as variants in sexual differentiation *in utero* may have on inherent behavioural patterns after birth. It would be wrong to exclude the use of the pre-viable fetus for research provided the conditions as outlined in the Recommended Code of Practice are followed.

7. Research on the Dead Fetus

The benefits to be gained from the use of the whole dead fetus in the prevention and treatment of disease and deformity are such that it would be retrogressive to prevent it, provided that it is carried out in terms of the Recommended Code.

8. Research on Fetal Tissues and Fetal Material Other than the Fetus

There is no ethical or legal objection to this practice.

9. Consent to Research

Where the fetus is viable the overriding responsibility of the doctor is to promote and preserve its life and the parent's consent can normally be inferred from procedures consistent with this claim. Where it is born alive and later dies, the Human Tissue Act (U.K.) applies (as it does also in New Zealand) and any objection of the parent to research must be heard. Where the fetus is born dead there is no statutory requirement to obtain the parent's consent but equally no power to ignore the parent's wishes. The parent should be offered the opportunity to express any special directions about the disposal.

10. Conscientious Objection

Where staff have a conscientious objection to fetal research they should not have any duty to participate in such. Experiments on the fetus or dissections for fetal tissues should not be carried out within the operating theatre or place of delivery.

11. Records of Fetuses, Fetal Tissue, and Fetal Material

Records should be kept of all fetal material supplied or received for research.

12. Recommended Code of Practice

The Code of Practice recommended by the committee is as follows:

This code has no binding legal force but is the result of a careful consideration of all relevant factors in the light of the available evidence. It is hoped that it will prove acceptable to the bodies statutorily responsible for disciplinary matters in the medical and nursing professions.

1. Where a fetus is viable after separation from the mother, it is unethical to carry out any experiments on it which are inconsistent with treatment necessary to promote its life.

2. The minimal limit of viability for human fetuses should be regarded as 20 weeks' gestational age. This corresponds to a weight of approximately 400-500 grammes.

3. The use of the whole dead fetus or tissues from dead fetuses for medical research is permissible subject to the following conditions:

(i) The provisions of the Human Tissue Act are observed where applicable.

(ii) Where the provisions of the Human Tissue Act do not apply, there is no known objection on the part of the parent who has had an opportunity to declare any wishes about the disposal of the fetus.

(iii) Dissection of the dead fetus or experiments on the fetus or fetal material do not occur in the operating theatre or place of delivery.

(iv) There is no monetary exchange for fetuses or fetal material.

(v) Full records are kept by the relevant institution.

4. The use of the whole pre-viable fetus is permissible provided that:

(i) The conditions in paragraph 3 are observed.

(ii) Only fetuses weighing less than 300 grammes are used.

(iii) The responsibility for deciding that the fetus is in a category which may be used for this type of research rests with the medical attendants at its birth and never with the intending research worker.

(iv) Such research is only carried out in departments directly related to a hospital and with the direct sanction of its ethical committee.

(v) Before permitting such research the ethical committee satisfies itself: (a) on the validity of the research; (b) that the required information cannot be obtained in any other way; and (c) that the investigators have the necessary facilities and skill.

5. It is unethical to administer drugs or carry out any procedures during pregnancy with the deliberate intent of ascertaining the harm that they might do to the fetus.

CONCLUSION

The Commission has no reason to believe that there have been any infringements of the law or abuses of medical and ethical practice arising from the use of fetuses or fetal material in this country but finds itself in

entire agreement with the findings and recommendations of the Advisory Committee in the United Kingdom. It is of the view that legislation is not necessary to implement the code of practice recommended by the group and that it should be sufficient to bring it to the notice of appropriate medical bodies in New Zealand with the invitation to act upon it.

RECOMMENDATION

That the Department of Health bring to the notice of all universities, medical associations and groups, and medical practitioners in New Zealand the recommendations made by the Advisory Group (U.K.) in their report entitled *The Use of Fetuses and Fetal Material for Research* and urge its adoption by them.

APPENDICES

Appendix 1

PERSONAL SUBMISSIONS

Among the many submissions which were received, there were over one hundred from people who felt strongly enough about their personal experiences to record them in writing for us to consider. Over one-half of these were heard in private in order that their confidential nature should be preserved. There were some people, however, who themselves elected to speak of their personal experiences at a public sitting.

The Commission recognised that the recollection and narration of events of a very personal nature was a difficult experience for those concerned and, on that account, was at pains to meet the convenience of those who wished to talk to us in private and endeavoured to make the interview as informal as possible. We were pleased to know that some at least of those who met us in this way obtained some emotional relief in being able to talk to a small, impartial, and concerned group about their experiences and the difficulties which they had encountered. Over half of these submissions related to abortion. The remainder related to various problems associated with sterilisation, problems faced by mothers, both married and unmarried, in bringing up pre-school children, and experiences in caring for adopted or handicapped children.

The value of these informal but very personal discussions lay in the more complete picture which we were able to obtain of all aspects of the subjects under our inquiry. In view of the need to preserve the anonymity of those whom we met in private, we do not propose to refer in any detail to the content of individual submissions.

It will be apparent that because the circumstances of each case were different it is impossible to place every case in a particular category. There were, however, features common to most of the personal experiences and we propose to deal with them under the appropriate headings.

CONTRACEPTION AND STERILISATION

A number of women explained to us the difficulties which they had encountered in obtaining access to a suitable form of contraception. Where women had found difficulties with particular techniques of contraception, particularly the pill, some had sought and obtained sterilisation. Most of these spoke of sterilisation in favourable terms and regarded the fees which they had incurred as having been well spent.

Some women, particularly the younger ones, told us that they had found it difficult to obtain sterilisation. Two women, one a mother of four children who had suffered post-natal depression, and the other, who had had six difficult pregnancies, were critical of the obstacles which they had encountered in hospitals and with medical practitioners when requesting sterilisation. A number of mothers said that their applications for

sterilisation had been refused because they were separated from their husbands.

Some men who had had vasectomies told us that they had experienced great relief from the knowledge that their wives no longer need be concerned about pregnancy. Some younger men reported that they had found it difficult to obtain vasectomies. One complained that a surgeon had refused to sterilise him until he was 35 years of age and had had at least four children. The surgeon was not prepared to listen when the patient said that he and his wife wanted only two children.

HELP AND ADVICE DURING PREGNANCY

A number of mothers spoke to us about the difficulties faced by them during their pregnancies, particularly where the pregnancies were unplanned. They needed help and support from their husbands, families, and friends to overcome the sickness, tiredness, and worry they experienced. Unmarried mothers, in particular, felt very much alone and told us how comforting it had been to be able to have someone with whom they could discuss their situation. One woman who suffered from depression felt the need for specialised counselling and believed that she would have benefited from it. She did not think that her position would have been helped by abortion which would only have caused even more mental problems and would have weighed heavily on her conscience.

ABORTION

About half of the women who made confidential submissions to us told us of their experiences in seeking and obtaining abortions. Some were very critical of the attitudes adopted by the doctors whom they had consulted. One woman, who felt so strongly on this matter that she elected to give her evidence in public, said that she had approached 23 doctors in an attempt to terminate her pregnancy but had received no help. Another was critical of what she termed the "pro-life" approach of psychiatrists and general practitioners. Yet another criticised doctors because "instead of attempting to solve my economic, personal, and social problems, all they were offering was the destruction of my baby."

Abortion Facilities

Some 39 women who had successfully obtained abortions made personal submissions to the Commission. Twenty of these were married and nineteen were single. Over half of these married women had obtained their abortions in a public hospital or at the Auckland Medical Aid Centre. Over half of the single women had had their abortions in Australia or by "back street" abortionists though none had obtained a "back street" abortion in recent years. Those who had obtained "back street" abortions in former years told us of the ordeals to which they had been subjected. Those who had obtained abortions at the Auckland Medical Aid Centre described the treatment which they had received there as being sympathetic and kindly.

Outcome of Search for Abortions

Most of the women who told us of their experiences of obtaining an abortion regarded the outcome as being satisfactory in that they suffered no adverse physical or psychiatric consequences. A few expressed feelings of doubt and regret about the decision they had made. One described it as a serious mistake which continued to worry her.

Twenty-two women who had considered an abortion but had not obtained one discussed with us their feelings on not having proceeded with their original intention. Twelve felt that the ultimate outcome had been unsatisfactory. Ten told us that they did not in any way regret not having obtained an abortion even though one would have been legally available to them.

HANDICAPPED CHILDREN

A number of parents of handicapped children spoke to us and told us of their experiences in rearing those children. Some had found it to have been rewarding in that it had helped them in their marriage and had resulted in closer family ties. To others the experience was the reverse. They had found the bringing up of a handicapped child to be quite beyond their resources.

ADOPTION

A number of parents of adopted children appeared before us. They told us that adoption had proved very satisfactory both for them and for the children they had adopted. On the other hand, some women who had been adopted as children told us of unhappy experiences of childhood which they believed had affected their adult life.

CONCLUSIONS

It is difficult to draw any conclusions from the individual submissions. Their value lies in the fact that they highlight some of the individual problems met by women in facing the issues of abortion, sterilisation, and contraception. If any single point emerged strongly from the submissions, it was to emphasise the need for help to be readily available for people who are confronted with situations which bring extreme distress to them and their families.

Appendix 2

A HISTORICAL BACKGROUND TO ABORTION

Important trends in society are seldom, if ever, the result of accident. The terms of our warrant lay down that the Commission is to investigate and report on present-day issues and laws, but the matters under consideration are, in essence, as old as recorded history. In them are interwoven diverse social, economic, political, philosophical, religious, biological, and medical factors. They can be better understood with some appreciation of the practices and attitudes of former civilisations, especially those from which so much of our culture is derived, and some knowledge of important discoveries and the development of ideas and legislation throughout the centuries. It seems useful, therefore, to furnish some historical background to the problems of abortion and infanticide in particular.

At first sight, anthropologists appear to have given less detailed attention to abortion as a specific topic than might have been expected, and objective studies giving anything like a comprehensive picture of the historical background to induced abortion are comparatively few. The chief reason is clearly the sheer magnitude of the task, a view propounded by Devereux in his analysis of abortion in 400 primitive societies. In support of this view, he warns against taking as authoritative the findings of any individual researcher. Even with data in respect of small, primitive tribes, he frequently found himself confronted by contradictory findings produced with ample documentation by scholars of high repute. This being the case with small societies with comparatively simple cultures, he stresses the difficulty of giving a representative picture of the situation in a community with a more complex social structure. (1)

In contrast, countless books have been written on the abortion controversy by a variety of people, most of whom hold strong personal opinions. Because of strongly-held beliefs, many of these writers tend to quote, or highlight, or draw inferences from those practices and those accounts which reinforce a particular point of view. One conclusion, however, is inescapable. In primitive and civilised societies alike, whether it is common or rare, whether regarded with approval, with disapproval, with apathy, or with tolerance, induced abortion as a means of dealing with unwanted pregnancy is always to be found. "There is every indication," says Devereux, "that abortion is an absolutely universal phenomenon and that it is impossible even to construct an imaginary social system in which no woman would ever feel at least impelled to abort." (2)

ABORTION IN PRIMITIVE SOCIETIES

The reasons for induced abortion in primitive communities may be grouped into broad, general categories, essentially very similar to those that obtain in modern society:

1. Personal motives of the woman with no pressures from outside.
2. Pressures from individuals or from the tribe as a whole.
3. Economic pressures. (3)

Within these fundamental categories, specific reasons for abortion take on an almost endless number of variations, ranging from medical or biological considerations to such things as fear of childbirth, extreme youth or advanced age, taboos during pregnancy or lactation, problems associated with a nomadic existence, economic factors, especially extreme poverty and the heavy burden of work borne by women, adultery, widowhood, cannibalism, dreams and omens, the desire to preserve youthful beauty, the reluctance to give up freedom and to assume the responsibilities of parenthood, unacceptable paternity, conquest, and slavery. In all but one of the tribes he studied, Devereux was able to verify the existence of abortion. Motives were often similar but by no means restricted to one or other of the categories mentioned. As might be expected from the varied reasons of which the above are a sample, the general attitude of the tribes differed greatly. Many revealed some uneasiness about the practice and displayed a vague fear of retribution from the gods or from nature.

Of 73 ethnic groups whose attitude he was able definitely to establish, it appeared that most primitive societies made some attempt to restrict abortion, either through tribal regulations, religious beliefs and taboos, or social customs. (4)

ABORTION IN EARLY CIVILISATIONS

Records show that abortion was well-known in all early civilisations. The woman herself commonly brought on the abortion, often using crude, painful, or dangerous procedures with serious risk to her health or even her life. At the same time, there are numerous references to the need for therapeutic abortions, to abortifacients and abortionists, as well as to laws to restrict or forbid abortions. It is said that reliable and safe abortifacients were produced by wise men in ancient China and records of their constitution and use handed down for the benefit of posterity with due warning to pregnant women not to resort to strange, untried, and more dangerous means. (5) The ancient Chinese book *Si-Yuen-Li* describes a chemical test using mercury to determine whether abortion has taken place. Penalties for abortion could be quite severe: a hundred strokes of the lash and three years' exile, the latter a punishment almost as dreaded as death. Other cases might go unpunished if inquiries into the circumstances of an abortion revealed mitigating circumstances. (6)

The Hindu Attitude

The *Atharva-Veda*, the last of the four early Hindu scriptures, the *Vedas*, composed between 1500 and 1000 B.C., refers to abortion as a very serious sin inimical to the elemental principle of creation. (7) In one of the 731

hymns and incantations which form the *Atharva-Veda*, Pushan, the god of wayfaring, who protects lost travellers, assumes the role of protector of sinners who have lost their way in life. He takes away disease which is a symbol of guilt, dissolves it in vapour and, in keeping with the custom of passing guilt on to others in ascending order of wickedness, "wipes off the misdeeds on him that practiseth abortion." (8) The later Hindu law-givers ranked abortion among crimes such as murder, incest, and adultery with the wife of a guru. Mention of abortion is found in almost all the ancient Hindu writers and law-givers but though they condemn it as a serious sin, they provided for difficult and exceptional cases, allowing pregnancies to be terminated where the woman's health was seriously affected. (9) The prevalence of abortion is almost certainly indicated by the frequent references to it in the ancient writings.

The Muslim Attitude

The Muslim view is much simpler to ascertain than that of Hinduism, the authoritative answers being found in the *Koran* or the *Hadith*, the traditions from the prophet Mohammed, or from the edicts of the Muftis and other ecclesiastical heads of Islam. In general the attitude is derived from the injunction from the *Koran*: "Murder not your children, for fear lest ye be reduced to poverty. We will provide for you and them." (10) At the same time tradition has it that birth control was practised during the life time of the Holy Prophet. Since then, there has been a tendency to interpret the Islamic injunctions in the light of social and economic needs, with therapeutic abortion being practised in a variety of Muslim countries.

The Middle East

As is the case with the ancient Hindu writings, the many laws dealing with abortion dating from the ancient civilisations of the Middle East give some idea of the extent of the problem and the concern of those civilisations with it as well as their attitude towards the unborn child. The Sumerian Code of approximately 2000 B.C., the Assyrian Code of 1500 B.C., the Babylonian Code of Hammurabi of 1300 B.C., the Hittite Code of the same period, and the Persian Code of 600 B.C. all dealt at some length with induced abortion, placing particular emphasis on assaults causing miscarriage. The Assyrian laws had stringent regulations concerning injuries which brought about miscarriage. The public penalty imposed on a man "who has struck a lady of birth and has caused her to cast the fruit of her womb" was a fine consisting of two talents fifty minas of lead, fifty blows with rods and one full month's work for the king. (11) Injuries causing miscarriage in women of lower birth brought private rather than public penalties, consisting usually of monetary compensation to the father who had been deprived of offspring. The penalty for self-induced abortion was very severe indeed: "If a woman has cast the fruit of her womb by her own act and charge and proof have been brought against her, she shall be impaled on stakes and not buried." (12) Quite apart from the horrible nature of the execution by impalement, the denial of burial

was regarded as a terrible punishment, for the spirit of the unburied person would find no rest but would be forced to wander about for eternity.

The Babylonian laws of Hammurabi were less severe than those of Assyria. They merely demanded monetary fines from the person inflicting injury resulting in miscarriage, the amount of the fine varying according to the social status of the victim. However, in the case of the death of a woman of high birth resulting from such an assault, the law of talion was applied and the daughter of the offender was put to death. Three laws from the Code of Hammurabi are:

> 209. If a man strikes the daughter of a free man and causes her to lose the fruit of her womb, he shall pay ten shekels of silver for the fruit of her womb.
> 210. If that woman dies, they shall put his daughter to death.
> 211. If he causes the daughter of a villein to lose the fruit of her womb by striking her, he shall pay five shekels of silver. (13)

The Hittites, whose laws in general showed a more humane outlook, also required compensation but varied the penalties for causing miscarriage according to how far the pregnancy had advanced.(14)

Ancient Egypt

Records which have come down to us from ancient Egypt contain possibly the earliest recorded recipes for contraceptives and abortifacients. It is apparent from these that the desire for contraception and abortion existed even though abortion was severely punished by law. (15) How common the practice was is not known, but children were certainly not unwelcome as they represented cheap labour, always a consideration in an agrarian feudal society. The large number of skeletons and mummies of children in Egyptian cemeteries indicate that infant mortality from natural causes was very high. For this reason, as well as for the loss of potential cheap labour, it seems logical to assume that the official attitude to abortion was that of intense disapproval.

The Attitude of Judaism

The attitude of the ancient Jews to abortion has proved a fruitful source of argument but the weight of opinion is that feticide was not regarded as a capital crime. The Old Testament has hardly anything to say about abortion, the only passage being in Exodus XXI, verses 22-23. This is part of the section dealing with murder and homicide, crimes involving blows and wounds causing harm or possibly leading to death, with a statement in verses 24-25 of the law of talion which is repeated in Leviticus XXIV: "Eye for eye, tooth for tooth, hand for hand, foot for foot, burning for burning, wound for wound, stripe for stripe." The passage in Exodus provides: "When men strive together and hurt a woman with child so that there is a miscarriage, and yet no harm follows, the one who hurt her shall be fined according as the woman's husband shall lay upon him, and he shall pay as the judges determine. If harm follows, then you shall give life for life."(16)

As only monetary compensation is required of the person causing the woman to miscarry without harm to herself, the implication is that the

unborn child was not regarded as a human being with a life of its own. This is in keeping with the Talmudic attitude that the fetus is deemed to be part of its mother rather than an independent unity.

There is a striking similarity between this passage and the Sumerian, Assyrian, Babylonian, and Hittite laws though it has not been established that any one civilisation borrowed its laws from another. It is perhaps worthy of note that they all refer to a type of assault that is uncommon today. Possibly the injuries were common enough in Middle Eastern societies where women continued to work alongside men until quite late in pregnancy. Men fighting might also presumably hurt a woman making an effort to separate them, especially under circumstances which inspired the law set out in Deuteronomy XXV, 11-12: "When men strive together one with another, and the wife of the one draweth near for to deliver her husband out of the hand of him that smiteth him, and putteth forth her hand, and taketh him by the secrets: then thou shalt cut off her hand, thine eye shall not pity her."(17)

Even though one country's laws may not have been influenced by those of another, it seems apparent that the underlying reasons for the form of the laws relating to violence towards pregnant women were very much the same. The status and rights of the father were the predominant consideration in the varying degrees of compensation or punishment exacted. He was entitled to compensation for being deprived of a potential heir, someone to work, to fight, to look after him in his old age. The unborn child was, by implication, entitled to protection because of its potential in these areas but was not regarded as having rights of its own.

Far-reaching consequences arose from a most interesting alternative to the wording of the Exodus passage found in the Septuagint version, the Greek translation of the Bible produced during the third century B.C. in Alexandria where a large community of Jews, dispersed outside Palestine by the turmoil of previous centuries, had congregated. The changed rendering of a single word in the Septuagint version gives a completely different statute regarding miscarriage. The word *ason* translated in the customary versions as "harm", "hurt", or "mischief", is rendered by "form" in the Septuagint. The need for a Greek version of the Bible first became apparent in Egypt where there were in circulation and in use by the Jews different versions of the "Law" which were regarded as unsatisfactory. At Alexandria, a "revision committee" consisting, according to tradition, of 72 elders from Palestine, made a concerted effort to produce an authoritative version of the "Law" and have it accepted. The complete Septuagint shows in a great many passages that it was translated from a text or texts differing considerably from that which is now regarded as standard. Whether the version of the Exodus passage comes from a different text, whether it is a mistranslation, whether it is an emendation to a dubious or corrupt portion of text, or whether it is a rendering to suit the climate of the time are only matters for conjecture. Whatever the explanation, the Septuagint version reads: "And if two men strive and smite a woman with child, and her child be born imperfectly formed, he shall be forced to pay a penalty: as the woman's husband may lay upon him, he shall pay with a valuation. But if it be perfectly formed,

he shall give life for life."(18) The "life for life" clause was thus applied to the fetus and a clear distinction was made between the "formed" and "unformed" fetus, the *embryo formatus* and the *embryo informatus* as Augustine later formulated it. Perhaps most important of all, the doctrine was accepted by Philo, the first century philosopher at Alexandria, who had a large following. Philo, in his "Special Laws", rendered the Septuagint passage, embroidered with his own philosophising, thus: "If a man come to blows with a woman who is pregnant and strikes her in the belly and she miscarries, then, if the result of the miscarriage is unshaped and undeveloped, he must be fined both for the assault and for obstructing the artist nature in her creative work of bringing into life the fairest of living creatures, man. But if the offspring is already shaped and all the limbs have their proper qualities and places in the system, he must die, for that which answers to this description is a human being, which he has destroyed in the laboratory of nature who judges that the time has not yet come for bringing it out into the light, like a statue lying in a sculptor's workshop, requiring nothing more than to be carried outside and released from confinement."(19)

Philo then goes on to condemn infanticide by exposure: "This ordinance carried with it the prohibition of something else more important, the exposure of infants, a sacrilegious practice which among many other nations, through their ingrained inhumanity, has come to be regarded with complacency. For if, on behalf of the child not yet brought to the birth by the appointed conclusion of the regular period, thought has to be taken to save it from disaster at the hands of the evil-minded, surely still more true is this of the full-born babe sent out as it were to settle in the new homeland assigned to mankind, there to partake of the gifts of nature. . . . So Moses implicitly and indirectly forbade the exposure of children when he pronounced the sentence of death against those who cause the miscarriage of mothers in cases where the fetus is fully formed."(20)

On the other hand, Josephus, Philo's younger contemporary, appears to use both the Hebrew and the Greek text, and gives his own rendering of a condensed version of the Mosaic code. His translation of the passage under discussion is: "He that kicketh a woman with child, if the woman miscarry, shall be fined by the judges for having, by the destruction of the fruit of her womb, diminished the population, and a further sum shall be presented by him to the woman's husband. If she die of the blow, he shall also die, the law claiming as its due the sacrifice of life for life."(21)

In the treatise *Against Apion*, Josephus goes somewhat further and describes both induced abortion and infanticide as akin to murder: "The law, moreover, enjoins us to bring up all our offspring, and forbids women to cause abortion of what is begotten, or to destroy it afterward; and if any woman appears to have so done, she will be a murderer of her child, by destroying a living creature and diminishing humankind; if anyone, therefore proceeds to such murder of offspring, he cannot be clean." (22) The apparent inconsistency in this passage when set against the first is ascribed to moral rhetoric rather than to a contradictory statement of the law.

The early Christians whose language was Greek used the Septuagint not the Hebrew version. The attitude to abortion and human life as

instanced in the writings of Philo, who had a large following, fitted well into their beliefs.

The veneration with which the Jews had earlier regarded the Septuagint gave way to a very contrary feeling as the Christian teachings spread and Jewish thought restricted itself more and more to the traditional Hebrew approach. In this the unborn child was not thought of as an individual with life that could be considered to be human. The lack of references to induced abortion may mean, not that it was unknown, but that it never became a common practice in Jewish society and, in consequence, legislation against it was unnecessary. This could be regarded as in keeping with the fervent belief of the Jews in the need for the continuance of the family and the racial line and the preservation of the way of life of the "chosen people." It also agreed with the Old Testament teaching that children should be regarded as a "blessing": "Be fruitful and multiply, and replenish the earth and subdue it."(23)

The *Talmud* has one reference to therapeutic abortion where the Mishnah provides that an abortion is to be performed to save the life of the mother: "If a woman has (life-threatening) difficulty in childbirth, one dismembers the embryo within her, limb by limb, because her life takes precedence over its life. Once its head (or "greater part") has emerged, it may not be touched, for we do not set aside one life for another." (24) Clearly, before birth, the fetus was not regarded as a person; from the moment of birth it was. Traditionally the direct threat to the mother's life was extended to include a serious, indirect threat to her life, or to her physical or psychological health, great stress being laid on care being taken to be satisfied that the threat was in fact serious.

Ancient Greece

Ancient Greek society, built on political foundations, subordinated the welfare of the individual to that of the community, certainly until about the 4th century B.C. when personal rights began to assume greater importance. Abortion, infanticide, and the exposure of unwanted or weakling children, who were of little value to the State, were regarded as legitimate means of controlling the population or keeping up its quality. Religion was indifferent to feticide and the laws of the city-states, with the possible exception of Thebes, provided no protection for the unborn child. Opinion is divided on just how common doing away with children by exposure was, or whether girls or boys were more frequently exposed, but references in literature to foundlings are common and mention of exposure is given in a dispassionate, matter-of-fact way. In Plato's *Theaetetus*, Socrates asks: "Besides, cannot midwives by medicine and charms arouse or allay at their pleasure the pangs of travail, or hasten childbirth in those who have had hard labour, or even if they think it advisable, cause a miscarriage?"(25)

Aristophanes refers to it as a natural occurrence:

"No sooner born than they exposed the babe,
(And that in winter), in an earthen crock,
Lest he should grow a man and slay his father."(26)

Admirers of Greek civilisation do not find it easy to accept that Athenians in particular, who traditionally disliked violence, resorted to methods of preventing undue growth of population which appear heartless or even barbarous. Their attitude, and that of ancient Greece generally, may better be appreciated by remembering that Greece was not a modern nation such as we know; its cities, where it was expected that the town-crier could be heard from one side to the other, bore no resemblance to a great city of today. Geographically, the country lent itself to a series of communities, more or less isolated, shut in by mountain frontiers—city-states made up of a series of family units, joined together in groups or clans, perhaps related to each other or grouped from earliest settlement days for the purposes of self-defence. Fertile land was scarce. Population tended to increase faster than food could be produced. Even with the passage of time, the improvement of communications with her colonies, and the growth of foreign trade, the Greek state retained the memories of earlier days with the constant threat of over-population, starvation, and attack from neighbouring states. The city did not want more citizens than it could support and it wanted those citizens to be worthy of the State and the Greek race as a whole. The Greek father, who had supreme authority, rejected, except in rare instances, all who were crippled, or deformed, or very delicate. At the same time, the State demanded sufficient citizens and soldiers to provide for the future. The funeral oration of Pericles may seem starkly realistic, even brutal, as he addressed himself to the parents of those who had fallen in the war: "You who are still of an age to beget children must keep a brave heart in the hope of having others in their stead; not only will they help you to forget those whom you have lost, but will help the city to fill up the ranks of its workers and its soldiers."(27)

In Sparta, a new-born infant faced a double scrutiny before it was permitted to survive. If the father in his discretion decided the baby might live, he still had to present it to the elders who made the final decision regarding life or death.

The two most familiar references cited to indicate the ancient Greek attitude are from Plato and Aristotle. There is no doubt that to both, abortion and infanticide were commonplace and provided the logical means of restricting the city to the limited size which they regarded as desirable. It is against this background that the commonly-quoted passages from their works can be appreciated. In the *Republic*, Plato portrays his ideal city governed not by political opportunists, but by highly educated, rigorously trained, completely dedicated leaders. For the citizens, the family and the individual would be subordinated to the State, avoiding all the evils he saw in the struggle for private possessions and the material things necessary for bringing up children. To this end he propounded legislation which would scarcely be suggested by the most ardent present day advocate of eugenics: "And on the young men, surely, who excel in war and other pursuits we must bestow honours and prizes, and in particular, the opportunity of more frequent intercourse with the women, which will at the same time be a plausible pretext for having them beget as many of the children as possible." "Right." "And the children thus born will be taken over by the officials appointed for this, men or

women or both, since I take it the official posts, too, are common to women and men." "Yes." ". . . Let us pursue our design. We said that the offspring should come from parents in their prime." "True." "Do you agree that the period of the prime may be fairly estimated at twenty years for a woman and thirty for a man?" "How do you reckon it?" he said. "The women," I said, "beginning at the age of twenty, shall bear for the state to the age of forty, and the man shall beget for the state from the time he passes his prime in swiftness of running to the age of fifty-five." "That is," he said, "the maturity and prime for both of body and mind. But when, I take it, the men and women have passed the age of lawful procreation, we shall leave the men free to form such relations with whomsoever they please, except daughter and mother and their direct descendants and ascendants, and likewise the women, first admonishing them preferably not even to bring to light anything whatever thus conceived, but if they are unable to prevent a birth to dispose of it on the understanding that we cannot rear such an offspring."(28)

In the *Laws* composed in his old age, some thirty years after the *Republic*, Plato deals in some detail with the size he regards as ideal for a city-state—enough land to support a number of inhabitants capable of defending themselves against injury from adjoining peoples. He proposes a constant figure of 5,040 households, each with its plot of land and each providing one soldier. The number 5,040 is fixed somewhat arbitrarily, the main consideration being that it should be sufficiently large but not too large and capable of division into numerous equal parts for the purposes both of war and peace. "The magistrates, whom we shall appoint as the highest and the most distinguished, shall consider how to deal with the excess or deficiency in families and contrive means as best they can to secure that the 5,040 households shall remain unaltered. There are many contrivances possible: where the fertility is great, there are methods of inhibition, and on the other side, there are methods of encouraging and stimulating the birth-rate, by means of honours and dishonours, and by admonitions addressed by the old to the young, which are capable in all ways of producing the required effect. Moreover, as a final step if we are faced with a superabundance of citizens, there still remains that ancient device which we have often mentioned, namely, the sending forth, in friendly wise from a friendly nation, of colonies consisting of such people as are deemed suitable."(29)

Aristotle, whose influence in this matter, as in so many other fields, was to be felt for two thousand years, also held firm views on the necessity for limiting a city-state to a size large enough for self-defence and small enough for self-knowledge: "What should be the limit will be easily ascertained by experience. For both governors and governed have duties to perform; the special functions of a governor are to command and to judge. But if the citizens of a state are to judge and to distribute offices according to merit, then they must know each other's characters; where they do not possess this knowledge, both the election to offices and the decision of lawsuits will go wrong. When the population is very large they are manifestly settled at haphazard, which clearly ought not to be."(30)

To achieve this ideal size, Aristotle justified infanticide and early

abortion on both demographic and eugenic grounds: "As to the exposure and rearing of children, let there be a law that no deformed child shall live, but that on the ground of an excess in the number of children, if the established customs of the state forbid this (for in our state population has a limit), no child is to be exposed; but when couples have children in excess, let abortion be procured before sense and life have begun; what may or may not lawfully be done in these cases depends on the question of life and sensation."(31)

His understanding of "life" and "sensation", matters which have since remained fundamental in the abortion issue, is set down in his remarkable works on natural history, the *Generation of Animals*, and the *History of Animals*. He knew nothing of the female egg which, of course, was not discovered until the nineteenth century but recognised that the process of generation began at conception. His theory was that the embryo was created by the active seed of the male working on the blood of the female, the passive matter: "What does happen is just what one would expect, since what the male contributes to generation is the form and the efficient cause, while the female contributes the material. That the female does not contribute semen to generation but does contribute something is clear. If, then, the male stands for the effective and active, and the female, considered as female, for the passive, it follows that what the female would contribute to the semen of the male would not be semen but material for the semen to work on."(32)

Aristotle did not know that sex was determined at the time of fertilisation and believed that the fetus came into existence when the distinctive features of sex could be made out. From his observations these features could not be distinguished until after forty days for the male and ninety days for the female. For him a further proof of life developing was animation or quickening at about the same time: "As to man's growth, first within his mother's womb and afterward to old age, the course of nature, insofar as man is specially concerned, is after the following manner. . . In the case of male children, the first movement usually occurs on the right hand side of the womb, and about the fortieth day but if the child be a female then on the left hand side and about the ninetieth day. However, we must by no means assume this to be an accurate statement of fact for there are many exceptions, in which the movement is manifested on the right hand side though a female child be coming, and on the left hand side though the infant be a male. And in short, these and all other phenomena are usually subject to differences that may be summed up as differences of degree.

About this period the embryo begins to resolve into distinct parts, it having hitherto consisted of a fleshlike substance without distinction of parts.

What is called effluxion is a destruction of the embryo within the first week, while abortion occurs up to the fortieth day; and the greater number of such embryos as perish do so within the space of these forty days.

In the case of a male embryo aborted at the fortieth day, if it be placed in cold water it holds together in a sort of membrane, but if it be placed in any other fluid it dissolves and disappears. If the membrane be pulled to

bits the embryo is revealed as big as one of the large kind of ants; and all the limbs are plain to see, including the penis, and the eyes also, which as in other animals are of great size. But the female embryo if it suffer abortion during the first three months, is as a rule to be found undifferentiated; if however it reach the fourth month it comes to be subdivided and quickly attains further differentiation. In short while within the womb, the female infant accomplishes the whole development of its parts more slowly than the male."(33)

What his theory of animation would have been if he had had the advantage of a microscope is a matter for conjecture. In believing that, after a certain time, the embryo took on life, he differed entirely from most of the philosophers and scientists of his day, including the Stoics and Platonists, who held that animation began at the moment of birth and that, in consequence, abortion was permissible throughout pregnancy. The influences of his theories regarding the development of the embryo were far-reaching. This influence can perhaps be appreciated better when it is realised that he was the great authority on almost all scientific matters as far as the universities were concerned, certainly until late in the seventeenth century, and in many until the nineteenth century, and that Darwin could write of him: "Linnaeus and Cuvier have been my two gods though in very different ways, but they were mere schoolboys to old Aristotle."(34)

The other Greek name entering most frequently into the abortion discussion is that of Hippocrates the "father of medicine", renowned for the so-called "Hippocratic Oath" and the Hippocratic writings traditionally ascribed to him and the greatest single force of all time in the development of a code of ethics and professional conduct among doctors. Little, if anything, can be stated for certain about Hippocrates who is said to have been born in 469 B.C. on the island of Cos and to have died a very old man. "All that we know with certainty of Hippocrates," says Sigerist, "is that he lived."(35) Aristotle described him as the "Great Hippocrates": "That city which is best adapted to the fulfilment of its work is to be deemed greatest, in the same sense of the word great in which Hippocrates might be called greater, not as a man, but as a physician, than someone else who was taller."(36) Galen, one of the most famous physicians of antiquity who lived at home for much of his life during the second century A.D., speaks of him with the greatest respect: "For everything appears to attract from and to go shares with everything else, and, as the most divine Hippocrates has said, there would seem to be a consensus in the movements of fluids and vapours."(37)

The so-called Hippocratic writings comprising 72 works on medicine attributed to him are now regarded as the remains of an extensive medical library as diverse in style and content as any modern collection of works on medicine. Modern scholars cannot agree which, if any, of the writings are genuinely his. Some are almost certainly earlier, many much later, than Hippocrates. What is important is that works on medicine were written standing for scientific knowledge free from superstition and hypothetical philosophy.

Surprise and even delight have been expressed that Hippocrates, who is

popularly thought to have opposed abortion, should have instructed a courtesan in how to bring on a miscarriage: "Living with a woman of my acquaintance was a very popular entertainer who used to bestow her favours on men. It was important for her not to become pregnant or her price would drop. News of her predicament came to me and, being informed of it, I ordered her to leap up and down in such a way that, in leaping, her heels touched her buttocks."(38)

The Nature of the Child, from which this incident is taken, is included in Littré's monumental edition of the Hippocratic Corpus. Whether Hippocrates or someone else was the author cannot be established with any degree of certainty as Jones makes clear: "Littré's problem, 'When was the Hippocratic collection published?' cannot be answered, for it is more than doubtful whether, as a whole, the collection was ever published at all. The publication of a modern work must in no way be compared with the circulation of a book in ancient times. Printing and the law of copyright have created a revolution. As soon as an ancient author let go out of his possession a single copy of his book, it was, to all intents and purposes, 'published'. Copies might be multiplied without permission. At least one hundred, perhaps three hundred years, separate the writing of the earliest work in the Corpus from the writing of the latest."(39)

Even more surprise has been expressed that the celebrated "Hippocratic Oath", so long the basis of medical ethics, should not have had more influence on the Greek attitude to abortion: "I swear by Apollo Physician, by Asclepius, by Health, by Panacea and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture. To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath but to nobody else. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anyone when asked to do so, nor will I suggest such a course. Similarly I will not give a woman a pessary to procure abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and my art; but if I transgress it and forswear myself, may the opposite befall me."(40)

It cannot be said with any certainty that the Oath was written by Hippocrates himself. Its composition has been put at times varying

between the sixth century B.C. and the first century A.D. Ludwig Edelstein (1902-1965), one of the great authorities on the Hippocratic writings, puts the date at somewhere in the fourth century B.C. It seems probable that the Oath owed much to the Pythagoreans and was taken by a young man at the end of his training in medicine, a private agreement between tutor and pupil. It was a personal contract not something framed for all physicians but for individuals who had been strongly influenced by the Pythagoreans. It seems reasonable to believe that this could occur in a society and in an age where medical schools as we know them did not exist, where there was no examination to pass to qualify as a doctor, no state or other authority to license or to lay down a set of rules. The doctor was first and foremost a craftsman, practising either as an itinerant or in a booth in the market-place. Edelstein makes out a convincing case for a Pythagorean background for the Oath: "Does this imply that the document must have been outlined by a philosopher rather than a physician? Not at all. The Hippocratic Oath is a program of medical ethics, and there is no reason to question that it was composed by a doctor.

One last question remains: what is the purpose of the Oath? Is this document an ideal program with no direct bearing on reality? Or was the oath actually administered? In my opinion one need not doubt that this oath was made by many an ancient physician and that it was sworn to and regarded by them as their "Golden Rule" of conduct. To be sure, no special societies of Pythagorean physicians are attested, no guilds are known for which Pythagorean philosophy was the statute of organisation. But the covenant is a private agreement between pupil and teacher. The Oath as a whole is hardly an obligation enforced upon the physician by any authority but rather one which he accepted of his own free will. It is not a legal engagement; as the wording indicates, it is a solemn promise given and vouchsafed only by the conscience of him who swears.

The so-called Hippocratic Oath has always been regarded as a message of timeless validity. From the interpretation given it follows that the document originated in a group representing a small segment of Greek opinion. That the oath was not at first accepted by all Greek physicians is certain. Medical writings, from the time of Hippocrates down to that of Galen, give evidence of the violation of almost every one of its injunctions. This is true not only in regard to the general rules concerning helpfulness, continence and secrecy. Such deviations one would naturally expect. But for centuries ancient physicians in opposition to the demands made in the Oath, put poison in the hands of those among their patients who intended to commit suicide; they administered abortion remedies; they practised surgery.

At the end of antiquity a decided change took place. Medical practice began to conform to that state of affairs which the Oath had envisaged. Surgery was separated from general practice. Resistance against suicide, against abortion, became common. Now the Oath began to be popular. It circulated in various forms adapted to the varying circumstances and purposes of the centuries. Generally considered the work of the great Hippocrates, its study became part of the medical curriculum. The

commentators supposed that the master had written the Oath as the first of all his books and made it incumbent on the beginner to read this treatise first.

Small wonder! A new religion arose that changed the very foundations of ancient civilisation. Yet, Pythagoreanism seemed to bridge the gulf between heathendom and the new belief. Christianity found itself in agreement with the principles of Pythagorean ethics, its concepts of holiness and purity, justice and forbearance. The Pythagorean god who forbade suicide to men, his creatures, was also the God of the Jews and the Christians. As early as in the "Teaching of the Twelve Apostles" the command was given: "Thou shalt not use philtres; thou shalt not procure abortion; nor commit infanticide." Even the Church Fathers abounded in praise of Hippocrates and his regulations for the practice of medicine.

As time went on, the Hippocratic Oath became the nucleus of all medical ethics. In all countries, in all epochs in which monotheism, in its purely religious, or in its more secularized form, was the accepted creed, the Hippocratic Oath was applauded as the embodiment of truth. Not only Jews and Christians, but the Arabs, the mediaeval doctors, men of the Renaissance, scientists of the Enlightenment, and scholars of the nineteenth century, embraced the ideals of the Oath."(41)

Ancient Rome

In ancient Rome, even more than in Greece, abortion, exposure and infanticide were commonly practised and taken for granted. Here again, the rights of the individual were subordinated to those of the State. At best until the time of the Empire, laws against these practices were regarded as superfluous, even as an intrusion, on the clearly-defined rights of the family head, the *pater-familias*, who had absolute power over the family, including that of life and death. It was the pater-familias who decided whether new-born children should be reared or exposed. There was some tradition that Romulus made a law forbidding the exposure of male children or the first-born female child, unless such children were, in the opinion of five neighbours, so deformed that they ought to be killed.(42) However, if such a law once existed, it was forgotten or ignored and exposure was common and certainly no crime in Rome of the Republic. Survival of the city was important and hard-won, and weakly children, in particular, were unwelcome. The sections of the Statutes of Justinian dealing with the *patria potestas* say: "Our children, begotten in lawful marriage, are in our power." and, "The power which we have over our children is peculiar to the citizens of Rome; for no other people have a power over their children, such as we have over ours."(43)

Gibbon, in the *Decline and Fall* comments: "The law of nature instructs most animals to cherish and educate their infant progeny. But the exclusive, absolute and perpetual dominion of the father over his children is peculiar to the Roman jurisprudence and seems to be coeval with the foundation of the city. The paternal power was instituted or confirmed by Romulus himself; and after the practice of three centuries, it was inscribed on the fourth table of the decemvirs."(44)

Fragments of Table 4 of the Twelve Tables, the code of Roman law drawn up and published 451-450 B.C., contain two clauses illustrating the uncompromising attitude of the Roman:

1. "Provision regarding the deformed child or monster which must be put to death immediately."
2. "Provision regarding the power of the father over his children, his right during the whole of their lifetime to throw them into prison, to scourge them, to force them to work in fetters in the fields, to sell them or to kill them."(45)

Seneca, five hundred years later, supported the killing of deformed or weakly children: "Mad dogs we knock on the head; the fierce and savage ox we slay; sickly sheep we put to the knife to keep them from infecting the flock; unnatural progeny we destroy; we drown even children who at birth are weakly or abnormal. Yet it is not anger but reason that separates the harmful from the sound."(46)

References to exposure are frequent in Latin literature, with foundlings spirited into the houses of the great or providing ready-made characters for plays. Similarly allusions in literature at all periods are clear proof that abortion was accepted as in no way unusual. Plautus in the *Truculentus* mentions abortion quite casually: "Look here! How could she give birth to a child she never carried? Why, she never showed any sign of being pregnant to my knowledge." "She hid it from you, fearing you'd urge her to have an abortion, and be the death of her baby boy."(47)

Though a variety of drugs and other abortifacients are mentioned, especially in medical works, crude mechanical procedures were also common, to the great danger of the women concerned. Even Ovid, the laureate of a society where morality did not exist, expressed horror at the lengths women would go to: "Corinna, rashly seeking to rid her heavy body of its load, now lies languishing in peril of her life."(48)

"Of what avail to fair woman, to rest free from the burdens of war, nor choose with shield on arm to march in the fierce array, if free from peril of battle, she suffer wounds from weapons of her own and arm her unforeseeing hands to her own undoing. She who first plucked forth the tender life deserved to die in the warfare she began. Ah, women, why will you thrust and pierce with the instrument, and give dire poisons to your children yet unborn?"(49)

Pliny, in one of his letters, refers to an abortion attempt which resulted in death: "Yet Domitian himself had not only incestuously debauched his brother's daughter, but was also accessory to her death; for that lady being a widow, endeavoured to procure an abortion and by that means lost her life."(50)

A feature of the social history of Rome, was the failure of the governing class to rear enough children to maintain its numbers. One factor which attracted a great deal of criticism and scorn from historians, political commentators, poets, and philosophers was the desire of society women to avoid child-bearing, partly to avoid the restrictions and dangers of pregnancy, partly from a desire to retain their youthful beauty, and for allied reasons. It would appear that there were plenty of professionals only too willing to prescribe contraceptives and medicines and to carry out

abortions. Juvenal, in his Sixth Satire, bitterly attacks them and the society in which they flourished: "These poor women, however, endure the perils of child-birth and all the troubles of nursing to which their lot condemns them; but how often does a gilded bed contain a woman that is lying-in? So great is the skill, so powerful the drugs of the abortionist paid to murder mankind within the womb!"(51)

Or again: "In so doing they show the same madness as those who strive by evil devices to cause abortion of the fetus itself which they have conceived, in order that their beauty may not be spoiled by the weight of the burden they bear and by the labour of parturition."(52)

"We may easily discover", says Gibbon, "that Tacitus indulges an honest pleasure in the contrast of barbarian virtue with the dissolute conduct of the Roman ladies."(53) Almost with an air of surprise, Tacitus, in the *Germania* describes customs of the early Teutonic tribes, customs which have persisted, developed, and influenced German attitudes: "No-one in Germany laughs at vice, nor do they call it the fashion to corrupt and to be corrupted. To limit the number of their children or to destroy any of their subsequent offspring is accounted infamous, and good habits are here more effectual than good laws elsewhere."(54)

Contrasting her conduct with the depravity of society women, Seneca praised his mother for her wholesome approach; "You have never been ashamed of your fruitfulness as though it were a reproach to your youth; you never concealed the signs of pregnancy as though it were an unbecoming burden, nor did you ever destroy your expected child within your womb after the fashion of many other women, whose attractions are to be found in their beauty alone."(55)

An incident related by Cicero, in his *Pro Cluentio* indicates that to many in Rome attacks on abortion as one of the features of a corrupt and demoralised society were not so much out of sympathy for the unborn child as for the deprivation of a much needed citizen for the State or a son to a father: "I remember a case which occurred while I was in Asia; how a certain woman of Miletus who had accepted a bribe from the alternative heirs and procured her own abortion by drugs, was condemned to death: and rightly, for she had cheated the father of his hopes, his name of continuity, his family of its support, his house of an heir, and the Republic of a citizen-to-be."(56)

It was hardly to be expected that a society which had seen so many stern struggles for survival, invasions, internal power struggles and civil wars, as well as wars to be conducted in other lands, a society which had seen proscriptions at Rome, and a slave rising crushed with thousands crucified along the Appian Way would have much feeling for the unborn child. But, in a largely vain endeavour to restore virtue to private life, reduce the worst excesses of the upper classes, and provide more citizens able to hold public office, various laws were brought in, some giving privileges to those with children, others with harsh punitive clauses for the unmarried, the childless, for fathers guilty of parricide, and for those who administered abortifacient drugs.

The "Lex Cornelia de sicariis", passed during the dictatorship of Sulla,

B.C.81, besides laying down penalties for assassins, included a clause against the provision or sale of abortifacient drugs: "Poisoners are capitally condemned who by hateful arts use poisons or magic charms to kill men, or publicly sell hurtful drugs."(57)

The "Lex Pompeia de parricidiis", B.C.52, inflicted horrible punishment for the murder of relatives, though the father was still not punished for the death of his child until the law was re-enacted in 318 A.D. by Constantine.

The Lex Julia, the Lex Papia Poppaea, and others of similar character during the principate of Augustus, attempting to restore virtue to private life, had little effect and were either evaded or not enforced. The Christians, Minucius Felix in the *Octavius*, and Tertullian, in the *Apology*, in the second century A.D. both attack current Roman practices. Whether Minucius Felix, traditionally a successful advocate practising at Rome, was an actual person is not certain, but the writer represents the cultured and professional classes of Rome and gives a good picture of the social and religious conditions at the end of the second century: "Among you I see newly-born sons at times exposed to wild beasts and birds, or violently strangled to a painful death; and there are women who, by medicinal draughts, extinguish in the womb and commit infanticide upon the offspring yet unborn."(58)

Tertullian is even more critical: "How many, think you, of these persons standing round and panting for Christian blood, how many of you, most just magistrates and most severe upon us, how many should I touch in their consciences for killing their own children, born to them? Since there is a difference between one kind of death and another, surely your way is more cruel, to choke out the breath in water, or to expose to cold, starvation and the dogs. For us murder is once for all forbidden; so even the child in the womb, while yet the mother's blood is still being drawn on to form the human being, it is not lawful for us to destroy. To forbid birth is only quicker murder. It makes no difference whether one take away the life once born or destroy it as it comes to birth. He is a man, who is to be a man; the fruit is always present in the seed."(59)

Plainly, new laws while indicating an awareness of the magnitude of the social problems of Rome, were largely ineffectual. Some ran counter to customs lost in antiquity, some conflicted with attitudes which had gradually crept in with the decimation of the noble families and the growth of a polyglot brood of citizens. On Sulla's Cornelian laws, Niebuhr says, "Sulla saw the state of dissolution in the republic, but he was unable to see that when old institutions have decayed and an effectual remedy is to be applied, new institutions must be created in the spirit of the old ones, but adapted to the circumstances of the time." A similar comment could be passed on the attempt by Augustus to restore the prescriptions of antiquity.

The Early Christian Church

It is not surprising that the new religion, Christianity, with its respect for life and its belief in immortality, should condemn murder, suicide,

infanticide, and abortion. What is remarkable is that the influence of its beliefs should become widespread so quickly. Though abortion is not specifically mentioned in the New Testament, it is regarded as one of the greatest sins in two important teaching manuals of Christian conduct of the latter part of the first century and the early second century A.D. The first part of the Didache, the "Two Ways" (The Way of Life and the Way of Death) sets out principles of Christian conduct amongst which are: "The second commandment of the teaching is this: 'Thou shalt do no murder, thou shalt not commit adultery; thou shalt not commit sodomy; thou shalt not commit fornication; thou shalt not steal; thou shalt not use magic; thou shalt not use philtres; thou shalt not procure abortion, nor commit infanticide.'"(60)

The "Epistle of Barnabas", possibly a general treatise, has a section very similar to that of the "Two Ways": "Thou shalt love thy neighbour more than thy own life. Thou shalt not procure abortion; thou shalt not commit infanticide."(61)

In conformity with this attitude, the teachings of the early Christian Fathers and the canons of the ecclesiastical councils both in the East and the West consistently condemned abortion.

About 200 A.D., Clement of Alexandria, traditionally regarded as the founder of the first school of Christian theology, in the *Paedagogus*, in which he portrayed Christ as the supreme educator, attacked promiscuity and the attendant practice of abortion: "But women who resort to some sort of deadly abortion drug kill not only the embryo, but, along with it, all human kindness." (62)

In the fourth century, Saint Basil, Archbishop of Cappadocia, in a canonical letter, categorically condemned abortion, making no distinction between the "formed" and "unformed" fetus, which gave rise to so much speculation by Augustine, Jerome and others and had so much bearing on later ecclesiastical and legal policy. "A woman", he wrote, "who deliberately destroys a fetus is answerable for murder. And any fine distinction as to its being completely formed or unformed is not admissible amongst us. For in this case, not only the child which is about to be born is vindicated, but also she herself who plotted against herself since women usually die from such attempts. And there is added to this crime the destruction of the embryo, a second murder—at least that is the intent of those who dare these deeds."(63)

In the West, Saint Jerome, advising on how to resist temptations in Rome wrote: "Some even ensure barrenness by the help of potions, murdering human beings before they are fully conceived, others, when they find that they are with child as the result of their sin, practise abortion with drugs, and so frequently bring about their own death, taking with them to the lower world the guilt of three crimes: suicide, adultery against Christ, and child murder."(64)

Augustine, in the early fifth century, wrote at great length on abortion and infanticide, and many allied matters, speculating on the problems of resurrection and ensoulment. His writings greatly influenced future Christian attitudes and it is worthy of note that, in 1930, Pope Pius XI, in his encyclical, "Casti Connubii", made frequent references to his

teaching. Influenced by the Septuagint version of Exodus and by the theories of Aristotle, he made a clear distinction between the "formed" and "unformed" fetus, confessing frankly that he did not know when it was given a rational soul and whether it would be certain of resurrection: "I do not dare either to affirm or deny that abortive offspring, who lived and died in the womb, will rise from the dead."(65)

In the *Enchiridion*, Augustine enunciates his philosophy: "No Christian should have the slightest doubt as to the fact that the bodies of all men, whether they have died or are yet to die, whether already or yet to be born, will be resurrected. Once this fact is established, then first of all comes the question about abortive fetuses. For if we say that there is a resurrection for them, then we can agree that at least as much is true of fetuses that are fully formed. But, with regard to unformed fetuses, who would not more readily think that they perish, like seeds that did not germinate?

On this score, a corollary question may be most carefully discussed by the most learned men, and still I do not know that any man can answer it, namely: When does a human being begin to live in the womb? Is there some form of hidden life, not yet apparent in the motions of a living thing? To deny, for example, that those fetuses ever lived which are cut away limb by limb and cast out of the wombs of pregnant women lest the mothers die also if the fetuses were left there dead, would seem much too rash. But, in any case, once a man begins to live, it is thereafter possible for him to die. And, once dead, wheresoever death overtook him, I cannot find the basis on which he would not have a share in the resurrection of the dead. By the same token, the resurrection is not to be denied in the cases of monsters which are born and live, even if they quickly die, nor should we believe they will be raised as they were, but rather in an amended nature and free from faults."(66)

As the church became more of a social force and assumed legislative power, its councils laid down severe penalties against abortion. The Council of Elvira in Spain, about 300 A.D., excommunicated women after abortion and prohibited their re-admission even on the death bed. The Council of Ancyra in Asia Minor in 314 A.D. excommunicated women "who slay what is generated and work to destroy it with abortifacients" but softened the ancient penalty of excommunication for life with a punishment of various degrees of penance for ten years. The Council of Lerida in Spain 524 A.D. continued the denunciation of abortion but allowed the mother to receive communion after seven years' penance.(67)

Augustine's teaching on abortion formed the basis of canon law, becoming the canon "Aliquando" — abortion being regarded as homicide only if the fetus was "formed". For a time under the decretals of Pope Gregory IX, the old canon, "Si Aliquis", the source of which is unknown but which dates back at least to 915 A.D., became law: "If anyone to satisfy lust or to implement hatred, in order that no offspring be born of him either does something to a man or woman or gives something to drink so that the person be not able to generate or conceive, let him be held a murderer." At the same time, the canon, "Sicut Ex", of Innocent III decreed that homicide occurred only if the fetus was vivified. In 1588

Sixtus V, in his constitution "Effraenatam" restored the stricter "Si Aliquis", but, three years later, Gregory XIV, by his constitution, "Sedes Apostolica", again differentiated between the fetus which was animated and the fetus that was not animated, a distinction which remained until finally changed by Pius IX in 1869. The encyclical, "Humanae Vitae", of 1968, maintained the firm attitude of the Roman Catholic Church, an attitude which remains in the most recent statements from the Vatican.

Early English Law

The legal situation in England, as in the rest of Christendom until the twelfth century, was that laid down by ecclesiastical law. The first commentaries on the English common law mentioning abortion were those of Henry of Bracton and Fleta in the thirteenth centuries. "If there is anyone who has struck a pregnant woman or has given her poison whereby he has caused an abortion, if the fetus be already formed or animated and particularly if it be animated he commits homicide."(68) Fleta's comment is very similar both to Bracton and the canon "Si Aliquis": "He, too, is a homicide who has pressed upon a pregnant woman or has given her poison or has struck her in order to procure an abortion or to prevent conception, if the fetus was already formed and quickened, and similarly he who has given or accepted poison with the intention of preventing procreation or conception."(69)

Sir Edward Coke, in his "Third Institute" published in the seventeenth century, stressed the importance in law of quickening and introduced a further distinction—whether the aborted fetus is dead or alive. "If a woman be quick with childe and by a potion or otherwise killeth it in her wombe; or if a man beat her, whereby the childe dieth, this is a great misprision and no murder; but if the childe be born alive, and dieth of the potion, battery, or other cause, this is murder: for in law it is accounted a reasonable creature in *rerum natura* when it is born alive."(70)

Blackstone, regarded as an important legal commentator both for Britain and America prior to modern legislation, dealt at some length with the rights of the person and followed Coke closely regarding abortion: "Life is the immediate gift of God, a right inherent by nature in every individual; and it begins in the contemplation of law as soon as the infant is able to stir in the mother's womb. For if a woman is quick with child, and by a potion, or otherwise, killeth it in her womb; or if anyone beat her, whereby the child dieth in her body, and she is delivered of a dead child, this, though not murder, was by the ancient law homicide or manslaughter. But at present it is not looked upon in quite so atrocious a light, though it remains a very heinous misdemeanour."(71)

It usually takes some time for scientific discoveries to find their expression in changed legal enactments. It is not surprising that it was not till 1837 that reference to quickening disappeared from British law as, until the seventeenth century, the learning of ancient Greece had been the predominant influence in the universities of all countries and the view was widely held that the classical philosophers and Aristotle in particular, were the fountain of wisdom from which all knowledge flowed. Hitherto

the great fundamental achievements of such men as Copernicus, Galileo, and Kepler had found no place in the teaching of the universities but the temper and climate of the seventeenth century demanded study of the new philosophy, namely, that systematic observation and experiment were the proper means of investigating natural happenings. Such an attitude led to the formation of learned societies, of which the Royal Society with its headquarters in London is a good example. Its motto, *Nullius in Verba* taken from the first Epistle of Horace to Maecenas, "I am not bound to revere the word of any particular master", was a clear indication that the Society intended to free itself from the authority of Aristotle and the other masters of antiquity.

Scientific Research

Change in the laws on abortion, closely interwoven as they are, not only with recent scientific findings but also with profound questions of morality and theology, quite clearly cannot be undertaken lightly. Research goes on and we merely summarise some of the relevant discoveries of the last two hundred years:

1653: William Harvey (*Exercitatio de Partu, XXXIV*) by careful observation deduced separateness of maternal and fetal circulations.

1677: van Leenwenhoek observed living male sperm.
de Graaf observed the embryo of the rabbit.

1759: Kaspar Frederick Wolff stated that the embryonic body was assembled out of "globules" with male and female contributing equally. This ended the "ovist" and "homunculist" arguments and theories of "emboitement" and "encapsulation".

1774: Hunter by his injection studies demonstrated conclusively the separateness of maternal and fetal circulation. The discovery is popularly attributed to William Hunter but it is now thought that it should be credited to his brother John. The claim to priority in the discovery led to a lifelong quarrel between the two brothers.

1827: von Baer observed the ovum of the dog.

Mid-19th Century: The botanist, Schleiden, and the physiologist, Schwann, firmly established the cell theory. The sperm and the ovum were identified as true cells.

1854: The penetration of the ovum of the frog by sperm was observed and its significance was appreciated.

1900-1930: Coghill studied the reflex and voluntary motor behaviour of amphibian embryos.

1930s: Davenport Hooker studied the reflex and voluntary motor behaviour of miscarried human embryos and fetuses from six weeks onward.

1930: Liberation of human ova from the ovary was observed.

1944: Penetration of the human ovum by sperm was served.

1950s: The first six days of human embryonic development was completely documented.

1956: The human diploid chromosome number of 46 was established.

1963: Intra-uterine therapy of the fetus was established.

1960s: The genetic code alphabet as a triplet sequence of four organic bases was recognised.

The structure of DNA as a double helix was established.

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Appendix 3

THE PROVISIONS OF THE ABORTION ACT 1967 (U.K.)

The law of abortion in England is to be found in sections 58 and 59 of the Offences against the Person Act 1861 and the Abortion Act 1967. The relevant provisions of the Offences Against the Person Act 1861 are as follows:

> 58. Administering drugs or using instruments to procure abortion.
> Every woman being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or any means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony.
>
> 59. Procuring drugs etc. to cause abortion.
> Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour.

The effect of the Abortion Act 1967 was twofold:

1. It liberalised the law of abortion by providing that a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith:

   (1) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman, or any existing children of her family, greater than if the pregnancy were terminated; or

   (2) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

   The Act further provided that where the continuance of a pregnancy would involve such risk of injury to health, as mentioned in paragraph (1) above, account might be taken of the pregnant woman's actual or reasonably foreseeable environment.

2. By defining the grounds on which a person terminating a pregnancy would not be guilty of an offence under the law relating to abortion, it overcame the difficulty previously encountered by the courts in defining when abortions were performed "unlawfully".

The Abortion Act 1967 resulted from the introduction of a private member's bill by Mr David Steele, member for Roxburgh, Selkirk and Peebles. It was originally known as the Medical Termination of Pregnancy Bill and was later known as the Abortion Bill. After a lengthy debate, the Bill was given the Royal Assent on 27 October 1967 and came into force six months later.

In moving the second reading of the Bill, Mr Steele outlined the law on abortion as it then was in England and Wales and said that it had developed from a series of cases. He said that there was total uncertainty about the exact legal position and that the law left far too much to the judgment of individual medical practitioners. He said that the likelihood of a woman being able to obtain termination of an unwanted pregnancy legally was largely dependent on where she lived and upon the practice of hospitals and the medical practitioners in her area. Estimates of the number of illegal abortions being carried out annually varied from 40,000 to 200,000.

At page 1078 of the Report of the Parliamentary Debate, Mr. Steele is recorded as saying that some members of the House thought that the Bill did not go far enough and that abortion should be left entirely as a matter for the woman concerned. He himself did not accept that view and what the House had to do was to try and find a balance of judgment between one extreme and the other.

Criticism of the Working of the Abortion Act 1967 (U.K.)

After the Abortion Act 1967 had been in force for a time, it became the subject of criticism. It was said that its operation had led to a number of abuses. These included the availability of abortion services to overseas visitors; the use of aborted fetuses for medical research; profiteering by private clinics charging inordinately high fees; terminations carried out significantly later in pregnancy than that permitted by the law; the non-application by some medical practitioners of the grounds upon which abortion was permitted by law. In February 1971, the then Secretary of State for Social Services, Sir Keith Joseph, in announcing the setting up of a Committee of Inquiry under the Chairmanship of Mrs Justice Lane, a Judge of the High Court, said: "The Government has now studied the working of the 1967 Abortion Act. Our conclusion is that, while the Act has operated for the benefit of many people, there is cause for real concern about the way in which certain of its provisions are working in practice."

In June 1971 the committee was appointed with the following terms of reference:

> To review the operation of the Abortion Act 1967 and on the basis that the conditions for legal abortion contained in paragraphs (a) and (b) of subsection (1) and in subsections (2), (3) and (4) of section (1) of the Act remain unaltered, to make recommendations.

In answer to a Parliamentary Question on 23 February 1971, Sir Keith Joseph said: "The Enquiry will be concerned with the way the Act is working and not with the principles that underlie it. It will be open to the committee not only to recommend changes in the law but also to suggest interim changes in the Regulations under the present Act should they find this necessary."

It is apparent that the Lane Committee treated Sir Keith's statement as being part of its terms of reference because the answer to the question is in fact set out on page 1 of the Report under the heading "Appointment and Terms of Reference."

In April 1974 the Report of the Lane Committee was presented to Parliament. It is a lengthy report which cannot conveniently be summarised. On 27 November 1974, Mr James White, a member of Parliament, introduced the Abortion (Amendment) Bill. The Bill received a Second Reading on 7 February 1975 (203 to 88). It was then referred to a Select Committee. The members of the committee were nominated by vote on 26 February 1975.

The Bill was extensively debated in the House of Commons before it was referred to the Select Committee. It aimed:

1. To ban all abortions for foreign women unless they had lived in Britain for the preceding 20 weeks.
2. To stop abortion touts and restrict private clinics and the pregnancy-testing agencies by making it illegal for women to seek, or any person to offer, advice or information for gain "tangible or otherwise" about the termination of pregnancy. The only exceptions were people approved by the Secretary of State and working on premises licensed for the purpose.
3. To make it illegal to perform abortions after 20 weeks except in certain medical conditions and unless they were performed by National Health Service consultants.
4. To control the use of fetuses in experimental research.
5. To restrict the grounds on which a woman could obtain abortion to cases of "grave risk to life" or "serious injury to physical or mental health of herself or her family."
6. To place on the doctor the burden of proving himself innocent of contravening the Act under pain of maximum penalty of £1000 fine and five years imprisonment.

The Select Committee originally consisted of fifteen members. During the course of the Parliamentary session the committee made four special reports and, with the last, reported the Bill to the House without amendment. The Bill then lapsed at the end of the session, in accordance with the rules of the House. The committee was re-established with the same membership, but, on 19 March 1976, six of the members of the committee, none of whom had voted for its re-establishment, resigned from it. Those who resigned were not in favour of the Abortion (Amendment) Bill. One member was appointed to replace those who had resigned. The original committee had in fact heard oral evidence and received more than 200 written submissions from organisations and individuals and several thousand letters giving comments and opinions. This oral evidence together with relevant written memoranda was published by the committee; other material was published later. The committee as re-constituted, held further meetings and took oral evidence in public. In July 1976 the committee reported and made the following recommendations:

1. Legislation to implement this Report should be introduced by the Government forthwith (paras. 26 and 100).

2. Section 1 of the Abortion Act 1967 should be amended to provide that, if in private practice, the two registered medical practitioners should not be partners and the one should not be employed as the assistant of the other or be employed or share a financial interest in the same nursing home or agency and that one of them should be of at least five years' standing (para. 15).

3. The quarterly returns on the treatment for the termination of pregnancy of foreign women should be published together with a full statement of the special facilities provided for the reception, counselling, and after-care of such patients (para. 35).

4. The Regulations made for the licensing and control of the use of places for the termination of pregnancy and by referral agencies and pregnancy advice bureaux should make special provision for those giving treatment to non-resident foreign women (para. 35).

5. Legislation should be introduced to require any person who terminates a pregnancy to notify the woman's general practitioner of the treatment she has received, provided her consent has been sought and obtained in accordance with regulations made by the Secretaries of State (para. 39).

6. Legislation should be introduced to require all referral agencies, pregnancy advisory bureaux and pregnancy testing agencies which charge fees to be licensed by the Secretaries of State (para. 47).

7. The legislation should oblige the Secretaries of State to make regulations by Statutory Instrument for licensing and controlling the use of places for giving treatment for the termination of pregnancy and by referral agencies, pregnancy advisory bureaux, and pregnancy testing agencies which charge fees (para. 60).

8. Legislation should be introduced to provide an upper time limit of 20 weeks' gestation on treatment for termination of pregnancy but provision should be made allowing such treatment where the child would be born with a major disability, whether physical or mental, or where it is necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman; and to provide that the Secretaries of State be empowered to vary the upper time limit by Statutory Instrument subject to the affirmative procedure (para. 72).

9. The Secretaries of State should monitor, review, and, in due course make a report to the House on the implementation of the Peel Report (para. 73).

10. The legislation should make provision to restrict the publication of particulars identifying any complainant or any witness who has had, or who has been advised about, an abortion and which is the subject of proceedings (para. 79).

11. The legislation to be introduced should give powers to senior police officers investigating offences to apply to a Judge to inspect and take copies of any entries in registers or other books kept by places for giving treatment for the termination of pregnancy, and by referral

agencies, pregnancy advice bureaux, and pregnancy testing agencies, which charge fees, for the purpose of any proceedings relating to illegal abortion under the Offences Against the Person Act 1861, or the Abortion Act 1967, or the legislation we propose (Para. 86).

12. The maximum fine on summary conviction of contravening the Regulations should be increased to £1,000 and provision should be made extending the time limit for summary proceedings to three years from the commission of the offence (para. 91).

13. In the case of offences committed by bodies corporate, then responsible officers shall also be liable (para. 93).

14. The Abortion Act 1967 should be amended to provide that references in the Act to termination of pregnancy include acts done with intent to terminate a pregnancy if such exists (para. 95).

15. Section 4 of the Abortion Act 1967 should be amended to make it clear that a conscientious objection may be on religious, ethical, or other grounds and the proviso that the burden of conscientious objection shall rest upon the person claiming it shall be deleted (para. 98).

The report of the Select Committee appears to have had a mixed reception in the United Kingdom. In the *Guardian* of 29 July 1976 it is said that the National Abortion Campaign, which wants abortion to be a woman's choice, described the Report as "confused and evasive". The *Evening Standard* of 28 July reports Jacquie Webber, Campaign Organiser for the Abortion Law Reform Association, as describing the report as "a recipe for increasing the risk to health and life of the pregnant woman." The British Pregnancy Advisory Service said the report was a victory because the committee had rejected nine out of eighteen recommendations contained in the Amendment Bill (*The Times* 29 July). The report was described by Life, an organisation set up to campaign against the 1967 Act, as "bitterly disappointing in that nowhere in the report was there recognition of 'the fundamental fact that the unborn child is a human being.'" (*Guardian* 29 July).

Mr David Steele, the promoter of the Bill which became the 1967 Act, was reported as saying, "Considering that the Select Committee this session consisted entirely of opponents of the 1967 Abortion Act, the report could have been much more destructive." *The Times*, 29 July, under the heading, "Going for the Second Million", said, "The first thing to be said about yesterday's Report of the Select Committee on abortion is that it is not a partisan document. The committee was bedevilled throughout its existence by the clamour and manoeuvring of passionately opposed factions."

At the time of writing this appendix, the recommendations of the committee await consideration by the House of Commons.

Statistical Information on Abortions Performed Since the Abortion Act 1967

Although the Abortion Act 1967 was not intended to provide for abortion on demand, and its provisions contain no mention of abortion on that basis, nonetheless, the provisions of the Act have been interpreted as

authorising virtual abortion on demand. It is a statistical fact that proportionately more deaths occur from childbirth than from first-trimester abortion. Therefore, it can be said that the continuance of pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. This point was made by Dr Tooley in an address given at a symposium held by the Medical Protection Society, in collaboration with the Royal College of General Practitioners, London, on 7 February 1965.

The following figures, taken from the Lane Report, Vol. 11, pages 18 and 19, and from a written answer by Dr Owen, Minister of Health, in the British House of Commons on 30 April 1976, set out the number of legal abortions performed in England and Wales under Abortion Act 1967, from 1969-1975 inclusive:

Year	Married Women	Single Women	Total
1969	17,992	21,907	39,899
1970	28,281	33,230	61,511
1971	38,078	47,912	85,990
1972	43,378	57,361	100,739
1973	71,426	82,026	153,452*
1974	66,941	82,321	149,262*
1975	43,322	52,423	95,745

*Residents and non-residents (in other years, residents only)

Appendix 4

ABORTION LAW IN THE UNITED STATES

Until 1975 the enactment of abortion legislation was left to the individual States in the United States of America. In January 1975 a majority of the judges of the United States Supreme Court delivered a judgment in the companion cases of *Roe v. Wade, Doe v. Bolton,* (410 U.S.113 36 L.Ed.2d 147 (1973)), holding that the criminal abortion statutes of the State of Texas were unconstitutional. In reaching that conclusion the majority of the Court, comprising seven judges, held that:

1. For the first trimester, the abortion decision and its implementation be left to the medical judgment of the pregnant woman's attending physician.
2. For the stage subsequent to the first trimester, a State, in promoting its interest in the health of the mother, may regulate abortions to protect the life of the mother.
3. For the stage subsequent to viability, the State, in promoting its interest in the potentiality of human life, may regulate, and even forbid, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

The judgments in these two cases and copies of the full court records have been made available to us through the courtesy of the United States Embassy. Because it has been urged upon us that we should accept the Supreme Court's decision, an examination of the two cases and the particular considerations upon which judgments turned is made in this appendix.

Roe v. Wade: The Facts

In this case, Jane Roe, a single woman, residing in Dallas County, Texas, instituted an action against the District Attorney of that County. Although the name is a pseudonym, it represented a real person, who sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the District Attorney from enforcing them. She alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion performed by a competent, licensed physician, under safe, clinical conditions; that she was unable to get a "legal" abortion in Texas because her life did not appear to be threatened by the continuation of her pregnancy; and that she could not afford to travel to another jurisdiction in order to secure a legal abortion under safe conditions. She claimed that the Texas statutes were unconstitutionally vague and that they abridged her right of personal privacy, protected by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the Constitution of the United States of America.

Doe v. Bolton: The Facts

John and Mary Doe (again the names are pseudonyms), a married couple, filed a companion complaint to that of Roe. They also sued the District Attorney as defendant, claiming that they had been deprived of similar constitutional rights, and sought relief from the abortion laws. The Does were a childless couple. Mrs Doe was suffering from a "neural-chemical" disorder and had been advised that she should avoid pregnancy until such time as her condition had materially improved. She also wished to avoid pregnancy for "other highly personal reasons." The Does wished to terminate the pregnancy by an abortion if in fact Mrs Doe became pregnant. They alleged that they would be unable to obtain an abortion legally in Texas. They attacked the same abortion statutes as did Miss Roe.

The United States Supreme Court held that the case of the Does rested upon a number of possibilities which might not in fact take place and that they did not have the necessary status to bring proceedings. Their complaint had been dismissed by a District Court and that dismissal was upheld by the Supreme Court.

Grounds of Argument in Roe v. Wade

The Supreme Court, however, considered Miss Roe's case and ultimately reached a majority decision in her favour. The Texan statutes of which she complained made it a crime to "procure an abortion" except with respect to "an abortion procured or attempted by medical advice for the purpose of saving the life of the mother." Texas had first enacted a criminal abortion statute in 1854. This was subsequently modified by language that remained substantially unchanged at the time of the hearing of Miss Roe's action. Her main point was that the Texan statutes improperly invaded a right, said to be possessed by a pregnant woman, to choose to terminate her pregnancy. It was claimed that this right was embodied in the concept of personal "liberty" referred to in the Fourteenth Amendment; or in personal, marital, familial, sexual privacy said to be protected by the Bill of Rights; or among those rights reserved to the people by the Ninth Amendment. The text of the Ninth Amendment (1791) is as follows:

> The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people.

The relevant portion of the Fourteenth Amendment (1868) is as follows:

> Section 1. All persons born or naturalised in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privilege or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction equal protection of the laws.

Basis of the Supreme Court Judgment

The majority of the Court held that while the Constitution did not explicitly mention any right of privacy, the Court, in a line of decisions, had recognised that a right of personal privacy existed under the Constitution. This right of privacy, whether it was founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon State action, as the Court felt it was, or, in the Ninth Amendment's reservation of rights to the people, as the District Court had determined, was broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The Court held, however, that a woman did not have an absolute right to terminate her pregnancy at whatever time, or in whatever way, or for whatever reason she alone chose and that the Court's previous decisions recognising a right of privacy also acknowledged that some State regulation in areas protected by that right was appropriate. The State could therefore properly assert an interest in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests became sufficiently compelling to sustain regulation of the factors that govern the abortion decision. The right of privacy could not therefore be said to be absolute The Court therefore concluded that the right of personal privacy included the making of a decision on abortion but that the right was not unqualified and must be considered against important State interests. There was a point therefore where the State had an interest in intervening to protect health, medical standards, and pre-natal life. The Court held that a fetus was not a "person" within the language and meaning of the Fourteenth Amendment. If it had been held to be a person, then the case brought by Miss Roe would have foundered for the right of the fetus to life would then have been guaranteed specifically by the Fourteenth Amendment. The word "person", as used in the Fourteenth Amendment, did not include the unborn. Nonetheless, a pregnant woman could not be isolated in her privacy and there was a time in pregnancy when the woman's privacy was no longer the only consideration, and it was reasonable and appropriate for the State to decide that another interest, that of the health of the mother or that of the potential human life, became significantly involved.

In the result, the Court held that the State of Texas could not override the rights of the pregnant woman in the way in which the statutes provided. It held that with respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, was at approximately the end of the first trimester because of the established medical fact that until the end of the first trimester mortality in abortion might be less than mortality in normal childbirth. The Court dealt with the other stages in pregnancy and ruled as follows:

1. A State Criminal Abortion Statute of the then current Texas type, that excepted from criminality only a life-saving procedure on behalf of the mother, without regard to pregnancy stage, and without recognition of the other interests involved, violated the Due Process Clause of the Fourteenth Amendment.

(1) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(2) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may regulate the abortion procedure in ways that are reasonably related to maternal health.

(3) For the stage subsequent to viability, the State, in promoting its interest in the potentiality of human life, may regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

2. The State may define the term "physician" to mean only a physician currently licensed by the State and may proscribe any abortion by a person who is not a physician so defined.

Mr Justice White, with whom Mr. Justice Rehnquist joined, dissented. Mr Justice White could find nothing in the language of the history of the Constitution to support the Court's judgment which he considered "fashioned" and announced a new constitutional right for pregnant mothers with scarcely any reason or authority for its action, with the result that the people and legislatures of 50 States in the Constitution were constitutionally disentitled to weigh the relative importance of the continued existence and development of the fetus on the one hand, against a "spectrum of possible impacts on the mother" on the other hand. Mr Justice White said that he could not accept the Court's exercise of its clear power of choice by interposing the Constitutional barrier to State efforts to protect human life and by investing mothers and doctors with the constitutionally protected right to exterminate it.

Mr Justice Rehnquist said that he had difficulty in concluding, as did the Court, that the right of "privacy" was involved in the case. A transaction resulting in an operation such as abortion was not "private" in the ordinary usage of that word.

We offer no comment on the validity of the decision of the majority, but two points may be made. They are:

1. The decision is one which turns on the law-making authority of an individual State within the framework of the United States Constitution. No such position arises in New Zealand, where Parliament is the supreme law-making authority.

2. While the judgments of all the judges are indicative of their breadth of reading, that of the majority proceeds on the basis that the question of when a life begins cannot be resolved. Indeed, Mr Justice Blackmun, who gave the leading judgment, said: "We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer."

The Commission is not in that position. All the witnesses who gave evidence before us were agreed that life begins at conception, and pregnancy at implantation.

On 22 January 1973, amendments to the Constitution were proposed. The Sub-Committee on Constitutional Amendments of the Committee on the Judiciary has conducted lengthy hearings on four resolutions aimed at the protection of unborn children and other persons and guaranteeing the right of life to the unborn, the ill, the aged, and the incapacitated. The text of these resolutions is:

S.J.Res.6

Section 1. With respect to the right to life guaranteed in this Constitution, every human being, subject to the jurisdiction of the United States, or of any State, shall be deemed, from the moment of fertilisation, to be a person and entitled to the right to life.

Section 2. Congress and the several States shall have concurrent power to enforce this article by appropriate legislation.

S.J.Res.10

Section 1. With respect to the right to life, the word "person" as used in this article and in the fifth and fourteenth articles of amendment to the Constitution of the United States, applies to all human beings, including their unborn offspring at every stage of their biological development, irrespective of age, health, function or condition of dependency.

Section 2. This article shall not apply in an emergency when a reasonable medical certainty exists that continuation of the pregnancy will cause the death of the mother.

Section 3. Congress and the several States shall have power to enforce this article by appropriate legislation within their respective jurisdictions.

S.J.Res.11

Section 1. With respect to the right to life, the word "person" as used in this article and in the fifth and fourteenth articles of amendment to the Constitution of the United States, applies to all human beings, irrespective of age, health, function or condition of dependency, including their unborn offspring at every stage of their biological development.

Section 2. No unborn person shall be deprived of life by any person: Provided, however, that nothing in this article shall prohibit a law permitting only those medical procedures required to prevent the death of the mother.

Section 3. Congress and the several States shall have the power to enforce this article by appropriate legislation within their respective jurisdictions.

S.J.Res.91

Article

The power to regulate the circumstances under which pregnancy may be terminated is reserved to the States.

On 17 September 1975, the Committee rejected Resolutions S.J.10, 11, and 91 by a majority vote, but the vote on S.J.91, which provided that the power to legislate on abortion should be left to the States, was equal. Until amendments to the Constitution are made, the Supreme Court decision stands and restrictive abortion statutes are regarded as unconstitutional. There are some States, however, which have since passed liberal abortion statutes.

The abortion issue was given some prominence in the 1976 Presidential Campaign.

Appendix 5

THE ABORTION LAWS OF THE STATES OF AUSTRALIA

All the states of Australia, with the exception of South Australia and the Northern Territory, legislate against abortion in statutes expressed in terms similar to sections 182-187 of the Crimes Act 1961 (N.Z.). The relevant statutory provisions are as follows:

New South Wales: Crimes Act 1900, Sections 82-84

82. Whosoever, being a woman with child, unlawfully administers to herself any drug or noxious thing, or unlawfully uses any instrument or other means, with intent in any such case to procure her miscarriage, shall be liable to penal servitude for ten years.

83. Whosoever unlawfully administers to, or causes to be taken by, any woman, whether with child or not, any drug or noxious thing, or unlawfully uses any instrument or other means, with intent in any such case to procure her miscarriage, shall be liable to penal servitude for ten years.

84. Whosoever unlawfully supplies or procures any drug or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used with intent to procure the miscarriage of any woman, whether with child or not, shall be liable to penal servitude for five years.

Victoria: Crimes Act 1958, Sections 65-66

65. Whosoever being a woman with child with intent to procure her own miscarriage unlawfully administers to herself any poison or other noxious thing or unlawfully uses any instrument or other means, and whosoever with intent to procure the miscarriage of any woman whether she is or is not with child unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means with the like intent, shall be guilty of felony, and shall be liable to imprisonment for a term of not more than fifteen years.

66. Whosoever unlawfully supplies or procures any poison or other noxious thing or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether with child or not, shall be guilty of a misdemeanour, and shall be liable to imprisonment for a term of not more than three years.

Queensland: Criminal Code 1828-1962, Sections 224-226

224. Attempts to Procure Abortion. Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment with hard labour for fourteen years.

225. The like by Women with Child. Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment with hard labour for seven years.

226. Supplying Drugs or Instruments to Procure Abortion. Any person who unlawfully supplies to or procures for any person anything whatever, knowing

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66. Whosoever unlawfully supplies or procures any poison or other noxious thing or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether with child or not, shall be guilty of a misdemeanour, and shall be liable to imprisonment for a term of not more than three years.

Queensland: Criminal Code 1828-1962, Sections 224-226

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that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment with hard labour for three years.

Western Australia: Criminal Code 1913, Sections 199-201

199. Any person who with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime and is liable to imprisonment with hard labour for fourteen years.

200. Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment with hard labour for seven years.

201. Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a misdemeanour, and is liable to imprisonment with hard labour for three years.

Tasmania: Criminal Code Act 1924, Section 134

134. Abortion—(1) Any woman who, being pregnant, unlawfully administers to herself, with intent to procure her own miscarriage, any poison or other noxious thing or with such intent unlawfully uses any instrument or other means whatsoever is guilty of a crime.

(2) Any person who, with intent to procure the miscarriage of a woman, whether she be pregnant or not, unlawfully administers to her, or causes her to take, any poison or other noxious thing, or with such intent unlawfully uses any instrument or other means whatsoever, is guilty of a crime.

Australian Capital Territory

The law is the same as in New South Wales.

THE INTERPRETATION OF THE LAW IN AUSTRALIA

The legislation in Australia, with the exception of South Australia and Northern Territory, is obviously modelled on the English statutes passed before the Abortion Act 1967. In its use of the word "unlawfully" it suffers from the same criticisms. The meaning given to this word in Australia is discussed in the text of *Family Planning and the Law in Australia*, by H. A. Finlay and Sandra Glasbeek (1973). At page 52 of that work the authors say:

"There are two important decisions on this question. In the English case of *R. v. Bourne* (1939) 1 K.B.687, it was held that for the abortion to be a crime the burden rests upon the Crown to satisfy the jury beyond reasonable doubt that it was not done in good faith for the purpose only of preserving the life of the mother.

"It was some years before the matter came before an Australian court. In 1958 in *R. v. Mackay* (1955) Q.S.R.48, the Supreme Court of Queensland held that on a charge of abortion the onus was on the Crown to establish that the operation was not performed in good faith for the preservation of the mother's life. The decision rested on section 282 of the Queensland Criminal Code which enacts that a surgical operation may be performed, *inter alia*, upon an unborn child for the preservation of the mother's life 'if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the

case.' The same defences were held to be available to an accused person as those in *R. v. Bourne.*

"The position in the common law States remained undetermined by any judicial decision until 1969. In that year two things happened. In South Australia, an amendment to the Criminal Law Consolidation Act 1935 was enacted, allowing abortions in certain circumstances. In Victoria, in *R. v. Davidson* (1969) V.R.667, the circumstances in which an abortion may be lawfully undertaken were set out by Menhennitt, J. in the following terms:

> For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him was (a) necessary to preserve the woman from a serious danger to her life or physical or mental health (not merely being the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and (b) in the circumstances not out of proportion to the danger to be averted. Accordingly, to establish that the use of an instrument with intent to procure a miscarriage was unlawful, the Crown must establish either (a) that the accused did not honestly believe on reasonable grounds that the act done by him was necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; or (b) that the accused did not honestly believe on reasonable grounds that the act done by him was in the circumstances proportionate to the need to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail.

"In a recent Victorian case of *R. v. Heath* (unreported) the defence sought to extend the situations in which the abortion could lawfully be performed, by putting forward the proposition that where the pregnant woman was either single, or separated from her husband, a prima facie case of serious risk to her health existed by reason of her circumstances. Her mental health, accordingly, was in jeopardy if the pregnancy was not terminated. Had this argument been accepted, it would have been necessary only to prove her marital status, or absence of cohabitation with her husband, for the defence to be successful. However, the argument was not accepted.

"The position in the other states is that while Bourne's case and Davidson's case are not of binding authority, they are persuasive authority and are likely to be accepted as such.

"In the recently reported N.S.W. case of *R. v. Wald,* Judge Levine in Quarter Sessions restated the principles of Bourne and Davidson as applying in New South Wales. He went further in holding that when determining mental health, regard should be had to 'the effects of economic or social stresses that may be pertaining at that time'.

"In Queensland and Western Australia it is immaterial whether the woman is pregnant or not, but in the other states an offence is committed only if the woman is pregnant, the wording being 'with child' (N.S.W., Vic., S.A., and A.C.T.) and 'being pregnant' (Tas.)."

It is necessary to refer specifically to the law in South Australia and in the Northern Territory. In South Australia the Criminal Law Consolidation Act Amendment Act 1969 liberalised the abortion laws of that State by providing as follows:

82a. (1) Notwithstanding anything contained in section 81 or section 82 of this Act, but subject to this section a person shall not be guilty of a felony or misdemeanour under either of those sections:

(a) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman—

(i) that the continuance of the pregnancy would involve greater risk to the life of the pregnant woman or greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; or

(ii) that there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped, and where the treatment for the termination of the pregnancy is carried out in a hospital or a hospital of a class declared by regulation to be a prescribed hospital or a hospital of a prescribed class for the purposes of this section; or

(b) if the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life, or to prevent grave injury to the physical or mental health of the pregnant woman.

(2) Paragraph (a) of subsection (1) of this section does not refer or apply to any woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the physical or mental health of a pregnant woman as is mentioned in subparagraph (i) of paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

The operations of these provisions is limited to women who have been resident in South Australia for at least two months before the termination of the pregnancy but the section is unclear in that it could be read as meaning immediately prior to the abortion or at some prior time in the woman's life.

Similar provisions have now also been enacted in the Northern Territory by the Criminal Law Consolidation Ordinance No. 2 (1973). The relevant provisions of that statute are as follows:

(3) It is not unlawful for a medical practitioner to carry out medical treatment or perform an operation with intent to procure the miscarriage of a woman who, he has reasonable cause to believe after medically examining her, has been pregnant for a period of not more than 23 weeks if—

(a) the medical practitioner and another medical practitioner are of the opinion, formed in good faith after medical examination of the woman by them, that, (i) the continuance of the pregnancy would involve greater risk to her life, or greater risk of injury to her physical or mental health, than if the pregnancy were terminated; or (ii) there is a substantial risk that, if the pregnancy were not terminated and the child were to be born, the child would have or suffer from, such physical or mental abnormalities as to be seriously handicapped; and

(b) the medical treatment or operation for the purpose of procuring the miscarriage is carried out or performed in a hospital.

(4) In determining the risk of injury to the physical or mental health of a woman for the purpose of subsection (3) (a) (i), account shall be taken of the woman's actual and reasonably foreseeable environment.

(5) Subject to subsection (6), no person is under a duty, whether by contract or by any other legal requirement, to participate in the procuring of the miscarriage of a woman as permitted by subsection (3) to which, in the circumstances, he has a conscientious objection, but, in any legal proceedings, the burden of proof of conscientious objection rests on the person claiming to rely on it.

(6) Nothing in subsection (5) affects any duty to participate in treatment that is necessary to save the life, or to prevent grave injury to the physical or mental health, of a pregnant woman.

(7) It is not unlawful for a medical practitioner to carry out medical treatment or perform an operation with intent to procure the miscarriage of a woman who, he has reasonable cause to believe after medically examining her, has been pregnant for a period of not more than 23 weeks if the medical practitioner is of the opinion, formed in good faith after his medical examination of her, that termination of the pregnancy is immediately necessary to save her life, or to prevent grave injury to her physical or mental health.

(8) It is not unlawful for a medical practitioner to carry out medical treatment or perform an operation with intent to procure the miscarriage of a woman who, he has reasonable cause to believe after medically examining her, has been pregnant for a period of not less than 23 weeks if the treatment was carried out or the operation performed in good faith for the purpose only of preserving her life.

(9) Nothing in this section relieves a medical practitioner from his liability in carrying out any medical treatment or performing an operation with intent to procure the miscarriage of a woman to carry it out or perform it—

(a) with the consent of the person having authority in law to give such a consent;

(b) with professional care; and

(c) otherwise according to law.

Under the South Australian enactment, provision is made for the passing of regulations to facilitate the working of the Act. These regulations list which hospitals are authorised to perform abortions and lay down a code for the reporting of abortions and the grounds upon which they are done. The legislation also provides for the setting up of a committee to examine and report to Parliament on abortions notified in South Australia. Since its inception it has been presided over by Sir Leonard Mallen. We have obtained from the Australian committee copies of the reports for the year ended 7 January 1971 and thereafter for the years ended 31 December 1971 to 1975 inclusive.

Relevant Statistics

The working of the South Australian legislation may be gauged from information contained in the Annual Reports of the Mallen Committee. Relevant information is as follows:

Year ended 7 January 1971

1. No. of abortions performed 1,330

subsequently corrected to 1,440 for year ended 31 December 1970

2. Incidence of abortions to live births (per 1,000) ... 58.7

3. Indications for abortion:

(1) Assault on the person ... ... 0.8 percent

(2) Potential damage to fetus (majority were Rubella) 4.9 percent

(3) Specified medical disorders ... ... 10.4 percent

(4) Psychiatric reasons ... ... 83.9 percent

Year ended 31 December 1971 (from 8 January 1971)

1. No. of abortions performed 2,509
2. Incidence of abortions to live births (per 1,000) ... 104.7
3. Indications for abortion:
(1) Specified psychiatric disorders ... ... 88.3 percent

It is not clear from the report what the percentages were for assault on the person, specified medical disorders, potential damage to fetus.

Comments

The committee in its report noted:

1. That the "emergency clause" (82)(1)(b) should be clarified.
2. Abortions had been done on patients from inter-state in contravention of the residential clause. The committee thought that the residential clause should be retained in spite of this.
3. That four doctors had been called before the committee to discuss and explain what appeared to be an excessive number of abortions carried out by them. One was reported to the South Australian Medical Board, which took action.
4. The increasing number of abortions, coupled with the necessity for reaching a decision and operating within strictly limited time, had imposed pressure on the gynaecological beds in the teaching hospitals.

Year ended 31 March 1972

1. No. of abortions performed 2,673
2. Incidence of abortions to live births

This is not stated in this year, nor in any of the subsequent years.

3. Indications for abortion:
(1) Assault on the person ... ... 0.6 percent
(2) Specified medical disorders ... ... 7.1 percent
(3) Potential damage to fetus ... ... 6.0 percent
(4) Specified psychiatric disorders ... ... 86.3 percent

Comments

The committee in its report noted:

1. That pressure still existed on public beds and teaching hospitals.
2. That there was an absence of reliable statistics on the degree of complications following upon abortions.
3. That the regulations should be amended to include:

(1) Availability of skilled assistance for resuscitation.
(2) Availability of blood or approved facilities for blood storage.
(3) A good standard of operating theatre facilities and equipment.
(4) A good standard of post-operative facilities and supervision.

It was thought that the institution of these standards would reduce the number of proclaimed hospitals (i.e., hospitals suitable for the doing of abortions) and would therefore impose a greater pressure on the teaching hospitals, a factor which was not desirable. (41.9 percent of abortions were carried out in public hospitals and 51.8 percent in metropolitan private hospitals.)

4. That the reports of complications following abortions were not accurate. Many doctors failed to report them. The incidence of recorded complications was: 1970: 5.15 percent; 1971: 3.9 percent; 1972: 4.8 percent; but the committee noted that at Oxford the figure was higher, as also it was at Adelaide. The committee noted that the longer the pregnancy, the higher the complication rate. However, it was quite sure that many complications were not being reported, and, to overcome this, the committee recommended that complications after abortion be made a notifiable disease.

5. The committee noted the disturbing increase in the number of abortions in those of 19 years and under. (15 percent in 1970 had risen to 27.9 percent in 1972.)

Year ended 31 December 1973

1. No. of abortions performed	2,833
2. Indications for abortion:	
(1) Assault on the person	0.5 percent
(2) Specified medical disorders	7.2 percent
(3) Potential damage to fetus	3.6 percent
(4) Specified psychiatric disorders	88.6 percent

Comments

The committee in its report noted:

1. That the reporting of complications was still unsatisfactory and assessment of the complication rate was difficult.

2. The increase in abortion numbers had caused shortage of beds in teaching hospitals.

3. That 50.58 percent of abortions had been done in public hospitals and 41 percent in private hospitals.

4. The further increase in abortions in the under 19 group from 27.9 percent in 1971 to 30.65 percent in 1973. (4.47 percent were performed on girls under 16.)

Year ended 31 December 1974

1. No. of abortions performed	2,852
2. Indications for abortion:	
(1) Assault on the person	0.35 percent
(2) Specified medical disorders	5.72 percent
(3) Potential damage to fetus	4.20 percent
(4) Specified psychiatric disorders	89.73 percent

Comments

The committee in its report noted:

1. That abortion clinics should be separated from gynaecological units.

2. That some improvement was noted in the reporting of cases but inadequacies remained.

3. That the level of abortions was about static.

4. That 56.35 percent of abortions had been done in medical teaching hospitals.

5. That complications were still not being reported.

6. That abortions were being carried out but were not being reported.

7. That there was a reduction in the number of abortions carried out on under 19 year olds.

8. That there was an increase from 122 in 1973 to 144 in 1974 in repeat abortions.

Year ended 31 December 1975

1. No. of abortions performed	2,916
2. Indications for abortion:	
(1) Assault on the person	4.94 percent
(2) Specified medical disorders	3.54 percent
(3) Potential damage to fetus	0.18 percent
(4) Specified psychiatric disorders	91.34 percent

Comments

The committee in its report noted:

1. The number of abortions done on patients between 13 and 19 was as follows: 1970, 200; 1971, 663; 1972, 746; 1973, 868; 1974, 806; 1975, 800. It also noted the increase in the number of abortions done for psychiatric reasons. The figures were: 1970, 83.9 percent; 1971, 83.0 percent; 1972, 88.6 percent; 1973, 89.7 percent; 1974, 91.3 percent; 1975, 94.7 percent.

2. The committee commented that, over the three years prior to 1975, the increase in the number of abortions matched approximately the increase in the population. It said that the reasons for the abortions were somewhat disturbing; more and more were being carried out on psychiatric grounds. It also reiterated the complaints that it had made in previous reports about the failure to report all abortions and the failure to note complications.

The Future

In Australia a Royal Commission on Human Relationships has completed its hearings and is now preparing its report. The many matters on which submissions have been made to that Commission included abortion. Recommendations on the laws of abortion in Australia may be made by that Commission but legislation is a matter for each state.

Appendix 6

ABORTION LAWS THROUGHOUT THE WORLD

Appendices 3, 4, and 5 discuss in some detail the abortion laws in the United Kingdom, the United States of America, and Australia. In this appendix, we give an outline of the laws in a number of other countries. Information is taken mainly from the 1971 World Health Organisation publication *Abortion Laws.* We are grateful to embassies and other representatives of governments for providing additional background material and for bringing much of the information up to date. Where we have been advised of recent changes to the law or where the law reflects some particular legislative policy or change in policy, we set out the terms in rather more detail.

EUROPE

Austria

The law governing abortion in Austria was changed with the introduction of the new Penal Code in 1974. Previously abortion had been permitted only to save the mother's life. The main provisions now are:

"Termination of Pregnancy

S.96 (1) Whoever terminates the pregnancy of a pregnant woman with her consent shall be liable to a term of imprisonment of one year and not exceeding three years if the act is committed in a professional capacity.

(2) If the person carrying out the termination is not a physician, he shall be liable to a term of imprisonment not exceeding three years if the act is committed in a professional capacity, or, if the act results in the death of the pregnant woman, to a term of imprisonment of not less than six months and not exceeding five years.

(3) A woman who herself undertakes the termination of her pregnancy or permits it to be terminated by another person shall be liable to a term of imprisonment not exceeding one year.

Non-Punishment of Termination of Pregnancy

S.97 (1) Notwithstanding S.96, the act (of termination) is not punishable:

(a) If the termination of pregnancy is undertaken by a physician, after preceding medical advice, within the first three months after the beginning of the pregnancy; or

(b) If the termination of pregnancy is essential to avert a serious danger, not otherwise able to be averted, to the life of the pregnant woman, or is essential to avert serious damage to the physical and mental health of the pregnant woman, or there exists a serious danger that the child will be severely handicapped mentally or physically, or the pregnant woman at the time of conception was a minor, and in all these instances the termination is undertaken by a physician; or

(c) If the termination of pregnancy is undertaken in order to save the pregnant woman from an immediate danger, not otherwise able to be averted, to her life, in circumstances where the assistance of a physician is not obtainable in time."

Belgium

In Belgium, abortion is prohibited except where the woman's life is at risk. A Commission has recently reported to the Government, and its findings will be the basis for a bill to amend the present laws which are no longer strictly applied.

Czechoslovakia

Abortion is legal if there are medical grounds (including the risk of a defective fetus, the extreme youth of the mother, or where pregnancy is the result of incest); where the woman is over 40 or has three or more living children; where pregnancy is the result of rape or other criminal act; where the woman's situation is difficult (including loss of the husband, serious state of health of the husband, difficult housing or financial situation affecting the standards of life for the family, especially of children under age and proven disruption of the family). The operation must be performed by a gynaecologist in a hospital. Certain medical conditions, (including pregnancy later than 12 weeks and genital infections), are contra-indications to abortion.

Denmark

In 1973 the Folketing (parliament) passed legislation making abortion freely available in Denmark. Under the revised Act any woman resident in Denmark is entitled to an abortion on request during the first 12 weeks of pregnancy.

Even after 12 weeks a woman is entitled to an abortion if there is a danger to her life and health or if pregnancy is the result of rape or incest. Other grounds for abortion after 12 weeks include a risk that the child will suffer serious physical or mental defects; that on account of illness, mental incapacity, tender age or immaturity the woman will be unable to give the child proper care; that the pregnancy, birth or care of the child may prove such a burden on the woman that consideration for her, the home, or her other children makes this necessary. In deciding abortion cases, attention must be paid to the applicant's age, work load and personal circumstances, and to the family's housing, economic, and health conditions.

Abortions may be performed only by a qualified physician and only at a hospital. Doctors and nursing staff are entitled to refuse to participate in the operation. The woman is then referred to another hospital where the operation takes place.

France

The law in France which permitted abortion only to save the mother's life was changed in November 1974 for a trial period of five years. The main provisions of the new laws are:

1. The law guarantees respect for every human being from the beginning of life. There can be no infringement of this principle except in cases of necessity and according to the conditions defined by the law.
2. When a pregnant woman, placed by her condition in a situation of distress, believes she must request the termination of her pregnancy, and when a doctor agrees to carry out this request, that termination can be performed only before the end of the tenth week of that pregnancy.

In no case should the voluntary termination of pregnancy constitute a means of birth control.

3. The voluntary termination of pregnancy may be performed only by a doctor. It can take place only in a public hospital or an approved private hospital.
4. Voluntary termination of pregnancy can at any time be performed if two doctors testify, after examination and discussion, that the continuation of the pregnancy places the health of the woman in grave danger, or that there is a strong probability that the unborn child has a particularly grave ailment recognised as incurable at the time of the diagnosis.
5. In any year no establishment may exceed a percentage of 25 percent of pregnancy terminations over the total of operations. Any excess will lead to the establishment being closed for one year. On a second offence the closure will be permanent.

East Germany

Instructions issued on 15 March 1965 laid down the specific indications for legal abortion. Permission for abortion is to be granted when:

1. A diagnosis based on medical examination and a prognosis which takes into account the living conditions of the woman lead to the expectation of a danger to her life or a serious threat to her physical and mental health as the result of carrying the pregnancy to term or through the burdens of child care.
2. The pregnant woman is in her 40th year or older.
3. The pregnant woman is less than 16 years of age.
4. The pregnant woman has already had four children with an average interval of less than 15 months between each delivery and her current pregnancy began less than six months after the last delivery.

5. The pregnant woman, either alone or together with her husband, has legal responsibility for five or more children living in the household.

6. The woman became pregnant as a result of rape.

7. It is highly probable that the child will be affected by a mental disease or by a serious abnormality.

These indications do not however apply if the pregnancy is of more than 12 weeks' duration, if the pregnant woman is suffering from a disease likely to be aggravated by the operation, and in cases of alleged rape, where, after investigation, no proceedings have been initiated by the competent authorities.

West Germany

The Fifteenth Amendment of the Penal Code came into force on 21 June 1976. It contains the changes and supplements to the Fifth Law for the Reform of Penal Law of 18 June 1974 called for by the verdict of the Federal Constitutional Court dated 25 February 1975. The new version of the penal regulations on abortion reads as follows:

"Abortion is permitted in the cases listed below:

(a) Abortion for medical reasons may be performed at any stage of pregnancy if a physician feels that it is necessary—taking into consideration the present and future conditions of life of the pregnant woman—to save her life or to avoid serious damage to her physical or mental health and if the danger cannot be eliminated in any other way which the pregnant woman can be expected to accept.

The above conditions are considered to be met also in the following cases:

(b) Until the end of the 22nd week after conception in cases coming under the eugenic indication, i.e., if there is a valid reason to assume that the child would suffer from a hereditary disease or an incurable complaint due to detrimental influences during pregnancy. In cases of that kind a pregnant woman cannot be expected to continue her pregnancy, and give birth to the child.

(c) Until the end of the 12th week after conception in cases coming under the ethical indication. These are cases in which pregnancy came about through rape, duress, or sexual abuse of children or persons unable to defend themselves.

(d) Also until the end of the 12th week after conception in cases of distress (social indication). This applies to cases in which an abortion is necessary to save the pregnant woman from a grave emergency. The situation must be so serious that the pregnant woman can under no circumstances be expected to continue the pregnancy, and abortion is only permitted if the emergency cannot be overcome in another way which the pregnant woman could be expected to accept.

If none of the above indications is given, abortion is an illegal act and all persons participating in the performance of an abortion are liable to punishment. The pregnant woman herself, however, remains always exempt from penalty for her participation if the abortion was performed by a physician within the first 22 weeks from conception and the pregnant woman has sought advice prior to the abortion. Moreover, the Court can let the pregnant woman go unpunished if she was in a state of distress when the abortion was performed.

Actions, the effect of which takes place before nidation, do not fall under the penal regulations on abortion. Penal law is not applicable to measures which take effect before nidation is completed, for instance the use of spirals.

An authorised abortion may only be performed in a hospital or another recognised institution. Nobody can be forced to assist with an abortion unless a pregnant woman is in fatal condition or there is a serious threat to her health."

Hungary

Abortion is covered by an ordinance passed on 24 June 1956. Application is made to a board. The ordinance prescribes that the board should authorise the interruption of pregnancy:

(a) If it is necessary to save the life of the pregnant woman in the event of a grave illness, in order to prevent the state of a patient giving rise to complications, and if there is a likelihood that the child would be affected by very serious lesions;

(b) If the personal or family circumstances of the applicant justify the termination of the pregnancy or if the applicant maintains her application in spite of attempts by the board to dissuade her.

Authorisation for an abortion on the grounds covered by (b) may be granted only during the first three months of pregnancy. Abortions may be performed only on an in-patient basis. Hospital establishments are required to furnish periodic reports of the abortions which have been performed in the establishments, while the boards must submit an annual report on their activity to the competent health authority.

Since January 1974, following a decision of the Council of Ministers on the Tasks of Population Policy, the Government has withdrawn unrestricted abortion on request for married women with fewer than two living children or those with two living children who have not previously had an abortion.

Italy

Under legislation introduced by Mussolini "to protect the race", abortions are illegal except to save the life of the mother or where pregnancy is the result of a criminal offence. A Constitutional Court ruling two years ago allowed abortion on the grounds of physical or mental health.

A bill for liberalisation of the abortion laws has been passed by the Chamber of Deputies but has not yet been approved by the Senate. The clauses are being keenly debated by the various political parties.

The bill allows the voluntary termination of pregnancies to women above the age of 16 for health, economic, social, or family reasons within the first 90 days of pregnancy.

Netherlands

Officially abortion is permitted only to save the mother's life. Since 1967 the estimated annual number of abortions has increased considerably. Several bills have been introduced to Parliament with a view to liberalising the law but up to the present, no change of legislation has occurred.

Norway

A new act "governing termination of pregnancy under certain circumstances" became operative in February 1964. The act introduced several situations in which termination is legal:

> "1. When such act is necessary to avert grave danger to the life or health of the woman. In determining the extent of the danger account shall be taken of whether the woman concerned is particularly disposed to somatic or mental disease, and likewise of living conditions or other circumstances which may make her ill or lead to a breakdown of her physical or mental health.
>
> 2. When there is grave danger that:
> (a) hereditary defects in either of the parents or
> (b) disease in the woman while she is pregnant, or
> (c) damage to the fetus in the womb may result in the child suffering from a serious disease or a major physical or mental defect.
>
> 3. When there is a reason to believe that the woman is pregnant because she has suffered gross violation under circumstances as defined in the Criminal Justice Act, and similarly when the woman is mentally deranged or notably mentally deficient."

The articles of the Criminal Code to which reference is made relate to rape, sexual intercourse with someone below the age of 16 or with inmates in certain institutions for the mentally diseased or mentally deficient, incest, and also if someone has taken advantage of his special position (as physician, minister, teacher, superior etc.), to violate the sexual integrity of the woman.

Unless special grounds exist, a pregnancy cannot be legally terminated after the third month. All operations must be undertaken in hospitals or clinics approved by the central health administration.

Romania

The following extract from the publication, *Law and Population Growth in Romania*, prepared under the auspices of the Legislative Council and the National Commission for Demography of Romania as part of the project settled between the United Nations Fund for Population Activities and the National Commission, gives a full background to Romanian legislation.

"The Romanian law establishes, as a general rule, the interdiction to interrupt pregnancy. The interdiction relies upon the consistently pursued line of protecting natality, since the liberty to interrupt pregnancy may seriously prejudice the natural growth of population. But, apart from this, and above all other considerations, this prohibition is called upon to protect in equal measure both the life of the woman and the intra-uterine life of the child to be.

The considerations which call for the prohibition of abortion are not only the result of a logical deduction or of ethical imperatives. They are fully supported by the negative experiment made in our country during the application of the former legal system which allowed the interruption of the course of pregnancy at the request of the expectant mother alone.

Liberty of abortion has had serious consequences on the health of the women who have interrupted their pregnancy; there was a particularly important growth of cases of sterility, of extra-uterine pregnancies, infections etc. Whilst 426,000 children were born in 1956, during the following years their number decreased gradually to reach 301,000 in 1963.

Cases when Abortion may be Authorised:

The law in force at present in our country establishes some derogations from the general rule which prohibits abortion when higher considerations justify the waiving of the child's right to live. Although such cases are admitted 'only exceptionally' they are more numerous than those provided by similar laws under other legislative systems because they rely not only on reasons of a medical nature—saving the mother's life—but equally on eugenic, social and ethical reasons.

In the first place, the interruption of pregnancy is allowed, according to the law, in cases when a choice must be made between the life of the mother and that of the child, when 'pregnancy puts the life of the woman in a perilous condition, which cannot be averted by other means'. Furthermore abortion is lawful when it is justified by eugenic considerations, when 'one of the parents is afflicted with a serious malady, which is transmissible by heredity or which induces serious congenital malformations'; a principal example of serious illness is mental deficiency, which also constitutes an obstacle to marriage.

It is under the same category of exceptions determined by eugenic reasons that falls the lawful interruption of pregnancy when 'the woman is over 40 years old' for the age of the mother may imperil the physical or the mental conditions of the child; likewise, if pregnancy is the result of an incest.

Another category of lawful abortion is justified by social considerations, namely when 'the woman is afflicted by serious physical or sensorial infirmities' or when 'she has already given birth to four children whom she is alone to support'. Finally, the last exception is founded upon purely ethical considerations, to wit 'pregnancy resulting from rape'.

Abortion is allowed in the abovesaid cases only during the first three months of pregnancy. In absolutely exceptional cases it may be effectuated within a term of six months at most, but only if the mother's life is menaced."

Sweden

In 1974, the Swedish Parliament approved new legislation on abortion. At the same time, it was decided that greater resources would be devoted to preventive measures.

The former Abortion Act dated from 1938. It was amended in 1946 and, on a lesser scale, in 1963. Abortions were permitted on medical, socio-medical, humanitarian and eugenic indications, or injury to fetus. Abortion prior to the 20th week of pregnancy required approval by the National Board of Health and Welfare or joint approval by two medical practitioners. After the 20th week, an abortion could be performed only with the permission of the Board of Health and Welfare. The 24th week constituted an absolute limit, which could be exceeded only in cases where the woman's life or health was at risk.

The new Abortion Act became operative on 1 January 1975. At the same time, increased efforts in the areas of medical services, counselling, and information about birth control were initiated.

The main principle contained in the new Abortion Act is that the woman herself decides if an abortion is to be carried out. The Act specifies that:

1. Abortion is free on demand up to the end of the 18th week of pregnancy.
2. Before the 12th week, the woman need consult only a doctor, but after the 12th week she is required to discuss the matter with a counsellor as well. The doctor decides whether there are any medical obstacles to an abortion. The woman may be refused an abortion only if the operation will mean a risk to her life or health.
3. After the end of the 18th week of pregnancy, the approval of the Board of Health and Welfare is necessary to obtain an abortion and there must be special reasons to take this step. Such approval may not be granted if the fetus is apparently viable.

Only a qualified medical practitioner may perform an abortion, and the operation must take place at a hospital or other medical institution approved by the Board of Health and Welfare.

Switzerland

Abortion is legal where there is a serious risk to the life, or of permanent danger to the health of the mother which cannot otherwise be averted. A specialist in the condition presenting the risk must give authorisation, and the pregnancy must be terminated by a second physician. In the canton of Geneva the authorising physicians form a college designated by the Council of State. There is a special commission to deal with aliens. Interpretation of the law varies in different cantons.

A new abortion law is at present being discussed by both Chambers of the National Assembly and their Commissions, but there is no indication yet of what the outcome may be.

Turkey

Under the terms of section 22 of the Turkish Law of 13 January 1960 on medical ethics, abortion was permitted only if it constituted the sole means of saving the life of the mother; the operation could be performed only on the basis of a detailed report by two specialists in gynaecology or, failing this, two general practitioners. This policy underwent a substantial change with the enactment of the law of 1 April 1965 on family planning and the regulations of 12 June 1967 concerning the interruption of pregnancy and sterilisation. As the law now stands, an abortion may be authorised where the life of the mother is endangered or is liable to be endangered by the pregnancy, or if it is impossible for the embryo or fetus to develop normally, or there is a risk of a serious congenital defect affecting the child or succeeding generations.

The Union of Soviet Socialist Republics

The 1955 Decree prescribes that abortions may be performed only in hospitals and other medical institutions, in accordance with instructions issued by the Ministry of Health of the U.S.S.R. The carrying out of abortions, either by physicians or persons without special qualifications, outside such hospitals and medical institutions remains a criminal offence. Instructions issued on 28 December 1955 for the implementation of the Decree prescribe that all pregnant women who apply for an abortion are entitled to have their pregnancy terminated, although not if any medical contra-indications are present. Contra-indications listed are: acute or chronic gonorrhoea, acute or chronic inflammatory conditions of the sexual organs, purulent foci, irrespective of localisation, acute infectious diseases, and a previous abortion within the preceding six months.

Yugoslavia

Under the terms of the Decree of 11 January 1952, abortions were authorised in Yugoslavia on medical, eugenic, ethical, (i.e., where pregnancy resulted from a criminal act) and, exceptionally, medico-social grounds. These indications were extended, most recently, by a decree dated 26 April 1969. According to the provisions of this decree, a pregnancy may be terminated with the agreement or on the application of the woman when:

1. It is medically established that there is no other way to save the life or avert a serious danger to the health of the woman during pregnancy or parturition, or after the latter (in such cases, an abortion may be performed at any stage of the pregnancy);
2. It may be expected, on the basis of scientific knowledge, that the child will be born with serious physical or mental defects as a result of disease in the parents (in this case, an abortion may be performed after the first trimester of pregnancy only if the operation will not cause serious harm to the health, or direct danger to the life, of the pregnant woman);
3. Conception is the result of a criminal act (rape, incest etc.) (The same proviso as indicated under item 2 applies in such cases).

In addition, a pregnancy may be terminated at the request of the pregnant woman if it would be likely to cause her serious personal, family, financial, or other difficulties, either during pregnancy or after parturition; in such cases, the abortion must be performed during the first three months of pregnancy.

The 1969 Decree also prescribes that the woman must be informed of the possible consequences of abortion and of the available methods of contraception.

Abortions must be performed in health establishments where the conditions are such as to ensure that the operation can be successfully carried out.

Other European Countries

Abortion is prohibited by law in Ireland, Spain and Portugal.

THE MIDDLE EAST AND ASIA

Israel

Officially abortion is illegal. The law dating from 1936 when Palestine was a British Mandate allowed abortion only to preserve the woman's life. After 1938, following the Bourne decision, it was allowed if the continuation of the pregnancy would make the woman a "physical or mental wreck". After 1952, as the result of a court ruling, it was permitted on medical grounds if performed "in good faith" by a physician and under proper medical conditions. Reports indicate that modern methods of birth control and family planning are not widely practised and that abortion, though technically illegal, is readily available.

China

In the People's Republic of China, abortion is available on request for medical, social, ethical, and eugenic reasons. There have been vigorous and successful campaigns for population control since 1956, stressing late marriage and the desirability of restricting births to two at well-spaced intervals. Much emphasis is placed on careful family planning, through contraception, and pre-marital sex is discouraged.

India

Abortion is governed by the medical Termination of Pregnancy Act 1971, the relevant clauses of which are:

"A pregnancy may be terminated by a registered medical practitioner:

10 (a) Where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is of the opinion, formed in good faith, that (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped; or

10 (b) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical

practitioners are of the opinion, formed in good faith, that (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or (ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

"No pregnancy of a woman who has not attained the age of eighteen years, or, who having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

"Save as otherwise provided, no pregnancy shall be terminated except with the consent of the pregnant woman.

"No termination of pregnancy shall be made in accordance with this Act at any place other than:

(a) A hospital established or maintained by Government, or

(b) A place for the time being approved for the purpose of this Act by Government."

Japan

In Japan, the provisions concerning abortion are contained in section 14 of the Eugenic Protection Law of July 1948 as amended in April 1960:

1. The physician designated by the Medical Association, which is a body corporate established in the prefectural district (hereinafter called the "designated physician"), may carry out the operation for interruption of pregnancy, at his discretion, in the case of persons subject to the provisions of any of the following items, with the consent of the person in question and the spouse:

(a) A person or his spouse, who suffers from psychosis, mental deficiency, psychopathy, hereditary somatic disease or hereditary malformation;

(b) A relative in blood within the 4th degree of consanguinity of a person or his spouse who suffers from hereditary psychosis, hereditary mental deficiency, hereditary psychopathy, hereditary somatic disease or hereditary malformation;

(c) A person or his spouse who is suffering from leprosy;

(d) A mother whose health may be affected seriously by the continuation of pregnancy or by delivery, from the physical or economic viewpoint;

(e) A person who has conceived as the result of an act of violence or a threat or while unable to resist or refuse.

2. With reference to the consent mentioned in the preceding subsection, the sole consent of the person in question shall suffice if the spouse cannot be located, or fails to declare his intentions, or dies after conception has occurred.

Singapore

A new Abortion Act came into force on 27 December 1974.

The Act allows for the termination of a pregnancy by a registered practitioner acting on the request of the pregnant woman and with her written consent.

The abortion may be carried out so long as the pregnancy does not exceed 24 weeks unless it is to save the life or prevent grave injury to the physical or mental health of the pregnant woman. Where the abortion is carried out on a woman whose pregnancy is of more than 16 but less than 24 weeks' duration, it must be carried out by a registered medical practitioner in possession of such surgical or obstetric qualifications as may be prescribed. The abortions must be carried out in a Government hospital or an approved institution.

South Korea

Abortion is illegal except to prevent the transmission of genetic disorders (including mental disorders) or where the health of the mother may suffer where pregnancy is the result of rape or incest.

Indonesia

In Indonesia, under the current criminal law, abortion is regarded as a criminal act and is therefore prohibited. The Department of Health in Indonesia anticipates that a new Act will be introduced in 1977 to permit abortion on "medical grounds". For this purpose an Inter-departmental Commission of Inquiries has been set up.

Other Countries of the Middle East and Asia

According to information available, in most of the countries of the Middle East and Asia, and in particular in those formerly under colonial rule, abortion laws are restrictive. In Saudi Arabia, Lebanon, Jordan, Burma, Thailand, Hong Kong and the Phillipines, it is absolutely prohibited. Afghanistan, Pakistan, Iran, Iraq, and Syria permit abortion to save the woman's life. Taiwan and Malaysia permit abortion on "medical grounds".

AFRICA

In Africa, most of the newly independent countries have retained the legislation introduced by the colonial country, and abortion is permitted by law only to preserve the life of the woman. In the following countries, however, abortion is legal to safeguard the life and health of the woman or on medical grounds for which no details are specified: Botswana, Gambia, Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Seychelles, Sierra Leone, Swaziland, Uganda, South Africa.

In Morocco, abortion is not punishable when it constitutes a necessary measure to safeguard the health of the mother and is openly performed by a physician or surgeon with the permission of the spouse. If the practitioner considers that the life of the mother is in danger, this permission is not required.

In Tunisia, the law was amended in 1965 to permit the artificial interruption of pregnancy when the operation is performed during the first three months and the parents have at least five living children. The

operation is also legal if the health of the mother is endangered by the continuation of the pregnancy. Operations must be performed in a hospital or authorised clinic by a licensed physician.

AMERICA

Canada

Under sections 251 and 252 of the Criminal Code 1953-1954, abortions are legal where a majority of a hospital's therapeutic abortion committee certifies that the pregnancy would, or would be likely to, endanger the woman's life or health. The operation must be carried out by a qualified medical practitioner in an approved hospital. In September 1975 the government established a committee to make a scientific study of the way in which the existing abortion law is actually operating, to investigate the problems relating to the operation of therapeutic abortion committees and to report to the Minister as to the extent to which the procedure for obtaining therapeutic abortions is operating equitably across the country. When the report is tabled, it will form the basis for further consideration of the law.

Mexico

The Federal Penal Code of Mexico states:

"*Art. 330.* One to three years in prison will be imposed on any individual causing a woman to have an abortion, whatever the means be, provided she consents in doing so. When there is no consent on her part, the term of prison will be from three to six years, and if there exists physical or moral violence, the penalty imposed shall be six to eight years in prison.

Art. 331. If the abortion is caused by a physician, surgeon, obstetrician or midwife, besides the corresponding sanctions in accordance with the previous article, he shall be suspended in the exercise of his profession from a term of two to five years.

Art. 332. Six months to a year in prison shall be imposed on the mother who voluntarily causes herself or consents that some other causes her to have an abortion, if these three circumstances concur:

(a) That she has not a bad reputation.

(b) That she has managed to hide her pregnancy.

(c) That this pregnancy is consequence of an illegitimate union.

If any of the above mentioned circumstances does not concur, one to five years in prison shall be imposed on her.

Art. 333. Abortion, when the pregnancy results from a rape, is not punishable.

Art. 334. No penalty is imposed where the physician attending the pregnant woman performs an abortion after forming the opinion that continuation of the pregnancy is liable to endanger the woman's life. Except in emergencies the opinion of another physician must be sought."

Argentina

The penal code is strict. Abortion is permissible only to save the life or health of a woman from danger which cannot be avoided by any other means or when the pregnancy results from rape for which penal action has been initiated.

"84. The person who through imprudence, negligence, inexpertness in his art or profession or inobservance of the regulations or duties of his office should cause death to another person shall be punished with imprisonment from six months to three years and special disqualification from five to ten years.

85. He that causes an abortion will be punished:

(a) With confinement or prison from three to ten years, if he operates without the woman's consent. This punishment may be increased up to fifteen years if the act be followed by the death of the woman.

(b) With confinement or prison from one to four years, if he operates with the woman's consent. The maximum punishment will be six years if the act be followed by the death of the woman.

86. Abortion practised by a qualified doctor with the consent of the pregnant woman is not punishable:

(a) If it has been done with the purpose of avoiding grave danger to the life or health of the mother and if this danger cannot be avoided by other means.

(b) If the pregnancy is the result of a rape for which penal action has been initiated. When the victim of the rape be a minor or a woman who is demented or an idiot, the consent of her legal representative will be required."

Brazil

Abortion is legal only where three physicians agree that it is necessary to save the life of the woman or where the pregnancy is the result of rape. Brazil's policy on abortion is based largely on demographic grounds.

Peru

The Sanitary Code of 1969 permits therapeutic abortion only where there exists incontrovertible proof of injury to health liable to cause the death of the product of conception or of the mother, and two physicians have pronounced themselves in favour of the operation. The Code specifically prohibits abortion based on ethical, social or economic considerations, and also as a method of birth control.

Appendix 7

H.—31B.

SESSION II

1921

NEW ZEALAND

MATERNAL MORTALITY IN NEW ZEALAND

REPORT OF SPECIAL COMMITTEE SET UP BY BOARD OF HEALTH TO CONSIDER AND REPORT ON THE QUESTION OF THE DEATHS OF MOTHERS IN CONNECTION WITH CHILDBIRTH

Laid on the Table of the House of Representatives by Leave.

REPORT OF SPECIAL COMMITTEE SET UP BY BOARD OF HEALTH AS ADOPTED BY THE BOARD AT ITS MEETING HELD ON 7TH OCTOBER, 1921.

THE committee appointed to consider and report on the question of the deaths of mothers in connection with childbirth have made careful inquiry and investigation, and have now the honour to submit the following report:

The issue was raised in May last by the publication of certain statistics by the Children's Bureau of the United States Department of Labour. These figures place New Zealand second from the top of the list of nations in respect of maternal mortality in pregnancy and childbirth. The Minister of Health thereupon addressed three questions to the Director-General of Health: (1) Were the figures for New Zealand correct? (2) If correct, what were the causes of this excessive maternal mortality in New Zealand? (3) How were these causes to be removed?

The Director-General of Health advised that as the matter was of grave importance the whole question should be referred to the Board of Health for its consideration. Accordingly, the Board of Health sat on the 27th July, 1921, and set up the present committee for the purpose of

investigating the issues raised by the Minister in his memorandum to the Director-General of Health, and generally the committee was empowered to make such recommendations in the premises as it might consider reasonable and necessary.

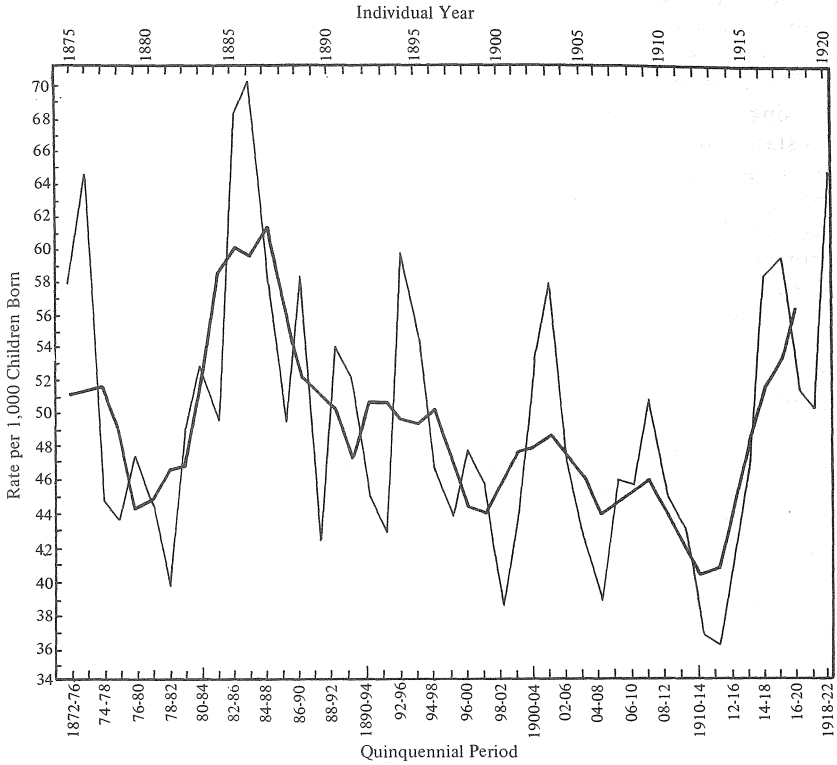
As to the issue of whether the figures given in the American statistics of maternal mortality in different countries constitute a fair and just comparison, we regret that we are unable to obtain any definite proof one way or the other. Mr Malcolm Fraser, the Government Statistician for New Zealand, commits himself to the statement that the figures so given are fairly comparable. Mr Fraser, however, makes this proviso, that he has no means of ascertaining the completeness of the methods of other countries for carrying out Bertillon's international system of compiling maternal-mortality statistics. It is very possible that the countries may differ in the method of mortality returns. For example, in the event of a woman dying in the course of pregnancy of say, phthisis, one country might return such a death as due to phthisis, while another might attribute it to pregnancy. While Mr Fraser, therefore, has no doubt as to the accuracy of our own mortality statistics, he is not in a position similarly to pledge himself with regard to the figures returned by other countries. There is, however, considerable doubt as to whether our own mortality is rightly classified. We consider that more definite instructions and information should be given to medical practitioners throughout the country, so that each death may be put under its appropriate heading, which does not appear to be always the case at present.

Dealing with the history of the matter, the committee has felt that it was its duty to go back over a considerable period of years, and we have had a graph of New Zealand maternal mortality prepared by the Statistician covering the period from 1872 to 1920. This graph is interesting. It goes to show that there are, with regard to maternal mortality in New Zealand, four varying phases or periods in our own history. The first phase or period runs from the year 1877 to 1881, when mortality was comparatively low in this country, reaching a minimum of 3.93 per 1,000 in 1880. The second cycle or period runs from 1882 to 1890, when there was a somewhat extraordinary increase in mortality, reaching a maximum of 7.31 in 1885. The third period may be assigned to the years 1890 to 1913, during which time, of some twenty years or more, there was on the whole a progressive decline from 5.42 in 1890 to 3.58 per 1,000 in 1913. The last and current period, beginning, say, from 1913 to 1920, shows another abnormal increase rising to the high figure 6.48 in the latter year. It has to be noted that, probably owing to greater statistical accuracy and more careful inquiry since about 1916, more cases have been included under puerperal mortality than before 1916. It has been suggested that an investigation of the mortality figures of other diseases, such as scarlet fever, rheumatic fever, phthisis, pneumonia, and diphtheria, would probably disclose similar fluctuations, and the committee has requested the Department to gather data and prepare graphs for comparison.

With reference to the published figures, it is fair to note that the mortality of the year 1917 was the highest since 1894. The one plain deduction from our investigation of these figures is that there has been a

remarkable increase since 1914 in the New Zealand maternal death-rate. Our own figures establish this fact, notwithstanding any doubt as to their exact comparability with the statistics of other countries. We enclose a copy of the graph for the information of the Board.

Graph Showing Death-rates of Women from Puerperal Causes (per 1,000 Children Born) for Individual Years, and Moving Average for Quinquennial Period 1872–1920



(Individual years shown by light line; quinquennial moving average by heavy line.)

We have endeavoured to investigate, so far as we were able, the causes of such high mortality. The principal causes of death are as follows: (1) Puerperal septicaemia; (2) puerperal albuminuria and convulsions: (3) puerperal haemorrhage; (4) accidents of pregnancy and other accidents of labour.

During the last quinquennial period the average annual maternal mortality has been 157 deaths, and of this number fifty-seven are due to sepsis. The recommendations hereinafter contained, though having a special application to sepsis as a cause of death, are to a great extent of

general application, and, it is hoped, will, if adopted, materially reduce the mortality due to other causes associated with pregnancy.

It should be noted that deaths from sepsis are largely preventable, and for this reason your committee has devoted special attention to this dominant cause. The factors which lead to the occurrence of sepsis in this country must be put down under three main heads.

(1) Abnormal virulence of organisms and diminished resistance of individuals, due possibly to conditions during and subsequent to the war period. Dr. Jellett stated that from his own experience at Home sepsis seemed to be harder to deal with, and in a more virulent form than during the "nineties".

The committee feels that the lack of domestic help and the fact of housing difficulties may well be factors contributing to the diminished resistance which apparently affects women nowadays. There is another disturbing cause to which we must draw attention. Evidence was forthcoming clearly indicating that in this country there is an abnormally high death-rate due to septic conditions following on attempts to procure abortion, which deaths are included in our figures of general maternal mortality.

(2) Unsuitable surroundings are another factor. Private houses are often quite unhealthy places for confinements. Moreover, some private maternity hospitals are not free from conditions which easily lead to septicaemia and allied troubles.

(3) The medical witnesses were agreed that another reason of septic mortality was the unduly large use of instruments and other operative measures at confinements, and they stated with emphasis that the use of anaesthetics and instruments was urged and pressed on medical men by the patients and their friends. Medical witnesses were agreed that some reduction in instrumental delivery was urgently necessary.

Having in mind the above-mentioned matters, we have carefully considered what remedies and reforms may be necessary to eliminate, or, at least, materially reduce, the evils of an excessive maternal death-rate in this country, and we beg to make the following

Recommendations

1. That the Health Department should consider the present form of certificate of cause of death with the view of seeing whether it could be amended so as to elicit from the medical man concerned a definite expression of opinion (a) as to the cause of death where there are associated diseases, and (b) as to associated causes, setting out primary, secondary, &c.

2. That every case of maternal death shall be forthwith personally investigated by the Medical Officer of Health, who shall report to the Director-General of Health.

3. That every case of notified puerperal sepsis shall be forthwith personally investigated by the Medical Officer of Health, who shall report to the Director-General of Health.

4. That all maternity hospitals, public and private, make a quarterly return to the Department of morbidity-rate as well as mortality-rate—a

temperature of 100 degrees occurring on two different days between the second and the tenth days of the puerperium shall be included in morbidity conditions. Dr. Jellett's observations on this point are apposite. He says: "It would be very satisfactory if it was made a standard for a hospital to work on what was known as the morbidity-rate rather than the mortality-rate. By the morbidity-rate it was the practice to group the cases according to temperatures during the puerperal period. In an ordinary properly-run hospital they might have a rate of about 8 percent., and if a hospital had a rate of 6 percent. it would be considered that the hospital was working satisfactorily. If a hospital had a morbidity-rate of 20 percent it would be considered that there was something wrong with the administration of the institution. He might say that the British Medical Association in England had gone into the question, and they had laid down a standard of morbidity by which a temperature occurring in labour was to be regarded as morbid when it reached a height of 100 degrees Fahr. on any two occasions between the second and the tenth day. Such a system was generally recognized as being a proper criterion of a hospital's technique."

5. That, as it is absolutely essential that every mother should be attended during confinement by a reliable and highly trained midwifery nurse, the committee recommends that facilities should be given to all practising maternity nurses to take a refresher or post-graduate course at the various St. Helens Hospitals, or other approved institutions, at regular intervals of, say, two or three years, and that compliance be made compulsory. The Government should subsidize cost of transport and accommodation in the case of nurses taking such course.

6. That the Hospitals and Charitable Institutions Act be amended to prevent the admission of one or more cases of confinement into any house for treatment in consideration of payment made unless such house be licensed for the purpose.

7. That the committee is strongly of opinion that a more strict and regular inspection of private maternity hospitals is necessary, and that for this purpose more nurse inspectors of proved competence and experience be obtained. A very careful revision of technique should also take place, and inspection must be directed especially to seeing that recommendations are carried out, and that technique is kept up to date.

8. That the committee considers that efficiently equipped private midwifery wards for paying patients should be established as soon as possible in connection with public midwifery institutions or in other suitable places.

9. That while the committee has reason to believe that the system of training midwives pursued in New Zealand is not inferior to that obtaining in other countries, still the committee is impressed with the necessity of improving the present training, especially with regard to the supreme importance of a thorough knowledge of asepsis. The committee therefore recommends that the syllabus and course of training be revised so as to secure a greater efficiency than at present obtained.

10. That the importance of a sound training in midwifery at the Otago Medical School should be recognized by the creation of a professorship

instead of the present lectureship, thus enhancing the status of this subject in the medical curriculum.

11. The committee finds on evidence before it that the use of instruments in midwifery practice is excessive, and suggests that the special attention of the medical profession be called to this fact, and that the co-operation and assistance of the profession should be sought in this connection. The committee learns with satisfaction that the medical profession through its organisation is alive to its responsibilities in this matter, and has already taken steps to investigate the question, and very shortly is holding a Dominion conference at which methods of technique are to be considered with the view of reducing to the lowest possible limit maternal mortality in this country.

The evidence shows that undue pressure is frequently brought by patients and friends to expedite the course of labour by the use of instruments. In this connection the committee believes that it should be widely known and clearly understood by the public that the great majority of cases of confinement do not require instrumental assistance.

12. The committee desires to stress the importance of the use of ante-natal clinics, and in private practice the serious importance of ante-natal examination. It cannot be too widely known that already ante-natal clinics have been established in each of the seven St. Helens Hospitals in New Zealand, and also at the maternity hospitals or wards under the control of Hospital Boards. An extension of these establishments, more especially as a function of the ordinary public hospital, is necessary, and the committee is pleased to recognize the fact that local hospital authorities are sympathetic to the cause of the further development of this work. The Health Department urges all pregnant women to seek skilled advice during the latter months of pregnancy at ante-natal clinics wherever available, or at the hands of the ordinary medical adviser. Such examination should enable the medical man to detect many abnormalities, and consequently avert dangerous complications.

Concluding Remarks

Before bringing this report to conclusion we desire to strike a note of reassurance. Childbirth is a normal physiological process, and to the healthy woman in healthy surroundings is attended with very small risk. Furthermore, there must not be undue alarm because of the statistics. It must not be overlooked that under the international "Bertillon" system of classification which is in use in New Zealand, and which has as its basis the maternal mortality-rate per thousand live births, our statistics of maternal mortality include not only deaths resulting at or after childbirth, but also those occurring during the whole course of pregnancy, and considered as essentially due to that condition.

Lastly, the committee strongly believes that if the preventive measures indicated in this report be adopted in this country, the reproach of an excessive maternal mortality under which New Zealand at present labours will early be removed.

C. J. PARR (Chairman).
D. McGAVIN.
J. S. ELLIOTT.

Appendix 8

Alleged Offences of Procuring or Attempting to Procure an Abortion by Instrument and/or Drugs Dealt With by Chemistry Division, DSIR, Auckland, 1924–1975

Year	No. of Offences	Particulars
1924	1	Use of instrument to procure an abortion.
1925	1	Supply of drugs with intent to procure an abortion.
1926	nil	
1927	nil	
1928	nil	
1929	nil	
1930	1	Supply of drugs with intent to procure an abortion.
1931	nil	
1932	nil	
1933	nil	
1934	1	Procuring an abortion by means of drugs and an instrument.
1935	3	Procuring an abortion by means of drugs and an instrument.
		Supply of drugs with intent to procure an abortion.
		Supply of drugs with intent to procure an abortion.
1936	nil	
1937	3	Supply of drugs with intent to procure an abortion.
		Supply of drugs with intent to procure an abortion.
		Use of instrument and drugs to procure an abortion on self. *Death.* (Died due to septicaemia.)
1938	nil	
1939	2	Supply of drugs with intent to procure an abortion.
		Death due to ingestion of drugs with intent to procure an abortion. *Death.*
1940	2	Use of instrument to procure an abortion.
		Use of instrument to procure an abortion causing death. *Death.*
1941	1	Use of drugs and instrument to procure an abortion.
1942	nil	
1943	nil	
1944	nil	
1945	nil	

(Note: Years 1941–45 war years. Police work associated with laboratory mainly sly grogging, illicit stills, and illegal sale of liquor.)

Year	No. of Offences	Particulars
1946	1	Use of instrument to procure an abortion.
1947	3	Death due to self-administration of drugs to procure an abortion. *Death.*
		Use of instrument to procure an abortion.
		Use of drugs and instrument to procure an abortion.
1948	nil	
1949	3	Abortion with instrument causing death. *Death.*
		Ingestion of drugs and alcohol to procure an abortion causing death. *Death.*
		Abortion with instrument causing death. *Death.*
1950	2	Attempted abortion with instrument causing death. *Death.*
		Abortion with drugs and instrument.
1951	5	Abortion procured by use of an instrument.
		Abortion procured by instrument and phenol.
		Death caused by injection of antiseptic into uterus. *Death.*
		Abortion procured by instrument and soap.
		Death due to air embolism after injection of soap into uterus. *Death.*
1952	nil	
1953	2	Death due to injection of soap into uterus. *Death.*
		Abortion procured with instrument and soap.
1954	4	Death due to injection of soap into uterus. *Death.*
		Death due to air embolism after injection of soap into uterus. *Death.*
		Use of instrument and soap to procure an abortion.
		Supply of drugs with the intention to procure an abortion.
1955	1	Death due to injection of soap into uterus. *Death.*
1956	nil	
1957	1	Use of instrument and soap to procure an abortion.
1958	1	Use of instrument and dettol to procure an abortion.
1959	nil	
1960	1	Use of instrument and soap to procure an abortion.
1961	1	Supply of drugs with the intention to procure an abortion.
1962	1	Use of instrument and dettol to procure an abortion.
1963	1	Death due to the use of an instrument to procure an abortion. *Death.*
1964	3	Use of instrument and soap to procure an abortion.
		Use of instrument and soap to procure an abortion.
		Use of a piece of pipe and soap to procure an abortion.

Year	No. of Offences	Particulars
1965	2	Use of plastic tube to procure an abortion. Use of instrument and soap to procure an abortion.
1966	4	Supply of drugs with the intention to procure an abortion. Death due to use of instrument to procure an abortion. *Death.* Use of instrument and soap to procure an abortion. Attempted abortion with excess alcohol and hot bath—inhaled vomit and died. *Death.*
1967	3	Use of an instrument to procure an abortion. Use of castor oil in an attempt to procure abortion. Use of an instrument and soap to procure an abortion.
1968	1	Supply of drugs with the intention to procure an abortion.
1969	2	Supply of drugs with the intention to procure an abortion. Supply of drugs with the intention to procure an abortion.
1970	2	Use of an instrument and soap to procure an abortion. Use of an instrument and dettol to procure an abortion.
1971	2	Use of piece of pipe and soap to procure an abortion. Use of an instrument to procure an abortion.
1972	1	Use of an instrument to procure an abortion.
1973	2	Use of an instrument and dettol to procure an abortion. Use of an instrument and dettol to procure an abortion.
1974	nil	
1975	nil	

Note:

(1) Many of these abortion charges were brought against people who made abortion a lucrative business and were charged several times over a period of years.

(2) No cases referred to DSIR, Auckland, since May 1973.

(3) Nearly all cases brought involved either the death or serious danger to health, e.g., septicaemia, of the woman involved, caused by the abortion or attempted abortion.

Appendix 9

NATURAL FAMILY PLANNING CENTRES IN NEW ZEALAND—1977

Alexandra, Central Otago
Ashburton
Auckland, Mater Hospital
Blenheim
Cambridge
Christchurch
Dunedin (3)
Edgecumbe
Fairlie
Gisborne
Gore
Greymouth
Hamilton
Hastings
Havelock North
Hawera
Henderson
Hokitika
Hunterville
Inglewood
Invercargill
Johnsonville
Kaikoura
Kaponga
Kawerau
Lower Hutt
Lumsden
Masterton
Matamata
Matata
Morrinsville
Mosgiel
Napier
Nelson
New Plymouth
Ngaruawahia
Oamaru
Orewa
Palmerston North, Hokowhitu
Palmerston North, Mater Hospital
Palmerston, Otago
Paraparaumu
Plimmerton
Porirua
Pukekohe
Reefton
Rotorua
Stratford
Takapuna
Taumarunui
Tauranga
Te Awamutu
Temuka
Timaru
Waihi
Waipawa and Waipukurau
Wairoa
Wanganui
Wellington Central
Westport
Whakatane
Whangaparaoa
Whangarei
Whataroa
Winton

Appendix 10

THE HOSPITALS AMENDMENT ACT 1975

ANALYSIS

1975, No. 5

An Act to amend the Hospitals Act 1957

[28 May 1975

BE IT ENACTED by the General Assembly of New Zealand in Parliament assembled, and by the authority of the same, as follows:

1. Short Title and commencement—(1) This Act may be cited as the Hospitals Amendment Act 1975, and shall be read together with and deemed part of the Hospitals Act 1957 (hereinafter referred to as the principal Act).

(2) This Act shall come into force on the 1st day of September 1975.

2. Therapeutic abortions to be carried out only in institutions under the control of a Hospital Board or in approved licensed hospital—The principal Act is hereby amended by inserting after section 140, the following section:

"140A (1) Nothing in section 182 (2) of the Crimes Act 1961 (which relates to the causing of the death of a child in good faith for the preservation of the life of the mother) shall apply unless the operation is performed in an institution under the control of a Hospital Board under this Act or in any licensed hospital that may be approved for the purpose by the Director-General of Health upon his being satisfied that it maintains or uses adequate and independent counselling services and also procedures to ensure that all operations authorised are within the law and that the facilities for operation and after-care are satisfactory:

"Provided that nothing in this section shall apply in any case where by reason of the urgency of the case the life of the mother is likely to be prejudiced by the time occupied in conveying her to such an institution or licensed hospital.

"(2) Whenever any therapeutic abortion, or other operation that could lead to or effect an abortion or subsequent unnatural miscarriage, is performed, a record of that operation and the reason for it, but without the patient's name, shall be made and forwarded within 1 month to the Director-General of Health."

This Act is administered in the Department of Health.

Appendix 11

ORGANISATIONS AND INDIVIDUALS WHO MADE SUBMISSIONS AND WITNESSES WHO APPEARED BEFORE THE COMMISSION

Abortion Law Reform Association of New Zealand (Inc.)
Abortion Law Reform Association of New Zealand (Palmerston North Branch)
Adamson, Mr J.
Adamson, Mrs V.
Aitchison, Mr A. and Mrs M.
Allan, Ms M. L.
Allen, Mr G.
Allen, Ms N. J.
Andrew, Ms S.
Andrews, Ms S.
Anglican Public and Social Affairs Committee
Ardley, Mr G. W. R.
Armstrong, Mr D. A.
Armstrong, Rev. G. A. W.
Armstrong, Mrs J.
Armstrong, Mrs M. E.
Associated Pentecostal Churches of New Zealand
Association of Anglican Women
Association of Presbyterian Women, Ashburton Presbyterial
Atkinson, Dr A. and Mrs P.
Auckland Catholic Diocesan Pastoral Council and Auckland Senate of Priests
Auckland Council for Civil Liberties (Inc.)
Auckland Diocesan Federation of Catholic Parent, Teacher, Friend Associations
Auckland Health Social Workers' Group
Auckland Hospital Board
Auckland Medical Aid Trust
Auckland University Students' Association
Auckland Women's Centre
Australia and New Zealand Presbytery of Free Presbyterian Church of Scotland
Australian and New Zealand College of Psychiatrists, New Zealand Branch
Bacon, Mrs K.
Bain, Mr D. W.
Baines, Mr R. T.
Banks, Mr C. G. and Mrs M. E.
Baptist Church, Miramar
Baptist Church Women's Fellowship, Riccarton
Barber, Mrs M.
Barclay, Mrs P.
Barclay, Mr. W. J.
Barker, Mrs M. C.
Barraclough, Mrs N.
Barry-Martin, Mrs N.
Barry-Martin, Mr P.
Bartlett, Miss P. M.
Barton, Mr H.D. *et al.*
Batt, Dr O. D.
Bawden, Mrs M.
Beasley, Dr D. M. G.
Beaven, Professor D. W.
Becroft, Mrs M.
Beer, Mr F. G.
Begg, Dr N. C.
Bellamy, Mrs H.
Bergeivaet, Mr and Mrs M.
Berghouse, Rev. P. J.
Best, Mrs M.
Biddle, Rev. P.
Biddles, Mrs E.

Billings, Dr E. L., Australia
Billings, Dr J. J., Australia
Black, Dr R.
Blackburn, Mr A.
Blackwell, Dr L. F.
Boag, Mr P. W.
Bone, Mrs J.
Bonham, Professor D. G.
Bonisch, Rev. Fr. D. K.
Bonnar, Mr J. *et al.*
Booth, Mr G. A.
Boustred, Mrs E.
Bown, Mrs F. A.
Boyd, Mrs V.
Boyes, Rev. J. R.
Boyes, Mrs M. L.
Bradford, Mrs J.
Brankin, Miss B.
Broadsheet Magazine Collective
Brodie, Miss E.
Broeke, Mr T. and Mrs J.
Brook, Mr B. A. and Mrs B. M.
Brooke, Mrs A. J.
Brookes, Professor R. H.
Brooks, Mrs P. A. *et al.*
Brown, Rev. C.
Brown, Mrs E.
Browne, Mr W. J.
Bruce, Ms H.
Bruce, Mrs J.
Bruce, Mr L. E.
Bruce, Mrs M. E.
Bruce, Mrs Y.
Buchanan, Dr L.
Buckley, Mr J. A.
Buckley, Ms S. S.
Burfitt, Mr J. R.
Burke, Mr J. R.
Burnett, Mrs H.
Burns, Sir Charles
Burns, Ms J.
Burns, Mrs M. *et al.*
Busch, Mrs D. O. *et al.*
Calvert, Mr A.
Calvert, Ms S.
Camp, Mr T. A.
Campbell, Mrs K.
Canterbury-Westland Young Nationals
Candy, Mr G. E.
Capill, Mr D. B.
Carey, Miss S. M.
Carey-Smith, Dr K. and Dr M. J.
Caseley, Dr R. T.
Casey, Mrs S.
Caswell, Miss S.
Catholic Bishops, Conference of
Catholic Education Council of New Zealand
Catholic Home and School Associations, Otago and Southland, Federation of
Catholic Maori Group of Southland
Catholic Nurses' Guild of New Zealand
Catholic Parent/Teacher Home and School Associations, Christchurch Diocesan Federation of
Catholic Parish Pastoral Council, Epsom
Catholic Priests of the Invercargill Area
Catholic Social Services, National Directorate
Catholic Women's League, Manaia
Catholic Women's League of New Zealand
Catholic Women's League, Te Puna
Catholic Women's League, Whakatane
Catley, Mrs C. C.
Cavanagh, Mr W. M.
Chambers, Mr D. J. *et al.*
Chemists' Guild of New Zealand (Inc.)
Child, Mrs S.
Chisholm, Mr T. M.
Chivers, Mrs A. C. *et al.*
Christchurch Families, Group of
Christchurch Social Workers, Group of
Christian Family Movement, Gore

Christian Family Movement, Oamaru
Christian Family Movement of Otago and Southland
Christian Family Movement, Sockburn
Clapham, Mrs J.
Clark, Miss B.
Clark, Rev. C. D.
Clark, Mr I. G.
Clark, Mrs J.
Clark, Mrs M. McG. *et al.*
Cleary, Ms D.
Clegg, Mrs M.
Clements, Mr P.
Clinton, Mr M. S. *et al.*
Clissold, Mrs J. M.
Cobeldick, Mr T. M.
Cochrane, Dr K. W.
Cole, Mr G. A.
Cole, Mr P.
Collins, Mr A. E.
Collins, Dr C. M.
Collins, Mrs D. M.
Commandear, Mrs P.
Committee for Human Life and Dignity, The
Committee for Life for the Handicapped and Members of Club 64
Comrie, Dr E. Y.
Concerned Citizens, Group of
Concerned Lawyers, Group of
Concerned Parents Association
Concerned Parents, Group of, Invercargill
Conder, Mrs C. M.
Coney, Ms S.
Connell, Mr S.
Connor, Mrs J.
Conradson, Mr J.
Conroy, Mr J.
Cooney, Dr L. J.
Cooper, Mrs W.
Corcoran, Mrs U
Cornwall, Mrs N. H.
Corston, Mr G. J. and Mrs K. M.
Council for the Single Mother and Her Child
Creagh, Rev. Dr J. D.
Crews, Mrs J. A.
Crothers, Mr C.
Crowley, Dr J. D.
Croxford, Mrs R.
Cull, Miss H.
Cullen, Mrs J.
Culliford, Mr P. J.
Cullinane, Rev. Fr. P. J.
Cumming, Mr P.
Cummins, Dr J. M.
Cuningham, Dr J. A. K.
Cunningham, Miss J.
Curtis, Mr T.
Cuthbert, Mrs A.
Daly, Mr W. G.
Dalziel, Mrs G.
Dann, Miss C. *et al.*
Darroch, Mr M. D. and Mrs A. F.
Davey, Mrs I. J.
Davidson, Mrs J.
Davin, Miss M. N.
de Jong, Mrs D. C.
Delargey, Archbishop (Now Cardinal) R. J.
Dell, Mrs M.
Devine, Mr. W. T.
Dick, Mrs R. G.
Dilworth, Mrs B. F.
Diocesan Pastoral Council, Christchurch
Dixon, Miss A.
Dixon, Ms C.
Dobson, Dr J. R. E.
Dominican Ex-Pupils' Association
Donnelly, Rev. Fr. F.
Donoghue, Mr C. F.
Dougan, Rev. Fr. H. F.
Dove, Dr D. W. C.
Dowd, Mrs C. E. *et al.*
Downer, Mr P. and Mrs D.
Downey, Mr P.
Doyle, Mr T. P.
Dravitzki, Mrs K.
Drayton, Dr K. D.
Duff, Mrs E.
Duffy, Mr T. D. and Mrs C. M.
du Fresne, Mrs K.
Dunckley, Mrs E. J.
Dunedin Collective for Women

Dunedin Diocesan Catholic Education Council
Dunedin Parents' Centre (Inc).
Dunleavy, Rev. Br. R.
Dunn, Dr H. P.
Dunn, Mrs J.
Dunne, Mr J. C. G.
Ecology Action (Otago) (Inc.)
Education, Department of
Ehrhardt, Mr C.
Eighteen Religious Leaders in Auckland
Eketahuna Public Meeting
Ellis, Mr J. H.
Emmaus Scripture Group
Emsley, Mr W.
Entwisle, Mr P.
Epsom Women, Group of
Evangelical Church of Whakatane
Evans, Miss V.
Eyre, Mr T.
Facer, Mr W. A.P.
Falkner, Dr M. E.
Fama, Dr P. G.
Family Rights Association (Inc.)
Family 75
Fardell, Mr G.
Farmer, Dr R. S. J.
Farnworth, Miss A. H.
Farrell, Mr J.
Federated Farmers of New Zealand (Inc.), Women's Division
Feminists for Life (New Zealand)
Feminists for Life (North Shore Branch)
Feminists for Life (Wellington Branch)
Ferguson, Miss L.
Fiddes, Dr T. McK.
Fieldhouse, Mrs A.
Finn, Mrs U.
Firth, Mr J. A.
Fitzgerald, Dr J. P. B.
Foate, Dr A. H.
Fogarty, Mrs A.
Forster, Mrs L. *et al.*
France, Dr J.
France, Miss S.
Francis, Mr D. J.
Fraser, Mr R. D.
Free Presbyterian Church, Kirk Session of the Auckland Congregation
Free Presbyterian Church of Scotland, Gisborne Congregation
Freer, Ms E. V.
Fromm, Ms H.
Frost, Mrs E. E. F.
Fulton, Mr H.
Furby, Mr B. S.
Gardiner, Mrs H.
General Practitioner Society
Geraghty, Sister A. F.
Geraghty, Mr A. M. and Mrs P.
Gibbons, Dr E.
Gibbs, Professor H. S.
Gibbs, Mrs J. B.
Gibbs, Mrs M.
Gibson, Mr G. and Mrs J.
Gibson, Mr T. H.
Gilbert, Miss G. M.
Gillespie, Sister A.
Gilmour, Mr C. and Mrs M.
Glenny, Rev. D.
Goldsborough, Ms R.
Goodger, Ms K.
Goodwin, Mr T.
Gordon, Mr D. D.
Gray, Mr V. R. W.
Green, Ms E.
Green, Professor G. H.
Greenaway, Mrs L.
Gregson, Professor R. A. M.
Grisé, Mr M. J. and Mrs P. M. E.
Gugenheim, Dr P. S, United Kingdom
Guild of St. Luke, Ss. Cosmas and Damian
Gunn, Mrs M.
Guthrie, Dr M. W.
Halfway House Group (Inc.)
Hall, Dr A.
Hall, Mrs B. J.
Hall, Mr J. G.
Hall, Ms S.
Hamilton Feminists
Hansen, Mrs P. J.
Hardy, Mrs P.

Harrington, Rev. Fr. B. T.
Harris, Dr J.
Hartfield, Dr V. J.
Harwood, Mrs R.
Haskell, Mr C. W.
Hassan, Dr N. G.
Hawker, Mrs B. A.
Hay, Dr J. V.
Healey, Mr D.
Healion, Rev. Fr. V. J.
Health, Department of
Heenan, Miss S. M.
Heffernan, Mr P. J.
Henwood, Mrs C.
Herd, Mrs J. J.
Hesketh, Mrs J.
Hewland, Dr R.
Hill, Dr B. H. R.
Hills, Mr M. D.
Hodge, Dr W. C.
Hodgetts, Mrs M.
Hodgins, Mr M. D.
Hogan, Mrs S. G.
Hogue, Mr L. B. and Mrs J. K.
Holm, Ms J. R.
Holmes, Dr A. D.
Holmes, Miss L.
Hood, Mrs L. J.
Horne, Mrs D. R.
Horsman, Mrs D. J.
Hoult, Mr B. and Mrs I.
Howard, Mrs E. V.
Howgate, Mr J.
Hubbard, Professor J. I.
Hubbard, Mr R. W.
Hughes, Mr C. M. and Mrs P. M.
Humanist Society of New Zealand, (Inc.)
Humanist Society of New Zealand (Inc.) (Christchurch Branch)
Hume, Mrs F. A.
Huntingford, Professor P. J., United Kingdom
Hunton, Dr R.
Hyde, Ms M.
Ikin, Mrs S. P.
Invercargill Public Meeting
Ireland, Mr B. M.
Irvine, Mrs M. G.
Jackson, Mr H. W.
James, Professor B.
James, Mrs C. J.
Jenkin, Mr I. W.
Jenkins, Mrs A. *et al.*
Jennett, Mr B. F.
Jessop, Mrs J.
Jewish Ministers of New Zealand, The Board of
Joachim, Sister M.
Johanson, Mrs M. D.
Johnson, Mrs C.
Johnson, Mr T. and Mrs M.
Julius, Mrs M. F.
Karam, Mr G. A. and Mrs M. Y.
Keenan, Mrs P.
Kellett, Mr J. K.
Kelly, Mr G. P.
Kelly, Mr J. R.
Kennedy, Mrs I.
Kennedy, Mrs J.
Kennedy, Miss S.
Kerr, Mrs F. E.
Kerr, Mr R. and Mrs C.
Kingham, Dr R. A.
Kingi, Mrs M. J.
Kitchin, Mrs J.
Knight, Mr J.
Knight, Mrs V.
Knights of the Southern Cross, New Zealand
Knowhow
Knox, Mrs H. D.
Lamont, Mr D. J.
Lamont, Mrs M. L. T.
Lane, Dr W. R.
Langford, Mrs E. M.
Lanigan, Mrs P.
Larson, Mr T.
Latimer House Working Group
Latimer, Mr R. J.
Laver, Ms E. M.
Layzell, Mr D. J.
Leeks, Dr S.
Lejeune, Professor J., France
Lennane, Dr K. J.
Leslie, Ms N.
Lewin, Mr A. J. and Mrs D. A.
Lewis, Ms V.

Life Force (New Zealand) (Inc.)
Liley, Professor Sir William
Linton, Mrs R. W.
Littler, Mr A. N.
Littlewood, Mr B. N.
Lloyd, Mr J. M.
Lockett, Mr J. D., United States of America
Loeffen, Mrs L. A.
Longden, Mrs J.
Longrigg, Ms P. A.
Lowson, Mr C. P.
Lutheran Church of New Zealand, Social Questions Committee
Lynch, Mr K. P. and Mrs A. M.
Lynch, Miss N.
Lynch, Mr P. P. and Mrs J. L.
Lyons, Mrs A. K.
Lyons, Mr D.
Lyttle, Mr H. G.
McArthur, Mr T. D. and Mrs M.
McBeath, Dr W. J.
Macbrayne, Mrs R. M. *et al.*
McBride, Mr G. A. and Mrs S. V.
McCabe, Mr A. E. J.
McCabe, Mr P.
McCallum, Mr A. and Mrs P.
McCallum, Mrs B. G. *et al.*
McCarthy, Mr D. G.
McCay, Rev. S. J. D.
McCluskey, Mrs S.
McCormick, Dr P.
McCormick, Rev. Fr. P.
McCreary, Professor J. R.
McCrostie, Dr H. H.
McDonald, Mr A.
McDonald, Dr P. R.
McDonnell, Mr W. C.
McDowell, Mrs E.
McDowell, Ms I.
McDowell, Mr M. J.
Macfarlane, Mr A.
McGettigan, Dr J. F.
McGill, Dr H.
McGough, Mrs E. *et al.*
McGrath, Mrs P.
MacKay, Dr M. G.
McKenzie, Miss J. C.
McKeown, Mrs T.
Mackey, Most Rev. Bishop J.
McKone, Mrs M.
MacLean, Dr N.
McLeod, Mrs S. P.
McLoughlin, Mr P. and Mrs H.
McMenamin, Mr J.
Macraild, Mrs E. M.
McVey, Ms K.
Maguire, Nurse M. P. *et al.*
Major, Mr M. J.
Major Superiors of Roman Catholic Religious Men and Women, Conference of
Malcolm, Ms M. J.
Malin, Mrs M. A.
Maloney, Rev. Fr. P. T.
Mandel, Rabbi M. R.
Mann, Dr L. R. B.
Mark, Mrs P. K.
Martin, Mr K. D. and Mrs D. M.
Martin, Mr R. S.
Martin, Mr S. F.
Marx, Rev. Fr. P., United States of America
Mason, Dr D. M.
Maud, Mrs P. L.
Medical Association of New Zealand
Medical Women's Association of New Zealand (Auckland Branch)
Medical Women's Association of New Zealand (Canterbury Branch)
Medical Women's Association of New Zealand (Otago Branch)
Medical Women's Association of New Zealand (Wellington Branch)
Medlicott, Dr T.
Megget, Mr R. C.
Mercer, Mrs M. J.
Mercier, Ms E.
Methodist Church of New Zealand, Public Questions Committee
Methodist Church, Wellsford
Methodist Women's Fellowship, Paeroa

Meyer, Mrs E.
Meyrick, Mrs E. N.
Miles, Ms J. M.
Miller, Mr B. J.
Mills, Mrs L. V.
Mills, Mrs V. J.
Milne, Mrs C.
Milne, Ms D.
Minehan, Ms R.
Minnitt, Dr D. F.
Mintz, Miss E.
Molloy, Mr A. P.
Molloy, Mr E. H.
Mooney, Mr T. B.
Moore, Mrs A.
Moore, Mrs J.
Moore, Mrs M.
Moran Social Centre
Morgan, Mr G. and Mrs H.
Morris, Mrs D.
Morton, Professor J. E.
Moulder, Ms J.
Mountain, Mrs A.
Murray, Rev. J. S.
Muscular Dystrophy Association of New Zealand (Inc.)
Musgrove, Dr J. P.
Mutu, Mrs A. M.
Nash, Dr D.
National Association of Family Planning Centres, Tutor Group
National Council of Women of New Zealand
National Marriage Guidance Council of New Zealand
National Organisation for Women (Auckland Branch)
National Organisation for Women (Christchurch Branch)
National Organisation for Women (Hamilton Branch)
National Organisation for Women (Nelson Branch)
National Organisation for Women (Upper Hutt Branch)
National Organisation for Women (Wellington Branch)
National Organisation for Women (Whangarei Branch)
Neuman, Mrs J. M.
New Plymouth Women's Action Group
New Zealand Association of Natural Family Planning Centres
New Zealand Association of Social Workers (Inc.)
New Zealand College of General Practitioners
New Zealand Council for Civil Liberties
New Zealand Demographic Society (Inc.), Council of
New Zealand Educational Institute (Regd.)
New Zealand Family Planning Association (Inc.)
New Zealand Family Planning Association (Inc.) (Dunedin Branch)
New Zealand Federation of Business and Professional Women's Clubs
New Zealand Federation of University Women
New Zealand Homemakers' Union (Upper Hutt Branch)
New Zealand Medical Students' Association
New Zealand Nurses' Association
New Zealand Nurses' Association (Southland Branch)
New Zealand Post Primary Teachers' Association
New Zealand Psychological Society
New Zealand Rationalist Association (Inc.)
New Zealand Social Credit Political League (Inc.)
New Zealand Society for the Intellectually Handicapped
New Zealand Society for the Protection of the Unborn Child
New Zealand Society for the Protection of the Unborn Child (Wairarapa Branch)

New Zealand Values Party, Women's Health Workshop, Auckland
Nolan, Rev. Fr. P.
Nurses' Reform Association of New Zealand
Nye, Mrs P.
Oamaru Parish Pastoral Council
Oatham, Ms D.
O'Brien, Mrs N.
O'Connor, Mr E. Z.
O'Connor, Miss M. P.
O'Connor, Mrs P. M.
Ogilvy, Mrs D. R.
O'Halloran, Mr R. J.
O'Leary, Ms S.
Oliver, Dr J.
Olney, Mrs J.
O'Neill, Mr B. P.
O'Neill, Mr C. J.
O'Neill, Mr J. S. and Mrs E. A.
O'Neill, Miss M.
Oomen, Mr C. P. and Mrs M. F. C.
Open Brethren Assembly, Te Awamutu
O'Regan, Mr J. R.
O'Reilly, Mrs E.
Orr, Mr G. S.
Orr, Mr K. A.
Orthodox Presbyterian Churches of New Zealand
Osborn, Mrs A. C.
O'Sullivan, Rev. Fr. O.
Painter, Mr D. J. *et al.*
Paremata Jaycees (Inc.)
Parish Council of Our Lady of Perpetual Help, Christchurch
Parish of Our Lady of The Assumption, Christchurch
Parker, Mrs M. A.
Patchett, Mr R. M.
Paterson, Mr J.
Patrick, Ms K. W. D.
Patterson, Mr H. A. R.
Pauline, Sister M.
Payne, Mr D. J. F.
Pearce, Mrs A. N.
Pearce, Mr P. I.
Pearce, Mr R. K.
Pearce, Mrs V. F.
Pegler, Mrs D.
Penhale, Ms E. M.
Penrose High School
Percy, Mrs D. *et al.*
Perkins, Mrs P.
Perrett, Miss S.
Perrott, Mr G. I. and Mrs S. G.
Petterson, Mrs J.
Pettigrew, Mr M.
Piggin, Mr D. M.
Pilmore, Mrs R. M. K.
Platts, Dr W. M.
Political Research Bureau
Post, Ms J. P.
Potter, Dr D.
Potts, Dr D. M., United Kingdom
Pregnancy Help, Auckland
Prendergast, Dr M.
Presbyterian Church, Hornby, Minister and Session
Presbyterian Church of New Zealand, Maori Synod
Presbyterian Church of New Zealand, Public Questions Committee
Presbyterian Women's Fellowship, Hornby
Pryor, Mrs M.
Purdue, Mrs C. M.
Pyatt, Rt Rev. Bishop W.A.
Raymond, Ms C.
Raynor, Mr G. D. and Mrs M. J.
Reformed Churches of New Zealand, Synodical Committee
Religious Society of Friends, Public Questions Committee
Renwick, Mr W. L.
Reurich, Rev. L.
Rhodes, Mr M. A.
Richardson, Mrs E. M.
Ridley-Smith, Dr R. M.
Right to Life, Auckland University
Right to Life, Otago University
Ritchie, Dr J.
Ritchie, Professor J. E.
Robati, Mrs N.
Roberts, Mrs B. K.
Roberts, Ms D.

Robertson, Mrs K. V.
Robinson, Dr J. L.
Robinson, Mrs J. W.
Robinson, Mr P. H. and Mrs A. M.
Roborgh, Mrs L.
Rodden, Miss M.
Roman Catholic Deanery of Priests, Wellington
Romlach, Mr P.
Rose, Mrs M. A.
Ross, Mrs S.
Rosser, Ms S. R.
Rotherham, Ms J.
Rotorua Parents Centre (Inc.)
Roughon, Staff Nurse D. *et al.*
Rowse, Mrs C. N.
Rowse, Mr J. R.
Royal College of Obstetricians and Gynaecologists
Rushton, Mrs C. J.
Russell, Mr B. J.
Rutherford, Dr A. M.
Rutter, Mr A. S.
Rutter, Dr F.
Ryan, Mrs M. A.
Ryan, Mrs M. J.
Ryan, Mr R.
Ryburn, Miss H.
Rymer, Very Rev. J. D.
Sacred Heart College, Board of Governors, Christchurch
Sacred Heart College Past Pupils' Association
Sacred Heart Parish, Invercargill
St. Andrew's Parish Pastoral Council, Tuakau
St. David's Presbyterian Church Session, Auckland
St. Joseph's Home and School Association, Oamaru
St. Joseph's Parish Pastoral Council, Christchurch
St. Josephs School Parent-Teacher Association, Papanui
St. Kevin's Parish Council, Wyndham
St. Mary's Catholic Church, Hamilton
St. Mary's Parish Council, Invercargill
St. Mary's Star of the Sea Parish Pastoral Council, Gisborne
St. Matthew's Parish Council, Christchurch
St. Patrick's College, Wellington, Staff of
St. Patrick's Parish Council, Kaponga
St. Patrick's Parish Pastoral Council, Masterton
St. Paul's Parish, Dallington
St. Peter and Paul's Ladies Guild, Johnsonville
St. Philomena's Ex-Pupils' Association
Salas, Mrs M.
Salvation Army, The
Sanson, Mr T. E.
Saunders, Mr J. E.
Savage, Mr R. C.
Savage, Dr W. D.
Saxby, Dr J. R. B.
Sayers, Ms J.
Scanlon, Mr A. V.
Scott, Mrs P.
Scully, Mr P.
Search Group, Invercargill
Sellar, Rev. Fr. S. J.
Sewell, Ms E.
Seymour, Ms R.
Shanley, Mrs M.
Shaw, Mrs A.
Shaw, Mrs M. D.
Shaw, Mr R. G. and Mrs A. M.
Shawyer, Ms J.
Simmons, Mrs B. K.
Smart, Mr S.
Smith, Mrs A. M.
Smith, Mr B.
Smith Ms B.
Smith, Mr G. J.
Smith, Mrs H.
Smith, Mrs J.
Smith, Mrs M. E.
Smith, Miss M. G.
Smith, Mr N.
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GLOSSARY OF TERMS USED IN THE REPORT

ABDOMINAL: Method of abortion—one which involves the opening of the abdomen.

ABORTIFACIENT: A substance which causes abortion.

ABORTION: The premature expulsion of the fetus or embryo from the womb after implantation.

Incomplete Abortion—the contents of the pregnant uterus are not completely expelled.

Induced Abortion—occurs as a result of interference either on medical (therapeutic) grounds or otherwise.

Septic Abortion—abortion associated with infection.

Spontaneous Abortion—occurs spontaneously, without interference.

Therapeutic Abortion—abortion performed to save the life or to prevent serious danger to the mental or physical health of the mother.

ABORTION RATE: Usually expressed as the number of abortions per thousand women of reproductive age.

ABORTION RATIO: Usually expressed as the number of abortions per hundred live births.

AETIOLOGY: The study or theory of the causation of any disease; the sum of knowledge regarding causes.

AMENORRHOEA: The absence of menstruation.

AMNIOCENTESIS: A procedure in which a needle is inserted through the abdominal wall into the uterine cavity of a pregnant woman and a sample of amniotic fluid is withdrawn. The cell and liquid components within the amniotic fluid are analysed for constituents indicating fetal disease, sex, and fetal and lung maturity. This procedure is usually performed after 14 weeks of pregnancy under local anaesthesia.

AMNION (or bag of waters): The membrane which surrounds the embryo or fetus inside the uterus and which contains fluid in which the fetus floats (Amniotic Fluid).

AMNIOTIC FLUID: The fluid within the amniotic sac that surrounds and cushions the fetus.

ANAESTHESIA: Loss of power and sensation. General anaesthesia involves total loss of sensation and consciousness.

Local anaesthesia, limited to a defined local area.

ANENCEPHALY: Absence of brain.

ANOVULAR CYCLE: Apparently normal menstrual cycle occurring unaccompanied by ovulation.

ANTE-NATAL: Before birth; used to describe events occurring between the time of conception and the onset of labour or the occurrence of abortion.

ANTIBODY: A substance produced in the bloodstream resulting from the reaction of the body to invading germs. Antibodies help both to destroy the invaders and to produce varying degrees of immunity against subsequent infection by the same germs.

ANTIGEN: A substance which causes the formation of antibodies in the blood which act in opposition to material or infections introduced from without.

BLASTULA: The stage of the development of the embryo which follows cleavage when the cells are arranged in a single layer to form a hollow sphere.

CANNULA: A specially designed hollow tube which may be introduced into the body for the injection or aspiration of fluid material in termination of pregnancy—See Karman Cannula.

CARDIOVASCULAR: Pertaining to the heart and blood vessels.

CELL REPLICATION: Cell division to make another identical cell.

CEREBRAL SUBSTRATUM: The lower layers of the main portion of the brain.

CERVICAL INCOMPETENCE: A weakness of the cervix which shows itself when the uterus is pregnant. The uterus may be unable to retain a pregnancy due to the inability of the cervix to remain closed following the increase in intra-uterine pressure.

CERVICAL LACERATION: Tearing of the cervix.

CERVIX: The neck of the uterus (or womb).

CHORION: The double layered nutritive envelope which protects and covers the fertilised ovum and within which the yolk sac lies.

CHORIONIC GONADOTROPHIN: A hormone produced by the placenta which is present in the urine in early pregnancy and the detection of which forms the basis of pregnancy tests.

CHROMOSOME: A structure in the cell nucleus composed of nucleic acids and protein. The deoxyribonucleic acid (DNA) in chromosomes is responsible for the determination and transmission of all hereditary characteristics, including a wide variety of diseases.

CHROMOSOMAL ABNORMALITY: An abnormal chromosomal pattern resulting from the loss, duplication, or rearrangement of genetic material.

COITUS: Sexual intercourse.

CONCEPTUS: The developing product of conception throughout the period of gestation.

CONGENITAL DEFECTS: Born with a person, existing at or before birth.

CONNECTIVE TISSUE: The tissue which binds together and is the support of the various structures of the body.

CORPUS LUTEUM: "Yellow Body"—a yellow mass in the ovary formed by a Graafian follicle which has matured and discharged its ovum. If the ovum has been fertilised, the corpus luteum grows and lasts for several months. It secretes progesterone necessary for the build up of the lining of the uterus. If the egg is not fertilised, it shrinks and degenerates.

CULDOSCOPY: Inspection of the pelvis by means of a culdoscope passed through the posterior fornix of the vagina. The fornix is the space between the cervix uteri and the anterior, posterior, and lateral vaginal walls.

DEMOGRAPHY: The scientific study of human population, especially its dynamics, as reflected in fertility, mortality, and migration.

DILATATION AND CURETTAGE (D. and C.): A minor gynaecological operation in which the cervix is stretched by dilators to enable the insertion of a curette into the cavity of the uterus for the purpose of scraping out the contents.

DOWN'S SYNDROME (Mongolism): A developmental abnormality due to the presence of an extra chromosome which results in the birth of a child who is

mentally handicapped and has other physical characteristics amongst which is a distinctive facial appearance.

ECTOPIC PREGNANCY: A pregnancy implanted outside the normal site in the uterine cavity. The most common site is in the Fallopian tubes.

ELECTRO-ENCEPHALOGRAPH: An instrument for recording the brain's electrical activity, "brain waves", made with electrodes on the intact scalp.

EMBRYO: The products of conception from two weeks after conception until approximately eight weeks development, at which time they are known as a fetus. This distinction between fetus and embryo is becoming less common.

ENDOMETRITIS: Inflammation of the endometrium, the mucous membrane that lines the cavity of the uterus. This is one of the more frequent forms of pelvic infection.

ENDOMETRIUM: The mucous membrane that lines the cavity of the uterus.

EPIDERMIS: The outermost layer of the skin.

ESTROGEN: A hormone which amongst other functions is responsible for the development of the secondary sexual characteristics of women. Natural estrogen is produced by the ovaries.

EX-NUPTIAL: A birth is deemed ex-nuptial if the mother and father of the child were not married to each other at the time of conception and had not married each other between the time of conception and the time of birth.

EXTENDED FAMILY: Consists of two or more nuclear families affiliated through an extension of the parent/child relationship, i.e., by joining the nuclear family of the married adult to that of his parents.

FALLOPIAN TUBES: Two hollow muscular passages connected to both sides of the uterus that transport ova (eggs) from the ovaries to the uterine cavity.

FECUNDITY: The maximum biological capacity for reproduction.

FERTILITY: Actual reproductive performance.

FERTILITY MEASURES: The principal measures of fertility referred to in this report are:

Crude Birth Rate—the ratio of the number of births to the total mean population during a period of time (usually a year). It is generally expressed as births per 1000 total mean population.

Age-specific Birth Rate—the number of births to women of a specified age compared with the number of women of that age. It is generally expressed as births per 1000 women of a specified age.

Total Fertility Rate—the sum of age-specific birth rates for all ages in the reproductive span observed in a given year expressed as the number of births 1000 women would have if they experienced a given set of age-specific birth rates throughout their reproductive life, or as the number of births per woman throughout her reproductive life. Trends in the total fertility rate give a broad indication of changes in average family size.

FETAL DEATH: The state in which the fetus shows none of the signs of life and is incapable of being made to function as a self-sustaining whole.

FETAL MATERIAL: Any or all of the contents of the uterus resulting from pregnancy excluding the fetus, i.e., placenta, fluids, and membranes.

FETAL TISSUE: A part or organ of the fetus, e.g., the lungs or liver.

FETOSCOPY: Direct visualisation of a fetus in utero by means of a miniature lens attached to a needle inserted through the abdominal wall or through the cervix.

FETUS: The products of conception from eight weeks development until birth.

FOLLICLE (GRAAFIAN): Any one of the small spherical sacs embedded in the ovary, each one of which contains an egg cell or ovum.

FULL-TERM PREGNANCY: A pregnancy of about 40 weeks' duration as calculated from the first day of the last menstrual period.

GENE: A biologic unit of heredity located on the chromosome. Acting with the environment and other genes it produces one or more characteristics of the organism.

GENETIC COUNSELLING: Discussion and advice regarding the possible characteristics of the children, based on a knowledge of the genetic characters of the parents and their ancestors. This is usually offered to couples with a family history of hereditary abnormalities.

GENOTYPE: The fundamental hereditary constitution (or combination of genes) of a person.

GESTATION: Pregnancy. Gestational Age is used to describe the age of a fetus or the duration of pregnancy.

HAEMOPHILIA: A severe hereditary bleeding disease affecting males and transmitted by females.

HAEMORRHAGE: A copious escape of blood from the blood vessels.

HISTOLOGY: The study of the minute structure of the tissues.

HORMONES: Kinds of internal secretions that pass into the blood and stimulate organs to action.

HYDATIDIFORM MOLE: A disease of the superficial layer of the chorion, the outer two membranes covering the fetus, which becomes overgrown during the first weeks of pregnancy and so increases in size as to grossly enlarge the womb and usually kill the fetus.

HYPERTONIC SOLUTION: One which contains a greater concentration of a dissolved substance than occurs in the solution with which it is to be compared or mixed.

HYPOTHALAMUS: A portion of the brain at the base of the cerebrum which controls amongst other functions the mechanism for regulating the functional activity of the pituitary gland. It is the co-ordinating centre for the nervous system.

HYSTERECTOMY: A surgical operation in which the uterus is removed. It is sometimes used as a method of abortion in the second or third trimester of pregnancy.

HYSTEROTOMY: A surgical operation in which the fetus is removed from the uterus as in a Caesarian section. It is used as a method of abortion in the second and third trimester of pregnancy.

ILLEGITIMACY RATE: The number of live ex-nuptial births expressed as a rate per 1000 single, widowed, and divorced women in a specified age range and within a specified population.

ILLEGITIMACY RATIO: The number of live ex-nuptial births expressed as a percentage of all live births (nuptial and ex-nuptial).

IMMUNOLOGY: The study of immunity, or the mechanism of protection of living organisms from disease or harmful substances.

IMPLANTATION: The attachment of the fertilised egg to the endometrium (the wall of the uterus), which usually occurs five to seven days after fertilisation of the ovum. It occupies a period of about four days.

INTRA-UTERINE: Within the uterus (womb).

INTRA-UTERINE CONTRACEPTIVE DEVICE (I.U.D.) : A contraceptive device which lies inside the uterine cavity.

KARMAN CANNULA (Catheter): A flexible polythene tube used in the termination of early pregnancy which is inserted into the uterus through the cervix and through which the contents of the uterus may be aspirated by applying suction. This was specially designed for the purpose by the man after whom it is named.

LACTATION: The period of the secretion of milk.

LAMINARIA TENTS: Rod-shaped structures prepared from dehydrated extract of the seaweed "laminaria" which are inserted into the cervix. Their function is to absorb water and expand, causing the cervix to dilate slowly.

LAPAROSCOPE: An instrument for visualising the abdominal cavity and its contents. It is an illuminated telescope which is inserted into the abdominal cavity through a very small incision in the abdominal wall.

LAPAROSCOPIC STERILISATION: Sterilisation which is performed through the laparoscope by coagulation of the Fallopian tubes.

LAPAROSCOPY: The act or process of examining the peritoneal cavity and its contents by means of a laparoscope. It is used as a method of tubal sterilisation of the female.

LAPAROTOMY: An operation involving the opening of the abdominal cavity.

LEGITIMATE: A birth is deemed to be legitimate if the parents were married to each other, either at the time of conception, or at the time of the birth, or at any stage during the intervening period.

LIVE BIRTH: A birth resulting in a child which shows signs of life.

LUTEINISATION: The process taking place in follicles which have matured and discharged their egg. The cells become a yellow colour and the follicle becomes corpus luteum.

MENARCHE: The establishment or beginning of the menstrual function.

MENSTRUAL ASPIRATION/REGULATION: A term applied to the aspiration of the contents of the uterus when the menstrual period is overdue but before diagnosis of pregnancy is possible.

MENSTRUATION: The periodic discharge of blood from the uterus occurring at more or less regular monthly intervals throughout the active reproductive life of women.

METABOLITES: Substances produced by the chemical processes participating in and essential to the phenomena of life.

MISCARRIAGE: The premature expulsion of the fetus or embryo from the womb after implantation.

MORBIDITY: The incidence of disease or ill-health.

MORBIDITY RATE: Usually expressed as the incidence of complications per 100,000 cases.

MUSCULAR DYSTROPHY: Hereditary disease, causing progressive weakness and wasting of the muscles.

MORTALITY: The incidence of death.

Maternal Mortality—the incidence of death occurring during pregnancy or the year following a pregnancy.

Perinatal Mortality— deaths occurring before birth and in children during the first week of life.

Neo-natal Mortality—death within the first month of life.
Infant Mortality—death occurring within the first year of life.

MORTALITY RATE: Usually expressed as deaths per 100,000 cases.

MULTIGRAVIDA: A woman who has been pregnant more than once.

MULTIPAROUS OR MULTIPARA: A woman who is giving birth for the second or third time or who has given birth to two or more children. The term usually refers to a woman who has borne several children.

NATURAL INCREASE: Difference between birth and death rates. Migration figures must, however, be taken into account for the true growth rates.

NEURAL CREST: First appearance of the neural or nervous system.

NEURAL TUBE DEFECTS: Development defects of the central nervous system in a fetus, e.g., spina bifida.

NUCLEAR FAMILY: A small group composed of husband and wife and immature children which constitutes a unit apart from the rest of the community.

OCCLUSION: The blocking up of an opening.

OVARY: The female gonad, the organ which produces the female sex cells or ova and hormones, including female hormones (estrogens).

OVULATION: The release of an unfertilized egg from one of the ovaries which usually occurs approximately once a month in women during their reproductive years.

OVUM: The female reproductive cell or "egg" which is produced in the ovaries.

OXYTOCIN: A hormone capable of inducing uterine contractions and producing labour. Natural oxytocin is produced by the pituitary gland.

PARACERVICAL BLOCK: A form of local anaesthesia used for minor operations on the uterus, including vaginal termination of pregnancy. Local anaesthetic is injected into the tissue on either side of the cervix where the nerves supplying the uterus are situated so causing local anaesthesia.

PARITY: Used to describe the number of births that have occurred, e.g., parity 2 means having given birth to two children.

PERINATAL: The time period from approximately a fetal weight of 500 grams to the first 28 days after birth.

PESSARY: A tablet or instrument for insertion into the vagina. May be designed to contain medication for treatment of a condition or act as a supportive structure for the treatment of genital prolapse.

PITUITARY GLAND: A pea-sized gland at the base of the brain which exercises control over the other glands of the body.

PLACENTA (Afterbirth): The disc-like structure which connects the fetus to the inside of the uterus via the umbilical cord and through which the fetus obtains its nourishment from its mother and gets rid of waste products. It also produces hormones which are essential for the maintenance of the pregnancy.

PLACENTAL VILLI: The network of roots put out by the blastula which secrete chorionic gonadotrophin and relay it to the corpus luteum via the maternal blood.

POST-NATAL: Relating to the period after the birth of the child.

POST-PARTUM: Pertaining to, or occurring during, the period following childbirth and delivery.

PREMATURE BIRTH: A birth taking place before the normal gestation period has been completed. This is usually also related to the birth of a child weighing 2500 grams (5½lb.) or less.

PRODUCTS OF CONCEPTION: This term includes all the organic/biological parts of the conceptus such as the fetus, placenta, amniotic fluid and cells, and the amniotic sac.

PROGESTERONE: A hormone secreted by the ovary and by the placenta. It is responsible for some of the changes taking place during the menstrual cycle and is necessary to the development of a normal pregnancy.

PROGESTOGEN: A substance with a progesterone-like action, present in some contraceptive pills.

PROSTAGLANDINS: A group of substances present in human tissues, having a wide range of action and being involved in many physiological processes. One of their properties about which most is known is that when administered in concentrated extracts to uterine muscle they cause uterine contraction with the consequent induction of labour or abortion. Prostaglandin Analogues—synthetically-produced compounds with similar properties.

PUERPERAL DEATH: Death of a woman due to the complications of pregnancy, labour, or childbirth.

PUERPERAL PSYCHOSIS: Mental disorder in the period or state of confinement after labour.

PUERPERIUM: The time period from the termination of labour to when the uterus regains its original size and shape, usually defined as 42 days.

PYREXIA: Fever, raised body temperature.

QUICKENING: The stage at which the movements of the fetus can be felt within the mother.

RENAL: Pertaining to the kidney.

REPLACEMENT FERTILITY: The level of reproduction consistent with ultimate zero population growth. Under contemporary conditions of mortality, this averages out to 2.11 children per woman over a lifetime. The figure allows for deaths among women before they reach childbearing age and also for the fact that slightly more males than females are born.

REPRODUCTIVE AGE GROUP: In demography the reproductive age group is taken as 16–44 years. The term is applied to all females in this broad age group.

RHESUS FACTOR: A series of antigens present on red blood cells, the most important of which is Rhesus D which is present on the red cells of 85 percent of the Caucasian population. Women without the factor Rhesus D positive may produce antibodies to the factor which in a subsequent pregnancy may cause destruction of the red corpuscles of a Rhesus positive fetus.

RUBELLA (German Measles): An acute infectious disease of viral origin. This tends to have to have a mild effect on the mother but if it occurs in early pregnancy (first three months), it may produce serious congenital defects in the child.

SALINE: A solution of common salt (sodium chloride) in water.

SALPINGECTOMY: Excision of a uterine tube (Fallopian tube).

SALPINGITIS: Inflammation of the Fallopian tubes.

SCROTUM: A pouch containing the male gonads (testes). Lying within it is part of the vas deferens which links the testes and the urethra.

SEBACEOUS GLANDS: Glands secreting a greasy lubricating substance.

SEMINAL VESICLES: Small paired sacs lying on either side of the upper part of the male urethra, the function of which is to collect and store the spermatozoa which pass down the vas deferens.

SENSITIZATION: Rendered sensitive, especially to proteins or bacteria by preliminary infection with such substances.

SEPSIS: Infection caused by the presence of various micro-organisms and/or their toxins which enter the bloodstream or tissues.

SEPTICAEMIA: The spread of an infection into the blood stream (blood poisoning).

SEXUALLY TRANSMITTED DISEASES (Venereal Disease): Infectious disease spread by sexual intercourse.

SPERMICIDE: Any agent which is destructive to sperm.

SPINA BIFIDA: A developmental defect in the bony vertebrae that normally encase and protect the spinal cord.

STERILISATION (Operation of): Any operation which renders the individual incapable of producing a child. In the female this is usually accomplished by obstructing the Fallopian tubes though it may be achieved by other operative procedures. Male sterilisation—(see Vasectomy).

STILL-BIRTH: A child born after the 28th week of pregnancy showing no signs of life.

SUBCORTEX: The part of the brain substance which underlies the cortex or outer layers of the brain.

TESTIS: The male gonad, responsible for the production of the male reproductive cells (spermatozoa) and the male hormones.

THERAPEUTIC: The treatment of disease.

THROMBOPHLEBITIS: A clot of blood in a blood vessel, together with inflammation of the wall of the vein.

THROMBOSIS: The clotting of blood within a blood vessel.

THROMBUS: A clot of blood that forms in one of the blood vessels or cavities of the heart, blocking the flow of blood.

TOXAEMIA OF PREGNANCY (Pre-eclampsia): A condition usually occurring in late pregnancy associated with high blood pressure, protein in the urine, and fluid retention.

TRANSLOCATION: Transfer of genetic material from one chromosome to another, the latter not being homologous with the former.

TRAUMA: Wound or damage to tissues.

TRIMESTER OF PREGNANCY: Refers to a three-month period of pregnancy, i.e., first, second, and third trimester of pregnancy.

TUBAL LIGATION: Any method of surgery that either ties, blocks, cauterizes, cuts, or clips the Fallopian tubes so that the egg which is released each month by the ovary cannot be reached and fertilized by the sperm.

ULTRA-SOUND SCANNING: The use of sound waves in diagnosis.

UMBILICUS: The navel. The point at which the fetus is connected via the umbilical cord to the placenta.

UREA: A principal waste product of protein metabolism in the human which is excreted in the urine.

UTERUS (The womb): Female organ of reproduction in which the fetus grows and develops.

UTUS PASTE: An iodized solution of soaps which may be injected into the uterus through the cervix and which may induce abortion.

VAGINAL METHOD OF ABORTION: A method of abortion which is carried out by approaching the uterus through the vagina, e.g., dilatation and curettage or vacuum aspiration of the uterus.

VAS DEFERENS: The duct connecting the testis to the seminal vesicles and urethra.

VASECTOMY (male sterilisation): The division and ligation of the vas deferens, usually approached by a small incision in the scrotum.

VENEREAL DISEASES: See Sexually Transmitted Diseases.

VIABLE: A term applied to a fetus which is capable of leading a separate existence.

VIROLOGY: That branch of biology which is concerned with viruses and virus diseases.

ZERO POPULATION GROWTH: A population where births equal deaths and long-term immigration equals long-term emigration over some defined period of time.

ZONA PELLUCIDA: The membrane surrounding the ovum.

ZYGOTE: The cell resulting from the fusion of the egg and the sperm.

ABBREVIATIONS OF PERIODICALS AND TERMS USED IN BIBLIOGRAPHY

Acta obstet. gynec. Scand. ...	Acta obstetrica et gynecologica Scandinavia
Acta psychiat. neurol. Scand. ...	Acta psychiatrica et neurologica Scandinavia
A.L.R.A.	Abortion Law Reform Association
Am. J. Comp. Law	American Journal of Comparative Law
Am. J. Dis. Child	American Journal of Diseases of Children
Am. J. Nurs.	American Journal of Nursing
Am. J. Obstet. Gynec.	American Journal of Obstetrics and Gynecology
Am. J. Orthopsychiat.	American Journal of Orthopsychiatry
Am. J. publ. Hlth.	American Journal of Public Health
Am. J. Psychiat.	American Journal of Psychiatry
Archs. Dis. Childh.	Archives of Disease in Childhood
Archs. Gen. Psychiat.	Archives of General Psychiatry
Ass. Stud. Ab.	Association for the Study of Abortion
Aust. J. Social Issues	Australian Journal of Social Issues
Aust. med. J....	Australian Medical Journal
Aust. N.Z.J. Psychiat.	Australian and New Zealand Journal of Psychiatry
Br. J. hosp. Med.	British Journal of Hospital Medicine
Br. J. prev. soc. Med.	British Journal of Preventive and Social Medicine
Br. med. Bull.	British Medical Bulletin
Br. med. J.	British Medical Journal
Community Hlth.	Community Health
Compreh. Psychiat.	Comprehensive Psychiatry
Crim. Law Rev.	Criminal Law Review
Demogr.	Demography
Electroenceph. Clin. Neurophysiol.	Electroencephalography and Clinical Neurophysiology
Eugenics Qt'ly	Eugenics Quarterly
Excerpta med.	Excerpta medica
Fam. Plann. Perspect.	Family Planning Perspectives
Fert. Steril.	Fertility and Sterility
Gynak.	Gynakologische
Int. J. Derm.	International Journal of Dermatology
Int. J. Gynec. Obstet.	International Journal of Gynecology and Obstetrics
I.P.P.F.	International Planned Parenthood Federation
I.R.C.A.R.	International Reference Centre for Abortion Research
J. Am. med. Ass.	Journal of the American Medical Association
J. Biosoc. Sci.	Journal of Biosocial Science
J. La. St. med. Soc.	Journal of the Louisiana State Medical Society
J. Marriage Fam.	Journal of Marriage and the Family
J. nerv. ment. Dis.	Journal of Nervous and Mental Diseases
J. Postgrad. Med.	Journal of Postgraduate Medicine

J. Reprod. Fert.	Journal of Reproduction and Fertility
J.R. Coll. Gen. Pract.	Journal of the Royal College of General Practitioners
J. Youth Adol.	Journal of Youth and Adolescence
Law Pop. Monogr. Ser. ...	Law and Population Monograph Series
Med.-leg. J., Lond.	Medico-legal Journal, London
Med.-leg. Soc. J.	Medico-legal Society Journal
Medicine Sci. Law	Medicine, Science and the Law
Mod. Med.	Modern Medicine
New Engl. J. Med.	New England Journal of Medicine
N.Z. Fam. Phys.	New Zealand Family Physician
N.Z. med. J.	New Zealand Medical Journal
N.Z. nurs. J.	New Zealand Nursing Journal
Nurs. Forum	Nursing Forum
Nurs. Mirror	Nursing Mirror
Nurs. Research	Nursing Research
Obstet. Gynec.	Obstetrics and Gynecology
Obstet. Gynaec. Br. Commonw....	Obstetrics and Gynaecology of the British Commonwealth
Pat. Mgmt.	Patient Management
Police Coll. Mag.	Police College Magazine
Polit. Ec. Plann. Broadsheet ...	Political and Economic Planning Broadsheet
Polit. Qt'ly	Political Quarterly
Poly. Soc. J.	Polynesian Society Journal
Popul. Bull.	Population Bulletin
Popul. Index	Population Index
Popul. Rep.	Population Report
Popul. Stud.	Population Studies
Postgrad. Med.	Postgraduate Medicine
Proc. R. Soc. Med.	Proceedings of the Royal Society of Medicine
Psychiat. Ann.	Psychiatric Annals
Publ. Opinion Qt'ly	Public Opinion Quarterly
Rep. Popul. Fam. Plann. ...	Reports on Population, Family Planning
Scient. Am.	Scientific American
Scott. med. J.	Scottish Medical Journal
Semin. Psychiat.	Seminars in Psychiatry
Social Sci. Med.	Social Science and Medicine
S.P.U.C.	Society for the Protection of the Unborn Child
Stud. Fam. Plann.	Studies in Family Planning
T.F.R.I.	Transnational Family Research Institute

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We are grateful to those publishers and authors who have given permission to us to quote from their publications.

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