



May 2018

Abortion Law Review
New Zealand Law Commission
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SUBMISSION – Law Commission Abortion Law Review

This submission is being made by Family First NZ, a registered charitable organisation that researches and advocates on family issues in the public domain.

We believe that abortion is *both* a health issue and a legal issue. The health of the mother, and the health of the unborn child - the legal safety of the mother, and the legal status of the unborn child.

Those who argue for the decriminalisation of abortion do so by prioritising the right of the pregnant woman to self-determination regarding decisions affecting her own body. The right of the unborn child to life, even the humanity of the unborn baby must be considered secondary, or denied entirely, for this point of view to hold.

However, this in itself creates an inconsistency with s182 of the Crimes Act¹, which recognises that:

182 Killing unborn child

(1) Every one is liable to imprisonment for a term not exceeding 14 years who causes the death of any child that has not become a human being in such a manner that he or she would have been guilty of murder if the child had become a human being.

(2) No one is guilty of any offence 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.

If the law is changed to recognise that harm done to aborted babies is not criminal (except given the existing exemptions) how can the law then criminalise harm done to other babies in the womb?

Clearly, when a pregnant woman is assaulted so that her baby is harmed or killed, it seems intuitive to agree that criminal liability subsists for the assailant. However, the perpetrator can only be prosecuted by a law that recognises this behaviour as harmful to a baby who is recognised as human. If the baby is not recognised as

¹ <http://www.legislation.govt.nz/act/public/1961/0043/137.0/DLM329352.html>

human, then the damage suffered through the assault could not be criminal except perhaps to the extent that it causes emotional trauma to the mother. Even recognition of this trauma first requires acknowledgement that the assault has resulted in something traumatic, namely the death or maiming of a child.

This inconsistency exists wherever an unborn child who is wanted is infinitely precious and irreplaceable while a child who might be in all other respects the same is not even recognised as human if the baby's mother decides on abortion.

To remove legislation about abortion from the criminal code and insert it to the health code is to equate a procedure to remove an unborn baby with a procedure to remove an appendix.

This, again, is to deny the humanity of the baby and again, creates inconsistency with other legislation which clearly recognizes the rights of the unborn child.

New Zealanders don't want an extreme abortion law - they want a law that works best for women's health and well-being, and which considers *all* human beings involved in a pregnancy.

- ☐ A law that protects women from unlicensed premises and unregistered abortionists
- ☐ A law that promotes and facilitates informed consent
- ☐ A law that requires honest information about abortion-related risks provided to pregnant women
- ☐ A law that provides women with independent pregnancy counselling
- ☐ A law that protects young girls by requiring parental involvement
- ☐ A law that limits the timeframe for having an abortion, except in exceptional circumstances
- ☐ A law that prevents abortions on the basis of gender
- ☐ A law that doesn't discriminate against disabled children e.g. those with Down syndrome

We therefore reject in the strongest terms the brief that has been given to the Law Commission suggesting that the issue of abortion is just a 'health issue' (*Letter from Minister of Justice Andrew Little to the Law Commission, 27 February 2018*²).

Objection to the review 'referral' by the Govt

In effect, what the government has given the Law Commission is not a request for a review and direction, but rather a specific direction on how to treat a social issue in law i.e. from both a health and criminal aspect to just a health aspect.

It is not a question of 'may' or 'could', but a directive with a specific outcome – "*to align with a health outcome*". While the Law Commission has been asked to consult with the general public – albeit in a very limited time frame - there is no requirement on the Law Commission to have to take into account the wide range of issues raised on such a hugely controversial issue. There is no allowance for the possibility that the Law Commission may actually believe that the current law is the best available.

Therefore, the Government is not actually asking the Law Commission for a review. It's an agenda (or pre-determined outcome) that the Law Commission must adhere to. This has the potential to create legal and ethical problems and ambiguities in the law.

² <http://www.lawcom.govt.nz/sites/default/files/projectAttachments/180227-LITTLE%20Hon%20A-Law%20Commission%20referral%20re%20abortion%20law.pdf>

Setting up a ‘rushed response’

The review of the abortion laws by the Law Commission and the very quick time allowed by the government to report back means that other issues – some which have greater importance and affect far more people – are being deferred. Yet a Law Commission member said in a recent interview that the reviews that the Law Commission do best are where they consider them at length.³

For example, the Review of the Property Relationships Act 1976 examining a review of law due to “*increasing diversity in relationships and families*” was due to be reported back on in November 2018 after being referred to the Law Commission by the Minister in December 2015 (an original consideration time of 3 years). This has now been deferred another six months to make way for the abortion law review.⁴ (*OIA response received by Family First 30 April 2018*)

Yet the consideration of abortion laws was referred by the Minister at the end of February and is due back “*within eight months*”.

In 2016, the Commission found nearly half the children born in New Zealand were to parents neither married nor in a civil union, and that a third of all marriages are remarriages. Therefore, these laws affect hundreds of thousands of families and people.

We argue that the Law Commission should not be used as a smoke-screen for an agenda being rushed through by a government.

Women have a right to be fully informed

A just-published research review paper “*Abortion and the Physical and Mental Health of Women - A review of the evidence for health professionals*” reviews the international evidence to date about the relationship between abortion and the physical and mental health of women.⁵ It shows that abortion is associated with a wide range of adverse physical and psychological outcomes, and it is essential that women are made fully aware of all the risks. It concludes that while studies on abortion have sometimes yielded inconsistent results, there is a clear correlation between abortion and adverse psychological outcomes.

Other conclusions based on the research analysis include:

- Intimate partner violence (IPV) is strongly correlated with abortion, with some research showing a 6-fold increase of IPV in women undergoing abortion compared to those in antenatal care. Abortion has also been linked to international trafficking and slavery of women. Presentation for abortion may be an opportunity to address the risk of coercion and intimate partner violence.
- Ambivalence to abortion is common and is linked to some adverse post-abortion outcomes.
- The prevalence of foetal abnormalities has increased in many countries and women commonly report a lack of information provided to them about the child’s condition, and the options open to them. (an example was recently covered in the NZ media.⁶)

³ https://www.radionz.co.nz/audio/player?audio_id=2018640535

⁴ <http://www.lawcom.govt.nz/our-projects/review-property-relationships-act-1976>

⁵ <https://www.familyfirst.org.nz/research/abortion-health-of-women-2018/>

⁶ https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11933819

- The physical effects of abortion include an increased risk of premature delivery in subsequent pregnancies, and this appears to be related to surgical abortion but not medical abortion.
- Significant inconsistencies exist in research about a possible link between abortion and the risk of breast cancer, yet there is evidence showing that carrying a pregnancy to term is protective against breast cancer.

In one significant finding, the research suggests that medical abortions (a medical abortion uses pills rather than surgery) outstrip surgical ones by a factor of at least four when it comes to the overall incidence of complications. This is concerning given that the Abortion Supervisory Committee has recently told politicians that it would be safer for women having a medical abortion to take the medicine at home.⁷ In fact, the Scottish government guidance says a woman must have another adult with her and the pill must only be taken up to ten weeks gestation, indicating that it's not a straightforward procedure.⁸

The research paper also includes NZ-based studies including the University of Otago study in 2008 which found that women who had an abortion faced a 30% increase in the risk of developing common mental health problems such as depression and anxiety.⁹ And a research paper entitled "*Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence*" by Professor David Fergusson, John Horwood, and Joseph Boden which was published in the 2013 edition of the Australian and New Zealand Journal of Psychiatry concluded that the evidence shows that abortion was not associated with a reduction in rates of mental health problems, but was associated with increases in risks of anxiety, alcohol and drug misuse, and suicidal behavior.¹⁰ They state: "*There is no available evidence to suggest that abortion has therapeutic effects in reducing the mental health risks of unwanted or unintended pregnancy. There is suggestive evidence that abortion may be associated with small to moderate increases in risks of some mental health problems.*"

Women deserve to know this information so they can make a truly informed decision, as they should with *any* health decision.

(The full research is contained in Appendix 5)

Basic legal safeguards are currently in place

The system currently puts basic legal safeguards in place. Even the Abortion Supervisory Committee (ASC) in its latest report to Parliament notes that "*The ASC recognises the merit in having a robust pathway in place, which requires certifying consultants to assess and certify patients and to ensure counselling is offered.*"¹¹

Contrary to media portrayal of comments by the ASC to the Select Committee, the concerns raised by the ASC in their 2016 report relate only to:

- Some of the wording in the Act being "outdated and clumsy"
- Complicated wording around referrals and consultation processes
- Allowing for technological advances
- Doctors are referred to as 'he'
- Medical practitioners are referred to as the "woman's own doctor" but this is not always the case

⁷ http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11995440

⁸ [http://www.sehd.scot.nhs.uk/cmo/CMO\(2017\)14.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2017)14.pdf)

⁹ <http://bjp.rcpsych.org/content/193/6/444>

¹⁰ <http://anp.sagepub.com/content/early/2013/04/02/0004867413484597>

¹¹ <https://www.justice.govt.nz/assets/Documents/Publications/ASC-Annual-Report-2017.pdf>

- The outdated term of “mentally subnormal”¹²

In their 2017 report, they say:

- The ASC does not propose amendments that would change the original intent of the ACT. The ASC recognises the merit in having a robust pathway in place, which requires certifying consultants to assess and certify patients and to ensure counselling is offered.¹³

Neither of these reports make any recommendation that s182 of the Crimes Act should be removed.

Claim: Changing the law is simply ratifying what’s already happening

What is being proposed is *not* simply a case of ratifying current practice. Instead it would attempt to introduce a *new* and extreme abortion law in NZ (as suggested by ALRANZ (Abortion Law Reform Association of NZ)¹⁴) who have argued for “*No abortion laws and no regulations around abortion*”¹⁵) - a law that could result in the removal of safeguards for women, the introduction of late-term abortion, the loss of freedom of conscience for healthcare providers, and gender-selective abortions, among other things.

Claim: Women who have abortions shouldn’t be criminals

Any New Zealand woman who has an abortion under the current legislative guidelines and protections is *not* committing an illegal act and is therefore *not* considered a criminal by our current laws. This claim is simply false scaremongering aimed at deceiving people into supporting the introduction of an extreme abortion law in New Zealand. **Women are not made criminals by the current legislative guidelines and protections.** The existing safeguards are there to protect women from unlicensed premises and coercion, and it is these safeguards most New Zealanders support.

“A woman who seeks or receives an unlawful abortion is not liable under section 183 of the Crimes Act 1961.”

NZ Law Commission website – Abortion Law Reform (April 2018)¹⁶

Claim: Abortion shouldn’t be in the Crimes Act, it’s a health issue

The current law recognises the scientific fact that there are at least two human beings involved in every pregnancy, and that abortion results in the loss of one of those lives. The current legal framework attempts to strike a balance between the wellbeing of the mother, and the fact that the deliberate taking of any innocent human life is a crime that must be safeguarded against.

And yes, abortion is *also* a health issue - it’s a surgical procedure that has some serious risk factors associated with it. A sound law needs to reflect that reality, and not leave women exposed to harms, such as those recently witnessed in the criminal trial of Kermit Gosnell¹⁷ who was able to operate a dangerous legal abortion facility which resulted in female client death and other atrocities due to extreme abortion laws. Criminal consequences for abortion providers who break the law should remain, in order to better protect all the parties involved.

¹² <https://www.justice.govt.nz/assets/Documents/Publications/asc-annual-report-2016.pdf>

¹³ <https://www.justice.govt.nz/assets/Documents/Publications/ASC-Annual-Report-2017.pdf>

¹⁴ <http://alranz.org/>

¹⁵ <https://www.newsroom.co.nz/2018/02/15/89105/labour-moves-to-legalise-abortion>

¹⁶ <http://www.lawcom.govt.nz/abortion>

¹⁷ https://www.washingtonpost.com/news/wonk/wp/2013/04/15/the-gosnell-case-heres-what-you-need-to-know/?noredirect=on&utm_term=.5ecb012749c8

Just a matter between a woman and her doctor?

In fact, there are at least two human beings involved in every pregnancy, and that's why we place such a strong emphasis on campaigns that discourage smoking or drinking during pregnancy in this country. It's also why, if it is needed, that doctors conduct life-saving surgery while a child is in utero.

Any responsible doctor knows that they are dealing with at least two patients that need care every time a pregnant woman comes under their supervision, and any responsible law should also do the same.

Claim: Women must have control over their own bodies

New Zealand women need to be informed of the effects that abortion can have on their bodies, and the current law needs to be strengthened to ensure that such informed consent from an independent provider is a legal requirement. There are also at least two bodies in every pregnancy, the body of the mother and the body of the unborn human being growing inside her womb. So, if we truly do believe that women must have control over their bodies, then surely *unborn* women also deserve the right to have control over their bodies too?

Claim: The right to 'choose'

Surely *all* New Zealand women deserve the right to choose, *including* the unborn little girl. Yes, NZ women should have the right to choose – their maternity care provider, their midwife, their doctor, the type of birth they want, etc, but abortion is something completely different altogether.

The question of choice is far more complex than the way it is often portrayed in the abortion debate. The law doesn't recognise personal choice as an absolute without limits; instead it always restricts choice when it conflicts with the wellbeing of others. In the case of abortion, those 'others' are the unborn human beings who will be robbed of ALL their choices if they are aborted.

A real choice is one that is fully informed; about all the risks, about all the options, about fetal development, and about what the abortion procedure actually entails.

Claim: Private decisions like abortion shouldn't be the government's business

All of us have a stake in what happens to the most vulnerable members of our community and to their mothers, and so we should all care about what shape our laws take when it comes to abortion.

Cases involving rape or incest, or where there are fetal abnormalities

When it comes to pregnancies that result from rape and/or incest, extreme violence has been done to those women. They deserve to be treated with the deepest compassion, given enormous support, and special care.

However, the circumstances of the baby's conception change nothing about the baby herself, or the extreme violence of abortion. So often when this issue is raised, people refer to the unborn child as if they are an extension of the rapist, or his vile act, completely forgetting that in actual fact the child is their own unique person quite independently of the tragic circumstances of their conception. That child is just as much an extension of the mother and adding abortion after rape simply adds violence to violence, creating a second victim of the rapist - the unborn child.

Many women who have kept their children conceived in rape tell a common story of finding a silver lining of love in that child, in an otherwise very dark situation. Women who keep their babies also avoid the serious

psychological risks associated with abortion which, according to some experts, could be amplified even further when added to the already horrific trauma caused by the sexual assault.

In one of the only studies of women who conceived as a result of rape, Dr Sandra Mahkorn found that 75 to 85 percent chose against abortion.¹⁸ None of the women who gave birth said they did not want their children or wished they had aborted instead. Of those who aborted, nearly half did so because of the demands of others. 94% of women who gave birth said abortion would not be a good solution to a pregnancy resulting from rape. 93% of those who had abortions said it “had not been a good solution to their problems” and they “would not recommend it to others in their situation.”¹⁹ Dr David Reardon, notes that this also applies to cases of incest:

Edith Young, a 12-year-old victim of incest impregnated by her stepfather, writes twenty-five years after the abortion of her child: “Throughout the years I have been depressed, suicidal, furious, outraged, lonely, and have felt a sense of loss... The abortion which was to ‘be in my best interest’ just has not been. As far as I can tell, it only ‘saved their reputations,’ ‘solved their problems,’ and ‘allowed their lives to go merrily on.’... My daughter, how I miss her so. I miss her regardless of the reason for her conception.”

Far from being open and shut cases for abortion, cases of rape and incest demand even greater sensitivity and support for the women involved. *Assuming* the answer to their circumstances may serve to compound their pre-existing trauma in the long-term.

Foetal abnormalities

Aborting a child because of possible abnormality is nothing less than blatant discrimination against people with disabilities. When reflecting on this argument we need to tear aside the veil of prejudice that drives the notion that it is somehow kinder to kill a person with a disability or a disease before she is born than to let her ‘live in that condition’. Shockingly, the types of disabilities included by pro-abortionists in the list of purportedly ‘good reasons’ for an abortion range from the truly severe to relatively minor; the latter part of the list grows lengthier every year. Abortion is becoming a search-and-destroy method for eliminating less-than-‘perfect’ people.

Again, this is not a simple ethical issue. It is contaminated with discrimination against the disabled and involves agreeing with the arguments of eugenicists, that some lives can legitimately be ended for reasons of genetic purity. This issue also opens the question of what defines ‘serious or fatal foetal abnormality’? Do we abort for a cleft palate, of a malformed limb? Is it possible to simply discard a foetus and try again, as though abortion were no more than a matter of pressing ‘control z’ on pregnancy? Does a baby that will live only days or hours not still deserve all the love that can be crammed into that time? Again, the fact that the answer to this question is often assumed as an obvious case for abortion makes pregnant women vulnerable to coercion and means that they are at greater risk of being unsupported in a decision to continue with the pregnancy.

In jurisdictions that have decriminalised abortion – China, Vietnam, Canada and two states in Australia – gestational time limits for disability-selective abortions have been removed and abortion for babies with disabilities is available right up to birth. The report on Iceland and their near 100% abortion rate from Down’s syndrome has led to controversy globally regarding equality and non-discrimination for persons with disabilities.²⁰

¹⁸ Mahkorn, “Pregnancy and Sexual Assault,” *The Psychological Aspects of Abortion*, eds. Mall & Watts, Washington, 1979, pp. 55-69.

¹⁹ Dr David Reardon, “Rape, Incest, and Abortion: Searching Beyond the Myths”, 1994. (Available here: <https://www.abortionfacts.com/reardon/rape-incest-and-abortion-searching-beyond-the-myths#1>).

²⁰ <https://www.cbsnews.com/news/down-syndrome-iceland/>

Sex selective abortions – targeting females

Allowing abortion for social reasons also raises the spectre of sex selective abortions. Sex selective abortion is a well-known problem in China and India, where son-preference cultures have resulted in extremely skewed sex ratios. Sex discrimination carried out via abortion is well documented and has resulted in millions of “missing” girls in some societies. The number of girls and women missing from the global population is estimated to be more than 160 million, with sex selection being a major culprit. The practice of sex selection has been widely condemned.

There is evidence that sex selective abortion is already occurring in some parts of Australia. Take for example, the high-profile case of Dr Mark Hobart who refused to perform a sex-selective abortion in Victoria²¹, or the investigation by SBS that found a higher number of boys than girls being born in some ethnic communities in Australia.²²

In a system where abortions are lawful on social grounds, there is no protection against antenatal sex discrimination and amongst son-preference cultures residing in New Zealand, it is baby girls who will suffer the most discrimination

Do the unborn feel pain?

There is substantial medical evidence that an unborn child is capable of experiencing pain at least by 20 weeks after fertilisation, if not earlier.²³

- Pain receptors (nociceptors) are present throughout the unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks after fertilisation.
- By 8 weeks after fertilisation, the unborn child reacts to touch. After 20 weeks, the unborn child reacts to stimuli that would be recognised as painful if applied to an adult human, for example, by recoiling.
- There is good evidence that stress hormones are released during invasive procedures on fetuses down to 18 weeks gestation or earlier.²⁴
- A double-standard of pain relief between clinical operations to correct problems and abortion exists. Amazing treatments have been given to unborn children in the womb to correct problems such as spina bifida or potential loss of limbs. Indeed, the National Institute of Child Health and Development predicts routine diagnosis and in utero treatment of congenital malformations by 2020.
- Foetal anaesthesia is routinely administered and is associated with a decrease in stress hormones compared to their level when painful stimuli are applied without such anaesthesia. In the United States, surgery of this type is being performed by 20 weeks after fertilisation and earlier in specialised units affiliated with children's hospitals.
- Great efforts are made to treat wanted babies, either in the womb or when born prematurely, and attempts are made to alleviate any pain or distress they may experience. Yet an unborn child of the same gestational age, whose parents have chosen abortion, is offered no pain relief, presumably because this would bring the reality of what is being done to a defenceless human being into too sharp a focus.

²¹ <http://www.heraldsun.com.au/news/opinion/doctor-risks-his-career-after-refusing-abortion-referral/news-story/a37067e66ed4f8d9a07ec9cb6fd28cf5>

²² <https://www.sbs.com.au/yourlanguage/korean/en/audiotrack/unusually-high-number-boys-born-parents-some-communities>

²³ <http://www.doctorsonfetalpain.com/>

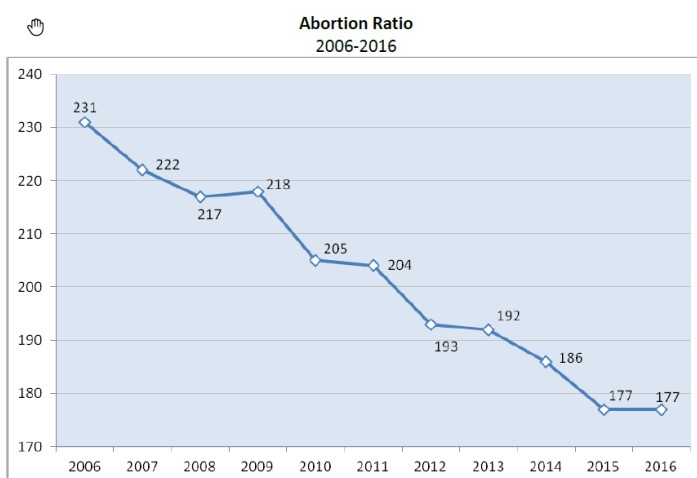
²⁴ Gitau R, Fisk NM, Cameron A, Teixeira J, Glover V. (2001). 'Fetal HPA stress responses to invasive procedures are independent of maternal responses', *Journal of Clinical Endocrinology and Metabolism*. 86, pp104-109

- Testifying before one of the US trials to determine the constitutionality of a ban on partial birth abortion, Oxford and Harvard trained neonatal paediatrician Professor Knowljeet Anand, certainly not a conventional pro-life activist, stated that: *"If the foetus is beyond 20 weeks of gestation, I would assume that there will be pain caused to the foetus. And I believe it will be severe and excruciating pain."*²⁵
- In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.
- Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioural, and learning disabilities later in life.
- The position, asserted by some physicians, that the unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and analysis, especially since 2007, provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

Reduced abortion numbers is a good thing

Everyone is welcoming the drop in the number of abortions – the lowest rate in over 25 years.²⁶

The rate will continue to drop as knowledge of the prenatal development of the unborn child increases, and as an increasingly pro-life younger generation become parents themselves.²⁷ The 'bunch of cells' argument which has driven the right-to-abortion argument is simply 'flat-earth science'. 3-D ultrasounds and smartphone apps allowing parents to listen to the heartbeat of their unborn child and keep track of their baby's progress in the womb, including heartbeats per minute, the number of times the baby kicks and the weight of the growing fetus, have contributed to an increasing awareness of the life of the child in the womb.²⁸



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

What do New Zealanders really think?

An independent poll of New Zealanders by Curia Market Research has found significant support for greater time limits on abortion, including from those who generally support abortion. There was surprisingly small

²⁵ Evidence supplied by Dr. Anand is summarised from page 196 of the Carhart v Ashcroft court ruling.

²⁶ http://www.stats.govt.nz/browse_for_stats/health/abortion/AbortionStatistics_HOTPYeDec16.aspx

²⁷ <http://www.gallup.com/poll/126581/generational-differences-abortion-narrow.aspx>

²⁸ <http://www.chooselife.org.nz/recent-news/new-app-allows-mums-to-track-babys-progress/>

support for the current Crimes Act time limit of 20 weeks²⁹, and overwhelming rejection of any extension to the limit. There was also strong support for legal safeguards.

There is no public mandate at all to liberalise the abortions laws. The vast majority of the population - including people who generally support abortion - show strong support and acceptance of the current legal framework and the presence of safeguards around issues such as coercion, standards for providers, and informed consent.

In the independent poll of 1,013 NZ'ers in December 2017, just 9% support the current legal limit³⁰ for an abortion of 20 weeks. Only 4% believe it should be later than 20 weeks (including up to birth), as proposed by pro-abortion group ALRANZ.³¹ 50% think the time limit should be shorter than the current 20 weeks, and a further 36% were unsure. Of those who did pick a time limit, 15 weeks was the median choice, according to Curia.

Significantly, 56% of women think the time limit should be less than the current 20 weeks. And incredibly, 53% of those who generally *support* abortion think the time limit should be less than the current 20 weeks - 29% of abortion supporters say 10 weeks or less.

Other results include:

- 65% of respondents agree that society should work together to reduce the number of abortions (only 17% disagree). Of those who generally *support* abortion, 63% agree with reducing the number of abortions (19% disagree). 74% of women agree (56% of men).
- 86% support the current legal requirements of providers and premises having to be licensed (only 8% disagree). Of those who generally *support* abortion, 92% support these legal requirements. 95% of women agree (78% of men).
- 90% oppose sex selective abortions (Only 4% support). Women are 94% opposed, and 91% of those who generally *support* abortion are opposed.
- 76% support doctors being required to verify a woman seeking an abortion is not under any coercion from a 3rd party (8% opposed). Women are 83% in support (men 69%). Of those who generally *support* abortion, 84% support this legal requirement.
- 52% say they generally support abortion and 29% oppose, 19% unsure. However, opposition to abortion exceeds support of abortion in areas of high deprivation (39% to 35%). NZ First voters are least supportive, Green voters most supportive.
- 49% support being able to have an abortion just because a woman doesn't want to be a mother (38% opposed, 13% unsure). Respondents in high areas of deprivation are evenly split on the issue. Green voters most supportive (73%), NZ First voters least supportive (38%).
- Women are more pro-life than men on most of the issues canvassed.

Full results – Appendix 1

Earlier surveys – also carried out by Curia Market Research - have found:

- A 2016 survey³² asked respondents whether they agreed with the following statement: “*Women who have abortions risk harming their mental health as a result of the abortion.*” Overall, 46% agreed with

²⁹ <http://www.legislation.govt.nz/act/public/1961/0043/latest/DLM329364.html>

³⁰ <http://www.legislation.govt.nz/act/public/1961/0043/latest/DLM329364.html>

³¹ <http://alranz.org/change-the-law/sample-legislations/>

³² <https://www.familyfirst.org.nz/wp-content/uploads/2017/03/Abortion-Mental-Health-Results-2016.pdf>

the statement, 21% were unsure or didn't say, and only 33% disagreed. Significantly, strongest agreement with the statement came from the younger 18-40 age bracket (50%).

Full results – Appendix 2

- A 2011 poll³³ found that the majority of New Zealanders (64%) believe that women considering an abortion have the right to be fully informed of the medical risks of abortion – and the alternatives.

Full results – Appendix 3

- A 2010 poll³⁴ found that 79% of respondents think parents should be notified if their daughter aged under 16 is seeking an abortion. And a 2011 poll³⁵ of 600 teenagers (15-21) nationwide found that 59% of young respondents thought the parents should be told if their school-age daughter is considering getting an abortion, so long as it won't put her in physical danger. 56% of youth respondents also said they believe an unborn child or foetus has a right to be born. Slightly more young women than young men agreed – 58% to 55%.

Full results – Appendix 4

Contrary to misrepresentation by pro-abortion groups, New Zealand women are either satisfied with the current regulation of abortion or want it made more restrictive. Women are not made criminals by the current legislative guidelines and protections. To claim otherwise is simply false scaremongering aimed at deceiving people into supporting the introduction of an extreme abortion law in New Zealand. The existing safeguards are there to protect women from unlicensed premises and coercion, and they are ones most New Zealanders support.

Our concern is that taking away the current safeguards will simply result in women being rushed or pressured into abortions that they don't actually want, and which the current system helps to protect against. Coercion to have an abortion is a big issue for some women.

Summary

As the *Women's Forum Australia* (WFA) said in their submission to the Queensland (Australia) review of their law relating to termination of pregnancy (2018)³⁶, for our society to be genuinely pro-woman on the sensitive issue of unplanned pregnancy, it is critical for us to consider legislation, policy and practices in a holistic and considered way. Simply focusing on providing women with the apparent 'choice of abortion' whenever they want it does not address or resolve the crux of the problem – that is, it does not resolve the underlying issues which make a woman feel, when faced with an unplanned pregnancy, that terminating it is her *only* choice.

WFA rightly argues that any legislative reform in this area should be directed at addressing the following issues, rather than simply seeking to facilitate greater access to abortion and calling it a "health issue":

- First, any legislative reform must include safeguards to ensure that women who seek abortions are giving fully informed consent. These include mandatory provision of information about risks, foetal development and alternatives to abortion, the opportunity to view ultrasounds and receive counselling independent of abortion providers, and the time and space necessary to make a decision. These safeguards are critical to ensure that women can make a real "choice" when it comes to abortion.

³³ <http://www.chooselife.org.nz/media-release/two-out-of-three-support-informed-consent-on-abortion/>

³⁴ <https://www.familyfirst.org.nz/wp-content/uploads/2011/02/Parental-Notification-Final-Results-Mar-2010.pdf>

³⁵ <https://www.familyfirst.org.nz/wp-content/uploads/2011/02/sex-ed-parental-notification-abortion-poll.doc>

³⁶ <http://www.womensforumaustralia.com/LiteratureRetrieve.aspx?ID=238529>

- Second, such reform must also attempt to address the societal issues that might make women view abortion as their only choice. Women who abort often cite reasons such as fear of intimate partner violence,³⁷ coercion from their partner or others, psychological pressures due to the pregnancy or otherwise, study and career pressures, and/or a lack of financial and emotional support.³⁸ Abortion under these circumstances is not choice - it's desperation. Instead of simply providing women with the so-called 'choice' of abortion on demand, in an attempt to address the symptoms of their situation, any reform must strive to address the underlying causes of abortion and to provide women with positive alternatives that are not going to expose them to further harm.³⁹ This includes much-needed adoption law reform, as well as addressing issues of domestic violence, access and affordability of childcare, flexible workplace and study arrangements and access to pregnancy and counselling support.
- Thirdly, any legislative reform must include protections against social abortions, late-term abortions and abortions on the basis of sex or disability. Abortion is a procedure with serious consequences for both the woman and her preborn child and should not be treated simply like any other medical procedure. Sex selective abortion in particular is something feminists on both sides of the political spectrum should be concerned about, as it is by and large females who stand to bear the brunt of discrimination, in keeping with international trends.⁴⁰
- Finally, whether one attributes moral significance or human rights to the preborn child, the biological reality is that abortion ends the life of a developing human being in its mother's womb. It is appropriate that the law includes deterrents for something as serious as this, and this is also recognised in offences such as '*Killing Unborn Child*',⁴¹ which aptly holds that it is a criminal offence for a person to assault a pregnant woman and kill or harm her preborn child.

Thank you for your consideration of this very important social issue.



Bob McCoskrie
National Director

³⁷ Taft AJ and Watson LF (2007), Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women, *Australian and New Zealand Journal of Public Health* Vol 31, No 2, pp 135-142.

³⁸ Finer LB, Frohworth LF, Dauphinee LA, Singh S and Moore AM (2005), Reasons U.S. women have abortions: quantitative and qualitative perspectives, *Perspectives on Sexual and Reproductive Health* Vol 37, No 2, pp 110-118.

³⁹ Coleman PK (2011), Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009, *The British Journal of Psychiatry* Aug 2011, Vol 199, No 3, pp 180-186.

⁴⁰ Hvistendahl, M, 2011, *Unnatural Selection: Choosing Boys Over Girls and the Consequences of a World Full of Men*, Public Affairs Publishing.

⁴¹ <http://www.legislation.govt.nz/act/public/1961/0043/137.0/DLM329352.html>

APPENDIX 1

ABORTION POLL December 2017

CLIENT:	Family First New Zealand
POLL DATES:	Mon 11 to Wed 13 December 2017. The median response was collected on Tue 12 December 2017.
TARGET POPULATION:	Eligible New Zealand voters.
SAMPLE POPULATION:	Eligible New Zealand voters who are contactable on a landline or mobile phone.
SAMPLE SIZE:	1,000 respondents agreed to participate.
SAMPLE SELECTION:	A random selection of 12,500 nationwide phone numbers.
WEIGHTING:	The results are weighted to reflect the overall voting adult population in terms of gender, age, area and deprivation.
SAMPLE ERROR:	Based on this sample of 1,000 respondents, the maximum sampling error (for a result of 50%) is +/- 3.1%, at the 95% confidence level.
CODE COMPLIANCE:	This poll was conducted in accordance with the New Zealand Political Polling Code, the Research Association New Zealand Code of Practice and the International Chamber of Commerce/European Society for Opinion and Market Research Code on Market and Social Research.



1. Would you describe yourself generally as someone who supports abortion or someone who opposes abortion?

Abortion

		Count	Col %
Abortion	Support	524	52%
	Oppose	298	29%
	Unsure/Refuse	190	19%
	Total	1013	100%

52% of respondents said they generally support abortion and 29% oppose. 19% unsure.

Abortion BY Gender

		Gender	
		Female	Male
		Col %	Col %
Abortion	Support	58%	46%
	Oppose	24%	35%
	Unsure/Refuse	18%	19%
	Total	100%	100%

Net support is +34% for women and +11% for men.

Abortion BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Abortion	Support	47%	55%	54%
	Oppose	34%	26%	28%
	Unsure/Refuse	19%	19%	18%
	Total	100%	100%	100%

Abortion BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Abortion	Support	59%	59%	35%
	Oppose	28%	24%	39%
	Unsure/Refuse	14%	17%	26%
	Total	100%	100%	100%

Less support for abortion in areas with high deprivation.

Abortion BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Abortion	Support	52%	56%	82%	45%	50%	25%
	Oppose	31%	21%	18%	23%	38%	63%
	Unsure/Refuse	16%	23%	0%	32%	12%	11%
	Total	100%	100%	100%	100%	100%	100%

Abortion BY Party Vote 2017

		Party Vote 2017					
		National	Labour	NZ First	Greens	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Abortion	Support	55%	59%	43%	88%	47%	32%
	Oppose	33%	26%	37%	12%	38%	31%
	Unsure/Refuse	12%	16%	20%	0%	15%	37%
	Total	100%	100%	100%	100%	100%	100%

NZ First supporters most opposed and Greens most supportive.

2. The latest government figures show that just under 13,000 abortions took place in NZ in 2016, down from more than 18,000 recorded in 2007. Regardless of differing views on the legality of abortion, do you agree or disagree that, as a society, we should be working together to reduce the number of abortions?

<And is that strongly agree/disagree or somewhat agree/disagree>

Reduce abortions

		Count	Col %
Reduce abortions	Strongly disagree	110	11%
	Somewhat disagree	63	6%
	Neutral	127	13%
	Somewhat agree	330	33%
	Strongly agree	322	32%
	Unsure/Refuse	58	6%
	Total	1010	100%

65% of respondents agree that society should work together to reduce the number of abortions and only 17% disagree.

Reduce abortions BY Gender

		Gender	
		Female	Male
		Col %	Col %
Reduce abortions	Strongly disagree	6%	15%
	Somewhat disagree	5%	7%
	Neutral	10%	15%
	Somewhat agree	34%	31%
	Strongly agree	40%	25%
	Unsure/Refuse	5%	6%
	Total	100%	100%

Net agreement by gender is +63% for women and +34% for men.

Reduce abortions BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Reduce abortions	Strongly disagree	18%	8%	5%
	Somewhat disagree	4%	7%	8%
	Neutral	14%	8%	17%
	Somewhat agree	33%	35%	29%
	Strongly agree	26%	36%	34%
	Unsure/Refuse	5%	6%	7%
	Total	100%	100%	100%

Reduce abortions BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Reduce abortions	Strongly disagree	13%	11%	6%
	Somewhat disagree	7%	4%	7%
	Neutral	16%	8%	10%
	Somewhat agree	31%	38%	30%
	Strongly agree	29%	30%	42%
	Unsure/Refuse	4%	10%	5%
	Total	100%	100%	100%

Reduce abortions BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Reduce abortions	Strongly disagree	15%	4%	15%
	Somewhat disagree	7%	7%	5%
	Neutral	10%	10%	19%
	Somewhat agree	34%	35%	28%
	Strongly agree	30%	35%	30%
	Unsure/Refuse	4%	9%	3%
	Total	100%	100%	100%

Reduce abortions BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Reduce abortions	Strongly disagree	4%	18%	0%	16%	4%	0%
	Somewhat disagree	7%	4%	5%	10%	10%	6%
	Neutral	7%	16%	0%	15%	24%	0%
	Somewhat agree	35%	31%	77%	22%	39%	15%
	Strongly agree	38%	27%	18%	30%	24%	67%
	Unsure/Refuse	8%	5%	0%	7%	0%	13%
	Total	100%	100%	100%	100%	100%	100%

Reduce abortions BY Party Vote 2017

		Party Vote 2017					
		National	Labour	NZ First	Greens	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Reduce abortions	Strongly disagree	5%	13%	1%	1%	1%	23%
	Somewhat disagree	6%	5%	7%	24%	6%	5%
	Neutral	12%	12%	11%	3%	18%	15%
	Somewhat agree	35%	39%	34%	32%	36%	19%
	Strongly agree	36%	23%	39%	38%	27%	35%
	Unsure/Refuse	6%	7%	9%	2%	11%	3%
	Total	100%	100%	100%	100%	100%	100%

Reduce abortions BY View on Abortion

		View on Abortion			
		Support	Oppose	Unsure/Refuse	Total
		Col %	Col %	Col %	Col %
Reduce abortions	Strongly disagree	8%	8%	25%	11%
	Somewhat disagree	11%	1%	3%	6%
	Neutral	13%	9%	17%	13%
	Somewhat agree	42%	28%	15%	33%
	Strongly agree	21%	51%	31%	32%
	Unsure/Refuse	5%	4%	11%	6%
	Total	100%	100%	100%	100%

Of those who generally support abortion 63% agree we should reduce the number of abortions and 19% disagree.

3. The law currently makes it illegal for abortions to be performed by unregistered abortion providers or on unlicensed premises - do you agree or disagree with these legal requirements?

Require abortion providers and premises to be registered

		Count	Col %
Require abortion providers and premises to be registered	Strongly disagree	76	7%
	Somewhat disagree	11	1%
	Neutral	14	1%
	Somewhat agree	169	17%
	Strongly agree	696	69%
	Unsure/Refuse	46	5%
	Total	1013	100%

86% support providers and premises to be licensed with only 8% disagreeing.

Require abortion providers and premises to be registered BY Gender

		Gender	
		Female	Male
		Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	5%	10%
	Somewhat disagree	0%	2%
	Neutral	0%	2%
	Somewhat agree	17%	17%
	Strongly agree	76%	61%
	Unsure/Refuse	2%	7%
	Total	100%	100%

Require abortion providers and premises to be registered BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	13%	5%	2%
	Somewhat disagree	0%	2%	2%
	Neutral	3%	1%	1%
	Somewhat agree	23%	14%	12%
	Strongly agree	52%	77%	81%
	Unsure/Refuse	9%	2%	3%
	Total	100%	100%	100%

Require abortion providers and premises to be registered BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	11%	6%	2%
	Somewhat disagree	0%	1%	2%
	Neutral	1%	0%	3%
	Somewhat agree	15%	18%	20%
	Strongly agree	65%	74%	72%
	Unsure/Refuse	7%	1%	2%
	Total	100%	100%	100%

Require abortion providers and premises to be registered BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	6%	6%	11%
	Somewhat disagree	0%	2%	1%
	Neutral	1%	3%	0%
	Somewhat agree	12%	19%	19%
	Strongly agree	79%	68%	58%
	Unsure/Refuse	1%	3%	10%
	Total	100%	100%	100%

Require abortion providers and premises to be registered BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	4%	12%	0%	2%	3%	0%
	Somewhat disagree	1%	1%	1%	1%	0%	0%
	Neutral	2%	1%	0%	0%	0%	2%
	Somewhat agree	15%	13%	29%	6%	44%	20%
	Strongly agree	71%	71%	70%	90%	43%	64%
	Unsure/Refuse	7%	1%	0%	1%	9%	15%
	Total	100%	100%	100%	100%	100%	100%

Require abortion providers and premises to be registered BY Party Vote 2017

		Party Vote 2017					
		National	Labour	NZ First	Greens	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	4%	3%	2%	0%	11%	21%
	Somewhat disagree	0%	1%	1%	0%	17%	1%
	Neutral	1%	0%	2%	17%	0%	1%
	Somewhat agree	18%	21%	15%	25%	0%	10%
	Strongly agree	75%	68%	80%	58%	73%	59%
	Unsure/Refuse	2%	7%	1%	0%	0%	8%
	Total	100%	100%	100%	100%	100%	100%

Require abortion providers and premises to be registered BY View on Abortion

		View on Abortion			
		Support	Oppose	Unsure/Refuse	Total
		Col %	Col %	Col %	Col %
Require abortion providers and premises to be registered	Strongly disagree	4%	7%	17%	7%
	Somewhat disagree	1%	1%	0%	1%
	Neutral	2%	1%	1%	1%
	Somewhat agree	19%	14%	15%	17%
	Strongly agree	73%	64%	64%	69%
	Unsure/Refuse	1%	12%	4%	5%
	Total	100%	100%	100%	100%

4. The law currently makes it a crime for abortions to be performed by a doctor on a woman after a certain number of weeks of pregnancy, except in exceptional circumstances. What do you think the time limit should be for legally performing an abortion, in terms of weeks?

Time limit for abortions

		Count	Col %
Time limit for abortions	5 weeks	75	7%
	10 weeks	172	17%
	15 weeks	169	17%
	20 weeks	96	9%
	30 weeks	15	2%
	40 weeks (up to birth)	24	2%
	Never allow	94	9%
	Unsure/Refuse	367	36%
	Total	1013	100%

36% of respondents were unsure what the time limit for abortions should be. 9% were against allowing abortions at any time. Of those who did pick a time limit, 15 weeks was the median choice.

Time limit for abortions BY Gender

		Gender	
		Female	Male
		Col %	Col %
Time limit for abortions	5 weeks	8%	7%
	10 weeks	21%	13%
	15 weeks	17%	16%
	20 weeks	8%	10%
	30 weeks	3%	0%
	40 weeks (up to birth)	2%	3%
	Never allow	10%	9%
	Unsure/Refuse	31%	41%
	Total	100%	100%

Time limit for abortions BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Time limit for abortions	5 weeks	6%	7%	10%
	10 weeks	15%	17%	19%
	15 weeks	14%	20%	16%
	20 weeks	12%	9%	6%
	30 weeks	3%	1%	1%
	40 weeks (up to birth)	3%	2%	2%
	Never allow	12%	8%	7%
	Unsure/Refuse	36%	35%	38%
	Total	100%	100%	100%

Time limit for abortions BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Time limit for abortions	5 weeks	8%	6%	9%
	10 weeks	13%	25%	17%
	15 weeks	17%	21%	12%
	20 weeks	13%	4%	7%
	30 weeks	1%	3%	1%
	40 weeks (up to birth)	2%	1%	5%
	Never allow	6%	11%	17%
	Unsure/Refuse	41%	29%	33%
	Total	100%	100%	100%

Time limit for abortions BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Time limit for abortions	5 weeks	9%	7%	5%
	10 weeks	18%	23%	8%
	15 weeks	14%	19%	17%
	20 weeks	9%	14%	3%
	30 weeks	3%	2%	0%
	40 weeks (up to birth)	4%	2%	2%
	Never allow	8%	6%	14%
	Unsure/Refuse	35%	27%	50%
	Total	100%	100%	100%

Time limit for abortions BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Time limit for abortions	5 weeks	3%	10%	1%	5%	8%	2%
	10 weeks	20%	15%	18%	24%	11%	6%
	15 weeks	20%	18%	53%	8%	9%	2%
	20 weeks	10%	9%	6%	4%	19%	0%
	30 weeks	2%	1%	0%	0%	3%	0%
	40 weeks (up to birth)	2%	4%	0%	1%	1%	4%
	Never allow	12%	6%	11%	2%	9%	43%
	Unsure/Refuse	32%	36%	11%	57%	41%	44%
	Total	100%	100%	100%	100%	100%	100%

Time limit for abortions BY Party Vote 2017

		Party Vote 2017					
		National Col %	Labour Col %	NZ First Col %	Greens Col %	Others Col %	Not Vote/Unsure Col %
Time limit for abortions	5 weeks	5%	10%	6%	1%	12%	9%
	10 weeks	20%	18%	13%	17%	0%	12%
	15 weeks	21%	15%	19%	20%	25%	10%
	20 weeks	9%	7%	0%	20%	15%	12%
	30 weeks	0%	4%	3%	0%	11%	0%
	40 weeks (up to birth)	1%	5%	4%	3%	0%	1%
	Never allow	11%	5%	10%	0%	7%	13%
	Unsure/Refuse	32%	36%	45%	38%	30%	42%
	Total	100%	100%	100%	100%	100%	100%

Time limit for abortions BY View on Abortion

		View on Abortion			
		Support Col %	Oppose Col %	Unsure/Refuse Col %	Total Col %
Time limit for abortions	5 weeks	7%	11%	5%	7%
	10 weeks	22%	12%	11%	17%
	15 weeks	24%	8%	12%	17%
	20 weeks	12%	6%	9%	9%
	30 weeks	3%	0%	0%	2%
	40 weeks (up to birth)	4%	1%	1%	2%
	Never allow	0%	31%	1%	9%
	Unsure/Refuse	29%	33%	62%	36%
	Total	100%	100%	100%	100%

- 5. Sex selective abortion is the practice of terminating a pregnancy based upon the sex of the unborn baby, most commonly when it is a girl. Do you support or oppose someone being able to have an abortion based solely on the sex of the child?**

Sex selective abortions

		Count	Col %
Sex selective abortions	Support	44	4%
	Oppose	912	90%
	Unsure/Refuse	57	6%
	Total	1013	100%

Only 4% of respondents support someone being able to have an abortion based solely on the sex of the child.

Sex selective abortions BY Gender

		Gender	
		Female	Male
		Col %	Col %
Sex selective abortions	Support	1%	7%
	Oppose	94%	86%
	Unsure/Refuse	4%	7%
	Total	100%	100%

Sex selective abortions BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Sex selective abortions	Support	8%	3%	2%
	Oppose	83%	95%	94%
	Unsure/Refuse	10%	2%	4%
	Total	100%	100%	100%

Sex selective abortions BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Sex selective abortions	Support	5%	3%	6%
	Oppose	89%	94%	86%
	Unsure/Refuse	6%	3%	8%
	Total	100%	100%	100%

Sex selective abortions BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Sex selective abortions	Support	6%	5%	1%
	Oppose	92%	90%	89%
	Unsure/Refuse	2%	5%	10%
	Total	100%	100%	100%

Sex selective abortions BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Sex selective abortions	Support	2%	2%	0%	1%	11%	7%
	Oppose	90%	94%	100%	95%	89%	65%
	Unsure/Refuse	8%	3%	0%	4%	0%	28%
	Total	100%	100%	100%	100%	100%	100%

Sex selective abortions BY Party Vote 2017

		Party Vote 2017					
		National	Labour	NZ First	Greens	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Sex selective abortions	Support	3%	2%	4%	5%	0%	10%
	Oppose	94%	89%	96%	95%	100%	82%
	Unsure/Refuse	3%	9%	0%	0%	0%	8%
	Total	100%	100%	100%	100%	100%	100%

Sex selective abortions BY View on Abortion

		View on Abortion			
		Support	Oppose	Unsure/Refuse	Total
		Col %	Col %	Col %	Col %
Sex selective abortions	Support	5%	5%	2%	4%
	Oppose	91%	87%	92%	90%
	Unsure/Refuse	4%	8%	7%	6%
	Total	100%	100%	100%	100%

Do you support or oppose a someone being able to have an abortion just because she doesn't want to be a mother?

Woman doesn't want to be mother abortions

		Count	Col %
Woman doesn't want to be mother abortions	Support	500	49%
	Oppose	382	38%
	Unsure/Refuse	131	13%
	Total	1013	100%

Woman doesn't want to be mother abortions BY Gender

		Gender	
		Female	Male
		Col %	Col %
Woman doesn't want to be mother abortions	Support	48%	50%
	Oppose	34%	41%
	Unsure/Refuse	18%	8%
	Total	100%	100%

Woman doesn't want to be mother abortions BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	58%	45%	43%
	Oppose	32%	42%	40%
	Unsure/Refuse	10%	12%	18%
	Total	100%	100%	100%

Woman doesn't want to be mother abortions BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	50%	50%	49%
	Oppose	36%	40%	39%
	Unsure/Refuse	14%	10%	12%
	Total	100%	100%	100%

Woman doesn't want to be mother abortions BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	55%	50%	44%
	Oppose	34%	37%	43%
	Unsure/Refuse	11%	14%	14%
	Total	100%	100%	100%

Woman doesn't want to be mother abortions BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	47%	55%	30%	44%	48%	21%
	Oppose	38%	35%	70%	35%	42%	54%
	Unsure/Refuse	15%	9%	0%	20%	10%	25%
	Total	100%	100%	100%	100%	100%	100%

Woman doesn't want to be mother abortions BY Party Vote 2017

		Party Vote 2017					
		National	Labour	NZ First	Greens	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	41%	54%	38%	73%	81%	52%
	Oppose	48%	32%	57%	22%	19%	28%
	Unsure/Refuse	10%	13%	6%	6%	0%	20%
	Total	100%	100%	100%	100%	100%	100%

Woman doesn't want to be mother abortions BY View on Abortion

		View on Abortion			
		Support	Oppose	Unsure/Refuse	Total
		Col %	Col %	Col %	Col %
Woman doesn't want to be mother abortions	Support	66%	22%	47%	49%
	Oppose	23%	68%	31%	38%
	Unsure/Refuse	11%	10%	22%	13%
	Total	100%	100%	100%	100%

- 6. Some say a factor that can be involved in a woman's decision to have an abortion is pressure from another person such as a partner or a family member. Some people have proposed doctors should be legally required to verify that a woman seeking an abortion is not under pressure from a third party. Do you support or oppose the proposal?**

Verify woman not under third party pressure to abort

		Count	Col %
Verify woman not under third party pressure to abort	Support	766	76%
	Oppose	84	8%
	Unsure/Refuse	160	16%
	Total	1010	100%

Verify woman not under third party pressure to abort BY Gender

		Gender	
		Female	Male
		Col %	Col %
Verify woman not under third party pressure to abort	Support	83%	69%
	Oppose	7%	9%
	Unsure/Refuse	9%	22%
	Total	100%	100%

Verify woman not under third party pressure to abort BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Verify woman not under third party pressure to abort	Support	71%	84%	71%
	Oppose	3%	11%	12%
	Unsure/Refuse	26%	5%	16%
	Total	100%	100%	100%

Verify woman not under third party pressure to abort BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Verify woman not under third party pressure to abort	Support	72%	87%	72%
	Oppose	7%	8%	13%
	Unsure/Refuse	22%	5%	14%
	Total	100%	100%	100%

Verify woman not under third party pressure to abort BY Deprivation

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Verify woman not under third party pressure to abort	Support	85%	77%	64%
	Oppose	5%	9%	11%
	Unsure/Refuse	10%	13%	25%
	Total	100%	100%	100%

Verify woman not under third party pressure to abort BY Household

		Household					
		Partner and kids	Partner only	Live with others	Live alone	Other	Unsure
		Col %	Col %	Col %	Col %	Col %	Col %
Verify woman not under third party pressure to abort	Support	82%	73%	88%	74%	88%	7%
	Oppose	9%	7%	1%	12%	8%	11%
	Unsure/Refuse	9%	20%	11%	14%	4%	82%
	Total	100%	100%	100%	100%	100%	100%

Verify woman not under third party pressure to abort BY Party Vote 2017

		Party Vote 2017					
		National Col %	Labour Col %	NZ First Col %	Greens Col %	Others Col %	Not Vote/Unsure Col %
Verify woman not under third party pressure to abort	Support	88%	76%	86%	91%	88%	50%
	Oppose	7%	12%	7%	4%	6%	8%
	Unsure/Refuse	5%	12%	7%	5%	6%	42%
	Total	100%	100%	100%	100%	100%	100%

Verify woman not under third party pressure to abort BY View on Abortion

		View on Abortion			
		Support Col %	Oppose Col %	Unsure/Refuse Col %	Total Col %
Verify woman not under third party pressure to abort	Support	84%	73%	57%	76%
	Oppose	8%	4%	16%	8%
	Unsure/Refuse	7%	24%	27%	16%
	Total	100%	100%	100%	100%

MARGINS OF ERROR

The following maximum sampling margin of errors apply for each demographic group:

- All 3.1%
- Women 4.0%
- Men 4.9%
- Under 40s 9.2%
- 41 to 60 4.8%
- Over 60s 4.5%
- Metro 5.2%
- Provincial 6.1%
- Rural 5.0%
- Deciles 1 to 3 6.3%
- Deciles 4 to 7 4.0%
- Deciles 8 to 10 7.7%
- Partner and kids 5.4%
- Partner only 4.8%
- Live alone 8.2%
- National voters 4.9%
- Labour voters 5.8%
- NZ First voters 11%
- Green voters 16%

- Other voters 21%
- Unsure voters 7.4%

David Farrar
Director
Curia Market Research

December 2017

APPENDIX 2

ABORTION (Mental Health) POLL November 2016

CLIENT:	Family First New Zealand
POLL DATES:	Wed 23 to Wed 30 November 2016. The median response was collected on Sun 27 November 2016.
TARGET POPULATION:	Eligible New Zealand voters.
SAMPLE POPULATION:	Eligible New Zealand voters who are contactable on a landline.
SAMPLE SIZE:	846 respondents agreed to participate.
SAMPLE SELECTION:	A random selection of 15,000 nationwide phone numbers.
WEIGHTING:	The results are weighted to reflect the overall voting adult population in terms of gender, age, and area.
SAMPLE ERROR:	Based on this sample of 846 respondents, the maximum sampling error (for a result of 50%) is +/- 3.4%, at the 95% confidence level.
CODE COMPLIANCE:	This poll was conducted in accordance with the New Zealand Political Polling Code, the Research Association New Zealand Code of Practice and the International Chamber of Commerce/European Society for Opinion and Market Research Code on Market and Social Research.



Women who have abortions risk harming their mental health as a result of the abortion

Women who have abortions risk harming their mental health as a result of the abortion

		Count	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	379	46%
	Disagree	271	33%
	Unsure/Refuse	178	22%
	Total	827	100%

Women who have abortions risk harming their mental health as a result of the abortion BY Gender

		Gender	
		Female	Male
		Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	46%	45%
	Disagree	38%	27%
	Unsure/Refuse	16%	28%
	Total	100%	100%

Women who have abortions risk harming their mental health as a result of the abortion BY Age

		Age		
		18 - 40	41 - 60	61+
		Col %	Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	50%	41%	47%
	Disagree	28%	40%	29%
	Unsure/Refuse	22%	18%	25%
	Total	100%	100%	100%

Women who have abortions risk harming their mental health as a result of the abortion BY Area

		Area		
		Metro	Provincial	Rural
		Col %	Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	42%	55%	41%
	Disagree	34%	31%	32%
	Unsure/Refuse	24%	14%	26%
	Total	100%	100%	100%

**Women who have abortions risk harming their mental health as a result of the abortion BY
Deprivation**

		Deprivation		
		Deciles 1 - 3	Deciles 4 - 7	Deciles 8 - 10
		Col %	Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	42%	47%	48%
	Disagree	31%	33%	34%
	Unsure/Refuse	26%	20%	19%
	Total	100%	100%	100%

**Women who have abortions risk harming their mental health as a result of the abortion BY
Parent of child under 18**

		Parent of child under 18	
		Yes	No
		Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	49%	44%
	Disagree	32%	33%
	Unsure/Refuse	18%	23%
	Total	100%	100%

**Women who have abortions risk harming their mental health as a result of the abortion BY Party
Vote 2014**

		Party Vote 2014			
		Nat	Lab	NZF	Gre
		Col %	Col %	Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	44%	43%	51%	29%
	Disagree	33%	38%	32%	47%
	Unsure/Refuse	23%	19%	17%	24%
	Total	100%	100%	100%	100%

		Party Vote 2014			
		National	Labour	Others	Not Vote/Unsure
		Col %	Col %	Col %	Col %
Women who have abortions risk harming their mental health as a result of the abortion	Agree	44%	43%	41%	53%
	Disagree	33%	38%	36%	26%
	Unsure/Refuse	23%	19%	23%	20%
	Total	100%	100%	100%	100%

MARGINS OF ERROR

The following maximum sampling margin of errors apply for each demographic group:

- All 3.4%
- Women 4.3%
- Men 5.4%
- Under 40s 9.5%
- 41 to 60 5.2%
- Over 60s 5.0%
- Metro 5.2%
- Provincial 6.3%
- Rural 6.3%
- Deciles 1 to 3 5.4%
- Deciles 4 to 7 5.2%
- Deciles 8 to 10 7.8%
- Parents 7.2%
- Non-parents 3.8%
- National voters 5.4%
- Labour voters 7.4%
- Other voters 9.6%
- Unsure voters 6.9%

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11 December 2016

APPENDIX 3

ABORTION ADVICE POLL March 2011

CLIENT:	Family First New Zealand
POLL DATES:	Evenings of Thursday 10, Sunday 13 and Thursday 17 March 2011
SAMPLE SIZE:	1,000 respondents agreed to participate.
SAMPLE SELECTION:	A random selection of 10,000 nationwide phone numbers, with the person in the household aged 18+ who next has a birthday asked to participate.
SAMPLE ERROR:	Based on this sample of 1,000 respondents, the maximum sampling error (for a result of 50%) is +/- 3.2%, at the 95% confidence level.

ABORTION ADVICE

Would you support a law that would require a woman considering an abortion to first see a doctor, who is not an abortion provider, to be informed of the medical risks and alternatives to abortion?

Require abortion seekers to see a non provider first

	Count	Col %
Require abortion seekers to see a non provider first Yes	631	64%
No	285	29%
Unsure/Refuse	75	8%

64% of respondents support abortion seekers being required to see a doctor who does not provide abortions initially.

Require abortion seekers to see a non provider first BY Gender + Age + Area

		Gender		Age				Area		
		Female	Male	18 - 30	31 - 45	46 - 60	61+	Metro	Provincial	
		Col %	Col %	Col %	Col %	Col %	Col %	Col %	Col %	
Require abortion seekers to see a non provider first Yes		65%	62%	62%	55%	67%	65%	60%	66%	
No		28%	30%	32%	35%	28%	26%	32%	27%	
Unsure/Refuse		7%	8%	6%	10%	5%	9%	8%	7%	

Somewhat surprisingly, **women slightly more in favour of this restriction, than men.**

DEMOGRAPHICS

Gender

		Count	Col %
Gender	Female	568	57%
	Male	420	43%
	Total	988	100%

Age

		Count	Col %
Age	18 - 30	50	5%
	31 - 45	176	18%
	46 - 60	362	37%
	61+	402	41%
	Total	990	100%

Area

		Count	Col %
Area	Metro	415	42%
	Provincial	273	27%
	Rural	312	31%
	Total	1000	100%

Metro is defined as Auckland, Wellington and Christchurch.

Provincial is all other cities in New Zealand.

Rural areas are all areas not Metro or Provincial.

Have children under 12

		Count	Col %
Have children under 12	Yes	195	20%
	No	792	80%
	Total	987	100%

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18 March 2011

APPENDIX 4

PARENTAL NOTIFICATION POLL Mar 2010

CLIENT:	Family First New Zealand
POLL DATES:	Evenings of Wednesday 24, Thursday 25 March and Sunday 28 March 2010
SAMPLE SIZE:	1,000 respondents agreed to participate.
SAMPLE SELECTION:	A random selection of 10,000 nationwide phone numbers.
SAMPLE ERROR:	Based on this sample of 1,000 respondents, the maximum sampling error (for a result of 50%) is +/- 3.2%, at the 95% confidence level.

DEMOGRAPHICS

	Gender	
	Count	%
Female	528	53%
Male	472	47%
Total	1000	100%

	Age	
	Count	%
18 - 40	300	30%
41 - 60	518	52%
61+	182	18%
Total	1000	100%

	Area	
	Count	%
Metro	435	44%
Provincial	252	25%
Rural	313	31%
Total	1000	100%

Metro is defined as Auckland, Wellington and Christchurch.

Provincial is all other cities in New Zealand.

Rural areas are all areas not Metro or Provincial.

	Have children under 12
--	------------------------

	Count	%
Yes	296	30%
No	704	70%
Total	1000	100%

PARENTAL NOTIFICATION FOR ABORTIONS?

Should the law require parents to always be informed before-hand if their daughter who is under 16 is pregnant and wants to have an abortion?

		Gender		Age			Total
		Female	Male	18 - 40	41 - 60	61+	
		Col %	Col %	Col %	Col %	Col %	Col %
Parental notification for under 16 yr old's abortions	Yes	79%	79%	80%	77%	84%	79%
	No	13%	11%	12%	14%	7%	12%
	Don't Know	6%	11%	9%	9%	7%	8%
	Refused	1%			0%	2%	1%
Total		100%	100%	100%	100%	100%	100%

79% of respondents think parents should be notified if their daughter is aged under 16 and is seeking an abortion. Older respondents more strongly agree, but **no difference by gender.**

		Area			Have children under 12		Total
		Metro	Provincial	Rural	Yes	No	
		Col %	Col %	Col %	Col %	Col %	Col %
Parental notification for under 16 yr old's abortions	Yes	79%	75%	82%	75%	81%	79%
	No	11%	15%	11%	14%	11%	12%
	Don't Know	9%	10%	6%	10%	8%	8%
	Refused	1%		1%	1%	0%	1%
Total		100%	100%	100%	100%	100%	100%

Those without children aged under 12 are slightly more supportive of parental notification than those who do have children under 12.

PARENTAL NOTIFICATION POLL OF TEENAGERS AND YOUNG ADULTS December 2011

CLIENT: Family First New Zealand

POLL DATES: Evenings of Sunday 4 to Tuesday 6 December 2011

SAMPLE SIZE: 600 respondents agreed to participate.

SAMPLE SELECTION: A random selection of 6,000 nationwide phone numbers, with anyone at home aged between 15 and 21 inclusive asked to take part.

SAMPLE ERROR: Based on this sample of 600 respondents, the maximum sampling error (for a result of 50%) is +/- 4.1%, at the 95% confidence level.

PARENTAL NOTIFICATION

Provided it won't put the girl in physical danger, should parents be told if their school-age daughter is pregnant and considering getting an abortion?

Tell parents if school-age daughter is considering abortion BY Gender + Age + Area

		Gender		Age			Area		
		Female	Male	15 - 17	18 - 19	20 - 21	Metro	Provincial	Rural
		Col %	Col %	Col %	Col %	Col %	Col %	Col %	Col %
Tell parents if school-age daughter is considering abortion	Yes	54%	63%	60%	57%	58%	58%	61%	58%
	No	37%	32%	35%	37%	31%	34%	34%	35%
	Unsure/Refuse	9%	5%	5%	7%	11%	8%	5%	8%

59% of young respondents thought the parents should be told if their school-age daughter is considering getting an abortion, so long as it won't put her in physical danger. More young men than women agreed, but both had majority agreement. 7% were unsure.

ABORTION

Do you believe an unborn child or foetus has a right to be born?

Unborn child or foetus has a right to be born BY Gender + Age + Area

		Gender		Age			Area		
		Female	Male	15 - 17	18 - 19	20 - 21	Metro	Provincial	Rural
		Col %	Col %	Col %	Col %	Col %	Col %	Col %	Col %
Unborn child or foetus has a right to be born	Yes	58%	55%	66%	47%	54%	56%	64%	48%
	No	28%	27%	25%	28%	33%	26%	27%	32%
	Unsure/Refuse	14%	18%	9%	25%	13%	17%	9%	20%

56% of youth respondents said they believe an unborn child or foetus has a right to be born. Slightly more young women than young men agreed – 58% to 55%. Those aged 15 to 17 were strongest in support – 66%.

DEMOGRAPHICS

Gender

		Count	Col %
Gender	Female	307	51%
	Male	293	49%
	Total	600	100%

Age

		Count	Col %
Age	15 – 17	255	43%
	18 – 19	208	35%
	20 – 21	137	23%
	Total	600	100%

Area

		Count	Col %
Area	Metro	303	51%
	Provincial	153	26%
	Rural	144	24%
	Total	600	100%

Metro is defined as Auckland, Wellington and Christchurch. Provincial is all other cities in New Zealand. Rural areas are all areas not Metro or Provincial.

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20 December 2011

APPENDIX 5

Abortion and the Physical and Mental Health of Women

A review of the evidence for health professionals

EXECUTIVE SUMMARY

Informed consent is one of the cornerstones of modern medical practice, expressed in numerous national and international codes of ethics, including that of the New Zealand Medical Association. It is just as applicable in relation to evidence about the effect of abortion on women as to any other procedure, and perhaps even more so because of the complex social, legal and ethical aspects of abortion.

This document is for health professionals and reviews international evidence to date about the relationship between abortion and the physical and mental health of women.

Women choose abortion for a wide variety of reasons including relationship problems, pressure from partners and family members, inability to cope, study and career aspirations, financial difficulties, lack of confidence as a mother, lack of community support, foetal disability and risk to her physical health.

Intimate partner violence (IPV) is strongly correlated with abortion, with some research showing a 6-fold increase of IPV in women undergoing abortion compared to those in antenatal care. Abortion has also been linked to international trafficking and slavery of women.

Ambivalence to abortion is common and is linked to some adverse post-abortion outcomes.

The prevalence of foetal abnormalities has increased in many countries and women commonly report a lack of information provided to them about the child's condition, and the options open to them.

The physical effects of abortion include an increased risk of premature delivery in subsequent pregnancies, and this appears to be related to surgical abortion but not medical abortion. However, when it comes to the overall incidence of complications, medical abortions outstrip surgical ones by a factor of at least four.

Significant inconsistencies exist in research about a possible link between abortion and the risk of breast cancer, yet there is evidence showing that carrying a pregnancy to term is protective against breast cancer.

Numerous studies have been undertaken about the relationship between abortion and overall mortality. While causal links cannot reliably be made, many studies have identified an increased risk of death in women undergoing abortion compared with those who have never been pregnant or carried a child to term, whether from suicide or other causes. Hence, pregnancy and carrying to term confer a protective effect even though the reasons are unclear. At the least, it is likely that there are common risk factors for both death and abortion.

The relationship between abortion and mental health has been the subject of intense research interest, yielding results that have not always been consistent. Nevertheless, there is clearly a correlation between abortion and adverse mental health outcomes.

A prominent researcher from the United States has argued that "[there is a] ... truly shameful and systematic bias that permeates the psychology of abortion. Professional organisations in the USA and elsewhere have arrogantly sought to distort the scientific literature and paternalistically deny women the information they deserve to make fully informed healthcare choices and receive necessary mental health counseling when and if an abortion decision proves detrimental."

Some researchers, including a research team from New Zealand, consider it possible that there is a casual link between abortion and harm to a woman's mental health; that is, abortion causes adverse mental health outcomes like depression, anxiety, substance abuse, and post-traumatic stress disorder, rather than there being simply a correlation between the two. Some studies consider it likely that 10% of the mental health burden results from abortion.

Many studies have also identified emotional distress after abortion, including feelings of sadness, loneliness, shame, guilt, grief, doubt, and regret. Some also report positive emotions like relief, happiness, and satisfaction.

When abortion is undertaken for foetal abnormality, the evidence is clearer – that abortion results in significant mental harm, including persistent grief, depression and post-traumatic stress.

In conclusion, abortion is associated with a wide range of adverse physical and psychological outcomes, and it is essential that women are made fully aware of all the risks. Presentation for abortion may also be an opportunity to address the risk of coercion and intimate partner violence.

INTRODUCTION

Women considering an abortion must be provided with accurate information about the procedure and its possible effects on their health – not least because it is most often carried out on healthy womenⁱ. Additionally, there are complex legal, social, ethical and personal questions relating to abortion that do not pertain to other procedures. Moreover, because ambivalence about an abortion decision is commonⁱⁱ, and ambivalence is related to post-abortion distress^{iii,iv,v}, the requirement to provide information is made even more acute.

Abortions have been conducted legally in many countries over the past few decades and considerable international research has been undertaken on the physical and psychological impact on women, and also on the circumstances surrounding the decision-making process.

The information that follows comes from this large body of research.

It should be noted that abortion research suffers from particular obstacles, one of which is reporting bias. In a prospective study of women aged 15 to 27, for example, the reported rate of abortion was 74% of what would be expected from national data sets^{vi}. In a Dutch cohort study, abortion history was clearly underreported, mentioned by only 1.2% of all women giving birth^{vii}. Underreporting of abortion leads to an underestimation of its effects^{viii}. Other sources of bias, expanded upon in the section on psychological effects below, include the fact that distressed women are often excluded from studies^{ix}, or refuse to participate. Moreover, many studies of the physical risks of abortion include only healthy women^x, specifically excluding women who are at higher risk of complications.

A significant amount of research begins and ends with the simple assertion that abortion, both medical and surgical, is 'safe'. This is particularly the case for politically driven research - for example to prove that abortion facilities don't need hospital admitting privileges or ambulatory surgical standards^{xi}, or to prove that women do not benefit from pre-abortion counselling^{xii,xiii}. However, risk and safety have subjective elements, and with regard to an abortion procedure, it is the woman herself who will interpret what the risks are and whether she considers abortion 'safe' or not, based on the information provided to her. Importantly, given the ongoing nature of much abortion research, definitive statements about safety are inappropriate.

This review of the evidence informs medical professionals of the issues that need to be raised with patients considering abortion. Medical professionals may consider providing an information sheet for patients.

MOTIVES UNDERLYING AN ABORTION DECISION

General

Medical practitioners need to be aware of the motivating factors that underlie an abortion decision, because there may be a need for referral to support services. For example, since intimate partner violence (IPV) is strongly correlated with abortion, practitioners need to ascertain whether a woman is at risk of physical, emotional or psychological harm^{xiv}. Or a woman may wish to proceed with pregnancy but does not have material support, necessitating referral to social services.

Some motivating factors may have implications for post-abortion effects, specifically mental health effects. For example, if a woman is motivated to have an abortion because of foetal disability, her risk for psychological harm is higher than if motivated by other reasons, like not being able to cope or fear of jeopardising her future^{xv}.

Deciding to have an abortion is far more complex than simply not intending to become pregnant^{xvi}. The concepts of pregnancy wantedness and intendedness are often used by researchers to understand why women might seek abortions. Yet women are ambivalent about pregnancy and abortion in ways that do not fall neatly into the categories some social scientists use for understanding ambivalence^{xvii}. Women rarely see babies themselves as a threat, and instead feel positively towards them. However, it is the related experiences, like the future stress and difficulty of parenthood, financial stress, loss of freedom, ongoing violence or deprivation that women may be hoping to avoid by seeking abortion^{xviii}.

Health professionals do not always recognise the complexities of women's lives and are at risk of presuming in favour of abortion. In a study of young pregnant black refugee/migrant women in government care, all women (even those pregnant as a result of rape) chose motherhood instead of abortion despite the difficulties they faced and despite the negative assumptions of healthcare professionals^{xix}. This study highlights the power held by individual healthcare professionals to create a caring environment that is woman-centred and culturally sensitive. Similarly, in a population of formerly homeless young women whose lives stabilised when they became mothers, the researchers concluded that "having a baby can serve as an asset to street exit for some homeless youth including motivating discontinuation of substance abuse; parenthood can activate hope and motivation; salience is high while the challenges are many; however, social service agencies have an essential and ongoing role to foster and support development for mothers and their children and to assist with avoidance of repetitive cycles of family trauma."^{xx}

In addition to the notion of pregnancy wantedness, pregnancy intention is likewise a blurry concept. Women do not always formulate pregnancy intentions, and many become pregnant without reference to intention. Pregnancy planning is an unattainable ideal for many women, and seems to be more within the province of privileged women, and/or those with stable relationships and financial security^{xxi}. Millions of women around the world will never achieve this, but will have children regardless. Borrero and colleagues show that pregnancy intendedness, happiness about pregnancy, and acceptability of pregnancy are all separate constructs. Many women are happy about pregnancy regardless of their intentions. And some women terminate wanted pregnancies because of financial, relationship or other personal problems. These authors recommend abandoning the term "planning" and instead propose assisting women to prepare for whatever might happen^{xxii}.

In most cases, no single factor motivates women to seek abortion. Rather, a variety of factors are involved. These include relationship problems, pressure from partners and family members, study and career aspirations, financial difficulties, lack of confidence as a mother, and lack of community support^{xxiii,xxiv}. Women report multiple disruptive events in their lives at the time of the abortion, including unemployment, separation from a partner, falling behind on rent or mortgage payments, and moving house^{xxv}.

Themes from the stories of women aged 18-24 who underwent abortions were described by researchers as follows: "There is more often than not a story of a boyfriend who was not supportive, or a pregnancy with a person they did not know well involving a 'poor decision', and alcohol seemed to be involved quite often. Parents are often not involved. ... to give future children a good life, they had to 'get through school' so 'gave up this one' ... Some noted that they didn't want a child brought up in their family or current living situation. Often described was the pain and anguish of being pregnant and very few knowing ... wondering if 'the right decision was made'..."^{xxvi}

The primary reasons change somewhat when an abortion is sought in the second trimester, and include delay due to indecision, poor or absent relationship with a partner^{xxvii}, late diagnosis of pregnancy, and lack of certainty about being pregnant^{xxviii,xxix}. The reasons why women find the decision to abort difficult include the humanity of the foetus, their perception of themselves and the impact of their decision upon others^{xxx,xxxi}.

As noted, ambivalence about an abortion decision is common^{xxxii,xxxiii}. And what is of particular concern is the relationship between ambivalence and the potential development of long-term post-abortion psychological distress^{xxxiv}, exacerbated by "impulsive and not fully internalized decisions"^{xxxv}.

There are two other risk factors for later psychological distress of which medical professionals need to be aware. The first of these is moral opposition to abortion. Women sometimes have abortions despite being morally opposed to them^{xxxvi}, which might indicate the presence of coercive influences in favour of abortion^{xxxvii}. Studies have identified more negative post-abortion effects when women are morally opposed to abortion^{xxxviii}.

The second risk factor is abortion for foetal disability or disease. Abortions of this type lead to more severe consequences not only for the woman but also for her partner. Numerous studies have identified a high incidence of negative emotions^{xxxix}, psychological distress^{xl}, post-traumatic symptoms^{xli} and somatic complaints^{xlii}. Furthermore, women may not be fully aware of the role and consequences of screening for foetal disability. For example, in relation to screening for Down's Syndrome, researchers found that only 37% of decisions were informed, 31% did not know that miscarriage was a potential consequence of amniocentesis, and only 62% knew that abortion would be offered if Down syndrome was identified^{xliii}.

Social support is of vital importance in the context of unexpected pregnancy or when a pregnant woman is unsure if she can cope. In these circumstances, women want nurturing and social network support, emotional support, and direct advice to provide some form of certainty in a difficult, frightening situation^{xliv}.

Foetal anomaly

In many countries, there has been an increase in the prevalence of foetal abnormalities, mainly due to increasing maternal age^{xlv,xlvi}. However, screening rates vary widely around the world due to a diversity of social and health policy environments. In 2010, screening rates were at 61% in England, 84% in France, and 26% in the Netherlands^{xlvii}.

A high percentage of pregnancies where a disability is identified may be terminated. For example, an estimated 99% of babies with Down syndrome are terminated in England and Wales (UK Department of Health statistics on abortion for foetal abnormality may be unreliable, for example reporting only 49% of all terminations for Down syndrome)^{xlviii}. Moreover, lower socioeconomic areas appear to have lower rates of antenatal detection and also termination of Down syndrome^{xlix}.

Where prenatal tests are routine, women may feel that they are more or less compulsory, and when they find themselves in a stressful situation a common coping mechanism is to comply with what they believe is the health professional's recommendation^l. Women's choices also rely heavily on the resources their family can access to cope with a disabled baby. A Norwegian study concluded that while screening technologies increase 'options' they also effectively decrease 'choice', that is, freely made decisions^{li}.

Factors that increase the chance of termination for sex chromosome abnormality included parents' fear and anxiety about children with disabilities, as well as directive counselling^{lii}. Nevertheless, some women are more likely to resist social norms and refuse termination for Down syndrome. For example, religious women, older women, women with a desire for more children, those pregnant at a later gestation, those with no history of abortion, women who are more familiar with children who have a disability (especially Down syndrome), women who hold positive attitudes toward individuals with disabilities, women who perceive there exists more social support for parenting a child with a disability, women who have knowledge of available services for people with disabilities, and those who have been provided with counselling by genetic specialists^{liii}.

International research shows that while health professionals tend to value accuracy and early testing for Down syndrome in prenatal care, women are instead more interested in test safety and comprehensive information^{liv}. In a Swedish study, 25.6% of women who opted for termination for foetal malformation reported that the “information provided was not adequate to enable a decision”. These women were uncertain of the future prognosis for the child and unsure of the implications of the anomaly, yet they terminated their pregnancies^{lv}. A Brazilian study found similarly that women did not always fully understand the malformation and needed greater attention by health professionals than they received. Yet, “when the option of continuing the pregnancy is chosen, a feeling of intense hope is observed, a feeling that change might be possible.”^{lvi} A recent study of 45 women receiving prenatal testing found that while they understood the testing, women had a poor understanding of Down syndrome, no knowledge of Edwards and Patau syndromes, and few knew someone with these syndromes^{lvii}.

Pregnant women and their families need accurate, up-to-date information about the care practices, quality of life, and resources available for individuals with disabilities and their families. Healthcare providers need to be aware that their own attitudes toward people with disabilities will have an influence on their ability to provide this information^{lviii}.

Intimate partner violence (IPV)

IPV is a strong risk factor for abortion all over the world^{lix, lx, lxi, lxii, lxiii, lxiv, lxv}. A WHO multi-country study of women’s health and domestic violence found that women with a history of IPV had increased odds of unintended pregnancy and almost three times the risk of abortion. In a study of London clinics, there was a six times higher rate of IPV in women undergoing abortion compared with women receiving antenatal care^{lxvi}.

Women who had experienced IPV were also more likely to experience suicidal ideation if they had a history of perinatal loss, whether it was abortion, stillbirth or miscarriage^{lxvii}. Furthermore, the association between IPV and repeat abortion indicates that there is often a repetitive cycle of abuse and pregnancy^{lxviii}.

In the USA, a survey of 4245 women identified the impact of gender-based violence across their life-course and how it impacted upon their pregnancy outcomes. Child sexual abuse was significantly related to teenage dating violence, which in turn was strongly linked to adult IPV. As women’s experiences of gender-based violence increased, so did their odds of experiencing an abortion^{lxix}. Coercion and pressure are well established risk factors for women’s psychological adjustment to abortion^{lxx, lxxi}.

Healthcare professionals should know which organisations and advocates are available to provide support in the clinical setting and in the community; for example social workers, victim advocates, domestic violence agencies, shelters, rape crisis centres, and child protective services^{lxxii}. Guidelines from some peak bodies (eg the Royal College of Obstetricians and Gynaecologists) recommend that healthcare services should identify issues such as IPV among women seeking abortion and refer them to appropriate support services. However, there is insufficient evidence to show whether screening increases uptake of assistance or reduces harm, hence more research is needed^{lxxiii}.

The foetus

The developmental age of the embryo/foetus at the time of abortion may be an important consideration for some women. A woman may want to know the size and characteristics of the embryo/foetus before coming to a final decision. In that case, accurate information based on the best scientific and diagnostic evidence needs to be made available. Later gestational stages may attract a higher degree of moral ambivalence, which might increase the risk of post-abortion effects. Furthermore, since different procedures may be used for different gestational ages, what method will be used is also important, along with sufficient detail.

It is possible that some women may ask for information about foetal sentience and foetal pain. Whilst this is a controversial issue and not well understood, it is possible, if not likely, depending upon developmental age, that the

foetus will experience pain^{lxxiv}. The presence of the nervous system, even at an early stage, is sufficient for this possibility to be seriously considered. Some researchers believe that pain sensation may occur before the 10th week of gestation (and possibly as early as the 6-7th weeks), due to maturation of particular neural structures as well as the lack of pain inhibition mechanisms^{lxxv}.

Abortion and trafficking/slavery

Abortion plays a part in the abuse and control of women and girls who are trafficked, not only for sex but also those exploited in labour such as agriculture, fishing, textile, manufacturing, mining, and domestic servitude^{lxxvi}. The risk of sexual violence is high for these women and girls, beginning at the point where they agree to or are forced to travel. Forced abortion is common for those trafficked into prostitution, and often provided by untrained or poorly qualified practitioners in unsafe settings. Other than abortion, trafficked women rarely have access to health care.

In a study of 107 survivors of sex trafficking in the USA, the women reported a total of 114 abortions, many forced^{lxxvii}. Over half the women said that the doctor performing the abortion was aware she was on the street. One woman's abortions were performed by a doctor who was also her client. Abortion is one of many severe physical and psychological health consequences that trafficked women experience. Healthcare professionals must seek training and protocols to identify and assist these women, who at present are often going unnoticed.

PHYSICAL EFFECTS OF ABORTION

Medical and surgical abortion

In many jurisdictions around the world, medical abortion is rapidly becoming more common than surgical abortion. For example, in 2014, medical abortions overtook surgical abortions in England and Wales for the first time^{lxxviii}. New Zealand appears to be an exception with only 15.4% of abortions being medical^{lxxix}.

The most common clinically significant adverse events are hospital admission, blood transfusion, emergency room treatment, IV antibiotics administration, infection and, rarely, death. Clinically significant outcomes are ongoing intrauterine pregnancy (the teratogenic effects of misoprostol are of concern), and ectopic pregnancy diagnosed after medical abortion treatment. Yet research by abortion providers without exception describes the procedures as safe and effective^{lxxx, lxxxi}.

A 2013 systematic review of 200mg mifepristone followed by misoprostol found that the rate of method failure was 4.8%, the hospitalisation rate was 0.3%, and the ongoing pregnancy rate was 1.1%. The authors concluded that "currently used medical misoprostol regimens are so effective and safe that additional research aimed at further clinical improvements will have little public health benefit."^{lxxxii} A 2015 systematic review, co-authored by a Danco consultant (Danco manufactures mifepristone), concluded that outpatient medical abortion regimens up to 70 days gestation are highly effective and severe adverse events are uncommon^{lxxxiii}. However, in a study by Niinimäki and co-workers, the incidence of adverse events was 4 times higher in medical versus surgical abortion (20% v 5.6%). Moreover, haemorrhage in medical versus surgical abortions was significantly higher at 15.6% compared with 2.1%, as was incomplete abortion (6.7% v 1.6%)^{lxxxiv}. The increase in complications with medical abortion was supported by other studies^{lxxxv, lxxxvi}.

A study of all Planned Parenthood affiliate data over 2009 and 2010 found one death over this two-year period, from an undiagnosed ectopic pregnancy. The rate of adverse events or outcomes was found to be 0.65% using a regimen of 200mg mifepristone and buccal misoprostol up to 49 days gestation. As this study only included clinic data, it may not have included all adverse events and outcomes. Some patients may not return with complaints, and staff may be motivated to conceal poor outcomes^{lxxxvii}. Planned Parenthood has improved safety in its administration of medical abortion after noting several deaths from infection, and after a 1996 meta-analysis of medical abortion, required

routine use of antibiotics. This has reduced deaths from infection substantially over the period 2001 to 2012. All medical abortion deaths around the world (at least those acknowledged by Planned Parenthood) have involved a vaginal route or no antibiotics^{lxxxviii}.

Despite the glowing reviews of medical abortion by providers and advocates, women find medical abortion substantially more painful than surgical abortion due to uterine contractions^{lxxxix}. High levels of pain are experienced by women in the days following their abortions, yet pain is a neglected issue by researchers and clinicians. The authors of this French study suggest that a higher dose of 600mg mifepristone rather than 200mg helps women to be more comfortable. However, USA abortion providers and advocates are lobbying for the FDA-approved protocol to be lowered to 200mg mifepristone^{xc, xci}. There are also increasing calls to allow midwives, nurses and physician assistants to provide medical abortion to expand access, as many doctors do not want to be involved in abortion practice^{xcii}.

Why do women choose medical abortion? Qualitative interviews with 22 women in the USA who were going to undergo a medical abortion identified five themes that underpinned their choice. A common reason was to avoid 'surgery', referring to aspiration abortion (some abortion providers argue this is not strictly surgical). Most aspiration abortions are performed under local anaesthetic, yet women have adverse reactions to hearing the electric pump, and experiencing the suction. They saw medical abortion as a more 'natural' process: "It just seems a little more human, a little more natural than the surgical track which seems so archaic." "... less invasive." "The medical abortion seemed more like a process that my body would know how to do ..." They perceived medical abortion as similar to a commonly occurring miscarriage, giving it a sense of normalcy. They spoke of respecting the baby, not wanting to cause suffering. The vast majority of women used the term "baby" or "child". Women may choose medical abortion to fit with schedules and commitments, or to avoid appointments at the clinic. They appreciated the home setting rather than the clinical setting. These findings indicate that surgical abortion is known by women to be traumatic^{xciii}. Medical abortion requires more patient participation than a surgical abortion, and women are more aware of the physical aspects of the process^{xciv, xcv}.

While the experiences of surgical versus medical abortion are vastly different for women, a large register linked study of 8294 women in Finland found no differences in outcomes of subsequent pregnancies after medical versus surgical^{xcvi}. Planned Parenthood data from the US also indicates that medical and surgical abortion in the first trimester have equivalent levels of safety and efficacy^{xcvii}. Surgical evacuation is still required for 2-8% of women after a medical abortion^{xcviii}.

With respect to later abortions, British Pregnancy Advisory Service surgeon Dr Richard Lyus claimed in 2013 that women were not being given choice of procedure. He claimed that most women prefer surgical over medical, and that in the second trimester surgical abortion is safer^{xcix}. Nevertheless, some clinicians expressed concern that surgical abortion may affect subsequent pregnancies (and more recent data confirms this). Speaking about medical abortion, he asks, "Why do most women having an abortion for foetal abnormality undergo a less safe procedure that takes longer and may be more unpleasant for the patient?" The answer is that access to surgical abortion for later pregnancies, especially by Dilatation and Evacuation (D&E), is extremely limited in England and Wales. This does not appear to be the case in New Zealand^c, but nevertheless does underscore concern about the potentially more negative impact of medical abortion on women undergoing second trimester abortions.

Authors of a USA systematic review argued that abortion providers do not need hospital admitting privileges or facilities to meet ambulatory surgical centre standards. They found that for surgical abortions major complications occurred in less than 0.1% of procedures, and hospitalisation was necessary in less than 0.5%^{ci}. Anaesthesia-related complications occurred in less than 0.5% of procedures. No deaths were reported, although few studies reported on deaths (therefore some deaths may in fact have occurred). It is noteworthy that most hospital-based studies of abortion included only healthy women with uncomplicated pregnancies.

Mortality

It is crucial to understand how many women die directly from their abortion procedures, but it is also important to find out whether women are more likely to die from any cause after abortion versus after giving birth, and not necessarily from gynaecological causes. The term “pregnancy-associated death” is defined as “the death of a woman while pregnant or within 1 year of termination of pregnancy, irrespective of the cause of death or the site of pregnancy.”^{cii} This reflects the fact that reproductive events have a profound impact upon women’s lives, reverberating beyond the physical and into their psychological health and well-being. Analyses of mortality data are complicated by a myriad of potential confounders and mediating factors such as physical and mental health, previous and subsequent pregnancies, relationship status, socioeconomic status, genetic factors, behavioural factors, and life experiences.

When deaths from all causes are examined in the first year following an abortion, several large studies have identified an increased risk compared either to giving birth or never being pregnant, although causality has not been confirmed^{ciii,civ,cv}.

A register-based study in Finland showed that the risk of suicide was decreased after birth (5.9 per 100 000 births) compared to non-pregnant women (11.3 per 100 000 person-years), while suicide risk was increased after miscarriage (18.1 per 100 000 miscarriages) and much more so after induced abortion (34.7 per 100 000 induced abortions). Women aged less than 25 were most at risk. The risks for accidental death and homicide also increased after abortion^{cvi}.

In another recent Finnish register study, the mortality rate for suicide after abortion was 21.8 per 100 000 women, while the rate was 3.3/100 000 in pregnancies ending in birth and 10.2 per 100 000 among non-pregnant women^{cvi}. This study was designed to follow up the finding from a 2004 Finnish study in which pregnancy-associated mortality for 1987-2000 was 36.7 per 100 000 pregnancies, while the age-adjusted mortality in the non-pregnant population was 57.0 per 100 000 person-years; women giving birth were at lowest risk of death (28.2 per 100 000) compared with women after induced abortion (83.1 per 100 000) or spontaneous abortion (51.9 per 100 000)^{cvi}. The authors conclude “after updating the current care guidelines, emphasising the need for psychological support, Finland has achieved a reduction in the suicide rate after termination of pregnancy.”^{cix}

A population register based study in Denmark over the years 1980 – 2004 found abortion was associated with significantly higher death rates up to ten years after abortion compared with women who gave birth. Women had an 80% increased risk of death after abortion compared to after birth within the first year. The same dataset revealed a dose effect of birth and pregnancy loss; that is, increasing numbers of births decreased mortality risks, while more perinatal losses were associated with greater risks of death^{cx}.

In stark contrast with all large record linked studies, a 2012 paper reported that the risk of death associated with childbirth is 14 times higher than that with abortion in the USA. Using CDC data, birth certificates, and Guttmacher Institute surveys, the authors surmise that abortion allows women to avoid caesarean delivery and also any complications that may arise in late pregnancy^{cx}. Despite its unique conclusion, this paper is now widely cited as evidence that abortion is safer than childbirth.

Maternal deaths are defined as the death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Maternal deaths^{cxii} are difficult to identify because this requires information regarding pregnancy status at or near the time of death, as well as the accurate medical cause of death, which are both difficult to ascertain^{cxiii}. A recent review of research methods demonstrates that the majority of published studies of maternal mortality are of very poor quality; most problematic is the conflation of induced and spontaneous abortion data^{cxiv}. Even global WHO data on maternal mortality has been criticised for errors, its figures being called “implausibly low” due to underreporting^{cxv}. In this WHO data, the abortion category refers to abortion, miscarriage, and ectopic pregnancy, and was measured at 7.9% of the global burden of maternal mortality, that is,

around 193 000 deaths annually^{cxvi}. On the other hand, the 2014 Global Burden of Disease Study calculated abortion deaths to be 14.9% of total maternal mortality, almost twice the WHO estimate^{cxvii}.

Risk of death resulting directly from complications during abortion is rare, but increases with each week of gestation^{cxviii}. Abortion-related deaths are normally expressed as a proportion of maternal mortality, and are almost always underestimated, being the least well measured. To measure deaths directly related to abortion procedures there are four sources of data: confidential enquiries, vital registration data, verbal autopsy (“a systematic tool used to collect health information from lay-person informants to assess causes of death”), and facility-based data sources^{cxix}. Using just one of these sources will lead to underestimation. Gerds *et al.* describe some of the barriers to measurement of abortion related deaths, which include women’s and practitioners’ unwillingness to participate in research, misclassification of deaths and complications, and underreporting. Abortion related deaths may be misclassified because of similarities to other obstetric complications such as miscarriage, haemorrhage or sepsis. Furthermore, illegal or stigmatized abortion leads to women being unwilling to seek help for complications. And even in the USA where abortion is widely practiced and accepted, doctors fail to report recent or current pregnancies on a minimum of 50% of death certificates^{cxx}. These errors result in abortion appearing safer than it really is.

The protective effects of giving birth are well-established yet not well understood. There are several possible explanations. First, the “healthy pregnant woman effect” suggests that healthier women are more likely to be able to conceive and carry to term, and have more contact with healthcare professionals than non-pregnant women. Second, pregnancy may produce direct health benefits. For example, pregnancies carried to term are associated with physiological changes that reduce the risk of reproductive cancers, and behavioural changes associated with being a parent improve healthy lifestyle behaviours and reduce risky behaviours. Third, perinatal loss may contribute to physiological or psychological effects that lead to an association with increased risk of suicide, substance abuse, PTSD, and poorer general health^{cxxi}. Women who have abortions may already take more risks or care less for their health. Alternatively, they may experience stress after an abortion that is linked to it, or abortion itself may produce psychological stresses that increase the risk of death^{cxii}.

Overall, the evidence points to common risk factors for both death and abortion. An abortion request should be viewed as a flag for women who might need assistance in various areas of their lives. The Finnish government has acted upon this and achieved a small reduction in post-abortion mortality by providing such post-abortion support^{cxiii}.

Subsequent pregnancies

The impact of abortion on subsequent pregnancies remains a contested field of research, even though numerous studies over the past decade have identified an increased risk of premature delivery^{cxxiv, cxv, cxvi, cxvii, cxviii, cxix, cxx, cxxi, cxxii}.

Brazil has a high rate of preterm birth and a large multicentre case control study has found that previous abortion is a risk factor^{cxiii}. A study of 9969 nulliparous women self-reporting their reproductive histories found that women with a history of induced abortion were at higher risk of spontaneous preterm birth and premature rupture of membranes than women without a history of induced abortion. Abortion was likely underreported so the risk is underestimated. There was no data on method (medical versus surgical)^{cxiv}.

Recent evidence strongly suggests that cervical trauma due to instrumentation during surgical abortion procedures may play a large part in premature births in subsequent pregnancies, since medical abortion does not appear to confer this risk.

A large analysis presented to the annual meeting of the European Society of Human Reproduction and Embryology in Lisbon, 2015, assessed 21 cohort studies including nearly two million women^{cxv}. The reviewers reported that the use of D&C for miscarriage or termination increased preterm birth in subsequent pregnancies by 29%, and very

preterm birth by 69%. The risk was highest for women who had several abortions. The authors urge the prevention of preterm labour by minimising the use of D&C.

These findings align with a large Scottish record linkage study indicating that surgical but not medical abortion increases the risk of spontaneous premature birth in a second pregnancy^{cxv}. A similar Scottish record linkage study showed that the association of preterm birth with abortion declined over the study period (1980 to 2008), and the authors propose that the decline is due to the increasing use of medical abortion as well as pre-treatment of the cervix prior to surgical abortion^{cxvii}.

In the Netherlands, a large nationwide cohort study found that surgical abortion was associated with preterm delivery, cervical incompetence, placental implantation or retention problems, and postpartum haemorrhage in subsequent pregnancies – the association was not found for medical abortions. Abortion history was clearly underreported, being mentioned by only 1.2% of all women giving birth, thus underestimating the outcomes^{cxviii}.

Other studies have not found any association between abortion and subsequent premature birth^{cxix,cxi,cxli}.

Women with a history of abortion have a modest reduction in risk of preeclampsia in later pregnancy, although it is unclear whether this is a causal relationship^{cxlii}.

In later pregnancies, a study of Finnish Registry Data 1983-2007 found abortion to be associated with smoking after the first trimester, and overweight during pregnancy; the authors recommend that doctors performing abortion should inform their patients about the importance of adequate prenatal care in subsequent pregnancies^{cxliii}.

Breast cancer

Whether breast cancer risk is elevated by abortion is a controversial question that has been the subject of numerous studies, several showing increased risk^{cxliv,cxlv,cxvi,cxvii,cxviii,cxlix,cl,cli,clii} and some showing none^{cliii,cliv,clv,clvi,clvii}. The field remains in dispute^{clviii,clix}, partly due to problems in some studies where research design has been poor. Problems include failure to ensure adequate follow-up time, use of inaccurate abortion registers, choosing inappropriate study populations and not adequately dealing with under-reporting of abortion. Nevertheless many commentators prefer to claim that the matter is settled^{clx}.

At the very least, and on precautionary grounds, women presenting for abortion need to be made aware of the intense research interest in this matter, and the divergent views of researchers. What is of direct relevance to women considering abortion is the uncontroversial fact that carrying a first pregnancy to birth is protective against breast cancer^{clxi,clxii}. This means that a woman will have higher breast cancer risk if she undergoes an abortion compared to carrying to term.

PSYCHOLOGICAL EFFECTS OF ABORTION

The highly complex psychology of abortion has been examined by hundreds of researchers over previous decades, with a diversity of methodologies and interpretations. In precise scientific terms the question of causality cannot be answered definitively as it is not possible to conduct a randomised controlled trial assigning some women to an abortion group and others to a birth group. Therefore, most studies examine the *association* between abortion and mental health, even though some researchers point to various characteristics of the data that infer causality^{clxiii}.

Reviews

Reviews have arrived at disparate conclusions^{clxiv,clxv,clxvi,clxvii,clxviii,clxix,clxx}, highlighting that the field is riven with disagreement^{clxxi,clxxii}, making the provision of guidance to physicians difficult. Taking into account more recent research, a 2013 review by Bellieni and Buonocore concludes that abortion is linked to a variety of adverse mental

health outcomes, arguing that foetal loss is traumatic, whether by miscarriage, induced abortion, or stillbirth^{clxxiii}. Nevertheless, some reviews advance a very strong view that there is no link^{clxxiv,clxxv}, unprepared to even acknowledge controversy in the field. While some researchers acknowledge an effect on some women, they can be quick to blame social mores as the cause of mental harm^{clxxvi}. In a poll conducted in New Zealand seeking the views of the general public about the effects of abortion on mental health, nearly half of all respondents agreed that abortion risked harming mental health.^{clxxvii}

One prominent researcher has described problems in the field as follows:

“[there is a] ... truly shameful and systematic bias that permeates the psychology of abortion. Professional organisations in the USA and elsewhere have arrogantly sought to distort the scientific literature and paternalistically deny women the information they deserve to make fully informed healthcare choices and receive necessary mental health counseling when and if an abortion decision proves detrimental.”^{clxxviii}

Comparison groups

One of the more contentious matters in studies on the psychological impact of abortion, which may have a bearing upon outcomes, involves what groups should be compared with one another. It is possible to compare women having an abortion with those having a miscarriage, with those who give birth, or with those who have never been pregnant. Additionally, it would be possible to compare groups based upon whether a pregnancy was intended or not, or wanted or not. However, the use of such terminology is fraught because there is no equivalence for example between an intended pregnancy and a wanted one, let alone whether seeking abortion simply equates with a pregnancy being unwanted^{clxxix,clxxx,clxxxi,clxxxii,clxxxiii}. Nevertheless, for studies on psychological effects of abortion, there seems to be some consensus that the most appropriate comparison is between women who abort an unintended pregnancy and those who do not^{clxxxiv}. This is not to deny that where other comparisons have been made, useful and informative data nonetheless exists.

The Turnaway Study

Before considering the bulk of the research, one study in particular deserves special mention for three reasons. First, because it claims to use the most appropriate comparison groups; second, because it has followed women longitudinally over 5 years; and third, because it has been influential, at least in part because the authors have chosen to derive numerous papers from the one data set, and also because the papers draw strong links to the policy implications the authors support.

The study in question is termed the ‘Turnaway Study’, because it compares women who have an abortion close to the gestational limit set by the clinic, with women seeking an abortion but denied one because their pregnancy was advanced beyond the gestational limit set by the clinic. These limits vary from 10 weeks to 23 weeks. A third comparison group was women receiving first trimester abortions.

The authors of the study claim that comparing ‘turnaways’ with those receiving an abortion is of most relevance because it allows a comparison free of the possibility that not wanting a pregnancy may be related to adverse mental health outcomes rather than the abortion itself. In other words, all women in the study do not want to be pregnant, and therefore any findings are related to the abortion alone and not whether a pregnancy was unintended or unwanted.

The study has resulted in at least 27 papers^{clxxxv}.

In brief, the primary finding of the study, and contrary to the majority of others, was that having an abortion does not have an adverse effect on a variety of mental health outcomes and other measures. This includes on emotional

responses^{clxxxvi,clxxxvii}, perceived stress and emotional support^{clxxxviii}, substance use and/or abuse^{clxxxix,cxc,cxci,cxcii}, self-esteem or life satisfaction^{cxciii}, partner relationship^{cxciv,cxcv}, depression, anxiety and post-traumatic stress^{cxcvi,cxcvii,cxcviii,cxcix}, and aspirational plans^{cc}.

Unfortunately, this plethora of papers carries the false appearance of a significant and varied body of work.

However, all the papers published as part of the Turnaway Study rely on a single flawed data set, hence all papers are in a sense pre-determined by it.

The Turnaway Study is the work of *Advancing New Standards in Reproductive Health* at the *Bixby Center for Global Reproductive Health* at the University of California. ANSIRH is committed to free and open access to abortion^{cci}, and funders of the work include like-minded organisations such as the David and Lucille Packard Foundation. Most of the papers include statements about the authors' desired political outcomes.

The Turnaway Study has a variety of flaws, but the essential one involves the initial selection of women, and this failing affects all that follows. Only 37.5% of women consented to participate at the time of their abortion or turnaway and a further 15% did not undertake the baseline interview. Hence, only 31.9% of women began the study, with further dropout yielding 22% participation at 5 years. It is unsurprising that those wishing not to participate would include those potentially most affected by the abortion, either initially or subsequently. And given that the turnaway group can only be derived from a small number of women and the abortion group from a very large pool, it is almost certain that the abortion group would represent women least likely to suffer adverse consequences.

Selection bias and other problems

The problem of selection bias appears in other papers as well. For example, in a study claiming there was no link between abortion and posttraumatic stress, 56% of those asked refused to participate, and then 49% of those who participated at the baseline interview did not respond at the 3-month mark^{ccii,cciii}, leaving a sample of just 29%. When a sample is self-selected in this way, just as in the Turnaway study, there is every reason why women who have reacted adversely to the abortion would not wish to participate^{cciv}.

Another important aspect of research design involves the timing of when surveys are conducted. For example, in a study by Toffol and coworkers^{ccv}, who concluded that abortion is associated with an overall reduction in anxiety, the baseline survey was administered prior to the abortion, which was conducted *later that day*. As has been pointed out^{ccvi}, it is not surprising that there would be some decline in anxiety given the highly anxious moments just prior to an abortion being used as a 'baseline', instead of a more accurate historical measure some time prior to pregnancy.

Another potential weakness of some studies is the failure to follow psychological effects for long enough – a few months or even years may be too short a time frame^{ccvii}. Phenomenological research suggests that women may cope well initially, but years later reappraise the event negatively^{ccviii,ccix}. Finally, there are two further problems. First, as noted, under-reporting of past abortions could result in misclassification, in that those who have had an abortion but claim not to have, may appear in the control group and hence dilute any adverse effect. And second, studies that rely on self-report about current or past psychological health risk memory recall bias and/or distortion due to cognitive dissonance in relation to a memory that is painful to relive^{ccx}.

Emotional distress

Numerous studies have identified emotional distress immediately after abortion and in the months following. Women experience a range of emotions after abortion, including sadness, loneliness, shame, guilt, grief, doubt and regret^{ccxi,ccxii,ccxiii,ccxiv,ccxv,ccxvi}. However, some studies also identify positive reactions like relief, happiness and satisfaction^{ccxvii}. In the longer term, some women exhibited cognitive dissonance, describing their abortions of 10

years or more ago in terms of negative emotions yet believing the correct choice was made^{ccxviii}. Specific strategies of avoidance were used to cope.

In a study of Canadian university students, all participants described significant grief 3 years after the index abortion^{ccxix}.

In a recent study by Coleman and co-workers designed to examine in depth responses to abortion, women reported “deep feelings of loss, existential concerns, and reduced quality of life, with heart-wrenching clarity. For many women, the abortion experience became a pivotal point in their lives, impacting their self-image, their personality, and their connectivity to others.”^{ccxx}

Among US college students - women who had an abortion and men whose partners had an abortion – one third of women and one third of men were uncomfortable and expressed regret about the abortion decision^{ccxxi}. A third of men and women also experienced a sense of longing for the aborted fetus. Moreover, they often use terms like “child” or “baby” to describe their loss.

In a comparison between the mental health effects of miscarriage compared to induced abortion, Broen and co-workers found that 5 years later, women who had an abortion experienced levels of avoidance, guilt, shame and relief that remained elevated compared to women who miscarried^{ccxxii}. In contrast, in a pilot study, Canario and co-workers found there to be no difference in emotional adjustment between women who had a miscarriage, induced abortion, or abortion for foetal anomalies^{ccxxiii}. These authors also found that a couple’s relationship could assist in emotional adjustment. Interestingly, in a qualitative study aimed at exploring women’s emotional difficulties after abortion, the author concludes that any difficulty results from “social disapproval, romantic relationship loss, and head versus heart conflict”^{ccxxiv}. It is important to note that in this study the women were recruited through an abortion talkline, and that about half of callers could not be recruited because they were “judged too distraught”.

Depression and anxiety

Results from a 2006 New Zealand study^{ccxxv} on mental health and abortion confirm other work showing a link between the two^{ccxxvi}. The New Zealand study revealed that 42% of women who had an abortion experienced major depression in the four years prior to interview. This is nearly twice the rate of those who had never been pregnant and 35 % higher than those who had continued their pregnancy. This study also showed that abortion increased the risk of anxiety disorders. The same research team undertook a more detailed follow up study correcting carefully for possible confounders, in which their earlier findings were confirmed^{ccxxvii}. In the more recent study, they concluded that women who had abortions experienced mental health disorders 30% more often compared to women who had not had an abortion. The authors went further to suggest that there were good grounds for causality, but that more work needed to be done before strong definitive statements about abortion causing mental health disorders could be made.

Another more recent paper from the same group showed that the extent to which women reported an adverse reaction to abortion correlated with the extent of mental health disorders^{ccxxviii}. Other researchers have also found a link between abortion and depression^{ccxxix,ccxxx,ccxxxi}, as well as anxiety^{ccxxxii}, although some groups have not been able to confirm this^{ccxxxiii,ccxxxiv,ccxxxv,ccxxxvi}. With regard to post-abortion anxiety and possibly depression, others have found these mood disorders to be related to pre-abortion factors rather than to the abortion itself^{ccxxxvii,ccxxxviii,ccxxxix}.

In a 2016, well-controlled study of 8005 American women, which attempted to replicate work by the New Zealand group, Sullins found a 30% elevated risk of depression and a 25% elevated risk of anxiety^{ccxl}. Sullins, like Coleman *et al.*^{ccxli}, estimates that approximately 10% of the prevalence of mental health disorders comes from induced abortion.

Although a very short-term investigation one week after abortion, Yilmaz *et al* found that symptoms of post abortion depression were more prevalent amongst those who had undergone a surgical abortion compared with a medical one^{ccxlii}.

Post-traumatic stress

A small proportion of women develop post traumatic stress disorder (PTSD) following abortion^{ccxliii,ccxliiv}. This may be related to cultural factors^{ccxlv}. More recent studies have confirmed an elevated risk of PTSD after abortion, which weakened but persisted after controlling for confounders^{ccxlvj,ccxlvi}. In one of these studies, abortions later in pregnancy were associated with higher PTSD scores^{ccxlvi}, and in a separate study, PTSD symptoms remained elevated after 3 years^{ccxliix}. Incidence of first psychiatric contact for neurotic, stress-related or somatoform disorder was elevated 2-3 months after an abortion^{ccli}.

In a French study comparing surgical versus medical abortion, PTSD scores were not only high at 6 weeks after abortion, but higher in the medical abortion group, even though these women had less advanced pregnancies^{ccli}. In their review of 48 studies, Daugirdaite *et al.*^{cclii} concluded that “Patients with advanced pregnancies, a history of previous traumas, mental health problems, and adverse psychosocial profiles should be considered as high risk for developing PTS [posttraumatic stress] and PTSD following reproductive loss.” The risk of PTS and PTSD in this review were considered alongside other reproductive losses such as miscarriage, stillbirth, neonatal death, perinatal death, and failed IVF.

Substance abuse and self-harm

In 1995, a UK study identified an increase in deliberate self-harm after abortion, which includes substance abuse.^{ccliii} This was corroborated more recently in the study by Sullins^{ccliv} and also by Olsson *et al.*^{cclv}. Among women whose first pregnancy was unintended, those who had an abortion were at greater risk of substance abuse compared with those who carried their unintended pregnancy to term^{cclvi}. When pregnancy was assessed in relation to past perinatal loss - which included abortion, stillbirth and miscarriage - only abortion was found to be associated with an increased risk of substance abuse during that pregnancy^{cclvii}. Other research has confirmed the relationship between abortion and substance abuse, perhaps as an attempt to cope with emotional loss^{cclviii,cclix,cclx}. It may be that of all the mental health problems related to abortion, substance abuse might contribute most to the community mental health burden^{cclxi,cclxii,cclxiii}.

Mental health during a subsequent pregnancy

Several studies have investigated the impact of abortion on women’s mental health during a subsequent pregnancy and found an association with depression, anxiety, PTSD, and substance abuse^{cclxiv,cclxv,cclxvi,cclxvii}. Pregnancy may be a particularly vulnerable time for some women who may experience difficult thoughts and emotions about a past pregnancy that ended in abortion. A study by Holmlund *et al* found no such association but suffered from similar selection bias as the Turnaway Study^{cclxviii}, managing to recruit only 18.3% of women asked to participate. Like the Turnaway, women distressed by their past abortion would selectively remove themselves from the research.

Other disorders

Several studies have identified other psychiatric complications following abortion. Women who have an abortion are at higher risk of psychiatric admission compared with women who carried to term^{cclxix,cclxx}. In a Californian study, women who had an abortion were over-represented in treatment categories that included bipolar disorder, neurotic depression and schizophrenic disorders^{cclxxi}. Nevertheless, a major UK study did not identify a difference in total psychiatric disorders between aborting women and those who carried to term^{cclxxii}. With regard to bipolar disorders, some researchers have found an association^{cclxxiii}, while others have not^{cclxxiv}. Sleep disorders and disturbances are also more common in women with a history of abortion^{cclxxv}.

Several studies have identified relationship problems between couples where there has been a history of abortion, manifesting as sexual dysfunction^{cclxxvi,cclxxvii,cclxxviii,cclxxix}. Furthermore, some evidence exists for a 'replacement pregnancy' phenomenon, where a subsequent pregnancy may be considered a way of resolving grief and stress about an abortion^{cclxxx}.

Past psychiatric history

Several studies have made the claim that it is not abortion *per se* that has an adverse impact on mental health outcomes, but instead women who access abortion already have poor mental health. For example, Danish researchers showed that the incidence of first psychiatric contact did not change pre versus post abortion^{cclxxxi}. However, there are significant weaknesses with the study, and others by the same group, that limit the conclusions that can be drawn^{cclxxxii}.

Nevertheless, Nilsen *et al* have identified a link between prior adolescent substance abuse and likelihood of having an abortion^{cclxxxiii}. In addition, work by Ditzhuijzen and co-workers has likewise found that women with a history of psychiatric ill health are over-represented among those who have abortions^{cclxxxiv,cclxxxv,cclxxxvi}. Even so, caution needs to be applied, as for one of these studies^{cclxxxvii} the response rate was just 13%, pointing to significant risk of selection bias.

Despite the controversy over this issue, some women describe their own experiences of abortion as linked to mental harm^{cclxxxviii,cclxxxix,ccxc,ccxci}.

The special case of abortion for foetal abnormality

There is a solid body of evidence showing that when an abortion is undertaken for reasons of foetal abnormality the after-effects can be particularly traumatic^{ccxcii,ccxciii,ccxciv}. Health professionals need to be aware that strong and persisting grief is likely, similar to that experienced for a stillbirth, but with the additional factor that the abortion was chosen^{ccxcv,ccxcvi,ccxcvii}.

Most women undergoing such procedures experience a range of difficult emotions including sadness, meaninglessness, loneliness, tiredness, grief, anger and frustration, as confirmed by many studies^{ccxcviii}.

Prior to late termination, women report feeling guilt, fear, anguish, unreality, relief, desperation, emptiness, and other conflicting emotions. 40% of women had only negative emotions^{ccxcix}.

In a major Scottish study, a majority of men and women experienced negative emotional responses and somatic complaints, including problems in their sexual relationships^{ccc}. Among women, 40% experienced coping problems lasting more than 12 months. But the effects can last much longer. For example, Dutch researchers found that grief and post-traumatic symptoms remained between 2 and 7 years after the event^{cccj}. In the same study, greater psychological distress was experienced by women when the foetus was at a more advanced gestational age. Other researchers found that, contrary to expectations, traumatic stress at 4 years was not significantly different to that experienced at 14 days^{cccii}. Recent research by the same group^{ccciii} has shown, using functional MRI, that the neural activation pathways underlying grief in women who terminated their pregnancies because of foetal abnormality are the same as those involved in physical pain.

More recent prospective research has identified adverse experiences following abortion for foetal anomaly. At four months, 8.8% experienced grief, 45.8% showed symptoms of posttraumatic stress, 12.2% exhibited psychological malfunctioning, and 27.9% had depression^{ccciv}. These symptoms declined over the following year.

Sometimes, during medical abortion for foetal abnormality, a baby is born alive. In the UK, live births following abortion were reported in 2.2% of abortions for foetal abnormality overall, and 4.8% of abortions without prior

feticide. When an infant is live born after termination, the baby is provided with comfort care until death in the delivery suite, usually around one hour after birth^{cccv}.

ABORTION STATISTICS FOR NEW ZEALAND 2016^{cccv}

In 2016, there were 12,823 abortions in NZ, approximately 10% of which were for non-residents. This translates to an age-standardised abortion rate of 13.5 per 1000 women of reproductive age (15 - 44 years old). There has been a steady decline from a peak of 18,382 abortions in 2007, with the most significant decline for women under the age of 25. The reasons for the decline are disputed. A significant percentage (43%) of all abortions in NZ occur where contraception has been used, most commonly condoms and the oral contraceptive pill.

A majority of women having abortions had a previous live birth (57%), and 36% had already had 1 or more abortions. There were 595 who had previously had 3 or more abortions (4.6%).

Most abortions occur in the first trimester (89.8%), by surgical means (84.3%), and the formal reason for the overwhelming majority of abortions falls within the category 'danger to mental health' (97%). 231 abortions (1.8%) involved a handicapped child, 72 (0.6%) involved danger to the life and/or physical health of the mother, and 4 (0.03%) involved a criminal offence such as rape or incest.

In approximately 0.4% of abortions there were complications adversely affecting the mother's health, such as retained placenta or foetus, haemorrhage, or perforation of the uterus.

SUMMARY

Abortion is associated with a wide range of adverse physical and psychological outcomes. While research proving causality is limited, and much research in this field is yet to be conducted, there is already a large body of evidence describing the adverse outcomes. Women are entitled to be made aware of all the associated risks. Furthermore, because women who present for abortion are often ambivalent, and ambivalence is a known risk factor for later adverse effects, it is imperative that health professionals provide all relevant information. The nature of abortion, with its complex medical, social, legal and ethical dimensions demands extra care on the part of health professionals.

ⁱ In NZ in 2016, the vast majority (97%; 12,437) of abortions were performed under the category 'Danger to Mental Health'. The remainder were performed under categories related to physical health of the mother or disability of the unborn child. 0.03% involved a criminal offence, such as rape or incest. Report of the Abortion Supervisory Committee 2017. See <https://www.justice.govt.nz/assets/Documents/Publications/ASC-Annual-Report-2017.pdf>.

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