1937.
NEW ZEALAND.

REPORT

OF THE

COMMITTEE OF INQUIRY

INTO

THE VARIOUS ASPECTS OF THE PROBLEM OF ABORTION IN NEW ZEALAND.

Laid on the Table of the House of Representatives by Leave.

CONTENTS.

CONSTITUTION AND TERMS OF REFERENCE OF COMMITTEE.

In accordance with the decision of Cabinet, a special Committee was appointed on 4th August, 1936,—

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

The following were appointed members of the Committee:—

Dr. D. G. McMillan, M.B., Ch.B. (N.Z.), M.P., Chairman.
Mrs. Janet Fraser.
Dr. Sylvia G. Chapman, M.D., D.G.O. (T.C.D.).
Dr. Thomas F. Corkill, M.D. (Edin.), M.R.C.P. (Edin.), M.C.O.G.
Dr. Tom L. Paget, L.R.C.P. (Lond.), M.R.C.S. (Eng.).

REPORT.

The Hon. the Minister of Health, Wellington.

Sir,—

The Committee set up by Cabinet to inquire into the various aspects of the Problem of Abortion in New Zealand has the honour to submit herewith its report.

HISTORICAL AND INTRODUCTION.

Since the rise in the death-rate from septic abortion in 1930, the Department of Health, the medical profession, and women's organizations and societies have shown great concern regarding the problem. The Obstetrical and Gynæcological Society of the New Zealand Branch of the British Medical Association conveyed to the Prime Minister a resolution passed at the meeting of its executive held in Wellington on 12th March, 1936, wherein it begged the Prime Minister to consider the advisability of setting up a Committee of inquiry to investigate this matter.

This recommendation having been favourably considered, the following Committee was appointed:—

Dr. D. G. McMillan, M.B., Ch.B. (N.Z.), M.P., Chairman.
Mrs. Janet Fraser.
Dr. Sylvia G. Chapman, M.D. (N.Z.), M.B., Ch.B. (N.Z.).
Dr. T. F. Corkill, M.D. (Edin.), M.R.C.P. (Edin.).
Dr. T. L. Paget, M.R.C.S. (Eng.), L.R.C.P. (Lond.).

Although the immediate purpose of this inquiry was to investigate the problem of septic abortion, it at once became apparent that this matter was so inextricably bound up with the subject of abortion in general that all aspects would require consideration.

The Committee has therefore attempted to make this wider survey and to bring before you as complete a picture as possible.

The Committee has been guided by the Order of Reference, which was as follows:—

I. To inquire into and report upon the incidence of abortion in New Zealand, including—
   (*a*) The incidence among married and single women:
   (*b*) Whether the rate of incidence has increased during recent years:
   (*c*) How New Zealand compares with other countries in this respect.

II. To inquire into and report upon the underlying causes for the occurrence of abortion in New Zealand, including medical, economic, social, and any other factors.

III. To advise as to the best means of combating and preventing the occurrence of abortion in New Zealand.

IV. Generally to make any other observations or recommendations that appear appropriate to the Committee on the subject.

The preliminary meeting of the Committee was held on the 18th August, and in all sixteen meetings have been held, of which thirteen meetings were held in Wellington, one in Dunedin, one in Auckland, and one in Christchurch.

Evidence was heard from—

British Medical Association.
Church of England.
Crown Solicitor.
Dominion Federation of Women's Institutes.
Dominion Federation of Women's Institutes (Auckland Branch).
Government Statistician.
Lecturer in Medical Jurisprudence, Otago Medical School.
Maternity Protection Society.
Mothers Union.
National Council of Women.
National Council of Women (Canterbury Branch).
New Zealand Labour Party (Auckland Women's Branch).
New Zealand Registered Nurses Association.
New Zealand Registered Nurses Association (Auckland Branch).
New Zealand Registered Nurses Association (Christchurch Branch).
Obstetrical and Gynæcological Society.
Obstetricians and Gynæcologists attached to the Public Hospitals in Auckland, Wellington, Christchurch, and Dunedin.
Pharmaceutical Society.
Police Department.
Presbyterian Church of New Zealand.
Roman Catholic Church.
Royal Society for the Health of Women and Children.
St. John Ambulance Association Nursing Guild.
Women's Division of the Farmers Union.
Women's Division of the Farmers Union (Otago Branch).
Women's Division of the Farmers Union (South Auckland Branch).
Women's International League for Peace and Freedom.
Women's Service Guild.
Working Women's Movement (Auckland Branch).

In addition to these, evidence was heard from twelve other persons.

The Committee would like to express its thanks to the witnesses, many of whom have gone to considerable trouble to collect information and prepare their evidence.

PART I.—INCIDENCE OF ABORTION IN NEW ZEALAND.

All the evidence brought before the Committee indicates that abortion is exceedingly frequent in New Zealand.

It is quite impossible to assess the incidence with complete accuracy, for the reason that a very considerable number of these cases do not come under medical or

hospital observation, but some definite indication of the frequency is given by the statistics obtained from various hospitals and practices.

In one urban district, for instance, in which the total live births for a two-year period were 4,000, the number of cases of abortion treated in the public hospital alone was 400.

When to this number were added the cases treated in the various private hospitals, those attended by doctors in the patients' homes, and those not medically attended at all, it was computed that a total of 1,000 abortions was a conservative figure. In other words, roughly twenty pregnancies in every 100 terminated in abortion.

Looked at from a somewhat different angle, figures were presented from one hospital showing that in a group of 568 unselected women of child-bearing age, there were 549 abortions in 2,301 pregnancies, or 23 per hundred.

How do these Cases originate?

It must be explained that a certain number of cases of abortion occur perfectly innocently as the result of some condition of ill health, or, occasionally, as the result of accident. These *spontaneous* cases constitute an entirely medical problem.

All other cases are artificially produced or *induced*.

A very small number of these are honourably performed by medical practitioners when the mother's life is seriously endangered.

This procedure is termed "*Therapeutic induction of abortion.*"

Certain important questions in relation to therapeutic abortion will be discussed at a later stage in this report.

The remainder of the induced cases are unlawfully produced by the person herself or by some other person—*criminal abortion*.

The Committee received much evidence regarding the methods used in the attempt to procure abortion.

In the first instance it was shown that the use of so-called abortifacient drugs was extensively practised and was usually a first resort.

Little need be said about the matter at this stage except to state that the New Zealand evidence entirely supports the opinions expressed elsewhere that drug-taking is rarely effective.

Those tempted to use these drugs should realize the futility of the practice for the purpose intended and the frequency with which disturbances of health are caused by taking them.

Their only value is as a lucrative source of gain to those people who, knowing their inefficacy, yet exploit the distress of certain women by selling them.

It is perfectly clear that the real menace is the instrumentally produced abortion, either self-induced by the person herself or the result of an illegal operation performed by some outside person.

These abortionists include a few unprincipled doctors and chemists, a few women with varying degrees of nursing training, and a number of unskilled people.

It was a matter of considerable importance for the Committee to attempt to determine first the extent to which spontaneous abortions contribute to the total figures: the prevalence of unlawful abortion could then be better realized.

Here again it was found exceedingly difficult to obtain exact figures, but the evidence suggests that probably less than seven pregnancies in every 100 terminate in spontaneous abortion.

Taking the records of one group of 1,095 women where the incentives to interference were probably at a minimum, it was found that out of a total of 2,180 pregnancies only 152, or 6·97 per cent., terminated in abortion, while in a series of 5,337 pregnancies in patients taken from the records of St. Helens Hospitals, 6 per cent. terminated in abortion.

Even assuming that *all* these were spontaneous (which was probably not the case), the incidence is approximately 6 per cent. to 7 per cent.

If, then, the total abortion rate is 20 per 100, it is clear that the incidence of criminal abortion is at least 13 in every 100 pregnancies.

The Committee believes that this figure can be accepted as a conservative estimate of the prevalence of unlawful abortion in New Zealand.

Some of the figures presented suggested a still higher incidence.

Applying the figures given to the whole of New Zealand it means that while in the year ending March, 1936, there were 24,395 live births there were probably 6,066 abortions, of which nearly two-thirds (4,000) were criminally induced.

The impression of the Committee is that this is an underestimate.

Serious as this is on general grounds, the matter is of particular importance in regard to the special problem which led to the setting-up of this Committee of inquiry—the *incidence of septic abortion.*

Septic infection, or blood-poisoning, is the most serious complication which may follow abortion.

Grave concern has been occasioned by a realization of the frequency of septic abortion, the most significant indication of which is the number of women who lose their lives as the result of this complication.

Attention has repeatedly been drawn to this problem by the officers of the Department of Health, the New Zealand Obstetrical and Gynæcological Society, and others interested in maternal welfare.

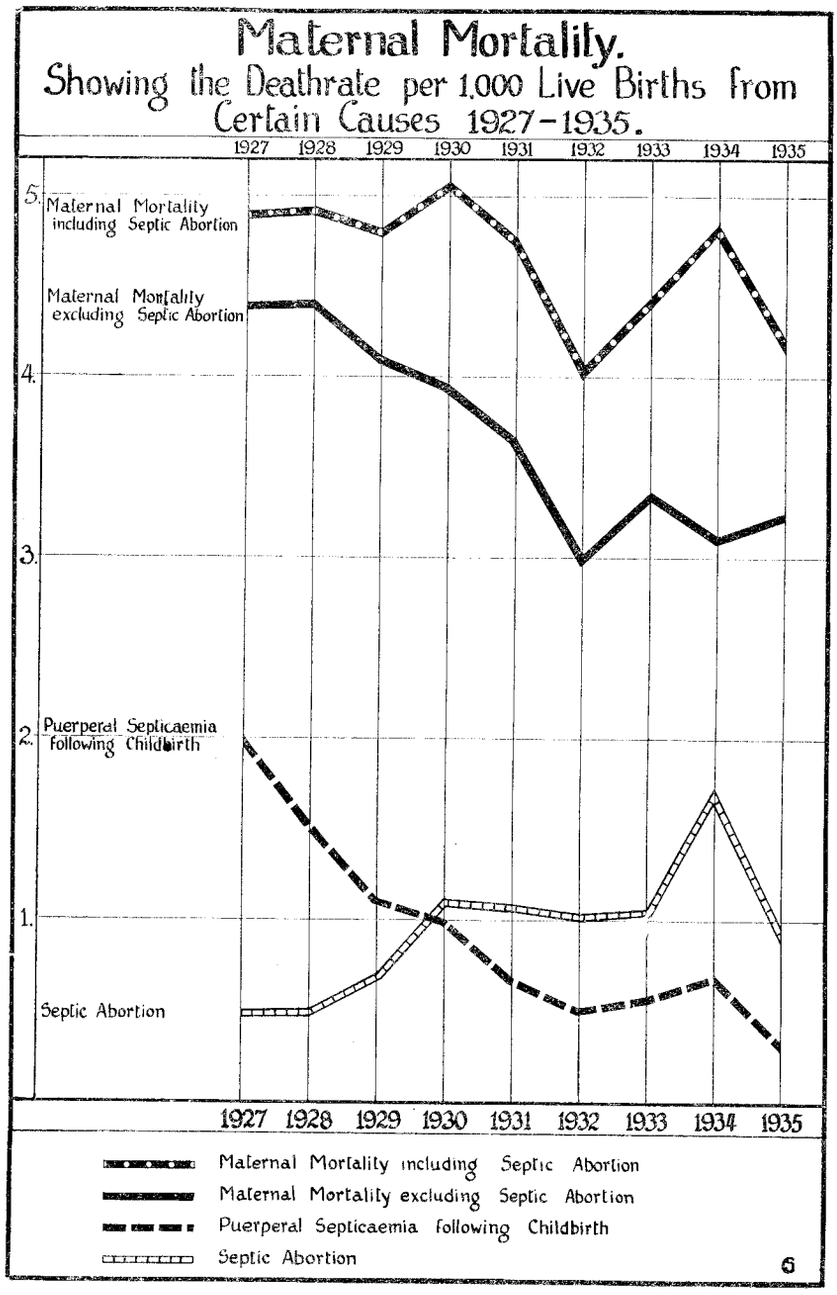
During the five-year period 1931–35, 176 women died from sepsis following abortion. In the same period there were only 70 deaths from sepsis following full-time child-birth. Some of the distressing repercussions from these tragedies have been revealed in the annual report of the Director-General of Health, 1936, which shows that in that period 338 children were left motherless by the death of 109 married women.

Another serious fact is that, while, owing to the strenuous efforts of those engaged in the direction and practice of midwifery, there has been a most gratifying fall in deaths from post-confinement sepsis from 2·02 per 1,000 live births in 1927 to 0·4 per 1,000 in 1935, deaths from post-abortion sepsis in the same period rose from 0·50 per 1,000 live births in 1927 to 1·73 per 1,000 in 1934, with a fall to 1 per 1,000 in 1935. These figures are illustrated by the following graph and accompanying table:—

Maternal Mortality.

Showing the numbers of deaths and the death-rate per 1,000 live births from certain causes, 1927 to 1935.

——	1927.	1928.	1929.	1930.	1931.	1932.	1933.	1934.	1935.
Maternal mortality, *including* septic abortion—									
Number	137	134	129	136	127	101	108	118	101
Rate	4·91	4·93	4·82	5·08	4·77	4·08	4·44	4·85	4·21
Maternal mortality, *excluding* septic abortion—									
Number	123	120	110	106	98	75	82	76	78
Rate	4·41	4·42	4·11	3·96	3·68	3·02	3·37	3·12	3·25
Puerperal septicæmia—									
Number	56	42	30	27	18	13	14	17	8
Rate	2·01	1·54	1·12	1·01	0·68	0·52	0·58	0·70	0·33
Septic abortion—									
Number—									
Married	14	14	19	26	26	24	16	29	17
Single				4	3	2	10	13	6
Rate	0·50	0·51	0·71	1·12	1·09	1·04	1·07	1·73	0·96



One of the unfortunate features of this matter from the public health point of view is the extent to which this increase in deaths from abortion sepsis is counterbalancing and masking the very real improvement which has been achieved by the obstetrical services in the work for which they may justly be held responsible.

According to the international system of recording, these cases are included in the total maternal mortality.

Actually in New Zealand in the five-year period mentioned, abortion sepsis was responsible for one-quarter of the total maternal deaths.

In the larger urban areas the position is even more unfortunate, as the following instance will indicate :—

Maternal Mortality in Urban Areas for the Five-year Period, 1930–34.

Urban Area.	Live Births.	Total Maternal Deaths.	Maternal Death-rate per 1,000 Live Births.	Maternal Deaths excluding Septic Abortion.	Maternal Death-rate per 1,000 Live Births excluding Septic Abortion.	Deaths from Septic Abortion.	Death-rate from Septic Abortion per 1,000 Live Births.
Auckland ..	14,290	81	5·67	55	3·85	26	1·82
Wellington ..	11,690	61	5·22	32	2·74	29	2·48
Christchurch ..	9,599	51	5·31	29	3·02	22	2·29
Dunedin	5,960	24	4·03	17	2·96	7	1·17
Total, four urban areas	41,539	217	5·22	133	3·20	84	2·02
Total, remainder of Dominion	58,623	273	4·66	204	3·48	69	1·18

In the case of the four urban areas deaths from septic abortion account for approximately two-fifths of the total maternal mortality.

With these cases excluded, the maternal mortality associated with child-birth proper was 3·20 per 1,000 live births.

Clearly, any comparison between different maternity services should be made on the basis of these latter figures alone.

What is the Cause of this High Incidence of Deaths from Septic Abortion.

The evidence offered to the Committee by medical witnesses indicates conclusively that sepsis, and death from sepsis particularly, is almost entirely due to illegal instrumental interference.

Spontaneous abortion, provided that proper medical care is given, rarely results in sepsis. Therapeutic abortion, done with all the safeguards of modern surgical practice, is associated with very little acute sepsis.

But criminal abortion is associated with an extremely high sepsis rate.

The reasons are not far to seek: the surreptitious nature of the operation and the lack of skill and surgical cleanliness so frequently shown by the operator make this result almost inevitable.

Has the Practice of Abortion increased in Recent Years?

In so far as the deaths from septic abortion can be taken as a comparative indication of the occurrence of abortion generally—and the Committee believes this is a fair index—there seems little doubt that there has been a marked increase.

A reference to the graph already given will indicate this rise.

There is reason to hope that the fall in 1935 means an improvement in the general situation.

Professor Dawson, giving evidence regarding admissions to the Dunedin Hospital, showed that in the five-year period 1931–35 there was an increase of 23·7 per cent. in the cases of abortion as compared with the previous five-year period.

The evidence of other medical witnesses was practically unanimous on this point.

How does New Zealand compare with other Countries in this Matter?

According to the report of the British Medical Association Committee on the Medical Aspects of Abortion (1936), the position in Great Britain would appear to be very similar to that existing in New Zealand.

In that report it is stated that the incidence of abortion is generally reckoned at from 16 per cent. to 20 per cent. of all pregnancies.

The spontaneous-abortion rate is suggested as probably about 5 per cent. of all pregnancies.

The evidence set before that Committee suggested that there has been an increase in criminal abortion in the last decade.

In England and Wales 13·4 per cent. of the total maternal deaths were due to abortion.

That Committee concludes that "illegal instrumentation contributes to an overwhelming degree to the mortality from abortion."

One of the most interesting investigations into this aspect of the subject is reported by Parish* in a study of 1,000 cases of abortion treated as in-patients in St. Giles's Hospital, Camberwell, during the years 1930 to 1934.

In 374 of these cases where instrumentation was admitted the febrile rate was 88·2 per cent., and the death-rate 3·7 per cent., while in 246 cases with no history of interference and presumably spontaneous the febrile rate was 5·7 per cent. and the mortality rate *nil.*

The following table compiled by the Government Statistician shows New Zealand's position in comparison with eleven other countries:—

Puerperal Mortality per 1,000 Live Births in Eleven Countries, 1934.

Country.	Septic Abortion.	Puerperal Sepsis following Child-birth.	Total Puerperal Mortality.	
			Including Septic Abortion.	Excluding Septic Abortion.
Norway	0·47	0·57	2·75	2·28
Netherlands	0·30	0·73	3·20	2·90
New Zealand	1·73	0·70	4·85	3·12
Switzerland	0·73	0·82	4·58	3·85
England and Wales ..	0·49	1·53	4·60	4·11
Australia	1·45	0·90	5·76	4·31
Irish Free State	0·07	1·73	4·68	4·61
Canada	0·58	1·23	5·26	4·68
United States of America ..	1·02	1·30	5·93	4·91
Union of South Africa ..	0·67	2·03	5·99	5·32
Scotland	0·38	2·30	6·20	5·82
Northern Ireland	0·32	1·85	6·27	5·95

PART II.—THE UNDERLYING CAUSES OF ABORTION IN NEW ZEALAND.

As seen by the Committee, the reasons which lead to a resort to abortion may be set out under the following broad headings:—

(1) Economic and domestic hardship.
(2) Fear of labour and its sequelæ.
(3) Pregnancy in the unmarried.
(4) Changes in social outlook.
(5) Ignorance of effective methods of contraception and of the dangers of abortion.
(6) Influence of advertising.

(1) Economic and Domestic Hardship.

(*a*) *Poverty.*—Cases arise where the parents are on the bread-line and have no means of supporting a child, but the Committee is of opinion that such extreme poverty is rare in New Zealand.

More common are the cases in which income is sufficient for a small family but a larger one would constitute hardship, or, alternatively, in which income is sufficient to support several small children but not to provide education, &c., in later life. The view, formerly widely accepted, that membership of a large

* "The Journal of Obstetrics and Gynæcology of the British Empire," December, 1935, p. 1107. T. M. Parish.

family is in itself a valuable contribution to education and to the training of responsible citizens, appears to be at a discount, and many parents now consider that advantages which can be *given* to a child as a result of family limitation outweigh the natural advantages of a large family in which the children develop initiative through companionship.

(*b*) *Housing.*—This constitutes an acute problem in crowded city areas. In many cases houses which are past repair and already condemned form the only shelter for a growing family. Ordinary domestic and hygienic conveniences are often lacking. Where a family is able to pay for better accommodation, difficulties frequently arise owing to the unwillingness of landlords to accept tenants with children, and, as the demand for houses exceeds the supply, landlords are able to pick and choose. The lack also of suitable cottages on farms for married couples with children probably has a considerable influence on the limitation or avoidance of families and leads to a premium being placed on childlessness because married couples without "encumbrances" can more easily obtain employment. This is an aspect of the problem that should receive earnest consideration.

(*c*) *Domestic.*—Lack of help in the home even by those who can afford it is a factor of very great importance. This applies especially to country life, where a woman's whole physical energy is taken up by attention to domestic matters and often also to farm-work, to the detriment of family life. The following is an account given to one witness by a farmer's wife, describing an average day's work:—

> "Rise 4.30, have cup of tea—wife to shed, set machines, hubby to bring cows—start milking 5 a.m., hard going to 8 o'clock; wife returns house to get breakfast, also see to children and cut lunches for them to take to school. Hubby feeds calves, fowls, and ducks, then breakfast. Load milk on express, harness horse, away to factory mile away—get whey return. Now 9 o'clock, wife has machines down and washes, hubby hose down shed. Drive whey down to paddocks and feed 40 pigs, returns, unharness horse, wash cart down, yoke team to plough, disk, &c. Wife to start housework about 10 o'clock, dinner at 12.30 to be ready, or taken down to paddocks (if harvesting 3 or 4 men are working). Usual times fencing, repairing sheds, fixing yards, besides other farm duties till 3.30—afternoon tea—children given something to eat on returning from school. Husband and wife to sheds again 4 till 7. Hubby washes machines, feeds calves, &c., wife in meantime has returned house, washed children and put to bed before sitting down to her tea at 8 o'clock—by time washed up is 9 o'clock—too tired to do anything else but crawl into bed."

The lack of adequate playing-areas, kindergartens, and other means of employing the time of the pre-school child outside the home is a matter that was brought before the notice of the Committee as another of the domestic difficulties. This is one of the factors preventing that amount of leisure which is necessary for the well-being of the mother.

(*d*) *Cost of Confinement.*—This was stressed particularly by country witnesses. Where a woman is beyond the reach of medical attendance and has to travel a considerable distance to hospital this adds materially to the cost of the confinement. To some women even moderate hospital and medical fees are prohibitive, and the problem is rendered more difficult still by the necessity for providing extra help in the home or on the farm during the wife's absence. It was, however, rightly pointed out by one witness that the fees paid to an abortionist and the economic waste due to subsequent ill health would in many cases more than pay the expenses of an ordinary confinement.

(2) Fear of Labour and its Sequelæ.

This was referred to by several witnesses, some of whom cited cases from their own experience. An erroneous idea seems to be prevalent among certain sections of the laity that the total abolition of pain during labour is possible for every patient. The fear that such relief will be withheld has been suggested as a cause for women seeking the abortionist. It would seem, however, that, with the increasing knowledge of methods of pain-relief in labour, more extensive ante-natal and post-natal care, and the cultivation of a more normal psychological outlook

among pregnant women, the fear complex will in future assume progressively less importance. The Committee believes that increasing attention is being paid to these aspects by the medical profession.

As to the bearing of this matter on the subject of abortion, several witnesses, among whom were two obstetricians of wide experience, expressed the opinion that, while fear of pregnancy and labour is rare, fear of infection following abortion is a factor the recognition of which is becoming more general.

The Committee is of opinion that fear of labour is not a major factor, and this opinion is supported by many witnesses.

Ill health was alleged as a cause in a few instances, but it would appear that, in spite of the ambiguous state of the law, no genuine case of ill health need resort to abortion by clandestine methods. This is referred to in greater detail elsewhere.

(3) Pregnancy in the Unmarried.

While this constitutes only a small part of the general problem of abortion, it is, nevertheless, a matter of great importance, and one which merits the closest study. Undoubtedly the general attitude towards the unmarried mother to-day is kinder and more tolerant than was formerly the case, but the fact remains that the single girl who determines to face the world with her child may find herself subject to unreasonable and unnecessary cruelty and injustice. Excellent work in assisting the single mother is done by various religious and charitable organizations, and where a girl is driven to the abortionist this is more likely to be due to fear of social ostracism than to lack of ways and means of caring for the child.

Several witnesses mentioned ignorance of matters relating to sex as being frequently responsible for pregnancy in the unmarried. This is undoubtedly the case, and the responsibility of parents, guardians, and teachers in this matter is evident. The evil influence of drinking on young people was also stressed, medical and social workers being well aware of the importance of this factor. Alcohol consumption need not be excessive to undermine self-control and dull the moral sense.

(4) Changes in the Social Outlook.

The Committee believes that, in the altered social outlook, particularly towards the rearing of large families, lies a very important cause for the present situation. This aspect of the matter is intimately interwoven with the economic considerations already set forth, but extends far beyond them.

The point of view of what we believe to be a very large body of women is illustrated by the following evidence, which is but one of many similar expressions of opinion heard by the Committee. This witness, speaking on behalf of a group with incomes of £300 to £400 per annum, stated:—

"On present incomes, not more than two or three children at the outside can be given educational and economic opportunities. It may be said that it is quite possible to mitigate to a quite tolerable degree the strain put upon the parents by the provision of (1) adequate wages for husbands, and (2) a system of domestic help for wives. With regard to (1) it is not probable within our lifetime that everybody will be guaranteed an income adequate to the needs of a family of, say, three children—'needs' as viewed by educated parents. The most sympathetic administration would have its hands full for many a year coping with the problem of helping those thousands of our people who have been just on or very near the bread-line. Those worst off hitherto need help first. A man earning between three and four hundred a year should not claim Government help to breed children, when there are such numbers of people living on a much lower wage. But it must be perfectly clear to each member of the Commission who figures the matter out that a salary of less than £400 will not enable more than two children to be given such chances of development as every parent reasonably desires. It is pertinent to ask here what is the average number of children in the families of the British middle class—which is mainly the stratum from which our legislators, rulers, and magistrates have been drawn. Do such people breed freely? Self-respecting parents prefer to do without such Government help as family allowances; but knowing the cost of training a child they claim the rights first, to decide how many children they will breed, and, secondly, to live themselves normally satisfied married lives. Few women, moreover, of average intelligence are to-day content to be breeding-machines, and their husbands support them in that attitude. With regard to domestic help, even were this, or nursing schools, or both, provided by the State, the responsibility

for her children's well-being would be still all-absorbing, at least during the first four years of each one's growth. Students of child psychology are insistent that the pre-school period is the most important in the life of the individual and requires the most skilful attention. Natural affection is not enough; it must be wedded to care for the child's mind. Now, willy-nilly, modern life itself takes such toll of nervous energy that there are few educated women to-day who go through all the child-bearing period and have sufficient nerve force to welcome each child that may 'come along' and rear it happily. Yet without adequate nervous energy in the mother what family can develop into healthy and well-balanced useful citizens? It necessarily follows that the output of children will be limited if the parents are to do their part adequately. Quantity, the mass production of the past, must give way to quality. That involves birth-control. How is it to be achieved?"

Without necessarily assenting to the sentiments expressed in the above quotation, the Committee considers that such opinions cannot but demand thoughtful consideration. Dread of large families or of close-interval pregnancies under modern conditions is undoubtedly a common reason for attempting to limit the family.

But having made all allowances for the more difficult circumstances of modern times, the more thoughtful consideration of some husbands for their wives and of some parents for their children, and a legitimate intention to maintain a higher standard of living, it seems clear that amongst a considerable section of the community the demand for the limitation of families has passed beyond these motives into regions of thoughtlessness and selfishness.

Furthermore, an attitude of pitying superiority towards the woman with many children appears to be a current fashion. Many witnesses expressed the opinion that a young and sensitive mother was frequently deterred from a further pregnancy, for which she would in other circumstances be quite prepared, or tempted to seek abortion, because of the fear of ridicule by current public opinion.

Still other women, it has been explained, are influenced by comparisons. Seeing their neighbours leading less burdensome and more pleasure-full lives, they decide to follow suit.

The modern desire for pleasure and freedom from responsibility has led many to lose sight of the ideal of the family as a service to the State and the unit of social life.

Unwillingness on the part of the wife to give up remunerative work is a factor that operates in certain cases; this may be due to the position of the wife as the support of an invalid husband and family, but in other cases the reason is obviously selfish.

While dealing with this question of social outlook, it will not be out of place to refer to an aspect which, though mentioned by only a few witnesses, is known to all social workers as a factor of increasing importance. This is the fear of war. It may take the form of (*a*) conscious visualization of the horrors of war, or (*b*) sub-conscious fear evidenced by excessive anxiety regarding the future. In either case it acts as a powerful deterrent from child-bearing, although it is doubtful whether those who are influenced by this fear would resort to abortion where contraception had failed.

Speaking of social conditions, some witnesses, under the impression that the average age at marriage was rising, attribute the increasing abortion-rate among the unmarried partly to this cause.

The actual fact is that the age at marriage has decreased of late years, but is still probably higher than would be the case if economic conditions were more favourable.

It is clear that, whether the motives be worthy or selfish, women of all classes are demanding the right to decide how many children they will have. Methods which depend on self-control are ruled out as impracticable. Contraceptives are largely used, and, judging by the marked decline in the birth-rate in recent years, are in many cases successful. In other cases, however, they are not so, and there is then frequently a resort to abortion.

(5) Ignorance of Effective Methods of Contraception and of the Dangers of Abortion.

The public as a whole is ignorant of the physiology of reproduction. This results in attempts being made to prevent conception by methods which are doomed to

failure at the outset. The use of defective methods owing to their comparative cheapness and the unnecessarily high cost of effective appliances are undoubtedly among the causes of such failure.

While it is not the function of this Committee to report upon the wider aspect of contraception, but to deal with it only in relation to the abortion problem, yet we would point out that the evidence given showed that, though contraception is widely practised, many of the methods used are unreliable, and not founded upon physiological knowledge, and that when they fail abortion is resorted to. Abortion is a delayed, dangerous, and unsatisfactory form of birth-control. It was stressed by some witnesses that many women have no idea of the risks to life and health involved in the procuring of abortion, a medical witness mentioning, among other evils, the tendency to spontaneous abortion arising from damage to the generative organs sustained at an initial induced abortion. Other witnesses, on the contrary, maintained that these risks are well known to the majority of women, but that when faced with an unwanted pregnancy they are willing to incur any risk. Fuller reference to these dangers appears in another section of the report.

(6) Influence of Advertising.

The attention of the Committee was drawn to advertisements appearing in certain periodicals which, while openly advocating the use of various contraceptives, referred to restraint and self-control in deprecatory terms. Abortifacients were advertised in terms which, while equally offensive, were less obvious. Other advertisements set forth the contents of certain books on sex matters of a very undesirable nature. The language of these advertisements can only be described as obscene, and their possible effects on immature and inexperienced minds can well be imagined.

A reprehensible practice is that of certain so-called "mail order chemists," who send out price-lists of contraceptives and abortifacients indiscriminately through the post. In some cases these advertisements were shown to be of a definitely misleading and fraudulent character.

PART III.—POSSIBLE REMEDIAL MEASURES.

Having reviewed the position as it exists in New Zealand, and having set out what appear to be the main causes, it now remains to consider possible preventive measures.

(1) The Relief of Economic Stress.

In so far as hardships resulting from economic difficulties are genuine, the Committee believes that there is a real call for and that there are definite possibilities of relief by the State.

Two classes in particular call for most sympathetic consideration:—

(1) The wives of the unemployed, or of those precariously employed.
(2) The wives of those engaged in small farming, especially in the dairy-farming districts of the North Island.

For such women we consider that much could be done by way of financial, domestic, and obstetrical help.

Financial Help.—In general terms all efforts at social betterment—the reduction of unemployment, the improvement of wages, and relief, the reduction of taxation, direct and indirect, and the provision of better housing conditions—should undoubtedly help to make conditions more secure and more satisfactory for the rearing of larger families.

But further than this, we believe that really adequate financial assistance *directly related to the encouragement of the family* is urgently called for.

It is perfectly clear that general financial improvement does not, itself, necessarily bring about larger families; limitation of the family is probably more prevalent amongst those more fortunately placed. What form this financial aid to the family should take requires much consideration.

The assistance is required not merely at the time of confinement, but also during the much longer period of the rearing and the education of the family.

A general extension of the maternity allowance under any national health scheme would afford some immediate financial assistance.

Income-tax exemption for children, however generous the scale, would not benefit these badly circumstanced cases, for already they are below the income-tax limit.

It would appear that further financial provision would have to take the form of a direct children's allowance.

It is suggested that this might be put into effect by amending the present Family Allowances Act to provide that—

(1) The amount be increased;
(2) The permissible income-level be increased;
(3) That, where given, the allowance be in respect of all the children in the family; and
(4) That the age-limit of the children be increased to sixteen.

Domestic Assistance.—Equally important is the provision of domestic assistance, and here we are faced with a problem of the greatest difficulty—a national problem which is affecting women in all walks of life and of which this is but one aspect.

In many farming districts it is clear that lack of domestic help is a greater burden to the harassed mother than even financial stringency.

Many admirable efforts are being made to give assistance in this direction—in the country by the housekeeper plans of the Women's Division of the Farmers' Union and other organizations, in the cities by the Mothers Help Society and similar agencies.

Extension of such system is highly desirable, and the possibility of their organization on a much larger scale with Government subsidy well deserves consideration.

In many cases these efforts are limited as much by lack of personnel as by lack of funds.

Alternatively, we suggest—

(1) That the Government should inaugurate and recruit a National Domestic Service Corps of young women agreeable to enter the domestic-service profession:
(2) That the recruits be guaranteed continuity of employment and remuneration as long as their service was satisfactory:
(3) That they undergo whatever training is considered desirable at technical school or otherwise:
(4) That they agree to perform service wherever required by the Domestic Service Department, which Department shall ensure that the living and working conditions are up to standard:
(5) That the service be made available to all women, and that first consideration be given to expectant mothers, mothers convalescent after childbirth, and mothers who have young families, and that the service be either free or charged for according to the circumstances of each case.

Again, realizing the fact that many of the considerations involved in this question of domestic help are beyond the scope of this Committee, we recommend that a full investigation should be made of the whole matter.

Obstetrical Aid.—As for obstetrical help, we believe that the position is in the main adequate and good.

As far as the larger centres are concerned, no woman, however poor her circumstances, need lack complete ante-natal supervision, for which no charge is made, and proper confinement care, at most moderate cost, in the St. Helens Hospitals or the various maternity annexes of the public hospitals; where the mother is actually indigent, free provision is available through the Hospital Boards or St. Helens Hospitals.

The country mother in certain districts is, however, much less well placed, although the Health Department through its district nurses, maternity annexes, and subsidized small country hospitals is trying to meet the need.

We commend all possible efforts in this direction, and suggest that transport difficulties as they affect the country mother be given special consideration.

To a certain extent transport difficulties can be eliminated by making more use of public hospitals nearest to the patient's residence, or of private maternity hospitals subsidized by the Hospital Board of the district.

Certain general criticisms of the maternity services are elsewhere discussed and certain recommendations are made.

It is in respect of overburdened and debilitated women of those classes who are not in a position to obtain it privately that we have suggested that the State might make provision for birth-control advice.

It is for such mothers especially that we have recommended the establishment of birth-control clinics in connection with our public hospitals.

We realize, however, that genuine economic hardship is not confined to the unemployed, the wives of struggling farmers, and those on the lowest wage-levels: relative to their own circumstances and responsibilities, the difficulties of many women whose husbands are in the lower-salaried groups, or in small businesses, for instance, are just as anxious. For these we should also advocate the extension of the maternity allowance and such further direct financial encouragement of the family as can be devised.

Here, too, is the definite need for domestic help—possibly on a subsidized plan.

Many of these women prefer to make their own private arrangements for their confinements, and to enable them to do so we suggest that further assistance might be given by the provision of more maternity hospitals of the intermediate type, in which these mothers may have all adequate facilities with the right of attendance by their own doctors. Here, too, we believe that proper knowledge of child spacing is most desirable, though we consider that this is a matter for private arrangement.

(2) Removal of Fear of Childbirth.

It has been indicated that whereas the majority of witnesses expressed the opinion that the fear of pregnancy and labour played little part in the demand for abortion, and that the majority of women were satisfied with the help and relief which they received at the time of their confinement, yet there were some witnesses who held very strongly that inadequate pain relief and lack of sympathetic understanding of the individual on the part of the attendants were factors of considerable importance.

We believe that these complaints are, as far as the maternity services in general are concerned, entirely unjustified.

Taken as a whole, there is probably a more general use of pain-relieving measures in New Zealand to-day than anywhere else in the world.

Nevertheless, while commending what has already been done, we trust that every endeavour will be made by the Health Department, the doctors of the Dominion, and those responsible for the management of our maternity hospitals to do everything possible to extend these pain-relieving measures within the limits of safety, and to encourage that sympathetic consideration of the individual which is so desirable.

While deprecating certain attacks which have been made on the St. Helens Hospitals, and appreciating the fact that there are other considerations involved besides the relieving of pain, we feel sure that the Health Department will investigate the possibility of improving the services rendered by these Hospitals by the introduction of resident medical officers.

We agree with one witness who expressed the opinion that too much had been done in the past in the way of publishing the risks of maternity.

We feel that there are real grounds for confidence in the obstetrical services of the Dominion and that any fear of pregnancy which does exist would be largely removed if the public were made aware that New Zealand now has a very low death-rate in actual childbirth, that relief in labour is largely used, and that further developments in this direction are continually being investigated.

(3) Control of Abortion amongst the Unmarried.

The evidence before the Committee indicates that, while this is not the major problem, it is, nevertheless, an important one.

Obviously, the main cause is a looseness of the moral standard, and the remedy must be educational.

It is not the province, nor is it within the capacity of this Committee, to make detailed recommendations on this matter, but we would urge upon all those concerned—the educational authorities, religious bodies, the various youth movements and women's organizations, and individual parents—the importance of enlightened education of the young in the matter of sex problems.

One factor of great importance we believe to be the widespread use of contraceptives amongst the unmarried.

It might, at first thought, seem likely that the use of contraceptives, however reprehensible, would tend to diminish the incidence of abortion.

But we believe that actually this is not the case: there is reason to think that many young women, relying on undependable methods of prevention, are tempted, and then, finding themselves in misfortune, resort to some method of abortion.

It is our opinion that not only is immorality encouraged by the indiscriminate sale of contraceptives, but, indirectly, criminal abortion has increased amongst the young.

For these reasons above all we are convinced that there should be a determined effort to suppress the indiscriminate sale of contraceptives.

While realizing the great practical difficulties, we believe that much could be done.

In particular, we believe that some effective measures could be devised to control the distribution of that type of contraceptive which is mainly used in these circumstances.

We recommend the consideration of the licensing of the importation of certain contraceptive goods.

We urge that the sale or distribution of contraceptives should be restricted entirely to registered practising chemists, doctors, hospital departments or clinics, and that their sale by other persons should be illegal and subject to severe penalty.

Evidence placed before the Committee showed that a profit up to 300 per cent. was being made on contraceptive appliances.

We recommend that the restriction on the advertisement of contraceptives should be more rigidly enforced, and particularly that the promiscuous advertisement and sale of contraceptives by "mail order" agencies should be made illegal.

We recommend that it should be made unlawful to supply contraceptives to young persons.

Difficulties and possibilities of evasion are of course obvious, but, nevertheless, similar restrictions have been applied with at least some measure of success in other directions.

We would also appeal to the Pharmaceutical Society and to the individual chemists, since the responsibility rests so largely with them, to co-operate most earnestly in this matter.

With regard to abortifacients, the recommendations we later make apply with even greater force to unmarried women.

Several witnesses, speaking on behalf of women's organizations, advocated the introduction of women police for the guidance and protection of the young in places of public resort.

Reference to the effect of alcohol on moral restraint has already been made.

The second big consideration is the care of the unmarried woman who is in trouble.

It has been suggested that if there were a more tolerant attitude towards such girls many who now resort to abortion would be prepared to go forward and face the future.

As one witness stated:—

> "She should be treated with the greatest tenderness. Usually she is more sinned against than sinning; but she carries all the blame which belongs not only to the man but also to society, which has been guilty of supine acquiescence in the surrender of standards of moral conduct.
>
> "She has to give birth to a child which has the rights of every unborn infant; and she has to re-establish herself in the community . . . It is terribly difficult for them afterwards with the child, and they need all the help they can get. It seems to me that some of them must go in sheer dread to the abortionist. My definite opinion is that something more needs to be done."

In all fairness to the many fine organizations which are helping these girls, the Committee is satisfied that there is no lack of tolerance, sympathy, and helpfulness with them.

If fault there is, it is in the attitude of the general public to this matter.

Some criticism has been directed at the St. Helens Hospitals because they are not freely open to unmarried women, but it is only right that the position should be made clear.

The actual position is that, in the majority of cases, the St. Helens Hospitals, which can only offer accommodation to an expectant mother for the period of her confinement, are *not suitable* for dealing with single women, who require protection and care before and after their confinements as well.

There are, throughout the country, many admirable institutions which are equipped to give this service.

Discussion before this Committee has, however, made it clear that where an unmarried mother can make adequate private arrangements for the care of herself and her infant after confinement, the St. Helens Hospitals are prepared to take her for the actual confinement period.

In regard to the maternity homes which deal with unmarried women, there has also been some criticism of the usual regulations in these homes which call for a period of residence in the home both before and, especially, after confinement.

It should be pointed out, however, that this is a wise and humane provision, entirely in the interests of the mothers and their babies: it ensures for the mother that very period of convalescence which other witnesses have so strongly advocated under other circumstances, it gives the baby protection in the most difficult early months, and it allows the helpers in the home an opportunity to make provision for the baby's future.

Here, again, where the mother is able to make adequate provision for herself and her infant, these regulations are certainly relaxed in some of the homes concerned, and we would commend this practice in suitable cases to those responsible for the management of all these homes.

Regarding the obstetrical care given to the unmarried mothers in these homes, the evidence given indicates clearly that it is of a standard equal to that in our other maternity hospitals.

Indeed, whereas the risks of childbirth amongst unmarried mothers the world over is notoriously high, amongst the women who place themselves in the care of these homes in New Zealand the maternal mortality and the infant mortality are both exceedingly low.

In the homes of which the members of the Committee have personal knowledge the same ante-natal care (indeed, since these patients are resident in the home and under close observation, more complete care) is given and the same methods of pain relief are used.

It is only right that these reassuring facts should be made public.

Regarding the provision for the children in these cases, while we are satisfied that the State and the various organizations responsible for their care deal with them in a kindly and sympathetic manner, we agree that every effort should be made to give them a fair prospect in life, to avoid any stigma, and to keep secret their misfortune.

It has been suggested by one witness that the privacy of an unmarried mother's affairs has been interfered with by the present regulations regarding the notification of births. Under the Child Welfare Act as it at present operates there is a duty on the Registrar to inform the Child Welfare Department of every birth, and the register is also open to the Plunket Society for purposes of following up

Good as the intention of these provisions is in the interests of the babies, the assertion has been made that in certain cases the knowledge of this lack of secrecy has deterred women from allowing their pregnancies to continue, and has constrained them to seek abortion.

The Committee is not prepared to comment on this complaint, but would suggest that it be investigated, and that, if there is any justification in it, the regulations be amended so that, while fully protecting the child, full secrecy is maintained.

(4) To meet Changes in Social Outlook.

The Committee has concluded that, beyond the economic and domestic considerations already discussed, there are many changes in modern social outlook which are operating in the direction of family limitation, and which, in many cases, lead to the practice of abortion.

Can anything be done to prevent the occurrence of abortion resulting from these tendencies in modern life?

Concerning birth-control the realities of the position must be faced. There can be no doubt that there is a widespread uncontrolled and ill-instructed use of contraceptives.

As one witness put it, "New Zealand is saturated with birth-control."

Owing to this extensive half-knowledge there is in many cases an entirely unwarranted dependence on their reliability to the exclusion of any measure of self-discipline whatever.

The Committee is under no illusion in this matter.

With this attitude prevailing in the community and provided with such a weapon—even though it is likely to explode in their own hands—women will continue to limit their families. No social legislation, however generous, will prevent it, nor, as far as the Committee can see, will legal prohibitions do much to restrict it.

Two lines of action are suggested:—

(1) To direct the knowledge of birth-control through more responsible channels, where, while the methods advised would be more reliable, the responsibilities and privileges of motherhood, the advisability of self-discipline in certain directions, and other aspects of the question could be discussed.

It is this view which has led the Committee to the recommendations it has made in the discussion of birth-control.

(2) To appeal to the womanhood of New Zealand in so far as selfish and unworthy motives have entered into our family life, to consider the grave physical and moral dangers, not to speak of the dangers of race suicide which are involved.

We can but urge all those who have to do with the education of our youth and the moulding of women's opinion to give these matters earnest consideration, and the Committee is of the opinion that it is necessary to develop the education of young people in biology and physiology in our primary and secondary schools as a foundation for a more rational and wholesome outlook on sex matters.

(5) Contraception.

The practice of contraception is a debatable question, and one on which the most varied evidence has been given.

Witnesses opposed this practice, some on moral grounds, some with the plea for a greater natural increase in the population of New Zealand.

Others again, particularly the representatives of women's organizations, advocated the establishment of clinics for the general instruction of married women in the practice of reliable methods of contraception. They expressed the opinion, and some of them supported their opinions with sound argument and overseas experience, that the instruction of the mothers of New Zealand in the practice of child-spacing rather than resulting in a diminution of the birth-rate might well

cause an increase in the size of many families, for, in addition to enabling mothers to plan their families, such clinics also specialize in propaganda calculated to awaken women to an appreciation of the privileges and responsibilities of motherhood.

The Committee agrees that the possession of reliable contraceptive knowledge by the married women of New Zealand would tend to augment rather than to diminish further the natural rate of increase of our population, for an additional factor to those given above lies in the large amount of sterility which follows induced abortion—that most unsatisfactory of all forms of birth-control.

The evidence laid before the Committee shows that in New Zealand every year thousands of women imperil, and indeed negate, their future prospects of motherhood by submitting to the induction of abortion.

It has been shown that abortion is a delayed, dangerous, and unsatisfactory form of birth-control, and it can quite logically be argued that if a reliable and simple method of contraception was known to all married people the abortion problem would assume very small proportions.

This is, to a large extent, true, but it must not be forgotten that both abortion and contraception have various aspects, and that apart from other objections there are practical difficulties which are not easily surmounted. There is no known contraceptive which is simple, inexpensive, and 100 per cent. reliable for the thoughtless, the careless, and the stupid.

Contraception may be considered under three headings :—

(1) The practice of contraception extramaritially, which only needs to be mentioned to be deprecated.

(2) The practice of contraception by married people irrespective of all other circumstances.

Evidence was given by responsible and representative women in support of a mother's right to say when she will bear her children, and, although we agree that this privilege might well be conceded her, we are of the opinion that it is not the function of the State to undertake the dissemination of the knowledge and give the practical instruction necessary to enable the general adoption of this principle.

This general instruction can well be left to the medical profession, who should also undertake the responsibility of impressing the privileges of motherhood upon young women seeking such advice.

In recommending that such general instruction should be left to the medical practitioners, we are cognizant of the fact that many members of that profession are at a loss to know what methods of contraception can be reliably recommended to lay persons.

A sub-committee of the Obstetrical Society, consisting of members who have made a special study of this problem, has been set up, and the presentation of their report will doubtless clarify the position in the minds of the medical profession.

(3) The practice of contraception by married women who, in the opinion of their medical attendant, should have temporary or permanent freedom from the fact or fear of pregnancy.

Not only are there cases in which severe illness exists making further pregnancies dangerous, but there is also a heterogenous group including all gradations of health and economic reasons.

Here we have the mother with health undermined and reserve vitality reduced to a minimum by the strain of bearing and rearing a large family. She approaches the menopausal stresses with anxiety and apprehension, having done her duty to family and race, often having lived an exemplary self-sacrificing life, the intolerable contemplation of a late pregnancy drives her to desperate measures often for the first time in her life.

Again, there is the relatively young, tired, anæmic, debilitated mother, with a number of young children born at very close intervals, often denied even a half-holiday, let alone an adequate one, unable to afford suitable domestic assistance, often with poor housing or domestic arrangements, and completely exhausted with the incessant round of cleaning, cooking, and the strain of the inevitable fretfulness of a number of young children.

The Committee is of the opinion that it is the State's duty to ensure that mothers within this group should obtain the respite that the health of themselves and their present and future families demands.

The economic aspects of these problems are dealt with in our general recommendations, but we also recommend that departments should be established, preferably in conjunction with the out-patients' departments of our public hospitals, whither medical practitioners could refer for instruction and equipment with contraceptive appliances mothers who in their opinion should be assured of temporary or permanent freedom from child-bearing.

It might be desirable that the certifying doctor's recommendation should be endorsed by the officer in charge of the department before admission, but that is a practical point which could be discussed at a later date with members of the Obstetrical Society and medical profession.

Though the Committee discounts the exaggerated statements that have been made at intervals about the sale of contraceptives to juveniles, and though no first-hand information on such matters was laid before the Committee, yet we are of the opinion that the sale of contraceptives to young persons should be prohibited.

(6) The Control of the Advertisement and Sale of Abortifacient Drugs and Appliances.

The Committee recommends the advertising and sale (except by doctor's prescription) of drugs euphemistically described as for the "correction of women's ailments" or "correction of irregularities" should be forbidden. For their alleged purpose of correcting functional menstrual irregularities they have no value; as abortifacients though usually ineffective their unrestricted sale should be forbidden. As stated previously, "their only value is as a lucrative source of gain to those people who, knowing their inefficiency, yet exploit the distress of certain women by selling them." An example of this exploitation was obtained by the Committee. The drugs were advertised as "corrective pills, ordinary strength, 7s. 6d.; extra strong, 12s. 6d.; special strength, 20s." A supply of the last was obtained, and analysis showed that they consisted of (1) a capsule containing about 12 drops of oil of savin, value about 6d., dangerous to health but usually useless for the purpose sold; (2) 9 tablets of quinine, worth about 1s., and quite ineffective; (3) 24 iron and aloes pills, worth about 6d., and equally ineffective. The gross profit on this 2s. worth of rubbish was at least 900 per cent. If it is possible to legislate to stop such fraudulent exploitation of people we recommend that it be done.

The Committee also recommends that the sale of surgical instruments which can be used for the purpose of procuring abortions, such as catheters, Bougies, and sea-tangle tents, be prohibited, except on the prescription of a medical practitioner, and that if possible their importation be placed under control.

PART IV.—QUESTIONS RELATING TO THE MEDICO-LEGAL ASPECTS OF ABORTION.

At the present time there is in many countries much criticism of the existing laws regarding abortion, and various suggestions have been made for the alteration of the law.

Such representations have, indeed, been made to this Committee.

A consideration of these matters, therefore, could not escape our attention.

The New Zealand Law regarding Abortion.

The law in regard to abortion as set down in sections 221, 222, and 223 of the Crimes Act, 1908, is as follows:—

Procuring Abortion.

"221. (1) Every one is liable to imprisonment with hard labour for life who, with intent to procure the miscarriage of any woman or girl, whether with child or not, unlawfully administers to or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent.

"(2) The woman or girl herself is not indictable under this section."

This section re-enacts s. 201 of the Criminal Code Act, 1893. *Cf.* s. 223, *infra*.

"Other means" must be read *ejusdem generis* with "instrument." (*R.* v. *Skellon* [1913] 33 N.Z.L.R. 102.)

"*Procuring her own Miscarriage.*

"222. Every woman or girl is liable to seven years' imprisonment with hard labour who, whether with child or not, unlawfully administers to herself, or permits to be administered to her, any poison or other noxious thing, or unlawfully uses on herself, or permits to be used on her, any instrument or other means whatsoever with intent to procure miscarriage."

This section re-enacts s. 202 of the Criminal Code Act, 1893.

"*Supplying the Means of Procuring Abortion.*

"223. (1) Every one is liable to three years' imprisonment with hard labour who unlawfully supplies or procures any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman or girl, whether with child or not.

"(2) Every one who commits this offence after a previous conviction for a like offence is liable to imprisonment with hard labour for life."

This section re-enacts s. 203 of the Criminal Code Act, 1893. In *R.* v. *Thompson* [1911] 30 N.Z.L.R. 690, a person was convicted of an attempt (s. 93, p. 209, *ante*) to procure a noxious thing although the thing actually procured was innoxious.

"Knowing" has the meaning of "believing," and a person supplying "a noxious thing" is guilty even when the person supplied, who states that he required it for procuring abortion, had no intention of using it and did not use it for that purpose. (*R.* v. *Nosworthy* [1907] 26 N.Z.L.R. 536.)

If the evidence shows that prisoner intended the instrument to be used for the purpose stated, it is sufficient without evidence of intention on the part of the woman to use it or allow it to be used (*R.* v. *Scully* [1903] 23 N.Z.L.R. 380).

The word "thing" where secondly used in this section includes only things *ejusdem generis* with instrument and capable of being used to produce miscarriage (*R.* v. *Austin* [1905] 24 N.Z.L.R. 893).

Therapeutic Abortion.—In New Zealand, as in Great Britain and other countries, the medical profession has always held that when the mother's life is seriously endangered by a continuation of the pregnancy the termination of the pregnancy is justifiable and right.

This the law allows, not specifically but by inference.

It is probably a correct statement of the position to say that, with advances in medical knowledge and thought, even the most conservative medical opinion, apart from that which is influenced by certain religious views, holds that the indications for the termination of pregnancy have been extended somewhat to include not only cases in which the mother's life is immediately jeopardized, but also certain cases in which her life is more remotely endangered.

This view is supported by the social thought of to-day.

This is not to say that the occasions for this operation are frequent; they are, indeed, infrequent.

The general standards which guide the medical profession in this matter are very strict, and are conscientiously conformed to by the majority of its members.

It is also a well-recognized rule of the profession that such operations should only be performed after consultation between two medical practitioners.

With this change in medical outlook, however, there has been no corresponding alteration in the law, which, as it stands, is as uncompromising as ever, and allows of no interference except to save the *life* of the mother.

It is a fact that the law is *interpreted* liberally, and no doctor who has acted honestly in the belief that the mother's health was seriously endangered has ever been challenged.

Nevertheless, it has been urged by a large body of the medical profession, especially of those most intimately affected by the question, that there are possible

dangers in the situation, and that the law should be altered to indicate more specifically the rightful position of the doctor in this matter; in other words, it is advocated that the present interpretation of the law should be incorporated in the law itself.

Much is made of the fact that an honourable practitioner occasionally finds himself in the unsatisfactory position of having actually to break the letter of the law in doing what according to accepted medical standards is in the best interests of the patient.

As safeguards against the possible dangers of a widening of the law, it has been suggested that new regulations should be introduced governing the practice of therapeutic abortion.

It has been recommended that operations should only be performed after adequate consultation, and that written certificates should be given by both parties to the consultation; that in certain cases the consultant should be a specialist; that all operations should be performed in public or licensed hospitals; that every therapeutic abortion should be notified to the Medical Officer of Health, to whom also the two certificates should be forwarded; and that every operation not performed under these conditions should be subject to strict investigation.

It has also been recommended by some that there should be a general notification of all abortions.

Those who are opposed to any alteration of the present state argue that any specific legalization of therapeutic abortion to save the serious impairment of health as well as to save life might lead to abuses of this sanction. They point out that even at the present time doctors differ considerably in their views and in their practice, and they fear that such divergences in thought and practice might be seriously exaggerated.

As to the suggested safeguarding regulations, there is by no means general agreement in the medical profession concerning their advisability or their value.

The Committee, having investigated the matter very fully, is satisfied that any disability under which the doctor rests in terminating a pregnancy for genuine, accepted therapeutic reasons is only theoretical.

No actual instance was brought before the Committee in which a doctor had been penalized or even subject to question when acting in good faith, nor was any evidence presented to show that any patient had suffered by reason of a doctor refraining from operating through fear of possible legal consequences.

Both medical and legal witnesses competent to speak on these medico-legal aspects were definite in their assurance that, under the existing law, no doctor acting in accordance with the accepted standards of the profession was in any danger.

The only person who need have any fear was one who ignored guidance of the existing standards of his profession, and to this extent the law was, at least in part, a deterrent against laxity of practice.

The Committee considers that, as it stands, the law has shown itself adaptable in practice to all reasonable changes in medical thought.

Further, the Committee was impressed by the possible dangers which might be associated with any alteration in the existing law.

While it is undoubtedly true that the majority of doctors are straightforward and honest in their interpretation of the indications for therapeutic abortion, it was made clear that even at the present time there are some who are inclined to terminate pregnancy for reasons which would not be accepted by most.

It would be quite impossible to lay down a hard-and-fast list of indications.

There are definite grounds for fearing that any alteration in the law would lead, in certain quarters, to a widening of the interpretations far beyond the intention of the alteration.

Under any alteration it would be exceedingly difficult to control the merging of the therapeutic into the social and economic reasons.

For these reasons, then, the Committee is not prepared to suggest any alteration in the law regarding therapeutic abortion; the Committee believes, however, that some benefit might accrue from the compulsory notification of all abortions to the Medical Officer of Health.

Abortion for Social and Economic Reasons.—Having received certain representations in favour of this practice, and having examined a large mass of evidence on this subject, the Committee is utterly opposed to any consideration of the legalization of abortion for social and economic reasons.

The Committee does not hesitate to state its first objection on moral grounds.

That the deliberate destruction of embryo human lives should be allowed for all the varying and indeterminate reasons suggested by different advocates would lead the way to intolerable license.

We would draw your attention and that of the public to the extreme views which are held by some of the most active advocates of legalized abortion.

In its most blatant form this advocacy is based on the argument of woman's right to determine for herself whether a pregnancy shall continue or not.

> "The right to abortion should be taken quite away from legal technicality and legal controversy. Up to the viability of her child it is as much a woman's right as the removal of a dangerously diseased appendix."

This is the view of Miss Stella Browne in her essay on "The Right to Abortion"* and of others who hold similar opinions.

Is any comment necessary?

The representative of one of the largest women's organizations in New Zealand who gave evidence before the Committee advocated the introduction of legislation permitting abortion under certain circumstances after a woman had had two children, subsequently qualifying the suggestion by the words "if contraceptives fail."

In the case of such ill-considered opinions, the Committee believes that it would be impossible to limit the practice if the law were in any way relaxed.

Of course there are others who confine their advocacy of legalized abortion to cases in which there are elements of real tragedy and which appeal to public sympathy, but, granting that there are many cases in which social and economic conditions create situations of great hardship, nevertheless the Committee is fairly convinced that abortion is not justifiable; the remedies lie in the removal of the causes and the alleviation of these difficult situations by social legislation and other measures, and in the education of the public conscience.

The Committee is also opposed to the legalization of abortion for social reasons on account of the very considerable risks to health which are associated with the practice.

Medical witnesses were agreed that, while the immediate risk to life in surgically performed termination of pregnancy was slight, there were very definite possibilities of more remote disabilities, and that such sequelæ occurred in a considerable proportion of cases.

In the case of a genuine therapeutic abortion these risks are outweighed by the dangers of the condition calling for the termination of pregnancy, but were the operation to be performed freely for social reasons the effect in the community might be very serious.

World-wide interest has been aroused in the matter through the experience on Soviet Russia, where, for a number of years, abortion for social and economic reasons was legalized and extensively practised.

The operations were performed in special hospitals and by skilled operators.

At first it was claimed that when the operation was done openly and carefully the risk to live was exceedingly small. It was stated, for instance, that in 1926 artificial abortion was carried out on 29,306 women in Moscow with no mortality, and that in a total of 175,000 operations in Moscow there were only nine deaths.

But now come most significant reports of the after-effects to these operations, which state that 43 per cent. of these women suffered from some definite illness as a result of the operation, and that "the most enthusiastic Russian advocates of legalized abortion are appalled at the growing evidence of serious pelvic disturbances, endocrine dysfunctions, sterility, ectopic pregnancy, and other complications following in the wake of artificial abortions."*

A recognition of these remoter dangers has undoubtedly been an important factor in bringing about the complete reversal of the previous policy in Russia, where abortion for social and economic reasons is now illegal.

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* "Abortion Spontaneous and Induced." Taussig.

The opinion of A. M. Ludovici, admittedly an extreme exponent, may well be considered when, in "The Case against Legalized Abortion"* he writes:—

> "If only the disingenuous propaganda in favour of legalized abortion would cease, and if only those who carried it on refrained from dinning into the ears of an uninformed gallery of women the alleged safety and harmlessness of abortion carried out under the best hospital conditions, there would be less eagerness to face the ordeal of criminal abortion.
>
> "So long as ignorant women are led to believe that abortion, when skilfully performed, is as easy and harmless as having a corn extracted, they will naturally infer that it can be done just as harmlessly in secret as in public, especially if they are assured that the surreptitious abortionist is skilled, as presumably they always are, and are, moreover, kept in total darkness concerning the kind of operation that is necessary for the interruption of pregnancy.
>
> "If, however, they knew the truth, which is that artificial abortion, even under the best hospital conditions, is a precarious undertaking, so frequently leading to invalidism as never to be 'safe'; if, moreover, we spread the truth about Russia's legalized abortions, and put a stop to the false reports circulated by ill-informed enthusiasts regarding the ease and safety of skilled induced abortion, we should be going a long way towards reducing criminal or surreptitious abortion to vanishing-point."

Sterilization.—Brief mention must be made of *sterilization*—an operation whereby further pregnancy is prevented—which has been put forward by certain witnesses as a method of preventing abortion.

Just as therapeutic abortion is, in certain cases, legitimately performed by medical practitioners, so has the operation of sterilization a recognized place in medical treatment of exceptional cases in which a woman's life is likely to be endangered or her health gravely impaired by further pregnancy.

It can, indeed, be reasonably argued that in such cases sterilization is very definitely to be preferred to the very unsatisfactory alternative of repeated thereapeutic abortion.

Nevertheless, any general extension of this practice would, in the opinion of the Committee, be open to serious abuse.

The Committee sees a tendency in some quarters to extend the indications for this operation far beyond the bounds of generally accepted medical opinion.

The attitude of the Committee towards this matter is therefore the same as towards more specific legalization of therapeutic abortion.

The Prosecution of the Criminal Abortionist.—A very disquieting aspect of this problem is the relative immunity of the criminal abortionist from punishment. Conviction for the crime is rare, even in cases where guilt appears to be proved beyond all reasonable doubt.

The Committee has sought to discover the reasons for the failure to obtain conviction.

It is apparent that the police authorities are faced with many difficulties. In the first instance conviction is largely dependent on the evidence of a woman who, in the eyes of the law, is an accomplice to the offence, and corroboration of her evidence may be demanded.

It has been suggested by certain witnesses that, if the woman were legally exempt from penalty, there would be less reticence about giving evidence and a greater fear on the part of the abortionist.

On the other hand, it has been stated to the Committee that where such an indemnity is actually given, this very fact operates against conviction.

The Commissioner of Police gave information that—

> "Juries are loth to convict in such cases and appear to be impressed by the argument usually advanced by counsel for the defence that, as it was at the solicitation of the woman that the offence was convicted, she is the principal offender, and they adopt the view that unless she also is charged it would be unfair to convict the abortionist. The fact that if the woman was charged she could not be called as a witness, and that, without her evidence, there would be no case, does not appear to weigh with them."

It would therefore appear that legalized exemption of the woman would not be a remedy.

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* "Abortion," by Stella Browne. Ludovici and Roberts.

The very serious statement has been made that—

> "In many cases professional abortionists have the assistance of one particular doctor who attends their patients when medical skill becomes necessary. The doctor either treats the patient successfully or sends her to hospital on his own personal note, and in neither case does the identity of the abortionist come to light. There is reason to believe that in many such cases the assistance of the doctor is given knowingly and in collaboration with the abortionist contrary to the rule laid down in Sydney Smith's 'Forensic Medicine,' 3rd edition, page 362, that 'It is no part of a doctor's duty to act as a detective, but it is equally certain that it is no part of his duty to act as a screen for the professional abortionist.'"

The Committee would earnestly draw the attention of the responsible medical authorities to the suggestion that there are even a few members of the profession who are prepared to "cover" the abortionist when difficulties arise.

It is quite well realized that there are many occasions on which the general practitioner quite innocently comes in contact with these cases: that is an entirely different matter.

It is a further complaint of the police that they are hampered by the fact that rarely are they notified of a case of criminal abortion until the woman's condition is so critical that it is impossible to obtain a statement from her, and if she dies the evidence she might have given is lost. Without such evidence there is little chance of successfully prosecuting the abortionist.

To overcome this difficulty it has been advocated that, where a patient is admitted to hospital and is suspected to be suffering from the effects of criminal abortion, it should be the duty of the responsible medical officer of the hospital to notify the police forthwith and supply all the information in his possession.

This suggestion, however, involving as it does the confidential relationship between doctor and patient, is open to serious objections.

It is proposed to consider the position of the medical practitioner in relation to criminal abortion more fully in a subsequent section.

Finally, it is evident that the general public as represented by some members of juries do not regard this crime with the same seriousness as does the law.

A heavy responsibility rests on the public in allowing the present position to continue.

The Committee cannot but take a serious view of the repeatedly demonstrated difficulties in securing convictions, even in the face of apparently conclusive evidence, of persons charged with inducing abortion, and consider that the time has arrived when careful consideration should be given to the condition of the law relating to such crimes and to what steps are necessary to discourage effectively their practice. With that object in view the Committee respectfully and earnestly directs the attention of the Government to the position that has arisen, and the serious social, physical, and moral consequences which are likely to follow if effective steps are not taken to enforce the clear intention of the law.

The Position of the Medical Practitioner in Relation to Criminal Abortion.—The duties and responsibilities of medical practitioners in connection with cases in which the performance of an illegal operation is suspected or known to have occurred are of great public importance.

Two main questions arise—(1) The duty of a doctor before the death of a patient or in a case where a fatal result is not expected, and (2) his duty in a case where the patient has died.

Concerning the first issue there are very conflicting opinions.

As already pointed out, it has been urged by the Police Department that in every case where a patient is admitted to a hospital and is suspected to be suffering from the effects of induced abortion or attempted abortion it should be the duty of the Medical Superintendent or Senior Medical Officer of the hospital to notify the police forthwith, and supply all information in his possession which would assist in establishing the identity of the offender and bringing him to justice.

The widely accepted view of the medical profession, supported by high legal authority, is that the bond of professional secrecy as between doctor and patient is so important that it would be entirely wrong for a doctor, without the patient's consent, to give information to the police before her death.

It has been insisted that, were it to be compulsory for the doctor to notify the police on the strength of information obtained in his professional capacity, patients would refrain from obtaining the necessary medical help under these circumstances, thus accentuating the problem of deaths from abortion rather than limiting it.

It has been stated that already in one centre a disinclination to enter hospital has been expressed by patients because they feared that the police would be informed.

It is agreed, however, that the doctor should attempt to persuade the patient, especially if her condition is serious, to make a statement to the police.

The actual legal position in New Zealand was made quite clear by the law officer of the Crown when asked by the New Zealand Obstetrical Society in 1932 for an opinion.

This opinion, as published in the *New Zealand Medical Journal* (Obstetrical Section), 29th October, 1932, was as follows :—

> " A doctor is under no legal obligation to inform the police as to the cause of the illness of a person which has been due to an illegal operation, either in a case where the patient recovers or in a case where the patient dies. He is, of course, under an obligation to insert in the certificate of death which he furnishes under the Births and Deaths Registration Act, 1924, the cause of death, both primary and secondary. In that certificate, where the death was the consequence of an illegal operation, he should insert the nature of the operation as the primary cause of death. He need not, of course, describe it as an illegal operation, but he would describe the type of operation and the reason why such operation was the primary cause of death—*e.g.*, owing to incompetence or ignorance, if that be the case.
>
> " In giving this ruling I am, of course, referring merely to the legal obligation—*i.e.*, the duties imposed according to law. Speaking generally, there is a moral duty on every person having knowledge of a serious crime which is an offence against morality as well as against law, to assist the police as far as possible in its detection and suppression. The confidence of a patient may be a legitimate ground for excluding that duty in some, or even in most, of the cases of this kind. But no doubt there are certain cases where the duty is clear. Instances are the case of a young and inexperienced woman who has reluctantly submitted to the operation at the hands of a person who is known as a practised abortionist, or where the operation has been done by violence and against the will of the subject. These, however, are questions of morality upon which varying opinions may be held, and upon which I do not desire to be taken as expressing a final opinion."

This legal opinion has not been challenged, though it has been criticised.

Although the Committee appreciates the difficulties under which the police are working, the evidence of other witnesses has led them to agree that any extension in the direction of compulsory notification to the police before death, and against the patient's wish, is open to serious objections and is therefore not advisable.

Regarding the second issue, there is general agreement that there is a duty on the doctor to assist the police, and that this should be done by withholding a certificate of death and informing the Coroner.

The position has been more clearly defined as a result of a recent amendment to section 41 of the Births and Deaths Registration Act, as contained in section 12 of the Statutes Amendment Act, 1936 :—

> " 12. (1) On the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall forthwith sign and deliver to the Registrar of the district in which the death occurred a certificate, on the printed form to be supplied for that purpose by the Registrar-General, stating to the best of his knowledge and belief the causes of death, both primary and secondary, the duration of the last illness of the deceased, the date on which he last saw the deceased alive, and such other particulars as may be required by the Registrar-General, and the particulars stated therein shall be entered in the register together with the name of the certifying medical practitioner.
>
> " (2) The medical practitioner shall at the same time sign and deliver to the undertaker or other person having charge of the burial a notice on the printed form to be supplied for that purpose by the Registrar-General to the effect that he has furnished a certificate under the last preceding subsection to the Registrar.
>
> " (3) In any case where, in the opinion of the medical practitioner, the death has occurred under any circumstances of suspicion, the practitioner shall forthwith report the case to the Coroner.

"(4) Every medical practitioner required to give a certificate and a notice as aforesaid, or to report to the Coroner as provided by the last preceding subsection, who refuses or neglects to do so is liable to a fine not exceeding five pounds."

Recently a consultation on this matter was held between the Minister of Health and members of the Council of the New Zealand Branch of the British Medical Association.

The Association expressed the opinion that the resolutions of the Royal College of Physicians (England), which were laid down as a result of a similar controversy in Great Britain, constituted the most satisfactory guide in these difficult and responsible situations, and informed the Minister that steps would be taken to make the position clear to all its members. The resolutions are as follows:—

"The College is of opinion—

"1. That a moral obligation rests upon every medical practitioner to respect the confidence of his patient; and that without her consent he is not justified in disclosing information obtained in the course of his professional attendance on her.

"2. That every medical practitioner who is convinced that criminal abortion has been practised on his patient should urge her, especially when she is likely to die, to make a statement which may be taken as evidence against the person who has performed the operation, provided always that her chances of recovery are not thereby prejudiced.

"3. That in the event of her refusal to make such a statement he is under no legal obligation (so the college is advised) to take further action, but he should continue to attend the patient to the best of his ability.

"4. That before taking any action which may lead to legal proceedings, a medical practitioner will be wise to obtain the best medical and legal advice available, both to ensure that the patient's statement may have value as legal evidence and to safeguard his own interest since in the present state of the law there is no certainty that he will be protected against subsequent litigation.

"5. That if the patient should die he should refuse to give a certificate of the cause of death, and should communicate with the Coroner.

"The college has been advised to the following effect:—

"1. That the medical practitioner is under no legal obligation either to urge the patient to make a statement, or, if she refuses to do so, to take any further action.

"2. That when a patient who is dangerously ill consents to give evidence, her statement may be taken in any of the following ways." [The procedure employed in taking this statement is then specified.]

The Committee is also of the opinion that if the medical profession closely follows this guidance and that of the amended section 41 of the Births and Deaths Registration Act, the public interests will best be served.

SUMMARY AND CONCLUSIONS.

I. The Committee is convinced that the induction of abortion is exceedingly common in New Zealand, and that it has definitely increased in recent years.

It has been estimated that at least one pregnancy in every five ends in abortion; in other words that some 6,000 abortions occur in New Zealand every year.

Of these, it is believed that 4,000, at a conservative estimate, are criminally induced either through the agency of criminal abortionists or by self-induction, either of which is equally dangerous.

It is clear that death from septic abortion occurs almost entirely in such cases.

Such deaths have greatly increased in recent years, and now constitute one-quarter of the total maternal mortality: in some urban districts it amounts to nearly half of the total maternal mortality.

New Zealand has, according to comparative international statistics, one of the highest death-rates from abortion in the world.

II. The Committee, after taking evidence from witnesses representing all sections of the community, has formed the conclusion that the main causes for this resort to abortion are—(1) Economic and domestic hardship; (2) changes in social and moral outlook; (3) pregnancy amongst the unmarried; and (4) in a small proportion of cases, fears of childbirth.

These matters are fully discussed.

III. Consideration has been given to the possible remedying of these causes.

(*a*) In so far as economic hardship is the primary factor, certain recommendations have been made regarding financial, domestic, and obstetrical help by the State.

(*b*) To lessen any fear of childbirth where this exists, it has been recommended that the public should be informed that New Zealand now has a very low death-rate in actual childbirth and that relief of pain in labour is largely used. At the same time the Committee has advocated that further efforts in the direction of pain relief should be explored.

(*c*) For dealing with the problem of the unmarried mother, the Committee considers that the attack must be along the lines of more careful education of the young in matters of sex, prohibition of the advertisement and sale of contraceptives to the young, and a more tolerant attitude on the part of society towards these girls and their children.

(*d*) The Committee believes, however, that the most important cause of all is a change in the outlook of women which expresses itself in a demand of the right to limit—or avoid—the family, coupled with a widespread half-knowledge and use of birth-control methods—often ineffective. These failing, the temptation to abortion follows.

The Committee can see only two directions in which abortion resulting from these tendencies can be controlled:—

(1) By the direction of birth-control knowledge through more responsible channels, where, while the methods would be more reliable, the responsibilities and privileges of motherhood, the advisability of self-discipline in certain directions, and other aspects of the matter would be discussed.

The Committee believes that it is through the agency of well-informed doctors, and, to a certain extent, through clinics associated with our hospitals, that this advice should be given.

It is not, however, considered that this is a matter for the State except to a limited degree.

(2) To appeal to the womanhood of New Zealand, in so far as selfish and unworthy motives have entered into our family life, to consider the grave physical and moral dangers, not to speak of the dangers of race suicide which are involved.

This, it is considered, is a matter for all women's social organizations to take up seriously.

IV. Certain further measures of a more general nature came under the examination of the Committee.

The prohibition of the promiscuous advertisement of contraceptives, and of their sale to the young; the licensing of the importation of certain types of contraceptives; the restriction of the sale or distribution of contraceptives to practising chemists, doctors, hospitals, and clinics; the prohibition of the advertisement, or of the sale, except on medical prescription, of certain drugs and appliances which might be used for abortion purposes; these measures are recommended.

The specific legalization of therapeutic abortion (by doctors for health reasons) as a safeguard to doctors was fully examined but is not recommended.

The Committee is satisfied that the present interpretation of the law is such that, where the reasons for the operation are valid, the doctor runs no risk of prosecution.

The risks of an alteration in the law are great.

Legalization of abortion for social and economic reasons was also put forward. The Committee has discussed the matter, and strongly condemns any countenancing of this measure.

Though it may be conceded that legalized performance of the operation by doctors in hospitals might reduce the incidence of surreptitious abortion and deaths from septic abortion, we do not accept this as any justification of a procedure which is associated with grave moral and physical dangers.

With regard to sterilization, the Committee adopts the same view as towards the specific legalization of therapeutic abortion.

It is believed that, where the reasons for the operation are in accord with generally accepted medical opinion, there is no bar to its performance.

We see, however, tendencies in the direction of extending this operation far beyond the bounds of this accepted medical opinion.

For this reason we do not recommend any alteration in the present position.

The failure to obtain the conviction of the criminal abortionist, even in cases where the guilt seems beyond all doubt, has been discussed as a matter of serious concern, and the Committee can only bring before the public its responsibility, as represented by members of juries, for the virtual encouragement of this evil practice.

Finally, the Committee, while fully conscious of its inability to place before you a complete and certain solution of this grave problem, or one which will satisfy all shades of opinion, believes that a definite service will have been done through this investigation if full publicity is given to the facts of the situation as here revealed, and if the public conscience is awakened to the fact that, although State aid and legal prohibitions may do something to remove causes and to deter crime, the ultimate issue rests with the attitude and action of the people themselves.

THANKS.

To Mr. C. Stubley, of the staff of the Department of Health, we extend our thanks for the efficient manner in which he carried out his duties as Secretary to the Committee, and also to Misses B. Frost and O. Clist who, as stenographers to the Committee, had a very arduous task, and whose excellent reports materially assisted the members of the Committee in their final deliberations.

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