This Annual Report covers the period from 1 July 2015 until 30 June 2016.
President’s and Chief Executive’s Report

2016 marks 80 years since the first meeting of what was to become Family Planning. Across this, our 80th year, we have celebrated our successes and taken some time to reflect on the things we have done well over the past eight decades. As part of the celebration, we have reached out to national and international personalities with an interest in our work to hear what they celebrate about Family Planning — you will see their testimonials throughout this report.

Our focus however has been firmly on the future — on recognising our organisational commitments under Te Tiriti o Waitangi - the Treaty of Waitangi; we’re identifying where and what we can and must do more, do better and do differently to ensure that sexual and reproductive health outcomes for Māori, in particular rangatahi Māori, are improved.

We make no apologies that across this year’s Annual Report we will refer time and time again to the issue of equity. We are clear about what we mean by equity and by what we’re working to achieve. Equity accentuates fairness in process and in result. Equity recognises differences and accommodates them to prevent the inequitable status quo from continuing.

Equity works towards equality by levelling the playing field. Think of equity as the means and equality as the end. Equity leads to equality.

Strategic Framework

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March to July 2015</td>
<td>Strategic Framework Consultation with staff, members, stakeholders.</td>
</tr>
<tr>
<td>August 2015</td>
<td>Senior management team reviews Draft Strategic Framework.</td>
</tr>
<tr>
<td>November 2015</td>
<td>Strategic Framework signed off by Family Planning Council and approved by members at the Annual General Meeting.</td>
</tr>
<tr>
<td>1 July 2016</td>
<td>Implementation of Strategic Framework begins.</td>
</tr>
</tbody>
</table>

A new Strategic Framework, which will guide our work until 2020, was signed off by Family Planning Council in November 2015 and presented to members for the first time at the 2015 Annual General Meeting.

The overarching principle of the new framework is equity. This aligns with the Te Tiriti o Waitangi principle to focus on the needs and aspirations of Māori in services, policies and processes. It also helps us to apply a strengths-based approach to our work.

As an organisation, and across the organisation, we are building our understanding of health equity issues – particularly as they apply to sexual and reproductive health. We are reassessing where and how our services are delivered, to reduce health inequalities and to ensure we offer Māori improved access to sexual and reproductive health services and information.
Two projects – one focussed on where and how we deliver clinical and health promotion services and the other looking at the way we offer clinical training – were identified as priorities during the Strategic Framework process. Initial work on both projects is now underway.

The new Strategic Framework has identified four outcome areas, each with two priorities and each with short, medium and long-term measurable targets.

**Outcome One:** Eliminate service inequities and deliver sexual and reproductive health and rights (SRHR) in the areas of highest need.

- **Priority One** – Provide services that are geographically located in areas of highest need.
- **Priority Two** – Ensure services are prioritised for rangatahi Māori/young people.

**Outcome Two:** A commitment from policy and decision makers to respect and protect sexual and reproductive health and rights (SRHR) and gender equality.

- **Priority One** – National and regional commitments to improving sexual and reproductive health equity with a focus on gender and ethnicity.
- **Priority Two** – Societal commitment to abortion law reform, including decriminalisation.

**Outcome Three:** Leading health organisation in the use of technology.

- **Priority One** – Enhance the delivery of services through technology.
- **Priority Two** – Develop external professional training and education capability through technology.

**Outcome Four:** Accelerate service development through greater efficiency and effectiveness.

- **Priority One** – Provide integrated and collaborative services to improve sexual and reproductive health outcomes.
- **Priority Two** – Maximise internal efficiencies and strengthen effectiveness.
Sexual and reproductive health outcomes are determined in large part by social and economic factors such as education, income, gender and ethnicity. Negative outcomes from early pregnancy and sexually transmitted infections (STIs) threaten the health of young people more than any other age group in New Zealand and in Pacific Island countries.

Ensuring our services are located in the areas of highest need has the potential to improve access and deliver real change in health outcomes for underserved communities.

These outcome areas and priorities are all underpinned by our new vision and mission.

**Vision:** Whakamanahia - Equity, Access, Choice.

**Mission:** Aotearoa’s leading provider and courageous advocate for sexual and reproductive wellbeing and rights.

### Māori Work Programme

A Māori Sexual and Reproductive Health Work Programme was put in place in 2014. The objectives of the first phase of the work programme were to build a foundation for a comprehensive long-term programme of work focussed on equity and Māori sexual and reproductive health and rights and to enhance our strategy and service provision in this area. Specific work areas in the first stage included the implementation of a health equity assessment tool training programme, strategies to improve health literacy, a literature review of best practice, policy and advocacy with an equity focus, workforce strategy and a service review.

The 2016-2020 Strategic Framework has a number of outcomes related directly to health equity and priorities specific to rangatahi Māori. Equity is clearly stated as part of the vision and values for the framework.

To enable a strong focus on health equity, and in particular to provide services that meet the needs and aspirations of Māori accessing sexual and reproductive health services, we are setting the expectation across our services and our staff that equity, and particularly the equity of health care for Māori, is an integral component of the services we provide.

A stocktake of phase one of the work programme began in May 2016 and will be completed in August 2016. The results of this stocktake will inform the development and implementation of phase two of the work programme.

### Legislation under scrutiny – again

New Zealand’s antiquated abortion laws were tested in court again in late 2015. The case had the potential to stop the Early Medical Abortion (EMA) service we provide at our Tauranga Clinic.

#### Timeframe

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 April 2015</td>
<td>Right to Life alleges that the Abortion Supervisory Committee had given us an unlawful licence for the EMA service at our Tauranga Clinic.</td>
</tr>
<tr>
<td>2 June 2015</td>
<td>Case heard in High Court, Wellington by Justice Williams.</td>
</tr>
<tr>
<td>1 October 2015</td>
<td>Court releases decision.</td>
</tr>
</tbody>
</table>

The point of law at issue was that the Abortion Supervisory Committee (ASC) had purported to allow us to carry out EMA in the first nine weeks of pregnancy, while the

---

“80 years of providing fantastic service to New Zealanders so thank you for everything you do.”
Prime Minister John Key

“It’s amazing that for 80 years now you have been providing this incredible service to New Zealand families, to people young and old, men and women. We have gone to you when we have needed help and support on those really personal health issues….. Thank you for being so accessible, so equitable, so available to us when we’ve needed you…..”
Green Party Co-leader Metiria Turei
governing legislation, the Contraception, Sterilisation, and Abortion Act, empowered the ASC to “authorise the holder to permit the performance of abortions in the institution to which the licence relates only during the first 12 weeks of pregnancy.” Right to Life argued that the licence we had been granted purported to permit something the ASC could not allow.

The Court agreed with Right to Life but refused to declare procedures unlawful and took action to remedy the situation. The Court:

- Declared the old licence unlawful
- Amended the terms of the ASC’s licence to allow EMA during the first 12 weeks of pregnancy, bringing the licence terms into line with what the statute prescribes
- Refused to void the licence because with the new wording in place, the licence now conforms to the law.

As a provider of abortion services, we are keenly aware of the fragility of the current law. Groups, like Right to Life, will continue to test our failing and antiquated laws. While we are relieved for the women of the Bay of Plenty that our service there is unaffected, this latest legal challenge highlights the need for abortion law reform.

In 2016, abortion should be treated as a health matter instead of a crime. This aligns with the 2012 advice from the United Nation’s Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which urged the New Zealand Government to review the abortion law and practice with a view to simplifying it and to ensure women’s autonomy to choose.

Health literacy

We have prioritised improving health literacy as a means to address inequities in health status and healthcare access. Improving health literacy allows people to understand and follow health care plans and so leads to better improvement in their health.

The Ministry of Health has issued a guide for reviewing health literacy in health services and we have completed an organisational health literacy audit which identified key areas for development.

Select Committee supports capacity to consent

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 May 2015</td>
<td>Petition presented to Whanganui MP Chester Borrows.</td>
</tr>
<tr>
<td>17 September 2015</td>
<td>Family Planning presents evidence to Select Committee.</td>
</tr>
<tr>
<td>7 July 2016</td>
<td>Select Committee releases report.</td>
</tr>
</tbody>
</table>

In early July 2016, the Justice and Electoral Select Committee released its report into a six-person petition calling for parents to be notified when a pregnancy is confirmed for a young person under 16.

The Justice and Electoral Select Committee decided that mandatory parental notification is not in the best interests of young people seeking abortion services. Even with a positive relationship with their parents, a young person may feel the need to maintain their privacy around sexual and reproductive health decisions. It may be that a young person with healthy family connections feels empowered to take responsibility and make informed decisions regarding their sexual and reproductive health. In other circumstances,
discussing sexual and reproductive health issues with parents could be unsafe or create significant barriers to accessing services.

New Zealand’s current legal framework acknowledges that young people have the capacity to provide informed consent.

The Select Committee concluded that the evidence presented by the relevant organisations (such as the New Zealand Medical Association, New Zealand Association of Counsellors, Abortion Supervisory Committee and the Health and Disability Commissioner) overwhelmingly demonstrated that, although it is best practice for a young person to tell her parents that she is pregnant, this should not be mandatory.

The Committee concluded that mandatory unconditional parental notification could result in some young people being forced into making a decision against their own wishes.

“Accordingly we do not think that a requirement to notify parents that their child is pregnant should be introduced. Ideally, and in most cases, a child will tell her parents so they can support her through the process. However, if a child has the capacity to consent to an abortion, but does not wish to tell her parents she is pregnant, this wish should be respected,” the Committee said.

Conference Collaboration

We are collaborating with the New Zealand Sexual Health Society and the Abortion Providers Group Aotearoa New Zealand (APGANZ) to jointly host the Sexual and Reproductive Health and Rights Conference Aotearoa New Zealand 2016. The conference will be held at Te Papa, Wellington, in November 2016. The conference themes are abortion, advocacy, health promotion and sexuality education, reproductive health, sexual health and trans identity.

Collaboration with other agencies in the sexual and reproductive health and rights field is a key element of our Strategic Framework.

Family Planning Council

There was a change to the governance of our organisation with the election of Andreas Prager as President at the 2015 Annual General Meeting. Andreas succeeded Dr Tammy Steeves who had completed the two terms as allowed by our constitution. Dr Steeves remains on Council as immediate past president.

Dr Pauline Horrill was re-elected Deputy President.

Other Council members are: Janice Fredric, Chris Nichol, Nicole Rosie, Carol Bellette and Madeleine Hawkesby-Browne. The Māori representatives on Council are Hokipera Ruakere and Dr Lilian Fraser. The youth representatives are Elizabeth (Lizzie) McLean, Te Kāhui Tapsell and Maira Haimoana.

Five Council members retired at the Annual General Meeting at the completion of their terms. Alison McKenzie, Nell O’Dwyer-Strang, Stacey Morrison, Bianca Hewitson and Linda Penno had all completed their terms as allowed for in our constitution.

Four new honorary life members were awarded at the 2015 Annual General Meeting. Dr Sue Bagshaw, Gill Lough, Jan Lockyer and Dr Helen Roberts were recognised for their outstanding contribution to our organisation.
In memorium

Former Family Planning President Christine Taylor passed away in Dunedin on 6 March 2016. Christine was president of Family Planning from 1982 until 1991. Her presidency coincided with two significant changes – increasing political pressure on Family Planning (including threats to our government funding) and a move from a regional branch system to a national organisation.

In 1994, as Immediate Past President, Christine attended the International Conference on Population and Development as an advisor to the New Zealand delegation. Family Planning’s International Programmes unit was established as a consequence of this landmark international meeting.

Former Family Planning Council member and Deputy President Professor Sir John Scott died on 20 October 2015. While a junior medical officer in Auckland, he became very much aware of the many problems confronting women presenting with miscarriages to Greenlane and National Women’s Hospitals. Sir John was invited in late 1996 to serve on Family Planning Council – a role he held until 2007. He was vice president of Family Planning from 2004 until 2007.

Family Planning member and feminist academic Beryl Hughes died on 7 December 2015 at the age of 95. Betty Weeber, a long time member alongside her late husband Ray, died on 27 October 2015.

Family Planning staff

Our staff work in clinics, health promotion units, at National Office and in small offices in towns across the country. Every year we ask them to do more – to take on more projects and to challenge their thinking – and every year that’s just what they do. We are grateful to them for their compassion to our clients, their commitment to our issues and their capacity to deliver more and more. We are grateful to each and every one of them.

Conclusion

We are reminded of the famous quote by Charles Schulz – creator of the iconic Peanuts cartoon strip, who said, “Just remember, once you’re over the hill you begin to pick up speed.”

This Annual Report, while a record of the year that has been, is also a signpost for the future.

We are committed to promoting change across society, government and among health care providers to make sure all people have the chance to live a healthy life. And we will make sure we remove barriers to our services and ensure all our staff have the skills, attitudes and knowledge to provide services to all people, across all groups and cultures.
Clinical Services

Clinic statistics

There were a total of 161,081 consultations during the year.

Over 20,000 new clients visited our clinics for the first time, accounting for 12 per cent of consultations.

Young people (under 22) continue to make up the largest group using our services at 43.1 per cent.

**Percentage of consultations by age group**

- Under 22 years: 43.1%
- 22-24 years: 13.8%
- 25-44 years: 37.2%
- 45 years & over: 5.9%

Of the clients we saw during the year, just under 16 per cent were Māori, just over eight per cent Asian, and just over five per cent were Pasifika.

**Percentage of consultations by ethnicity**

- Māori: 15.8%
- Asian: 8.3%
- Pasifika: 5.2%
- Other: 70.8%

Fractionally fewer than three-quarters of consultations at our clinics involved some sort of contraceptive service. Long acting reversible contraception continues to be popular with contraceptive implant insertions making up 2.6 per cent of contraception consultations and IUD or IUS inserts making up almost four per cent of contraceptive consultations.

STI checks were completed at almost a quarter of all consultations (39,205). Our clinicians also completed more than 19,000 cervical screens during the year.

“For 80 years now, Family Planning New Zealand has been New Zealand’s most trusted provider of sexual and reproductive healthcare. “Family Planning offers confidential, non-judgemental care and works with people of any gender, age, nationality or sexual orientation.... They provide care no matter what, and that’s how I know we’re part of the same worldwide movement.”

Cecile Richards – Chief Executive and President, Planned Parenthood Federation of America
Nurse prescribing a reality

After years of advocating for nurse prescribing, changes will be made in mid-September 2016 to allow suitably qualified and approved registered nurses to prescribe from a list of commonly used medicines.

The case for the expansion of registered nurse prescribing is compelling. It enables nurses to make a bigger contribution to health care in New Zealand and should lead to the achievement of more equitable results for groups with poorer outcomes, particularly Māori and Pasifika people and those in remote and rural areas.

For Family Planning, this means more scope for our nurses to practise, resulting in a greater ability to meet our clients’ needs more quickly and efficiently.

Standing orders for nurse practitioners

Amendments have been made to the Medicines (Standing Orders) Regulations 2002 to allow nurse practitioners and optometrists to issue standing orders from 17 August 2016. From that date, nurse practitioners will be able to issue standing orders under the same conditions that apply to medical practitioners and dentists.

Changes to referral process

Women coming to our Auckland, Wellington or Christchurch clinics seeking an abortion referral are now being offered a longer appointment time, which means that all the pre-termination work can be done in one clinic visit and one follow-up phone call. Previously, women were making at least two visits ahead of the procedure.

Contraceptive pill over the counter

Family Planning did not support a recent application to the Medicines Classification Committee (MCC) for the contraceptive pill to be available over the counter. In response to the application, we submitted to MCC that pharmacy dispensing would make little difference to access because women would still have to pay a dispensing fee of as much as $45. We told the committee that if they were committed to expanding access and to equity of access, they should work to allow initiatives such as nurse prescribing.

The MCC noted that the major representative medical bodies, including Family Planning, did not support the application and that most of the specialist organisations canvassed supported a collaborative prescribing model. The MCC has yet to make a final decision.

Nurse practitioner

Congratulations to Dunedin nurse Emma Macfarlane who qualified as a nurse practitioner during the year under review. Emma is the fourth Family Planning nurse to achieve this qualification.

Paper published

New Zealand women’s experience of their first year using the Jadelle contraceptive implant was the subject of a paper published in the March 2016 issue of the Journal of Primary Health Care. The authors are Family Planning National Medical Advisor Dr Christine Roke and former Family Planning doctors Helen Roberts and Anna Whitehead.
The paper says the majority of New Zealand women using Jadelle were satisfied with this method of contraception during their first year of use. Implant removals were most likely to be related to prolonged bleeding although the most common bleeding pattern was regular periods.

**E-referral system**

Family Planning joined the Healthlink Careselect eReferral platform in March 2016. This is an e-referral service available to GPs and other health care providers – currently it is used by 99 per cent of New Zealand GPs – which enables them to search, find and refer electronically to the most suitable health provider for their patient’s specific needs.

A keyword search for “sexual and reproductive health” will identify us as a provider of these services and allow the creation of an e-referral that will be sent to us via a secure online form.

The fact that our clinicians will receive a comprehensive referral document containing information identifying treatments and tests already carried out by the referring doctor or provider is a huge benefit for us – and for the clients being referred to us.

**Medtech merge**

In early May, we completed our project to have all our client records in one national Medtech database. Working from one database benefits our clients and our clinicians as it avoids duplicate records and means our clinicians have one comprehensive medical record for each client. Our original database project began in 2011 with 26 databases in clinics across the country.

**STI self-testing trial**

A pilot project is underway in our Dunedin and Margaret Sparrow (Wellington) clinics to determine if we can offer clients (and their partners) the opportunity to self-test for sexually transmissible infections. Clients would complete a simple questionnaire to determine if self-testing might be an option for them. If so, they would provide a sample which we would send to a laboratory for testing.

Negative results (those with no further action needed) would be sent by text. Our nurses would call clients requiring further treatment and arrange a follow-up appointment for them.

**Ashburton Clinic moves**

Our Ashburton Clinic moved to a new location within the Community House at 44 Cass Street, Ashburton, in late May.

**Phone consultations**

There were 6,945 phone consultations during the year under review. Some 44.7 per cent of phone consultation clients were under 22 and 11.4 per cent were over 22 and with a Community Services Card. Some 10 per cent of phone consultations were with clients who identified as Māori and 4.2 per cent with clients who identified as Pasifika.

Phone consultations were introduced in late 2014 as one of a number of initiatives to remove barriers to accessing our services.
The range of services we are able to offer as a phone consultation has increased over time and now includes:

- Repeat contraceptive pill prescriptions. This is the most popular of the phone consultation services with 52 per cent of phone consultations over the year being for repeat contraceptive pill prescriptions.
- Emergency contraception
- Pre-consultations for women wanting an implant or an IUD
- Discussion and advice about contraceptive options
- Condom prescriptions.

An 0800 free calling number remains in place for Whangarei, Kaitaia, Whanganui, Gisborne and West Auckland.

In response to media reports regarding a lack of access to emergency contraception in Wairoa, we responded quickly to implement an 0800 ECP service in the area. This service is also to be rolled out in Greymouth, Ashburton and Timaru.

**Ask for an Appointment**

Some 28,997 Ask for an Appointment forms were received through our website during the year under review. The form went live in January 2015 and between then and 30 June 2015, some 9,484 Ask for an Appointment forms were received.

**Ask for an Appointment forms submitted by month**

---

“The New Zealand Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Family Planning have been working together with respective health ministers to highlight the importance of equitable access to timely and affordable contraception…. We’ve seen some very positive statistics in the past year or so with increasing use of long acting reversible methods of contraception, reduction in teen pregnancy rates and reduction in termination of pregnancy… Let’s keep working together as professional organisations to achieve these goals.”

Professor Lesley McCowan
– Head of the Department of Obstetrics and Gynaecology, University of Auckland
IUDs and more

There were 16,604 consultations for long acting reversible contraception (LARCs) during the 2015/16 year. Highly-effective LARC options are increasingly popular with young clients – just over a quarter of all LARC consultations were for women under 22 years of age.

Over the year, Māori clients had one quarter of implant insertion appointments and Pasifika clients just under 10 per cent. Just over 10 per cent of IUD/IUS fits were for Māori clients and just over 4 per cent of IUD/IUS fits were for Pasifika clients.

In response to negative feedback about the difficulty of inserting TT380 IUDs into some women, Pharmac organised for a generic Multiload called Load 375 to be available and subsidised from 1 May 2016. This IUD is licensed for 5 years and comes in just the standard size. Our clinicians report that the Load 375 makes it much easier for women who have not had children to have a copper IUD insertion.

Also newly available is the Jaydess intra uterine device. A smaller version of the Mirena and offering three years contraception, this device is proving valuable for women who haven’t had children as it is easier to insert.

Change to screening protocol

We welcomed the announcement from Health Minister Jonathan Coleman that from 2018 cervical screens will be analysed for human papillomavirus (HPV) rather than cytology. We support the change to a more sensitive test which will allow women to have five-yearly screens rather than three-yearly as currently.

The best protection for women against cervical cancer is to have the HPV vaccination and then to have regular cervical screens.

Another change in 2018 will be that the age at which women begin having cervical screens will rise from 20 to 25. International evidence shows that screening before the age of 25 does not make any difference to the mortality rate for women who have developed cervical cancer. Most young women under 25 who acquire the HPV virus are able to get rid of it, if they have a good immune system over the next few years, without it causing any harm at all.

Client survey

A survey of clients in our 16 clinics with the highest number of Māori and Pasifika clients was completed between mid-March and mid-April 2016. The survey found that between 95 and 98 per cent of clients surveyed were happy, mostly happy or very happy with the services they received. Some 98.7 per cent of clients surveyed were happy, mostly happy or very happy with the way their appointment was made while 99.2 per cent of respondents agreed or strongly agreed that they were listened to during their consultation.

However, there is room for improvement in the service offered to some clients, with issues identified around making appointments, waiting times and a lack of appointment options. There are plans in place to make service improvements in response to what our clients tell us.
Policy and Research

Position statements

Six new external position statements have been published during the year. These statements reflect our position on a range of sexual and reproductive health issues.

- **STIs and HIV.** We support sexuality education, safer sex practices, and regular, non-judgemental testing and treatment to help prevent sexually transmitted infections and HIV.

- **Contraception.** We believe that everyone has the right to effective contraception.

- **Sexual orientation and gender identity.** We believe that people of all sexual orientations and gender identities have a right to the highest level of health and wellbeing.

- **Young people and access to services.** We believe that all young people have a right to free, confidential sexual and reproductive health services, information and sexuality education.

- **Equity.** We are committed to equity, where all people have the opportunity to achieve the highest level of health.

- **Abortion.** We believe everyone has the right to high-quality, legal and safe abortion services.

Key submissions

Keeping sexual and reproductive health issues firmly on the agenda was the focus of the 22 submissions we made during the year under review.

We contributed to the Ministry of Justice consultation on strengthening New Zealand’s legislative response to family violence. We highlighted the importance of including the health system and health professionals in discussions of violence. We also made the point that violence was gendered in nature and recommended that this be a guiding principle for legislative change.

We have been supporting the Ministry of Health with the development of the national Sexual and Reproductive Health Action Plan. We made a number of recommendations; these included making sexual and reproductive health visible in the health strategy and having a stronger focus on health equity.

Our submission to the Ministry for Women on the Government’s eighth periodic report on the implementation of CEDAW focused on the need for abortion law reform, consistent comprehensive sexuality education, better coordination across Ministries, and support for a national plan for sexual and reproductive health.
Quality

Family Planning completed its second three-yearly Te Wana external review in June 2016, with accreditation granted in October.

Meeting Te Wana standards is important for Family Planning to:

• Maintain and expand our quality improvement framework
• Develop a culture of reflection and continuous improvement
• Show that we have integrated systems for meeting the standards
• Continue to work towards meeting the needs of stakeholders and service users
• Strengthen our networks
• Participate in a peer review system
• Develop our workforce
• Maintain our external accreditation.

IPPF Accreditation

In May this year, we began our five-yearly accreditation review as a Member Association of the International Planned Parenthood Federation (IPPF). Family Planning has been a member of IPPF since 1955 and our last accreditation was completed in May 2010.

Accreditation determines a Member Association’s level of compliance with IPPF standards and responsibilities of membership, and helps IPPF’s Governing Bodies, Secretariat and Member Associations ensure that Member Associations comply with the Federation’s standards.

While outside the year under review, we completed the accreditation in August this year. We fully met all 48 standards, making us the first country in the IPPF’s East and South East Asia and Oceania Region to pass the third phase accreditation.
Clinical Training and Development

A total of 432 participants attended 51 Ministry of Health-contracted Clinical Training and Development courses across the year. This was 119 more attendees than agreed upon in our contract.

Some 10.8 per cent (47) of the participants identified as Māori and 12.7 per cent (55) worked for a Māori health provider. Around 92 per cent of course attendees are registered nurses with the balance being midwives (4.4 per cent) and doctors (4 per cent).

Health Promotion

Online consultations

Our online consultation service for community-based educators was launched in May 2016. The service gives the opportunity for a free one-on-one consultation across a wide-range of sexuality education topics with one of our health promotion staff. Topics that can be covered include:

- Support for programme development
- Strategies for effective teaching and learning
- Tools and resources for teaching and assessment
- Advice and support for creating safe, health promoting environments
- Communicating with parent/whānau community
- Professional learning and development opportunities for staff.

The consultations can be booked using a form on our website, and held via Skype or other online platform.

The Colours of Sexuality

*The Colours of Sexuality* is a new electronic resource for use in secondary schools with students with learning disabilities. The activities in this resource use the concept of a journey to help students see their sexuality and sexual progression as a normal developmental stage.

The resource includes information and activities on:

- Building friendships
- Managing emotions
- Public/private body parts
- Appropriate touch
- Assertive communication
- Positive decision making.
Courses

We are now offering a half day Teaching About Relationships workshop, designed for educators of young people. This workshop examines recent research, considers issues to think about when discussing relationships and examines a range of tried and true activities and resources for teaching young people about healthy and unhealthy relationships.

Contraceptive Pill Flip Card Set

This resource is a set of 17 A5 laminated cards, each with an illustration of a current contraceptive pill option. This resource has been designed to be used in education and clinic settings, and for clinical training and development. Each card is ideal for discussion on identifying and comparing contraceptive pill options and on 'how to use' contraceptive pills.

Margaret Sparrow Research Grant

Dunedin health promoter Louise Pearman was the recipient of the Margaret Sparrow Research Grant in 2015.

The aim of her research was to look at what the trans and gender diverse population in New Zealand consider as their sexual and reproductive health needs. The research sought to identify what trans people need from clinical services and health promotion to better their sexual and reproductive health.

Louise’s report, with 12 recommendations, is a positive step towards creating a framework that works with, and acknowledges that trans people are sexual beings and have unique sexual and reproductive health needs and rights.
International Programmes

Five Pacific Parliamentarians were in Wellington in early July 2015 to participate in an Open Hearing at Parliament focussed on engaging boys and men in sexual and reproductive health and rights in the Pacific.

The Open Hearing involved parliamentarians from New Zealand, Kiribati, Papua New Guinea, Samoa, Tonga and Tuvalu. It was hosted by the New Zealand Parliamentarians Group on Population and Development (NZPPD). Our International Programmes unit is the secretariat for NZPPD.

Eleven oral submissions from regional groups were delivered – three from New Zealand groups.

The report of the Open Hearing was presented at Parliament on 17 February 2016. It made 14 key recommendations for future action. Among these were:

- Form a Pacific Regional Parliamentary Group on Population and Development
- Develop, where necessary, a national policy framework that supports the sustainability of a comprehensive sexuality education/family life education curriculum through the formal education system
- Engage and train male sexual and reproductive health and rights champions. These men can assist in debunking myths associated with male-specific reproductive services and encourage other men to take responsibility for the development of healthy families.

Kiribati programme

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2012</td>
<td>Phase One of project begins.</td>
</tr>
<tr>
<td>March 2015</td>
<td>Review.</td>
</tr>
<tr>
<td>April 2015</td>
<td>Phase two begins with expansion to six outer islands.</td>
</tr>
<tr>
<td>March 2020</td>
<td>Phase Two to conclude.</td>
</tr>
</tbody>
</table>

Our chief executive visited the Healthy Families Project in Kiribati just prior to Christmas 2015. She spent time in the capital, South Tarawa, learning more about the Healthy Families Project and demonstrating support for our partner organisation, the Kiribati Family Health Association.

Jackie also had the opportunity to see one of the project’s newest activities – a workshop at the Kiribati Teacher’s College – aimed at improving the sexual and reproductive health knowledge and skills of Kiribati’s large youth population.

Year one of the second phase of the Kiribati Healthy Families Project concluded successfully. Phase one activities such as clinical training, mobile clinics and advocacy meetings continued on South Tarawa and the project expanded to include the islands of Abemama, Aia, Aranuka, Butaritari, Marakeri and North Tarawa. New activities have also been implemented to improve sexual and reproductive health for youth, sex workers and people living with disabilities.

A key result from the project has been the increase in uptake of sexual and reproductive health services. Our recently-released research report, Family Planning in South Tarawa,
Kiribati: Usage and Barriers, indicates that the percentage of women aged 15 to 49 using modern contraceptive methods has increased in South Tarawa from just 16 per cent in 2009 to an estimated 39 per cent in 2015. Kiribati Family Health Association clinic data shows that STI testing increased from 584 clients in 2014 to 1,184 clients in 2015.

Workshops in Tuvalu and Papua New Guinea

We held a workshop in Tuvalu with the Tuvalu Family Health Association (TuFHA) in July 2015. The workshop focussed on developing a plan to ensure that sexual and reproductive health is a strong part of national implementation plans for the Sustainable Development Goals (SDGs). A similar workshop was held with the Safe Motherhood Alliance in Papua New Guinea in August 2015.

Following the workshops, we released two videos we made in partnership with TuFHA and the Safe Motherhood Alliance. With sexual and reproductive health and rights still a taboo subject for many people in the Pacific region, the goal of the videos was to use the Sustainable Development Goals as a tool to encourage people to start talking about sexual and reproductive health issues.

And, in October 2015, we launched our Voices from the Pacific video – part of an advocacy programme to raise awareness of the SDGs. The videos can be viewed on our YouTube channel.

CID code of conduct signatory

Family Planning is now a signatory to the Council for International Development's (CID) Code of Conduct. This Code requires members to meet high standards of corporate governance, public accountability and financial management.

Family Planning is one of seven New Zealand non-Government organisations who have so far become Code of Conduct signatories.

The CID Code of Conduct is a voluntary, self-regulatory sector code of good practice that aims to improve international development outcomes and increase stakeholder trust by enhancing the transparency and accountability of signatory organisations.

1 For queries or concerns around the CID code of conduct, visit http://www.cid.org.nz/about-2/code-of-conduct/
Advocacy

Film evening

For the first time we held a Human Rights Day event in Wellington in December 2015 with the screening of *A Quiet Inquisition*. Set in Nicaragua, the human rights award-winning film follows Dr Carla Cerrato as she struggles to contend with the implications of a new law that prohibits the termination of any pregnancy, even when a woman’s life is at stake. The film content allowed us to contrast and compare the situation with New Zealand where abortion still sits within the Crimes Act.

On the world stage

Our chief executive led the New Zealand Delegation to the 49th session of the Commission on Population and Development in New York in early April 2016. The theme for the session was “strengthening the demographic evidence base for the post-2015 development agenda. Two outcome documents were produced – a step forwards from 2015 where there were no outcome documents, as a decision was not made.

Our chief executive also attended the invitation-only International Dialogue on Sexual and Reproductive Health in Berlin and the EURONGOS meeting in Oslo. EURONGOS is a meeting of all European NGOs working in international development. A key topic at both meetings was discussion about the new Sustainable Development Goals (SDGs). Internationally, New Zealand is seen as having real credibility in SRHR issues and for making a significant contribution – despite our small size and geographical isolation.

Sustainable Development Goals

17 Sustainable Development Goals (SDGs) have been adopted at the United Nations. The goals are to be achieved by 2030 by all 193 United Nations member states.

- The SDGs include two targets specifically on sexual and reproductive health. This means that 193 countries, including New Zealand, and all United Nations member countries in the Pacific, have committed to achieving universal access to sexual and reproductive health by 2030.
- They highlight the urgent need to achieve gender equality and the empowerment of all women and girls.
- One of the goals is specifically about reducing inequality and, in alignment with our Strategic Framework, highlights the importance of not leaving anyone behind.

She was also present at Women Deliver in Copenhagen from 16 to 19 May 2016 – the largest gathering on girls’ and women’s health, rights and wellbeing for more than a decade and one of the first major global conferences following the launch of the Sustainable Development Goals. The focus of the conference was on how to implement the SDGs as they relate to girls and women, with a specific focus on health – in particular maternal, sexual and reproductive health and rights – and how these issues intersect with gender equality, education, environment, and economic empowerment.
Our people

Director Health Promotion Frances Bird left Family Planning in March this year after 12 years with the organisation. Frances was a key member of our Senior Management Team for that time. Alongside the management of our team of health promoters, Frances was also responsible for the development of a number of new resources and campaigns. Our new Director Health Promotion Kelly Atkinson started with us on Monday 11 July 2016.

Research manager Dr Helen Roberts retired in July 2015 after working for us for thirty-one years and 10 months. Helen will continue her work as Senior Lecturer Women’s Health in the Department of Obstetrics and Gynaecology at the University of Auckland. Helen started working for us on 14 August 1983.

Quality Co-ordinator Gill Tait retired in September 2015 after 23 years with us. During that time, Gill held a number of roles across the organisation and was responsible for the introduction of the Reportable Events Register and our first Te Wana quality review. Gill was previously Locality Manager for our clinics in Wellington, Lower Hutt, Porirua, Whanganui and Blenheim.

Dunedin nurse Gaye Harrison retired after 33 years working for Family Planning. Gaye has retired to Nelson.

Jayne Davies started as the Regional Manager for the Central Region on 16 February 2016. Jayne succeeded Jane Hooker who moved to Australia with her family.

New Southern Regional Manager Anne Stewart started with us on 12 October 2015.

Staff milestones:

30 years
- Hamilton nurse Jan Gilby
- Christchurch medical receptionist Anne Moody
- Christchurch nurse Alma Johnson

20 years
- Blenheim medical receptionist Angela Cull
- Takapuna senior medical receptionist Phillipa Sagar
- Invercargill doctor Dianne Denholm

10 years
- Hamilton medical receptionist Celeste Miller
- Southern Health Promotion Area Manager Paul Scammell
- Christchurch doctor Monica Ford
- Christchurch medical receptionist Vicki Grindley
- Wellington doctor Beth Messenger
NZ Family Planning Association (Inc)

Summary Financial Statements
For the year ended 30 June 2016

The specific disclosures included in these summary financial statements have been extracted from the full financial report dated 30 June 2016.

The summary financial statements cannot be expected to provide as complete an understanding as provided by a full financial report of the statement of comprehensive revenue and expense, financial position and cash flows.

New Zealand Family Planning Association transitioned to Public Benefit Entity Standard Reduced Disclosure Regime from "Old GAAP" (generally accepted accounting principles) effective 1 July 2015 and has subsequently restated comparative financial information in accordance with the adopted reporting standards. A reconciliation of the changes and associated notes are detailed in the full financial report.

A copy of the full financial report can be obtained from Family Planning’s National Office at Level 6, 203 - 209 Willis Street, Wellington 6142.

The summary financial statements were authorised by the Family Planning Council on 23 September 2016.

The full financial report has been audited by Ernst & Young who have given an unqualified opinion.

The summary financial statements have not been examined by the auditor for consistency with the full financial report.

Statement of Comprehensive Revenue and Expense
For the year ended 30 June 2016

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue from non-exchange transactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government contracts</td>
<td>11,869,557</td>
<td>11,791,424</td>
</tr>
<tr>
<td>Grants revenue</td>
<td>686,701</td>
<td>554,493</td>
</tr>
<tr>
<td>Direct charges revenue - subsidised</td>
<td>1,667,034</td>
<td>1,637,211</td>
</tr>
<tr>
<td>Other non-exchange income</td>
<td>304,746</td>
<td>183,685</td>
</tr>
<tr>
<td><strong>Revenue from exchange transactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct charges revenue –full cost recovery</td>
<td>882,683</td>
<td>941,626</td>
</tr>
<tr>
<td>Rental revenue</td>
<td>14,233</td>
<td>37,621</td>
</tr>
<tr>
<td>Other exchange income</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>15,424,954</td>
<td>15,146,060</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee costs</td>
<td>9,927,935</td>
<td>9,863,978</td>
</tr>
<tr>
<td>Remuneration of key management personnel</td>
<td>906,223</td>
<td>897,958</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>277,771</td>
<td>294,659</td>
</tr>
<tr>
<td>General expenses</td>
<td>4,246,684</td>
<td>4,404,505</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>15,358,613</td>
<td>15,461,100</td>
</tr>
<tr>
<td><strong>Finance costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance income</td>
<td>321,183</td>
<td>363,053</td>
</tr>
<tr>
<td><strong>Net finance costs</strong></td>
<td>321,183</td>
<td>363,053</td>
</tr>
<tr>
<td><strong>Net surplus for the year</strong></td>
<td>387,524</td>
<td>48,013</td>
</tr>
</tbody>
</table>
NZ Family Planning Association (Inc)

Statement of Financial Position
As at 30 June 2016

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>177,730</td>
<td>317,924</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>1,030,411</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>281,671</td>
<td>251,516</td>
</tr>
<tr>
<td></td>
<td>459,401</td>
<td>1,599,851</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>1,543,253</td>
<td>1,518,891</td>
</tr>
<tr>
<td>Investments</td>
<td>7,147,291</td>
<td>5,584,847</td>
</tr>
<tr>
<td>Receivables from non-exchange transactions</td>
<td>4,120</td>
<td>3,144</td>
</tr>
<tr>
<td>Receivables from exchange transactions</td>
<td>86,006</td>
<td>81,946</td>
</tr>
<tr>
<td>GST receivable</td>
<td>-</td>
<td>47,221</td>
</tr>
<tr>
<td>Prepayments</td>
<td>30,024</td>
<td>24,353</td>
</tr>
<tr>
<td>Inventories</td>
<td>183,280</td>
<td>213,185</td>
</tr>
<tr>
<td></td>
<td>8,993,974</td>
<td>7,473,587</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>9,453,375</td>
<td>9,073,438</td>
</tr>
<tr>
<td><strong>LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payables under exchange transactions</td>
<td>412,310</td>
<td>555,271</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>634,622</td>
<td>636,774</td>
</tr>
<tr>
<td>Employee benefits liability</td>
<td>967,433</td>
<td>860,113</td>
</tr>
<tr>
<td>GST payable</td>
<td>182</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2,014,547</td>
<td>2,052,158</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits liability</td>
<td>92,778</td>
<td>62,754</td>
</tr>
<tr>
<td></td>
<td>92,778</td>
<td>62,754</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td>2,107,325</td>
<td>2,114,912</td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7,346,050</td>
<td>6,958,526</td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated comprehensive revenue and expense</td>
<td>7,346,050</td>
<td>6,958,526</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY</strong></td>
<td>7,346,050</td>
<td>6,958,526</td>
</tr>
</tbody>
</table>
NZ Family Planning Association (Inc)

Statement of Changes in Net Assets/Equity
For the year ended 30 June 2016

<table>
<thead>
<tr>
<th></th>
<th>Accumulated comprehensive revenue and expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 1 July 2015 (restated)</td>
<td>6,958,526</td>
</tr>
<tr>
<td>Total comprehensive revenue and expense for the year</td>
<td>387,524</td>
</tr>
<tr>
<td>At 30 June 2016</td>
<td>7,346,050</td>
</tr>
</tbody>
</table>

Statement of Cash Flows
For the year ended 30 June 2016

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership subscriptions</td>
<td>3,113</td>
<td>3,760</td>
</tr>
<tr>
<td>Fundraising, donations and bequests</td>
<td>143,583</td>
<td>43,955</td>
</tr>
<tr>
<td>Government contracts</td>
<td>11,869,558</td>
<td>11,761,617</td>
</tr>
<tr>
<td>Receipts from grants and subsidies</td>
<td>686,701</td>
<td>554,493</td>
</tr>
<tr>
<td>Receipts from other goods and services provided to customers - non-exchange transactions</td>
<td>1,822,931</td>
<td>1,955,576</td>
</tr>
<tr>
<td>Receipts from other goods and services provided to customers - exchange transactions</td>
<td>886,211</td>
<td>1,026,980</td>
</tr>
<tr>
<td>Interest received</td>
<td>289,150</td>
<td>313,459</td>
</tr>
<tr>
<td>Payments to suppliers</td>
<td>(3,966,049)</td>
<td>(3,994,799)</td>
</tr>
<tr>
<td>Payments to employees</td>
<td>(10,834,160)</td>
<td>(10,761,937)</td>
</tr>
<tr>
<td>Grants, contributions and sponsorships paid</td>
<td>(208,944)</td>
<td>(224,439)</td>
</tr>
<tr>
<td><strong>Net cash flows from operating activities</strong></td>
<td>692,094</td>
<td>678,665</td>
</tr>
</tbody>
</table>

| **Cash flows from investing activities**             |       |               |
| Purchase of sale of financial instruments (net movement) | (500,000) | (500,000)   |
| Purchase of property, plant and equipment            | (71,900) | (90,987)     |
| Purchase of intangibles                              | (95,832) | (61,415)     |
| **Net cash flows from used in investing activities** | (667,732) | (652,402)   |

Net increase in cash and cash equivalents             | 24,362 | 26,263        |
Cash and cash equivalents at beginning of period       | 1,518,891 | 1,492,628   |
Cash and cash equivalents at end of period             | 1,543,253 | 1,518,891    |
For the year ended 30 June 2016

Family Planning received grant revenue for specific projects during the year. These included the following:

**GRANT REVENUE**

<table>
<thead>
<tr>
<th>New Zealand sourced</th>
<th>2016</th>
<th>2015 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Foreign Affairs and Trade (MFAT) grant for Healthy Families projects in Kiribati.</td>
<td>526,118</td>
<td>471,698</td>
</tr>
<tr>
<td>Ministry of Social Development grant for Feeling Special, Feeling Safe programme.</td>
<td>13,600</td>
<td>13,600</td>
</tr>
<tr>
<td>Ministry of Social Development grant for ‘Are You That Somone’ campaign.</td>
<td>50,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>589,719</strong></td>
<td><strong>485,298</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internationally sourced</th>
<th>2016</th>
<th>2015 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Pacific Alliance (2015 US$19,733)</td>
<td>-</td>
<td>25,078</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>96,982</strong></td>
<td><strong>69,195</strong></td>
</tr>
</tbody>
</table>

**Total** 686,701 554,493

The grants have been spent in accordance with the conditions attached to each grant.
The monies received from grantors as listed under International relate specifically to work done in relation to international population & development advocacy & programmes by the Family Planning International Programmes division.

Grants in advance at 30 June 2016 totals $566,356 (2015 - $592,474). All of this balance relates to International Programmes.

**OPERATING LEASE COMMITMENTS**

Future minimum rentals payable under non-cancellable operating leases as at 30 June 2016 and 2015 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future rental of operating leases for premises</td>
<td>1,605,088</td>
<td>1,203,247</td>
</tr>
<tr>
<td>Other leases</td>
<td>24,276</td>
<td>41,412</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,629,364</strong></td>
<td><strong>1,244,659</strong></td>
</tr>
</tbody>
</table>
Family Planning Council:
President: Andreas Prager
Deputy President: Dr Pauline Horrill
Council: Carol Bellette, Madeleine Hawkesby-Brown, Janice Fredric, Chris Nichol, Nicole Rosie.
Māori representatives: Hokipera Ruakere, Dr Lilian Fraser.
Youth representatives: Maira Haimoana, Elizabeth (Lizzie) McLean, Te Kāhui Tapsell.
Immediate past president: Dr Tammy Steeves

Senior Management Team
Chief Executive: Jackie Edmond, Deputy Chief Executive, Director Clinic Services: Kirsty Walsh
Director Health Promotion: Frances Bird (until 24 March 2016), National Medical Advisor: Dr Christine Roke
National Nurse Advisor: Rose Stewart, Financial Controller: Trevor Thomas

Honorary Life Members
Mrs Joyce Armstrong MNZM, Dr Sue Bagshaw, Mrs Daphne Bell MNZM, Dr Pat Boulton, Dr Katherine Bowden MNZM, Mrs Jan Brown, Mrs Gillian Burrell, Hon Steve Chadwick, Ms Candis Craven ONZM, Mrs Margaret Dagg, Mrs Helen Eskett MNZM, Mrs Sue Farrant, Dame Jenny Gibbs DNZM, Dr Maxine Gray, Dr Gill Greer MNZM, CBE, Mrs Naomi Haynes, Mrs Dina Hutton, Ms Peggy Kelly, Dr Win Kennedy, Dr Elspeth Kjestrup QSO, Mrs Jean Lawrie, Mrs Gill Lough, Mrs Jan Lockyer, Mrs Joy Martin, Ms Linda Penno, Mr Dean Reynolds, Dr Helen Roberts, Beverley Lady Scott, Professor Sir John Scott, KBE, MD, BMedSc, FRCP, FRACP, FRSNZ (deceased 20 October 2015), Mrs June Shaw (deceased 7 August 2016), Mrs Moya Shaw (deceased 12 June 2016), Dame Margaret Sparrow DNZM, MBE, Mrs Sheila Stancombe, Mrs Christine Taylor MBE (deceased 6 March 2016), Mrs Dawn Wardle, Mrs Glenys Wood, Mrs Valda Woods, Mr Simon Woolf.

Honorary Vice Presidents
Dr Ruth Black, Dr Katherine Bowden MNZM, Dame Silvia Cartwright PCNZM, DBE, QSO, Dr Margaret Catley-Carlson, Rt Hon Helen Clark, Ms Margaret Dagg, Hon Liane Dalziel MP, Hon Christine Fletcher QSO, Hon George Gair CMG, QSO, (deceased 17 August 2015), Dame Jenny Gibbs DNZM, Professor John Hutton, Mrs Areta Koopu CBE, Mr Halfdan Mahler, Hon Katherine O’Regan, Professor Malcolm Potts, Mr Dean Reynolds, Rt Hon Dame Jenny Shipley DNZM, Dame Margaret Sparrow DNZM, MBE, Hon Judith Tizard, Dame Catherine Tizard ONZ, GCMG, GCVO, DBE, QSO, Dr Marilyn Waring CNZM, Hon Fran Wilde, CNZM, QSO.