

# **STANDARDS OF CARE FOR WOMEN REQUESTING ABORTION IN AOTEAROA NEW ZEALAND**

**Report of a Standards Committee to the Abortion  
Supervisory Committee**

**January 2018**

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## ABBREVIATIONS

APC	Annual Practicing Certificate
ASC	Abortion Supervisory Committee
BMI	Body Mass Index
BP	Blood Pressure
CS&A Act	Contraception Sterilisation and Abortion Act 1977
D&E	Dilation and Evacuation
EMA	Early Medical Abortion
DHB	District Health Board
DP	Depo Provera
ESR	Institute of Environmental Science and Research
FP	Family Planning
FRANZCOG	Fellow Royal Australian and New Zealand College of Obstetricians and Gynaecologists
FRCOG	Fellow Royal College of Obstetricians and Gynaecologists
FRNZCGP	Fellow Royal New Zealand College of General Practitioners
HPCAA	Health Practitioners Competence Assurance Act 2003
HDC Act	Health and Disability Commissioner Act 1994
HR	Heart Rate
IU	Intrauterine
IUD	Intrauterine Device
IUS	Intrauterine System
IV	Intravenous
LARC	Long Acting Reversible Contraception
MEDSAC	Medical Sexual Assault Clinicians Aotearoa
MEDSAFE	NZ Medicines and Medical Device Safety Authority
MCNZ	Medical Council of New Zealand
MVA	Manual Vacuum Aspiration
NAF	National Abortion Federation
NSAID	Nonsteroidal Anti-inflammatory Drug
NZ	New Zealand
NZMA	New Zealand Medical Association
NZMFMN	NZ Maternal Fetal Medicine Network
NZNO	New Zealand Nurses Organisation
PID	Pelvic Inflammatory Disease
POC	Products of Conception
RPOC	Retained Products of Conception
STI	Sexually Transmitted Infection
UK	United Kingdom
US	Ultrasound

## GLOSSARY OF MĀORI TERMS

Aotearoa	New Zealand
Atawhai	Temporary care arrangements
Atua	Spiritual aspects/deities
Hapu	Subtribe- membership determined by descent
Hapūtanga	Pregnancy
He Korowai Oranga	New Zealand's Māori Health Strategy
Hinengaro	Mental wellbeing
Iwi	Tribe
Kai atawhai	Sheltering, protection
Karakia	Prayer
Korari	Phormium tenax, New Zealand flax
Koro/kaumatua/tohunga	Māori man elder with spiritual expertise
Kuia/kaumatua/tohunga	Māori woman elder with spiritual expertise
Mātauranga Māori	Māori knowledge
Mana	Inherent dignity
Mana wāhine	The inherent prestige of women
Manaaki	Show respect for, support, care, protect
Manaakitanga	The process of showing generosity, support and care for others
Mauri	Life force
Nga hauora o wāhine	The health of people who identify as women, and/or those who have a pregnancy
Noa	Ordinariness
Tangata	Inter-related kin
Tangata whenua	People of the land
Tapu	Sacredness
Te reo Māori	Māori language
Te whare tangata	Womb, literally translated to house of people
Te Whariki Takapou	Māori sexual and reproductive health organisation
Tiakitanga	Protection, guardianship
Tinana	Physical wellbeing
Tino rangatiratanga	Collective self-determination and ability to make their own informed choice, autonomy, control, power, self government
Wahine/wāhine	Māori woman/women
Wairua	Spiritual domains of wellbeing
Whānau	Members of immediate and extended family/ family and community aspects of wellbeing
Whangai	Adoption of a child within an extended family
Whenua	Ancestral land/pregnancy tissue/placenta
Whenua ki te whenua	Returning pregnancy tissue/placenta to ancestral lands

## DEVELOPMENT OF THE STANDARDS

The first Standards Document was developed in 2009 by a Standards Committee appointed by the Abortion Supervisory Committee (ASC).

In 2017 the ASC reconvened a committee to revise the Standards to account for changes in clinical practice and to strengthen the regimen around post-procedure care and oversight.

The Committee was supported by funding from the Ministry of Justice.

Recommendations from a Justice and Electoral Committee Report in 2016 requested the ASC work on best practice guidelines for pre- and post- procedure care and mandatory follow-up for women under 16 years old; especially for those who do not inform a parent or caregiver.

Members of the 2017 Standards Committee include 8 doctors, a nurse/midwife, a social worker, a Māori consultant and a consumer consultant.

The committee acknowledges that these Standards are a consensus between international evidence-based best practice, the requirements of New Zealand abortion law, advice from the ASC and Māori and consumer consultants.

### **2017 ASC Standards Committee Members:**

Dr Alison Knowles (Chair)  
Professor Peter Stone  
Dr Jade Le Grice, Ngāpuhi, Te Rarawa  
George Parker  
Dr Sylvia Ross  
Dr Michelle Wise  
Dr Christine Roke  
Assoc Professor Mike Stitely  
Dr Simon Snook  
Chrissie Sygrove  
Nergis Narayan  
Dr David Bivona

This document includes **Standards** and **Recommendations**.

**Standards** are intended to be mandatory and should be followed in virtually all cases. Exceptions will be rare and difficult to justify. The standards are designed to permit audit.

Where the committee felt the outcomes of an intervention were less certain, practitioners have been given more flexibility and a **recommendation** has been made based on best available evidence, expert opinion and advice from the Abortion Supervisory Committee. Recommendations are steering in nature, but when not adhered to, there should be documented justification.

## 1. INTRODUCTION

Abortion is one of the most commonly performed gynaecological procedures in Aotearoa New Zealand and is experienced by about thirty percent of women during their lifetime.

Unintended pregnancies will always occur. The complexities of managing sexual behaviour and the fallibility of contraception mean unwanted pregnancies are inevitable.

Abortion services have a responsibility to manaaki (show respect for, support, care, protect) those who decide to engage with them. Good provision of manaakitanga (the process of showing generosity, support and care for others) works to enhance people's mana (inherent dignity), retains the safety and health of their interconnected mauri (life force), and mobilises their tino rangatiratanga (ability to make their own informed choices). Service providers can express manaakitanga in diverse ways. Manaakitanga can be inferred through a warm and welcoming smile or physical procedures such as a caring touch. It may also be inferred through conversation that creates a space to allow people to open up, share, and feel safe in doing so, or through humour that makes people feel included and put at ease.

While these Standards are primarily intended for those involved in abortion care, they will also be a useful reference for those required to fund and provide abortion facilities. Others who may find the document useful include staff who work in Family Planning, Sexual Health, Primary Care, Gynaecology, Student Health and Social Work.

Women accessing abortion services should expect to be treated in accordance with these Standards.

## 2. BACKGROUND

Worldwide, there are an estimated 40-50 million abortions a year. Almost half of these abortions are estimated to be unsafe resulting in the unnecessary death of 47 000 women. The World Health Organization states that safe abortion services, as provided for by law, need to be freely available to women and their families.

It is acknowledged that those countries with the most restrictive abortion laws have the greatest rate of unsafe abortion.

Abortion numbers in New Zealand have declined from 18,382 in 2007 to 12,823 in 2016. The general abortion rate has fallen from 21.1 to 13.5 per 1000 women aged 15-44 years. This compares to rates of about 16 in England/Wales and 11 in Scotland. The decline is most dramatic in the under 24 year age group.

The reason for the declining abortion rate is likely to be multifactorial but coincides with greater availability and use of long-acting reversible contraception (LARC), especially among younger women.

It is worth noting that since 2007 there has also been greater access to abortion throughout New Zealand, greater uptake of medical abortion, and the publication of the first ASC Standards Document. The Standards Committee makes the point that improved access and standards of care in abortion services has coincided with reduced abortion rates in New Zealand.

The Crimes Act 1961, the Contraception, Sterilisation, and Abortion Act 1977 (CS&A Act), and the Care of Children Act 2004 specify the circumstances for which abortions may be authorised in New Zealand (Appendices 1, 2 & 3). The legal aspects of the CS&A Act are overseen and administered by the ASC. This committee of three, two of whom must be medical practitioners, is appointed by and reports directly to Parliament.

Under the Contraception, Sterilisation and Abortion Act 1977, there is a requirement to have an ASC. The committee has various functions and powers under section 14 including the following, which have relevance to this document:

- 14(1)(c) To prescribe standards in respect of facilities to be provided in licensed institutions for the performance of abortions:
- (i) that licensed institutions maintain adequate facilities for the performance of abortions; and
  - (ii) that all staff employed in licensed institutions in connection with the performance of abortions are competent.

The Granting of Licences by the Abortion Supervisory Committee is covered under Section 21(1), a, b, c, d and e of the CS&A Act.

Licences can be either full or limited depending on the gestations at which they may perform an abortion and the authors refer those holding or applying for a licence to the above sections of the law.

The ASC is also entrusted by Parliament in section 14(1)(i) of the CS&A Act to take all reasonable and practicable steps to ensure that the administration of the abortion law is

consistent throughout New Zealand, and to ensure the effective operation of the CS&A Act and the procedures there under.

While grounds for an abortion are set out in the Crimes Act 1961 and the administration of the law is overseen by the ASC, patient care and treatment is a core health service and is the responsibility of District Health Boards, medical professionals and the Ministry of Health.

Since 1978 there has been an accurate record of abortion numbers in New Zealand because all abortions must be notified to the ASC and these are collated by Stats New Zealand and reported to Parliament in the Annual Report of the ASC.

Since the current law came into effect in 1978 there have been no deaths notified by the ASC in their annual reports.

### **3. AIM OF THE STANDARDS DOCUMENT**

The Aim of this Standards Document is to ensure all women in New Zealand considering abortion have access to a service of uniformly high quality.

Specifically, the Standards relate to access to services in a timely manner, services that are culturally appropriate, and are designed to produce optimal clinical outcomes.

It is intended that the Standards be defined in such a way to permit audit to identify areas that can be improved.

## 4. CARE PATHWAY

### FIRST CONTACT

1. Woman confirms her pregnancy and initiates discussion with a health care provider
2. Woman requests consideration of abortion

### BEFORE THE ABORTION

1. Verification of gestational age
2. Woman offered referral for professional counselling
3. Identification of women who require extra support before, during or after their abortion
4. Blood tests and genital swabs
5. Discussion of medical or surgical abortion
6. Discussion of post abortion contraception
7. Appointments made to meet certifying consultants

### AT THE ABORTION SERVICE

1. Identification of women who require extra support
2. Legal certification by two certifying consultants
3. Informed consent
4. Medical or surgical abortion
5. Contraception
6. Verification and documentation of completion of procedure
7. Legal notification of abortion
8. Discharge planning and advice
9. Arrangement for follow-up of women requiring additional support, especially those under the age of 16

### ABORTION FOLLOW UP

1. Clinical assessment of physical and emotional health
2. Contraception follow-up
3. Post abortion counselling information
4. Active follow-up of women requiring additional support, especially those under the age of 16

## 5. NEW ZEALAND ABORTION LAW AND ETHICS

Abortion law in New Zealand is written in sections 10 to 46 of the Contraception, Sterilisation and Abortion Act 1977 (CSA Act), sections 182 to 187a of the Crimes Act 1961 and section 38 of the Care of Children Act 2004.

Under the CS&A Act there must be an Abortion Supervisory Committee (ASC) whose role is to keep under review all provisions of the abortion law, and the operation and effect of those provisions in practice.

The grounds by which a woman may have an abortion in New Zealand (Crimes Act 1961) are determined by a law written 56 years ago. The circumstances and procedures under which abortions may be authorised (CS&A Act) are determined by a law written 40 years ago. It is acknowledged by the ASC and the authors of this Standards Document that there have been significant changes in healthcare delivery and medical technologies since these laws were passed.

### **Where can an abortion be done?**

Abortions can only be carried out in an institution licensed for the purpose in accordance with the CS&A Act. It is the role of the ASC to grant licences and to this end the ASC reviews each institution before renewing the licence on an annual basis. The law relating to the granting, duration, renewal, and cancellation of licences is found in sections 21 through to 25 of the CS&A Act.

### **Who can authorise an abortion?**

Abortions cannot be performed unless authorised by two certifying consultants. It is the role of the ASC to set up and maintain a list of medical practitioners appointed as certifying consultants.

### **Who can perform an abortion?**

A Medical Practitioner registered with the Medical Council of New Zealand.

### **Age of Access**

The legal situation regarding age of access to abortion services is set out in the Care of Children Act 2004(Section 38) which states that:

38 (1) If given by a female child (of whatever age), the following have the same effect as if she were of full age:

- a) a consent to the carrying out of any medical or surgical procedure for the purpose of terminating her pregnancy by a person professionally qualified to carry it out; and
- b) a refusal to consent to the carrying out of any procedures of that kind.

### **Counselling**

The law states in section 35 of the CS&A Act, certifying consultants shall advise a woman seeking an abortion of her right to seek counselling from any appropriate person or agency. It is also the role of the ASC to ensure licensed institutions provide access to counselling services that meet professional standards.

## **Grounds for Abortion**

Grounds for an abortion are stated in section 187A of the Crimes Act 1961:

(1) An abortion is unlawful unless, in the case of a pregnancy of not more than 20 weeks gestation, if the person doing the act believes:

- a) That the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or the physical or mental health, of the woman or girl; or
- aa) That there is substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or
- b) That the pregnancy is the result of sexual intercourse between-
  - (i) A parent and a child; or
  - (ii) A brother and sister, whether of the whole blood or of the half blood; or
  - (iii) A grandparent and grandchild; or
- c) That the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1) of this Act; or
- d) That the woman or girl is severely subnormal within the meaning of section 138(2) of this Act.

(2) The following matters, while not in themselves grounds for a lawful abortion, may be taken into account in determining whether continuance of the pregnancy would result in serious danger to her life or to her physical or mental health:

- a) The age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years:
- b) The fact (where such is the case) that there are reasonable grounds for believing that the pregnancy is the result of (sexual violation).

(3) In the case of pregnancies of more than 20 weeks gestation, the person doing the act believes the miscarriage is necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health.

## **Medical Abortion and NZ Law**

In 2002 the Abortion Supervisory Committee stated a case for the opinion of the High Court, under section 28 of the CS&A Act. Two questions of interpretation were put to the Court. On 10 April 2003 Justice Durie answered the questions as follows:

“[56] The first question is: *“What is the meaning of ‘performed’ in s 18 of the Contraception Sterilisation and Abortion Act 1977 in relation to a medical as distinct from a surgical abortion? Is the act of performing an abortion the administration of the drug or drugs, or does it require the complete expulsion of the embryo or fetus?”*

“‘Performed’ in s.18 means ‘begun and carried out or completed’. The act of performing an abortion, in the case of a medical abortion, is the administration of the drug or drugs with the

intent of procuring foetal death or expulsion. The fetus need not be expelled for an abortion to be completed.”

“[57] The second question is: *“If an abortion is not performed until expulsion of the embryo or foetus, will a doctor act illegally under the Contraception Sterilisation and Abortion Act 1977 if that doctor does not require a woman to remain on licensed institution premises until expulsion of the embryo or fetus?”*

“For the reasons given, the expulsion of the fetus is not required for an abortion to be considered to be “performed”. Therefore, a doctor does not require a woman to remain on licensed institution premises until expulsion has occurred. For the reasons given, nor need a woman remain on the premises in the period between the administration of the drugs.”

Refer to Report of the ASC 2003.

### **Unapproved use of Medicines**

Mifepristone and Misoprostol are registered medicines in New Zealand but their use as recommended in this document is ‘unapproved’ or ‘off label’ or varies from that described in the Medsafe Data Sheet.

Medsafe states ‘If the use of a medicine is unapproved, the consumer should be so advised and the provider should be frank about the standard of support for the use and any safety concerns’. Prescription of an approved medication for off label use leads to an increased professional responsibility and liability. There should be rationale for the ‘off label’ use within available medical evidence and guidelines. It is recommended that the decision to prescribe for off label use is discussed with the patient, though it is acknowledged that when use of a medication for off label use is common and usual practice, obtaining consent may not be considered necessary. International consensus is that the use of mifepristone and misoprostol as described in this document are common and usual practice. It is therefore the opinion of this Standards document that obtaining specific consent for ‘off label’ use of misoprostol or variation from ‘Data Sheet’ use of mifepristone and is not necessary in the context of high quality abortion care.

### **Duty of Care and Conscientious Objection**

The Medical Council of New Zealand has a guide to legislation and ethical standards that govern medical practice in Aotearoa New Zealand. This guide states that medical practitioners should follow the following principles of ethical behaviour:

- 1. Consider the health and wellbeing of the patient to be your first priority*
- 2. Respect the rights, autonomy and freedom of choice of the patient*

The Medical Council of New Zealand publication, Good Medical Practice 2016 also states:

*You must not refuse or delay treatment because you believe that a patient’s actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to affect your relationship with them. Your personal beliefs, including political, religious, and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right. Do not express your personal beliefs in ways that exploit their vulnerability or that are likely to cause them distress.*

Justice MacKenzie in the High Court December 2010 defined two options that a doctor with a conscientious objection to abortion has when approached by a patient seeking an abortion:

1. *Inform the patient that she can obtain the service from another health practitioner or family planning clinic; or*
2. *Arrange referral to another doctor in accordance with proper professional standards.*

This means that the doctor should make it clear to the patient at the outset that there are other providers or make a referral to these, but not to engage in a consultation and then state his/her objection nor refuse information or referral.

Should a medical practitioner be called to provide care for a woman having an abortion, the doctor should attend and provide the necessary care. Whilst the doctor with conscientious objection would not be expected to initiate an abortion, should complications arise, he or she should provide medical care as in any clinical situation. For example, haemorrhage during or after abortion may require treatment including surgical treatment and this should be provided.

## 6. ORGANISATION OF SERVICES

### 6.1 PRINCIPLES OF CARE AND SERVICE OBJECTIVES

The care of women considering or undergoing abortion should be woman centred and the care should fulfil the requirements of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumer Rights Regulations 1996. Due regard should also be given to the Health Practitioners Competence Assurance Act section 174 and to Te Tiriti o Waitangi.

#### **Woman Centred**

Woman-centred, comprehensive abortion care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights and is comprised of three key elements:

1. Choice
2. Access
3. Quality

#### **1. Choice**

In the broadest sense *choice* means the right and opportunity to select between options: For example, choice of abortion procedures, providers, facilities and contraception. A woman's choices must be informed by complete and accurate information and the opportunity to ask questions of, and express concerns to, knowledgeable health care providers. To be woman-centred in their care, health care providers must recognise and respond to a woman's right to choices within the circumstances of her environment.

#### **2. Access**

It is the professional and ethical responsibility of primary and women's health care providers to implement abortion care according to the New Zealand law. A woman's access to services is determined in part by the availability of trained, technically competent providers in medically safe facilities that are easily reached - preferably in local communities and at as many service-delivery points as possible. A woman's access is hampered if the time and distance required to reach a 'licensed institution' are excessive. A woman has better access when services are affordable and delivered in a timely manner without undue logistical and administrative obstacles.

#### **3. Quality**

High-quality abortion care includes many factors that will vary somewhat given local contexts and available resources. Some fundamental aspects of high quality care are:

- Tailoring each woman's care to her social circumstances and individual needs
- Providing accurate, appropriate information and counselling that supports women in making fully informed choices
- Following International and New Zealand Clinical Standards
- Offering post-abortion contraception services to help women prevent unwanted pregnancies, practice birth spacing and avoid repeat abortions
- Ensuring confidentiality, privacy, respect and positive interactions between women and abortion services

- Having regular audit of the care which is provided.

*While the majority of abortion-service users identify as women, abortion providers should give some consideration to the accessibility of their services to trans and gender-non-conforming service users and should ensure awareness of, and attention to, the specific abortion care needs of sexuality, sex characteristic, and gender diverse service users.*

### **Te Tiriti o Waitangi**

Māori are tangata whenua (the people of the land), indigenous to Aotearoa New Zealand.

Māori health and wellbeing are inseparable from the historical context of colonisation and European domination in Aotearoa New Zealand. Māori have experienced forced sale of land, warfare and depopulation, which has disconnected many from their ancestral lands, knowledge and practices. This has created, and continues to maintain, Eurocentric modes of culture and health care provision. Historically, mātauranga Māori in reproductive healthcare has been devalued, invalidated and marginalised. Māori reproductive health inequities with New Zealand Europeans persist.

He Korowai Oranga (2002) provides guidelines for a working partnership between tangata whenua and the government, in the spirit of good faith of Te Tiriti o Waitangi. This involves the government supporting tangata whenua-led development to mobilise tino rangatiratanga (collective self-determination) and optimal outcomes for whānau (immediate and extended family). The government is required to safeguard Māori Health concepts and mātauranga Māori in health care provision and medical practice. Good quality and culturally responsive abortion services should be oriented to dynamic, contemporary Māori knowledge and promote the sanctity of every Māori person, in the pursuit of Māori health equity across all aspects of Māori health.

This requires The Ministry of Health, DHBs and all healthcare providers to collaborate and work towards improved outcomes for Māori, with defined processes from staff training and public education, right through to ongoing audit and evaluation. See standard 6.3 for specific Māori Health standards.

Providing culturally competent care for Māori seeking abortion increases the likelihood of Māori engaging with services in a timely manner, will improve adherence to investigation requirements, treatment plans, contraception, and a holistic appraisal of Māori women's health status.

## **6.2 ACCESS AND REFERRAL TO ABORTION SERVICES**

All District Health Boards (DHBs) are required to provide access to abortion services for women in their catchment areas. In achieving this, it is expected that DHBs will provide services as close as practicable to the domicile of the woman, recruit and support staff providing abortion services and develop inter-regional services.

See appendix 4: Ministry of Health Manatu Hauora. Specialist Medical and Surgical Services. Gynaecology Services. Tier Two Service Specification.

**Standard 6.2.1**

DHBs should ensure all women who are eligible for publicly funded health care have access to abortion services.

**Standard 6.2.2**

Wherever possible women should have access to services within their own DHB or area of domicile but if this is not practicable, the DHB of domicile must make and fund appropriate arrangements with another abortion provider as close as possible to the domicile of the woman. This funding should include transport and accommodation costs.

*Recommendation*

*Women should not have to travel more than two hours to access first trimester abortion services.*

**Standard 6.2.3**

As with other pregnancy services, DHB abortion services should be free to all women eligible for publicly funded health services in New Zealand. The pre-abortion assessment, counselling and follow up appointments should also be free.

**Standard 6.2.4**

Abortion services should have local strategies in place for providing information to women, doctors and other professionals in the community on choices available within the service and routes of access to the service.

**Standard 6.2.5**

DHBs should ensure access to both medical and surgical abortions.

*Recommendation*

*Wherever possible, female abortion service providers should be available on request.*

**Standard 6.2.6**

Abortion services should be able to provide pre-abortion assessment. Although it may be helpful for a referring health care provider to complete the pre-abortion assessment, a woman should have access to these requirements within the abortion service.

**Standard 6.2.7**

Appropriate information and support should be available for those who do not proceed to abortion. With the woman's consent, her primary healthcare provider should be notified so she can transition to antenatal care.

**Standard 6.2.8**

Services should be structured to minimise delay. See section 6.4

**Standard 6.2.9**

Doctors who use telehealth to refer or certify a woman for an abortion are referred to the Medical Council of New Zealand Statement on telehealth. See appendix 5.

### **Standard 6.2.10**

Abortion Services should have access to suitably trained competent interpreters. Abortion services are referred to Coles Medical Practice in New Zealand. Chapter 8. The Use of interpreters. See appendix 6.

## **6.3 MĀORI HEALTH**

### **Historical and contemporary Māori understandings of abortion**

NZ Abortion Services have developed through western social frameworks. Modern history of abortion has arisen within the context of advancing women's rights and reproductive justice, focussing on the importance of women taking leadership and responsibility for reproductive decisions. This differs from traditional Māori understandings of reproduction, anchored in mātauranga Māori where wāhine have not traditionally made reproductive decisions in isolation, but instead whānau provided support and shared responsibility for one another. This may include whānau offering to raise other members' children as their own through atawhai (temporary care arrangements) or whangai (arrangements with more permanency). In these arrangements, biological parents remain part of the lives of their offspring but may not provide day to day care.

Current western thinking around pregnancy and abortion as 'unplanned' or 'unwanted' is not consistent with mātauranga Māori, where the conception was not disavowed but acknowledged in the context of circumstances that prevented it being carried to term.

In te reo Māori, accidental or deliberate loss of conception are not linguistically distinguished. This has parallels in the English language and gynaecology, where in the past, the word 'abortion' encompassed both induced and spontaneous expulsion of an embryo or fetus before viability.

Historically, however, Māori did practice accepted methods to end pregnancies.

Contemporary Māori understandings and perspectives on abortion are diverse, informed by a dynamic cultural interplay between mātauranga Māori, western knowledge systems and wider global influences.

### **Manaakitanga in abortion services**

Manaakitanga is the process of showing generosity, support and care for others. Manaakitanga is important in the following contexts when healthcare providers and Abortion Services engage with Māori:

#### **A) Interactional context**

Referrers and abortion services should be aware of the cultural aspects of the person they are engaging with, drawing upon their own genuineness and warmth to engage the holistic dimensions of the person.

People should be supported to honour their decision to attend reproductive health services in a way that attends to their mana, mauri and rangatiratanga – allowing them to feel dignified and safe in this decision.

People should be reassured they are not alone in seeking an abortion, and be affirmed in understanding the contextual reasons and drivers of abortion decisions beyond individual accountability.

Practices need to be open enough to allow people to exercise their tino rangatiratanga and autonomy in their engagement with all stages of these practices, and consider the varied, nuanced and unique ways people create a sense of safety.

## **B) Transitioning to spaces for consultation and procedures**

Referral and abortion services should consider how they mediate the space between tapu (sacredness) during consultation and procedures, and noa (ordinariness) before and after encountering reproductive health services.

Entrance areas and spaces are important to the provision of manaaki, with clear markers as to the cultural and social environment where abortion experiences are situated and meaning is made.

Māori have the right to be offered karakia (prayer), by a kuia chaplain/kaumatua/tohunga (Māori women elder with spiritual expertise) or specialist in nga hauora o wāhine (the health of women, and/or those who have a pregnancy).

Further practices that facilitate transition between spaces of tapu and noa are essential. These can be collaboratively designed with supportive Māori kuia/kaumātua.

Staff should be trained in Māori understandings of mana wāhine (the inherent prestige of women), meanings of te whare tangata (womb, literally translated to house of people), the tapu nature of people in hapūtanga (pregnancy), gestation and foetal development.

Services should provide spaces that cater to the possibility of whānau involvement and support for a person seeking an abortion. If whānau are present, staff should ensure the woman retains her rangatiratanga in abortion decision making and be mindful that this may cause conflict or be abrasive for whānau who would prefer to retain and support the pregnancy.

Māori may wear taonga/valuables of spiritual significance. Staff should be aware and respectful of taonga and discuss any need to handle taonga with the woman.

Wāhine should be given the opportunity to wash after their procedure.

## **C) Service management**

Te Tiriti o Waitangi will inform the DHB and the abortion service manager's approach and strategy to support Māori workforce development in abortion care – to train, recruit, and support Māori staff who have stake in decision-making, planning, development and delivery of abortion services.

Ideally, abortion services will have trained Māori abortion counsellors or social workers who have knowledge about Māori understandings of reproduction and abortion.

All Māori staff should be linked into networks of support and ongoing training towards leadership in mātauranga Māori, gender, and reproductive justice. A highly relevant organisation to develop a relationship with to support these aims, is Māori sexual and reproductive health organisation, Te Whariki Takapou.

## **D) Facilitating holistic wellbeing post-abortion**

Through tiakitanga (protection, guardianship), health services have a duty of care and obligation to facilitate te hauora o nga wāhine holistically, and consider aspects of Māori health that include atua (spiritual aspects), whenua (ancestral land), and tangata (inter-related kin). Individual and whānau reproductive health intersects all of these areas.

Appropriate manaakitanga from first contact with a health provider through to the procedure through to post abortion care is important to ensure peoples rangatirantanga is preserved into the future.

This can be addressed in the following ways:

***Hinengaro - mental wellbeing*** – the degree to which space has been made available to the person to feel safe to open up, how she makes sense of these experiences, how this may be mediated by the cultural and social environment, norms, assumptions, routine practices (eg. foyer décor, conversations, physical procedures, visible ultrasound)

***Tinana - physical wellbeing*** – the degree to which the person’s behaviour and non-verbal communication has been attended to, to ascertain what they need, how comfortable she feels voicing disquiet or unease, interprets bodily sensations, elicits support, is taken seriously and offered adequate support (e.g. engagement and due regard for safety in physical procedures, pain relief or contraceptive options)

***Wairua - spiritual wellbeing*** – the degree to which respect is maintained for where she is at spiritually, how she makes meaning of this through her senses, and is provided with time, space, and whatever she needs to ease her wairua (e.g spiritual, aspirational, & religious needs)

***Whānau – family and community aspects of wellbeing*** – the degree to which the possible challenges she might be managing with whānau are understood, clarity in her decision regarding whether or not to involve them in this process, spaces to cater for whānau who are there to support her, support to reflect upon whether or not to broach conversation with whānau afterwards, and if appropriate, reflections on future whānau aspirations (eg. pre & post-abortion conversations & comfortable spaces for whānau support).

## **E) Whenua ki te whenua. Returning pregnancy tissue to ancestral lands**

The practice of whenua ki te whenua is significant in reproductive health because it nurtures connections between atua, tangata and whenua, and kai atawhai.

There is diversity within whānau, hapū and iwi knowledge and approaches to whenua ki te whenua.

Kai atawhai (sheltering, protection), can occur through respect and acknowledgement of the developing tissue, and part of the mother, when this is returned to whenua (land) of ancestral significance that is likely to be part of future descendants' lives.

Tino rangatiratanga should be encouraged in decisions about whether to practice whenua ki te whenua, and it should be presented as an option in context with its meaning. This may be introduced as a way for the women to broach their decision with whānau after the abortion and elicit support, if appropriate.

Māori are diverse in their awareness, knowledge, and engagement with Māori customs, and some create new and reworked practices for their unique circumstances and contexts. While discussion and sharing of knowledge about practices such as whenua ki te whenua is important, Māori should not feel pressured to adhere to them but supported to engage to the extent that they feel comfortable.

Abortion Services should be able to enact kai atawhai for those who are not in a position to do so, and a default position requires pregnancy tissue be returned to a designated area of whenua that will be protected and nurtured forever.

#### **Standard 6.3.1**

Staff should complete a Te Tiriti o Waitangi course, and have the capacity to reflect upon their own cultural assumptions about Māori, and how these might influence their capacity to provide manaakitanga.

#### **Standard 6.3.2**

Cultural competence should be incorporated into abortion providers' continuing education. This should include an awareness of Māori health incorporating four domains: 1) hinengaro, 2) tinana, 3) wairua, and 4) whānau, and how they apply to Māori reproductive health. It should also address historical and contemporary understandings of Māori women's health, abortion and practice.

#### *Recommendation*

*Cultural competency should be incorporated into staff performance reviews and where ever possible this should be with a Māori staff member.*

#### **Standard 6.3.3**

Abortion Services should provide environments conducive to manaakitanga – including a calming and pleasant décor in entrances and spaces for public enjoyment.

#### **Standard 6.3.4**

Māori women should be consulted on service delivery and design.

#### **Standard 6.3.5**

Abortion service managers should support Māori workforce development with a view to having Māori staff options.

#### **Standard 6.3.6**

Abortion services should establish relationships with Māori sexual and reproductive health organisations. For example Te Whariki Takapou.

*Recommendation*

*Where ever possible abortion services should provide information resources for Māori individuals and whānau, developed by Māori and for Māori – as resources become available.*

**Standard 6.3.7**

Abortion services should establish relationships with Māori spiritual experts: Chaplain, kuia/kaumātua, and/or kuia/tohunga – with specialist understanding of te hauora o nga wāhine. These Māori spiritual experts should be available to offer support to Māori women having an abortion.

**Standard 6.3.8**

Abortion services should make provision to manaaki whānau who have come along to support those who are considering abortion.

**Standard 6.3.9**

Abortion service staff should be familiar with the basic principles of tapu and noa, and practical ways of respecting these concepts, as outlined above.

**Standard 6.3.10**

Māori and their whānau should be given the opportunity to have karakia at any stage of the abortion process, especially prior to heightened situations.

**Standard 6.3.11**

Abortion service staff should be respectful of taonga/valuables worn with spiritual significance. Permission and explanation should be sought before touching or removing taonga.

**Standard 6.3.12**

Abortion services should make provision for women to wash after their procedure - for example, a shower or private space with warm water and washcloths or towels.

**Standard 6.3.13**

Abortion service staff should understand the significance of whenua ki te whenua in the context of mātauranga Māori, the concept of kai atawhai, and the diversity in Māori knowledge about, and engagement with this practice.

**Standard 6.3.14**

Korari or pots should be available to those who wish to kai atawhai their pregnancy tissue or practice whenua ki te whenua.

**Standard 6.3.15**

Abortion services should be able to enact kai atawhai for those who are not in a position to do so, and return pregnancy tissue to a designated area of whenua that will be protected and nurtured forever.

## 6.4 WAITING TIMES IN ABORTION SERVICES

The earlier in a pregnancy an abortion is performed the safer and less painful it is. The procedure takes less time, costs less money and is less stressful for patients and clinicians. Early abortions also give a woman more choice as to how and when her abortion is to be done.

Health care providers should be aware of this and as soon as it is evident that a woman is considering an abortion she should be offered referral to an abortion service for counselling and medical assessment so that she is given as much support and time as possible in making a decision. Simply sending the woman away to think about her decision can cause unnecessary delays in accessing abortion services. These delays can deprive the woman of the choice of a medical abortion or necessitate the need to refer to second trimester services.

### Standard 6.4.1

Assuming legal requirements are met, women should not wait longer than two weeks from when they first request referral for consideration of abortion to time of procedure. However, some women may choose to have more time for decision making.

### Standard 6.4.2

If a woman requires an abortion for serious medical reasons (for example severe pre-eclampsia, sepsis or psychosis) she should be able to be assessed urgently for certification.

#### *Recommendation*

*Where abortion services offer a one day assessment, counselling, certification and procedure service, women should not have to spend longer than six hours at the service.*

## 6.5 SETTINGS FOR ABORTION CARE

As long as legal requirements are fulfilled, the vast majority of abortions can be safely provided by qualified practitioners in primary care facilities.

### Standard 6.5.1

No abortion shall be performed elsewhere than in an institution licensed for the purpose in accordance with the CS&A Act. An institution may either have a full licence (may perform an abortion regardless of the length of time the pregnancy has been continuing) or a limited licence (may only perform abortions during the first 12 weeks of the pregnancy).

#### *Recommendation*

*Medical and surgical abortion services should be integrated to ensure women are given a genuine choice of abortion method and surgical backup is available for failed or complicated medical abortion.*

### Standard 6.5.2

In an abortion service, some women may require inpatient care. An adequate number of inpatient beds or transfer arrangements should therefore be in place to accommodate these women. Institutions are required under the terms of their licence to have timely access to adequate facilities for the accommodation of patients for one or more nights.

### **Standard 6.5.3**

Any patients with more than mild systemic disease should have their abortions conducted in a location that has emergency medical backup (for example anaesthetist on the premises). Those at risk of cardiovascular, respiratory or airway compromise during sedation should be referred for an anaesthetic opinion prior to surgery and have an anaesthetist present during the abortion. These patients may include those with severe heart, lung, liver, renal disease or severe obesity.

### **Standard 6.5.4**

Abortion Services should provide environments conducive to manaakitanga. This includes the capacity to provide space for whānau, and a calming décor throughout. The environment should be warm, comforting, and welcoming.

## **6.6 MINIMUM THEATRE SAFETY REQUIREMENTS**

### **Standard 6.6.1**

Surgical abortion should be performed in a location that is adequate in size and equipped to deal with a cardiopulmonary emergency. This should include:

- Adequate room to perform resuscitation should this prove necessary
- Appropriate lighting
- An operating table, trolley or chair which can be tilted head down readily is preferable but not mandatory
- An adequate suction source, catheters and handpiece
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient
- A means of inflating the lungs with oxygen (for example, a self-inflating bag and mask) together with ready access to a range of equipment for advanced airway management (for example, masks, oropharyngeal airways, laryngeal mask airways, laryngoscopes, endotracheal tubes)
- Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment and fluids including drugs for reversal of benzodiazepines and opioids
- Appropriate drugs to manage haemorrhage including syntometrine and misoprostol
- A pulse oximeter
- A sphygmomanometer or other device for measuring blood pressure
- Ready access to a defibrillator
- A means of summoning emergency assistance
- Adequate access throughout the facility to allow the patient to be transported easily and safely
- A clinical emergency response plan to manage potential clinical deterioration.
- Appropriate numbers of staff trained in advanced cardiopulmonary resuscitation immediately available to assist at the time of any emergency

## 7. INFORMATION FOR WOMEN

### Standard 7.1

Abortion services should have either a web resource, telephone resource or links to an up to date New Zealand based website which provides the following information and support to both those seeking an abortion and those supporting someone having an abortion:

- Location of the abortion service
- How to access the service
- Costs associated with pre-abortion assessment, investigations and travel
- Travel options to access the service
- Timeframes from initial contact to having the abortion
- How to get time off work/school and how to get a medical certificate
- How to get post-abortion support in an unsupportive home environment
- Rights and entitlements and how to access subsidies for costs

### Standard 7.2

Verbal advice should be supported by impartial printed information that the woman can understand and may take away to consider further before the procedure.

### Standard 7.3

Abortion service staff should possess accurate knowledge about possible complications and sequelae of abortion. They should provide women with this information so that they can give informed consent.

### Standard 7.4

The following information should be made available to women both verbally and in writing prior to them consenting to an abortion procedure:

- Abortion is safer than continuing a pregnancy to term and complications are uncommon
- The different methods of abortion that are available within their local service and for what gestations
- Information about immediate complications of abortion, which can include haemorrhage. With surgical abortion - uterine perforation, cervical lacerations and anaesthetic complications can also occur. In the event of one of these complications, women should be aware that they may need to be transferred to a hospital facility where a blood transfusion or other surgery (suction procedure, laparoscopy, laparotomy or hysterectomy) may be required
- Less immediate short-term complications for which a woman may present to her primary care provider include incomplete abortion, continuing pregnancy, pelvic infection and short term emotional distress
- Very rarely, women present with psychological issues weeks, months or years after an abortion. This is more likely if psychological issues were present before the abortion. Refer to Section 8.3. Individualised Psychosocial Assessment and Referral for Support.

It should be emphasised that the incidence of the above complications is dramatically reduced for abortions performed early in pregnancy and by experienced clinicians in medically safe facilities.

*Recommendation*

*Abortion services should make available printed information that is written by Māori, for Māori, in accordance with contemporary mātauranga Māori.*

**Standard 7.5**

Printed information should be provided to women and whānau that offers a glossary of medical terms associated with abortion. For example: medical abortion, surgical abortion, gestation, trimester, drugs used in abortion, anatomy, medical equipment, types of contraception. See appendix 7.

## 8. BEFORE THE ABORTION

### 8.1 THE ABORTION DECISION

It is acknowledged that women will have received a varying amount of counselling and support prior to attendance at an abortion service and will vary in their degree of certainty about their abortion decision. All women attending an abortion service should have the opportunity to discuss the implications of their intended course of action (be it continuing the pregnancy or having an abortion) and require support in reaching their final decision. This degree of support is a routine responsibility of an abortion service and is different from formal counselling.

#### Standard 8.1.1

Women should be offered the following information to assist in their decision and abortion experience:

- Basic anatomy and physiology as relevant to their gestation
- An understanding of the process of abortion and its possible complications
- Fetal development (which may include showing pictures of the stage of fetal development)
- Information about the advantages of having an abortion earlier rather than later in a pregnancy and the differences between a medical and surgical abortion
- Products of conception – kai atawhai or disposal options
- An understanding of how people make sense of the loss of conception in abortion, grief and loss processes, and variabilities within a contemporary cultural context in Aotearoa
- Contraception education

### 8.2 COUNSELLING

Abortion providers are referred to the “Standards of Practice for the Provision of Counselling” published by the ASC in 1998. See appendix 8.

This 2018 Standards Document, however, acknowledges the need to update the counselling standards to reflect not only changes in abortion services but also changes in social work and counselling practice in New Zealand and internationally.

Counselling has been defined as ‘the process of enhancing a subject’s ability to assess and understand the index situation, evaluate options and make informed choice or decision. This entails sensitive provision of comprehensive information in a nondirective or non-judgmental manner.’

#### Standard 8.2.1

Certifying consultants and other professionals caring for a woman requesting abortion should advise a woman of her right to seek counselling and facilitate her referral to a suitably trained and credentialed professional whose counselling practice meets the needs of the ASC. The service must be free and easily accessible.

### *Recommendation*

*Counselling should be available on site and without the need for a further visit.*

#### **Standard 8.2.2**

Counselling options available to women and significant others (partners and whānau) should include:

- Pre-decision/pregnancy options counselling
- Pre-abortion counselling
- Post abortion counselling

#### **Standard 8.2.3**

Abortion services should try to identify those that require additional support and these women should be actively encouraged to see a counselling professional before they proceed with abortion (refer to section 8.3 on Individualised Psychosocial Assessment and Referral for Support).

#### **Standard 8.2.4**

All women should be given the opportunity to be seen on their own to address issues of coercion and to facilitate honest and open discussion. The process should be safe and respectful.

#### **Standard 8.2.4**

Abortion services should have available professionals with suitable training in counselling.

#### **Standard 8.2.5**

Professionals providing counselling in abortion care should:

- Hold a relevant qualification or have equivalent training in abortion counselling
- Be registered members of their profession:
  - Social workers should hold an annual practicing certificate and valid competence certificate
  - Counsellors should be members of The New Zealand Association of Counsellors Te Roopukaiwhiriwhiri o Aotearoa
- Be doing regular pregnancy counselling for women considering abortion
- Have supervision and peer review
- Clinical supervision is a formal and disciplined working alliance which is generally between a more experienced and a less experienced abortion provider (social worker, counsellor, nurse or doctor), in which the supervisee's clinical work is reviewed and reflected upon, with the aims of: improving the supervisee's work with clients, ensuring client welfare, supporting the supervisee in relation to their work, and supporting the supervisee's professional development

#### **Standard 8.2.6**

Women presenting to an abortion service should undergo family violence routine enquiry and referral to appropriate community resources should be available.

**Standard 8.2.7**

Abortion services should have an active plan to recruit Māori staff, with a view to provide Māori women with the option to see a Māori counsellor. All counsellors are required to abide by cultural competency requirements as stated in section 6.3 Māori Health.

**8.3 INDIVIDUALISED PSYCHOSOCIAL ASSESSMENT AND REFERRAL FOR SUPPORT**

The following guidelines have been developed taking into account the Report of the Abortion Supervisory Committee (2016) and related new legislation such as the Crimes Amendment Act 2001, and Vulnerable Children Act 2014.

The goal of psychosocial assessment is to better understand the client and any additional challenges she may be facing in order to provide individualised and appropriate care, and to arrange referral for additional support needs if required. This will help ensure optimal outcomes from the women's abortion experiences.

**Standard 8.3.1**

Abortion services should ensure individualised psychosocial assessment of all women who attend for an abortion to determine areas of need for referral to additional services. This psychosocial assessment can be provided by appropriately trained social workers, counsellors, nurses or doctors.

**Standard 8.3.2**

Individualised psychosocial assessment may encompass the following:

- health history
- family/social history
- cultural and spiritual assessment
- financial assessment
- mental wellness assessment
- family violence risk assessment
- sexual violence risk assessment

Special attention should be given to young women, women with limited mental capacity, those women who disclose family or sexual violence and those who do not understand or speak English.

**Standard 8.3.3**

If women attending an abortion service reveal additional areas of social or health concern, including circumstances of family and/or sexual violence, they should be informed of relevant services in their area that are available to them including the offer of referral and follow up care to ensure they are supported to access the assistance they need.

## Pre and Post Abortion Counselling Support

### **Standard 8.3.4**

Women should be informed of the range of emotional responses they may experience before, during and after an abortion and if they have formal counselling, this should be tailored to their individual needs.

## Working with Young Women

Young women (10 to 19 years) may face additional challenges relating to their age and reproductive experience. A young woman's emotional reaction towards her unintended or unwanted pregnancy may be complex, unique to the individual and likely to change over time as she processes the news.

### **Standard 8.3.5**

Young women should be provided with accurate, age-appropriate education, information and support related to their chosen pregnancy option.

### **Standard 8.3.6**

Abortion services should assess the specific psychosocial needs of young women including their level of support, current/historical mental health, care and protection and substance abuse concerns.

### **Standard 8.3.7**

In order to assess risk and ensure an informed and independent decision is being made, young women should be seen on their own initially.

If the requirements for valid consent are met it is not legally necessary to obtain consent from a person with parental responsibilities. The young person should be supported to make decisions about whether they would like family/whānau members involved in their care and/or other appropriate forms of support. The guiding principle for family involvement is to strengthen the family relationship and potential support for the future, unless a risk from within the family is identified.

### **Standard 8.3.8**

Abortion services should suggest or support a young person to involve parent(s) or another adult (such as family/whānau member or specialist youth worker) but generally should not override the patient's view.

### **Standard 8.3.9**

Before the abortion procedure, the young woman should be encouraged to give information and contact details of a significant other whom they trust, preferably a person over 18 years.

### **Standard 8.3.10**

When young women are being physically or sexually abused, they are often unable to prevent unwanted pregnancy without additional assistance to ensure personal safety. Abortion services should be alert to the possibility of abuse, particularly when a young woman refuses to involve her parents, there is a history of repeat abortions or is accompanied by a controlling adult.

When abuse is suspected, the primary concern is the wellbeing of the young woman and children she may have care of. Refer to Standard 8.3.15.

**Standard 8.3.11**

Post-abortion counselling and support should be offered to all young women.

**Standard 8.3.12**

Abortion services should establish working relationships with school/community based youth specific health services.

**Standard 8.3.13**

When following up young women, communication technologies should be consistent with the patient's preferred mode of communication (e.g. text message appointment reminders). Importance should be placed on consistent follow-up, outreach and multidisciplinary teamwork.

**Working with Women in Situations of Family Violence**

Family violence increases the risk for abortion, unintended pregnancy and sexually transmitted infection.

Family violence covers a broad range of controlling behaviours of a physical, sexual and/or psychological nature. It typically involves fear, intimidation, and emotional deprivation. It can occur within a variety of close interpersonal relationships such as between partners, parents and children, siblings, and in relationships where significant others are not part of the physical household but are part of the family or fulfilling the function of family.

Health harm from abuse is cumulative; family violence routine enquiry identifies at-risk individuals and increases opportunities for early intervention.

**Standard 8.3.14**

Abortion services should ensure all women are asked about family violence and safety is assessed.

**Standard 8.3.15**

When family violence is identified or suspected, it is the duty of the clinician to be familiar with the procedures to be observed. Clinicians should refer to their clinic or DHB violence intervention policies and documents. Abortion services are referred to Ministry of Health Family Violence Guidelines: <http://www.health.govt.nz/our-work/preventative-health-wellness/family-violence>.

**Standard 8.3.16**

Abortion Social Workers/Counsellors should have access to training to increase their understanding of social and cultural contexts in which family abuse occurs and they should endeavour to respect the dignity of the person, whilst safeguarding and helping them understand their right to safety.

**Standard 8.3.17**

Routine enquiry should be accompanied by the provision of appropriate information support and timely referrals to specialist intervention services.

**Standard 8.3.18**

Abortion services cannot assure confidentiality where there is the possibility of homicide, suicide or child maltreatment risk. Clinicians should assure women that they will do their best to work with them to help increase safety of all involved.

**Standard 8.3.19**

When the abortion service is required to disclose information to Oranga Tamariki Ministry for Children, or the Police, the clinician should be mindful of the need to preserve evidence and accurate record keeping.

**Working with Migrant and Refugee women**

Abortion services should be responsive to immigrant and refugee women's cultural and linguistic needs. Clinicians should be aware of the social, cultural and religious sensitivities that migrant and refugee women may have regarding their sexual and reproductive rights.

The service should accommodate for interpreting, establishing rapport and careful explanation. Standard 6.2.10 states that services should have access to suitably trained competent interpreters.

While women may ask to use family or friends or partners as interpreters, this is not good practice and the use of independent professional interpretation services is the best way of ensuring informed decision making and consent on the part of the women.

**Standard 8.3.20**

For migrant and refugee women who have limited English proficiency, a qualified interpreter should be used.

**Standard 8.3.21**

In some migrant or refugee groups, interpreters may be known to the woman or her family, and in these circumstances, the woman should be given the opportunity to decline the assistance of that person and be offered an alternative.

*Recommendation*

*The gender of the interpreter should be considered.*

**Working with women who have experienced Sexual Assault**

Decisions around pregnancy resulting from rape are very personal and victims deserve a full range of options without judgement or coercion from others. The cornerstone of advocacy is supporting women in regaining control over their bodies and lives by explaining all available options and supporting their decision about what is best for them and their family. This may or may not include laying a complaint with Police.

Providing early intervention following sexual assault helps with the recovery process and healing. Abortion staff should also be sensitive to the needs of survivors of historical sexual assault.

**Standard 8.3.22**

All women who are pregnant as a result of rape and are requesting an abortion should be encouraged to see a social worker or counsellor before proceeding to abortion.

### **Standard 8.3.23**

Abortion services should have guidelines for the management of women who have been sexually assaulted. This should include options for further counselling, making an ACC claim, and making a complaint to Police.

### **Standard 8.3.24**

When a woman is pregnant as a result of rape she may choose to have her pregnancy tissue given to Police for forensic analysis to identify the alleged offender. Abortion services should have protocols in place for pregnancy tissue collection for forensic analysis. Local Police, ESR, and MEDSAC may be consulted when establishing these protocols. See appendix 9.

### **Standard 8.3.25**

Early medical abortion is not suitable for forensic collection of products of conception.

## **Working with Women who have Limited Mental Capacity**

Certifying consultants are referred to section 34 of the CS&A Act: Special provisions where patient is ‘mentally subnormal’:

*“In any case where the patient lacks the capacity to consent, by reason of any mental incapacity, to an abortion, the persons charged, under section 33, with determining whether to authorise the abortion shall, before determining the case, consult with a medical practitioner or other person believed by them to be qualified and experienced in the field and able to make an assessment of the patient’s condition and the likely effect on it of the continuance of the pregnancy or an abortion.”*

Under the Code of Health and Disability Services Consumers’ Rights every consumer is presumed competent to make an informed choice and give informed consent. There must be reasonable grounds for believing that the individual consumer is not competent.

In some circumstances it may not be possible to obtain the patient’s informed consent. For example, the patient may have an intellectual disability, be unconscious or suffer dementia. In such cases doctors should try to contact a legal guardian or an appropriate person who is in the position to grant consent on behalf of the patient.

The only individuals who are entitled to grant consent on behalf of a patient are legal guardians (welfare guardians under the Protection of Personal Property Rights Act, or parents/guardians under the Guardianship Act), or someone with enduring powers of attorney.

Under Right 7 (4) of the Code, if the patient is not competent to make an informed choice and give informed consent; and no person entitled to consent on behalf of the patient is available, a doctor may provide services without obtaining the informed consent of the patient when:

- (a) it is in the best interests of the patient; and
- (b) reasonable steps have been taken to ascertain the views of the patient; and either
- (c) the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice that the patient would have made if he or she were competent; or

- (d) if the patient's views have not been ascertained, the provider takes into account the views of other suitable people who are interested in the welfare of the patient and available to advise the provider.

If the clinician has not been able to ascertain the patient's views and no suitable person is available to give advice and the delay will not be harmful, it is wise to seek a second opinion from an experienced colleague before providing treatment. The doctor should document this colleague's views in the patient record.

In the situation where a patient has diminished competence the doctor is required to obtain consent from the patient for the aspects of the treatment that the patient understands. Patients not competent to give informed consent are still entitled to information about the procedure.

## **8.4 MEDICAL ASSESSMENT**

### **Standard 8.4.1**

Confirmation of pregnancy should be documented (eg. Urine hCG).

### **Standard 8.4.2**

Gestational age should be verified and documented. This may be done by clinical means (a bimanual examination which agrees with LMP dates) or ultrasound scan. Quantitative hCG measurement may be helpful but should not solely be used as a measure of gestational age.

### **Standard 8.4.3**

Limited ultrasound scanning should be available for those with uncertain dates or when there is a discrepancy between LMP and uterine size. A 'limited ultrasound examination' should include the following:

- (a) Scan of the uterus in transverse and longitudinal planes to confirm intrauterine pregnancy
- (b) Evaluation of embryo/fetal number
- (c) Measurements to document gestational age
- (d) Evaluation of yolk sac and cardiac activity
- (e) Placental location in second/third trimester

#### *Recommendation*

*If an ultrasound is required, it should be available within the abortion service rather than by a community provider. The reasons for this are:*

- (a) There are often delays in getting a scan in the community*
- (b) Many community providers charge a co-payment*
- (c) There is inconvenience and cost associated with attending a scan appointment*
- (d) Community providers are sometimes insensitive to a woman's situation*

### **Standard 8.4.4**

If a woman has an ultrasound she should be informed beforehand that she has the option to either view or not view the scan.

**Standard 8.4.5**

Rhesus status should be documented.

**Standard 8.4.6**

Relevant medical history should be obtained and documented.

**Standard 8.4.7**

If the woman has a history of anaemia or risk of bleeding, a recent haemoglobin should be documented.

**Standard 8.4.8**

Women should be offered screening tests for chlamydia and gonorrhoea.

**Standard 8.4.9**

Screening for other STIs should follow New Zealand Sexual Health Service Guidelines. See appendix 10.

**Standard 8.4.10**

Women-centred care requires that women make an informed choice and give consent for STI screening.

**Standard 8.4.11**

Women who test positive for a STI should receive therapeutic doses of the appropriate antibiotics. These may commence as late as the day of the procedure and should not delay scheduling of the procedure. The abortion service should offer to meet and treat sexual partners if they are attending the appointment. If this is not possible NZSHS partner notification guidelines should be followed.

**Standard 8.4.12**

If there are no contraindications, women should be given a choice of medical or surgical abortion, according to gestational age.

**Standard 8.4.13**

Post abortion contraception should be discussed in advance of the abortion and written information offered.

**Standard 8.4.14**

Heart rate and blood pressure should be recorded before the abortion. Physical examination may be done as indicated by medical history and patient symptoms.

**Standard 8.4.15**

Abortion Services should have a written protocol for the evaluation of suspected ectopic pregnancy.

Ectopic pregnancy should be excluded when a woman presents with any of the following:

- (a) *Transvaginal US shows no IU pregnancy and  $\beta$ HCG > 2000 IU/L.*
- (b) *Abdominal US shows no IU pregnancy and  $\beta$ HCG > 3500 IU/L.*
- (c) *Insufficient tissue is obtained at the time of abortion.*

*(d) Suspicious adnexal mass, pain or bleeding*

## **8.5 CERTIFICATION**

### **Standard 8.5.1**

All certifying consultants should:

- (a) Have a current Annual Practising Certificate from the Medical Council of New Zealand.*
- (b) Have a postgraduate qualification which includes women's health (for example, but not restricted to, Diploma in Obstetrics and Medical Gynaecology, Diploma in Sexual and Reproductive Health, FRNZCGP, FRANZCOG, Family Planning Certificate).*
- (c) Have knowledge of New Zealand abortion law and sign a statement of confirmation of familiarity with relevant sections of the Crimes Act 1961, the CS&A Act 1977 and the Care of Children Act 2004.*
- (d) Participate in a continuing professional development programme that includes abortion care.*
- (e) Acknowledge their responsibilities around the protection of women with an identified need for additional support, especially those under 16 years old and recognise the risk and safety issues around parental notification.*
- (f) Abide by cultural competency requirements as stated in section 6.3 Māori Health.*

## **8.6 NURSING AND MANAGEMENT**

Good nursing leadership in the abortion care is invaluable to support best practice across the range of issues that arise.

Nurses and midwives working in this specialist area need appropriate continuing professional development to enable them to provide high quality care. They need opportunities to develop and practise leadership, mentoring and supervisory skills.

An abortion champion should be identified in every service, one who shares the “vision” and supervises and supports the nursing and management teams. This champion can be anyone who works within the service and need not be a manager or nurse - it can be a social worker, counsellor, doctor or midwife.

Nurses and midwives have a professional responsibility to act with integrity and ensure that their personal views do not affect or influence the care of women. All women should be treated as unique individuals with respect and dignity. It is important that nurses understand the complexity of decision making around the request to have an abortion.

Abortion services should provide opportunities for nurses from outside their service to participate in abortion care, develop activities to recruit and retain nurses, and support career development in abortion care. Additionally, future workforce development efforts should include engagement with nursing education institutions.

Nurses and midwives providing abortion care should have a sound knowledge base and appropriate education and training with up-to-date knowledge of evidence based practice.

They should have robust competency assessment in performing practical and assessment skills. Retention is influenced by flexibility in practice, including: advocating for patients, translating one's skill set, believing that nursing is shared work, and juggling multiple roles. Providing on the job training opportunities for knowledge and skill advancement best enables career development.

#### **Standard 8.6.1**

Abortion services should have a clearly identified Manager and/or Charge Nurse who oversees the abortion service. The Manager may also be responsible for the provision and management of appropriate counselling services or be able to ensure patient access to such services.

#### **Standard 8.6.2**

Abortion services should allocate funds for professional training, ongoing education and updates in abortion care.

#### **Standard 8.6.3**

Abortion service Managers should actively recruit and support a 'champion' for the service.

#### **Standard 8.6.4**

Managers of abortion services should make provision for all nursing, midwifery and counselling staff to attend professional supervision on a regular basis.

#### **Standard 8.6.5**

Managers of abortion services should have a strategy for training, recruitment and retention of staff.

#### **Standard 8.6.6**

Training for Abortion Service nursing and midwifery staff should include:

- (a) Physical, mental, emotional and cultural aspects of abortion.*
- (b) Abortion decision making and psycho/social assessment skills.*
- (c) Assessment skills for identifying women who require extra support and a knowledge of systems for follow up as required.*
- (d) Current knowledge of contraception methods.*
- (e) Telephone triage skills.*
- (f) Clinical skills required for abortion services.*
- (g) Professional supervision.*
- (h) Cultural competency requirements as stated in section 6.3, Māori health.*

#### *Recommendation*

*More nurse –midwife led care in abortion services should be encouraged.*

#### *Recommendation*

*More nurse led research into related topics should be encouraged to extend the evidence base for abortion care.*

## 9. ABORTION PROCEDURE

### 9.1 DEFINITION OF GESTATION

The duration of pregnancy is determined from the first day of the last menstrual period.

According to Section 88 of the New Zealand Public Health and Disability Act 2000 Maternity Services:

**First trimester** is from the LMP date until the end of the fourteenth week of pregnancy (1-12 weeks after conception, 0-104 days in the table below)

**Second trimester** is from the beginning of the 15th week until the end of the 28th week of pregnancy (13 to 26 weeks after conception. 105+ days in the table below)

**Third trimester** is from the beginning of the 29th week of pregnancy until established labour

Table 9.1 Gestation in weeks and days from LMP

Completed weeks	0	1	2	3	4	5	6	7	8	9	10	11	12
Days	0-6	7-13	14-20	21-27	28-34	35-41	42-48	49-55	56-62	63-69	70-76	77-83	84-90
Completed weeks	13	14	15	16	17	18	19	20	21	22	23	24	
Days	91-97	98-104	105-111	112-118	119-125	126-132	133-139	140-146	147-153	154-160	161-167	168-174	

### 9.2 MEDICAL COMPETENCY

#### Standard 9.2.1

All doctors performing abortions should:

- (a) *Have a current Annual Practising Certificate from the Medical Council of New Zealand.*
- (b) *Have a postgraduate qualification in women's health, for example, but not restricted to FRANZCOG or Diploma in Obstetrics and Medical Gynaecology.*
- (c) *Receive training in the performance of abortions and in the prevention, recognition and management of complications.*
- (d) *Have knowledge of abortion law and sign a statement of familiarity with the relevant Acts.*
- (e) *Participate in a relevant continuing professional development programme.*
- (f) *Have competency in airway management, cardiovascular resuscitation and IV cannulation.*
- (g) *Have orientation to unit policies - both health and safety and clinical.*
- (h) *Have an annual performance appraisal.*
- (i) *Where possible attend multidisciplinary clinical unit meetings, peer group meetings and abortion conferences.*

- (j) Undertake a re-entry to practice process after a year of not operating or providing medical abortions.*
- (k) Have knowledge and competency in prescribing and/or administering all methods of contraception available in New Zealand*
- (l) Meet cultural competency requirements as stated in section 6.3 Māori health.*

## **9.3 LEGAL CERTIFICATION AND NOTIFICATION**

### **Standard 9.3.1**

The doctor performing the abortion should check legal certification is complete and notify the ASC of the abortion. (ASC Form No. 4). Under New Zealand law the doctor performing the abortion does not have to be one of the certifying consultants.

## **9.4 INFORMED CONSENT**

### **Standard 9.4.1**

The doctor performing the abortion must obtain informed consent. There should be documentation that the woman understands the procedure and accepts the risks and possible complications of both the abortion and any sedation or anaesthetic. If an IUD, IUS or Implant is to be inserted at the same time as the abortion, consent for this should also be obtained and documented.

## **9.5 CHOICE OF ABORTION METHOD**

Medical and surgical abortion are both well established as safe procedures. Choice of abortion method is dependent on a woman's preference, her personal circumstances, her gestation and medical history, operator skill, and local service provision. Satisfaction rates after medical or surgical abortion are similar.

Reasons to choose a SURGICAL abortion

- It requires fewer office visits
- The procedure takes a short amount of time
- It is more effective than medical abortion (less risk of requiring further intervention)
- Women usually do not have heavy bleeding at home
- An IUD or IUS can be fitted at the same time

Reasons to choose a MEDICAL abortion

- It requires no surgery
- It requires no anaesthesia
- It has the potential for greater privacy
- Some women feel it gives them greater control over their bodies
- It may feel more "natural" for some women

### **Standard 9.5.1**

All services should actively promote the earliest possible abortion procedure and work towards being able to offer women a choice of methods appropriate for each gestation period.

## **9.6 PREVENTION OF INFECTIVE MORBIDITY**

Post-abortion sepsis is polymicrobial (chlamydia, gonorrhoea, endogenous vaginal anaerobes). International consensus is that routine antibiotic prophylaxis should be given prior to first trimester surgical abortion but not prior to first trimester medical abortion.

Previously in this document, Standards 8.4.8 and 8.4.9 state that all women should be offered screening for Chlamydia and Gonorrhoea and screening for other STIs should follow NZSHS Guidelines.

### **Standard 9.6.1**

All abortion providers should have policies to minimise post-abortion infective morbidity.

### **Standard 9.6.2**

All abortion providers should offer antibiotic prophylaxis prior to surgical abortion.

*Recommended antibiotic regimens are*

- a) 200mg doxycycline orally preop or
- b) 500mg azithromycin orally preop

### **Standard 9.6.3**

Only women with prosthetic heart valves, previous bacterial endocarditis or a surgically constructed pulmonary shunt should be considered for pre-operative endocarditis prophylaxis.

## **9.7 FIRST TRIMESTER SURGICAL ABORTION**

Standard suction abortion may be offered throughout the first trimester.

### **Standard 9.7.1**

There is no lower limit of gestation for surgical abortion.

### **Standard 9.7.2**

Portable electric, manual (MVA) devices or wall suction may be used.

### **Standard 9.7.3**

Procedures should usually be done under conscious sedation with local anaesthetic.

*Recommendation*

*Fasting is not required prior to light conscious sedation for first trimester surgical abortion.*

### **Standard 9.7.4**

Surgical abortion under light sedation and local anaesthetic is safer than under general anaesthetic. However, in some circumstances it is more appropriate for women to have their abortion done under general anaesthetic. For example, because of very young age,

comorbidities or extreme anxiety. This should be presented as a realistic option for these women, and if the service cannot offer a general anaesthetic, referral pathways should be in place.

**Standard 9.7.5**

Patient comfort during the procedure should be a priority and supportive methods to reduce pain and anxiety are recommended. This should include empathetic staff, gentle technique, and verbal reassurance.

**Standard 9.7.6**

A preoperative nonsteroidal anti-inflammatory should be offered.

*Recommended NSAIDs are*

- 1) *Ibuprofen 600mg orally or*
- 2) *Naproxen 550mg orally or*
- 3) *Diclofenac 50mg orally*

**Standard 9.7.7**

Routine paracetamol is not recommended.

**Standard 9.7.8**

A preoperative benzodiazepine should be offered.

*Recommended benzodiazepines are*

- 1) *Midazolam 7.5mg orally or*
- 2) *Lorazepam 1-2mg orally or*
- 3) *Midazolam 1-2 mg IV*

**Standard 9.7.9**

Cervical preparation with misoprostol 400mcg (buccal, sublingual or vaginal) 1-3 hours before the procedure should be offered.

**Standard 9.7.10**

Venous access should be in place prior to the procedure taking place.

**Standard 9.7.11**

There should be a minimum of three appropriately trained staff present in theatre: the operating doctor, the practitioner administering sedation and monitoring cardiopulmonary function of the patient, and at least one additional staff member to provide assistance to the operator or practitioner providing sedation as required.

**Standard 9.7.12**

Intravenous fentanyl 50-100 mcg prior to commencing the procedure should be offered.

*Recommendation*

*Self-regulated nitrous oxide may be offered during the procedure.*

**Standard 9.7.13**

Pre-procedure bimanual examination should be done by the doctor doing the abortion.

**Standard 9.7.14**

Paracervical block with up to 20ml lignocaine 1% plain should be performed

**Standard 9.7.15**

All instruments entering the uterus should be sterile.

*Recommendation*

*A 'no touch' technique is recommended.*

**Standard 9.7.16**

The cervix should be dilated gently and gradually.

*Recommendation*

*The uterus should be emptied using the smallest possible plastic cannula and blunt forceps if required.*

**Standard 9.7.17**

Sharp curettage should not be used.

**Standard 9.7.18**

Routine use of oxytocin or ergometrine is not required.

**Standard 9.7.19**

The doctor performing the abortion should ensure the pregnancy is terminated.

This can be done by inspection of aspirated tissue or immediate transvaginal ultrasound.

If the gestation is under 7 weeks then examination of the tissue is essential to visualise a gestational sac or chorionic villi. This rules out an ectopic pregnancy or failed abortion. If a gestational sac or villi are not sighted then the abortion service should have a protocol in place for follow-up serum hCGs.

**Standard 9.7.20**

Routine histopathology is not required but should be available if there is a clinical suspicion of pathology.

## **9.8 FIRST TRIMESTER MEDICAL ABORTION**

Medical abortion using mifepristone and misoprostol is a safe and effective option at all gestations.

The earlier the woman has a medical abortion, the greater the chance of success without further medical intervention.

Combined mifepristone and misoprostol regimens have success rates of over 95%.

**Standard 9.8.1**

In accordance with New Zealand law both mifepristone and misoprostol must be given within a licensed institution but the woman may go home to complete her abortion.

**Standard 9.8.2**

As part of the consent for medical abortion the woman should be informed that a uterine aspiration may be necessary.

**Standard 9.8.3**

IUDs must be removed prior to medical abortion

***The following regimen is recommended for gestations up to 9 weeks (63 days):***

*Mifepristone 200mg orally followed 24-48 hours later by misoprostol 800 micrograms buccally, sublingually or vaginally. If abortion has not occurred 4 hours after misoprostol, a second dose of misoprostol 400 micrograms may be given.*

*Because New Zealand abortion law requires the drugs to be given on a licensed premise some providers may offer to give mifepristone and misoprostol simultaneously to save the woman another clinic visit. If this is done both the abortion provider and the woman must acknowledge reduced efficacy and a greater chance of a failed abortion.*

***The following regimen is recommended for gestations from 9 weeks (64 days) to 13 weeks 6 days (97 days)***

*Mifepristone 200mg orally followed 24-48 hours later by misoprostol 800 micrograms buccally, sublingually or vaginally, followed by misoprostol 400 micrograms buccally every 3 hours until the pregnancy is passed.*

**Standard 9.8.4**

In first trimester medical abortion, if a woman goes home to complete her abortion, she should remain under the care of the abortion service until documentation that her abortion is complete.

The doctor prescribing the mifepristone and misoprostol is considered the medical practitioner performing the abortion and is primarily responsible for the care of the woman.

**Standard 9.8.5**

A woman who has gone home to complete her medical abortion must have clear documentation of when to seek medical help and be able to contact the abortion service during clinic hours for advice and management of side effects or complications. For after-hours advice either the abortion service or a specific medical abortion after hours service should be available to provide advice to women.

**Standard 9.8.6**

Abortion services must ensure that hospital emergency department staff and on call gynaecology staff have information available to manage medical abortion complications.

**Standard 9.8.7**

Completion of medical abortion should be documented by serum hCG, clinical means or ultrasound. For first trimester medical abortion, completion may be confirmed by a drop in hCG level of 80% one week after mifepristone administration. The woman should be notified of this result.

**9.9 SECOND AND THIRD TRIMESTER MEDICAL ABORTION**

Staff should be suitably trained in working with women undergoing second and third trimester abortions. The reasons for later abortion presentations are varied and relate to the impact of the pregnancy or its complications on the health of the woman. At times these abortions place psychological stresses and difficulties on both the women and staff and this needs to be acknowledged in the service and provided for. This includes nursing, midwifery, medical and counselling staff.

Grounds for abortion are assessed and confirmed by certifying consultants. Regardless of gestation, there is no legal requirement for the woman to see a psychiatrist.

Even if a health care practitioner has not been involved in the abortion process, there is a duty of care to provide supportive nursing, midwifery and medical care.

**Standard 9.9.1**

There should be clear and accessible guidelines in every DHB for referral for women for consideration of 2<sup>nd</sup> and 3<sup>rd</sup> trimester abortion.

**Standard 9.9.2**

All units should provide women with written information on the abortion process after the first trimester.

**Standard 9.9.3**

Access to admission should be possible at any time during the 2<sup>nd</sup> or 3<sup>rd</sup> trimester abortion process.

**Standard 9.9.4**

Specific training in the medical management of 2<sup>nd</sup> and 3<sup>rd</sup> trimester abortion should include labour and birth processes and complications, as well as aftercare, breast care and management of medical conditions.

**Standard 9.9.5**

Training should address the reasons why women seek late abortions and how to support women through the process. Reasons include late recognition of pregnancy, the impact of pregnancy complications such as fetal abnormality, infection, rupture of membranes pre-viability, maternal medical conditions, poor access, slow services, ambivalence and denial.

**Standard 9.9.6**

When the gestation exceeds 22 weeks, part of the counselling and abortion process should include a consideration of feticide. The New Zealand Maternal Fetal Medicine Network (NZMFMN) has determined that except in exceptional circumstances, feticide should be part of the medical abortion process after 22 weeks. Should a woman not consent to feticide, the

NZMFMN considers the abortion should not go ahead because induction of labour where there is a possibility of neonatal survival is not an abortion.

**Standard 9.9.7**

Abortion in the 2nd and 3rd trimester should be performed in units with access to gynaecological specialist support, an operating theatre and blood products

**Standard 9.9.8**

All Abortion Services should use a standard and documented 2<sup>nd</sup>/3<sup>rd</sup> trimester medication regimen.

***Suggested Regimen for second and third trimester medical abortion:***

*Mifepristone 200mg stat.*

*36-48 hours later admission to the unit (if not already an inpatient) and commencement of misoprostol regimen.*

*800mcg misoprostol vaginally followed by 3 hourly misoprostol 400mcg (buccal or vaginal) for four further doses or until fetal expulsion has occurred.*

*From 28 weeks it is recommended that the dose of misoprostol be reduced and this should be clinician determined.*

*Clinical review including vaginal examination of the cervix is required after this point if delivery has not occurred.*

*Based on clinical findings it may be reasonable to continue with misoprostol or to restart the protocol, including mifepristone, which may or may not include time for the woman to go on leave from the hospital.*

***Previous caesarean section:***

*The rate of uterine rupture in women with previous caesarean section undergoing second trimester medical abortion is increased (0.28-0.4%). It is accepted that reduced doses of misoprostol may be appropriate in this group.*

***Third trimester hysterotomy:***

*In the third trimester, hysterotomy in women with previous caesarean section may be deemed clinically appropriate after counselling and certification.*

*There may be circumstances where hysterotomy is considered safer than medical abortion, for example in the presence of significant maternal comorbidities.*

**Standard 9.9.9**

Inhibition of lactation (Cabergoline 500mcg stat) should be offered and breast care explained to the woman.

**Standard 9.9.10**

After 20 weeks (or >400grams if gestation unclear) all pregnancy outcomes with fetal death including abortion must be reported to the Perinatal and Maternal Mortality Review Committee.

**Standard 9.9.11**

Women undergoing abortion where there has been fetal abnormality, infection or other pregnancy complications should be offered a fetal post mortem and a follow up appointment with an appropriately trained specialist.

**Standard 9.9.12**

Counselling should be available to women following the abortion both in the short term and in the future. This may best be accessed by referral from the woman's own doctor at a later time but availability of this is the responsibility of the abortion provider. This counselling may include pre-pregnancy and early pregnancy counselling as appropriate.

**9.10 SECOND TRIMESTER SURGICAL ABORTION**

Suction abortion may be performed from 14 to 16 weeks gestation using large bore cannulae but the method of choice in this gestation range varies according to the skills and experience of local doctors.

Beyond 15 weeks' gestation, surgical abortion by dilation and evacuation is safe and effective but should be performed by trained operators with sufficient experience and caseloads to maintain their skills. The upper limit of surgical abortion is dependent on operator training, skill and experience.

**Standard 9.10.1**

Cervical preparation is essential for second trimester surgical abortion.

*No regimen of cervical preparation has been shown to be more effective than another. Acceptable methods include pharmacologic (misoprostol or mifepristone) or mechanical (Dilapan-S® or laminaria). Individual services should determine a cervical preparation regimen for second trimester surgical abortion that suits their system of care and that also allows for individualisation based on patient factors, gestational age and operator preference.*

**9.11 AFTERCARE****Standard 9.11.1**

Anti D prophylaxis must be offered to all Rh D negative women on the day of their abortion.

Rh(D) immunoglobulin - VF 250IU should be given to all women with singleton pregnancies up to 12 weeks.

Rh(D) immunoglobulin -VF 625IU should be given to all women with multiple pregnancies or those beyond 12 weeks gestation.

**Standard 9.11.2**

Following abortion, women should be given a verbal and written account of the symptoms they may experience. They should have a list of symptoms which require urgent medical consultation.

**Standard 9.11.3**

Urgent clinical assessment and emergency gynaecology admission should be available when necessary.

### *Recommendation*

*Women should have a 24 hour helpline number to phone if they are worried about their symptoms.*

#### **Standard 9.11.4**

All women should be offered a letter on discharge which has sufficient information to allow another practitioner elsewhere to deal with any complications. The discharge letter should also be sent to the primary referrer and it should be received within 4 days of the abortion.

#### **Standard 9.11.5**

All women should be offered access to further counselling after the abortion. This need only be short-term counselling for up to six visits. The woman's partner may be involved if requested and appropriate. Counselling aims to assist clients to make meaning of the circumstances before, during and after their abortion– to support their tino rangatiratanga, and holistic wellbeing. Women need to know this is a free service provided by their DHB.

## **9.12 CONTRACEPTION**

Abortion services play a very important role in preventing further unintended pregnancies.

Abortion services should have unbiased and accurate information on contraceptive methods.

Abortion services should ensure a women centred approach when providing contraceptive counselling at the time of abortion.

Clinicians should share their knowledge and expertise of contraception to help women:

- a) clear up misconceptions
- b) understand the relative advantages and disadvantages of various methods
- c) select an option that works for her current circumstances and future reproductive aspirations.
- d) understand that long acting reversible contraceptives (IUD, IUS, implants) are the most effective in reducing post abortion pregnancy
- e) understand that she can get pregnant within 2 weeks of an abortion

However, education should not impose the clinicians' preference on a woman, and although contraception should be encouraged, a woman should not be coerced into choosing a method or any particular method.

Abortion service clinicians are referred to The Faculty of Sexual and Reproductive Healthcare Guideline, Contraception After Pregnancy January 2017, Chapter 3. Contraception after Abortion. See appendix 11.

The effectiveness of different methods is displayed in the table below.

**Table 9.12.1 Percentage of women experiencing an unintended pregnancy within the first year of use with typical use and perfect use (adapted from FSRH Guideline 2017)**

<b>METHOD</b>	<b>TYPICAL USE %</b>	<b>PERFECT USE %</b>
No method	85	85
Fertility awareness	24	<5
Condom	18	2
Combined pill	9	0.3
Progestogen-only pill	9	0.3
Progestogen-only injection	6	0.2
*Copper IUD	0.8	0.6
*Levonorgestrel IUS	0.2	0.2
*Progestogen-only implant	0.05	0.05
Tubal ligation	0.5	0.5
Vasectomy	0.15	0.1

\*LARC

#### **Standard 9.12.1**

All women having an abortion should have post abortion contraception discussed before the abortion is commenced. Education about the full range of methods available in New Zealand should be offered, with discussion about what they have previously tried and the suitability of these methods. This may involve the sexual partner.

#### **Standard 9.12.2**

Contraception information should be available in different languages and in a range of formats including audio-visual.

#### **Standard 9.12.3**

Web based contraception information should be available on the abortion services website or links to web resources made available. For example [familyplanning.org.nz](http://familyplanning.org.nz)

#### **Standard 9.12.4**

Contraceptive supplies should be made available or appropriate prescriptions given on the day of the abortion.

#### **Standard 9.12.5**

Women should be given the option of having their chosen method of contraception initiated immediately following abortion.

For example, an IUD, IUS or implant can be inserted at the same time as a surgical abortion. An IUD or IUS can be inserted as soon as completion of a medical abortion has been verified. An implant can be inserted at the same time as administration of mifepristone in medical abortion

**Standard 9.12.5**

Abortion services should have adequate numbers of trained staff who can insert IUDs, IUSs and Implants.

**Standard 9.12.6**

Abortion service clinicians should document contraception discussion and consent.

**Standard 9.12.7**

If a woman cannot start her chosen method immediately, arrangements for follow-up or referral to services who can initiate the method should be made. An interim method of contraception should be offered and/or supplied in the meantime.

*Recommendation*

*Women who meet the criteria for a Special Authority for an IUS should have one available free of charge so that it can be fitted at the time of a surgical abortion.*

*DHBs are encouraged to fund IUS's for women who have tried and not tolerated other LARC methods but want very reliable contraception and choose an IUS.*

**9.13 KAI ATAWHAI AND DISPOSAL OF PREGNANCY TISSUE****Standard 9.13.1**

Pregnancy tissue should be considered biohazardous and there should be a protocol for tissue disposal in place.

**Standard 9.13.2**

Abortion services should provide Māori korari or pots, along with verbal and written information outlining procedures to follow for those who wish to kai atawhai the conception, by the practice of whenua ki te whenua.

**Standard 9.13.3**

Abortion services should be able to enact kai atawhai for those who are not in a position to do so, and return the pregnancy tissue to a designated area of whenua that will be protected and nurtured forever.

## 10. ABORTION FOLLOW UP

### Standard 10.1

A post abortion assessment should be offered by the referring Health Care Provider after the abortion. If this visit is within 2 weeks of the abortion it should be offered free under Section 88 of Maternity Services. Women should be informed about this and encouraged to attend by both their Health Care Provider and the abortion service.

### Standard 10.2

The discharge letter should reach the referrer within 4 days with a recommendation for active follow up for those that have been identified as needing additional support.

### Standard 10.3

Active follow-up means 3 further attempts to contact the woman if she does not book or attend a follow up appointment. As long as preservation of confidentiality is a priority, up to three different methods of contacting the woman should be utilised (phone call, text, email).

### Standard 10.4

This appointment should include a holistic assessment of health:

**hinengaro** - mental wellbeing,

**tinana** - physical wellbeing,

**wairua** - spiritual wellbeing,

**whānau** - family and community wellbeing.

If necessary, arrangements should be made for further medical review, contraception advice or counselling.

### Standard 10.5

The follow-up appointment should include discussion of contraception.

### Standard 10.6

A pelvic examination is not required at the follow-up assessment unless there are clinical indications or the woman had an IUD/IUS fitted at the time of the abortion, when a check of the strings should be offered.

## 11. STANDARDS FOR AUDIT AND SERVICE ACCREDITATION

Audit provides an opportunity for abortion services, DHBs and the ASC to assess whether they are meeting the Aim of this Standards Document.

The Aim of **Standards of Care for Women Requesting Abortion in Aotearoa New Zealand** is to ensure all women in New Zealand considering abortion have access to a service of uniformly high quality.

Specifically, women should have:

1. Access to services in a timely manner
2. Services which are culturally appropriate
3. Services which produce optimal clinical outcomes

Abortion services should conduct regular audit of the care they provide. The standards within this document can serve as criteria for audit.

The ASC, DHBs and abortion services should collect data to assess their performance against a specified standard, key performance indicator or target. These targets should be attainable.

Abortion services, DHBs and the ASC may initially have different targets but they should all strive to make changes which improve the quality of care available in Aotearoa and then repeat data collection and audit to determine whether care has been improved.

AUDITABLE OUTCOME	Suggested TARGET
Percentage of women who have access to an abortion within 2 hours of her home	95%
Percentage of women who waited less than 2 weeks from first requesting referral to abortion procedure	97%
Percentage of services that have spaces for whānau support	95%
Percentage of staff who have completed a Te Tiriti o Waitangi course	90%
Percentage of women who have their Rhesus status documented	100%
Percentage of DHBs which offer women both medical and surgical abortion in the first trimester	100%

## 12. APPENDICES

1. Sections 182 to 187a of the Crimes Act 1961
2. Sections 10 to 46 of the Contraception, Sterilisation and Abortion Act 1977
3. Section 38 of the Care of Children Act
4. Ministry of Health Manatu Hauora. Specialist Medical and Surgical Services. Gynaecology Services. Tier Two Service Specification.
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