Abortion services

Summary of DHB quarterly survey responses

Tēnā koutou

As you are aware, for the first time this year district health boards (DHBs) were asked to provide information on abortion services as part of the DHB quarterly reporting process. We received the majority of DHB survey responses by the report back date in August 2020. Many thanks for your time and attention to these surveys. They are a valuable information source and have highlighted workforce and training as priority issues to be addressed.

The Regulatory Assurance team is continuing to develop and progress the new abortion services work programme. This includes workstreams on service design and workforce, which are intended to address issues raised by DHBs such as limited access to timely and equitable abortion services. Under the workforce workstream, the Ministry will work with the relevant Responsible Authorities and Colleges to ensure a coordinated approach to the development of training packages for health professionals delivering abortion services. The workstream will also consider workforce sustainability for abortion services.

The summary below is based on the information provided by 19 DHBs, and the level of detail provided varied across responses. The Ministry is considering how best to capture this information in a more consistent way in the future.

Nāku iti noa, nā

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Note

We have collated key themes from the responses, so the topic headings below are not an exact match with the original survey questions. See appendix one for the original abortion services survey questions.

Availability of early medical abortion (EMA)

- Several DHBs provide EMA services only. The gestational limit for EMA provision, where specified, varied between 8-10 weeks.
- Some DHBs do not have any provision for EMA within their district.
- Several DHBs contract out EMA services to other providers, either within their district or to another DHB.

Availability of second and third trimester medical abortion

- Fewer DHBs provide second and third trimester medical abortion services.
- Consequently, contracting out medical abortion services was more common from the second trimester.
- Very few DHBs provide feticide services, which is required from 22 weeks.

Issues raised regarding provision of medical abortion

- One DHB stated they are willing to offer medical abortions beyond EMA, but do not have the appropriate clinical space to support this.
- One DHB noted that "From 22 weeks gestation it is unlikely that feticide would be available for a pregnancy without a fetal abnormality and so induction of labour would not be available." This was echoed by other DHBs as a limiting factor for the availability of abortions after 22 weeks for other indications.
- It has been suggested that the Ministry of Health develop a national guideline for availability of service for induction of labour from 22 weeks.

Availability of first trimester and early second trimester surgical abortion

- The majority of DHBs provide surgical abortions up to the end of the first trimester or early second trimester of pregnancy.
- Several DHBs are either contracting out all surgical abortion services to other DHBs or community providers, or second trimester surgical abortions.
Care pathways for women to access later gestation abortions

- There is significant variation between DHBs in terms of what services are provided within their region.
- The gestation and indications for which women are referred to providers in other regions also varies.
- DHBs that do not provide services within their region generally hold contracts with other DHBs, often multiple contracts for medical, surgical and later gestation abortions.
- Some DHBs contract to community or private providers.
- One DHB stated that they refer women over 20 weeks, for indications other than fetal abnormality, to an Australian clinic. This was the only DHB which mentioned overseas referrals in their response.

Issues raised regarding care pathways for later gestation abortions

- In general, there is very limited availability of services from 22 weeks if there is no fetal abnormality or severe health risk to the woman.
- This is further limited by the requirement for feticide, which is not provided by most DHBs and is frequently unavailable unless there is a diagnosis of fetal abnormality.
- This significant limitation in service provision at later gestations is due to both the low numbers of feticide providers and the exercising of conscientious objection by those providers.
- Many women requiring feticide must travel for the procedure and then return to their DHB of residence for induction of labour and delivery.

Improving access to sustainable, timely and equitable abortion services

- Some DHBs noted greater access to EMA since the Abortion Legislation Act 2020 passed. This has reduced delays and requirements to travel.
- Several DHBs noted this has improved equitable access or outcomes for young people, Māori and Pacific people, who previously had a low uptake of early medical abortion compared to surgical abortions.
- Since the law changes, surgical abortions are available at earlier gestations in some DHBs as there are fewer delays.
- Utilising telehealth or virtual/remote consultations has reduced the number of visits required.
- Most DHBs have implemented or are implementing self-referral processes.
• Several DHBs are considering or using other settings now that licensed facilities are no longer required.
• Some DHBs are exploring alternative staffing options. For example, one DHB is transitioning to a nursing and midwifery led model of care to make the service more sustainable and cost effective, and potentially closer to home. Another DHB is recruiting a clinical nurse specialist to oversee abortion services.

Issues raised regarding ensuring access to sustainable, timely and equitable services

• Most issues DHBs raised were related to the availability of appropriate staff and other workforce issues. For example:
  o DHBs that have not provided services locally for some time may not have an established workforce.
  o There is some concern that the GPs who are currently providing services are nearing retirement age.
  o Some DHBs raised the need to train and upskill staff, especially in locations where abortion services were not previously provided. This can limit the expansion of locations for abortion service provision.
  o There is a need to train a larger workforce for 2nd and 3rd trimester abortion services.
  o There is a need for the provision of training for surgeons and specialists, in particular providers of feticide.
• Some DHBs stated they lacked appropriate spaces within hospitals.
• No DHBs raised counselling as an issue, other than commenting that it was being provided on an optional basis.

Health practitioner workforce for later gestation abortions

• Conscientious objection is proving to be a major barrier in ensuring the availability and continuity of this workforce and the services they provide.
• Some medical practitioners are unwilling to be involved outside of care for severe fetal abnormality.
• There are also high levels of conscientious objection in the midwifery and nursing workforce for abortions after 20 weeks.
• Providers of feticide are likely to object to being involved if the abortion is not because of fetal abnormality or severe health risk to the woman.
• Recruiting staff for these abortions can be difficult.
• Other comments reflected the small workforce more generally. Some DHBs are concerned their services could be vulnerable if the small number of currently employed staff were to end their contracts.

• The issue of an aging workforce was raised again. A high proportion of existing medical practitioners providing these services are nearing retirement. Some DHBs are already engaged in succession planning.

• One DHB reported difficulty in recruiting and maintaining workforce locally, as very few later gestation abortions are required in their region annually.

**Workforce planning**

Almost all DHBs who responded are engaged in workforce planning. This included a variety of strategies:

• Developing an employment strategy to ensure staff are committed to providing abortion care as part of their job description, consistent with the new legislation.

• Surveying gynaecology nurses and midwives to determine if there are sufficient staff to develop a local abortion service.

• Training another anaesthetist and identifying doctors who wish to train in this work.

• Changes to the model of care to a nurse and midwife led model. Training for nurses and midwives in dating scanning, pre-assessment, counselling and prescribing is to be explored.

• Developing an implementation plan which includes access to a specialist surgeon from outside the DHB region.

• Liaising with providers from around the country to find suitable providers for DHBs where conscientious objection is limiting service provision.

• Recruitment is underway in some DHBs.

**Ministry of Health support**

• Some DHBs wanted support from the Ministry of Health regarding training and employment. Comments on this topic included:
  - The need for a nationwide plan to ensure education, training and maintaining continuity of workforce.
  - Support from the Ministry to implement training and employment planning.
  - Ministry support required to coordinate national approach to workforce education and planning.

• It has been suggested that the Ministry of Health develop a national guideline for availability of medical abortion and induction of labour from 22 weeks.
Appendix One: Abortion services survey questions

SI3 - Ensuring delivery of Service Coverage - Quarter 4 2019/20

The information request below will be included in the DHB quarterly reporting process, which is due on 14 August 2020.

1. Up to how many weeks of pregnancy is medical abortion available within your region?

2. Up to how many weeks of pregnancy is surgical abortion available within your region currently?

3. If later-term abortion services are not available within your region, what is your DHB’s current care pathway to ensure woman are able to access this service?

4. Please summarise any plans you have to enhance access to sustainable, timely and equitable abortion services within your DHB region.

5. Is the availability of practitioners that are qualified and experienced to perform later-term abortions a concern for your region?

6. If so, please summarise any workforce plans you have to address this.

7. Should we have follow-up questions, please provide contact details including name, role, email and phone number for a nominee in your organisation.