MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Interim Standards for Abortion Services in New Zealand

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EXPLANATORY NOTE

NEW LEGISLATION

In March 2020, changes were made to the law to largely decriminalise abortion, better align the regulation of abortion services with other health services and modernise the legal framework for abortion services in New Zealand. The legislative amendments updated the primary legislation for abortion, including the Contraception, Sterilisation, and Abortion Act 1977 (CSA Act) and the Crimes Act 1961. They also made changes to the Health Practitioners Competence Assurance Act 2003 and the Health and Disability Commissioner Act 1994. The updated versions of the legislation is available on the New Zealand Legislation website (http://www.legislation.govt.nz/).

Under the amended CSA Act, the Ministry of Health (the Ministry) becomes the kaitiaki of abortion services in New Zealand. Oversight of abortion services is transferred to the Ministry from the Abortion Supervisory Committee (ASC) and the Ministry of Justice. The amended CSA Act requires the Director-General of Health to develop and publish standards for abortion services and counselling services relating to abortion services.

PURPOSE OF THIS DOCUMENT

This document specifies a set of interim standards that the Ministry expects all abortion service providers (including counselling service providers) to comply with from 24 March 2020.

The standards are intended to set the minimum level of service expected by relevant health and disability regulators. A breach of the standards may amount to a breach of the Code of Health and Disability Services Consumers' Rights, including Right 4(2) (the right to have services provided that comply with legal, professional, ethical, and other relevant standards). The standards may be enforced by the Health and Disability Commissioner or by a health practitioner's regulatory authority, where appropriate.

These interim standards capture existing abortion-specific standards from the 'Standards of Care for Women Requesting an Abortion in Aotearoa New Zealand'.[1]

The focus for these interim standards is to provide guidance for the health sector from 24 March 2020 until such time as the interim standards are replaced. The Ministry has made changes to the text of the ASC Standards where necessary to ensure the interim standards reflect the new legislation and its implications. The new legislation makes two of the ASC standards irrelevant[2]; this document excludes any reference to them. Four new standards have been added in the interim standards to ensure compliance with the amended CSA Act - refer to page 22.

We intend to review the interim standards and discuss the establishment of a formal clinician-led guidance process in partnership with sector stakeholders and service consumers during 2020, to align the standards for abortion services to the updated health and disability standards.

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[1] Abortion Supervisory Committee. 2018. *Standards of Care for Women Requesting Abortion in Aotearoa New Zealand.* Wellington: Abortion Supervisory Committee.

[2] ASC standards 6.5.1 and 8.5.1. are inconsistent with the amended legislation.

EXISTING HEALTH AND DISABILITY SERVICES STANDARDS

The Ministry is responsible for defining and maintaining core standards of care and service delivery across the health and disability system. Specific standards are mandatory under the Health and Disability Services Safety Act 2001 and are used to certify hospitals; rest homes; residential disability care; and fertility services. These current relevant standards include:

- NZS 8134.0:2008 Health and Disability Services (General) Standard
- NZS 8134.1:2008 Health and Disability Services (Core) Standards
- NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standard
- NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standard
- NZS 8181.0:2007 Fertility Services.

Other standards for health and disability services are not mandatory under legislation but form part of the contractual requirements of the Ministry or DHBs in order to receive funding for providing these services. The health and disability services standards can be found on the Standards New Zealand website standards.govt.nz/sponsored-standards/health-care-services-standards

The Ministry is currently reviewing the health and disability services standards in partnership with Standards New Zealand, consumers and health and disability services providers to update and refine the standards to better reflect current best practice and align with changing models of care. The review is expected to be completed by end of 2020 and there is an opportunity to incorporate abortion services into the standards.

For more information about the health and disability services standards review see health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standards/health-and-disability-services-standards-and-fertility-services-standard-review

ABORTION SUPERVISORY COMMITTEE'S STANDARDS

Published in 2018, the revised version of the Abortion Supervisory Committee's (ASC) *Standards of Care for Women Requesting an Abortion in Aotearoa New Zealand* outlined standards that relate to all aspects of abortion care. Under the CSA Act before it was amended in 2020, abortions could only be performed at premises licensed by the ASC. The ASC required all service providers to comply with its standards to:

- ensure compliance with the legislation
- ensure a minimum level of safe and accessible abortion services are available
- facilitate consistency of service provision across the country.

The ASC Standards set out the requirements for abortion services under the now-outdated legislative framework, starting with a woman needing to access information about abortion, what and how services should be accessed, the availability of counselling services, information about an abortion process and procedure and what and how follow-up and related support services should be available.

INTERIM STANDARDS FOR ABORTION SERVICES

ACCESS AND REFERRAL TO ABORTION SERVICES

- District health boards (DHBs) should ensure all women who are eligible for publicly funded health care have access to abortion services. *(ASC 6.2.1)*

- Wherever possible women should have access to services within their own DHB area or domicile, but if this is not practical, the DHB of domicile must make and fund appropriate arrangements with other abortion providers as close as possible to the domicile of the woman. This funding should include transport and accommodation costs.[3] *(ASC 6.2.2)*

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

- 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. *(ASC 6.2.3)*

- Abortion services should have local strategies in place for providing women, doctors and other professionals in the community with choices available within the service and routes of access to the service. *(ASC 6.2.4)*

- District health boards should ensure access to both medical and surgical abortions. *(ASC 6.2.5)*

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

- Abortion services should be able to provide pre-abortion assessment. Although it may be helpful for a referring health provider to complete the pre-abortion assessment, a woman should have access to these requirements within the abortion service. *(ASC 6.2.6).*

- Appropriate information and support should be available for those who do not proceed to abortion. With the woman's consent, her primary health care provider should be notified so she can transition to antenatal care. *(ASC 6.2.7)*

- Services should be structured to minimise delay. *(ASC 6.2.8)*

- Doctors who use telehealth services to refer a woman for an abortion are referred to the Medical Council of New Zealand's Statement on telehealth at https://www.mcnz.org.nz/assets/standards/d2837a2633/Statement-on-telehealthv3.pdf *(ASC 6.2.9)*

[3] This requirement applies to service funders i.e. DHBs only, not private practitioners.

- 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. (ASC 6.2.10)*

MĀORI HEALTH

- 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. *(ASC 6.3.1)*

- 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. *(ASC 6.3.2)*

  Recommendation: *Cultural competency should be incorporated into staff performance reviews and wherever possible this should be with a Māori staff member.*

- Abortion services should provide environments conducive to manaakitanga – including a calming and pleasant decor in entrances and spaces for public enjoyment. *(ASC 6.3.3)*

- Māori women should be consulted on service delivery and design. *(ASC 6.3.4)*

- Abortion service managers should support Māori workforce development with a view to having Māori staff options*. (ASC 6.3.5)*

- Abortion services should establish relationships with Māori sexual and reproductive health organisations, for example, Te Whariki Takapou. *(ASC 6.3.6)*

  Recommendation: Wherever possible abortion services should provide information resources for Māori individuals and whānau, developed by Māori and for Māori -as resources become available.

- Abortion services should establish relationships with Maori 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*. (ASC 6.3.7)*

- Abortion services should make provision to manaaki whānau who have come along to support those who are considering an abortion. *(ASC 6.3.8)*

- Abortion service staff should be familiar with the basic principles of tapu and noa and practical ways of respecting these concepts. *(ASC 6.3.9)*

- Māori and their whānau should be given the opportunity to have karakia at any stage of the abortion process, especially prior to heightened situations. *(ASC 6.3.10)*

- Abortion service staff should be respectful of taonga/valuables worn with spiritual significance. Permission and explanation should be sought before touching or removing taonga. (*ASC 6.3.11*)

- 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. *(ASC 6.3.12)*

- 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. *(ASC 6.3.13)*

- Korari or pots should be available to those who wish to kai atawhai their pregnancy tissue or practice whenua ki te whenua. *(ASC 6.3.14)*

- 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. *(ASC 6.3.15)*

WAITING TIMES IN ABORTION SERVICES

- Assuming legal requirements are met[4], women should not wait longer than two weeks from when they first request referral[5] for an abortion to time of procedure. However, some women may choose to have more time for decision making. *(Wording change to reflect new legislation) (ASC 6.4.1)*

- 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 by a suitability qualified health practitioner. *(Wording change to reflect new legislation)*. *(ASC 6.4.2)*

  Recommendation: *Where abortion services offer a one day assessment, counselling, and procedure service, women should not have to spend longer than six hours at the service. (Wording change to reflect new legislation)*

SETTINGS FOR ABORTION CARE

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*.

[4] A statutory test applies to all abortions at or after 20 weeks gestation.

[5] Under the amended CSA Act, a woman must be permitted to access abortion services without a referral.

- For those women who may require inpatient care, an adequate number of inpatient beds or transfer arrangements should be in place. Abortion service providers must have timely access to adequate facilities for the accommodation of patients for one or more nights. *(ASC 6.5.2)* (*Changed wording)*

- Any patients with more than mild systemic disease should have their abortions conducted in a location that has emergency medical backup (for example, an 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. *(ASC 6.5.3)*

- 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. *(ASC 6.5.4)*

MINIMUM THEATRE SAFETY REQUIREMENTS

- 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 number of staff trained in advanced cardiopulmonary resuscitation immediately available to assist at the time of any emergency. *(ASC 6.6.1)*

INFORMATION FOR WOMEN

- Abortion services should have either a web resource, telephone resource or links to the Ministry of Health for information and advice to support 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, investigation 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.

  Refer to health.govt.nz/abortion *(Wording change to reflect new legislation.) (ASC 7.1)*

- Verbal advice should be supported by impartial printed information that the woman can understand and may take away to consider further before the procedure. *(ASC 7.2)*

- 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. *(ASC 7.3)*

- The following information should be made available to women both verbally and in writing prior to them consenting to the procedure:
  - Abortion is safer than continuing a pregnancy.
  - 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 the *Individualised Psychosocial Assessment and Referral for Support* section (page 10 below) *(ASC 7.4)*.

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

- 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. *(ASC 7.5)*

BEFORE THE ABORTION[6]

The Abortion Decision

- 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. *(ASC 8.1.1)*

Counselling

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

- Health practitioners 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 credentialled professional whose counselling practice meets these standards. *(ASC 8.2.1) (Wording changed*)

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

  Please note: Compliance with new s12(2) of the CSA means that Counselling services must not be mandatory for women seeking abortion services. Women should be made aware that this is the case.

[6] New standard applies to obtaining an abortion at or over 20 weeks gestation. Refer to page 24.

- Counselling options available to women and significant others (partners and whānau) should include:
  - pre-decision/pregnancy options counselling
  - pre-abortion counselling
  - post-abortion counselling. *(ASC 8.2.2)*

- 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 an abortion. *(ASC 8.2.3)*

- All women should be given the opportunity to be seen on their own to address the issues of coercion and to facilitate honest and open discussion. The process should be safe and respectful. *(ASC 8.2.4)*

- Abortion services should have available professionals with suitable training in counselling. *(ASC 8.2.4a)*

- 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
  - have clinical supervision arrangements in place. *(ASC 8.2.5)*

- Women presenting to an abortion service should undergo family violence routine enquiry and referral to appropriate community resources should be available*. (ASC 8.2.6)*

- 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. [See guidance note below.] *(ASC 8.2.7)*

Individualised Psychosocial Assessment and Referral for Support

- 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 psychological assessment can be provided by appropriately trained social workers, counsellors, nurses or doctors. *(ASC 8.3.1)*

- 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 and 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. *(ASC 8.3.2)*

- 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. *(ASC 8.3.3)*

Pre and Post Abortion Counselling Support

- 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. *(ASC 8.3.4)*

WORKING WITH YOUNG WOMEN

- Young women should be provided with accurate, age-appropriate education, information and support related to their chosen pregnancy option. *(ASC 8.3.5)*

- 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. *(ASC 8.3.6)*

- 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. *(ASC 8.3.7)*

- Abortion services should suggest or support a young person to involve parent(s) or another adult (such as a family/whānau member or a specialist youth worker) but generally should not override the patient's view. *(ASC 8.3.8)*

- 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. *(ASC 8.3.9)*

- When young woman 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 person 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. *(ASC 8.3.10)*

- Post-abortion counselling and support should be offered to all young women. *(ASC 8.3.11)*

- Abortion services should establish working relationships with school/community based youth specific health services. *(ASC 8.3.12)*

- When following up young women, communication technologies should be consistent with the patient's preferred mode of communication. Importance should be placed on consistent follow-up, outreach and multidisciplinary teamwork. *(ASC 8.3.13)*

WORKING WITH WOMEN IN SITUATIONS OF FAMILY VIOLENCE

- Abortion services should ensure all women are asked about family violence and safety is assessed. *(ASC 8.3.14)*

- 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 the Ministry of Health Family Violence Guidelines. https://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence

- 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. *(ASC 8.3.16)*

- Routine enquiry should be accompanied by the provision of appropriate information support and timely referrals to specialist intervention services. *(ASC 8.3.17)*
- 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 increase the safety of all involved. *(ASC 8.3.18)*

- 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 record keeping. *(ASC 8.3.19)*

WORKING WITH MIGRANT AND REFUGEE WOMEN

- For migrant and refugee women who have limited English proficiency, a qualified interpreter should be used. *(ASC 8.3.20)*

- 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. (*ASC 8.3.21)*

WORKING WITH WOMEN WHO HAVE EXPERIENCED SEXUAL ASSAULT

- 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. *(ASC 8.3.22)*

- Abortion services should have guidelines for the management of women who have been sexually assaulted. This should include options for counselling, making an ACC claim and making a complaint to the police. *(ASC 8.3.23)*

- 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, Environmental Science and Research Ltd (ESR) and Medical Sexual Assault Clinicians Aotearoa (MEDSAC) may be consulted when establishing these protocols. *(ASC 8.3.24)*

- Early medical abortion is not suitable for forensic collection of products of conception. *(ASC 8.3.25)*

WORKING WITH WOMEN WHO HAVE LIMITED MENTAL CAPACITY

Refer to the Code of Health and Disability Services Consumers' Rights https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/ - in particular see Right 7.

MEDICAL ASSESSMENT

- Confirmation of pregnancy should be documented (eg. Urine hCG). *(ASC 8.4.1)*

- Gestational age should be verified and documented. They may be done by clinical means or ultrasound. Quantitative hCG measurement may be helpful but should not solely be used as a measure of gestational age. *(ASC 8.4.2)*

- Limited ultrasound scanning should be available for those with uncertain dates or when there is a discrepancy between the last menstrual period (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.

- If a woman has an ultrasound she should be informed beforehand that she has the option to either view or not view the scan. *(ASC 8.4.4)*

- Rhesus status should be documented. *(ASC 8.4.5)*

- Relevant medical history should be obtained and documented. *(ASC 8.4.6)*

- If the woman has a history of anaemia or risk of bleeding, a recent haemoglobin should be documented. *(ASC 8.4.7)*

- Women should be offered screening tests for chlamydia and gonorrhoea. *(ASC 8.4.8)*

- Screening for other sexually transmitted infections (STIs) should follow New Zealand Sexual Health Service Guidelines. *(ASC 8.4.9)*

- Women-centred care requires that women make an informed choice and give consent for STI screening. *(ASC 8.4.10)*

- Women who test positive for a STI should receive therapeutic doses of 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. *(ASC 8.4.11)*

- If there are no contraindications, women should be given a choice of medical or surgical abortion, according to gestational age. *(ASC 8.4.12)*

- Post abortion contraception should be discussed in advance of the abortion and written information offered. *(ASC 8.4.13)*

- Heart rate and blood pressure should be recorded before the abortion. Physical examination may be done as indicated by medical history and patient symptoms. *(ASC 8.4.14)*

- 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 ultrasound (US) shows no IU pregnancy and βHCG >2000IU/L
  (b) Abdominal US shows no IU pregnancy and βHCG > 3500IU/L.
  (c) Insufficient tissue is obtained at the time of an abortion.
  (d) Suspicious adnexal mass, pain or bleeding *(ASC 8.4.15)*.

NURSING AND MANAGEMENT

- Abortion services should be 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. *(ASC 8.6.1*)

- Abortion services should allocate funds for professional training, ongoing education and updates in abortion care*. (ASC 8.6.2)*

- Abortion service Managers should actively recruit and support 'a champion' for the service. *(ASC 8.6.3)*

- Managers of abortion services should make provision for all nursing, midwifery and counselling staff to attend professional supervision on a regular basis. *(ASC 8.6.4)*

- Managers of abortion services should have a strategy for training, recruitment and retention of staff. *(ASC 8.6.5)*

- 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 ASC standards 6.3.1 – 6.3.15. *(ASC 8.6.6)*

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.*

THE ABORTION PROCEDURE

Medical Competency

- 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 of 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 intravenous (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 ASC standards 6.3.1 – 6.3.15. *(ASC 9.2.1)*

Informed Consent

- The health practitioner 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. *(Wording change to reflect new legislation.) (ASC 9.4.1)*

Choice of Abortion Method

- All services should actively promote the earliest possible abortion procedure and work towards being able to offer women a choice of [abortion] methods appropriate for each gestation period. *(ASC 9.5.1)*

Prevention of Infective Morbidity

- All abortion providers should have policies to minimise post-abortion infective morbidity. *(ASC 9.6.1)*

- All abortion providers should offer antibiotic prophylaxis prior to surgical abortion. *(ASC 9.6.2)*

- Only women with prosthetic heart valves, previous bacterial endocarditis or a surgically constructed pulmonary shunt should be considered for pre-operative endocarditis prophylaxis. *(ASC 9.6.3)*

First Trimester Surgical Abortion

- Standard suction abortion may be offered throughout the first trimester.

- There is no lower limit of gestation for surgical abortion. (ASC 9.7.1)

- Portable electric, manual (MVA) devices or wall suction may be used. (ASC 9.7.2)

- Procedures should usually be done under conscious sedation with local anaesthetic. (ASC 9.7.3)

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

- 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. (*ASC 9.7.4*)

- 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. (*ASC 9.7.5*)

- All Abortion Services should use a standard and documented 1st trimester medication regimen for surgical abortion.[7]

- Venous access should be in place prior to the procedure taking place. (*ASC 9.7.10*)

- 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. (*ASC 9.7.11*)

- Pre-procedure bimanual examination should be done by the doctor doing the abortion. (*ASC 9.7.13*)

- Paracervical block should be performed. (*ASC 9.7.14*)

- All instruments entering the uterus should be sterile. (*ASC 9.7.15*)

Recommendation: *A 'no touch' technique is recommended.*

- The cervix should be dilated gently and gradually. (*ASC 9.7.16*)

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

- Sharp curettage should not be used. (*ASC 9.7.17*)

- Routine use of oxytocin or ergometrine is not required. (*ASC 9.7.18*)

- 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. *(ASC 9.7.19)*

- Routine histopathology is not required but should be available if there is a clinical suspicion of pathology. (*ASC 9.7.20*)

First Trimester Medical Abortion

- All Abortion Services should use a standard and documented 1st trimester medication regimen.

[7] Refer to ASC Standards 9.7.6.- 9.7.9 and 9.7.12.

- As part of the consent for medical abortion the woman should be informed that a uterine aspiration may be necessary. (*ASC 9.8.2*)

- IUDs must be removed prior to a medical abortion (*ASC 9.8.3*)

- In first trimester medical abortion, a woman having or completing her abortion at home should remain under the care of the abortion service until documentation about her abortion is complete. *(ASC 9.8.4)*

- A woman who has her abortion at home (or goes home to complete her medical abortion) must have clear documentation 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. *(Wording change to reflect new legislation.) (ASC 9.8.5)*

- Abortion services must ensure that hospital emergency department staff and on call gynaecology staff have information available to manage medical abortion complications. *(ASC 9.8.6)*

- 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 the abortion medication is administered. The woman should be notified of this result. *(ASC 9.8.7)*

Second and Third Trimester Medical Abortion

- There should be clear and accessible guidelines in every DHB for referral for women for consideration of 2nd and 3rd trimester abortion. *(ASC 9.9.1)*

- All units should provide women with written information on the abortion process after the first trimester. *(ASC 9.9.2)*

- Access to admission should be possible at any time during the 2nd or 3rd trimester abortion process. *(ASC 9.9.3)*

- Specific training in the medical management of 2nd and 3rd trimester abortion should include labour and birth processes and complications, as well as aftercare, breast care and management of medical conditions. *(ASC 9.9.4)*

- 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. *(ASC 9.9.5)*

- 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 the possibility of neonatal survival is not an abortion. *(ASC 9.9.6)*

- Abortion in the 2nd and 3rd trimester should be performed in units with access to gynaecological specialist support, an operating theatre and blood products *(ASC 9.9.7)*

- All Abortion Services should use a standard and documented 2nd/3rd trimester medication regimen. *(ASC 9.9.8)*

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 medication 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.

- Inhibition of lactation should be offered and breast care explained to the woman. *(ASC 9.9.9)*

- 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. *(ASC 9.9.10)*

- 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. *(ASC 9.9.11)*

Referral Protocols

- Counselling must 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. *(Wording change to reflect new legislation). (ASC 9.9.12)*

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.

- Cervical preparation is essential for second trimester surgical abortion.

- No regimen of cervical preparation has been shown to be more effective than another.

- 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. *(ASC 9.10.1)*

AFTERCARE

- Anti D prophylaxis must be offered to all Rh D negative women on the day of their abortion. *(ASC 9.11.1)*

- Following abortion, women should be given a verbal and written account of the symptoms they may experience. They should have a list of symptoms that require urgent medical consultation. *(ASC 9.11.2)*

- Urgent clinical assessment and emergency gynaecology admission should be available when necessary. *(ASC 9.11.3)*

- 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 (if any) and it should be received within four days of the abortion. *(ASC 9.11.4)*

- All women must be offered access to further counselling after an abortion under the CSA Act. 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. *(Wording change to reflect new legislation)*. *(ASC 9.11.5)*

CONTRACEPTION

- All women having an abortion should have post-abortion contraception discussed before the abortion is commenced. Education about the full range of [contraceptive] 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. *(ASC 9.12.1)*

- Contraception information should be available in different languages and in a range of formats including audio-visual. *(ASC 9.12.2)*

- Web-based contraception information should be available on the abortion services website or links to web resources made available. *(ASC 9.12.3)*

- Contraceptive supplies should be made available or appropriate prescriptions given on the day of the abortion. *(ASC 9.12.4)*

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

- For example, an intrauterine device (IUD), intrauterine system (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. *(ASC 9.12.5)*

- Abortion services should have adequate numbers of trained staff who can insert IUDs, IUSs, and implants. *(ASC 9.12.5a)*

- Abortion service clinicians should document contraception discussions and consent. *(ASC 9.12.6)*

- 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. *(ASC 9.12.7)*

  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 long acting reversible contraceptive (LARC) methods but want very reliable contraception and choose an IUS.*

KAI ATAWHAI AND DISPOSAL OF PREGNANCY TISSUE

- Pregnancy tissue should be considered biohazardous and there should be a protocol for tissue disposal in place. *(ASC 9.13.1)*

- 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. *(ASC 9.13.2)*

- 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. *(ASC 9.13.3)*

ABORTION FOLLOW UP

- A post-abortion assessment should be offered by the referring health care provider after the abortion. If this visit is within two weeks of the abortion, it should be offered under the Section 88 Maternity Services Notice. Women should be informed about this and encouraged to attend by both their health care provider and the abortion service. *(ASC 10.1)*

- The discharge letter should reach the referrer (if there was one) within four days with a recommendation for active follow-up for those that have been identified as needing addition support. (Wording change to reflect new legislation). *(ASC 10.2)*

- Active follow-up means three 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). *(ASC 10.3)*

- This appointment should include a holistic assessment of health:
  - Hinengaro – mental wellbeing
  - Tinana – physical wellbeing
  - Wairua – spiritual wellbeing
  - Whānau – family and community wellbeing. *(ASC 10.4)*

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

- The follow-up appointment should include discussion of contraception. *(ASC 10.5)*

- 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. *(ASC 10.6)*

NEW STANDARDS - THE ENACTMENT OF THE CSA AMENDED ACT ON THE 24 MARCH 2020

The amended CSA requires abortion service providers to accommodate:

- *Conscientious objection* – Abortion service providers must accommodate staff who have a conscientious objection to providing or assisting with providing abortion services, or information or advisory services about whether to terminate a pregnancy, in accordance with the requirements of the CSA Act. This may include arranging for those services to be carried out by an existing employee. However, abortion service providers are not required to accommodate such staff where doing so would cause an unreasonable disruption to the provision of health services.

  Some staff may not have a conscientious objection to providing abortion services in general but may object to providing services in particular circumstances for example after a certain gestational age of the fetus.

  Under the CSA Act, if any person providing abortion services has a conscientious objection to providing, or assisting with providing, any of the services requested, that person must tell the woman at the earliest opportunity -

  (a) of their conscientious objection; and

  (b) how to access the contact details of another person who is the closest provider of the service requested.

  The closest provider is determined taking into account -

  (a) the physical distance between the providers; and
  (b) the date and time that the woman makes the request; and
  (c) the operating hours of the provider requested.

A conscientious objection cannot override a health practitioner's professional and legal duty to provide prompt and appropriate medical assistance to any person in a medical emergency.

- *Trans-gender accessibility* - 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.

- *A new statutory test which applies to all abortions at or over 20 weeks gestation* – abortion service providers need to implement appropriate policy and procedure to ensure compliance with section 11 of the CSA, subsections 1 and 2, i.e.

  1. A qualified health practitioner may only provide abortion services to a woman who is more than 20 weeks pregnant if the health practitioner reasonably believes that the abortion is clinically appropriate in the circumstances.

2. In considering whether the abortion is clinically appropriate in the circumstances, the qualified health practitioner must
   (a) Consult at least 1 other qualified health practitioner; and
   (b) Have regard to
      i. All relevant legal, professional and ethical standards to which the qualified health practitioner is subject; and
      ii. The woman's
         (a) physical health; and
         (b) mental health; and
         (c) overall wellbeing; and
      iii. the gestational age of the fetus.
3. Subsection (2) does not apply in a medical emergency.

- *Provide information* required by the (new) section 20 of the CSA as set out in (new) Schedule 2 CSA and any additional information required by the Director-General of Health. See http://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237644.html#LMS237644 for the list of information required by Schedule 2.