STANDARDS OF CARE FOR WOMEN REQUESTING INDUCED ABORTION IN NEW ZEALAND

Report of a Standards Committee to the Abortion Supervisory Committee

October 2009

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ABBREVIATIONS

ALRANZ	Abortion Law Reform Association of New Zealand
APC	Annual Practising Certificate
ASC	Abortion Supervisory Committee
ASAP	American Society of Anaesthesiology Physical status
Beta HCG	Beta human chorionic gonadotrophin
BMI	Body mass index
CS&A Act	Contraception, Sterilisation and Abortion Act 1977
D&E	Dilatation and evacuation
EMA	Early medical abortion
DHB	District Health Board
DP	Depo Provera
FP	Family Planning
FRANZCOG	Fellow Royal Australian and New Zealand College of Obstetricians and Gynaecologists
FRCOG	Fellow Royal College of Obstetricians and Gynaecologists
HPCAA	Health Practitioners Competence Assurance Act 2003
HDC Act	Health and Disability Commissioner Act 1994
IU	Intrauterine
IUD	Intrauterine device
IUS	Intrauterine system (Mirena)
IV	Intravenous
MTOP	Medical termination of pregnancy
MVA	Manual vacuum aspiration
NAF	National Abortion Federation
NZMA	New Zealand Medical Association
NZNO	New Zealand Nurses Organisation
PID	Pelvic inflammatory disease
POC	Products of conception
RPOC	Retained products of conception
STI	Sexually Transmitted Infection
STOP	Surgical termination of pregnancy
TOP	Termination of pregnancy
UK	United Kingdom
US	Ultrasound

DEVELOPMENT OF THE STANDARDS

This Standards document was developed in 2009 by a Standards Committee convened by the Abortion Supervisory Committee.

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

Members included representatives from Nursing, Women's Health Management, Social Work, General Practice and Specialist Gynaecology.

Development of the Standards was led by Dr Alison Knowles.

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An initial draft document was circulated for peer review by abortion providers, certifying consultants, Ministry of Health, District Health Boards, Medical Council of New Zealand, RNZCGP, RANZCOG, NZNO, Family Planning, NZ Association of Counsellors, Aotearoa NZ Association of Social Workers, ALRANZ and consumer groups.

After this review process, the document was amended to include **Standards** and **Recommendations.**

Standards are intended to be mandatory and must 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 feedback from the peer review. Recommendations are only steering in nature, but when not adhered to, there should be documented justification.

1. INTRODUCTION

Induced abortion is one of the most commonly performed gynaecological procedures in New Zealand and affects about one third of women during their lifetime.[1, 2]

In 2008, 17,940 terminations of pregnancy were performed in New Zealand. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists acknowledges abortion is an important health issue.[3]

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

District Health Boards are required to provide terminations by statute and abortion has been deemed to be a core service in the New Zealand public health system.[4]

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 or Social Work.

2. BACKGROUND

Worldwide, an estimated 46 million pregnancies are terminated each year. Almost half of these abortions are estimated to be unsafe. About 13% of pregnancy related deaths worldwide are attributed to unsafe abortion. The World Health Organization states that safe abortion services, as provided for by law, need to be freely available to women and their families.[5]

Unwanted pregnancies occur because women are unable to regulate their fertility by contraception alone. The complexities of managing sexual behaviour and the fallibility of contraception mean unwanted pregnancies are inevitable.[2]

In New Zealand, under the Contraception, Sterilisation and Abortion Act 1977 there is a requirement to have an Abortion Supervisory Committee. 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:
14(1)(d) To take all reasonable and practicable steps to ensure-

(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 of the CS&A Act 1977.

Licences can be either full or limited depending on the range of services provided and the authors refer those holding or applying for a licence to perform abortions to the above sections of the law.

The ASC is also entrusted by Parliament in section 14(1)(i) of the 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 this Act and the procedures thereunder.

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 Statistics 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 may need improvement.

Where possible, the standards and recommendations within this document are based on legal requirements, evidence based research and overseas best practice guidelines which have been tailored to New Zealand systems.

(This is the first such document with a national focus. It is expected that revisions will occur as a result of quality improvement activities and changes in clinical practice. Appended and referenced are a number of resources providing detailed information from which this standard was developed.)

4. CARE PATHWAY

FIRST CONTACT

1. Woman initiates discussion with a primary health care provider or other professional about her pregnancy.
2. Woman requests referral for consideration of abortion.
3. If this first person of contact is a doctor, pre abortion assessment may be commenced and the referral to an abortion clinic made. Otherwise the woman should be referred to a doctor for this assessment.

PRE ABORTION ASSESSMENT

May be done by a doctor within or outside an abortion service.

1. Woman offered referral for professional counselling.
2. Verification of gestational age by ultrasound scan or clinical means.
3. Routine Antenatal blood screen.
4. Genital swabs for STIs.
5. Choice of medical or surgical abortion.
6. Discussion of post abortion contraception.
7. Time and date for appointment at abortion clinic arranged.
8. Referral letter.
9. Legal certification.

ABORTION PROCEDURE

1. Ensure legal certification complete.
2. Informed consent.
3. Antibiotic prophylaxis.
4. Medical or surgical abortion.
5. Anti D if necessary.
6. Contraception.
7. Discharge planning and advice.
8. Arrangement for post abortion counselling if required.
9. Documentation of completion of procedure.
10. Legal notification of abortion.

ABORTION FOLLOW UP

1. Clinical assessment of physical and emotional health.
2. Contraception follow-up.
3. Post abortion counselling information.

5. LEGAL AND ETHICAL ASPECTS OF ABORTION

5.1 THE LAW

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

Under the CS&A Act 1977 there must be an Abortion Supervisory Committee whose role is to keep under review all provisions of the abortion law, and the operation and effect of those provisions in practice.

In Summary:
Abortions can only be carried out in an institution licensed for the purpose in accordance with the CS&A Act 1977. It is the role of the ASC to grant licences and to this end the committee 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 1977.

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.

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:

(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.

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.

Every medical practitioner who is consulted by a woman who wishes to have an abortion shall arrange for the case to be considered in accordance with the CS&A Act.

Two certifying consultants must consider each case and issue a certificate which shall be forwarded to the holder of the licence for the institution where the abortion is to be performed.

The grounds for an abortion are detailed in the Crimes Act 1961 and include serious danger to the life, physical or mental health of the woman, any form of incest or sexual relationship with a guardian, mental subnormality and since 1978, fetal

abnormality when the pregnancy is less than 20 weeks gestation. Extremes of maternal age or sexual violation may be taken into account but are not in themselves grounds for abortion.

5.2 CONSCIENTIOUS OBJECTION AND ETHICS

Under section 46 of the CS&A Act no person shall be under any obligation to perform or assist in the performance of an abortion.

However, under section 118 of the Health Practitioners Competence Assurance Act 2003 (HPCAA), the Medical Council of New Zealand is responsible for setting standards of clinical competence, cultural competence, and ethical conduct of doctors. The Council has developed a number of standards which doctors in New Zealand are required to comply with when providing care to women who request induced abortion. These standards include 'Good Medical Practice' and the Council is currently working on a draft document entitled 'Beliefs and Medical Practice'.

Section 174 of the HPCAA states:

1. This section applies whenever-
    a. A person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation or other reproductive health services; and
    b. The health practitioner objects on the ground of conscience to providing the service.

2. When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another practitioner or from a family planning clinic.

It is the Council's view that referral under part 2 of the clause must be timely and must comply with the guidance outlined in the document 'Beliefs and Medical Practice' when it is published.

The New Zealand Medical Association has also published a 'Code of Ethics for the New Zealand Medical Profession'. In this publication doctors are expected to consider the health and well being of the patient to be their first priority and to respect the rights, autonomy and freedom of choice of the patient.[7]

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 must also be given to the Health Practitioners Competence Assurance Act section174.

All abortion facilities must be licensed in accordance with the CS&A Act.

All district health boards (DHBs) are required to provide access to termination of pregnancy services for women in their catchment areas.[4] 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.

6.2 ACCESS AND REFERRAL TO ABORTION SERVICES

Standard 1

DHBs must ensure all women have access to abortion services.

Standard 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 must include transport and accommodation costs.

Recommendation 2.1

Women should not have to travel more than two hours to access first trimester abortion services.[4]

Standard 3

As with other pregnancy services, DHB abortion services must be free to all women eligible for publicly funded health services in New Zealand. The pre-abortion assessment, counselling and follow up appointments must also be free.[8]

Standard 4

Abortion services must 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.[2]

Standard 5

DHBs must ensure access to both medical and surgical abortions.[2]

Recommendation 5.1
Access should be ensured for those with special requirements. For example, non-English speaking women should have access to an interpreter and if possible a female doctor available on request.

Standard 6
Although it may be helpful for a referring doctor to certify and perform the pre-abortion assessment, this is not mandatory and a woman must have access to these requirements within the abortion service.

Standard 7

Appropriate information and support must be available for those who do not proceed to abortion. The referring professional must be notified of this decision so that antenatal care can be arranged.

Standard 8

Services must be structured to minimise delay (for example, telephone or electronic referral system, formal care pathway, accept referrals from a variety of sources).[2, 9]

6.3 MAORI HEALTH

All Health and Disability service providers need to recognise the cultural values and beliefs that influence the effectiveness of services for Maori. An abortion service must be provided in a way that will contribute to the objectives of He Korowai Oranga (Maori Health strategy as referred to in the New Zealand Health Strategy). It should aim to improve Maori Health and reduce inequalities between Maori and Non-Maori.

Standard 9
All service providers must consult and include Maori in service delivery and design.

Standard 10
Maori patients must be offered the opportunity to include cultural practices of their choice (e.g. karakia or prayer) and be made aware of the option of saving the pregnancy tissue for burial and how to go about this.

6.4 WAITING TIMES IN ABORTION SERVICES

It is generally acknowledged that the earlier in a pregnancy an abortion is performed the safer and less painful it is. The procedure also takes less time and is less stressful for patients and clinicians.

Referring doctors should be aware of this and as soon as it is evident that a woman is clearly not happy about the diagnosis of pregnancy she should be offered referral to professional DHB pregnancy counselling services so that she is given as much support as possible in making a decision. Simply sending the woman away to think about her decision can cause unnecessary delays in accessing abortion services.

Standard 11

Women must not wait longer than two weeks from time of referral to time of procedure. However some women may choose to have more time for decision making.

Standard 12

If a woman requires an abortion for urgent medical reasons (for example severe pre-eclampsia or psychosis) she must be given the opportunity to be seen within twenty-four hours.

6.5 SETTINGS FOR ABORTION CARE

Standard 13

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 13.1

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 14

In the absence of medical contraindications, surgical abortion must be available on a day stay basis.

Standard 15

In early medical abortion the patient may be managed on a day stay basis or at home with telephone contact (after administration of abortifacients in a licensed premise).

Standard 16

In an abortion service some women may require inpatient care.[2] An adequate number of inpatient beds or transfer arrangements must 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.

Recommendation 16.1

Abortion patients should be cared for separately from other patients and it is recommended this be within clinic time dedicated to women requesting abortion.

Standard 17

Any patients with more than mild systemic disease must 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 must be referred for an anaesthetic opinion prior to surgery and have an anaesthetist present during the abortion. These patients include those with severe heart, lung, liver, renal disease or morbid obesity (BMI 40+).[2, 13, 14]

Standard 18

Women having second-trimester abortions by medical means must be cared for by an appropriately trained and experienced midwife or nurse.

Standard 19

Women having second trimester abortions by medical means must be offered a single room.[2, 10]

6.6 MINIMAL THEATRE SAFETY REQUIREMENTS

Standard 20

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

a) *Operating table that can be readily tilted.*

b) *Adequate uncluttered floor space to perform resuscitation.*

c) *Adequate suction and room lighting.*

d) *Supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.*

e) *Self-inflating bag suitable for artificial ventilation together with a range of equipment for advanced airway management (masks, oropharyngeal airways, laryngeal mask airways, laryngoscopes, endotracheal tubes).*

f) *Appropriate drugs for cardiopulmonary resuscitation (adrenaline, atropine, 50% dextrose, lignocaine, naloxone, flumazenil, intravenous fluids, emergency oxygen supply) and intravenous equipment.*

g) *Pulse oximeter.*

h) *Device for measuring blood pressure.*

i) *Timely access to an ECG and defibrillator.*

j) *Means of summoning emergency assistance.*

k) *Appropriate numbers of staff trained in advanced cardiopulmonary resuscitation immediately available to assist at the time of any emergency.*[6, 14, 15]

7. INFORMATION FOR WOMEN

Standard 21

Verbal advice must be supported by impartial printed information that the woman can understand and may take away to consider further before the procedure.[2, 10, 15]

Recommendation 21.1
There should be the provision of nationally developed written patient information which ensures accuracy and readability. This should be available in several languages. Appropriate local information may be provided as a supplement.

Standard 22

Clinicians providing abortion services must possess accurate knowledge about possible complications and sequelae of abortion. They must provide women with this information so that they can give informed consent.[2]

Standard 23

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

a) *Abortion is safer than continuing a pregnancy to term and complications are uncommon.*

b) *The different methods of abortion that are available within their local service and for what gestations.*

c) *Information about immediate complications of abortion which can include haemorrhage, uterine perforation, cervical lacerations and anaesthetic complications. Should one of these complications occur women should be aware that blood transfusion, laparoscopy, laparotomy or hysterectomy may be required.*

d) *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.*

e) *Very rare long term complications in subsequent pregnancies can include miscarriage or preterm birth. Some women may also rarely present with psychological problems especially when these existed prior to the abortion.*

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. Women should be assured there is no association between abortion and breast cancer, ectopic pregnancy, placenta praevia or infertility.

8. PRE ABORTION ASSESSMENT

8.1 CERTIFICATION

Standard 24

All certifying consultants must:

a) *Have an 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, 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 women's health or sexual and reproductive health.*

8.2 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 or terminating their pregnancy) 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 25

Women must be offered the following information to assist in their decision and abortion experience.[2]

a) *Basic anatomy and physiology as relevant to their gestation.*

b) *An understanding of the process of abortion and its possible (but rare) complications.*

c) *Fetal development (which may include showing pictures of the stage of fetal development).*

d) *Products of conception - disposal options.*

e) *An understanding of grief and loss processes in a cultural context.*

f) *Contraception education.*

8.3 COUNSELLING

Abortion providers are referred to the "Standards of Practice for the Provision of Counselling" published by the ASC in 1998.[16]

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'.[2]

Standard 26

Certifying consultants and other professionals caring for a woman requesting abortion must 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 standards of the ASC. This service must be free and easily accessible.

Standard 27

Clinic staff must try to identify those that require additional support and these women must be actively encouraged to see a counselling professional before they proceed with abortion.[2]

Standard 28

All women must be given the opportunity to be seen on their own to confront issues of coercion and to facilitate honest and open discussion.

Standard 29

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

Professionals providing counselling in abortion care must:

a) *hold a relevant qualification or have equivalent training in abortion counselling.*

b) *be registered members of their profession, e.g., counselling or social work.*

c) *be doing regular pregnancy counselling for women considering abortion.*

d) *have supervision and peer review.*

Standard 30

Women presenting to an abortion service must undergo family violence screening and referral to appropriate community resources must be available.

8.4 MEDICAL ASSESSMENT

Standard 31

Confirmation of pregnancy must be documented.

Standard 32

Gestational age must be verified and documented.

Recommendation 32.1
Ultrasonography is recommended because it more accurately establishes gestational age, viability and site. It allows streamlining of care and may assist a woman and her abortion provider choose between medical and surgical methods.

Standard 33

If a woman has an ultrasound she must be informed that she is able to view the scan.

Standard 34

Haemoglobin and rhesus status must be documented.

Recommendation 34.1
Routine antenatal blood screen is recommended.

Standard 35

Relevant medical history must be obtained and documented.

Standard 36

Women must be offered screening tests for chlamydia, gonorrhoea and trichomonas.

Recommendation 36.1
Because of problems with adequate follow-up it is not considered appropriate for cervical cytology to be performed within an abortion service. However, a referring practitioner can take the opportunity to ascertain a woman's cervical cytology history and offer screening according to national guidelines.

Standard 37

Women who test positive for an STI must 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 must offer to meet and treat sexual partners if they are attending the appointment.[15]

Standard 38

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

Standard 39

A referral letter must be completed by the referring doctor and sent to the abortion clinic.

Standard 40

Post abortion contraception must be discussed and if possible prescribed by the assessing doctor.[2]

Standard 41

Vital signs (blood pressure, pulse, temperature) must be recorded before abortion. Physical examination may be done as indicated by medical history and patient symptoms.[2, 15]

Standard 42

Abortion units must have a written protocol for the evaluation of suspected ectopic pregnancy.[15]

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

a) *Transvaginal US shows no IU pregnancy and betaHCG>2000IU/L.*

b) *Abdominal US shows no IU pregnancy and betaHCG>3500IU/L.*

c) *Insufficient tissue is obtained at the time of abortion.*

d) *Suspicious adnexal mass, pain or bleeding*

8.5 NURSING AND MANAGEMENT

Standard 43

The unit must have a clearly identified Unit Manager/Charge Nurse Manager who oversees the abortion service and ensures all nursing staff have regular specific abortion training, resuscitation training, clinical supervision and support. The Unit 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 44

The service must allocate funds for managerial training and ongoing education in abortion care.

Standard 45

The Unit Manager must actively support and encourage staff to enable debriefing and review of practice.

Standard 46

The Unit Manager must regularly attend national and/or international meetings on abortion care, for example the New Zealand Abortion Providers Conference.

Standard 47

The DHB and Unit Manager must have a strategy for training, recruitment and retention of staff.

Standard 48

Training for abortion service staff must include:

a) *Physical, mental, emotional, cultural aspects of abortion.*

b) Counselling skills.

c) Up to date knowledge of contraception methods.

d) MTOP and postoperative telephone triage skills.

e) Skills required for MTOP and STOP.

f) Regular unit level in-service education sessions.

g) Access to supervision and audit.

8.6 SECOND TRIMESTER TERMINATIONS

Staff who work within a termination of pregnancy service may be influenced by the gestation of the women they are caring for. Staff should be suitably trained in working with second trimester gestations. Psychological stresses and difficulties on both women and staff need to be acknowledged in the service and provided for. This includes nursing, medical and counselling staff.

Standard 49

Specific training in the medical management of second trimester abortion must include labour and birth processes, as well as aftercare and breast care.[2]

Standard 50

Training for second trimester abortions must address the reasons why women seek late abortions (late recognition of pregnancy, fetal abnormality, poor access, slow services, ambivalence, denial) and how to support women through the process.

Standard 51

Where the gestation exceeds 22 weeks part of the counselling and abortion process must include a consideration of fetocide.[2, 15]

9. ABORTION PROCEDURE

9.1 DEFINITION OF GESTATION

Gestation is generally based on weeks from last menstrual period rather than conceptual weeks.

Whether this is based on clinical assessment or ultrasound, it is generally accepted that the margin of error for such an assessment in the first trimester is up to 7 days. This has implications in abortion care because of method choice (medical or surgical), licensing of institutions, and operator skill.

9.2 MEDICAL COMPETENCY

Standard 52

All doctors performing abortions, whether surgical or medical, must:

a) *Have an 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 a caseload of at least 50 cases per year if they are operators or 20 cases per year if they are EMA providers.*

g) *Have evidence of current competency in airway management, cardiovascular resuscitation and IV cannulation.*

h) *Have orientation to unit policies - both health and safety and clinical.*

i) *Have an annual performance appraisal.*

j) *Where possible attend multidisciplinary clinical unit meetings, peer group meetings and abortion conferences.*

k) *Undertake a re-entry to practice process after a year of not operating or providing medical abortions.*

9.3 LEGAL CERTIFICATION AND NOTIFICATION

Standard 53

The doctor performing the abortion must 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 54

The doctor performing the abortion must obtain informed consent. There must be documentation that the woman understands the procedure and accepts the risks and possible complications of both the abortion and any sedation or anaesthetic.[2, 13, 14]

9.5 CHOICE OF ABORTION METHOD

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

Standard 55

All services must actively promote the earliest possible abortion procedure and work towards being able to offer women a choice of methods appropriate for each gestation period.[2]

Recommendation 55.1
Abortion beyond 22 weeks is uncommon and requires special expertise and support staff and for many areas it may be best if such situations are managed by arrangement with those with the necessary experience.

9.6 PREVENTION OF INFECTIVE MORBIDITY

There is no international consensus on the best way to prevent infective morbidity after abortion. Traditionally New Zealand abortion providers have used 'screen and treat' protocols.

However, there is a lack of consistency as to what STI pathology tests are used in New Zealand and what tests are funded by local DHBs. There is also inconsistency among referring doctors as to what swabs are taken and by whom (doctor, nurse or the patient herself). NAF and RCOG guidelines both recommend universal antibiotic prophylaxis as a minimum standard.

Standard 36 of this document states 'Women must be offered screening tests for chlamydia, gonorrhoea and trichomonas'.

Standard 56

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

Recommendation 56.1
Universal antibiotic prophylaxis is recommended for all women who do not have recent reliable STI test results available.

A suggested regimen is: Metronidazole 1g rectally at the time of abortion, plus either:

- *Doxycycline 100mg bd 7 days OR*
- *Azithromycin 1g orally on day of abortion.*

Standard 57

Only women with prosthetic heart valves, previous bacterial endocarditis or a surgically constructed pulmonary shunt should be considered for pre-operative endocarditis prophylaxis.[15]

9.7 SURGICAL METHODS OF ABORTION

For first trimester suction termination, either electric or manual (MVA) devices may be used. Both are effective and acceptable to women and clinicians. Operating times are shorter with electric aspiration.

Standard 58

Standard suction termination may be offered to all women up to 15 weeks gestation, depending on the experience of the operator and his/her familiarity with the techniques required.

Standard 59

Cervical preparation must be routine for all surgical abortions. For first trimester abortions, misoprostol should be given 1 to 3 hours prior to theatre. The most effective routes of administration are vaginal, sublingual and buccal.[2]

Standard 60

All instruments entering the uterine cavity must be sterile.

Recommendation 60.1
A 'no touch' technique is recommended [2,15]

Recommendation 60.2
The cervix should be dilated gently and gradually.[15]

Recommendation 60.3
The uterus should usually be emptied using the smallest possible flexible plastic suction curette and blunt forceps (if required) only. Sharp curette with metal instruments should not be used routinely.[2]

Standard 61

Patient comfort level during the procedure must be a priority.[2, 15]

Recommendation 61.1

Procedures should usually be done with conscious sedation and local anaesthesia (paracervical block). Preoperative oral midazolam and intraoperative IV fentanyl, together with supportive nursing is generally sufficient to ensure adequate analgesia. Self regulated nitrous oxide may also be available.

Recommendation 61.2

Abortion providers should acknowledge that general anaesthesia is sometimes required because of patient anxiety, young age or medical indications. It should be presented as a realistic choice.

Standard 62

Beyond 15 weeks gestation, surgical abortion by dilatation and evacuation is safe and effective but must be performed by specialist gynaecologists with sufficient experience and caseloads to maintain their skills. The upper limit of surgical abortion is dependent on operator skill and experience. Cervical preparation is essential. Mifepristone is as effective as mechanical-osmotic dilators in softening and dilating the cervix before the procedure.

Recommendation 62.1

The pregnancy tissue should be visually checked after all abortions to confirm and document completion of the procedure. Histopathology is not necessary but should be available if there is clinical suspicion of pathology. [2, 15]

Standard 63

Women who choose an intrauterine device or intrauterine system for contraception must be given the option of having one fitted at the time of abortion. After second trimester abortion, it is more likely the device will be expelled.[2]

Standard 64

Reliable venous access must be in place for all surgical abortions prior to the procedure taking place.

Standard 65

There must 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.[13, 14]

Standard 66

To increase confidence that a gestation sac has been removed in early terminations (< 7 weeks), protocols must include safeguards such as flotation of the aspirate using a lightbox or follow-up serum HCGs.

9.8 MEDICAL METHODS OF ABORTION

Medical abortion using mifepristone and misoprostol is a safe option at all gestations. Providers should refer to the "Guidelines for the use of Mifepristone Medical Abortion in New Zealand" published by the ASC in 2004.[18] However, this is a relatively new field and providers must be aware of new developments and research in the field of medical abortions and undertake ongoing medical education.

Standard 67
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.

Recommendation 67.1
The following regimen is recommended for gestations up to 9 weeks (63 days):

Mifepristone 200mg orally followed 1-3 days 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 can be given.

Standard 68
In early medical abortion, if a woman goes home to complete her abortion, she must remain under the care of the abortion provider 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.

Recommendation 68.1
If a woman who has gone home to complete her EMA requires readmission for clinical assessment, parenteral analgesia or surgical intervention before her abortion is complete, it is the responsibility of the abortion provider to ensure safe and prompt access to this. These are basic requirements of a medical abortion service and except in an emergency, should not be delegated to an emergency department or on call gynaecology registrar who may be very busy, have no specific training in abortion care and be unable to provide optimal woman centred care.

Recommendation 68.2
The following regimen may be used for medical abortions beyond 9 weeks (63 days):

Mifepristone 200mg orally followed 1-2 days later by misoprostol 800 micrograms buccally, sublingually or vaginally, then misoprostol 400 micrograms sublingually or buccally 3 hourly for a further 4 doses. Women must remain in the hospital until passage of products of conception has occurred.

Standard 69
Completion of medical abortion must be documented by clinical means, ultrasound or HCG testing.

9.9 AFTERCARE

Standard 70

Anti D prophylaxis must be offered to all Rh D negative women on the day of their abortion.[2, 10, 19]

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 71

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

Standard 72

Urgent clinical assessment and emergency gynaecology admission must be available when necessary.[2]

Recommendation 72.1
Ideally women should have a 24 hour helpline number to phone if they are worried about their symptoms.

Standard 73

All women must 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.[2]

Standard 74

All women must 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 address any unresolved issues related to their abortion and support their emotional recovery. Women need to know this is a free service provided by their DHB.

9.10 CONTRACEPTION

Standard 75

All women having an abortion must have post abortion contraception discussed. Education about the range of methods available in New Zealand must be available and this may involve their sexual partner.

Standard 76

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

Recommendation 76.1
The use of long acting reversible contraceptives (IUD, IUS, DP, implants) should be encouraged.

Recommendation 76.2
The chosen method of contraception should be initiated immediately following abortion.

Recommendation 76.3
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.

9.11 DISPOSAL OF PREGNANCY TISSUE

Standard 77

All pregnancy tissue must be considered biohazardous and there must be a protocol for tissue disposal in place.[15]

Standard 78

Local protocols for disposal of pregnancy tissue must be explained to women and they must be given the option of taking the tissue home for burial with written information outlining safety issues.

10. ABORTION FOLLOW UP

Standard 79

A post abortion assessment must be offered by the referring doctor 10 to 14 days after the abortion. Women should be encouraged to avail themselves of this free service.

Standard 80

This appointment must include a clinical assessment of physical and emotional health with special regard to possible post abortion complications. If necessary, arrangements should be made for further review or counselling.

Standard 81

The follow-up appointment must include discussion of contraception.

Standard 82

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.

11. STANDARDS FOR AUDIT AND SERVICE ACCREDITATION

Standard 83
Abortion providers should regularly audit clinical service provision in terms of quality as well as access, process and outcome issues from a consumer viewpoint.

The Standards within this document can serve as criteria for audit. Some illustrative examples of audit suggestions are below:

Standard 1
DHBs must ensure all women have access to abortion services.

Audit Point:
DHBs to provide ASC with regular reporting on services provided.

Standard 11
Women should not wait longer than two weeks from time of referral to time of procedure.

Audit Point:
Waiting interval between referral and abortion.

Standard 24
All certifying consultants must:

a) *Have an 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, Diploma in Obstetrics and Medical Gynaecology, Diploma in Sexual and Reproductive Health, FRNZCGP, 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 women's health or sexual and reproductive health.*

Audit Point:
ASC to record submission of Annual Practising Certificate and qualifications of certifying consultants.

Standard 58
Cervical preparation should be routine for all surgical abortions. For first trimester abortions, misoprostol should be given 1 to 3 hours prior to theatre. The most effective routes of administration are vaginal, sublingual and buccal.

Audit Point:
Time interval between administration of misoprostol and start of surgical abortion.

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. ASC Standards of Practice for the Provision of Counselling, *Counselling Advisory Committee April 1998*
5. Guidelines for the use of Mifepristone Medical Abortion in New Zealand, *Report of a Technical Committee to the ASC, September 2004*
6. *Graph : Abortion Methods by Gestation*

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18. Technical Committee to the ASC. ASC Guidelines for the Use of Mifepristone Medical Abortion in New Zealand. Wellington: Abortion Supervisory Committee; 2004 Sep.

19. NZ Blood Service. Guidelines for the Use of Rh(D) Immunoglobulin-VF CSL Bioplasma. Wellington; 2008.