AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Chief Executive's Office
Level 1
Building 37
Auckland City Hospital
PO Box 92189
Victoria Street West
Auckland 1142
Ph: (09) 630-9943 ext: 22342
Email: ailsac@adhb.govt.nz

7 May 2020

[redacted]

Re Official Information Request – Abortion services concerning second and third trimesters

I refer to your official information request dated 22 March 2020 requesting the following information:

You have requested responses to 31 questions or sub-questions relating to second and third trimester abortion services. We have attempted to provide as full a response as possible, however some information is withheld, under section 9(2)(a) of the Official Information Act as the small numbers and/or further breakdown may lead to the identification of individual persons. This response covers DHB funded second and third trimester abortion services for Waitemata, Auckland and Counties Manukau DHBs. The DHBs do not hold information about private provision by other providers. It is understood that services are provided in the catchment by some private providers, but these are not DHB funded. Some information about these services is available in the public domain through the reports of the Abortion Supervisory Committee to which you have referred in your letter.

Responses are provided below to your questions which have been copied using your numbering system. Your questions are copied below and italicized. Our response to each question follows. Please note that we have redacted the names and contact details of staff under section 9(2)(a) of the Official Information Act to protect their privacy.

1. *Access to abortion services (surgical or medical) within the catchment area of your DHB, whether via public or private services (including but not limited to DHBs, clinics, GPs or otherwise), namely regarding:*

(a) *Whether second and third trimester abortions were available in the 12 months prior to enactment of the ALA 2020.*

Yes.

(b) *Whether there was access to abortion services sufficient to meet the demand in the 12 months prior to enactment of the ALA 2020.*

Yes.

(c) *Notification (undertaken or scheduled) to the public by the DHB about access to abortion services subsequent to the enactment of the ALA 2020.*

The following information was made available to the public through the DHBs' annual plans 2018-2019 and 2019 – 2020.

2018/19

Review and Change in Service: Termination services – Metro Auckland DHBs
Review and change service in response to the 2017 Abortion Supervisory Committee report

2019/2020

Review and change in service	Termination services Review and change service in response to the 2017/18 Abortion Supervisory Committee report	Review to determine safe, legal, equitable, women-centred services provided 'closer to home'.	Metro-regional

(d) *Whether the access to abortion services is projected to be sufficient to meet the demand for abortion services in the 12 months subsequent to the enactment of the ALA 2020.*

Yes, noting however that all services may be impacted by the health system's response and personal health issues (such as an increase in unplanned pregnancies) associated with Covid-19, and that this is beyond the DHBs' control.

2. *The identity of which entities are <u>providing</u> abortion services (surgical or medical) within the catchment area of the DHB, whether via public or private services (including but not limited to DHBs, clinics, GPs or otherwise).*

It is accepted that the DHB may not necessarily have information regarding the identity of all private entities providing abortion services; and hence this aspect of the request is limited to information held by your DHB (or able to be accessed by your DHB) about the identity of public and private providers of abortion services.

Excluding privately funded and provided abortion services, services provided

by or funded by the three DHBs include:
Waitemata DHB – medical only (surgical outsourced to ADHB)
Auckland DHB – medical and surgical (regional surgical service which is only carried out up to 19 weeks gestation)
Counties Manukau – medical only (surgical outsourced to ADHB).

3. *Provision of abortion services (surgical or medical) within the catchment area of your DHB, namely:*

(a) The number of second trimester abortions carried out in the 12 months prior to enactment of the ALA 2020 and whether such were medical or surgical abortions.

The number of medical and surgical second and third trimester abortions provided in the catchment areas of WDHB, ADHB and CMDHB is shown in the table below. Both second and third trimester data is included as there are a small number of third trimester abortions, and hence the potential for individuals to be identified. However it is noted that all surgical abortions were undertaken for gestations less than 20 weeks. There is some variation in date ranges based on information that was readily available.

	WDHB (24/04/19 – 23/04/20)	**ADHB** (2019 Calendar Year)	**CMH** (24/04/19 – 23/04/20)
Medical (note ADHB stats also include services provided to women from other DHBs)	23	63	32
Surgical (note this volume of services was delivered to women from a number of DHB catchments areas including ADHB, WDHB and CM)	0 (Outsourced to ADHB)	299	0 (Outsourced to ADHB)

(b) The number of third trimesters abortions carried out in the 12 months prior to enactment of the ALA 2020 and whether such were medical or surgical abortions.

See response to 3a.

(c) *The gestation (in weeks) of the pregnancy.*

See response in introduction regarding small numbers.

(d) *The legal grounds for the carrying out of the abortion.*

See response in introduction regarding small numbers.

4. (a) *The number of operating certifying consultants available to provide the service.*

Waitemata – 5 certifying consultants

Auckland – 15 certifying consultants, 3 operating certifying consultants

Counties Manukau – 10 certifying consultants

(b) *The age of operating certifying consultants available to provide the service. This request may be answered by reference to the age range that a consultant falls within (eg 30s, 40s, 50s, 60s years of age).*

This information is withheld as it may identify specific staff.

(c) *Where any second or third trimester abortion was not carried out, whether the DHB declined to provide such services and whether that was as a result of the unavailability of personnel.*

No.

(d) *And if so, where were the women transferred to or referred to, whether in New Zealand or Australia or elsewhere.*

Not Applicable.

(e) *Whether the abortions carried out* ***in*** *the 12 months prior to enactment of the ALA 2020 were undertaken* ***in*** *conjunction with a multi-disciplinary medical team.*

Yes.

(f) *Any projected number of second trimester abortions and third trimester abortions to be carried out in the 12 months and 24 months subsequent to the enactment of the ALA 2020.*

There is no evidence that there should be any material difference in the number of abortions pre- and post- enactment of the ALA 2020.

5. *The identity of which entities provide the resourcing of abortion services (surgical or medical) within the catchment area of your DHB, whether via public or private services (including but not limited to DHBs, clinics, GPs or otherwise).*

It is accepted that the DHB may not necessarily have information regarding the identity of all private entities resourcing abortion services; and hence this aspect of the request is limited to information held by your DHB (or able to be accessed by your DHB) about the identity of entities resourcing abortion services.

This category of request is limited to information about the identity of the providers of human resources as outlined in the next category.

Waitemata DHB – DHB staff
Auckland DHB – DHB staff and contracted specialists.
Counties Manukau – DHB staff.

6. *Human resourcing of abortion services (surgical or medical) within the catchment area of your DHB, namely regarding certifying consultants, operating doctors, theatre staff, nurses, support staff, namely:*

(a) *Whether the DHB had sufficient staff (whether employees, contractors or otherwise) to meet the demand in the 12 months prior to enactment of the ALA 2020.*

Yes.

(b) *Whether in the 12 months prior to enactment of the ALA 2020 the DHB seconded staff or personnel to or from other providers of abortion services to meet that demand.*

No.

(c) *Whether the DHB will have sufficient staff (whether employees, contractors or otherwise) to meet any projected demand in the 12 months and 24 months subsequent to enactment of the ALA 2020.*

The DHBs are obliged to ensure abortion services are available, and hence will, as with any other service, aim to have sufficient staff whether employees or contracted providers.

7. *The identity of which entities (whether Ministries or Departments or otherwise) are funding abortion services (surgical or medical) within the catchment area of your DHB, whether via public or private services (including but not limited to DHBs, clinics, GPs or otherwise).*

It is accepted that the DHB may not necessarily have information regarding the identity of all private entities funding abortion services; and hence this aspect of the request is limited to information held by your DHB (or able to be accessed by your DHB) about the identity of entities funding abortion services.

Since the enactment of the new legislation, the District Health Board is the only funder. Funding comes from baseline funding.

8. *Funding abortion services (surgical or medical) within the catchment area of your DHB, namely:*

   (a) Whether second and third trimester abortions were funded by the DHB in the 12 months prior to enactment of the ALA 2020.

   Yes.

   (b) Whether second and third trimester abortions will be funded by the DHB in the 12 months subsequent to enactment of the ALA 2020.

   Yes.

8. *Since 1 December 2017 any Ministry of Health advice (or by any other Ministries or Departments or otherwise) to your DHB regarding access to, or provision of or funding of surgical or medical abortion services*

As this question relates to the functions of the Ministry of Health, they have offered to answer this question on our behalf. If you require follow up, please contact the OIA Coordinator from the Ministry of Health at oiagr@health.govt.nz.

9. *Since 1 December 2017 any advice by the DHB to the Minister of Health regarding access to, or provision of or funding of surgical or medical abortion services throughout New Zealand and the particular area for which your DHB is responsible.*

The Waitematā DHB funder, on behalf of the metro Auckland DHBs, has verbally advised the Ministry of Health relationship manager of plans to undertake a review of abortion services.

Advice is contained in the Annual Planning documentation referred to above.

10. *The DHB's policies, stance or advice regarding conscience objections regarding abortion services, whether by any medical health practitioner, employee, contractor or otherwise.*

Please refer to the attached DHB policies.

11. *Since 1 December 2017 any DHB review of its policies, stance or advice regarding conscience objections regarding abortion services, whether by any medical health practitioner, employee, contractor or otherwise.*

The Auckland DHB policy (attached) has been reviewed since 2017 and a revised policy was circulated for approval. It has not been finalised at the date of the law change and will require further review in light of the new legislation.

12. *Since 1 December 2017 any DHB review of or consideration of steps taken or steps to be taken to manage, respond to or implement the enactment of the ALA 2020, namely regarding:*

(a) The new conscience objection provisions.

(b) The new wider lawful access to abortion services.

(c) Providing abortion services in response to the new wider lawful access.

(d) Human resourcing abortion services in response to the new wider lawful access.

(e) Funding abortion services in response to the new wider lawful access.

The metro Auckland DHBs undertook a review of abortion services. This review was undertaken in part in preparation for legislative reform. Steps within relevant services to enact any changes required under the law change are underway however, given the changes were passed before the level 4 lockdown further consideration hasn't been given to all of the aspects you have mentioned above.

As a response to this review, a procurement process is likely to be undertaken in support of the new model of care possible under the new legislative framework. The detail of this process is not yet complete, but will be notified through the Government Electronic Tendering Services (GETS). This is specific to first trimester services only.

Under the old legislation, the Ministry of Justice funded the certifying consultants who tended to be General Practitioners. ADHB has taken steps to ensure that these certifying consultants can continue their work for ADHB in the absence of Ministry of Justice funding.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive

Conscientious Objection relating to Termination of Pregnancy

Unique Identifier	PP01/STF/102 – v03.00
Document Type	Clinical Guideline
Risk of non-compliance	may result in significant harm to the patient/DHB
Function	Clinical Practice, Patient Care
User Group(s) • Organisation(s) • Directorate(s) • Department(s) • Used for which patients? • Used by which staff? • Excluded	Auckland DHB only Auckland District Health Board All directorates As above All registered medical practitioners, registered nurses or midwives or other persons performing or assisting in the performance of a termination of pregnancy in Auckland DHB.
Keywords	
Author	SCD - Regional Gynaecology Day Services
Authorisation • Owner • Delegate / Issuer	 Chief Medical Officer Director – Women's Health
Edited by	Clinical Policy Facilitator
First issued	01 September 2007
This version issued	18 January 2019 – updated 18 January 2019 – reclassified from PP01/STF/074
Review frequency	3 yearly

Contents

1. Purpose of guideline

Auckland District Health Board (Auckland DBH) respects a woman's decision to have a termination of pregnancy in compliance with legislative requirements (Crimes Act 1961, The Contraception, Sterilization and Abortion Act 1977). Auckland DHB also respects the rights of staff to refuse, on the grounds of conscience, cultural, religious or moral objection, to perform or assist in the performance of a termination of a pregnancy (see s.46 Contraception, Sterilization and Abortion Act 1977).

2. Definitions

The following terms are used within this document.

Term	Definition
Abortion or (termination of pregnancy)	The definition of Abortion, as per the Contraception, Sterilization, and Abortion Act 1977. A medical or surgical procedure carried out or to be carried out for the purpose of procuring: • The destruction or death of an embryo or fetus after implantation; or • The premature expulsion or removal of an embryo or fetus after implantation, otherwise than for the purpose of inducing the birth of a fetus believed to be viable or removing a fetus that has died:"
Core function	A work activity: • Of a type anticipated at the time the individual was employed in their present role; and • From which it is not reasonably practicable for ADHB to excuse employees in the individual's position.
Staff	'Staff' includes students, volunteers and contractors covered by the policy.
Performing or assisting in the performance of a termination of pregnancy	"Performing or assisting in the performance of an termination of pregnancy" is defined below in the section 4 Roles and responsibilities

3. Staff rights and obligations

3.1 Staff rights and obligations in relation to termination of pregnancy

Staff who conscientiously object, do not have to perform or assist in the performance of a termination of pregnancy.

Note: Staff employed in a role, where performing or assisting with termination of pregnancy is a core function, will have been employed on the basis that they are willing and able to do so.

Staff must inform their employer of their conscientious stance relating to termination of pregnancy as soon as practicable after they become aware that as part of their clinical role they may be asked from time to time to assist in the performance of a termination of pregnancy in order for the employer to ensure a safe and appropriate service can be maintained.

Staff may change their views relating to termination of pregnancy, but must inform their employer of this change as soon as practicable.

Staff must record any conscientious objection on the Staff Declaration in Relation to Termination of Pregnancy (contact askHR for a copy)

3.2 Emergency situations

Staff who conscientiously object to performing or assisting in the performance of a termination must, along with other staff, assist in the event of an emergency during a termination of pregnancy. Emergency intervention is for the mothers benefit rather than for the purpose of procuring the termination of pregnancy. Ongoing emergency intervention should not be used to facilitate the abortion where the staff involved object

3.3 Recruitment and employment

No staff member can be denied employment solely on the grounds of their conscientious objection towards termination of pregnancy. However application for a role where assisting in terminations of pregnancy is a core function by necessity indicates the applicant does not conscientiously object.

When assisting in terminations of pregnancy is a core function of the position being applied for the applicant must be informed of this and should be informed that willingness to undertake these functions is a requirement for the position. The candidate should be asked to confirm their willingness to undertake the position functions.

For staff (nurses, midwives, medical or allied health workers) who, it is anticipated, may be involved in the provision of a termination of pregnancy service but for whom it is not a core function, at interview, the interviewer must discuss with them what termination of pregnancy services are/may be provided by that unit. The right of staff to conscientiously object and what this relates to must also be discussed.

For other staff for whom involvement of provision of TOP services is not anticipated, it is not necessary to specifically raise the question of conscientious objection.

4. Roles and responsibilities

4.1 Performing or assisting in the performance of a termination of pregnancy

Staff who conscientiously object to participating in a termination of pregnancy may decline to be involved in any or all of the following:

- The administration of any medication and/or insertion (or assistance with an insertion) of a device that will procure a termination of pregnancy.

- Performing or assisting in the performance of a surgical procedure that is undertaken to terminate a pregnancy or will have the likely effect of terminating a pregnancy.
- Immediate pre and post-operative care necessary for the termination of pregnancy procedure, for example giving sedation or assisting in recovery.
- In relation to a 'medical termination of pregnancy', the termination of pregnancy is considered to commence with the administration of medication and/or insertion (or assistance with an insertion) of a device that will procure a termination of pregnancy and will cease once the embryo/fetus and placenta are delivered.
- Obtaining consent for a termination of pregnancy and/or any directly associated counseling

Assisting in the performance of a termination of pregnancy does not include services provided prior to, or following, the medical or surgical procedure intended to terminate pregnancy.

For example:

- Escorts to scanning
- Treatment of post procedure complications.
- Referrals as appropriate to internal and external agencies.
- Meal Deliveries
- Purchase of equipment

5. Staff declaration relating to termination of pregnancy

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Staff declaration stating conscientious objection to termination of pregnancy (TOP)

Name: _____

Position: _____ **Date:** _____

This declaration records any conscientious objection to performing or assisting in the performance of a termination of pregnancy. It should be read together with the ADHB policy *Conscientious Objection Relating to Termination of Pregnancy*. The declaration, if required, should be completed at the commencement of employment and forwarded to the staff member's line manager. It is the responsibility of the staff member to keep the information up to date. This form shall be stored on your personal employment file for the sole purpose of indicating your stance, and a copy shall be retained in the unit to assist with clinical planning.

Note:

- Where involvement in termination of pregnancy is a core function of a staff member's position they will have been employed on the basis that they do not object and are able to carry out those functions.
- Staff must assist in the event of an emergency during a termination of pregnancy regardless of conscientious objection. Emergency intervention is for the mother's benefit rather than for the purpose of procuring the termination of pregnancy.

Please identify the relevant circumstances in which you object to assisting in the performance of a termination of pregnancy.

(e.g All TOPs, TOPs for reasons other than fetal abnormality, or TOP in 2nd or 3rd trimester)

_____

_____

_____

_____

6. Legislation

- Contraception, Sterilization and Abortion Act 1977
- Crimes Act 1961

7. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

8. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.

Guideline: Referral Pathway and Management of Termination of Pregnancy for Women Residing in and/or Booked to Birth in the Counties Manukau Health Facilities.

Purpose

The purpose of this guideline is to promote consistent evidence, a care pathway and legal based care for pregnant women for whom termination of pregnancy (TOP) may be an option.

Responsibility

All Medical staff, Registered Midwives, Nurses, Social Workers caring for pregnant women in Counties Manukau Health (CM Health).

CM Health recognises and accepts that staff may exercise their right to conscientiously object to being involved in TOP procedures.

Guideline

1. Background

1.1 Termination of Pregnancy in New Zealand is governed by section 187A of the Crimes Act 1961.

1.2 When considering and assessing a woman for TOP, patients should be made aware that certain legal, as well as clinical, requirements must be met before a TOP can be offered as an option.

1.3 Under 20 weeks gestation TOP can be considered if continuing the pregnancy would result in serious danger to the life, or to the physical or mental health of the woman,
OR
If there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped

1.4 From 20 weeks gestation, consideration of a TOP may be indicated when there is a pre-existing maternal medical or psychiatric health condition that poses a serious risk of death or serious permanent injury to the physical or mental health of the mother or such a condition will arise if the pregnancy continues. This may in some cases include situations where there is a fetal abnormality but it is important to remember that a TOP can only be lawfully performed when all the legal requirements are met and the existence of a fetal abnormality alone does not meet the legal criteria after 19+6 weeks gestation.

2. Referral pathway by gestation when there is no associated fetal abnormality:

2.1 Prior to 13 weeks gestation:

Direct referral from primary care to Epsom Day Unit (EDU), Greenlane Hospital, Auckland.

2.2 From 12 weeks and 6 days to 17 weeks and 6 days gestation:

- Primary Care referral to Counties Manukau Fetal Medicine Service (CMFM) for Social Worker consultation including an interpreter if English is not the woman's first language.
- Assessment of mental state and acute referral to psychiatric crisis team if acute risk identified (see Appendix 1 for the process).
- Referral to EDU if TOP is still requested.

2.3 From 18 weeks to 21 weeks and 6 days gestation:

- Primary care referral to CMFM service for Social Worker consultation
- Assessment of mental state and acute referral to psychiatric crisis team if acute risk identified (see Appendix 1 for the process).
- If no acute risk identified, and a TOP is still requested, referral should be made to the first certifying consultant at CM Health (an up to date list of certifying consultants is held by the CMFM service).
- Referral for a psychiatric assessment may be considered necessary by the first certifying consultant (see Appendix 1 for the process)
- The first certifying consultant is responsible for referring to the second certifying consultant and for arranging the procedure if both agree. Referral to a third certifying consultant may be required if a consensus is not achieved.
- Use of an interpreter should be considered when English is not the woman's first language.
- The patient should be advised that organising a TOP is a process that involves several steps and that the procedure can only be performed if two certifying consultants agree that the legal criteria are met.
- See below for the process.

2.4 From 22 weeks gestation and beyond

- As for 18 weeks to 21 and 6 days gestation (see 2.3 above).
- Discussion with the woman that feticide is part of the process and what this entails.

3. Referral pathway when there is an associated fetal abnormality at all gestations

- Referral to CMFM service from primary care.
- Confirmation of the fetal abnormality determined and a second opinion sought from another CMFM Obstetrician if required.
- Identification of the prognosis. This may require assistance from a neonatologist or other specialist/sub-specialist. This discussion should occur not only in a timely manner, but also allowing the patient time to understand the situation and given an opportunity to ask questions. All of this may require additional appointments to be arranged which should, again, occur in a timely fashion. It may also require use of an interpreter if English is not the woman's first language.
- Identifying the consequences of the diagnosis / prognosis and particularly any impact on the physical and mental health of the mother may require specialist psychiatric input. (See Appendix 1 for the referral process).

- Explanation of the various options that the patient has, including the pros and cons of the options. If TOP is chosen, discussion should include the aspect that feticide is required as part of the process if gestation is 22 weeks or greater.
- Referral to CMFM Social workers for counselling should be offered to all women those continuing with the pregnancy and those contemplating TOP.
- If TOP is the chosen option the patient should be advised that organising a TOP is a process that involves several steps and that the procedure can only be performed if two certifying consultants agree that the legal criteria are met. They should also be advised that timing will depend on safe staffing levels being available to provide the care and support they will require.

4. If TOP is the considered option and this is to occur through CM Health (this includes all TOPs 18 weeks and beyond and all TOPs for fetal abnormality).

The following steps should ordinarily be taken:

4.1 Discussion should take place between the Obstetrician (first certifying consultant) and the counsellor to confirm that there are no social or other circumstances that may not fit the criteria or any indications that the patient could be being coerced into this by another party.

4.2 If the patient wishes to proceed with a TOP, and the legal criteria are met, the first certifying consultant should sign the Abortion Supervisory Committee (ASC) form and

4.3 The first certifying consultant then to arrange for the second certifying consultant to separately interview the patient before signing the ASC form. If the certifying consultants do not agree, they should complete the appropriate part of the ASC form and refer for a third opinion.

4.4 **The first certifying consultant, or their delegate should:**

- Provide verbal and written information explaining the following:
  - The termination procedure.
  - That when the gestation is **22 weeks gestation or greater,** that feticide is part of the process. Discussion should include what this entails. (*In the rare case when the patient declines feticide (for psychiatric reasons) an individual management plan, involving all relevant Health Practitioners, should be made. Discussion with the patient is also needed that if a viable baby with a survivable condition is delivered, the Health Professionals may have a duty of care to resuscitate the baby and that the neonate may live. The principles the health professionals will follow are as any other situation of a baby of the same gestation. (Refer to Neonatal Unit guideline Kidz First Neonatal Unit Management of Pregnancies at Borderline Viability).*
  - What pain relief is available
  - The associated risks which include: a retained placenta, infection and post-partum haemorrhage (both primary and secondary).

- When the TOP is for fetal abnormality:
  - Discuss all the investigations that may be required and provide clear documentation for staff to follow through.

- Discuss fetal post mortem and its usefulness for the specific abnormality. If the patient declines, alternative investigations that may help to confirm diagnosis and assess recurrence risk for the next pregnancy should be discussed

- Ensure the woman is booked as a CM Health patient – all necessary documentation should be completed and Lead Maternity Carer (LMC) informed. Community midwifery care should be arranged if she does not have an LMC.

- **Discuss and arrange procedure, timing and place of admission based on gestation**:

  Up to 19 weeks and 6 days gestation: discuss with the Charge Nurse on the Gynaecology Care Unit (GCU) regarding the timing of induction prior to administration of Mifegynae. Unless circumstance dictates otherwise, admission should be restricted to Monday through to Thursday.

  From 20 weeks gestation to 21 weeks and 6 days: discuss with the Birthing & Assessment (B&A) Charge Midwife (CMW) or Midwife Manager responsible for B&A North regarding timing of induction prior to administration of Mifegynae. Unless circumstance dictates otherwise admission should be restricted to Monday through to Thursday. Maximum of two TOP patients in any one week – CMW must consider any intrauterine deaths (IUD) already booked/ in labour (unless safety issues override). Once the admission time is arranged CMW should notify ward clerks of patients date and time of admission. This can be recorded on their pink list at B&A reception desk.

  From 22 weeks onwards: as for 20 weeks, above, but also to arrange feticide with CMFM specialists.

- Confirm ASC forms including ASC3 have been signed and sent to the Obstetrics and Gynaecology (O&G) Service Manager.
- Obtain written consent for Misoprostol.
- Chart the Mifepristone and Misoprostol as per the guideline on a drug chart. If any variations are planned, an explanation should be given for the reason.
- Confirm that the patient knows when and where to be admitted.
- Discuss what to expect post-delivery including when it is appropriate to see the GP and/ or LMC.
- CMFM follow up is recommended for TOPs performed for fetal reasons.
- Suppression of lactation offered if appropriate.
- Liaison with the CMFM Midwife
- Discuss involvement of the Bereavement Care Team service.
- Discuss disposal of pregnancy tissue and document clearly in the patient's notes.

Link to the pamphlet Medical Management for Termination of Pregnancy
Medical Management for Termination of Pregnancy

References

Section 187A of the Crimes Act 1961.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
TOP	Termination of Pregnancy
ADHB	Auckland District Health Board
NNU	Neonatal Unit
ASC	Abortion Supervisory Committee
CMW	Charge Midwife

Associated Documents

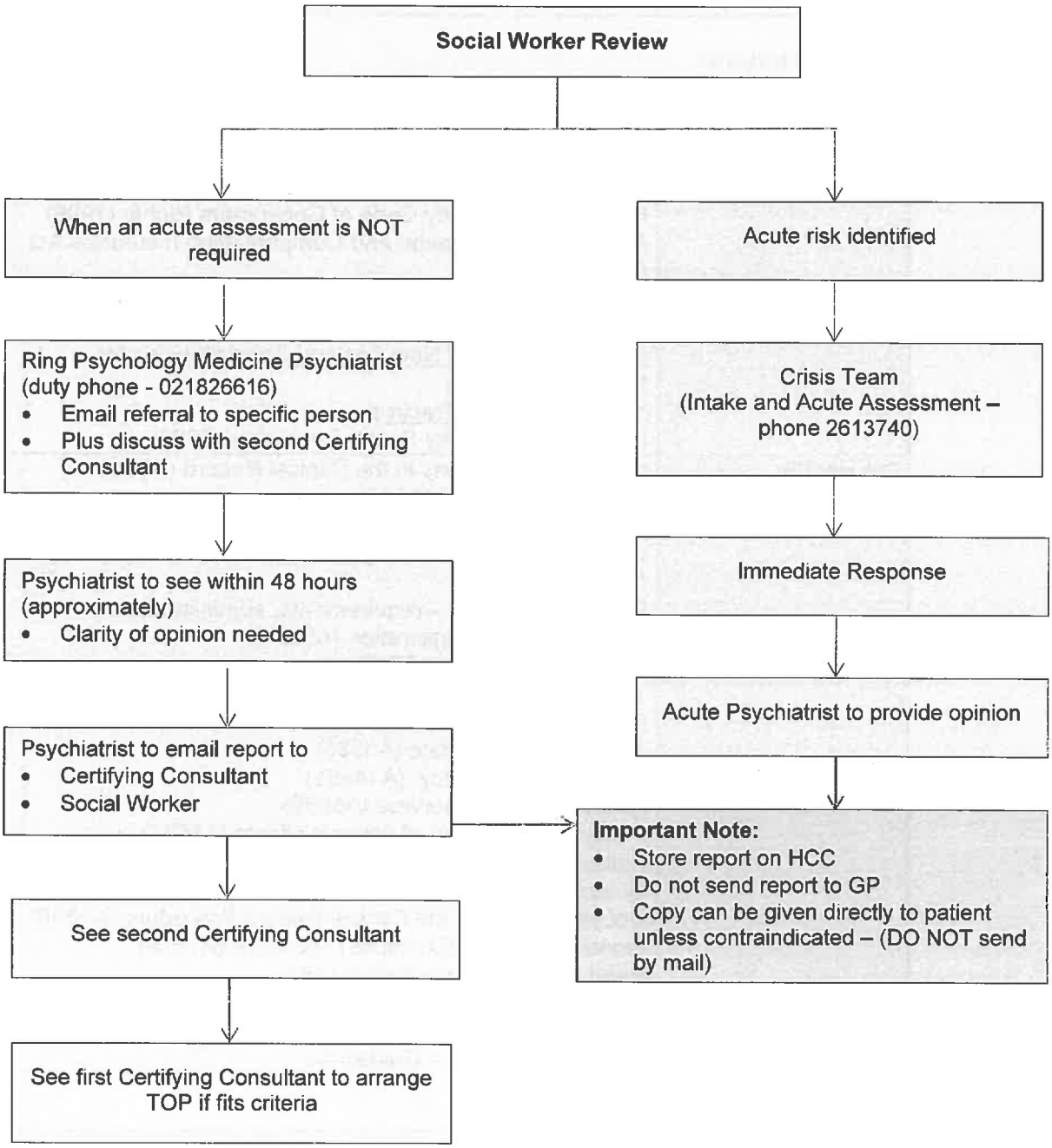
Other documents relevant to this guideline are listed below:

NZ Legislation/Standards	Health Practitioners Competency Assurance Act (2003) Privacy Act (1993) Health Information Privacy Code Revised (2008) Health and Disability Code of Consumers Rights (1996) Accident Rehabilitation and Compensation Insurance Act (1992) Humans Right Act (1993) Official Information Act (1982) Nursing Council of New Zealand Competencies for Registered Nurses Nurses Scope of Practice Health and Disability Sector Standards (2008)
CM Health Documents	Use of Abbreviations in the Clinical Record (A5540) Informed Consent (A5528) Informed Consent (Children and Youth) Policy (A5529) Standing Orders for Delegated Medical Authority Policy (A7344) Policy; Medication – requirements, administration, certification and registration (A5554) Smokefree Policy: (A5746) The Safe Management and Privacy of Health Information Policy (A5548) Tikanga Best Practice (A5535) Hand Hygiene Policy (A14551) Policy Clinical Observers (A5536) Policy: Identification of patients/clients (A5564) Policy: Refusing Treatment (A5531) Nurse Credentialing Guideline(A2560) Documentation in the Clinical Record Procedure (A7359) Blood Body Fluid Exposure Procedure (A7599) Hand Hygiene Procedure (A7385) Standard Precautions Procedure (A5587) Kidz First Neonatal Unit – Management of Pregnancies at Borderline Viability - Guidelines
Other related documents	None

Appendix 1

CM Health Referral Pathway for Psychiatric Consultation for Women Considering TOP

No acute risk identified
Referral to first certifying consultant.
If first or second certifying consultants request psychiatric input



Request for second trimester termination of Pregnancy (13-20 weeks gestation)

Contents

1. Overview

1.1 Purpose

The purpose of this document is to provide the Social Worker(s) employed by Waitemata District Health Board (WDHB) Maternity Services with a process for managing requests for termination of pregnancies between 13 – 20 weeks gestation

1.2 Scope

The scope of this document extends to the Social Workers employed by Maternity Services, Women's Health at North Shore and Waitakere Hospitals.

Request for second trimester termination of Pregnancy (13-20 weeks gestation)

1.3 Associated documents

Type	Description
Legislation	Contraception, Sterilisation, Abortion Act 1977
Legislation	The Crimes Act 1961
Legislation	The Care of Children Act 2004 s.38

2. Background

The process for termination of pregnancies is carefully legislated for under the Contraception, Sterilisation, Abortion Act 1977 s.10 – 46 and the Crimes Act 1961 s.182 -187a and is regulated by the Abortion Supervisory Committee under the Department of Justice. Terminations can only occur if two certifying Consultants agree that all criteria are met.

WDHB provides funding for second trimester surgical terminations of pregnancy (STSTOP) greater than 12+6 weeks gestation and has a contractual arrangement with three licensed private Gynaecologist listed in section 3 below to perform this procedure in the Epsom Day Unit (the regional termination provider) at Greenlane Clinical Centre.

WDHB offers pre-decision counselling by trained women's health Social Workers to women referred to their service by health professionals.

3. Licensees

Consultants who are licensed by the Abortion Supervisory Committee who perform a STSTOP in the Auckland District Health Board region are as follows:

[redacted]
Mobile: [redacted]
Fax: [redacted]
Email: [redacted]

[redacted]
Phone: [redacted]
Mobile: [redacted]
Fax: [redacted]
Email: [redacted]

[redacted]

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Phone: [redacted]
Mobile: [redacted]
Fax [redacted]
Email: [redacted]

4. Eligibility for referral for consideration of second trimester surgical termination of pregnancy (≤17+6/40 gestation)

4.1 Referral criteria

Women being referred for consideration of STSTOP must meet the following criteria

- Their gestation should be ≤ 17+6 weeks gestation (as per USS report) at the time of proposed STSTOP
- They must reside at an address in the WDHB region otherwise re-direct the referral to the appropriate DHB
- They must be eligible for publically funded healthcare in New Zealand as set out in the WDHB policy "Eligibility for Publicly Funded Healthcare"
- If they do not meet the eligibility criteria for a public funded STSTOP, they can make payment arrangements in advance of the procedure either to the DHB or to the operating surgeon.

5. Referral

5.1 Access for referral

Women who meet the eligibility criteria for surgical termination should be referred to the Maternity Social Workers at North Shore by a registered health professional.
If a self- referral is made to the Social Worker, then only pre-decision counselling can be offered. If the woman wishes to proceed then she must see a registered health professional to make a referral with accompanying test results and ultrasound report to be provided.

Note: Referrals should be faxed to Women's Health Social Worker with the following information.

5.2 Details required on referral

The following details are required on the letter from the referring health professional:

- Full name of patient including aliases
- NHI number
- Full address
- Contact phone number
- Number of weeks gestation.
- Any relevant obstetric information e.g. previous caesarean sections.

The following test results must be included in the referral letter:

- Ultra sound scan report including accurate gestation
- First antenatal bloods including Full Blood Count, Blood Group, Hep B status, Rubella immunity status and Syphilis
- HIV status (*If time pressured, it is possible to get the HIV test done in Hospital by Blood Service by Outpatients. Web Éclair will show results.*)
- Vaginal & Chlamydial Swabs

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Note: Emphasise to referring health professional that without these results the woman cannot be referred for consideration of STSTOP and the STSTOP cannot be done unless an exceptional circumstance exists and is agreed to by the operating surgeon. Results need to be at least one day clear of the date the Doctor is planning to seeing the patient for their first appointment.

5.3 Confirmation of receipt of referral

On receipt of the referral, the Social Worker will advise the referring health professional that the woman will be contacted to arrange a meeting for pre-decision counselling.

6. Process for arranging pre-decision counselling and for booking the appointment for consideration of STSTOP

The table below describes the process for making appointments with the Licensed Consultants in the Epsom Day Unit at Greenlane Clinical Centre.

Step	Action
1	**Check referral letter and investigations from referring health professional** • Check patient's current pregnancy gestation and status from her ultrasound report. • Ensure all the test results listed in section 6.2 have been received or that these have been done and results are pending. • Register new out-patient booking onto PIMS • Check residency status and eligibility for funded healthcare as stated in section 4.1 • Check ability to speak and understand English language remembering that medical information can be difficult to understand. If an interpreter is required make arrangements through WATIS for appointments at North Shore Hospital and Greenlane Clinical Centre.
2	• **Contact Greenlane Clinical Centre** to make an appointment as soon as possible on ph. [redacted] (Advise of Interpreter arrangements)
3	The Licensed Consultants have set times to see women at Epsom Day Unit for their first appointment. These appointments cannot be negotiated. • [redacted] - Thursday afternoon • [redacted] - Thursday evening • [redacted] - Thursday evening
4	**Phone the woman to arrange a time to meet for pre-decision counselling** • Advise the woman that counselling is her option prior to an abortion to assist her with an exploration of her decision making and or choices. • If she agrees, negotiate a suitable time and place to meet. The woman may bring a support person and be advised to allow approximately an hour for this appointment. • If she is unable to meet, then offer a phone interview when convenient to her taking into account her privacy and safety. Subsequent to a phone interview, send written information sheet to an agreed address or email this to her if requested. **Note:** See Appendix 1 for the patient information leaflet
5	**Meet the woman at the pre-arranged time for pre-decision counselling**
6	Complete the Surgical Termination Assessment Tool **Note:** See Appendix 2 for the Surgical Termination Assessment Tool
7	**Explain the Social Work role in this STSTOP process:** • It is not a Social Work decision regarding meeting the criteria for termination of

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	pregnancy.
	• Two certifying Consultants must consider each case and issue a certificate when authorized.
	• This is a legal/medical process and where legal criteria for a termination over 12 weeks and 6 days must be met as set out in the Contraception, Sterilisation, Abortion Act 1977 s.32 and the Crimes Act 1961 (as amended) where a pregnancy is not more than 17+6 weeks. Refer to Crimes Act s.187A – s.187A(1)(a), s.131A), s.187A(1)(aa), s187A(1)(b), s.187A(1)(c), and s.187A(d) within the meaning of s.138 (2) of the Crimes Act.
	• The grounds for abortion as detailed in the Crimes Act 1961 include:
	  • Serious danger to life
	  • Physical or mental health of the woman
	  • Any form of incest or sexual relationship with a guardian
	  • Mental sub-normality
	  • Fetal abnormality when the pregnancy is less than 17+6 weeks
	  • Extremes of maternal age or sexual violation may be taken into account but are not in themselves grounds for abortion

8	**Make sure they are meeting one of the eligibility criteria above.** • Check what support the woman has and explore her reasons for not being able to continue with this pregnancy. **Note:** Women are often very anxious and guarded, but will talk a lot more openly once they understand why this information is needed and that it will be treated respectfully and confidentially unless there is a risk to her personal safety.
9	**Discuss contraception failure (if applicable) and alternatives available – see Contraception – Your Choice (Family Planning)** • Doctors performing the STSTOP can assist with future contraception requirements which can be discussed at the first appointment. • If a Tubal Ligation is requested, explain that the licensed consultant will not be able to do a Laparoscopic Sterilisation at the same time as the termination. The patient must see her GP and be referred to Gynaecology Outpatients for discussion and booking of a Laparoscopic Sterilisation
10	**Check if the woman has a support person** who may know about her pregnancy and could go with her to her appointments and drive her home following her procedure on Friday.
11	**STSTOP Patient information leaflet** Go through the information sheet with her and • Explain the steps of the procedure. • Reassure the woman that she will be given medication for pain management and good anaesthetic care • Explain that they will not be able to drive home or for 24 hours after STSTOP procedure performed on Friday morning.
12	**Reflect the loss of the pregnancy** • Acknowledge that this is a pregnancy loss and there may be mixed feelings of sadness, sometimes guilt, sometimes disbelief. • Explore ways of saying goodbye to the baby if this seems appropriate and talk about self-care, forgiveness if there is spiritual reflection. • **This can be a time of revisiting the woman's decision-making. Advise women that if they are uncertain, they can change their minds and cancel their appointment. You may explore options more at this time or arrange another appointment with you.** • Invite the woman to ring after the termination for post abortion reflection. Provide

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	contact details in the handout leaflet with written details of appointments.
13	**Write a report for the Licensed Consultant** Following the pre-decision counselling appointment, write a small report to the licensed consultant explaining how you believe the criteria of a STSTOP is being met. This report indicates WDHB agreement for funding of the procedure unless otherwise indicated.
14	**Fax this report with ALL the required results to the appropriate Licensed Consultant** as per the address list or to the Gynaecological Booking Clerk at Day Surgery at Greenlane Clinical Centre. The Booking Clerk co-ordinates the whole process at GLCC including theatre space allocation. For [redacted]: **Fax:** [redacted] **Phone:** [redacted] **For** [redacted]: **Fax:** [redacted] **by Wednesday 1200**
15	**If an interpreter is required,** arrange this through WDHB Interpreter Services before the 1st appointment with the licensed Consultant on Thursday and for the procedure on Friday. **Note:** Make sure that the woman is aware that this has occurred. This is a very sensitive situation and some women feel their privacy could be breeched through an interpreter
16	**Any outstanding test results must be sent through to the appropriate Licensed Consultant on Wednesday morning**. If the results are going to be any later, suggest to the referring health professional that these are to be sent directly to the Licensed Consultant or make arrangements with the Booking Clerk at GLCC in urgent situations (i.e.: when the woman will not be able to have a STSTOP the following week due to her gestational age)

7. Process for second trimester surgical termination of pregnancy

These terminations are done at Greenlane Clinical Centre by surgical dilatation and evacuation method under intravenous sedation and pain relief or general anaesthetic.

7.1 1st medical appointment - outpatient

The licensed Consultant will see women at Epsom Day Unit, on Level 5 at Greenlane Clinical Centre (GLCC) for their first medical appointment. This appointment will last approximately 30 minutes.

During the first appointment the doctor will explain the procedure and it's risks and will talk about the reasons behind the woman's decision to request termination of her pregnancy.

Following this appointment, two certifying consultants must be satisfied that all legal and medical criteria are met in accordance with Section 32 of the Contraception, Sterilisation, and Abortion Act 1977.

When satisfied with criteria being met, then an examination and physical preparation for the procedure will commence.

7.2 2nd medical appointment - outpatient

Women are then required to return on Friday morning to the Short Stay Surgical unit on level 2 of GLCC for the STSTOP procedure and can expect to remain in the Unit for approximately three hours from time of arrival to discharge home.

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8. Request for second trimester termination of pregnancy from 18 - 20 weeks gestation

Surgical termination of pregnancy will not be agreed to from 18 to 20 weeks gestation by the above three Consultants despite the law permitting abortion up to 20 weeks.

Women requesting a termination of pregnancy between 18 and 20 weeks gestation must be advised that they may wish to consider going to Australia for a surgical termination at their own expense.

If however there are serious mental health risks or physical abnormalities identified for the in-utero baby then a referral should be made to ASC licensed WDHB O & G Consultants: [redacted] for discussion. They can consider offering a medical termination at North Shore Hospital. **Refer to the WDHB Medical Termination of Pregnancy policy.**

9. Age of applicant

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:

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

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."*

10. 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. Section 174 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) states

"1 (a). A person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilization or other reproductive health services; and
1 (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."

The New Zealand Medical Association has 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.

11. Booking a pregnancy failure (≤17+6/40 gestation) for surgical evacuation of the uterus using one of the private Licensees

On occasion women present with a second trimester fetal demise (miscarriage) and prefer surgical evacuation to medical induction of labour. This same process can be used to book these women to have surgical treatment by the above named licensees.

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12. Booking a fetal abnormality (≤17+6/40 gestation) for surgical evacuation of the uterus using one of the private Licensees

On occasion women present with a second trimester fetal abnormality and prefer surgical evacuation to medical induction of labour. This same process can be used to book these women to have surgical treatment by the above named licensees.

13. References:

1	Standards of Care for Women requesting induced abortion in New Zealand – October 2009
2	Eligibility for Publically Funded Healthcare
3	Contraception- Your Choice Information (familyplanning.org.nz)
4	WDHB MTOP in the 2nd & 3rd trimester policy
5	WDHB Patient Information leaflet for
6	WDHB Social Worker Surgical termination Assessment tool

Appendix 1: Patient Information Leaflet

Having a second trimester surgical termination of pregnancy

Appendix 2: Social Work Surgical Termination Assessment Tool

Second trimester surgical termination of pregnancy - Assessment Tool