S&RH NZ COLLEGE OF SEXUAL & REPRODUCTIVE HEALTH

MODULE 1

Consultation – communication and decision making

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MANATŪ HAUORA MINISTRY OF HEALTH

Health New Zealand Te Whatu Ora

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1. LEARNING OBJECTIVES AND MODULE OVERVIEW

Learning objectives

After completing this module, you will:

1. Be informed about current abortion legislation in Aotearoa New Zealand, patient rights and the professional regulations and guidelines prepared for abortion providers
2. Have explored and considered means of providing effective patient-centred care as an abortion provider in Aoteoroa New Zealand; ensuring people are treated in a culturally safe manner, with dignity and respect, and are partners in the decision-making process
3. Be able to establish the gestation and location of pregnancies and determine any factors that may impact on the choice of abortion method
4. Be prepared to communicate effectively with people requesting abortion, including rangatahi (youth), Māori, Pacific, disabled people, diverse sexual orientation, gender identity, gender expression and sex characteristics people (SOGIESC) and whānau members, about pregnancy options including abortion procedures and the abortion process as well as contraception options.

Module overview

This module is made up of four parts:

1. The first provides an outline of abortion law in Aotearoa New Zealand, patient rights and the professional standards and guidelines prepared for abortion providers, and the use of telehealth in the abortion setting. Making a decision about an unintended pregnancy, and the abortion process itself, may be a distressing and difficult experience for the pregnant person. It is very important that healthcare providers meet their obligations under Te Tiriti o Waitangi and the Code of Health and Disability Services Consumer's Rights to ensure that people are treated in a culturally safe manner, with respect and dignity, effective communication, and as partners in the decision-making process.

2. The communication section in this module provides a brief outline of tikanga in abortion care, cultural safety considerations and issues in abortion care for people with disabilities

3. The third section of this module provides details of the pre-abortion assessment, which includes taking a detailed medical history and determining the gestational age

4. The final part of this module outlines the shared decision-making process; for the pregnancy outcome, abortion options and sexually transmitted infections (STI) screening and contraception decisions

2. ABORTION IN AOTEAROA NEW ZEALAND

Meeting Te Tiriti obligations to Māori

The NZCSRH recognises and respects Te Tiriti o Waitangi as Aotearoa New Zealand's founding document, which captures the fundamental relationship between the Crown and Iwi. In doing so, we commit to the intent of Te Tiriti o Waitangi that established Iwi Māori as equal partners alongside the Crown and its agencies. We prioritise health gain for Māori based on the rights that Māori hold as tangata whenua. A major objective during the development of this abortion training programme has been to identify ways to meet Tiriti obligations when providing abortion health care.

Understanding Te Tiriti o Waitangi

Recent teachings on Te Tiriti have moved away from the three "Ps" (partnership, participation and protection) to a broader and deeper understanding of what Te Tiriti o Waitangi means in both historic and contemporary settings. This is influenced by the Waitangi Tribunal findings of Wai 2575 and its recommendations for achieving equitable health in Aotearoa. NZCSRH expects health care practitioners to have up to date knowledge of the interpretation of the articles of Te Tiriti o Waitangi. When health care practitioners understand how pre-colonial Māori lived, the influence of colonisation and the tools/laws that were used to systematically dilute mātauranga Māori (Māori knowledge), it is easier to understand why there are such disparities and inequities in health in Aotearoa New Zealand. This is particularly important in relation to pre-colonial and post-colonial attitudes to abortion and its impact on Māori. Understanding Te Tiriti o Waitangi and applying this to our individual roles is central to achieving health equity.

The impact of Wai 2575

The Waitangi Tribunal report Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, Waitangi Tribunal 2019) found that the existing primary healthcare framework did not meet the Crown's obligations under Te Tiriti o Waitangi and was failing Māori, who experience severe health inequities. One of the primary purposes of the Pae Ora (Healthy Futures) Act 2022 is to strive to eliminate this health inequity and to protect, promote and improve the health of all New Zealanders.

The Waitangi Tribunal recommended the use of five principles derived from Te Tiriti when working to fulfil the health care rights of Māori, expanded on below (from the Manatu Hauora Ministry of Health Te Tiriti o Waitangi Framework):

- Tino rangatiratanga: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- Equity: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- Active protection: The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- Options: The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- Partnership: The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

The New Zealand Aotearoa Abortion Clinical Guideline outlines the following actions to take to meet Tiriti obligations in abortion care:

- Tino rangatiratanga (Article 2 – Mana motuhake, self-determination) – Health practitioners support the right of Māori to undergo an abortion, conceptualising the person's decision to have an abortion as a continuation of a much older, Māori collective-endorsed practice of determining one's own health and wellbeing and that of the whānau.
- Equity (Article 3 – Oritetanga, Māori health equity, justice and action) – Health practitioners can contribute to equitable abortion health outcomes for Māori by ensuring that at a minimum abortion outcomes match those of other New Zealanders. Equitable abortion outcomes will be achieved when the guideline recommendations are implemented in ways that give effect to the principles of Te Tiriti o Waitangi, and relevant professional competencies and Ngā Paerewa are met.
- Active protection (Article 4 – Te Ritenga, right to beliefs and values) – Health practitioners share evidence-based information about abortion so that Māori can make decisions and prepare themselves to uphold their tikanga or cultural practice (eg, karakia, rongoā, support person, container for and a location to place products of conception).
- Options – Health practitioners ensure that Māori process are able to uphold their tikanga or cultural practice throughout the abortion process, whether the abortion takes place at a kaupapa Māori or a mainstream service. The process must complement a Māori person's mana or inherent authority and dignity, support their tikanga or cultural practice, and be culturally safe as defined by Māori.
- Partnership (Article 1 – Kāwanatanga, governance) – Health practitioners work in partnership with Māori, including a person's whānau if requested, before, during and following an abortion. A partnered approach to the process and decision-making ensures Māori can enact their rangatiratanga or self-determine their futures while exercising mana motuhake or authority over their bodies and reproductive health.

Mana whenua status

Mana whenua refers to the mana upheld by local Māori people who have historic and territorial rights over the land in a particular area and is derived through whakapapa links to that area. It differs from tangata whenua (people of the land, indigenous people) in that is refers to the people who have local tribal or sub tribal authority.

It is important to understand who holds mana whenua status in your area when planning and providing any health service in Aotearoa New Zealand. Mana whenua have a special cultural and spiritual relationship with the environment and so may be able to provide advice or support in some instances.

Legislation and abortion in Aotearoa New Zealand

The Abortion Legislation Act (2020)

The Abortion Legislation Act (2020) came into force on 24 March, 2020. This Act amended earlier legislation for abortion provision contained within the Contraception, Sterilisation, and Abortion Act 1977 and the Crimes Act 1961. Before 2020, abortions had to be carried out on licensed premises, and the person requesting a abortion was required to obtain authorisation for the procedure from two certifying consultants. Part 1, Section 8 of the Abortion Legislation Act (2020) replaced several earlier sections of the Contraception, Sterilisation, and Abortion Act 1977, including those directly related to provision of abortion services as shown below. A qualified health practitioner is defined within the Act as a health practitioner who is acting in accordance with the Health Practitioners Competence Assurance Act 2003.

8 Sections 10 to 46 replaced
Replace sections 10 to 46 with:

10 Provision of abortion services to women not more than 20 weeks pregnant
A qualified health practitioner may provide abortion services to a woman who is not more than 20 weeks pregnant.

11 Provision of abortion services to women more than 20 weeks pregnant

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

(2) In considering whether the abortion is clinically appropriate in the circumstances, the qualified health practitioner must—

- (a) consult at least 1 other qualified health practitioner; and
- (b) have regard to—
  - (i) all relevant legal, professional, and ethical standards to which the qualified health practitioner is subject; and
  - (ii) the woman's—
    - (A) physical health; and
    - (B) mental health; and
    - (C) overall well-being; and
  - (iii) the gestational age of the fetus.

(3) Subsection (2) does not apply in a medical emergency.

Above: The start of Part 1, Section 8 of the The Abortion Legislation Act (2020). Part 1 contains amendments to the Contraception, Sterilisation, and Abortion Act 1977, including the replacement sections 10 and 11 as shown in the grey box. Read the full Act here.

There is no definition of 'woman' within the Abortion Legislation Act 2020 and other legislation relevant to the provision of abortion services in Aotearoa New Zealand, despite the term being used frequently and throughout. The Ministry of Health has stated that is guided by the Women's Health Strategy (https://www.health.govt.nz/new-zealand-health-system/setting-direction-our-new-health-system/womens-health-strategy) as part of the Pae Ora – Healthy Futures Strategies in its interpretation of the use of 'woman'. The Women's Health Strategy acknowledges that:

> "The health needs discussed in this strategy can be experienced by people with diverse gender identities and expressions and sex characteristics. This includes those with variations of sex characteristics or intersex people, transgender men, non-binary people, takatāpui and MVPFAFF+. While the term 'women' is used throughout the strategy, priorities in this health strategy will be relevant to wider groups of people. It is intended that the development and design of specific actions flowing from this strategy will be inclusive of rainbow voices and work to drive services and approaches that respond to rainbow needs and aspirations. We also recognise that not all women will experience some of the health issues that are referred to as 'women-specific' throughout the strategy."

Registered health practitioners can perform surgical abortions or prescribe medicines for medical abortions if it is a health service permitted within their scope of practice and the practitioner holds a current practicing certificate. Abortion is within scope of practice for doctors, midwives, nurse practitioners and registered nurses.

Safe Areas

An amendment to the Contraception, Sterilisation, and Abortion Act 1977, the Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Act 2022, allows for the creation of a "Safe Area" up to 150 metres around premises which provide abortion services. These zones are created to protect the safety, well-being, privacy and dignity of people seeking abortion services from harrassment by anti-abortion protestors. Once a Safe Area is established, people engaging in prohibited behaviours can be fined up to $1,000.

Below: Prohibited behaviours in a Safe Area. Section 13A of the Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Act 2022:

> A person must not—
>
> (a) obstruct a person in a safe area who is approaching, entering, or leaving any building in which abortion services are provided; or
>
> (b) make a visual recording of another person in a safe area in a manner that is likely to cause emotional distress to a person accessing, providing, or assisting with providing, abortion services; or
>
> (c) do any of the following in a safe area in a manner that could be easily seen or heard by another person (A) who may be accessing, providing, or assisting with providing, abortion services:
>
> i. advise or persuade A to refrain from accessing or providing abortion services (unless the advice or persuasion is by a person who is, with the consent of A, accompanying A):
>
> ii. inform A about matters related to the provision of abortion services, other than during the course of providing those services, or assisting with provision of those services (unless the information is provided by a person who is, with the consent of A, accompanying A):
>
> iii. engage in protest about matters relating to the provision of abortion services.

The Minister of Health, in consultation with the Minister of Justice, can recommend that a safe area be created on request by a facility. Abortion service providers are able to apply for a safe zone. For further information on safe zones and the application process please refer to the Ministry website (details here). Providers who would like to apply for a safe area should email AbortionServices@health.govt.nz.

Conscientious objection

Section 14 of the Contraception, Sterilisation, and Abortion Act 1977 was also replaced as part of the Abortion Legislation Act 2020 and provides clear guidance around management of conscientious objection. If a health practitioner has a conscientious objection to providing abortion services, they must inform the patient at the earliest opportunity:

- Of their conscientious objection; and
- How to access the contact details of another person who is the closest provider of the service requested.

Health practitioners have a legal duty to provide prompt and appropriate medical assistance to any person in a medical emergency, including abortion.

Age of consent for abortion services

There is no lower legal age limit for having an abortion in Aotearoa New Zealand. Abortion services for under 16 year olds are governed by the Care of Children Act 2004.

The Care of Children Act 2004 Section 38 states:

> Section 38 Consent to abortion
>
> 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 on her 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 on her of any procedure of that kind.
>
> 2) This section overrides section 36*.
>
> * section 36 addresses the child's rights to consent to procedures generally

Gillick competence is where a young person who is under the age of 16 years is judged as being able to make a decision about the provision of medical services without their parents' input if he or she fully understands the medical treatment that is proposed. Gillick competence originated in the UK in 1985 and has been adopted in varying degrees by other Commonwealth countries. In Aotearoa New Zealand, Gillick competence is most obviously seen as reflected in the Health and Disability Services (Safety) Act 2001. In abortion care it is relevant to contraception provision as there is no lower limit to age of consent. The Fraser guidelines are used to decide if child can consent to contraceptive or sexual health advice and treatment.

Notification

To comply with the amendments to the Contraception, Sterilisation, and Abortion Act 1977 abortion service providers must submit a notification to the Ministry of Health within one month of the abortion. The Ministry of Health collates the national data on abortions and uses this to report on issues such as timely and equitable access to abortion services. Abortion providers must also submit an annual report on their abortion services by 31 March each year: further information and assistance with the reporting process can be found here including links to 'Learn Online' training webinars on the abortion notification and annual reporting processes.

The MOH Abortion Services work programme produces annual reports describing abortion services (the most recent report can be accessed here). Before the Abortion Legislation Act 2020 was passed, the Abortion Supervisory Committee (Ministry of Justice) produced annual reports, which can be accessed here.

Unapproved use of medicines (Section 25)

Unapproved (off-label) medicines have not been assessed by Medsafe for quality, efficacy or safety of use for a specific therapeutic indication. However, under Section 25 of the Medicines Act 1981, unapproved medicines can be prescribed by authorised healthcare providers in New Zealand provided the Code of Health and Disability Services Consumers' Rights has been applied. People have the right to be fully informed about unapproved medicines and any safety concerns, including in writing (if requested), prior to consenting to their use for EMA. Verbal informed consent is sufficient and should be documented in the patient notes. It is not necessary to obtain written consent.

Link here to presentation about Section 25

Patient rights

All New Zealanders have ten basic rights when accessing healthcare; these are described in the Code of Health and Disability Services Consumers' Rights (see below). New Zealand also supports the UN Declaration on the Rights of Indigenous Peoples and is a signatory to the Convention on the Rights of Persons with Disabilities.

> The Code of Health and Disability Services Consumers' Rights 1996 outlines these ten basic rights of all healthcare users, and abortion care providers should ensure these are met with all patients:
>
> - The right to be treated with respect
> - The right to be treated fairly
> - The right to dignity and independence
> - The right to have good care and support that fits your needs
> - The right to be told things in a way that you understand
> - The right to be told everything you need to know about your care and support
> - The right to make choices about your care and support
> - The right to have support
> - The right to decide if you want to be part of training, teaching or research
> - The right to make a complaint

All people presenting for abortion care bring a history of their own life experience with them. These experiences may impact on their choice to have a abortion, their comfort around this decision, who they wish to support them, and their choice of type of abortion and type of analgesia/anaesthesia. It is important as the health practitioner providing the abortion that you ensure you allow the person to navigate their care in a supported unjudged way. This requires culturally safe care and reflection on your own biases, explicit and implicit, to ensure that these do not affect the consultation.

There has been considerable stigma surrounding abortion in the past, and negative attitudes are still prevalent in some parts of Aotearoa New Zealand society today. Abortion service providers need to be confident that they can provide individualised care without judgement, treating each person fairly, and with respect. If safe access to the facility may be affected by anti-abortion protestors, abortion care providers can now apply to have a Safe Area enforced under the Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Act 2022.

Professional standards and guidelines

The New Zealand Aotearoa Abortion Clinical Guideline (2021), available to download here, provides summary guidelines and recommendations for best practice abortion care. All abortion service providers need to be familiar with the clinical guidance in this document, and its recommendations regarding Te Tiriti, health equity and abortion provision. It has been prepared for use alongside Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. The New Zealand Aotearoa Abortion Clinical Guideline is licensed under the Creative Commons Attribution 4.0 International licence, and the summary recommendations are reproduced or linked to throughout these training modules.

In late February, 2022, the updated Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 came into effect, combining four previous sets of Standards, including the Interim Standards for Abortion Services in New Zealand, and reflecting a shift towards more person- and whānau-centred health and disability services. Overnight inpatient abortion services are required to comply with the Ngā Paerewa Standard, as are all inpatient hospital services, providers of fertility services, primary maternity centres, hospices, age-related residential care, residential addiction, mental health, and disability services. The Ministry of Health's website describes Ngā Paerewa as also fit for use by abortion service providers in New Zealand Aotearoa. The New Zealand Aotearoa Clinical Guideline suggests that community-based abortion providers, while not required to comply, could consider adopting the Ngā Paerewa Standard as it fits to their setting, as it provides a current best practice framework.

Resources currently available from the Ministry of Health for implementation of Ngā Paerewa include a short HealthCERT eLearning module available at LearnOnline (Compliance with Te Tiriti o Waitangi requirements in

Ngā Paerewa), which focuses on meeting Te Tiriti requirements, and a presentation detailing sector specific guidance for abortion providers.

The Ministry of Health has sponsored access to Ngā Paerewa, at the Standards New Zealand website (under copyright license LN001406), which permits personal use of the PDF version free of charge, to view or print a single copy. It is expected that trainees on this course will have their own copy of the Standard and become familiar with its contents.

Impact of telehealth; advantages and disadvantages

> New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.3.1 states: "*Offer people the options of clinical assessment via telehealth or in-person*"

Telehealth is the use of information or communication technologies to deliver health services to patients.

The New Zealand Telehealth Forum and Resource Centre has guidance and resources for people who want to set up, improve or use a telehealth service within New Zealand. Their website maintains a list of sources of regulations, standards, and guidelines on the role of telehealth in New Zealand, including professional body guidance statements. Statements on telehealth by the Medical Council of New Zealand (MCNZ), The Royal New Zealand College of General Practitioners, Allied Health Aotearoa New Zealand and the Nurse Executives of New Zealand Inc. among others, can be accessed from this website.

The required standards of care for telehealth are the same as those for in-person consultations. This should include 24-hour support of the patient and confirmed availability of local support and emergency services. The advantages of telehealth for some people seeking abortion include convenience, improved access, e.g. for those in isolated locations, and confidentiality, e.g. for people concerned about engaging with their local service due to privacy concerns.

However, all abortion providers using telehealth need to be aware of its limitations to ensure that they do not attempt to provide a service that puts patients' safety at risk. In particular they need to be mindful of the inherent risks in providing treatment when an in-person examination of the patient is not possible, including:

- Assessing psychological state without the cues obtained in a face-to-face interview
- Assessment of physical health
- Assessment of gestational age

When delivering abortion by telehealth, a physical examination to estimate gestational age is not possible. There is evidence that if a person is sure of their LMP or conception date, it will be unlikely that they are more than seven days out on their estimation. Confirming gestational age by ultrasound is often still possible when delivering abortion by telehealth. Most people can access a local imaging service even if there is not a local abortion provider. However, there will be situations where confirming gestational age by ultrasound is difficult or impossible, which may significantly delay the abortion care.

Therefore, if ultrasound or an in-person face-to-face consultation is a significant barrier to a person obtaining a abortion, the practitioner may deliver abortion to a person who is sure that their gestational age is less than 63 days without ultrasound or physical examination.

Concerning prescribing or supplying of medicines, the MCNZ guidance on Telehealth, 2020 (Standard 16) states that "*Before prescribing any medicine for the first time to a patient, an in-person consultation is recommended practice. If, in the circumstances you are unable to see the patient in person, consider a telehealth consultation with the patient or discuss the patient's treatment with another New Zealand registered health practitioner who can verify the patient's medical history and identity*". If the clinical situation is urgent, it also states that it may be reasonable to provide a prescription "*provided that you obtain the relevant medical history and inform the patient's regular doctor as soon as possible*".

While prescription of EMA medicines via telehealth could meet an urgent clinical need, it is not always possible to notify the patient's own doctor for confidentiality reasons. Providers are advised to document the reason(s) for not informing the patient's own doctor in their clinical notes.

Further reading and resources:

The Ministry of Health has developed an e-learning module, "Changes to the abortion law", about recent changes to the abortion laws in Aotearoa New Zealand and what they mean for health practitioners. This course takes between 10–20 minutes to complete and is available through the Ministry of Health's Learn Online platform. It contains information about abortions pre- and post- 20 weeks, self-referral, employer obligations, counselling and reporting. The LearnOnline website requires an account, log-in and agreement to a privacy policy for access, then use this link for the Abortion Services Main Page which has a further link to the e-learning module.

Aiken, A.R.A., Lohr, P.A., Lord, J., Ghosh, N., Starling, J. (2021). Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. BJOG 128: 1464-1474. https://doi.org/10.1111/1471-0528.16668

Kaneshiro, B., Edelman, A., Sneeringer, R.K., Ponce de Leon, R.G. (2011). Expanding medical abortion: can medical abortion be effectively provided without the routine use of ultrasound? Contraception 83:194-201. https://doi.org/10.1016/j.contraception.2010.07.023

Additional resources not already available in main text:

- Ministry of Health Abortion Services Aotearoa New Zealand: 2020 Annual report 2021
- Abortion Supervisory Committee annual reports
- Ministry of Health Abortion reporting information for health practitioners
- Ministry of Health Ngā Paerewa webpages
  - eLearning module "Compliance with Te Tiriti o Waitangi requirements in Ngā Paerewa"
  - Presentation for abortion service providers
- Health New Zealand - Te Whatu Ora Abortion services

3. COMMUNICATION

In this example of a telehealth consultation, Simon Snook of the Women's Clinic discusses abortion options with Emma, who is unexpectedly pregnant and living with her partner in a campervan in Central Otago. The 26 minute conversation includes abortion options and safety, Emma's medical history, estimated gestation and contraception options, and a description of the EMA process

What is Tikanga?

One of the ways we honour and respect our obligations to Te Tiriti o Waitangi and tangata whenua (the indigenous people of the land) is through the appropriate use of tikanga. Tikanga is following specific protocols and procedures with the intent to honour Māori holistic cultural practices. These practices reflect spirituality and indigenous values such as tapu, noa and mana. Māori beliefs, values and concepts are inherited and practiced from generation to generation. Important values are also te reo (the language), whenua (the land) and the concepts of whānau, hapū and iwi (family and extended family group). Integral to tikanga are Māori world views encompassing the atua (gods), creation story and a holistic approach to health spanning the realms of wairua (spirituality), hinengaro (psychological), tinana (physical) and whānau (family).

Te Ao Māori in Sexual and Reproductive Health

Tikanga key concepts

The connection to wairua (spirit) is particularly intrinsic to Māori traditional beliefs and in healthcare settings we can maintain and protect a person's wairua, tinana and hinengaro with specific practices such as karakia (incantations, blessings, prayers). Behaviour and practices not consistent with beliefs, values and concepts can distress Māori and cause lack of confidence and hence participation in health care services.

In later modules we describe specific ways in which practicing tikanga with the intent to honour a pregnant person's beliefs may enhance abortion care for both Māori and non Māori.

Practicing tikanga safely can often feel overwhelming for health care professionals. The best way to work through this is asking for help from colleagues, learning more from your local iwi, seeking formal training and learning from the people you see in your health care setting. As in any culture, no two people will believe, value or practice in the same way and there are whanau, iwi, and regional differences to be aware of. Be guided by the person in front of you, acknowledging their sovereignty (tino rangatiratanga) in deciding what path, karakia, supports they would like during their care. When using and offering tikanga in the right way with the right intention it is mana enhancing for you, the pregnant person and their whānau.

The following audiovisual aid discusses how the concepts of tapu (restricted), noa, (free from restriction) and mana are used to guide tikanga.

Māori Models of Healthcare in Sexual and Reproductive Health

Family violence

A routine enquiry about intimate partner violence (IPV) should be made to all people attending abortion services, accompanied if necessary, by the provision of appropriate information and support. The 2016 Ministry of Health Family Violence Assessment and Intervention Guideline is a practical tool to help health providers make safe and effective interventions to assist victims of interpersonal violence and abuse.

IPV is common among women and those in the LGBTQIA+ community. One in three Aotearoa New Zealand women have experienced physical or sexual violence by a male intimate partner in their lifetime. In one study of 62 women attending an abortion clinic in Aotearoa New Zealand, the self-reported lifetime prevalence of physical or sexual abuse was 50%. It is important for those working in reproductive health settings to be aware that sexual assault occurs in the context of relationships. IPV can also include reproductive and sexual coercion.

Reproductive coercion includes behaviours that interfere with contraception use or pregnancy, such as threatening to end a relationship if the person does not get pregnant, or if they do not terminate a pregnancy.

Sexual coercion includes behaviours of pressuring or manipulating a person into unwanted sexual activity through non-physical means. Past or current IPV in a person's life can have profound implications for physical, sexual and reproductive and psychological health. Healthcare providers need to have the skills to identify IPV, and provide appropriate support, referrals and follow-up care as required.

Questions you may consider asking include:

- Does your partner support your decision about when or if you want to become pregnant?
- Has your partner ever forced you to do something sexually that you didn't want to do or refused your request to use condoms?
- Has your partner ever tried to get you pregnant when you didn't want to be pregnant?
- Are you worried your partner will hurt you if choose not to do what they want with the pregnancy?

The World Health Organization (WHO) recommends five minimum requirements which need to be in place prior to the implementation of routine inquiry for IPV:

- A protocol on standard IPV response procedure
- Staff training on how to ask, and appropriate minimum response guidelines
- A private setting
- Assurance of confidentiality of response
- A system for referral to appropriate support services

New Zealand is taking a leading role in terms of recognising and implementing a national system change approach for supporting health care providers' response to victims of IPV and child abuse. Contact your Ministry of Health's Violence Intervention Program (VIP) Coordinator to obtain more information about the program.

IVP Referral pathways:

- If there is an imminent threat to patient, staff or others: call on-site security or 111
- If an alleged assault or abuse needs urgent intervention, contact:
  - Police
  - Oranga Tamariki
- Ensure the person has a safe place to go. Consider:
  - Hospital admission
  - Emergency shelter e.g. Women's Refuge
  - Family or friends
- Consider the need for an acute adult mental health assessment
- Arrange an appropriate follow-up consultation or phone call
- Other resources:
  - It's Not OK website and Family Violence Information Line: 0800 456 450 (available 24 hours a day, 7 days a week)
  - Shine website and helpline 0508 744 633 (available 24 hours a day, 7 days a week)
  - Safe to talk – Kōrero mai ka ora website and Sexual Harm Helpline: 0800 044 334 or text 4334 (available 24 hours a day, 7 days a week)

Rangatahi / Young people

Rangitahi / young people who are seeking abortion care need to be provided with youth friendly care. There are a number of courses on youth friendly care including the Working with Youth: HEEADSSS Assessment developed by The Goodfellow Unit at the University of Auckland.

Abortion care for youth has similar outcomes to those for other people seeking abortion. However, there are issues that are important to consider for youth seeking abortion care including safety at home and sexual coercion. It is important that abortion services have policies on how to manage care and protection concerns.

Rangitahi / youth may have strong concerns about confidentiality. It is important to reassure the person that abortion care is confidential, and that information does not need to be shared with whanau or other health care providers if they do not want it to be. However there are instances where confidentiality must be broken, for example, if they or someone else is at risk, and they must be made aware of this.

Cultural safety

Cultural safety emphasises self-reflection upon one's own cultural mores and the likely effect of how bias and prejudice arising from that cultural perspective might affect professional behaviour and equitable health outcomes. In the 1990s, Irihapeti Ramsden and other Māori nurses developed the key definitions and strived for social justice using the model of health practitioners as 'border workers', working at the interface between the system, the patients and the whānau. An important proficiency in providing culturally safe abortion care is that "safety" is determined by patients, whānau and communities. Culturally practitioners make the time and space for open, authentic conversations and listen to and action feedback and recommendations. The cultural safety training plan released in February 2023 by The College of Medical Councils (CMC) in partnership with Te ORA Māori Medical Practitioners Association provides the latest components that contribute to optimal health for Māori. It is a superb, comprehensive resource for individuals and organisations to grow their knowledge base to support the evolution of health care practitioner training towards cultural safety. Their approach incorporates three components in a framework to ensure all elements of "culture" are considered.

- Hauora Māori - historical and contemporary Māori health knowledge
- Cultural competency - knowledge and skills to work effectively within cross cultural contexts
- Cultural Safety - developing critical consciousness using self-reflection on internal biases

Providing culturally safe abortion care in Aotearoa New Zealand includes a broader approach to include the diverse population: the 2018 census data shows that our population includes members of over 160 ethnic groups. The Ministry for Ethnic Communities, established in 2021, represents the 20 per cent of New Zealanders who identify as belonging to African, Asian, Continental European, Latin American or Middle Eastern ethnicities. Their website resources include the Ethnic Communities' Data Dashboard, an interactive tool to explore national and regional data on ethnic communities from the 2018 census; and an introductory Intercultural Capability online learning programme.

Just over eight per cent of the population belong to ethnicities which fall within Stats NZ's 'Pacific Peoples' grouping, with two thirds of these people born in Aotearoa New Zealand. The largest Pacific community, making up almost half of the Pacific Peoples group, is Samoan, followed by those identifying as Tongan (just over one quarter of the group).

Further reading and resources for cultural competency continuing education:

- The New Zealand Medical Council statement on cultural safety
- "What is cultural competence?" on the Health Navigator website
- Le Va's Engaging Pasifika cultural competency training programme
- The Populations section of the Ministry of Health website
- Learning and education modules on understanding bias in health care from the Health Quality & Safety Commission New Zealand (HQSC)
- eCALD® online courses for health practitioners to gain cultural understanding and develop skills to work with migrant and refugee patients from Asian, Middle Eastern, Latin American or African backgrounds.
- The Languages section of the Health Navigator website
- Connecting Now (0800 854 737) a professional telephone interpreting service who help government agencies to communicate with clients with limited English through telephone/video interpreters available 24 hours a day, seven days a week, in over 180 languages

Abortion services and disabled people

As part of the process of developing this training content, The New Zealand College of Sexual and Reproductive Health (NZCSRH) sought feedback from people that identified as having disabilities, about their experiences accessing sexual and reproductive healthcare in Aotearoa New Zealand. A report was produced from the findings of an online survey distributed through social media and community contacts, a follow-up hui that took place over zoom and one on one interviews. The major conclusions from this work with regard to abortion training are summarised below, and the full report is available here.

The survey had good engagement, with 63 participants taking part. In Aotearoa, disabled people make up 24% of the population as reported by the 2013 Disability Survey, the most recent data currently available. Participants mostly came from the main centres of Dunedin, Wellington, and Auckland.

The major overarching theme from the responses is that disabled people are having some negative experiences when accessing sexual and reproductive healthcare in Aotearoa. The survey found that participants were having difficulties feeling heard (or were completely unable to be heard) by practitioners during appointments (46% of participants) and being able to speak for themselves at those appointments (24% of participants). It is essential that clinicians listen and learn from people about their specific requirements to access services, and consider the added needs of chronically ill disabled people or those with complex medical needs when providing their abortion care.

Participants reported in interviews following the survey that there are additional things to take into consideration when making choices with their healthcare. They all spoke of preferring to use their general practitioner over more "transactional" forms of sexual healthcare such as through family planning or hospital sexual health clinics.

> *"I prefer to go to my GP as she knows my entire history and if it ends up turning into a complex thing, then she is already involved"*

The reasons given for choosing their GP over other care services overlap with the issues that over 85% of our survey participants rated as very important or essential in their appointments with sexual and reproductive healthcare practitioners:

- Reliable and safe treatment
- High clinical quality and knowledgeable staff
- Confidentiality
- Non-judgemental services
- Sympathetic and kind staff
- Having control over the process, the ability to stop at any stage and take time if needed
- Good advice and information
- Choice in abortion procedures, medical and surgical options, and pain relief options
- Ease of access to clinic/services
- Opportunity for counselling if required
- Fast access to treatment
- Provision of more effective contraception services as part of a abortion service
- STI Screen and treatment available as part of abortion care

In comparison, the thing that was labelled of least importance was:

- Little wait time in the clinic (13% of participants rated it "not important" and 40% of participants rated it "Quite important")

  "For me personally, I would be prepared to wait all day for one doctor/nurse that is kind, compassionate, listens and is knowledgeable. My chronic illnesses are complex so I need a professional who is prepared for listening"

Several of the survey participants spoke of lacking a strong therapeutic relationship with their care provider, and they voiced a need for stronger relationships to be developed.

There was additional crossover with LGBTQI+ and Māori issues, highlighting the need for an intersectional approach to care.

> *"Cultural competency – especially for rangatahi Māori, who might be struggling with the idea of abortion. For me, I didn't know the spiritual ramifications of abortion in my Māori community (for those unaware, it's often that the wairua of your pēpi still exists and can become a guardian for you in your life), and I had already started forming a connection to my pēpi when I had my abortion, although I don't regret my abortion at all, and I think I gave them the right send-off when I did undergo my abortion. But I wish someone had given me some ao Māori guidance regarding abortion. I've mostly kept quiet about my experience for seven years because I'm innately worried about how my Māori community will treat me, even though realistically my community would most likely awhi me and my choice. I was also young and relatively alone when I had my abortion and am no longer in contact with the main support person who helped me through it, and I know I now fit into some racially negative stereotypes which could possibly be used against me, so it has made retelling my story quite difficult and isolating."*

In the survey, 22% of the participants marked access to transportation to and from sexual and reproductive healthcare appointments as a significant issue. One participant brought up the use of a medical practice run taxi service that provided transport for people to and from appointments. This is also a model that has been used in the wider medical care sector. An alternative to a taxi service could be providing partial or full funding of taxi services depending on the needs of the person, the area they are travelling from and the access to public transport available. Considerations surrounding privacy relating to this type of service would need to be investigated further.

> *"For people living in rural communities who can't get the access even more than me who lives in a city. The transport thing is so important, it's getting people to those appointments because once you're there you're taken care of well. It's just getting there and back is the issue. If we don't know where to go first of all that's a major issue and then on top of that it's how do you even get there in the first place? Can you find it yourself? Is it safe to go to that sort of place?"*

In summary:

- The disabled person needs to play the central role to discussions about their care. There is a saying in disability advocacy "nothing about us, without us". Disabled people are often experts on their own support requirements, and this should be recognised and respected by healthcare providers.
- Abortion service providers should be aware of the need to take an intersectional approach to care with many people, whose multiple identities as, for example, disabled and Māori, or disabled and rainbow people, need to be considered for optimal care
- Practitioners need to carefully consider how accessible their service is for those with a range of physical and intellectual disabilities.

The Convention on the Rights of Persons with Disabilities (ratified 2008) from the United Nations is a 50-article international human rights treaty intended to protect the rights and dignity of persons with disabilities. Note in particular Part 1 of Article 23 (Respect for home and the family) which states that:

1. Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
   a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
   b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;
   c) Persons with disabilities, including children, retain their fertility on an equal basis with others

Further reading and resources:

- The New Zealand Disability Strategy aims to provide guidance on disability issues (2016 - 2026) for government agencies, other organisations and individuals
- Whaikaha – Ministry of Disabled People website
- The Office for Disability Issues website
- Disabled Persons Assembly NZ website
- People First New Zealand – Ngā Tāngata Tuatahi website
- New Zealand Sign Language interpreter service available here

Abortion services and rainbow people

Abortion services must provide care for all pregnant people, including trans, intersex, non-binary, and gender nonconforming people. It is important to affirm each individual's personal identity and that of the person's partner (or partners if they are in a polyamorous relationship) and use the person's preferred pronouns (such as he/him, she/her, they/them) and their name. Careful consideration of language use, and the use of non-gendered terms, will help in providing a more inclusive environment for rainbow people.

The Aotearoa New Zealand Trans and Non-Binary Health Survey, Counting Ourselves, is an anonymous health survey designed by and for trans and non-binary people, with the 2022 survey currently underway. Analysis of the 2018 survey responses found that transgender participants were more likely to report negative primary healthcare experiences, and barriers accessing care, when compared to the general population. In comments in the survey, many participants noted they had experienced gaps in knowledge and confidence on the part of healthcare practitioners when providing gender affirming care.

People undergoing testosterone therapy need to use contraception to prevent pregnancy, and if an unintentional pregnancy occurs, testosterone is contraindicated because of potential harm to the foetus from the androgenising effects of treatment. As for all people requiring abortion care, transgender patients need to be informed and involved with all decisions related to their care. A survey of transmasculine people living in Sweden found that pelvic examination could be a particularly problematic and difficult part of their experiences of sexual and reproductive health care. The authors found that better experiences of pelvic exams depended on an empathetic approach by the health care practitioner, involving the person and informing them about the procedure at all stages.

Abortion in transmasculine people who take testosterone may be complicated due to atrophic changes. Dilatation of the cervical canal can be more difficult and consideration should be given to referral to an experienced abortion provider.

We recommend exploring these websites and their resources to learn about providing a welcoming and supportive healthcareservice for rainbow people:

- "Supporting Aotearoa's Rainbow People": This online resource is designed for mental health professionals, however, it contains comprehensive information and advice for all health professionals based on findings from the Rainbow Mental Health Support Experiences Study and the Out Loud Aotearoa Project.
- Gender Minorities Aotearoa has a freely available online course "Supporting Transgender People" available here. "This course is designed to increase your knowledge of issues affecting transgender people in Aotearoa, and to build your confidence in speaking about these issues and supporting transgender people. It is a 101 course and suitable for people with any level of knowledge on transgender issues." The course is in three sections and is estimated to take two to three hours to complete. Links for further reading are available in some sections. This website also includes a transgender language glossary which covers many rainbow community terms, while focusing on gender and transgender identities.

Whānau, partner and friend support

People accessing abortion services may choose to be accompanied by whānau members, partners or friends to help them through the process. Joint counselling for the pregnant person and their partner should be available if requested by the pregnant person. It is important to have time alone with the pregnant person to ensure you are complying with their wishes without pressure or coercion.

Where possible during the pre-abortion clinical assessment and procedure itself, healthcare practitioners should aim to include and involve support people as requested by the pregnant person, while ensuring that all decisions are made by the pregnant person.

The DECIDE National Abortion Telehealth Service website has information and advice for people supporting friends and loved ones having an abortion.

4. MEDICAL HISTORY AND ESTABLISHING GESTATION AND LOCATION OF PREGNANCY

Focused medical history: contraindications and complication risks

The pregnancy should be confirmed by urine or serum testing, and a focused medical history needs to be taken to identify any contraindications or risk factors for abortion and to aid in subsequent contraceptive choice.

New Zealand Aotearoa Abortion Clinical Guideline 2021,

- Recommendation 1.3.2 is: "*Confirm pregnancy by urine or serum β-hCG or ultrasound*" and
- Recommendation 1.3.4 is: "*Obtain relevant medical history*"

Absolute contraindications to EMA include:

- Allergy to mifepristone or misoprostol
- Adrenal failure
- Poorly controlled severe asthma
- Steroid dependency
- Hereditary porphyria
- Intrauterine contraception (IUC) in situ – it is okay to proceed if this is removed
- Known or suspected ectopic pregnancy

Relative contraindications to EMA include:

- Greater than 70 days of pregnancy
- Severe anaemia
- Serious or unstable health conditions such as ischaemic heart disease, uncontrolled epilepsy, renal failure, or hepatic failure
- A known bleeding disorder or taking anticoagulant medicines

The New Zealand Aotearoa Abortion Clinical Guideline recommends that an EMA can be provided for pregnancies up to 10 weeks (70 days). N.B. mifepristone is at present (2022) licensed in New Zealand for up to 63 days. The off-label use of mifepristone is discussed in greater detail in Module 2

Of patients having EMA, 1% will have heavy bleeding which can be unpredictable in terms of timing. It may be safer for a patient with severe anaemia, an unstable health condition or a bleeding disorder to have surgical management or an EMA in a hospital setting. Haemoglobin testing is not routinely recommended but is recommended for people with a medical history of anaemia including postpartum haemorrhage or heavy menstrual bleeding or current symptoms.

New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.3.5 states: "*Recommend selective testing of haemoglobin as indicated by medical history and/or current symptoms*"

While the risk of heavy bleeding and cervical shock following an EMA are low, this increases with gestational age. It is essential to ensure people having an EMA in the community are safe and able to access emergency health care facilities if required. Determining whether this is the case needs to form a part of each individual's consultation process. If there are social or practical barriers to emergency care access, then an at home EMA is not appropriate, and other options (e.g. early surgical abortion, or EMA in a different setting) should be offered as part of the shared decision-making process.

Examples of potential barriers to emergency care access:

- No reliable telephone access, or a limited ability to communicate with an emergency health service (e.g. language barriers)
- No transport or no adult companion at home

- Physical distance – e.g. being further than one hour from the nearest emergency health service.

Medical history and surgical abortion

There are no absolute contraindications to surgical abortion and conditions that increase the risk are often considered contraindications to EMA. People seeking an abortion who have a complicated medical or surgical history may be recommended to have a surgical abortion in a hospital rather than community service. Management of complex medical conditions and surgical abortion are covered in Module 3.

Establishing gestation and location of pregnancy

New Zealand Aotearoa Abortion Clinical Guideline 2021,

- Recommendation 1.3.3 is: "*Determine gestational age of the pregnancy by clinical means (history including last menstrual period, with or without examination) or ultrasound scan*".
- Recommendation 1.3.7 is: "*Recommend selective ultrasound prior to first-trimester abortion if there is uncertainty about gestational age by clinical means, or if there are symptoms or signs suspicious for ectopic pregnancy*".
- Recommendation 1.3.10 is: "*Perform relevant physical examination as indicated*"

Normal early intrauterine pregnancy (IUP)

It is important to understand normal and abnormal early pregnancy development to ensure that abortion care is provided safely. Bleeding and/or pain in early pregnancy are not normal and need further evaluation. Abortion providers should be aware of early pregnancy assessment services available for people with early pregnancy complications in their community and have referral systems to them.

Structures generally develop in the following predictable sequence during early pregnancy:

1. Gestational sac
2. Double decidual reaction
3. Yolk sac (intrauterine gestational sac with yolk sac confirms early IUP)
4. Embryo
5. Embryonic cardiac activity

The timing of structure development is also predictable:

- Gestational sac: Visible at approximately 5 weeks gestation, ± 4 days
- Yolk sac: Visible at approximately 5 ½ weeks gestation, ± 4 days.
- Embryo and cardiac activity: Visible at approximately 6 weeks gestation, ± 4 days

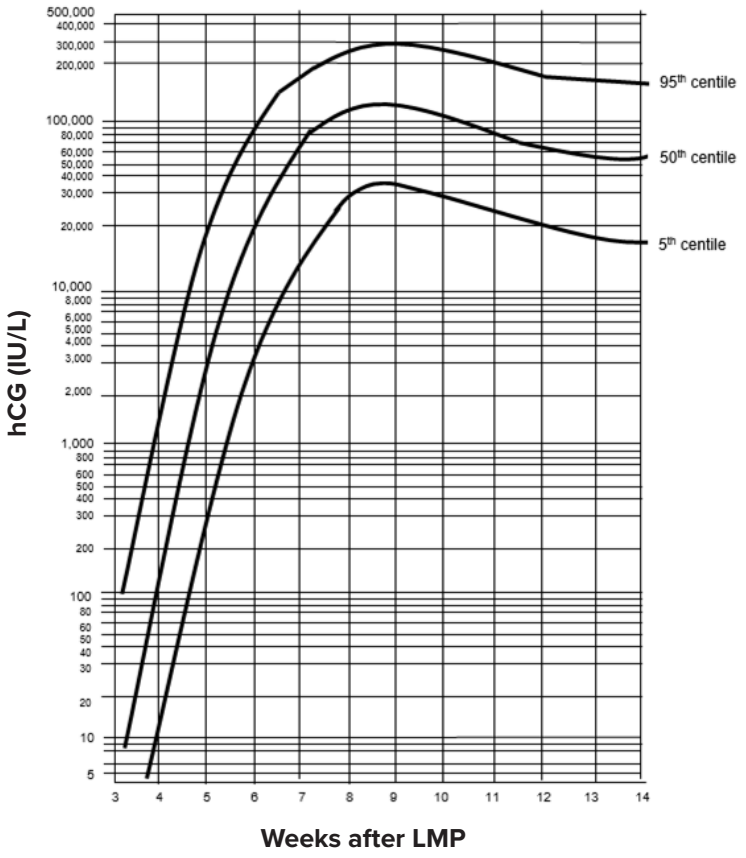

Figure 1. First trimester βhCG levels. Source: New Zealand Obstetric Ultrasound Guidelines

Some key points to remember about intrauterine pregnancy include:

- If a fertilised egg implants in the endometrium, pregnancy hormones sustain the pregnancy
- A gestational sac is the first ultrasound evidence of pregnancy and is visible by 5 weeks
- The yolk sac is the first ultrasound finding that confirms an intrauterine pregnancy (IUP); it typically appears at 5½ weeks gestation
- The yolk sac partially nourishes the developing embryo
- Before an embryo is visible, the mean sac diameter (MSD) can support estimating gestational age by LMP/ bimanual examination
- The embryo follows a predictable path of development and can be used to date a pregnancy based on its size; it appears around 6 weeks
- Once an embryo is visible, the crown-rump length (CRL) should be used to calculate gestational age (accuracy +/– four days)

For further information on ultrasound in pregnancy, see: The New Zealand Obstetric Ultrasound Guidelines, 2019

Last menstrual period (LMP)

Providers need to take a standard menstrual history focusing on the first day of the patient's last menstrual period (LMP), including:

- How sure they are of the date
- If it was a normal menses for them
- Any recent use of hormonal contraception (including pill, injection, intrauterine, implant)
- If their menstrual cycles are regular and if so, the average length of the cycle

In studies of people seeking first trimester abortion who were reasonably certain of their LMP, self-reported gestational age correlated closely to ultrasound gestational age.

Physical examination

A bimanual examination helps to estimate the gestational age – the size of the uterus increases by approximately one cm for each week from four weeks to 12 weeks' gestation. A study of pelvic examination to assess gestation agreed with ultrasound for 92% of experienced providers; however it should be noted that the estimation of gestational age can be less accurate in the presence of obesity

If the gestational age estimates based on the menstrual history and pelvic examination are consistent, and the person has no symptoms of pain or bleeding, then proceed with the EMA or surgical abortion. A systematic review found no evidence that routine ultrasound improved safety or efficacy compared with other diagnostic methods. If there are any concerns, however, arrange for an ultrasound scan. An ultrasound decision tool is available to download here.

The roles of ultrasound (US) in early pregnancy are to determine the pregnancy location (to confirm an IUP), confirm the number (single or multiple), document gestational age, and if appropriate, to detect fetal cardiac activity. Point of care ultrasound (POCUS) with a handheld device can achieve these outcomes via an abdominal scan. However, a transvaginal ultrasound may need to be performed if an intrauterine pregnancy (IUP) is not identified on a transabdominal scan. For more information on this see Module 4.

If providing an abortion via telehealth, see see Impact of telehealth; advantages and disadvantages.

Interpretation of βhCG

βhCG must be correlated with ultrasound appearances in cases where an ultrasound scan has been completed – refer to local clinical guidelines or for more information on obstetric ultrasound see this link. If the βhCG is significantly higher than anticipated, consider the possibly of a molar pregnancy and manage as per standard guidelines for gestational trophoblastic disease. βhCG alone should not be used for dating and must be corelated with the LMP, clinical examination and/or the ultrasound scan findings. Figure 1 and 2 show total hCG levels in the first trimester, and over the entire pregnancy demonstrating the drop in second and third trimester to levels found in early first trimester.

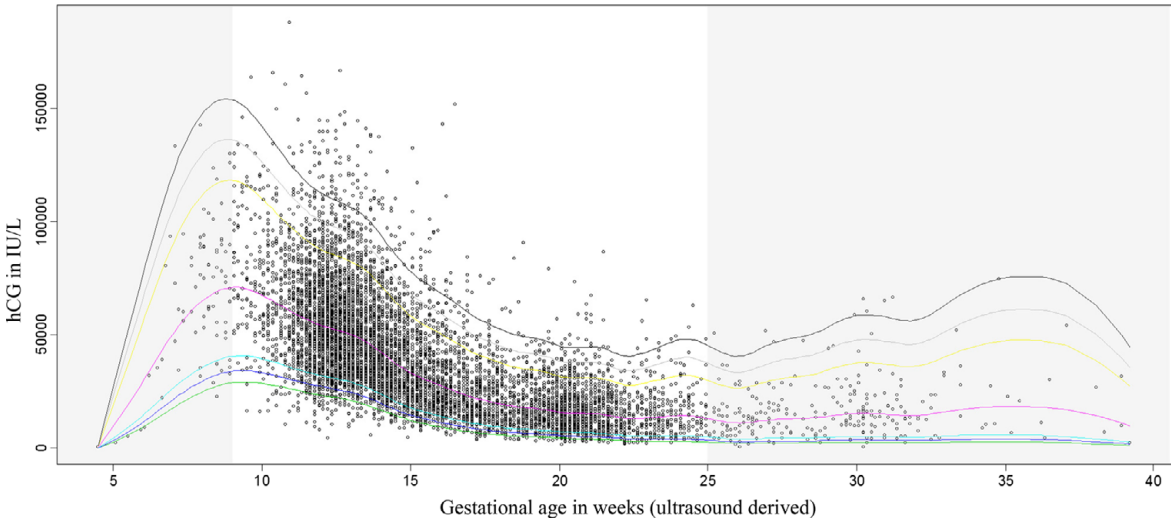

Figure 2. Centile curves for total hCG (not βhCG) during an entire pregnancy. Source: Korevaar T.I.M., Steegers E.A.P., De Rijke Y.B., *et al*. Reference ranges and determinants of total hCG levels during pregnancy: the Generation R Study. Eur J Epidemiol. 2015;30(9):1057–66. Available here

Interpretation of ultrasound

Yolk sac

The presence of a yolk sac within the intrauterine gestational sac confirms an intrauterine pregnancy and essentially excludes ectopic pregnancy. Heterotopic pregnancy, where an IUP and an extrauterine pregnancy coexist, is very rare but should be considered if there are suggestive ultrasound features, particularly in the setting of assisted reproductive technology.

Crown-rump length (CRL)

Growth is approximately 1.2mm per day but may be less in a normally developing pregnancy. Interval growth of CRL alone should not be used as a determinant of pregnancy loss. Figure 3 shows the rate of increase in CRL over the first 14 weeks of pregnancy.

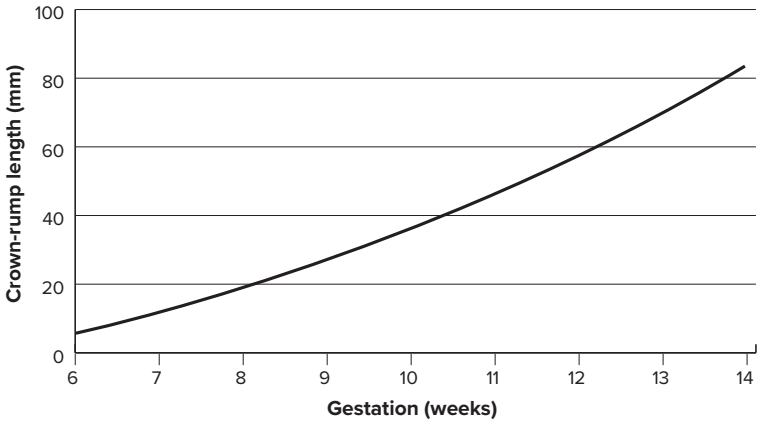

Figure 3. Crown-rump length during early pregnancy. Source: Westerway SC, Davison A, Cowell S. 2000. Ultrasonic fetal measurements: new Australian standards for the new millennium. Aust NZ J Obstet Gynaecol 40(3): 297–302. Available here

Cardiac activity

Embryonic cardiac activity (pulsatility) should always be visualised with a CRL ≥7 mm. A slow embryonic heart rate of <80 bpm may suggest a guarded prognosis for the pregnancy. Suggest a follow-up ultrasound scan if clinically appropriate.

Ultrasound and miscarriage diagnosis

Information on the diagnosis of early pregnancy loss by ultrasound are available in the "Early pregnancy loss" section of the New Zealand Obstetric Ultrasound Guidelines, and further detail on this is provided in Module 4 . It is very important not to misdiagnose miscarriage for people with a wanted pregnancy. However, there is no need to confirm an "ongoing pregnancy" prior to proceeding to an abortion.

Pregnancy of unknown location

> New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.3.9 states that: "*Where there is clinical suspicion of ectopic pregnancy, refer the person to an early pregnancy unit/service*"

Pregnancy of unknown location (PUL) is defined as the situation when the pregnancy test is positive but there are no signs of intrauterine pregnancy nor is an extrauterine pregnancy visible on transvaginal ultrasonography.

The definition of **ectopic pregnancy** is when a fertilised ovum implants outside of the uterine cavity. Approximately 1% of known pregnancies are ectopic. The vast majority of ectopic pregnancies are located in the fallopian tube. The aetiology of ectopic pregnancy includes the following factors:

- Obstruction or dysfunction of the tubal transport mechanisms
- An intrinsic abnormality of the fertilised ovum
- Conception late in cycle
- Transmigration of the fertilised ovum to contralateral tube

Risk factors for ectopic pregnancy include:

- A previous ectopic pregnancy (increases the risk 10 times)
- A history of pelvic infection (e.g. STI, PID, endometritis)
- Intrauterine contraception in situ
- Adhesions from previous pelvic surgery or endometriosis

However, in 50% of ectopic pregnancies, no risk factors are identified. Typical symptoms include:

- Amenorrhea with PV spotting or bleeding (the most common presentation)
- Pelvic pain, usually one-sided
- Other pregnancy symptoms
- If ruptured, then symptoms of shock (e.g. pallor, sweating, fainting, increasing pain, shoulder tip pain)

The characteristic signs of ectopic pregnancy include:

- Tenderness or signs of peritonism on abdominal examination
- Cervical motion tenderness (CMT) on pelvic examination
- Adnexal tenderness or mass
- If ruptured, then signs of shock and an acute abdomen

The diagnosis of an ectopic pregnancy is usually made with a strong index of suspicion based on the presentation and clinical findings, serial serum βhCG and a confirmatory pelvic ultrasound scan provided there are no symptoms or signs of shock. It is expected that an intrauterine gestational sac will be seen using trans-vaginal ultrasound (TVUS) at a βhCG level of 1500–2000 IU/L. If this is not present, then suspect an ectopic and ensure follow-up and appropriate management.

Management depends upon whether the patient is haemodynamically stable. If the patient is haemodynamically unstable, or there is significant concern about the degree of pain or bleeding, refer directly to secondary care (emergency department). If the patient is stable, then it may be appropriate to refer to an early pregnancy assessment service for ultrasound diagnosis and specialist management.

Miscarriage

Suspect miscarriage in patients presenting with bleeding or other symptoms and signs of early pregnancy complications who have pain or a pregnancy of six weeks gestation or more or a pregnancy of uncertain gestation.

Management:

- If haemodynamically unstable, or there is significant concern about the degree of pain or bleeding, refer directly to secondary care; or
- Refer to an early pregnancy assessment service for ultrasound diagnosis and specialist management.

Inform the patient that the diagnosis of miscarriage using one ultrasound scan cannot be guaranteed to be 100% accurate and there is a small chance that the diagnosis may be incorrect, particularly at very early gestational ages.

In the absence of a previous scan confirming an intrauterine pregnancy, always be aware of the possibility of a pregnancy of unknown location.

Further reading and resources:

- For further information on the diagnosis and management of ectopic pregnancy and miscarriage, see NICE Guideline 126: "Ectopic pregnancy and miscarriage: diagnosis and initial management"
- To read more about ectopic pregnancy, see Richardson A, Gallos I, Dobson S, Campbell BK, Coomarasamy A, Raine-Fenning N. (2016). Accuracy of first-trimester ultrasound in diagnosis of tubal ectopic pregnancy in the absence of an obvious extrauterine embryo: systematic review and meta-analysis. Ultrasound Obs Gynecol 2016;47:28–37. Available here
- To read more about how to determine nonviability, see Doubilet PM, Benson CB, Bourne T, *et al*. (2013). Diagnostic criteria for nonviable pregnancy early in the first trimester. N Engl J Med 2013;369:1443–51. Available here
- For a video on decision counselling following a positive pregnancy test results, click here

5. DECISION MAKING

Overview

This section focuses on decision-making, the final stage of the pre-abortion process, once the pregnancy is confirmed and gestation estimated. Health practitioners need to effectively communicate the pregnancy and abortion options available to the person, providing them with the information they require to make their decisions. They also need to ensure that the person is aware that counselling is available to them. Abortion related counselling must be in line with the Standard for Abortion Counselling in Aotearoa New Zealand (Ministry of Health, 2022). Health practitioners should have established contacts to refer people for counselling in their local area, or to The National Abortion Telehealth Service (decide.org.nz) counselling service.

New Zealand Aotearoa Abortion Clinical Guideline 2021,

- Recommendation 1.1.1 states: "*Offer people who are considering having an abortion information as outlined in Appendix B: Providing information for people considering an abortion*" and
- Recommendation 1.1.3 is to: "*Advise people to seek support if they need it, and how to access counselling and/or social supports*"

Informed consent

All people in Aotearoa New Zealand have the right to make an informed choice about their health care and, in most instances, must give permission to proceed with treatment. That permission is called informed consent. It is an interactive process between the health practitioner, the person and sometimes those close to the person, such as their family or whānau.

New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.2.1 states: "*Follow the appropriate best-practice guidelines in relation to obtaining consent (Ngā Paerewa Section 1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices)*"

It is the practitioner's responsibility to ensure informed consent is obtained, and to communicate and work with the person to help them make the best decision for themselves. The practitioner undertaking the treatment is responsible for the overall informed consent process. The person has the right to refuse treatment and withdraw consent. All people are presumed competent to give informed consent unless established otherwise. Verbal informed consent is usually sufficient, (if an early surgical abortion is to be carried out under general anaesthesia written informed consent is required), and should be clearly documented in the clinical notes.

In this video Professor Lynley Anderson of The Bioethics Centre at the University of Otago describes what informed consent is, and why getting it is important.

Further reading and resources:

- The New Zealand Code of Health and Disability Services Consumers' Rights 1996
- The Medical Council of New Zealand statement "Informed Consent: Helping patients make informed decisions about their care" is part of the Council's communication and consent standards
- Te Kaunihera Tapuhi o Aotearoa - Nursing Council of New Zealand's Tikanga Whanonga – Code of Conduct
- A consensus statement on informed consent and decision making from the New Zealand College of Midwives
- The Pharmacy Council of New Zealand Code of Ethics is available as a PDF

Pregnancy options – referral pathways

Decision to continue pregnancy

New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.1.2 states: "*Offer people who choose to continue their pregnancy information and support to transition to antenatal care*"

People who decide to continue with pregnancy should be transferred to Lead Maternity Carer (LMC) care. The "Find Your Midwife" website is a nationwide resource which allows people to select a LMC or a referral from a general practitioner may be required to access local maternity services.

Early pregnancy complications

Refer to the local gynaecology or early pregnancy service. If urgent care is required, refer immediately to the nearest emergency health services.

Ambivalence

Ensure that the pregnant person is aware of their abortion options with reference to gestational age. Suggest that they give themselves more time to make their decision. Make a follow-up appointment and offer pre-decision abortion counselling.

Abortion options and pathways

First trimester options

> New Zealand Aotearoa Abortion Clinical Guideline 2021, recommendation 1.4.1 states: "*Offer a choice of medical or surgical abortion, as appropriate to gestational age, medical history, person's preference and personal circumstances, health practitioner skill and local service provision. Offer information on the benefits and risks of each method to help people make a decision*"

People requesting an abortion should be offered an informed choice of medical or surgical methods, taking into account the gestational age, their medical history and local service provision options. Health practitioners also need to ensure that the person's home setting is suitable and safe, and that they will have access to emergency care if required, before offering an EMA in the home setting. Health practitioners should be well prepared to describe and discuss the options for abortion, communicating clearly in a manner best suited to the individual's needs. Table 1 is a summary of information that may help people make this decision. The table compares EMA and surgical abortion to 14 weeks and is adapted from Table 2 in Appendix B of the New Zealand Aotearoa Abortion Clinical Guideline 2021.

Table 1. Comparison between medical and surgical abortion (adapted from the New Zealand Aotearoa Abortion Clinical Guideline 2021 – Appendix B, Table 2)

	Medical abortion (to 70 days gestation)	**Early surgical abortion** (to approximately 14 weeks gestation)
Factor which may inform decision-making	• No surgery is required • No anaesthesia is required • It has potential for greater privacy • The procedure is completed by the person • It may feel more 'natural' (akin to a miscarriage) for some people • It will be painful, but pain can be managed with analgesics • The person is likely to have heavy bleeding and may see possible evidence of products of conception • For EMA, other side effects can include fever, nausea and diarrhoea	• The procedure is shorter • It is usually less painful as anaesthesia and analgesia are offered beforehand • The procedure is completed by a health practitioner • It is more effective than medical abortion (less risk of requiring further intervention) • An IUC, LNG-IUS or LNG implant can be fitted at the same time • There is less bleeding and the person does not have to see any possible evidence of products of conception unless they want to.
Timeframe and follow-up	• Duration of abortion can vary. Evidence is the abortion is likely to occur within 4–6 hours of taking the second medicine. However, it is possible that it may take days in extreme circumstances. • It is imperative to get the follow-up serum β-hCG test and the result, as it is the only way to know that the abortion is complete and there is no ongoing pregnancy	• The procedure itself is completed within 5–10 minutes • This is followed by 30–60 minutes of observation time

For further information for people choosing between EMA and surgical abortion in the first trimester, the following websites and resources are recommended:

- DECIDE (Decide.org.nz) is the National Abortion Telehealth Service. The DECIDE website provides user-focused information about the abortion services available in New Zealand, abortion care and how to find a local provider.
- International Planned Parenthood Federation (IPPF) has created a visual resource which may be useful for explaining abortion options, e.g. in combination with a translation service, when English is not the person's first language. There is a small amount of text, and it is currently available in English, French, Spanish, Hindi and Nepalese versions
- IPPF also provides a three-minute surgical abortion explainer video for people considering this option
- An overview table developed in the United States comparing EMA to early surgical abortion is available here

Change of decision to continue pregnancy after beginning the abortion process

People who choose to have an abortion are unlikely to change their mind.

There is no robust data regarding the pregnancy continuation rate after only taking 200 mg of mifepristone (the first medicine taken for EMA, which can also be used for cervical priming in early surgical abortion). It is likely that gestational age impacts outcomes.

There has been a proposal that taking progesterone after mifepristone would reverse the effect of the mifepristone, resulting in higher rates of continuing pregnancy for people who choose not to take the misoprostol. However, there is no evidence to support the safe use of progesterone as abortion reversal. The only randomised controlled trial to investigate this was stopped early due to high rates of significant blood loss with hospital admission for people in both the placebo and progesterone arms of the trial. The conclusion is people who do not take their misoprostol after the mifepristone are at increased risk of heavy bleeding requiring hospital admission.

People who change their minds about wanting an abortion after taking mifepristone need to be provided with evidence-based care to ensure they remain safe and well, including supporting any complications that occur. If someone presents after taking mifepristone and does not wish to continue with their abortion:

- Offer an ultrasound scan to establish if the pregnancy has continued
- Advise that if the pregnancy is seen to be continuing on ultrasound, there is a reasonable chance it will continue. However, there is an increased risk of pregnancy loss later in the pregnancy
- Advise that mifepristone is not known to cause birth anomalies
- Advise that there is no evidence to support treatment with progesterone and it should not be offered
- Offer counselling
- Advise of ongoing pregnancy options including abortion options
- Refer on for antenatal care if indicated

Abortion options after the first trimester

Abortion after 14 weeks is carried out through a surgical procedure (dilation and evacuation, usually under general anaesthetic) or with medicines (in a hospital or specialist clinic setting). Pregnant people with gestational age greater than 14 weeks should be referred to their local or regional abortion service for discussion of these options, taking into account the gestational age, their medical and surgical history, health practitioner skill and local/regional service provision.

Opportunistic STI screening

New Zealand Aotearoa Abortion Clinical Guideline 2021,

- Recommendation 1.3.11 states: "*Consider a routine sexual health check-up, in accordance with the New Zealand Sexual Health Society (NZSHS) guidelines*".
- Recommendation 1.3.12 states: "*Offer routine testing for chlamydia and gonorrhoea for all people having medical or surgical abortion - sexually transmitted infection (STI) screening should not cause delay to providing timely abortion care*".
- Recommendation 1.3.13 states: "*Consider testing for bacterial vaginosis if symptomatic and requested by the person*" and
- Recommendation 1.3.14 states: "*Treat people who test positive for an STI in accordance with NZSHS guidelines. Antibiotic treatment may commence as late as the day of the procedure and should not delay scheduling of the procedure. For treatment of sexual contacts, follow the* NZSHS Partner Notification guideline. *Consider meeting and treating sexual partner if they are attending the appointment*."

Practitioners should routinely offer opportunistic testing for chlamydia, and gonorrhoea using a vulvovaginal nuclear acid amplification test (NAAT) swab. This can be performed as part of a pelvic examination or self-collected. It is also advised to offer screening for other sexually transmitted infections following the Aotearoa New Zealand STI Guidelines.

- Ensure informed consent for screening, including pre- and post-test counselling
- Do not delay scheduling the abortion appointment while awaiting swab results
- Treat people who test positive for a STI appropriately following the Aotearoa New Zealand STI Guidelines
- Follow the NZSHS partner notification/contact tracing guidelines

Introduction to contraception options

A narrated presentation on 'Contraception after abortion' by Dr Helen Paterson is available here.

New Zealand Aotearoa Abortion Clinical Guideline 2021,

- Recommendation 1.1.4 states: "*Offer contraception counselling in accordance with New Zealand Aotearoa's Guidance on Contraception*".
- Recommendation 5.3.1 states: "*Offer contraception counselling in accordance with New Zealand Aotearoa's Guidance on Contraception and criteria 1.7.1 in Section 1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices*".

Peri-abortion contraceptive counselling and contraception provision, especially of long-acting reversible contraception (LARC), is an important part of abortion care to prevent subsequent unplanned pregnancies and provide future contraceptive options. Abortion service providers should be able to offer or facilitate access to all methods of contraception, including LARC, to individuals before they are discharged from the service after abortion. The Ministry of Health document 'New Zealand Aotearoa's guidance on contraception' (2020) provides advice and guidance on contraception counselling and options following abortion.

Contraceptive counselling should be individualised, person focused, non-coercive and tiered whereby the most effective contraceptive options are presented first. Information should be provided about the higher relative efficacy of LARC, including implants and intrauterine methods, compared to user-dependent, shorter-acting methods such as an oral contraceptive pill (OCP). The discussion process should be performed using shared decision making with the choice lying with the person ('the user is the chooser').

Provision of contraception should ideally occur at the time of the abortion. Consider providing the emergency contraceptive pill (ECP)/script for the ECP in advance for all patients not using LARC.

Contraceptive implants (Jadelle®) and injectables (Depo Provera®) can be administered as part of an EMA on the day mifepristone is taken. However, practitioners need to explain that having the Depo Provera® injection at the same time as mifepristone may increase the risk of ongoing pregnancy, although overall the risk is low.

Intrauterine contraception (IUC), including levonorgestrel containing intrauterine systems (IUS), should be inserted as soon as possible after an EMA when it is reasonably certain that the person is no longer pregnant. Expulsion rates of IUCs inserted immediately post abortion are higher. However, at six months more people are likely to have an IUC in situ compared to those who have delayed insertion. Abortion service providers should ensure that there are enough staff able to provide IUC or a progestogen-only implant so that individuals who choose these methods and are medically eligible can initiate them immediately after an abortion.

Combined hormonal contraception and POP can be safely started immediately at any time after abortion.

For people having a surgical aspiration abortion, contraception can be started on the day of the procedure. Progestogen implants can be inserted whilst the person is waiting for their procedure or after the procedure, and IUD can be inserted once the uterus has been evacuated. It is important to inform the person that there is a slightly higher expulsion rate of an IUD following a surgical abortion. The optimal length of the IUD strings also needs to be considered carefully as the uterus may involute (decrease in size) after the abortion, causing the strings to become longer. Strings may need to be trimmed and it is important to realise this is not necessarily a sign of a partial expulsion in this situation

Medical eligibility criteria for contraception are provided by;

- Faculty of Sexual and Reproductive Healthcare UK Medical Eligibility Criteria for Contraceptive Use (FSRH UK MEC)
- WHO Medical eligibility criteria for contraceptive use (5th edition 2015)

6. REVIEW OF KEY LEARNING POINTS

1. Abortion legislation in Aotearoa New Zealand and patient rights

- The Abortion Legislation Act 2020 made several changes to the provision of abortion in Aotearoa New Zealand:
  - A qualified health practitioner may provide abortion services to people up to 20 weeks pregnant
  - People can self-refer for abortion services
  - Counselling should be available on request but no longer required
  - Post 20 weeks gestation a qualified health practitioner must determine whether an abortion is clinically appropriate. This requirement does not apply in a medical emergency.
  - If a health provider has a conscientious objection to abortion, they must inform a patient requesting the service of this at the earliest opportunity and provide contact details for the nearest abortion provider
- The Contraception, Sterilisation, and Abortion (Safe Areas) Amendment Act 2022 allows for the creation of safe zones on request to the Ministry of Health, working with the Ministry of Justice.
- There is no legal age limit for having an abortion in Aotearoa New Zealand. Abortion services for under 16-year-olds are governed by the Care of Children Act 2004.
- The Code of Health and Disability Services Consumer's Rights, Te Tiriti o Waitangi, the UN Declaration on the Rights of Indigenous Peoples and the Convention on the Rights of Persons with Disabilities protect patient's rights in Aotearoa New Zealand. Outcome 1 of the Ngā Paerewa Health and Disability Standard (NZS 8134:2021) outlines standards for the health sector to aid in meeting these obligations.
- Telehealth services have advantages for some people seeking abortion however all abortion providers using telehealth need to be aware of its limitations to ensure that they do not attempt to provide a service that puts patients' safety at risk

2. Providing patient-centred abortion care

- Abortion service providers need to be able to provide high-quality care to Māori in a way that respects their identity, tikanga and worldview as Māori. Cultural safety training should be incorporated into abortion providers' continuing education
- Abortion service providers should routinely enquire about intimate family violence and be alert to any evidence of reproductive coercion. A system for referral to appropriate support services should be in place.
- Disabled people are often experts on their own conditions, and this should be recognised and respected by abortion care providers. Barriers limiting accessibility and effective communication need to be identified and overcome before providing abortion services.

3. Establishing the gestation and location of pregnancy and focused medical history

- The pregnancy should be confirmed by urine or serum testing, and a focused medical history needs to be taken to identify any contraindications or risk factors for early medical abortion (surgical abortion then advised)
- The gestation can be determined by ultrasound, the LMP date, and bimanual examination
- βhCG alone should not be used for dating and must be corelated with the LMP, clinical examination and/or the ultrasound scan findings. If the βhCG is significantly higher than anticipated, consider the possible of a molar pregnancy
- Approximately 1% of known pregnancies are ectopic (when a fertilised ovum implants outside of the uterine cavity). If suspected, patients should be referred for further ultrasound assessment or emergency care. Typical symptoms include:
  - Amenorrhea with PV spotting or bleeding (the most common presentation)
  - Pelvic pain, usually one-sided
  - Other pregnancy symptoms
  - If ruptured, then symptoms of shock (e.g. pallor, sweating, fainting, increasing pain, shoulder tip pain)

4. Effective shared decision making with people about their pregnancy outcome

- Health practitioners should be well prepared to describe and discuss the options for continuing pregnancy and abortion, communicating clearly in a manner best suited to the individual's needs
- It is the abortion service provider's responsibility to ensure informed consent is obtained, and to communicate and work with the person to help them make the best decision for themselves
- In instances where the pregnant person appears to feel ambivalent about abortion, suggest they give themselves more time, make a follow-up appointment and offer counselling
- People requesting an abortion should be offered an informed choice of medical or surgical methods, taking into account the gestational age, their medical history, health practitioner skill and local service provision options
- Practitioners should routinely offer opportunistic testing for STI, and contraceptive counselling and provision

7. FURTHER READING AND RESOURCES

In addition to the relevant legislation, other useful readings and resources not already linked within this document include:

Communication

Curtis, E., Jones, R., Tipene-Leach, D. *et al.* (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174. https://doi.org/10.1186/s12939-019-1082-3

Moseson, H., Fix, L., Ragosta, S., Forsberg, H., *et al*. (2021). Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States. American Journal of Obstetrics and Gynecology, 224(4), 376.e1-376.e11. https://doi.org/10.1016/j.ajog.2020.09.035

Whitehouse, K.C., Blaylock, R., Makleff, S., Lohr, P.A. (2021). It's a small bit of advice, but actually on the day, made such a difference...: perceptions of quality in abortion care in England and Wales. Reproductive Health 18, 221. https://doi.org/10.1186/s12978-021-01270-0

Fanslow J.L., Kelly P., Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health. Available from: https://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence

Mahanaimy, M., Gerdts, C., Moseson, H. (2020). What constitutes a good healthcare experience for unintended pregnancy? A qualitative study among young people in California. Culture, Health & Sexuality, 1–14. https://doi.org/10.1080/13691058.2020.1840631

Vodopivec, S., Bokal, E.V., Pinter, B. (2019). Counselling before first trimester abortion and acceptability of the procedure: Results from a Slovenian cross-sectional study. The European Journal of Contraception & Reproductive Health Care : The Official Journal of the European Society of Contraception, 24(6), 487–493. https://doi.org/10.1080/13625187.2019.1670346

Whitehead A., Fanslow J. (2005). Prevalence of family violence amongst women attending an abortion clinic in New Zealand. Aust New Zeal J Obstet Gynaecol 45:321–4. Available from: https://dx.doi.org/10.1111/j.1479-828X.2005.00420.x

Establishing gestation and location of pregnancy

Aiken, A.R.A., Lohr, P.A., Lord, J., *et al*. (2021). Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. BJOG 128: 1464-1474. https://doi.org/10.1111/1471-0528.16668

Doubilet P.M., Benson C.B., Bourne T., *et al.* (2013). Diagnostic criteria for nonviable pregnancy early in the first trimester. N Engl J Med. 369:1443–51. https://dx.doi.org/10.1056/NEJMra1302417

National Institute for Health and Care Excellence. (2019). Ectopic pregnancy and miscarriage: diagnosis and initial management. NICE guideline [NG126]. Available from: https://www.nice.org.uk/guidance/ng126

Richardson A., Gallos I., Dobson S., *et al*. (2016). Accuracy of first-trimester ultrasound in diagnosis of tubal ectopic pregnancy in the absence of an obvious extrauterine embryo: systematic review and meta-analysis. Ultrasound Obs Gynecol 47:28–37. Available from: https://dx.doi.org/10.1002/uog.14844

Decision making

NZCSRH Abortion Training 2022: Comparison of early abortion options, adapted from RHEDI

Aamlid, I.B., Dahl, B., & Sommerseth, E. (2021). Women's experiences with information before medication abortion at home, support during the process and follow-up procedures—A qualitative study. Sexual & Reproductive Healthcare : Official Journal of the Swedish Association of Midwives, 27, 100582. https://doi.org/10.1016/j.srhc.2020.100582

Heath, J., Mitchell, N., Fletcher, J. (2019). A comparison of termination of pregnancy procedures: Patient choice, emotional impact and satisfaction with care. Sexual & Reproductive Healthcare : Official Journal of the Swedish Association of Midwives, 19, 42–49. https://doi.org/10.1016/j.srhc.2018.12.002

Wingo, E., Ralph, L.J., Kaller, S., Biggs, M.A. (2021). Abortion method preference among people presenting for abortion care. Contraception, 103(4), 269–275. https://doi.org/10.1016/j.contraception.2020.12.010

Contraception after abortion

RCOG. (2022). Best practice in post-abortion contraception. https://www.rcog.org.uk/media/53fhrbz2/post-abortion-contraception-best-practice-paper-2022.pdf

8. QUIZ ON CONSULTATION – COMMUNICATION AND DECISION MAKING

Click here to access a quiz and test your understanding of the concepts discussed in the module.

9. FEEDBACK: NEW ZEALAND COLLEGE OF SEXUAL & REPRODUCTIVE HEALTH ABORTION TRAINING

Your feedback is invaluable to us to assist in improving the course. We would appreciate your assistance by completing the short form on the Abortion Training website feedback page.