BEST PRACTICE

SPECIAL EDITION

Termination of Pregnancy in New Zealand

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better medicine

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Best Practice Journal (BPJ)

ISSN 1177-5645

BPJ, Special Edition: Termination in New Zealand

January 2010

BPJ is published and owned by bpac^{nz}

Level 8, 10 George Street, Dunedin, New Zealand.

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Bpac^{nz} Ltd is currently funded through contracts with PHARMAC and DHBNZ.

Contact us:
Mail: P.O. Box 6032, Dunedin
Email: editor@bpac.org.nz
Free-fax: 0800 27 22 69

www.bpac.org.nz

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Key Concepts:

The role of the general practitioner is to advise their patients on options available, to refer to a termination clinic for consideration for termination if requested, and to arrange the appropriate pre- referral tests and follow-up.

- It is not the role of general practitioners to discuss their own personal views about termination. If a general practitioner is not able to refer personally, then arrangements must be made for the woman to be seen as soon as possible by another doctor in the area
- The role of the certifying consultant is to determine if there are legal grounds for termination and to arrange a termination if appropriate
- The earlier in pregnancy a termination is performed, the lower the risk of complications
- Under New Zealand law, a fully informed consenting woman may be considered for a termination of pregnancy. Young women under the age of 16 do not need to inform, or seek consent from their parent or guardian
- As with all patients, women (including those aged 16 and younger) seeking a termination have the right to confidentiality. Partners, parents and family members are only informed if the woman agrees to this.
- Education and access to appropriate contraception can play an important role in working towards a reduction in numbers of unplanned pregnancies.

Termination Law In New Zealand

The Contraception, Sterilisation and Abortion Act 1977 and the Crimes Act 1961 (amendments 1977 & 1978) are the basis for the law governing termination in New Zealand.

In New Zealand, the law allows a woman to obtain a termination at any gestation of pregnancy if two doctors who have been appointed as certifying consultants by the Abortion Supervisory Committee agree that there are sufficient grounds under Section 187a of the Crimes Act 1961 and the Contraception, Sterilisation and Abortion Act 1977.

Grounds for performing the termination (s.187a Crimes Act 1961 (as amended))

EITHER

where pregnancy is NOT MORE THAN 20 weeks

1) a) That the continuance of the pregnancy would result in serious danger to (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl, or

b) That there is substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped, or

2) That the pregnancy is the result of sexual intercourse between

- A parent and child; or
- A brother and sister, whether of the whole blood or of the half blood; or
- A grandparent and grandchild

3) That the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1) of the Crimes Act 1961, or

4) That the woman or girl is severely subnormal within the meaning of section 138(2) of the Crimes Act 1961

The following considerations, though not grounds in themselves, may also be taken into account in determining for the purposes of 1a):

- The age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years.
- There are reasonable grounds for believing that the pregnancy is the result of sexual violation.

OR

where pregnancy is OVER 20 weeks

That the termination is necessary

- to save the life of the woman or girl
- to prevent serious permanent injury to her (i) physical health (ii) mental health

NB: foetal abnormality, lethal or otherwise, is not grounds in itself for a termination over 20 weeks in New Zealand.

It is the role of the two certifying consultants to determine whether there are grounds under New Zealand law for performing a termination. It is not the role of the general practitioner to determine whether there are legal grounds for termination.

The Role of the GP

Before Referring

- Confirm the woman is pregnant with a positive pregnancy test
- Be prepared to discuss the options available to her: continuation of pregnancy, adoption or referral for consideration for a termination of pregnancy. If appropriate **allow time**, for her to consider these options and bring her decision to a further consultation
- If a woman seeks an early medical termination then refer promptly as it needs to be performed at less than nine weeks gestation. An ultrasound scan should be arranged as soon as possible to confirm gestational age. If the pregnancy is very early, a serum bHCG is also very helpful.
- Women should be made aware of the availability of free professional counselling which can be arranged when contact is made with the clinic
- Be prepared to discuss the different methods of termination available (discussed later in this document).

Under New Zealand law, a fully informed consenting woman may access a termination regardless of age. Young women under 16 do not need to inform their parents or seek parental consent.

A woman does not need the consent of her partner before having a termination.

Religious / Moral Conflict

It is not the role of general practitioners to discuss their own personal views about termination. If a general practitioner is not able to refer personally, then arrangements must be made for the woman to be seen as soon as possible by another doctor in the area

If any doctor has difficulty giving advice or referring a woman for consideration for termination because of moral or religious belief, and they know that this conflict might affect the advice and treatment provided, then this must be explained to the patient. The patient should be told that they have the right to see another doctor, and have information about access to alternative services readily available to them.

The Medical Council of NZ "Good Medical Practice" makes these points:[2]

- Respect the right of patients to make an informed choice about their care
- Make sure your personal beliefs do not influence your patient's care
- Respect and protect confidential information.

Ideally a practice should state clearly in the practice information leaflet, any website and in the practice premises if there are doctors who have a conflict that might interfere with their ability to refer for consideration for termination of pregnancy or provide contraceptive advice.

Making the Referral

If the woman requests referral for consideration for a termination of pregnancy, the referral should include:

- Relevant obstetric, gynaecological, medical, surgical, social, psychiatric history, and include contraception used at time of conception
- First antenatal bloods
- For very early gestations of pregnancy (under six weeks) a BHCG is very useful
- STI screening and treatment (see box page 6) and smear if appropriate

  Ensure copies of the results will be sent to the clinic that you are referring to

Assess gestation as accurately as possible by history (using LMP) and by examination. Arrange an urgent scan if the woman seeks an early medical termination to confirm that gestation is under nine weeks, and intra-uterine

Encourage the woman to return to you for follow-up post termination and to discuss ongoing contraception.

At the clinic, the woman will see nurses, counsellors if required, and two registered certifying consultants. If the woman's referring doctor is a certifying consultant then she will only need to see one more certifying consultant at the clinic.

The certifying consultants will go over any relevant medical, surgical and psychiatric history with the woman. They will do a routine pre-op assessment and examination and assess her legal eligibility for a termination. If one certifying consultant declines certification, the woman is entitled to be referred to other certifying consultants for further consideration of her legal eligibility.

Once the woman has two certificates she may proceed to termination.

Claiming under Section 88

Claiming for First Trimester Non-LMC termination services under the Section 88 Maternity Services Notice

To make a claim for funding for termination of pregnancy services, a Provider has to be authorised by the Ministry of Health under the Primary Maternity Services Notice 2007 ('the Notice') pursuant to Section 88 of the Public Health and Disability Act 2000.

An 'authorised' General Practitioner is able to claim a fee under the Non-LMC First Trimester Module of the Notice of $150 for assessment, care, advice and referral in relation to termination of pregnancy and $40 for the post termination follow-up consultation.

If you are not an 'authorised' provider at the time of the consultation you will not be able to claim retrospectively. You will need to make a decision whether or not to charge the patient.

To become an authorised maternity provider you will need to contact Ministry of Heath Sector Service Directorate and complete an application form. Once the application has been approved, you will be issued with a Payee number, Agreement number and a Section 88 Maternity Advice Notice.

You can contact the Sector Services Directorate by:

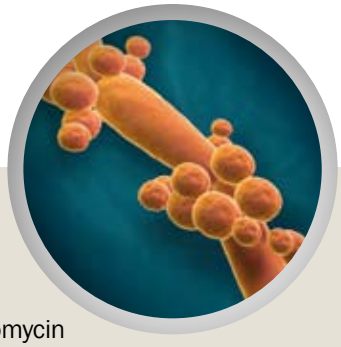
Phone: 0800 281 222

Post: Sector Services,
Private Bag 1942,
Dunedin

Follow-Up Post Termination

It is an important role of the referring general practitioner to arrange follow-up post termination. It is recommended the follow-up include:

- Assessment and management of any complications arising from the termination, that may include excessive bleeding, pain, discharge, or fever
- Contraception (in almost 55% of terminations no contraception was used and in 35% of cases there has been a previous termination)
- Offer free post termination counselling for woman who may have problems come to terms with having had an abortion. Referral to free post abortion counselling can be arranged by contacting the termination clinic



Screening and Treatment of Sexually Transmitted Infection

Screening for *Chlamydia trachomatis* is imperative. In a 2005 study, 7.7% of women tested positive pre termination of pregnancy.[3] Untreated Chlamydia is associated with significant post-op morbidity, including endometritis, salpingitis and pelvic inflammatory disease.

A endocervical swab for a PCR test for Chlamydia is the gold standard as there is a high false negative rate with urine tests for Chlamydia in women.

Screening for *Neisseria gonorrhoea* is mandatory and should be done on a separate endocervical swab then transported to the laboratory as soon as possible. There is approximately a 50% loss of viable organisms if it takes more than 24 hrs before the sample gets to the laboratory.

Most laboratories are able to check for other infections such as Trichomonas vaginalis and Bacterial vaginosis on the same swab, if not then send a third swab (high vaginal).

If any swabs come back as positive for infection, it is important that the GP make contact with the woman and arrange for immediate treatment for both the woman and her partner(s).

Treatment for Chlamydia: Azithromycin 1 g stat (certified condition)

Treatment for Gonorrhoea: If penicillin susceptible use Amoxycillin 3 g and Probenecid 1 g stat . If Ciprofloxacin susceptible use Ciprofloxacin 500 mg stat. If Ciprofloxacin resistant use Ceftriaxone 250 mg IM.

When treating Gonorrhoea infection, treatment regimens should include treatment for Chlamydia as well, as co-infection is common.

Treatment for Bacterial vaginosis/*Gardnerella vaginalis* / Trichomonas (both confirmed or indeterminant): Ornidazole 1.5 g stat, or tinidazole 2 g stat or Metronidazole 2 g stat or 400 mg tds for 7 days

Some clinics consider giving treatment for Group B Streptococcus agalactiae where cultured. Contact your local clinic for advice.

Advise the woman not to have sexual intercourse until she has been seen at clinic as re-infection can cause unnecessary delays in any procedures.

Contraception

General practitioners, sexual health clinics and family planning clinics play a major role in the provision of advice and access to contraception.

In the 2007 Abortion Supervisory Committee report, women accessing a termination reported using the following methods of contraception at the time of conception:

- 54.8% No method
- 26.7% Condoms
- 13.4% Oral contraceptives
- 2% Natural Family Planning
- 1.2% Morning After Pill
- 1.1% Intrauterine Device
- 0.5% Injection (Depo-Provera)

While most women will be prescribed appropriate contraception at the time of accessing termination services, it is recommended that contraception is again fully discussed with the woman when she returns for her post termination follow-up check. Recall systems can be valuable for ensuring contraception is maintained.

Future Reproductive Outcome There is no evidence of an association between induced termination and subsequent ectopic pregnancy, placenta praevia or infertility. There may be a slight increase in the risk of subsequent late miscarriage or preterm labour in those woman who have had five or more abortions but study results are not consistent.

Psychological sequelae Some studies suggest a very small increase in rates of self-harm and mental health illness among women who have had a termination but these findings do not imply a causal association and may reflect continuation of pre-existing conditions.

Statistics

- Approximately one in five pregnancies is terminated (in New Zealand and worldwide). In the UK one third of women will have had one termination of pregnancy before the age of 45.
- In New Zealand, 18,380 terminations were performed in 2007.[1]
- The termination rate has been relatively stable over the past decade and is similar to Australia and USA.
- The termination rate is highest amongst women aged 20–24 years with the median age of 25 years – this has stayed the same over the last twenty years.
- In 2007, most terminations (65%) were a woman's first termination. The majority of terminations were performed during the 9th–11th week of gestation. The risk of complications is less when terminations are performed at early gestations.
- Only 0.3% of terminations happen after 20 weeks gestation.
- 98–99% of all terminations in New Zealand are granted on the basis of serious danger to the mental health of the woman. Similar statistics are found in the UK.

Methods of Termination

Methods of termination

- Medical termination in the first trimester (MTOP)
- Surgical termination in the first trimester (STOP)
- Medical termination in the second trimester
- Surgical termination in the second trimester

Medical termination in the first trimester (MTOP)

In 2001 Mifegyne (mifepristone) 200 mg (formerly known as RU486) was approved by MedSafe, the Medicines Assessment Advisory Committee and the Ministry of Health for four indications:

- Early medical termination of pregnancy
- Priming the cervix before a surgical termination
- Second trimester medical termination of pregnancy
- Induction of labour for foetal death in utero

Mifepristone is an anti-progesterone that in pregnancy causes decidual shedding in pregnancies less than nine weeks gestation, sensitizes the myometrium to the contraction-inducing action of prostaglandin and causes cervical ripening.

Misoprostol is a prostaglandin analogue that causes uterine contractions and cervical dilatation.

In New Zealand early medical terminations consist of 200 mg mifepristone orally, followed 24–72 hours later by the vaginal administration of 800 mcg misoprostol (a prostaglandin analogue). This can be followed by smaller doses of oral misoprostol if required.

New Zealand law states that oral mifepristone followed by misoprostol 24 to 48 hours later, depending on the clinical proptocol, must be taken in a licensed institution. If a woman lives close by she may not have to stay in the clinic after taking the medication, but it is important she knows who to call should she have any bleeding.

Medical termination is recommended by the UK RCOG as the method of choice for women up to nine weeks gestation.[4] Medical terminations are associated with less infection and no perforation as compared with surgical termination. Bleeding may be a complication of medical termination.

Medical contraindications for early medical termination and use of Mifepristone.

- No confirmation of pregnancy
- Ectopic pregnancy
- Known bleeding disorder or current anticoagulant medication
- Chronic adrenal failure
- Porphyria
- Anaemia (Hb <100 g/L)
- IUCD in-situ

- Known allergy to either mifepristone or misoprostol
- Severe cardiovascular disease or greater than two cardiovascular risk factors
- Renal or liver failure
- Malnutrition
- Multiple uterine scars or history of uterine rupture
- Long-term steroid medication (mifepristone may make steroids less effective and hence increased doses may be needed)
- Breast feeding (theoretical risk of mifepristone being excreted in breast milk and so women are advised not to breast feed for two to three days after mifepristone)

Social contraindications for early medical termination[5]

- Woman unwilling to proceed to surgical termination if indicated
- Living more than one hour's travelling time from emergency medical services
- Lack of direct telephone access or unable to communicate easily by telephone e.g language difficulties
- Lack of reliable transport i.e. car or money for taxis (for return visits and in the advent of an emergency)
- Unsuitable home environment and/or lack of support
- Woman's inability to cope with cramping and heavy bleeding

Surgical termination in the first trimester (STOP)

Surgical termination is performed under general anesthetic or conscious sedation (fentanyl and midazolam IV). All first trimester surgical operations use suction.

One to three hours prior to surgical termination being performed, misoprostol may be given orally to soften and dilate the cervix.

Second trimester termination of pregnancy

Mifepristone can also be used to induce labour and a termination of pregnancy after 12 weeks gestation. The woman is admitted to a clinic and is given mifepristone followed by repeated doses of misoprostol. This method of second trimester termination is used in some of the larger units in New Zealand.

The interval between the administration of misoprostol and delivery of the products of conception is on average 6-8 hours. This reflects a marked reduction in time to delivery when compared with the past practice of using oxytocin.

Other methods used are laminaria (thin rods of a dried kelp species that are used to slowly dilate the cervix) followed by a surgical termination under general anesthetic, and dilatation and evacuation following mifepristone administration.

Ectopic pregnancy

Mifepristone has **NOT** been shown to be effective in treating ectopic pregnancy. Every effort must be made to exclude an ectopic pregnancy pre-termination, however some will be missed. A pseudo-gestational sac may be present on ultrasound, which may mimic an early intrauterine pregnancy. If no products are seen following a medical or surgical termination, then follow-up to exclude an ectopic pregnancy must be done.

Management of **side effects and complications**

The data on complications due to terminations performed in New Zealand is incomplete. Approximately 30% of women return to their referring general practitioner for follow-up therefore there are no reliable figures available. The follow up visit is important to ensure that both the physical, and psychological health is maintained and contraception organised.

Managing early medical termination in the community

Pain: It is very common for women to experience abdominal cramps in the hours following prostaglandin intake, but the severity varies from patient to patient. The peak of pain and bleeding occurs at the expulsion of the gestation sac. Pain is modified by such factors as fear and anxiety. Full preliminary information and support during the procedure can modify the pain.

Usually a hot water bottle and oral analgesics (paracetamol, NSAIDs, codeine) will be sufficient to control the pain in most women. Some women may also require anti-nausea medication.

Bleeding is a normal consequence of the termination process but may exceed a woman's previous experience of menstrual bleeding. As with pain management, informing the patient in advance of what to expect is essential.

The heaviest bleeding usually occurs at the time of expulsion of the gestational sac which for 5% of women will be before misoprostol administration. Bleeding after a medical termination is commonly more erratic than after a surgical termination and may still be present several weeks after the procedure.

- 77% of women describe their bleeding as "spotting" at 15 days
- 9% continue to have some bleeding at 30 days
- 1% continue to have some bleeding at 60 days

Women should be told to initiate contact if bleeding soaks through two thick full-size sanitary pads per hour for two consecutive hours. The size of the clots and the accompanying symptoms (such as dizziness, weakness) must be factored into the assessment.

Depending on these variables, a doctor may advise admission to hospital for evaluation.

Surgical intervention for excessive bleeding is required in less than 1% of first trimester medical terminations. The woman should have been given her clinic contact number and advice can be sought here first.

Temperature: Hot flushes and fever are also fairly common side effects of high dose misoprostol. These symptoms are usually short-lived and resolve spontaneously.

A post termination temperature greater than 38°C that persists for several hours warrants evaluation for infection as would be done after miscarriage. This includes endocervical swabs for Chlamydia and Gonorrhea and a standard high vaginal swab. A FBC and CRP can also be helpful.

Infection: Endometritis is a rare complication of medical termination, especially patients screened and treated for STIs. Persistent pelvic pain in the days after a termination

should be evaluated for possible endometritis or incomplete termination. Either condition may cause the uterus to feel slightly enlarged, softened and tender.

A seven day course of a broad-spectrum antibiotic (such as amoxycillin with clavulanic acid or erythromycin) may be used for treatment of infection, while awaiting swab results to further guide treatment.

Uterine/cervical trauma: Cervical and uterine trauma does not occur in early medical terminations.

Failed termination: 10 out of 1000 medical terminations may fail to achieve expulsion of the pregnancy. If there is any doubt about a continuing pregnancy, two serum HCGs taken two days apart will be helpful. If hormone levels are not dropping appropriately, then the woman should be immediately referred to your local gynecology clinic for scan and assessment for ongoing pregnancy including ectopic.

Managing Surgical terminations in the Community

Fever, bleeding and pain are all signs which can signify infection or retained products of conception and these need to be checked at follow-up. If an IUCD has been inserted at the time of the termination, it is often not necessary to remove it as symptoms can often be managed without having to remove the device. However if the clinical condition of the woman warrants it, removal may be necessary. The woman must then be informed she is no longer protected from pregnancy and other contraception will need to be arranged.

Pain: It is usual to experience some crampy abdominal pain for a short while following the procedure. This often responds well to simple analgesia (paracetamol, NSAIDs) and reassurance.

Bleeding: Bleeding usually settles in the first week to ten days after a surgical termination. Fresh bleeding, clots or prolonged bleeding may be a sign of retained products of conception, a failed termination or infection. Heavy bleeding should be managed as for a miscarriage.

Prolonged light bleeding will often settle with a course of antibiotics such as amoxycillin with clavulanic acid or erythromycin. If bleeding persists, arrange an ultrasound scan. Consider the role of contraception such as Depo Provera in causing persistent bleeding.

Infection: Post-termination infection can range from a low grade endometritis to, rarely, a full-blown pelvic inflammatory disease with septicaemia. Prophylactic antibiotics reduce the subsequent incidence of infection and are used routinely in New-Zealand clinics. If there is no temperature and fresh bleeding is minimal , but you suspect a low grade infection on clinical grounds, such as pain on pelvic examination, then a trial of a broad spectrum antibiotic (such as amoxycillin and clavulanic acid or erythromycin) may deal with low-grade infections without the need for more invasive interventions.

Uterine/cervical trauma: The advent of misoprostol as a pre-op medication has significantly reduced the incidence of cervical trauma. **Trauma at the tenaculum site may sometimes be seen at follow-up examination, and conservative management is recommended. Uterine trauma will usually have been identified at operation or in the immediate post-operative period and managed at the clinic. If in doubt a gynaecological opinion can be sought.**

Failed termination: There is approximately one failure per 1000 surgical terminations. Bear the possibility in mind if the woman tells you she still feels pregnant at the post-op check up. If there is any doubt about a continuing pregnancy, two serum HCGs taken two days apart will be helpful. If hormone levels are not dropping appropriately, then the woman should be immediately referred to your local gynaecology clinic for scan and assessment to determine if there is an ongoing and possibly ectopic pregnancy.

Access to Services

At present in New Zealand, there are issues around equity of access. The majority of DHBs are either experiencing access issues, or expect to, due to workforce constraints and, in some areas lack of facilities. This is especially so for second trimester terminations.

Some women are required to travel long distances to access a termination service.

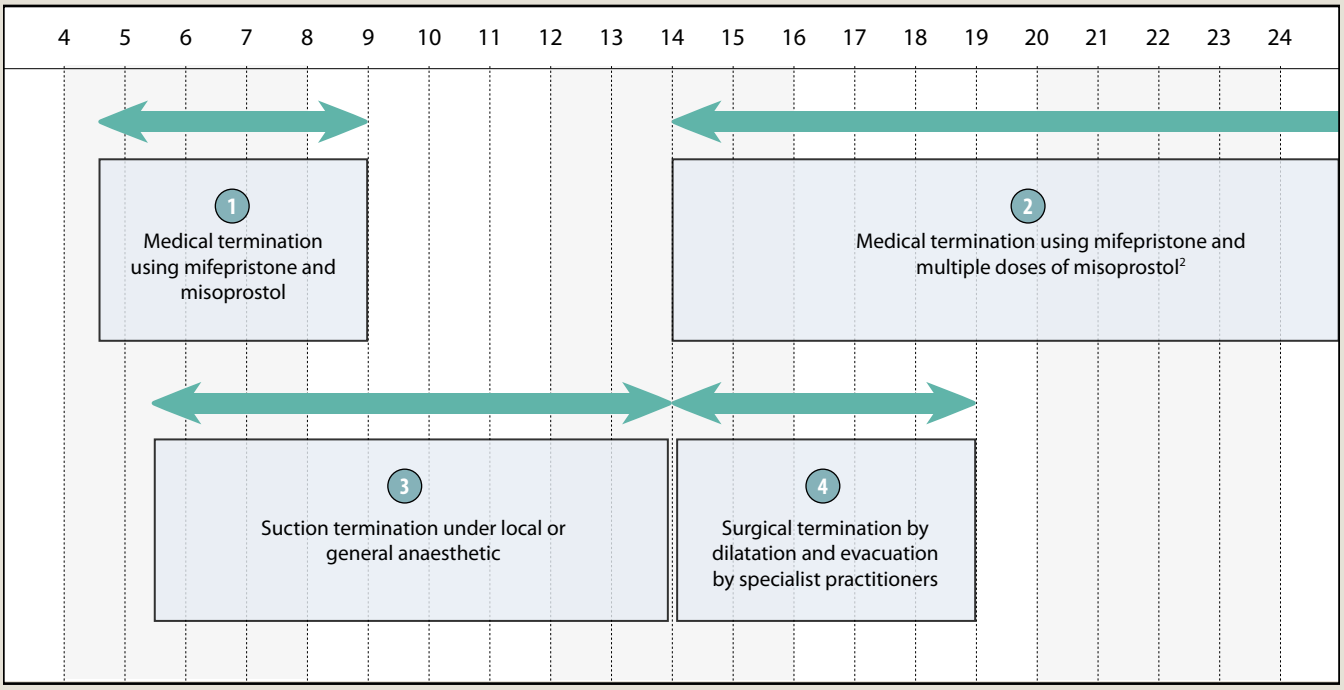
If the woman is going to have to leave her family and travel outside her area to access a termination service, the referring doctor can discuss travel arrangements with the travel coordinator at their local DHB (this may vary from region to region).

A recent study reported women who live in regions that do not offer local termination of pregnancy (TOP) services must travel on average 221 km to access TOP services. This equates to an average return-trip distance of 442 km. Three of the five regions that do not have local TOP services available have a higher than average proportion of Māori population.[5]

See **www.abortion.gen.nz** for a list of DHBs and the licensed termination clinics in each area with contact details.

Appendix 1: Recommended methods of termination for different gestations in NZ, (adapted from UK RCOG[4])

Gestation (weeks from date of last menstrual period)



1. **Early Medical termination** using an oral dose of the anti-progesterone, mifepristone, followed by an appropriate (vaginal or oral) dose of misoprostol.
2. **Medical termination** using an oral dose as appropriate of the anti-progesterone, mifepristone, followed by multiple doses (vaginal or oral) of misoprostol.
3. **Surgical termination** using electric or manual suction, under local or, if appropriate, general anaesthetic. The uterus is emptied using a suction curette. Sharp curettage with metal instruments may be necessary.
4. **Surgical termination** at later gestations usually performed after preparation and dilatation of the cervix with Laminaria followed some hours later with a combination of suction curettage and specialist forceps, performed under local or general anaesthetic as appropriate.

References:

1. Statistics New-Zealand Tatauranga Aotearoa July 2008 (www.stats.govt.nz/default.htm)
2. Medical Council of New-Zealand- Good Medical Practice;A guide of doctors(August 2004).www.mcnz.org.nz/portals/0/guidance/goodmedpractice.pdf
3. Rose S, Lawton B, Brown S et al. High rates of Chlamydia in patients referred for termination of pregnancy: treatment, contact tracing, and implications for screening. NZ Med J. 2005 Mar 11;118(1211)
4. UK Royal College Obstetrics & Gynaecology Guideline. The Care of Women Requesting Induced Termination. Evidence-based Clinical Guideline Number 7; September 2004

   Adapted from: www.rcog.org.uk/resources/Public/pdf/termination_summary.pdf
5. Silva M, McNeil R. Geographical access to Termination of Pregnancy Services in New Zealand. Australian and New Zealand Journal of Public Health Vol 32, No 6, 519-521

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Contact
Jamie Murley
bestpractice Decision Support
Level 8, 10 George Street
PO Box 6032
Dunedin
Ph: 03 479 2816 Fax: 03 479 2569
Email: **jamiem@bpac.org.nz**

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