# What does abortion law reform mean for primary care practitioners in New Zealand?

Emma Macfarlane, Michael Stitely, Helen Paterson


## ABSTRACT

New Zealand achieved a major sexual reproductive health and rights milestone when abortion ceased to be a crime. Introduction of the Abortion Legislation Act 2020 has significantly changed the way abortion care can be provided in New Zealand, with the potential to improve access, reduce inequities and transform the abortion experience for those people who choose to end their pregnancy. The primary care sector stands to be a key player in the provision of first-trimester abortion care. However, with issues relating to funding, training and access to medications yet to be resolved, the health sector is not yet ready to provide best-practice abortion care within the new legislative framework.


On 23 March 2020 the Abortion Legislation Act (AL) 2020 was passed into law with the result that abortion in New Zealand is no longer a crime.[1] There is now scope for qualified health practitioners to provide abortion care that is evidence based, aimed at reducing inequities in access and more acceptable to pregnant people and their whānau. However, in almost 12 months since the law reform, little has changed in the way that abortion services are configured, and we are yet to realise the full extent of abortion care within a decriminalised environment.

A review of the literature was undertaken using the databases Medline and Google Scholar. The following key words were used: abortion, abortion law reform, primary care, mid-level health providers. Any references of papers identified through the literature review that seemed relevant were located and considered for inclusion in the review. This review includes relevant New Zealand legislation and standards and international recommendations on provision of abortion in primary care. The aim of this paper is to review the international literature to inform how optimal, first-trimester abortion care can be provided in the primary care setting post abortion law reform in Aotearoa New Zealand.

**Figure 1:** Key points of Abortion Law Reform in New Zealand

- No statutory test for abortions <20 weeks gestation
- Abortions can be provided by a range of health practitioners
- Provision remains for conscientious objection
- No requirement for licensed premises

## Background

Abortion is one of the most common gynaecological procedures, and one in four women internationally will have an abortion in their lifetime.[2] For the year ending 2019 the general abortion rate in New Zealand was 13.5 abortions per 1,000 women (pregnant people) aged 15–44, and 19% of all known pregnancies ended in abortion.[3] The term 'woman' is used by the AL Act. We consider this to be inclusive of transgender, gender-fluid, non-binary and gender non-conforming people.


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The previous laws governing abortion in New Zealand were sections 182A–187A of the Crimes Act 1961 and sections 10–46 of the Contraception, Sterilisation and Abortion (CSA) Act 1977.[4,5] With safe abortions readily available, the only rational purpose for criminalising abortion is to deter, punish and place the rights of the fetus over the rights and autonomy of the pregnant person.[6] New Zealand's abortion laws were considered by some as a violation of human rights, and in 2019 Abortion Law Reform Aotearoa New Zealand (ALRANZ) brought a case to the Office of Human Rights Proceedings. The complaint was subsequently withdrawn when the AL Act 2020 was passed, as the AL Act addressed the issues raised by ALRANZ.[7]

The intention of the AL Bill 2019[8] was to decriminalise abortion and bring the legal framework for abortion in New Zealand in line with how other health services are delivered, and in doing so treat abortion as a health issue rather than a criminal justice issue.[9] Decriminalisation of abortion can be defined as not punishing anyone for providing or having an abortion, and not involving the criminal justice system in deciding who can have an abortion. Above all it means treating abortion like any other health procedure.[6]

Implementation of the AL Act transferred supervision of abortion services from the Ministry of Justice to the Ministry of Health (MOH). The MOH is now responsible for ensuring that abortion care and counselling are provided according to standards published by the Director-General.[1] Currently, these are the Interim Standards for Abortion Services in New Zealand (the 'Interim Abortion Standards'), which, published in April 2020, are an amended version of the 2018 Abortion Standards.[10] Abortion has been included in the draft Health and Disability Services Standards Review.[11]

Recently, the MOH released a report from district health boards (DHBs) on abortion service provision post abortion-law reform. The results identify issues relating to workforce development, training and the way in which services are delivered. These issues continue to negatively impact on equitable access and timeliness of abortion care.[12]

## The new law: there is no statutory test for abortion before 20 weeks gestation

Under the AL Act 2020, health-practitioner approval is not required for an abortion before 20 weeks gestation.[1] Under previous legislation, two certifying consultants had to agree that the person met the criteria for having an abortion as specified by section 187A of the Crimes Act.[4] Most pregnant people less than 20 weeks had an abortion on the grounds that continuing the pregnancy posed a serious danger to life, or physical or mental health.[4] The decision to have an abortion was not the pregnant person's and there was the potential for an abortion request to be declined. Under the AL Act, people less than 20 weeks pregnant who seek an abortion can obtain an abortion from a suitably qualified health practitioner.[1] This means that up until 20 weeks' gestation it is the pregnant person's choice to have an abortion. For pregnant people over 20 weeks, the suitably qualified health practitioner must consult with another health practitioner, decide whether an abortion is clinically appropriate and "have regard to; all relevant legal, professional, and ethical standards to which the qualified health practitioner is subject; and the woman's physical health; and mental health; and overall well-being; and the gestational age of the fetus."[1] This means that, once they have been pregnant for more than 20 weeks, it is not solely the pregnant person's choice to have an abortion. The final decision remains with the health practitioner.

## Abortion care can be provided by a range of health practitioners

The AL Act 2020 states that abortions can be provided by a "qualified health practitioner," as defined by the Health Practitioners Competence Assurance Act.[1] However, what this actually means for practitioners requires clarification.

The World Health Organization (WHO) advocates the shifting and sharing of abortion care from specialist providers to mid-level providers, such as registered nurses, nurse practitioners and midwives. The WHO recommends that these health practitioners can safely provide EMA and aspiration abortion in the primary care

setting.[13] The rationale for training mid-level health providers in abortion care is to increase access to abortion and reduce the burden of cost to the healthcare system, while not compromising on safety.[14]

Health practitioners who are not abortion providers can refer the pregnant person to an abortion provider. However, section 13 of the AL Act 2020 states that provision of abortion care is not contingent on a referral from another health practitioner and that pregnant people can self-refer.[1]

## What about conscientious objection?

Sections 14 and 15 of the Abortion Legislation Act 2020 maintains a health practitioner's legal right to conscientiously object to provide or assist with abortion, sterilisation, contraception or advice regarding pregnancy options.[1] The key differences between the AL Act 2020 and the CSA Act 1977 are that conscientious objectors must now disclose their stance as soon as possible and provide contact details of the closest provider. However, if the conscientious objection causes an unreasonable disruption to the service, an employer can take steps, including provision of less favourable terms of employment, termination or retirement.[1]

It could be seen that the new legislation does go some way in addressing the impact of conscientious objection on abortion services. However, it is less likely to address the impact in primary care where practitioners provide a range of services and whose patients may not be aware of their stance. Unless conscientious objectors are made to publically disclose their objection, there is always the potential for pregnant people to be denied care.

## Where abortions can be provided

Before the introduction of the AL Act 2020, pregnant people were required to be referred to one of 27 licensed institutions.[5] The new legislation does not limit where abortions can be provided. Early abortion services provided in primary care are safe and effective.[13] Early medical abortion (EMA) involves taking two medications 36–48 hours apart to end the pregnancy. The recommended medications are mifepristone and misoprostol.[15] EMA is well suited to primary care as it does not require procedural training or technical facilities, and pregnant people can be monitored as outpatients.[16,17] EMA providers can be trained in manual vacuum aspiration as a back-up for a failed EMA, and most EMA complications can be safely managed in primary care.[17] However, a few complications associated with EMA require emergency referral.[17] Therefore it is important to have referral pathways in place to secondary care.[14]

Primary health providers, particularly in rural areas, have the potential to increase access to EMA. Pregnant people living in rural or remote regions rely on primary healthcare services to meet their basic health needs. Strengthening primary care is a way of reducing health inequities.[17] Furthermore, abortion may be more acceptable when provided by a primary health practitioner. One study of pregnant people attending either a primary care university clinic or a free-standing abortion clinic found that most preferred to receive early abortion care with their trusted primary provider. The authors suggest integrating early abortion care into primary care to improve access and health outcomes for people with an unintended pregnancy.[18]

The Interim Abortion Standards recommend that people should not be required to travel more than two hours to access an abortion.[10] Providing first-trimester abortion in primary care may significantly decrease the travel some people presently undertake to have an abortion, and also allow for provision of EMA via telemedicine.

Under the previous law, administration of abortion pills was defined as the abortion.[19] People were required to be observed taking the medication on a licensed premise, and as the most effective regime is to take the medications 36–48 hours apart, people had to return to the clinic for the second dose.[15] Removing the requirement for abortion to be provided on licensed premises makes self-managed abortion possible.

A recent Cochrane review shows that self-managed EMA is as effective as provider-administered EMA and is acceptable to women.[20] A self-managed EMA allows a pregnant person to take the abortion pills at a time and place that suits them without supervision. It also means that the person can self-assess completion of the procedure

by using appropriate pregnancy test kits and symptom checklists.[20] The aim of self-managed abortion is to increase access and acceptability, and it has the potential to reduce demand on health services.[20] The role of the primary care clinician in self-managed EMA is to provide assessment, information and advice to the pregnant person on how to take the medication correctly, how they can self-assess progress and how they can access help and information as needed.[20]

## What is required for successful implementation of abortion into primary care?

Clinicians should receive training and support to competently provide safe abortion care. Primary care should also have tool kits, which could include assessment templates, clinical decision-making support tools and information and summary-of-care templates, in case the pregnant person presents acutely to another health provider.[16]

Prior to the repeal of the Eighth Amendment, Ireland essentially did not provide abortions, and subsequent to the repeal, practitioners in primary and secondary care needed to rapidly acquire the skills to provide the service. The government was criticised for its lack of support and leadership.[21] Nepal's success in making safe, legal abortion widely available has been attributed to a number of factors, including commitment and leadership by the Nepalese government and a comprehensive approach to implementation of abortion services. Abortion programmes and policies were based on international evidence for best-practice abortion care and the training of mid-level providers to increase the number of clinicians able to provide care to a wider geographical area.[22] New Zealand currently does not have a primary care-based training programme for abortion, but the New Zealand College of Sexual and Reproductive Health is developing an online learning module for provision of EMA.

For task shifting of abortion care to non-specialist providers to occur we need the support and leadership of our current abortion providers, who will be crucial in leading training and providing ongoing support to new providers.[23] Specialist obstetricians in Nepal provided training, oversight and support to the mid-level health providers who subsequently provided abortion care in the communities.[22] Specialist providers will always be needed to provide emergency care, and although their roles in abortion care will be different, they will remain crucial to the provision of safe and effective abortion care.[23]

Perhaps the most important factor in the success of expanding health-worker roles by task shifting is their willingness to provide abortion care. Willingness is influenced by a number of factors, such as personal views on abortion, the method of abortion they are asked to perform, gestation of the fetus and health-provider perceptions of their roles as preservers of life. One way that has been shown to be successful in increasing willingness to provide abortion care is through values-clarification workshops.[24]

It will be important for health regulatory bodies to ensure that abortion care is clearly included in appropriate scopes of practice.[23] The Midwifery Council of New Zealand has provided a clear statement that abortion is within the midwifery scope of practice. Midwives, as authorised prescribers, can prescribe the medications required for abortion and, with appropriate training, can perform surgical abortion to the extent allowed by their scope.[25]

Essential to provision of EMA is the ability to provide the required medications with as few barriers as possible. Nurses often provide medications under standing orders as per the Medicines (Standing Orders) Regulations 2002, whereby non-prescribers can administer or supply specific medications according to a written instruction issued by an authorised practitioner, nurse practitioner or optometrist.[26] In practice, standing orders can pose a significant amount of work for an organisation to comply with the requirements of the legislation. A scenario exists for a non-prescriber who wishes to provide EMA but lacks a supportive prescriber to administer a standing order. One solution would be to develop a national standing order for misoprostol and mifepristone and a network of supportive prescribers to administer the standing order. A further solution would

be to ensure that the medications can be prescribed by all non-medical prescribers.

There are a range of non-medical prescribers in New Zealand. Under the interpretations of the Medicines Act 1981 authorised prescriber means "a nurse practitioner; or an optometrist; or a practitioner; or a registered midwife; or a designated prescriber," where a "designated prescriber" is a registered health professional who has undertaken further education and training in order to be able to prescribe.[27] Currently, there appears to be confusion regarding whether a designated prescriber is an authorised prescriber or not. For example, in an overview of non-medical prescribing in New Zealand, designated prescribers are clearly distinguished from authorised prescribers.[28] However, this is in contrast to the interpretations section of the Medicines Act 1981, which lists designated prescribers among authorised prescribers.[27]

There are two levels of registered nurse (RN) designated prescribers in New Zealand: (1) prescribing in primary health and speciality teams, and (2) prescribing in community health.[29] RN prescribers in primary health and specialty teams have undertaken further training, including a Nursing Council approved postgraduate diploma in RN prescribing for long-term conditions. They can prescribe from a list of medications as per their area of practice and competency.[30] The list includes misoprostol but not mifepristone. The second level of RN prescribers, community prescribers, work within DHBs or other health organisations and undergo a recertification programme to become prescribers. The medications list at this level of prescribing is more limited and does not include either misoprostol or mifepristone.[29]

A further way of reducing barriers to EMA is for health practitioners to supply the medications from a Practitioner Supply Order (PSO). PHARMAC announced on 2 July 2020 that mifepristone and misoprostol would be listed in Section B of the pharmaceutical schedule effective from1 August 2020. This means that these medications can be supplied on PSO so that pregnant people are not required to go to a pharmacy for dispensing. However, this is currently temporarily restricted to Family Planning clinics and abortion providers with DHB contracts to allow time for the Interim Abortion Standards to be updated and the establishment of national clinical guidelines. It is envisaged that these restrictions will then be removed, allowing access to funded EMA medications on PSO for all suitably qualified prescribers.[31]

Currently, the brand of misoprostol imported into New Zealand is not approved by Medsafe for use as an abortifacient. Therefore, it is prescribed by authorised prescribers only under Section 25 of the Medicines Act 1981.[27] Ongoing it will be important to gain clarification regarding the legal status of designated prescribers as authorised prescribers and for mifepristone to be added to the schedule of medicines they can prescribe. Without this move, designated prescribers will be dependent on standing orders, which may impact on equity of access to abortifacients.

How abortion will be funded in primary care requires clarification. Presently the Primary Maternity Services Notice Review 2021 specifically excludes funding of abortion (termination of pregnancy). It also excludes nurses from being maternity providers which poses a barrier to provision of autonomous first trimester abortion care by nurses.[32]

**Figure 2:** What is required for first trimester abortion to be provided in primary care.

- Updated abortion standards
- Appropriate training and support for abortion providers
- Access to EMA drugs on PSO in primary care
- Support for non-prescribers to provided EMA

## Conclusion

One of the more pressing requirements to providing safe abortion care in the community is the provision of comprehensive and accessible training for health practitioners. Unless there is adequate and appropriate funding for the primary care sector, including for the training of midwives, nurses and nurse practitioners, there will be no incentive to undertake the training nor the provision of abortion care, with the result that access to safe abortion will not be improved. Fundamental to equitable provision of EMA is access to funded

mifepristone and misoprostol by a range of qualified health practitioners. We need clarification regarding the legal status of designated prescribers under the Medicines Act 1981 to prescribe misoprostol as a section 25 drug and, for misoprostol and mifepristone to be added to the schedule of medicines for both levels of RN designated prescribing. Trained non-prescribers should be supported to provide EMA via a national standing order.

In passing the AL Act 2020, New Zealand achieved a major milestone in sexual and reproductive health and human rights. With new legislative and regulatory frameworks, health practitioners in primary care have the potential to be key players in shaping the future of abortion care. Further research is required to develop a framework for provision of optimal first trimester abortion care in the primary sector in Aotearoa New Zealand.

**Competing interests:**
Ms Macfarlane reports: I am a committee member of Abortion Providers Group Aotearoa New Zealand (APGANZ) and a member of The College of Sexual and Reproductive Health. I was actively involved in campaigning in support of abortion law reform. While undertaking this research I was the recipient of the University of Otago Dunbar Scholarship which paid for my PhD fees and a monthly stipend. Dr Paterson reports: I received professional fees from Southern District Health Board and professional fees from Ministry of Justice, outside the submitted work; I was the Chair of Abortion Providers Group Aotearoa and a member of the committee, sat on the Ministry of Health Abortion Standards working group and presently act in an un-payed advisory role for the Ministry of Health abortion guidelines development. I am a member of The College of Sexual and Reproductive Health and have been funded to attend an educational conference by Bayer. I and Michael Stitely hold a contraception-related patent.

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**Author information:**
Emma Macfarlane: Lecturer, Department of Women's and Children's Health, Otago Medical School, University of Otago, Dunedin.
Associate Professor Michael Stitely: Head of Department, Department of Women's and Children's Health, Otago Medical School, University of Otago, Dunedin.
Dr Helen Paterson: Senior Lecturer, Department of Women's and Children's Health, Otago Medical School, University of Otago, Dunedin.

**Corresponding author:**
Emma Macfarlane, Department of Women's and Children's Health, Otago Medical School – Dunedin Campus, PO Box 56, Dunedin 9054, +64 3 470 9750 emma.macfarlane@otago.ac.nz.

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