MINISTRY OF HEALTH
MANATŪ HAUORA

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New Zealand Aotearoa Abortion Clinical Guideline

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Foreword

Safe, consistent and quality abortion care should be available to everyone in Aotearoa New Zealand, regardless of their situation or where they live.

Until last year, abortion came under the Crimes Act. There were significant restrictions for health practitioners and people seeking an abortion, making access to abortion care difficult.

On 24 March 2020, New Zealand changed the law to decriminalise abortion, allowing work to begin to ensure abortions in this country are safe, accessible and equitable. Patients can self-refer, and an abortion no longer needs to be agreed to by two health practitioners. Abortion care can now be provided in a wider range of health settings.

The law change also saw responsibility for abortion services move to the Ministry of Health, recognising abortion as a health issue. As with any other health service, the use of clinical guidance supports consistent, quality provision of care. It paves the way for standardised practice across the country.

This guideline combines sound medical evidence with current international best practice, while reflecting the unique context of abortion services in Aotearoa New Zealand. It is underpinned by the principles of Te Tiriti o Waitangi, to support health practitioners to meet their obligations and ensure that clinical practice is culturally safe and relevant.

As well as a driver for consistency and quality, the guideline is also one of the ways we support the improvements to the accessibility of abortion services.

Abortion services via telehealth, selective (and not routine ultrasound) for pre-abortion assessment and low-sensitivity urine testing for post abortion confirmation are all examples of progress in removing barriers to access. Patients are now able to receive timely abortion care when and where they need it, without always needing to attend a clinic.

This guideline should be read in conjunction with Ngā Paerewa, the 2021 Health and Disability Services Standard, as these documents replace the Interim Standards for Abortion services in New Zealand. Ngā Paewera is required to be met by providers of abortion care delivered as an overnight hospital service.

Abortion service providers outside of this setting will find value in assessing their services against relevant aspects of Ngā Paerewa as the standard of care for health and disability services. Both this guideline and Ngā Paerewa play an important role in our work to achieve safe, equitable, accessible, consistent and quality service provision across the sector.

This guideline is a result of collaboration between clinicians, academics and professional colleges and councils from across New Zealand's health sector. Thank you to those who helped to shape this guidance by sharing their expertise, knowledge and experience.

I'd also like to acknowledge all abortion care providers across the system, including district health boards, primary care providers, public health organisations and private clinics. Together, you deliver a vital service and help us to continually improve that service for people in Aotearoa.

Hon Dr Ayesha Verrall
Associate Health Minister

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Introduction

Scope and purpose

The *New Zealand Aotearoa Abortion Clinical Guideline* (the guideline) presents the current accepted best clinical practice for providing abortion services in New Zealand Aotearoa. It is designed for use by health practitioners who provide abortion services within their scope of practice.

The guideline should underpin clinical judgement and decision-making to guide treatment and support of people using abortion services. This includes:
giving effect to the principles of Te Tiriti o Waitangi (Te Tiriti) as responsible Te Tiriti partners and stewards of the health and disability system in meeting the rights and interests of Māori (Te Puni Kōkiri 2001)

- ensuring abortion services are as **safe, effective, person- and whānau-centred, equitable, efficient and timely** as possible
- ensuring nationally consistent advice is available to health practitioners providing abortion services throughout New Zealand Aotearoa.

The guideline sits alongside the legislation and other relevant clinical guidelines, and should be read in conjunction with Ngā Paerewa Health and Disability Services Standard 8134:2021 (Ngā Paerewa) (Standards New Zealand 2021) and the corresponding **guidance for the health and disability sector, including abortion services**. Together, Ngā Paerewa, the sector guidance and this guideline provide a suite of information about best practice abortion provision.

Development approach

Eleven literature reviews addressing 18 clinical research questions were completed to inform the development of this guideline. There was little New Zealand evidence identified that met the various inclusion criteria.

Recommendations in this guideline were developed by expert consensus, considering the evidence from the reviews of relevant clinical literature, guidelines developed in the last five years from health jurisdictions similar to New Zealand and using similar rigorous methods, and good practice principles. Where evidence for outcomes of an intervention is clear or where good practice consensus has been built over time, these guidelines make recommendations. Where evidence for outcomes of an intervention or practice is uncertain, or where patient preference must be considered, these guidelines provide flexibility for the practitioner by offering options and actions to consider as part of their clinical management. These distinctions are addressed in the 'Clinical guidance' within each section.

Te Tiriti o Waitangi and Māori health

Giving effect to Te Tiriti o Waitangi can be demonstrated through the practical application of the principles as articulated by the courts and the Waitangi Tribunal (Waitangi Tribunal 2019). Applying the principles to abortion service delivery is vital to enabling Māori to express their **mana** and ensures they receive high-quality, culturally safe and equitable health outcomes (Curtis et al 2019). Utilising the principles to work effectively and respectfully with Māori requires abortion services and health practitioners to demonstrate the principles of Te Tiriti in their day-to-day practice with Māori.

The principles of Te Tiriti o Waitangi provide the framework for abortion providers and health practitioners providing abortion services to Māori. How these principles apply to abortion services is supported by Ngā Paerewa and, in particular, **1.1 Pae ora healthy futures**.

The Waitangi Tribunal concluded that persistent health inequities experienced by Māori across almost every disease state were the consequence of the failure to apply the principles of Te Tiriti o Waitangi at structural, organisational and health practitioner levels of the health and disability sector. Giving effect to Te Tiriti requires health practitioners to know the principles of Te Tiriti o Waitangi and be able to capably apply these in partnership with Māori in their day-to-day abortion clinical practice.

For the health and disability sector, the **principles of Te Tiriti o Waitangi** are:

- tino rangatiratanga
- equity
- active protection
- options
- partnership.

Appendix A: Abortion and Māori provides further information and a list of guidelines and statements from relevant professional associations.

To this end, the guideline supports health practitioners to give effect to relevant principles of Te Tiriti o Waitangi in providing abortion services to Māori in relation to pre-assessment, medical abortion, surgical abortion, abortion post 20 weeks' gestation and post-abortion management. Appendices (Appendix A: Abortion and Māori, Appendix B: Providing information for people considering an abortion and Appendix C: Provision of counselling) supplement this guidance.

Ngā Paerewa and this guideline

Ngā Paerewa Health and Disability Services Standard 8134:2021 sets out the minimum requirements for acceptable care and support within services specified in the Health and Disability Services (Safety) Act 2001. Ngā Paerewa was developed in collaboration with the abortion services sector and is fit for use by all abortion services that are certified under the Health and Disability Services (Safety) Act 2001. Ngā Paerewa focuses on putting Māori, Pacific peoples and other New Zealanders at the centre and supporting providers to give effect to the sector's obligations to Māori under Te Tiriti o Waitangi.

Specific sections, subsections and criteria applicable to abortion services are set out in the criteria application framework in Ngā Paerewa. All abortion service providers should be familiar with and understand these requirements, as they promote current accepted best practice. Services not required to be certified under the Health and Disability Services (Safety) Act 2001, including community-based abortion providers, may want to consider adopting this standard appropriate to the size, scope and complexity of their service setting.

For the purpose of this clinical guideline, the clinical recommendations have been developed to sit alongside the standards. We refer to some of the standards that are directly related to abortion care, but health practitioners would be expected to be familiar with both documents.

Health equity

Health equity in New Zealand Aotearoa recognises people have differences in health outcomes that are not only avoidable but unfair and unjust. The structural determinants of health and wellbeing – for example, income, employment, education, housing and multiple forms of discrimination – negatively impact people's health but people have little control over these. Health inequities, like inequitable abortion outcomes, are not about people 'making bad choices', 'having bad genes' or 'not accessing medical care' but are the result of avoidable structural determinants in our communities (Toi Te Ora Public Health 2021). When health practitioners understand the structures that create inequitable abortion outcomes, they can utilise different approaches and resources to achieve equitable abortion health outcomes.

Achieving equitable abortion outcomes for Māori happens when abortion service providers and health practitioners understand the structures that create Māori disadvantage and are supported to implement the guideline recommendations in ways that give effect to the principles of Te Tiriti o Waitangi, and meet professional competencies and Ngā Paerewa.

Other population groups in New Zealand Aotearoa also experience inequities that are unfair and unjust. Achieving equitable abortion outcomes for these people – for example, people who are young, homeless, unemployed or LGBTQI-plus – happens when abortion service providers and health practitioners understand the structures that create disadvantage and are supported to implement the guideline recommendations in ways that give effect to people's human rights while also meeting professional competencies and Ngā Paerewa.

Last, health practitioners should be aware that many peoples in New Zealand Aotearoa conceptualise anatomy, pregnancy, gender, sexuality, reproduction, contraception and abortion in different ways according to their worldviews. Therefore, health practitioners should use proven health literacy practices to communicate effectively with everyone using their services (Ministry of Health 2015). Also see the sector guidance for Ngā Paerewa **1.4 E whakautetia ana ahau | I am treated with respect** and criteria 1.4.2.

Summary of recommendations

The following table lists the recommendations provided throughout the guideline.

	Recommendations
Pre-abortion assessment	
1.1.1	Offer people who are considering having an abortion information as outlined in Appendix B: Providing information for people considering an abortion.
1.1.2	Offer people who choose to continue their pregnancy information and support to transition to antenatal care.
1.1.3	Advise people to seek support if they need it, and how to access counselling and/or social supports.
1.1.4	Offer contraception counselling in accordance with **New Zealand Aotearoa's Guidance on Contraception**.
1.2.1	Follow the appropriate best-practice guidelines in relation to obtaining consent (Ngā Paerewa **1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices**).
1.3.1	Offer people the options of clinical assessment via telehealth or in-person.
1.3.2	Confirm pregnancy by urine or serum β-hCG or ultrasound.
1.3.3	Determine gestational age of the pregnancy by clinical means (history including last menstrual period, with or without examination) or ultrasound scan.
1.3.4	Obtain relevant medical history.
1.3.5	Recommend selective testing of haemoglobin as indicated by medical history and/or current symptoms.
1.3.6	Recommend testing of rhesus status for people having medical abortion > 10 weeks' gestation, or surgical abortion at any stage of pregnancy.
1.3.7	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.
1.3.8	Recommend routine ultrasound prior to second-trimester abortion, in order to verify gestational age and localise the placenta.
1.3.9	Where there is clinical suspicion of ectopic pregnancy, refer the person to an early pregnancy unit/service.
1.3.10	Perform relevant physical examination as indicated.
1.3.11	Consider a routine sexual health check-up, in accordance with the **New Zealand Sexual Health Society (NZSHS) guidelines**.

	Recommendations
1.3.12	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.
1.3.13	Consider testing for bacterial vaginosis if symptomatic and requested by the person.
1.3.14	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.
1.4.1	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. See Table 2: Consideration of medical and surgical abortion in Appendix B.
Medical abortion	
2.1.1	Remove intrauterine contraception prior to a medical abortion.
2.1.2	Do not routinely offer antibiotic prophylaxis to people who are having a medical abortion.
2.2.1	Offer inpatient setting to people having a medical abortion before 10 weeks' gestation if social or medical circumstances dictate.
2.2.2	For medical abortion up to 10+0 weeks' gestation, recommend combination regime that includes 200 mg oral dose of mifepristone and 800 micrograms dose of misoprostol.
2.2.3	For medical abortion up to 10+0 weeks' gestation, offer buccal, sublingual or vaginal route of administration of misoprostol to reduce risk of ongoing pregnancy.
2.2.4	For medical abortion up to 10+0 weeks' gestation, offer interval dosing (24–48 hours) of mifepristone and misoprostol.
2.2.5	For medical abortion up to 10+0 weeks' gestation, offer follow-up assessment either in-person or by telehealth. Confirm the abortion is complete and exclude ongoing pregnancy by: • serum β-hCG testing: Completion may be confirmed by a drop in serum β-hCG level of 80% or more from day of mifepristone to 7–14 days after mifepristone. If less than 80% drop, investigate further and manage as appropriate • urine β-hCG testing: A negative low-sensitivity urine pregnancy test at 3 or 4 weeks after treatment will exclude an ongoing pregnancy. If positive, investigate further and manage as appropriate • ultrasound scan. **It is especially important to confirm abortion is complete if ultrasound has not been performed before early medical abortion, to exclude ectopic pregnancy.**
2.3.1	Offer inpatient setting to people having a medical abortion after 10 weeks' gestation.

	Recommendations
2.3.2	For people who are having a medical abortion between 10+1 and 20+0 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36–48 hours after the mifepristone) of: • 800 micrograms misoprostol, given vaginally, or • 600 micrograms misoprostol, given sublingually, for people who decline vaginal misoprostol. Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.
Surgical abortion	
3.1.1	Offer surgical abortion as early as requested (there is no lower limit of gestation for surgical abortion).
3.1.2	Venous access should be in place prior to the procedure taking place.
3.1.3	Perform a pre-procedure bimanual examination.
3.1.4	Ensure that every abortion is complete. This can be done by clinical assessment of the uterus, visual inspection of products of conception or ultrasound scan. If the gestation is < 7 weeks, visually inspect the aspirated tissue; if there is doubt that the gestational sac and chorionic villi are clearly visualised, ensure follow-up with serum β-hCG or ultrasound scan to exclude ongoing pregnancy or ectopic pregnancy.
3.1.5	Recommend routine antibiotic prophylaxis to reduce the risk of post-abortion upper genital tract infection.
3.1.6	Consider metronidazole 1 g per rectum at end of procedure for antibiotic prophylaxis. Alternatively, consider oral doxycycline 100 mg twice a day for 3 days for antibiotic prophylaxis. Do not routinely offer metronidazole in combination with another broad-spectrum antibiotic such as doxycycline.
3.2.1	Recommend cervical priming prior to surgical abortion before to 14 weeks' gestation, to reduce the risk of incomplete abortion and make the procedure easier to perform.
3.2.2	For people having surgical abortion prior to 14 weeks' gestation, offer cervical priming with 400 micrograms misoprostol, administered sublingual 1 hour prior, buccal 1–3 hours prior or vaginal 3 hours prior.
3.2.3	For people having surgical abortion prior to 14 weeks' gestation where misoprostol is contraindicated, consider cervical priming with 200 mg oral mifepristone 24–48 hours prior, to make the procedure easier to perform.
3.3.1	From 14 weeks' gestation, recommend cervical priming to increase baseline cervical dilation and reduce procedural difficulty.
3.3.2	From 14 to 15 weeks' gestation, consider cervical priming with either osmotic dilators or combination mifepristone and misoprostol.
3.3.3	From 16 weeks' gestation, recommend cervical priming with osmotic dilators. Consider mifepristone for cervical priming in addition to osmotic dilators. Mifepristone 200 mg oral can be administered at the same time as the dilators are inserted.
3.3.4	For people having cervical priming with osmotic dilators, consider inserting osmotic dilators the day before the abortion procedure. Do not offer misoprostol if dilators were inserted the day before.

	Recommendations
3.4.1	Beyond 15 weeks' gestation, surgical abortion by dilation and evacuation is safe and effective and should be performed by trained health practitioners with sufficient experience and caseloads to maintain their skills. The upper gestational limit of surgical abortion is dependent on health practitioner training, skill and experience.
3.4.2	Consider using intra-procedure ultrasonography to aid in: • visualising instruments • locating fetal parts • verifying an empty uterus • reducing the risk of uterine perforation • shortening the procedure.
3.5.1	Recommend pre-operative analgesia with nonsteroidal anti-inflammatory drugs (NSAIDs).
3.5.2	For people who are having surgical abortion, consider local anaesthesia alone, procedural sedation with local anaesthesia, deep sedation or general anaesthesia.
3.5.3	When using procedural sedation for a surgical abortion, use intravenous rather than oral sedation.
3.5.4	Offer supportive methods to reduce pain and anxiety, including empathetic staff, gentle technique, music and verbal reassurance.
3.5.5	When using general anaesthesia for a surgical abortion, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.
Abortion post 20 weeks' gestation	
4.1.1	Offer interval treatment with mifepristone and misoprostol using a standard protocol to people who are having a medical abortion post 20 weeks' gestation. • For people who are having a medical abortion between 20+0 and 23+6 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36–48 hours after the mifepristone) of: – 800 micrograms misoprostol, given vaginally, or – 600 micrograms misoprostol, given sublingually, for people who decline vaginal misoprostol. Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion. • For people who are having a medical abortion between 24+0 and 25+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 400 micrograms (vaginal, buccal or sublingual) every 3 hours until delivery. • For people who are having a medical abortion between 25+1 and 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 200 micrograms misoprostol (vaginal, buccal or sublingual) every 4 hours until delivery. • For people who are having a medical abortion after 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.
4.1.2	Abortion post 20 weeks' gestation should be performed in settings with access to specialist support, an operating theatre and blood products. Access to admission should be possible at any time.
4.1.3	For people having an abortion post 20 weeks' gestation, advanced analgesic care should be available.
4.1.4	Consider hysterotomy where dilation and evacuation and medical abortion are contraindicated.

	Recommendations
4.1.5	Feticide is recommended for all abortions at 22 weeks' gestation or later and should be provided using an evidence-based protocol by an appropriately trained practitioner.
4.1.6	Offer inhibition of lactation and explain breast care.
4.1.7	Offer a follow-up check and investigation, which may include, as appropriate, fetal post-mortem examination and genetic testing.
Post-abortion management	
5.1.1	Do not routinely offer anti-D prophylaxis to people who are having a medical abortion < 10 weeks' gestation.
5.1.2	Consider anti-D prophylaxis for people who are rhesus D negative and are having a surgical abortion up to and including 10+0 weeks' gestation.
5.1.3	Offer anti-D prophylaxis to people who are rhesus D negative and are having a medical or surgical abortion after 10+0 weeks' gestation.
5.1.4	Anti-D prophylaxis supply should not cause delay to providing timely abortion care.
5.2.1	Following abortion, give verbal and written information on what to expect. See Table 1: Information for people considering an abortion in Appendix B.
5.2.2	Advise people to seek support if they need it, and how to access counselling and/or social supports.
5.2.3	Disposal of any products of conception must consider the person's individual choice as required by criteria **1.7.8 in Section 1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices**.
5.3.1	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**.
5.4.1	Consider selective follow-up with their health practitioner for people who: • are at risk of (or develop) complications • still need contraception • may need ongoing mental health support • are living with complexities • are young, or • request follow-up.

1 Pre-abortion assessment

Te Tiriti o Waitangi and Māori undergoing pre-abortion assessment

Tino rangatiratanga – Health practitioners support the right of Māori to undergo the pre-abortion assessment, 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.

Partnership – Health practitioners work in partnership with Māori, including a person's whānau if requested, for the pre-abortion assessment. 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.

Active protection – 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). Health practitioners actively support Māori to make decisions that are best for them.

Options – Health practitioners ensure that Māori have an abortion pre-assessment process that enables them to uphold their tikanga or cultural practice regardless of whether the abortion pre-assessment takes place at a kaupapa Māori or a mainstream service. Wherever the pre-assessment takes place, 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.

Equity – Health practitioners can contribute to equitable abortion health outcomes for Māori by ensuring that at a minimum pre-abortion assessment outcomes match those of other New Zealanders. Equitable pre-abortion assessment 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.

1.1 Provision of information

	Recommendations
1.1.1	Offer people who are considering having an abortion information as outlined in Appendix B: Providing information for people considering an abortion.
1.1.2	Offer people who choose to continue their pregnancy information and support to transition to antenatal care.
1.1.3	Advise people to seek support if they need it, and how to access counselling and/or social supports.
1.1.4	Offer contraception counselling in accordance with **New Zealand Aotearoa's Guidance on Contraception**.

Clinical guidance

All information must be personalised, as each person will have a different level of understanding of the abortion process. People having an abortion are more satisfied with their experience when they feel well informed about the abortion. It is particularly important to inform people what levels of pain and bleeding to expect. This differs for medical and surgical abortions; see Table 2: Consideration of medical and surgical abortion in Appendix B for more information.

Detecting complication risks (such as a bleeding disorder) and contraindications (such as severe anaemia) is an important part of providing safe abortion care. This may include psychosocial, cultural and spiritual dimensions of the person.

Health practitioners should also be aware of the legal requirements regarding informing people of the availability of counselling, while recognising that counselling attendance must not be a requirement for having an abortion (Abortion Legislation Act 2020, section 8). See Appendix C: Provision of counselling for more information and refer to the abortion services sector guidance for criteria **3.2.3 in Section 3.2 Taku huarahi ki te oranga | My pathway to wellbeing**.

1.2 Decision-making and informed consent

	Recommendations
1.2.1	Follow the appropriate best-practice guidelines in relation to obtaining consent (Ngā Paerewa **1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices**).

1.3 Pre-abortion clinical assessment

	Recommendations
1.3.1	Offer people the options of clinical assessment via telehealth or in-person.
1.3.2	Confirm pregnancy by urine or serum β-hCG or ultrasound.
1.3.3	Determine gestational age of the pregnancy by clinical means (history including last menstrual period, with or without examination) or ultrasound scan.
1.3.4	Obtain relevant medical history.
1.3.5	Recommend selective testing of haemoglobin as indicated by medical history and/or current symptoms.
1.3.6	Recommend testing of rhesus status for people having medical abortion > 10 weeks' gestation, or surgical abortion at any stage of pregnancy.
1.3.7	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.
1.3.8	Recommend routine ultrasound prior to second-trimester abortion, in order to verify gestational age and localise the placenta.
1.3.9	Where there is clinical suspicion of ectopic pregnancy, refer the person to an early pregnancy unit/service.
1.3.10	Perform relevant physical examination as indicated.
1.3.11	Consider a routine sexual health check-up, in accordance with the **New Zealand Sexual Health Society (NZSHS) guidelines**.
1.3.12	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.
1.3.13	Consider testing for bacterial vaginosis if symptomatic and requested by the person.
1.3.14	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.

Clinical guidance

The pre-abortion clinical assessment enables health practitioners to plan for a safe abortion. It is important to determine the gestational age of the pregnancy as early as practicable. Abortions performed earlier are safer than those performed later. Moreover, accessing services earlier gives people more choice, as abortions can be performed medically or surgically early in pregnancy. Findings from the person's history, examination and investigations may lead the health practitioner to recommend one method over another. The Royal College of Obstetricians and Gynaecologists (RCOG) has developed a **decision aid** for early medical abortion without ultrasound to support this process (RCOG 2020b). This tool has been adapted by other organisations to suit their requirements.

The COVID-19 pandemic disrupted the usual delivery of abortion care, and abortion services changed how they provided care in order to meet public health restrictions. Evidence-based protocols to minimise in-person contact were developed, including assessment and provision of early medical abortion via telehealth and eliminating ultrasound and blood tests. These practices have since been recommended by professional organisations and implemented in clinical services internationally.

Several studies assessed outcomes for early medical abortion (EMA) completed via telemedicine; however, these were practice descriptive only. No randomised controlled trials (RCTs) were identified. A retrospective cohort study was conducted in England and involved women who had an EMA two months before or after a service model change due to COVID-19 restrictions (Aiken et al 2021). Prior to the change, women were assessed in person and had an ultrasound (traditional cohort n=22,158). Following the change, women were assessed in-person or via telemedicine without ultrasound (telemedicine-hybrid cohort; n=29,984 with n=18,435 provided fully via telemedicine). Outcomes were success, safety and acceptability. The study found the rate of success of EMA was 98.2% in the traditional cohort compared with 98.8% in the telemedicine-hybrid cohort ($p>0.99$); and within the telemedicine-hybrid cohort, the rate of success was higher in the fully telemedicine group (99.2% compared with 98.1%, $p<0.001$). There was no difference in significant adverse events between cohorts, nor between groups within the telemedicine-hybrid cohort (0.02% compared with 0.03%, $p=0.532$). Patient-reported outcome data were available for 2,453 participants; 96% were 'satisfied' or 'very satisfied' with their care or rated it as 'good' or 'very good'. Both telehealth and in-person assessment appear to be reasonable and safe options for the delivery of EMA. Telemedicine is practical for many people regardless of location or availability of in-person services. Not all health practitioners offering abortion care will have telehealth capability. For detailed considerations about providing care by telehealth, health practitioners are directed to the Medical Council of New Zealand guideline on telehealth (Medical Council of New Zealand 2020).

Abortion providers in New Zealand Aotearoa currently test haemoglobin where there is a history of anaemia or risk of bleeding. This is similar to Canadian and American guidelines. Some population groups are more likely to have or be at risk of anaemia, including those with a diet low in iron such as vegetarians and vegans, or those who are on restrictive diets, have had previous anaemia or recent pregnancy or are breastfeeding, and those with recent heavy blood loss from menses or chronic diseases such as gastrointestinal diseases. No evidence was identified on whether routine measurement of haemoglobin before early medical or first-trimester surgical abortion results in safer outcomes compared with selective or no haemoglobin testing. Selective testing of haemoglobin as indicated by medical history and/or symptoms therefore remains appropriate.

Ultrasound is used to determine or confirm gestational age and intrauterine location, thus excluding the possibility of an ectopic pregnancy, and for assessing pregnancy-related abnormalities (Kapp et al 2013; Schmidt-Hansen et al 2020b). However, waiting for ultrasound evidence of these before conducting an abortion may mean people have to attend multiple appointments, which may cause distress and consume health system resources unnecessarily (Kapp et al 2013; Schmidt-Hansen et al 2020b). The risk of a missed ectopic pregnancy is an uncommon but serious risk of proceeding with abortion care without an ultrasound. Abortion providers in New Zealand Aotearoa currently advise that limited ultrasound scanning should be available for people with uncertain gestational age or a discrepancy between last menstrual period and uterine size. Canadian, American and British guidelines suggest that ultrasound is not necessary for the delivery of first-trimester abortion (Costescu and Guilbert 2018; Costescu et al 2016; National Abortion Federation 2020; NICE 2019a).

One meta-analysis on whether routine ultrasound before EMA or first-trimester surgical abortion improves safety and reduces complications found no studies met the inclusion criteria. It is reasonable to provide abortion in the absence of ultrasound as long as certain criteria are met. Ultrasound can be offered for selective clinical indications only (ie, where gestational age is uncertain, or in people who have symptoms or signs suspicious of ectopic pregnancy). If people have signs or symptoms suspicious of ectopic pregnancy, health practitioners should refer to local early pregnancy or gynaecology services. Common symptoms include abdominal pain, pelvic pain, and vaginal bleeding with or without clots; common signs include pelvic tenderness, adnexal tenderness and abdominal tenderness. The 2019 National Institute for Health Care and Excellence (NICE) Guideline (**Section 1.4**) has detailed recommendations on using ultrasound scans for diagnosis of tubal ectopic pregnancy (NICE 2019d).

The clinical assessment also provides an opportunity to screen people for other conditions, such as STIs. Historically in New Zealand Aotearoa, abortion providers have required chlamydia, gonorrhoea and bacterial vaginosis (BV) testing prior to abortion. Chlamydia and gonorrhoea are common and can be associated with symptoms and long-term sequelae; early treatment with antibiotics has benefit. The New Zealand Sexual Health Society recommends testing for chlamydia and gonorrhoea in people presenting for abortion care (New Zealand Sexual Health Society 2017). Thus, the recommendation is to routinely offer STI screening opportunistically and treat as indicated in order to reduce the risk of complications from STIs. Screening for and treating STIs should not be a barrier to timely provision of abortion care.

Routine screening for BV may not be required. Many people with a positive gram stain for BV do not have symptoms or long-term sequelae. Evidence is unclear whether there are clinically important differences in the rate of post-abortion infection in people with BV who were treated with metronidazole antibiotics in addition to usual antibiotic prophylaxis. Selective testing for BV can be offered for clinical indications. The purpose of doing so in people who have symptoms is to treat their symptoms not to reduce their risk of post-abortion infection.

1.4 Choice of abortion method

	Recommendations
1.4.1	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. See Table 2: Consideration of medical and surgical abortion in Appendix B.

Clinical guidance

In New Zealand Aotearoa, a choice between medical and surgical abortion is offered to people as appropriate for gestational age. Both methods are well established as safe procedures. Choice of abortion method should be based on a person's preference, their personal circumstances, number of weeks' gestation and medical history, health practitioner skill and local service provision. People's reported satisfaction rates after an abortion are similar for both medical and surgical methods. Evidence suggests satisfaction is higher when people have a choice between abortion methods.

Further information about the characteristics of medical and surgical abortions is included in Table 2: Consideration of medical and surgical abortion in Appendix B. People report the information included in the table supported them to make an informed decision between abortion methods.

For further direction on supporting informed decision-making, see 'Te Tiriti o Waitangi and Māori undergoing pre-abortion assessment' at the start of this section.

2 Medical abortion

Te Tiriti o Waitangi and Māori undergoing a medical abortion

Tino rangatiratanga – Health practitioners support the right of Māori to undergo a medical 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.

Partnership – Health practitioners work in partnership with Māori who are having a medical abortion to make decisions that will enhance their rangatiratanga or self-determination over the process while exercising mana motuhake or authority over their bodies and reproductive health.

Active protection – Health practitioners ensure Māori have evidence-based information about the medical abortion process so that they can make decisions and preparations that will 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 have a medical abortion that enables them to uphold their tikanga or cultural practice regardless of whether the abortion involves a kaupapa Māori or a mainstream health service. Wherever the medical abortion takes place, 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.

Equity – Health practitioners can contribute to equitable abortion health outcomes for Māori by ensuring that at a minimum medical abortion outcomes match those of other New Zealanders. Equitable medical 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.

2.1 Considerations for all medical abortions

	Recommendations
2.1.1	Remove intrauterine contraception prior to a medical abortion.
2.1.2	Do not routinely offer antibiotic prophylaxis to people who are having a medical abortion.

2.2 Early medical abortion (EMA)

	Recommendations
2.2.1	Offer inpatient setting to people having a medical abortion before 10 weeks' gestation if social or medical circumstances dictate.
2.2.2	For medical abortion up to 10+0 weeks' gestation, recommend combination regime that includes 200 mg oral dose of mifepristone and 800 micrograms dose of misoprostol.
2.2.3	For medical abortion up to 10+0 weeks' gestation, offer buccal, sublingual or vaginal route of administration of misoprostol to reduce risk of ongoing pregnancy.
2.2.4	For medical abortion up to 10+0 weeks' gestation, offer interval dosing (24–48 hours) of mifepristone and misoprostol.
2.2.5	For medical abortion up to 10+0 weeks' gestation, offer follow-up assessment either in person or by telehealth. Confirm the abortion is complete and exclude ongoing pregnancy by: • serum β-hCG testing: Completion may be confirmed by a drop in serum β-hCG level of 80% or more from day of mifepristone to 7–14 days after mifepristone. If less than 80% drop, investigate further and manage as appropriate • urine β-hCG testing: A negative low-sensitivity urine pregnancy test at 3 or 4 weeks after treatment will exclude an ongoing pregnancy. If positive, investigate further and manage as appropriate • ultrasound scan. **It is especially important to confirm abortion is complete if ultrasound has not been performed before early medical abortion, to exclude ectopic pregnancy.**

Clinical guidance

Medical methods for the provision of first-trimester abortions in New Zealand Aotearoa are well established. In 2011, a Cochrane review compared different medical methods, and concluded the growing body of evidence has established the safety and effectiveness of the current regimen of combination mifepristone and misoprostol (Kulier et al 2011). An informal survey by Abortion Providers Group Aotearoa New Zealand in 2016 found usual practice in New Zealand Aotearoa is to administer 200 mg mifepristone followed 24–48 hours later by 800 micrograms buccal misoprostol.

Mifepristone is currently approved in New Zealand for use in medical abortion, up to 63 days of amenorrhea. The approved dose is 600 mg. However, the use of a 200 mg dose has been widely researched internationally, has been found to be as safe and effective as the higher dose and is endorsed by many international organisations. EMA has also been found to be effective up to 70 days amenorrhea; however, at the time of drafting the guideline this was not approved in New Zealand.

Although misoprostol is an approved medicine in New Zealand, it is not approved for use in abortion care. However, it can be regarded and used as a supported indication. This is similar to other medications that are not approved for the indication they are sometimes used. The use of misoprostol for abortion care has been widely researched internationally and is endorsed by many international organisations. Written consent is not necessary.

One systematic review of 33 trials involving 22,275 participants reported on dose and routes of misoprostol administration in a combined regimen with 200 mg mifepristone (Abubeker et al 2020). Six studies compared administration of 400 micrograms with higher doses of misoprostol across the four routes (buccal, oral, sublingual, vaginal). Overall, doses of 800 micrograms showed higher effectiveness than 400 microgram doses (moderate quality). One of these studies was an RCT of 300 participants comparing mifepristone and 400 micrograms oral misoprostol first dose, followed by a second dose of either 400 micrograms oral misoprostol or placebo. There was a lower rate of ongoing pregnancy in the group who received two doses of 400 micrograms oral misoprostol (low quality). There were no trials of second-dose non-oral misoprostol, or second-dose misoprostol offered as needed.

Thirteen studies assessed different routes of administration of an 800 micrograms dose of misoprostol. Evidence from four studies found oral administration (ie, swallowing the tablet) resulted in a higher rate of ongoing pregnancy compared with buccal (RR 3.61 (1.20–10.80), low quality) or vaginal (RR 6.70 (1.88–23.86), moderate quality) administration, with similar rates of successful abortion, safety and satisfaction across all three routes.

Both reviews reported on dosing interval. The NICE evidence review H included 3 RCTs (1,380 participants) where simultaneous administration of mifepristone and misoprostol (vaginal, 400 micrograms or 800 micrograms) was compared with interval dosing of 24–48 hours (NICE 2019c). No differences were found for the outcomes of ongoing pregnancy, haemorrhage requiring blood transfusion, or satisfaction (very low to low quality). The Abubeker systematic review included 8 RCTs (5,962 participants) comparing misoprostol administration (oral or vaginal, 400 micrograms or 800 micrograms) within 8 hours of mifepristone and 24–48 hours later and found no difference in the outcomes of effectiveness, safety and satisfaction (very low to moderate quality) (Abubeker et al 2020).

These findings contrast with the experience of some Abortion Services Clinical Guidance working group members and with the findings of a retrospective cohort study of 28,901 participants in the United Kingdom, where simultaneous dosing was found to be less effective than 24- to 48-hour interval dosing (94.5% compared with 97.1% respectively, $p<0.001$) (Lohr 2018). This study also reported a difference in outcomes by gestation, with absolute effectiveness declining in both groups with increasing gestational age categories, and with the differences in relative effectiveness remaining.

The evidence from the literature did not support a change to current usual practice. If the health practitioner or person prefers a dosing interval of less than 8 hours, consider vaginal route of misoprostol administration, and limiting to pregnancies of less than 9+0 weeks' gestation.

A risk of early medical abortion is ongoing pregnancy. Although uncommon, the only way to exclude ongoing pregnancy is to follow up. Current practice in New Zealand is to follow up EMA with serum β-hCG to ensure there is an adequate drop from baseline (on the day of mifepristone administration) to one week after. However, on review of international guidelines, some recommend urine hCG testing along with self-assessment (follow-up telephone call, telephone consultation with standardised questionnaire, online questionnaire, text message). The literature review considered whether urine hCG testing is an effective, safe and acceptable way to confirm completion of EMA. No trials were found comparing the effectiveness of follow-up urine β-hCG testing with serum β-hCG testing. However, there were two systematic reviews that support low-sensitivity urine hCG testing as a safe, effective and acceptable method of confirming completion of EMA compared with follow-up by a routine in-person clinic visit (Baiju et al 2019; Schmidt-Hansen et al 2020a). Therefore, offering several options for follow-up after EMA was considered reasonable.

2.3 10 to 20+0 weeks

	Recommendations
2.3.1	Offer inpatient setting to people having a medical abortion after 10 weeks' gestation.
2.3.2	For people who are having a medical abortion between 10+1 and 20+0 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36–48 hours after the mifepristone) of: • 800 micrograms misoprostol, given vaginally, or • 600 micrograms misoprostol, given sublingually, for people who decline vaginal misoprostol. Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.

3 Surgical abortion

Te Tiriti o Waitangi and Māori undergoing a surgical abortion

Tino rangatiratanga – Health practitioners support the right of Māori to undergo a surgical 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.

Partnership – Health practitioners work in partnership with Māori who are having a surgical abortion to make decisions that will enhance their rangatiratanga or self-determination over the process while exercising mana motuhake or authority over their bodies and reproductive health.

Active protection – Health practitioners ensure Māori have evidence-based information about the surgical abortion process so that they can make decisions and preparations that will uphold their tikanga or cultural practice (eg, karakia, rongoā, support person, and container for and a location to place products of conception).

Options – Health practitioners ensure that Māori have a surgical abortion that enables them to uphold their tikanga or cultural practice regardless of whether the abortion takes place at a kaupapa Māori or a mainstream abortion service. Wherever the surgical abortion takes place, 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.

Equity – Health practitioners can contribute to equitable abortion health outcomes for Māori by ensuring that at a minimum surgical abortion outcomes match those of other New Zealanders. Equitable surgical 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.

3.1 Considerations for all surgical abortions

	Recommendations
3.1.1	Offer surgical abortion as early as requested (there is no lower limit of gestation for surgical abortion).
3.1.2	Venous access should be in place prior to the procedure taking place.
3.1.3	Perform a pre-procedure bimanual examination.
3.1.4	Ensure that every abortion is complete. This can be done by clinical assessment of the uterus, visual inspection of products of conception or ultrasound scan. If the gestation is < 7 weeks, visually inspect the aspirated tissue; if there is doubt that the gestational sac and chorionic villi are clearly visualised, ensure follow-up with serum β-hCG or ultrasound scan to exclude ongoing pregnancy or ectopic pregnancy.
3.1.5	Recommend routine antibiotic prophylaxis to reduce the risk of post-abortion upper genital tract infection.
3.1.6	Consider metronidazole 1 g per rectum at end of procedure for antibiotic prophylaxis. Alternatively, consider oral doxycycline 100 mg twice a day for 3 days for antibiotic prophylaxis. Do not routinely offer metronidazole in combination with another broad-spectrum antibiotic such as doxycycline.

Clinical guidance

First-trimester surgical abortion using vacuum aspiration carries a risk of retained products of conception, which may require further intervention or lead to complications such as endometritis.

The evidence review included the Interim Standards for Abortion Services New Zealand and four current international guidelines from the UK, USA and Canada. It also did a literature search for RCTs and systematic reviews of RCTs that evaluated routine inspection (visual or ultrasound) after first-trimester surgical abortion compared with no or selective inspection.

One RCT the review identified involved 809 women having first-trimester surgical procedure for abortion or miscarriage and compared routine transvaginal ultrasound to no ultrasound. It found a reduced rate of retained products of conception in the ultrasound group (3.7% vs 0.7%, $p<0.01$) (Debby et al 2006). This trial was graded as low quality. No trials were found evaluating visual inspection.

Current practice in New Zealand Aotearoa is that the health practitioner performing the surgical abortion is responsible for ensuring the abortion is complete. This can be done by clinical assessment of the uterus, immediate transvaginal ultrasound scan or visual inspection of the aspirated tissue. The current research evidence does not support a recommendation for routine transvaginal ultrasound scan.

However, if the gestation is under 7 weeks, the recommendation is for routine inspection of the aspirated tissue. This is current New Zealand Aotearoa practice and is also recommended by the National Abortion Federation (2020). If there is doubt that a gestational sac and chorionic villi are clearly visualised, then the health practitioner performing the abortion must arrange follow-up serum β-hCGs or ultrasound scan to exclude ongoing pregnancy and ectopic pregnancy.

Reducing infective morbidity has shifted in New Zealand Aotearoa from a screen-and-treat model to providing routine antibiotic prophylaxis for people undergoing surgical abortion. This change reflects international best practice and is based on a Cochrane review of 15 placebo-controlled RCTs, which showed routine perioperative antibiotics for surgical abortion reduced post-abortion upper genital tract infection by an average of 41% compared with placebo (Low et al 2012).

The literature search was for RCTs and systematic reviews of RCTs that evaluated the optimal prophylactic antibiotic regime. The NICE evidence review D described two RCTs comparing different regimes, and found no difference in post-surgical abortion infection. It concluded that if post-operative doxycycline is used, 7 days is not better than 3 days, and that combination doxycycline and metronidazole is no better than doxycycline alone, thus combining metronidazole with another broad-spectrum antibiotic like doxycycline should be avoided (NICE 2019b). The review further states that there is not enough evidence to recommend one regime over another for routine antibiotic prophylaxis, but notes that the Cochrane review showed a reduction in post-abortion infection with the use of nitromidazoles (eg, metronidazole), tetracyclines and beta lactams (Low et al 2012; NICE 2019b). It is suggested that 1 g metronidazole given rectally at the end of the surgical case is a reasonable option for antibiotic prophylaxis, given its effectiveness for a broader range of infections than doxycycline or azithromycin and anti-anaerobe properties, and given it is not currently used for STI treatment.

For a person having surgical abortion who was not screened for STI in advance, offer STI screening, based on an individual risk assessment, and consider empiric treatment on the day.

3.2 Cervical priming up to and including 13+6 weeks' gestation

	Recommendations
3.2.1	Recommend cervical priming prior to surgical abortion before14 weeks' gestation, to reduce the risk of incomplete abortion and make the procedure easier to perform.
3.2.2	For people having surgical abortion prior to 14 weeks' gestation, offer cervical priming with 400 micrograms misoprostol, administered sublingual 1 hour prior, buccal 1–3 hours prior or vaginal 3 hours prior.
3.2.3	For people having surgical abortion prior to 14 weeks' gestation where misoprostol is contraindicated, consider cervical priming with 200 mg oral mifepristone 24–48 hours prior, to make the procedure easier to perform.

Clinical guidance

Cervical priming for an abortion is when the cervix is softened or dilated, either by medicinal or mechanical means, before an operation. Cervical priming up to and including 13+6 weeks' gestation is achieved via prostaglandins, and usual practice in New Zealand Aotearoa is to use sublingual or buccal misoprostol 1–3 hours prior to the procedure.

The literature search was for RCTs and systematic reviews of RCTs that evaluated regimes for cervical priming prior to surgical abortion (up to and including 13+6 weeks' gestation). One systematic review and one RCT published after the review were included (Hamdaoui et al 2021; O'Shea et al 2020).

The review included 18 RCTs (n=8,538) of different regimes of cervical priming (O'Shea et al 2020). Compared with no cervical priming, cervical priming with misoprostol was more effective, in that it was associated with lower rates of incomplete abortion and easier cervical dilatation/less force required to dilate. There was no difference in safety outcomes, such as cervical trauma or uterine perforation. There were more side effects with cervical priming, such as pain and bleeding before the procedure. Comparing route of administration of misoprostol, there was more pre-operative bleeding with sublingual than with vaginal, but no difference in the other outcomes of ease of cervical dilation and pre-operative pain. No included trials evaluated buccal misoprostol. This study was appraised as high quality.

The RCT of 110 women having a surgical abortion with cervical priming compared 200 mg oral mifepristone given 36 hours prior and 400 micrograms buccal misoprostol given 3 hours prior (Hamdaoui et al 2021). Dilation pain during mechanical cervical dilation and during aspiration was lower in the mifepristone group compared with the misoprostol group. The procedure was easier to perform in the mifepristone group. However, these findings are limited because the outcome measures were subjective and the participants were not blinded to their allocation. This study was appraised as low quality.

The current evidence is strong enough to support a recommendation of routine first-trimester cervical priming with misoprostol to reduce the risk of incomplete abortion, as is current practice in New Zealand Aotearoa. The evidence is not strong enough to support a recommendation of one regime over another, but using sublingual, vaginal or buccal misoprostol 1–3 hours prior is reasonable. These routes of administration are probably similar in effectiveness and onset of action, but buccal may have fewer side effects, such as fever and chills (based on studies of EMA and the experience of New Zealand Aotearoa health practitioners). Routine use of mifepristone is not recommended due to timing of administration and cost (10 times the price of misoprostol); however, mifepristone can be considered as an alternative if misoprostol cannot be used.

3.3 Cervical priming from 14+0 weeks' gestation to 19+6 weeks' gestation

	Recommendations
3.3.1	From 14 weeks' gestation, recommend cervical priming, to increase baseline cervical dilation and reduce procedural difficulty.
3.3.2	From 14 to 15 weeks' gestation, consider cervical priming with either osmotic dilators or combination mifepristone and misoprostol.
3.3.3	From 16 weeks' gestation, recommend cervical priming with osmotic dilators. Consider mifepristone for cervical priming in addition to osmotic dilators. Mifepristone 200 mg oral can be administered at the same time as the dilators are inserted.
3.3.4	For people having cervical priming with osmotic dilators, consider inserting osmotic dilators the day before the abortion procedure. Do not offer misoprostol if dilators were inserted the day before.

Clinical guidance

Cervical priming for an abortion is when the cervix is softened or dilated, by either medicinal or mechanical means, before an operation. Cervical priming at 14 weeks' gestation or greater is achieved via osmotic dilators (laminaria, or synthetic hydrophilic dilators such as Dilapan or Lamicel) and/or prostaglandins (misoprostol and/or mifepristone). Cervical preparation before a second-trimester abortion reduces the risk of uterine perforation and cervical laceration (Shaw et al 2017).

The literature search was for RCTs and systematic reviews of RCTs that evaluated regimes for cervical priming prior to surgical abortion (at 14 weeks' gestation or beyond). One systematic review was included (O'Shea et al 2021).

The review included 15 trials of 2,454 women undergoing surgical abortion from 14 weeks' gestation up to and including 23+6 weeks' gestation (O'Shea et al 2021). The authors found that cervical priming regimens that included osmotic dilators typically had greater baseline cervical dilation and reduced procedural difficulty compared with regimens that did not use dilators. One trial found decreased procedural difficulty when dilators and mifepristone (200 mg oral mifepristone administered 24 hours prior) were used in combination compared with dilators alone. Three trials found no difference in baseline cervical dilation when dilators and misoprostol (buccal or vaginal) were used in combination compared with dilators alone. One trial found that dilators placed the day before, compared with on the same day, had higher baseline cervical dilatation.

The current evidence is strong enough to support a recommendation of routine second-trimester cervical priming to improve baseline cervical dilation and reduce procedural difficulty, as is current practice in New Zealand Aotearoa. The evidence on which regime of cervical ripening at different gestational ages is less clear. For abortions at 14–15 weeks' gestation, it is reasonable to offer either osmotic dilators or combination mifepristone and misoprostol. For people having surgical abortion at 16 weeks' gestation or later, dilators would be recommended, and it is reasonable to add mifepristone to further reduce procedural difficulty. However, adding misoprostol was found to be no more effective than dilators alone.

3.4 Surgical abortion from 14+0 weeks' gestation to 19+6 weeks' gestation

	Recommendations
3.4.1	Beyond 15 weeks' gestation, surgical abortion by dilation and evacuation is safe and effective and should be performed by trained health practitioners with sufficient experience and caseloads to maintain their skills. The upper gestational limit of surgical abortion is dependent on health practitioner training, skill and experience.
3.4.2	Consider using intra-procedure ultrasonography to aid in: • visualising instruments • locating fetal parts • verifying an empty uterus • reducing the risk of uterine perforation • shortening the procedure.

3.5 Analgesia, anaesthesia and sedation

	Recommendations
3.5.1	Recommend pre-operative analgesia with nonsteroidal anti-inflammatory drugs (NSAIDs).
3.5.2	For people who are having surgical abortion, consider local anaesthesia alone, procedural sedation with local anaesthesia, deep sedation or general anaesthesia.
3.5.3	When using procedural sedation for a surgical abortion, use intravenous rather than oral sedation.
3.5.4	Offer supportive methods to reduce pain and anxiety, including empathetic staff, gentle technique, music and verbal reassurance.
3.5.5	When using general anaesthesia for a surgical abortion, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.

Clinical guidance

To help people make an informed choice, discuss the options with them and explain that:

- having local anaesthesia alone means they will be able to spend less time in the abortion service
- having intravenous sedation plus local anaesthesia will help if they are anxious about the procedure
- with deep sedation or general anaesthesia, they will not usually be aware during the procedure.

The literature search was for RCTs and systematic review of RCTs that evaluated different methods of pharmacologic pain control prior to first-trimester surgical abortion, specifically comparing NSAIDs with other analgesics or with placebo. One systematic review and two RCTs published since the review were included (Açmaz et al 2013; Renner et al 2009; Roche et al 2012). A Cochrane review of 40 trials (study participants n=5,131) reported on two comparisons of interest: paracervical block with pre-medication (two trials used NSAIDs) compared with paracervical block alone; and NSAIDs compared with placebo (one trial) (Renner et al 2009). Pre-medication with NSAIDs improved pain during and after the procedure. The two trials published after the review were too small (31 and 20 patients respectively received pre-medication with NSAIDs) to make any meaningful conclusions (Açmaz et al 2013; Roche et al 2012).

The published research evaluated was low quality, and a large high-quality research trial in this area is still warranted. However, other trials have shown that paracetamol, oral lorazepam and nitrous oxide do not improve pain control compared with placebo. Thus, if pre-medication is used in addition to paracervical block, the recommendation is for use of an NSAID.

4 Abortion post 20 weeks' gestation

The recommendations and guidance outlined in this section are specific to post 20-week abortion and should be read alongside the rest of the guideline. Table 3: Additional information for abortion post 20 weeks in Appendix B contains additional information that should be shared with people considering having an abortion post 20 weeks' gestation.

All pregnancy outcomes with fetal death after 20 weeks' gestation (or > 400 g if gestation unclear), including abortion, are considered stillbirth and must be reported to the Perinatal and Maternal Mortality Review Committee. Further, the birth must be added to the Births, Deaths and Marriages register with the Department of Internal Affairs and the fetus must be buried or cremated in an appropriate manner.

Te Tiriti o Waitangi and Māori undergoing an abortion post 20 weeks' gestation

Tino rangatiratanga – Health practitioners support the right of Māori to undergo an abortion post 20 weeks' gestation, 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.

Partnership – Health practitioners work in partnership with Māori who are having an abortion post 20 weeks' gestation to make decisions that will enhance their rangatiratanga or self-determination over the process while exercising mana motuhake or authority over their bodies and reproductive health.

Active protection – Health practitioners ensure Māori have evidence-based information about the post 20 weeks' abortion process so that they can make decisions and preparations that will uphold their tikanga or cultural practice (eg, karakia, rongoā, support person, container for and a location to place fetal tissue, or fetus and placenta).

Options – Health practitioners ensure that Māori have an abortion post 20 weeks' gestation that enables them to uphold their tikanga or cultural practice regardless of whether the abortion takes place at a kaupapa Māori or a mainstream abortion service. Wherever the surgical abortion takes place, 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.

Equity – 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 post 20 weeks' gestation 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.

4.1 Recommendations specific to post 20-week abortions

	Recommendations
4.1.1	Offer interval treatment with mifepristone and misoprostol using a standard protocol to people who are having a medical abortion post 20 weeks' gestation. • For people who are having a medical abortion between 20+0 and 23+6 weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36–48 hours after the mifepristone) of: – 800 micrograms misoprostol, given vaginally, or – 600 micrograms misoprostol, given sublingually, for people who decline vaginal misoprostol. • Follow the initial dose with 400 microgram doses of misoprostol (vaginal, buccal or sublingual), given every 3 hours until expulsion. • For people who are having a medical abortion between 24+0 and 25+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 400 micrograms (vaginal, buccal or sublingual) every 3 hours until delivery. • For people who are having a medical abortion between 25+1 and 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 200 micrograms misoprostol (vaginal, buccal or sublingual) every 4 hours until delivery. • For people who are having a medical abortion after 28+0 weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.
4.1.2	Abortion post 20 weeks' gestation should be performed in settings with access to specialist support, an operating theatre and blood products. Access to admission should be possible at any time.
4.1.3	For people having an abortion post 20 weeks' gestation, advanced analgesic care should be available.
4.1.4	Consider hysterotomy where dilation and evacuation and medical abortion are contraindicated.
4.1.5	Feticide is recommended for all abortions at 22 weeks' gestation or later and should be provided using an evidence-based protocol by an appropriately trained practitioner.

	Recommendations
4.1.6	Offer inhibition of lactation and explain breast care.
4.1.7	Offer a follow-up check and investigation, which may include, as appropriate, fetal post-mortem examination and genetic testing.

Clinical guidance

Much of the literature reviewed to inform the guideline development did not separate clinical evidence before and after 20 weeks' gestation. Specifications for later-stage abortions are most commonly informed by the legislative framework of the country in which the research is conducted.

The Maternal Fetal Medicine National Service considers that if a person does not consent to feticide at 22 weeks' gestation or later, the abortion should not proceed. An induction of labour where there is a possibility of neonatal survival is not an abortion. In cases when birth is indicated at peri-viable gestation because of severe maternal or fetal complications, a feticide should be discussed as part of clinical management, taking into account the likelihood of fetal survival and clinical context. In some cases, the fetus is not deemed to be viable and therefore a feticide may not be needed prior to induction of labour.

Access to a multidisciplinary team is preferable to support people having an abortion post 20 weeks' gestation to ensure that all their needs are met.

5 Post-abortion management

Te Tiriti o Waitangi and post-abortion management with Māori

Tino rangatiratanga – Health practitioners support the right of Māori to receive post-abortion management, 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 and whānau health and wellbeing.

Partnership – Health practitioners work in partnership with Māori to ensure their post-abortion management and associated decision-making – including the information about their transition, transfer and discharge – enhances their rangatiratanga or self-determination over the process while exercising mana motuhake or authority over their bodies and reproductive health.

Active protection – Health practitioners ensure Māori have evidence-based information about their post-abortion management so that they can make decisions and preparations that will uphold their tikanga or cultural practice (eg, karakia, rongoā, support person, container for and a location to place the products of conception).

Options – Health practitioners ensure that Māori receive post-abortion management that enables them to uphold their tikanga or cultural practice regardless of whether post-management takes place at a kaupapa Māori or a mainstream abortion service or at home. Wherever the process takes place, it 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.

Equity – Health practitioners can contribute to equitable abortion outcomes for Māori by ensuring post-abortion management outcomes at a minimum match those of other New Zealanders. Equitable post-abortion management 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.

5.1 Anti D prophylaxis

	Recommendations
5.1.1	Do not routinely offer anti-D prophylaxis to people who are having a medical abortion < 10 weeks' gestation.
5.1.2	Consider anti-D prophylaxis for people who are rhesus D negative and are having a surgical abortion up to and including 10+0 weeks' gestation.
5.1.3	Offer anti-D prophylaxis to people who are rhesus D negative and are having a medical or surgical abortion after 10+0 weeks' gestation.
5.1.4	Anti-D prophylaxis supply should not cause delay to providing timely abortion care.

Clinical guidance

In New Zealand Aotearoa, current practice is to offer anti-D to all rhesus D negative people having a medical or surgical abortion at any stage in pregnancy.

There is no high-quality evidence to support this practice. There is evidence of changes in practice due to COVID-19 restrictions in New Zealand Aotearoa and internationally during 2020 and 2021. Other international guidelines have changed their recommendations. The RCOG recommends offering anti-D prophylaxis only to people who are rhesus D negative and are having an abortion after 10+0 weeks' gestation (RCOG 2020a). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommends giving a dose of rhesus D immunoglobulin 250 micrograms to all rhesus D negative women with no preformed anti-D antibodies to prevent rhesus D alloimmunisation (RANZCOG 2020). The recommendation to not offer anti-D for EMA aligns with these guidelines.

5.2 Provision of information

	Recommendations
5.2.1	Following abortion, give verbal and written information on what to expect. See Table 1: Information for people considering an abortion in Appendix B.
5.2.2	Advise people to seek support if they need it, and how to access counselling and/or social supports.
5.2.3	Disposal of any products of conception must consider the person's individual choice as required by criteria **1.7.8 in Section 1.7 Kua whai mōhio ahau, ā, ka taea e au te mahi whiringa | I am informed and able to make choices**.

5.3 Contraception

	Recommendations
5.3.1	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**.

Clinical guidance

New Zealand Aotearoa's Guidance on Contraception includes guidance on contraception after abortion and underpins this guideline's recommendations on contraception (Ministry of Health 2020a).

Contraception counselling should be a routine part of abortion services. Contraception counselling should identify the person's preference for contraception and include advice based on all contraception options.

Whenever contraceptive counselling is provided, care should be taken to ensure individuals do not feel under pressure to choose a method of contraception. People have reported positively that insertion of an Intrauterine contraception (IUC), Levonorgestrel intrauterine system (52 mg or 13.5 mg) (LNG-IUS) or Subdermal levonorgestrel implant (LNG) at the time of abortion is convenient. Insertion of contraception at the time of abortion is also associated with high continuation rates and a reduced risk for another unintended pregnancy.

5.4 Follow-up

	Recommendations
5.4.1	Consider selective follow-up with their health practitioner for people who: • are at risk of (or develop) complications • still need contraception • may need ongoing mental health support • are living with complexities • are young, or • request follow-up.

Clinical guidance

There is insufficient evidence to advise people having either first-trimester surgical or second-trimester medical abortion to see their general practitioner for a routine follow-up visit after abortion, which is currently usual practice in New Zealand Aotearoa. In the literature review, no trials were found comparing routine in-person follow-up visit with no follow-up, or selective follow-up, to evaluate safety.

Existing American and Canadian guidelines on follow-up after first-trimester surgical and second-trimester medical abortion do not recommend routine follow-up after these types of abortion and indicate that follow-up is not necessary (Costescu and Guilbert 2018; National Abortion Federation 2020). It is appropriate to offer a person a follow-up consultation with their own health practitioner in select cases, rather than routinely. People who have had IUC placed have the option to self-assess for presence of strings to ensure correct placement or to see their GP for a pelvic examination.

All people having an EMA should have a follow-up consultation with their health practitioner (see Section 2.2).

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Appendices

Appendix A: Abortion and Māori

Historical context

Before the Treaty of Waitangi was signed in 1840, Māori people initiated safe and effective abortions within their whānau and hapū. A review of early oral compositions and narratives compiled by Māori and in te reo Māori confirms that Māori had extensive knowledge of initiating abortions, a detailed vocabulary to describe fetal maturation and fetal tissue, practices for the provision of pre- and post-abortion care, specific karakia and a catalogue of plant-based and other abortifacients (rongoā) for the abortion process. No stigma was associated with an abortion that was initiated; simply, it was understood by all that Māori had tino rangatiratanga or the self-determining right over their bodies to initiate an abortion (Gabel 2021).

After 1840, the colonising process put an end to the self-determining right of Māori to control their reproductive health and initiate an abortion. As a consequence, whānau, hapū and iwi knowledges about initiating abortions were subjugated. Māori have been deprived of these knowledges for more than 200 years.

By 2020, the shame and stigma associated with abortion had become entrenched in Māori communities. However, fragments of older, pre-colonial hapū and iwi knowledges about abortion are somewhat protected by the fact of being recorded in te reo Māori, stored in sound and written archives and maintained as part of the traditional oral compositions of various hapū and iwi.

The Abortion Legislation Act 2020, in combination with the principles of Te Tiriti o Waitangi, provides whānau, hapū and iwi with the opportunity to revitalise their older knowledges and practices for abortion. The intention is for Māori, in the context of abortion, to enact their rangatiratanga or self-determining rights and mana motuhake or autonomy over their bodies and their reproductive health and wellbeing.

Further guidance

Health practitioners may find support from their professional association to be helpful in terms of giving effect to the principles of Te Tiriti o Waitangi, although there is much work to be done in this field as a recent review of 18 regulated health practitioner competency documents found (Came et al 2021). Professional support may include the following:

- Medical Council of New Zealand: **Statement on cultural safety**
- Medical Council of New Zealand: **He Ara Hauora Māori: A Pathway to Māori Health Equity**
- Midwifery Council of New Zealand: **Statement on Cultural Competence for Midwives**
- Nursing Council of New Zealand: **Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice**
- The Royal Australasian College of Physicians: **Guideline commentary on consulting with Māori and their whānau**.
- Health practitioners may also value becoming familiar with the following:
- Māuri Ora Associates: **Best Health Outcomes for Māori: Practice implications**
- University of Otago MIHI 501 Health Professionals Course: **Application of Hui Process and Meihana Model to Clinical Practice**
- **Improving Māori health through clinical assessment: Waikare o te Waka o Meihana (**Pitama et al 2007).

Cultural safety

Practising in a culturally safe way is important and a requirement of Te Tiriti o Waitangi, particularly in relation to the principles of *Active protection*, *Options* and *Partnership*. It is important that health practitioners know that tikanga or correct protocols and practices are often specific to whānau, hapū and iwi and that tikanga is not a 'one size fits all' concept. Similarly, mātauranga Māori or Māori knowledge is not a single entity; rather it includes traditional and contemporary mātauranga Māori, and mātauranga Māori that is specific to hapū and iwi environments that include land, seas, waterways, weather systems, the stars, flora and fauna, and things seen and unseen. Older forms of mātauranga Māori have been somewhat protected from colonisation by virtue of having been composed or narrated in te reo Māori (Green 2018).

Rangatiratanga or self-determining rights over tikanga and mātauranga Māori is crucial to its safety and survival. For this reason, health practitioners should be very careful not impose their understanding of tikanga or mātauranga Māori on Māori through the abortion process. Nor should they assume that all Māori are familiar with terms such as tikanga, mātauranga and Te Tiriti o Waitangi. Unfamiliarity with such terms can be experienced by Māori as a diminishment of their mana as expressed by Te Tiriti o Waitangi; an outcome that is antithetical to Te Tiriti, the Abortion Clinical Guideline and Ngā Paerewa (Ministry of Health 2020b).

Appendix B: Providing information for people considering an abortion

Provision of information for people considering an abortion is a critical part of abortion service provision and information should be delivered in a way that meets the requirements of Ngā Paerewa, **1.6 Ka kitea ngā whakawhitiwhitinga whai hua | Effective communication occurs**. Table 1: Information for people considering an abortion and Table 2: Consideration of medical and surgical abortion below provide advice specific to abortions and this information should be considered alongside Ngā Paerewa.

Health practitioners should also be aware of the legal requirements regarding informing people of the availability of counselling, while recognising that counselling attendance must not be a requirement of accessing abortion services (Abortion Legislation Act 2020, section 8).

The Ministry of Health maintains a list of **questions and answers on abortion in New Zealand**.

Other useful resources

- **Best Practice Framework for the Delivery of Sexual Health Promotion Services to Pacific Communities in New Zealand** (Veukiso-Ulugia nd)
- **Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults** (Oliphant et al 2018).

Table 1: Information for people considering an abortion

What would people who are considering an abortion like to know?
People should be provided with detailed information to help prepare for the abortion as early as possible. This should include: • what it involves and what happens afterwards • how much pain and bleeding to expect.
The degree of pain felt by people having an abortion is highly variable and dependent on: • gestation • individual factors including anxiety level, support and gynaecological history • type of pain relief used.
In the case of medical abortion, explain that they may see the products of the conception pass, and what this might look like.
People should be reassured that abortion is not associated with increased risk of infertility, cancer or mental health issues.
While complications are uncommon, people should be aware of the possible risks and complications of an abortion, for example: • bleeding • damage to the uterus • incomplete abortion • continuing pregnancy (more common with EMA) • pelvic infection • anaesthetic complications (surgical only). Some of these complications may require admission to the hospital or further medical management.
For contraception counselling after abortion, please refer to **New Zealand Aotearoa's Guidance on Contraception**.
Māori people may benefit from knowing that: • before 1840, Māori were supported by their whānau and members of their hapū to initiate an abortion and no shame was attached to initiating an abortion • they can have a support person or people with them or close by during the pre-abortion assessment, medical or surgical and post-abortion management processes • they can maintain their own tikanga or practices during the pre-abortion assessment, medical or surgical and post-abortion management processes • they will be given information and support from their health practitioner to make decisions about the abortion process that is best for them • if they want, they can involve their whānau in their abortion • their health practitioner is required to provide a caring and supportive service that is imbued with manaakitanga or respect and kindness • if they wish, they may bring their own waterproof container for products of conception • if they wish, they may arrange a private location where they can place the products of conception and where these will not be disturbed by other activities.
If a person raises abortion reversal, a health practitioner should ensure the person understands that abortions cannot be reversed. The American College of Obstetricians and Gynecologists (ACOG) does not support the use of progesterone to "stop" a medication abortion due to the lack of scientific evidence. In order to test clinical effectiveness and safety of an abortion pill "reversal" protocol, a larger randomised clinical trial is needed (Gossman et al 2020).

To support informed decision-making, people considering an abortion should be provided information about the differences between medical and surgical abortion methods. This information could include the characteristics outlined in Table 2.

Table 2: Consideration of medical and surgical abortion

Medical abortion
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.
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 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.
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.
Surgical abortion
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.
The procedure itself is completed within 5–10 minutes. This is followed by 30–60 minutes of observation time.
There is less bleeding and the person does not have to see any possible evidence of products of conception unless they want to.

Table 3: Additional information for abortion post 20 weeks' gestation

Legislative requirements
A person considering having an abortion post 20 weeks needs to be aware of the legislative requirements (Abortion Legislation Act 2020, section 11), including the following. • A qualified health practitioner may only provide abortion services to a person who is more than 20 weeks pregnant if the health practitioner reasonably believes that the abortion is clinically appropriate in the circumstances. • In considering whether the abortion is clinically appropriate in the circumstances, the qualified health practitioner must – – consult at least 1 other qualified health practitioner; and – have regard to – ○ all relevant legal, professional, and ethical standards to which the qualified health practitioner is subject; and ○ the person's– ❖ physical health; and ❖ mental health; and ❖ overall wellbeing; and ○ the gestational age of the fetus.
After 20 weeks (or > 400 g if gestation unclear), all pregnancy outcomes with fetal death including abortion must be reported to the Perinatal and Maternal Mortality Review Committee. Further, the birth must be added to the Births, Deaths and Marriages register with the Department of Internal Affairs, and the fetus must be buried or cremated in an appropriate manner.
Where a fetus is stillborn after 20 completed weeks of pregnancy and/or weighs more than 400 g, there is a requirement to register their birth and bury or cremate them in an appropriate manner. The death is not registered, but a medical certificate is completed at the hospital.

Appendix C: Provision of counselling

Provision of counselling to people considering an abortion

Unbiased counselling options available to the person and significant others (partners and whānau) should include:

- pre-decision/pregnancy options counselling
- pre-abortion counselling
- post-abortion counselling, including contraception if not already agreed.

All people should be given the opportunity to be seen on their own to address the issues of coercion and to facilitate honest and open discussion. The process should be safe, respectful and affordable.

- The role of counselling in an abortion service is to talk with people considering having an abortion about their feelings and beliefs.
- Counselling creates a space where people feel that it is safe to ask questions and they are listened to without an agenda.
- It is essential that the person providing counselling support is someone who will give accurate information and models unbiased language.
- The central tenet is of acceptance and support of a person regardless of the decision they make. The decision assessment invites, but does not require, the person to discuss feelings and thoughts about their decision.
- The decision assessment is about learning about their experience of making the decision, checking in about support and planning for post-abortion coping.

Health practitioners should also be aware of the legal requirements regarding informing people of the availability of counselling, while recognising that counselling attendance must not be a requirement for having an abortion (Abortion Legislation Act 2020, section 8).

Note that NICE **Section 1.14** (2019a) includes information on other places of support.

- Advise people to seek support if they need it, and how to access it (if relevant). This could include:
  - support from family and friends or pastoral support
  - peer support, or support groups for people who have had an abortion
  - counselling or psychological interventions.