38. We generally support the specified principles and core assumptions and prefer Option 1 as the service provision model.

39. We trust that consideration will be given to comments and suggestions we have made with a view to optimising resources and ensuring a sustainable well trained workforce.

Marilyn Head
NZ Nurses Organisation

33. The NTP does not adequately cover travel and accommodation for TOP as its policy excludes the many women referred by GPs and Primary Healthcare organisations. When payment is made via the NTP, it is a contribution and may not cover all the costs incurred for the woman and her support person. This aspect of the NTP greatly affects rural women such as those from Invercargill to Timaru, West Coast, Northland, Waitemata, Counties-Manukau and Waikato DHBs. It is not only logistically complex organising out of district travel, it can be problematic in other ways as many women needing TOP are ill equipped either financially or emotionally to travel outside their local districts and support networks.

34. This is particularly true of young people who are very vulnerable and should not be left to negotiate their care in an unfamiliar city, or even country. Women must be provided with adequate support if they need to travel outside their area. DHBs need a very clear process for referral outside the district and full funding should be provided for travel, safe accommodation and a support person if necessary. Reimbursement of travel costs is impractical and unnecessary. It is the DHB's responsibility to provide services for TOP.

35. NZNO notes that the level of travel funding provided has not kept pace with increases in the cost of living.

Service Model Options

36. Option 1 is NZNO's preferred choice at this stage, but that is dependent upon details as to how this is going to be nationally coordinated and implemented.

CONCLUSION

37. NZNO again thanks DHBNZ for the opportunity to comment on this discussion document, which we believe accurately assesses the inadequacies of the current situation regarding services for TOP, defines a clear pathway for developing equitable access to nationally consistent services, and confirms DHBs prime obligation to ensure provision of local services.

27. Furthermore, Women are often unaware of fetal abnormality until the routine 18 week anatomy scan. As many DHBs have a cut-off point of 20 weeks or less, counselling, decision making, grieving and abortion all have to be decided within one or two weeks – an almost impossible timeframe.

28. In fact there is no legal gestation cut-off point for TOP in Aotearoa, since the Section 187A (3) of the Crimes Act also allows TOP pre and post 20 weeks. In practice. DHBs assign their own cut-off points which can vary according to circumstance. This lack of consistency is a further complicating factor, particularly for nurse managers trying to find treatment for women who may be eligible for TOP in one DHB where services are not available, but not eligible in another DHB where they are.

29. In this context NZNO notes the recent vigorous debate in the United Kingdom which has been resolved with a cut-off point at 24/40 week gestation. The Australian state of Victoria is having the same debate at present.

30. The discussion document does not consider this 'cut off' point, or distinctions made between women aborting because of fetal anomalies and those aborting on mental or physical health grounds, or the importance of timely psychiatric consultations. In practice, however, NZNO notes that all these factors have a profound effect on staff's willingness to care for women needing TOP services.

31. Pregnancy is a normal aspect of women's health and NZNO strongly supports the position that all DHBs have a legal responsibility to provide first and second trimester termination services in their areas. Women should not be expected to travel large distances, or outside the country to access legally provided health services.

Travel Assistance Policy

32. NZNO agrees that the narrow referral criteria for the National Travel Policy (NTP) for TOP should be reviewed so it is able to accept referrals from GPs and Primary Healthcare organisations.

22. NZNO suggests that first trimester medical abortion is a service that can be provided easily using existing women's health outpatient space with nurses/midwives working under clear guidelines and standing orders and having access to nationally consistent training and professional supervision.

23. NZNO notes that the Abortion Supervisory Committee has set up a Standards Committee to investigate this possibility and advises that NZNO's Women's Health Section is going to investigate national guidelines for nurses working with women experiencing 'Pregnancy Loss', both spontaneous and induced.

24. NZNO generally believes that health services should be publically provided but accepts that a sustainable TOP service may require some private input. We note that the privately funded Auckland Medical Aid Centre (AMAC) works well for both publicly funded and private patients and that there is wide support for community organisations, such as Family Planning, to begin providing medical abortions. NZNO therefore supports well funded public access to private as well as public clinics so there is choice for women.

25. Current legislation does not take into account changes in contraception and maternity care which make it more likely for women to turn to their Lead Maternity Carer (LMC), Family Planning Nurses and Nurse Practitioners for referral to TOP service. None of these health practitioners are able to provide referrals, an unnecessary obstruction which may cause TOP in the first trimester to be delayed to the second trimester, with the consequent increase in health risk. Delayed referrals particularly impact on rural women who rarely have a choice of provider.

26. Conversely, NZNO members are also concerned that women who present early are disadvantaged in services that do not provide the option of Medical Abortion up to 9/40 week gestation. It has been highlighted in many regions that these women get "bumped" to accommodate those women who are presenting later.

based in Women's Health and lack relevant expertise in contraception, basic counselling, and family violence dynamics. Training in calming, restraint and de-escalating skills for nurses is very limited and there is little consideration given to the physical security of both patients and staff. Such conditions contribute to recruitment and retention difficulties.

18. NZNO suggests that providing education to nurses and midwives in established services should be part of the role of the Nurse/Midwife Advisor to the Abortion Supervisory Committee. We note that the position is currently vacant.

19. Nurses often feel isolated from other nurses and health professionals who are opposed to abortion provision and there is a social stigma towards those who admit publicly to working in this area. No financial recompense is available to nurses/midwives, though the idea of working in an area where there could be social discomfort was one of the principle drivers in payment for certifying consultants by the Dept. of Justice under the Contraception, Sterilization and Abortion Act (1977).

20. We note, too, the confusion regarding the role of midwives in providing TOP care. The Midwifery Council has consistently expressed the view that providing abortion care is outside the scope of practice of midwives, though they concede that, in practice, core midwives working in tertiary hospitals do provide this care. This not only complicates the employment of midwives, it also raises serious questions about professional indemnity. There is no issue with those core midwives who have dual registration as nurses and midwives.

21. To ensure a sustainable workforce in abortion care, DHBs need well developed policies, well organised and understood protocols, appropriate facilities and willingly trained midwives/nurses with access to professional supervision. NZNO notes that a good model is to be found with the nursing/midwifery staff at Level J Unit, Wellington.

health care workers. Comprehensive feedback by members of our Women's Health and Nurses for Young Persons Aotearoa sections and those working in Youth clinics and Family Planning clinics, testifies to the concerns our members have for ensuring equitable access to safe, affordable and timely TOP services.

NZNO POLICY AND POSITION

15. The New Zealand Nurses Organisation **supports** the recommendations and believes that, depending upon how it is implemented, **Option 1**, local service provision backed by 3 regional services, is probably the most practical means of ensuring equitable access to services for TOPs for all New Zealand women.

SERVICES FOR TERMINATIONS OF PREGNANCY.

16. NZNO agrees that currently services for TOP are:

- inconsistent – not all DHBs provide or fund all services and cut off points for termination vary; and
- inequitable - local access is variable and often not timely.

We note that:

- there are problems with staffing;
- some women are travelling long distances with inadequate compensation or support ; and
- there is a lack of transparency about the availability of services.

Discussion

17. Safe and accessible services are dependent upon there being sufficient trained staff available. Currently staffing problems are exacerbated by the lack of in-service training available to nurses and midwives and lack of professional supervision. Many nurses working in abortion care in NZ are not

- **agree** that there is a need for consistent training, professional supervision and an agreed cut-off point for TOP services across all DHBs;
- **agree** that education services to nurses and midwives could be provided by the nurse/midwife Advisor to the Abortion Supervisory Committee;
- **agree** that Level J Unit, Wellington Hospital provides a good model for nursing/midwifery staff;
- **note** our support for well funded public access to private and public clinics**;**
- **agree** that delays would be minimized if primary health practitioners such as Lead Maternity Carers, Family Planning nurses and Nurse Practitioners were able to give referrals**;** and
- **note** that NZNO has staff and members expert in this field who could contribute constructively to discussion about the provision of nationally consistent services for TOP.

ABOUT THE NEW ZEALAND NURSES ORGANISATION

12. NZNO is a Te Tiriti o Waitangi based organisation. It is the leading professional body and nursing union in Aotearoa New Zealand, representing over 43 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Te Runanga o Aotearoa NZNO comprises Māori membership and is the arm through which our Treaty based partnership is articulated.
13. The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.
14. NZNO has consulted its members in the preparation of this submission including NZNO staff, particularly our Professional Nursing Advisors, and NZNO members, through our Colleges and Sections, Regional and other

8. NZNO believes that policy relating to travel assistance should cover all costs, regardless of where the service is provided and should include appropriate support for accommodation and counselling/support person where necessary.
9. NZNO prefers Option 1 - a Local Services Model backed up by 3 nationally coordinated and run Regional Services – but notes that support for this option is provisional upon details of its operation.
10. NZNO generally supports the draft recommendations.

RECOMMENDATIONS

11. The New Zealand Nurses Organisation recommends that you:

- **note** our support for DHBs to meet their obligations to provide local services for first and second trimester TOP;
- **note** our support for the draft principles;
- **note** our provisional support for Option 1;
- **note** our support for a nationally consistent model with all DHBs being required to adopt the guidelines the Abortion Supervisory Committee is developing;
- **note** NZNO's interest in developing national guidelines for nurses working with women experiencing pregnancy loss;
- **agree** that where services cannot be provided locally, travel should be fully funded;
- **note** our support for increasing the use of medical terminations over time;
- **agree** that first trimester medical abortion could be provided quickly and efficiently using outpatient space with nurses/midwives working under clear guidelines and standing orders;
- **agree** that there are legislative barriers to timely access to TOP services which pose a health risk to women;

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes this opportunity to comment on the Services for Terminations of Pregnancy discussion paper and congratulates DHBNZ for a commendably clear, concise and practical document.

2. NZNO believes the background and overview of the services currently provided for terminations of pregnancy (TOP) are accurately described and assessed, and understands that the scope of the proposed project is limited to ensuring the availability of services to all New Zealand women.

3. In this regard, some general observations on factors contributing to inequitable access to TOPs are made, primarily discussing current barriers within DHBs to staffing, training and professional supervision in the provision of TOP services, for which we offer some suggestions.

4. We also draw your attention to the fact that it is not commonly realised that TOP for fetal abnormality is often above 18/40 week gestation and there is insufficient time for necessary counselling and care when many DHBs have a cut-off point TOP of 20 weeks or less. The lack of a consistent cut off point amongst DHBs complicates equitable service provision; NZNO notes that the recent debate in the United Kingdom has established 24 weeks as a cut off point.

5. NZNO strongly agrees that *all* DHBs have a responsibility to provide a full range of safe, sustainable TOP services locally and that only in extreme and unexpected circumstances should women have to travel outside their local area to access such services.

6. NZNO generally supports the principles and core assumptions regarding service.

7. We comment on the core assumptions regarding “Project and other assumptions”, noting legislative barriers and service provider obligations.

New Zealand Nurses Organisation

Submission to the District Health Boards New Zealand Incorporated

on the

Services for Terminations of Pregnancy Discussion Paper

due July 11, 2008

Inquiries to: Marilyn Head
New Zealand Nurses Organisation
PO Box 2128, Wellington
Phone: 04 499 9533
DDI: 04 494 6372
Email: marilynh@nzno.org.nz