

Abortion services in a high-needs district: a community-based model of care

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ABSTRACT

INTRODUCTION: In 2009, a high-deprivation district health board in New Zealand set up a community-based abortion clinic in order to provide a local service and to avoid out-of-region referrals. The service offers medical abortions for women with pregnancies of up to 63 days' gestation, and surgical abortion with local anaesthetic for women with pregnancies of up to 14 weeks' gestation.

AIM: To describe the services developed and assess safety and timeliness for the first year of community-based services.

METHODS: An audit of clinical records for patients seen in 2010 was performed in order to obtain data on location of services, timeliness, safety and complications.

RESULTS: Eighty-two percent of locally provided abortions in 2010 were medical abortions, completed on average less than two days after referral to the service. One percent of patients experienced haemorrhaging post abortion, and 4% had retained products. These rates are within accepted standards for an abortion service.

DISCUSSION: This report illustrates that a community-based model of care can be both clinically and culturally safe, while providing a much-needed service to a high-needs population.

KEYWORDS: Abortion, induced; community health services; delivery of health care; New Zealand

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Introduction

Abortion services in New Zealand are designated as a core service that is publicly funded and must be made accessible by all district health boards (DHBs) around the country.¹ Despite this, abortion services have tended to concentrate in larger urban areas, forcing many women to travel considerable distances to access these services outside their communities.² In 2009, a local abortion service was established in a high-deprivation DHB. This report aims to describe the community-based abortion service offered by this DHB, and show through the data of its first full year of operation that a community-based population responsive service can offer safe and timely services to a high-needs community.

The DHB's population is mostly urban, with a large Maori population (44%), and with the high-

est level of deprivation of any other district, with two thirds of the population (65%) living in decile 1–3 (with decile 1 indicating the highest level of deprivation on a scale of 1 to 10).³ This trend is further exacerbated when split by ethnicity, with 77% of Maori living within deciles 1–3.

Until the opening of the local abortion service women were transferred out of region for their abortion.

The community clinic

The community clinic is a small clinic set in a commercial area near the centre of town offering sexual health and contraception services. Prior to the establishment of the local abortion service, patients considering termination of pregnancy would visit the community clinic either directly or via referral from a general practitioner (GP).

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The community clinic would organise counselling and referral to the abortion service, ensure all clinical investigations required, including blood tests, microbiological assessment, and referral for gestational dating ultrasound. The midwife/counsellor would then liaise with the patient/whanau (family/support) with regard to travel assistance. Post-abortion counselling and care was also offered locally.

After the abortion service was established within the community clinic in 2009, patient flow remained the same through the early stages, but abortion was offered locally. For women preferring medical abortion, second certification is either undertaken by telephone or in person by the visiting doctor completing the abortion.

Surgical abortion with local anaesthetic is offered by a visiting doctor one morning a week, three weeks out of four, for women with pregnancies up to 14 weeks' gestation. The procedure is undertaken in a consultation room on a gynaecological examination couch. During their wait before and after the procedure, each woman has private use of one of the other consultation rooms in which they can rest in a reclining chair.

Medical abortion is offered to women with pregnancies up to 63 days' gestation. Mifepristone is given initially, followed by 800 mcg misoprostol given via the buccal route 24 hours later. Women generally return home after the misoprostol for abortion to occur. Follow-up of patients for medical abortion is primarily undertaken by a midwife/counsellor, who telephones all patients on the day of misoprostol administration and the day following abortion at a minimum. There is also active follow-up by the midwife/counsellor

to ensure that post-abortion serum beta-HCG (human chorionic gonadotropin) is undertaken to confirm abortion. Secondary medical advice is offered by telephone by the visiting doctor who completed the abortion via a contact number given to all patients. The patients also have the option of visiting the clinic after abortion for medical or counselling follow-up. The clinic offers full contraception assistance to all patients attending for abortion, including the fitting of intrauterine devices (IUDs) or contraceptive implants.

Methods

A manual record search was performed on the notes of all women entering the abortion service in 2010. Data included date of presentation; date of termination; method of termination; laboratory results, including beta-HCG and ferritin; and complications.

A search was done for each patient for hospital admissions since termination, ultrasound scan of uterus and laboratory investigations. This was performed to ensure that complications that did not present at the clinic and that had not been reported to the clinic would not be omitted. There is a small possibility that complications that occurred out of region may have been missed from this audit.

Results

A total of 180 women from the DHB had an abortion in 2010. Of these, 81% (n=145) had an abortion locally, while the remaining 19% went outside the region for the service. Of the patients who had an abortion at the local clinic, the major-

Table 1. Safety of medical termination of pregnancy

	Tairawhiti DHB	Accepted Standard (RANZCOG)
Blood loss requiring transfusion	0%	<0.1%
Loss to follow-up for serum beta-HCG	1%	No accepted standard
Ongoing pregnancy	1%	1–3%
Retained products of conception	4%	<5%

DHB District health board

HCG Human chorionic gonadotropin

RANZCOG Royal Australian and New Zealand College of Obstetricians and Gynaecologists

ity (82%, n=120) had a medical abortion. Women choosing medical abortions have the shortest wait for the service, with an average of less than two days from referral to termination. Surgical abortions performed out of region have an average wait of two days longer (7.9 days) than surgical abortions performed locally (5.6 days).

For all abortions performed locally, there were no serious complications. Table 1 shows the rate of complications specifically for medical abortions carried out locally, compared to the accepted standard outlined by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).⁴ Complication rates were very low and within accepted standards.

Discussion

The retrospective case review revealed that most women from the DHB accessing abortion services had medical abortions locally, with minimal waiting time from referral to completion of service. Women accessing surgical abortions locally also accessed the service more rapidly than those travelling to a different district for the service. In a low decile area, the time and expense saved from avoiding travel to other regions can be significant for patients. Safety outcomes also achieved recognised standards, and loss to follow-up for completion of post-abortion serum beta-HCG was extremely low at 1%.

Setting up of an abortion service in the DHB provided a number of challenges. Conscientious objection amongst hospital staff hindered development of the service within the secondary care facility. This led to the setting of a community clinic being raised as an alternative. This was the first time in New Zealand that such a service has been offered from a sexual health clinic. The experience has shown that this community approach is an excellent fit for a service that is naturally an integral part of community sexual health.

Despite concerns to the contrary, abortion provision in a community setting was shown to be safe and effective, with low and acceptable complication rates. There is evidence that once a woman

WHAT GAP THIS FILLS

What we already know: Abortion services in New Zealand are mostly available through larger hospital-based clinics, and community-based models of abortion care are rare.

What this study adds: This short study provides some evidence that a well-structured, community-based service in a low resource setting can offer safe and timely abortion services for a high-needs population.

is sure of her decision, termination should be undertaken as soon as possible for the benefit of the woman's emotional wellbeing.⁵ Local provision of service and availability of medical termination can assist greatly in improving timeliness.⁶

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COMPETING INTERESTS

Dr Snook is a Director of ISTAR Ltd, a listed charity involved in the importation and distribution of mifepristone within New Zealand and Australia.