

Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Termination of pregnancy

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Cultural acknowledgement

The Department of Health acknowledges the Traditional Custodians of the lands, waters and seas across the State of Queensland on which we work and live. We also acknowledge First Nations peoples in Queensland are both Aboriginal Peoples and Torres Strait Islander Peoples and pay respect to the Aboriginal and Torres Strait Islander Elders past, present and emerging.

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This guideline does not address all elements of standard practice and accepts that individual clinicians are responsible for:

- Providing care within the context of locally available resources, expertise, and scope of practice
- Supporting consumer rights and informed decision making, including the right to decline intervention or ongoing management
- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- Ensuring informed consent is obtained prior to delivering care
- Meeting all legislative requirements and professional standards
- Applying standard precautions, and additional precautions as necessary, when delivering care
- Documenting all care in accordance with mandatory and local requirements

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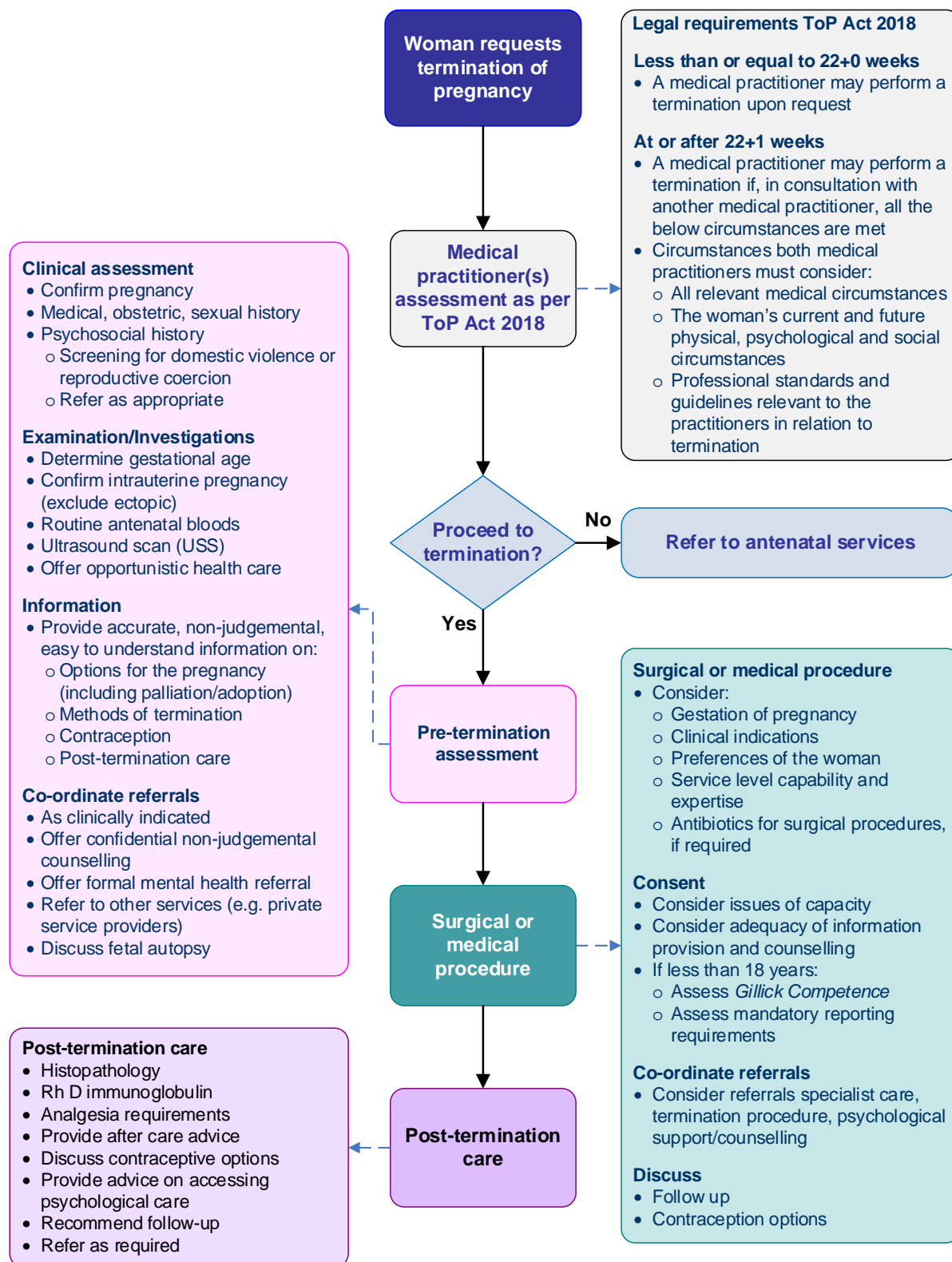
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Flow Chart: Summary of termination of pregnancy

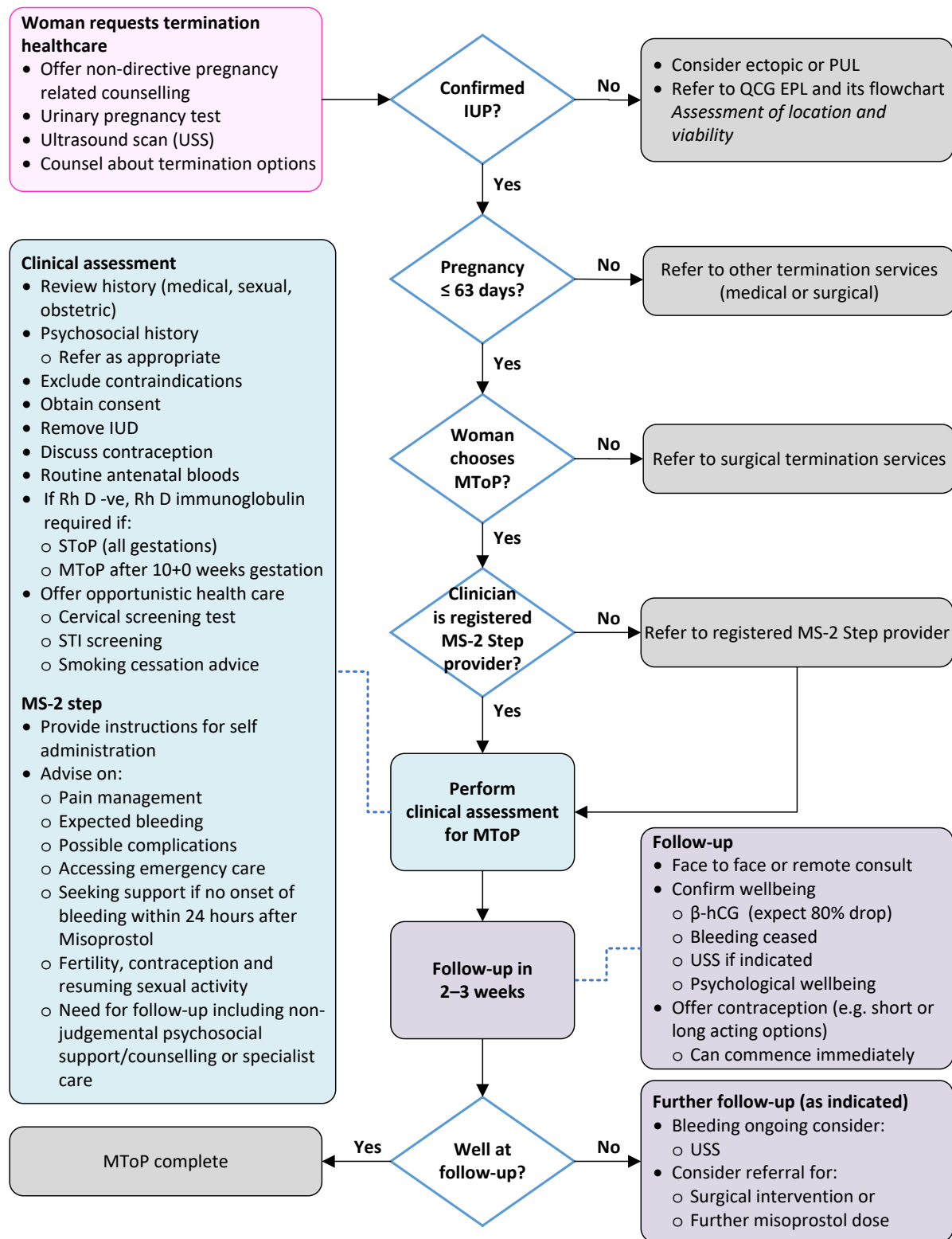


Conscientious objection

- Disclose objection if termination is requested
- Without delay, transfer care to other service or to provider who does not have conscientious objection

ToP: termination of pregnancy, **Rh D:** rhesus D

Flowchart: Medical termination with MS-2 Step



Conscientious objection

- Disclose objection if termination is requested
- Without delay, transfer care to other service or to provider who does not have conscientious objection

β-hCG: beta human chorionic gonadotrophin, EPL: early pregnancy loss, IUD: intrauterine device, IUP: intrauterine pregnancy, MToP: medical termination of pregnancy, PUL: pregnancy of unknown location
 QCG: Queensland Clinical Guidelines, Rh D: Rhesus D, USS: ultrasound scan, ≤: less than or equal to

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Abbreviations

β-hCG	Beta human chorionic gonadotropin
CSCF	Clinical Services Capability Framework
FMH	Feto-maternal haemorrhage
GP	General Practitioner
HHS	Hospital and Health Services
MToP	Medical termination of pregnancy
Rh D	Rhesus immunoglobulin
STI	Sexually transmitted infection(s)
SToP	Surgical termination of pregnancy
ToP Act	<i>Termination of Pregnancy Act 2018 (Qld)</i>
USS	Ultrasound scan

Definition of terms

Complex case	May be one in which, in the judgement of the treating health practitioner(s), there are circumstances that complicate the decision-making process and/or care and management of a woman requesting termination of pregnancy. This may include (but is not automatically a requirement of or limited to) issues related to a woman's medical, social or economic circumstances, capacity to consent, mental health, congenital anomalies, age or gestation of pregnancy at which termination of pregnancy is requested.
Conscientious objector	A registered health practitioner or student who refuses to advise or provide or participate in a lawful treatment or procedure because it conflicts with their own personal beliefs, values or moral concerns. ¹
Healthcare professional	Any healthcare provider involved in the care of a woman requesting termination of pregnancy (i.e. includes social worker, counsellor, hospital liaison officer as well as medical officer and registered nurse or midwife).
Long acting reversible contraception	At the time of a surgical termination of pregnancy all forms of long acting reversible contraception may be inserted including intrauterine devices (Copper bearing or Levonorgestrel varieties) injections or implants. At the time of medical termination of pregnancy implants and injections may be utilised immediately.
Live birth	Describes a baby where there are signs of life after birth of the baby is completed regardless of gestation or birthweight. ^{2,3} Signs of life may include ³ : beating of the heart, pulsation of the umbilical cord, breath efforts, definite movement of the voluntary muscles, any other evidence of life.
Multidisciplinary team	Membership of the healthcare team is influenced by the needs of the woman, availability of staff, and other local resourcing issues. May include but is not limited to: nurse, midwife, obstetrician, general practitioner, feto-maternal specialist, social worker, counsellor or hospital liaison officer.
Obstetrician	Local facilities may, as required, differentiate the roles and responsibilities assigned in this document to an "Obstetrician" according to their specific practitioner group requirements; for example, to gynaecologists, general practitioner obstetricians, specialist obstetricians, consultants, senior registrars and obstetric fellows.
Performance of a termination	Refer to Section 2.1 Performance of a termination.
Registered health practitioner	In Australia, health practitioners are registered under the Health Practitioner Regulation National Law. This sets out a framework for the registration and discipline of registered health practitioners and establishes National Boards that set standards, codes and guidelines that registered health practitioners must meet.
Student health practitioner	In this document, refers to a person enrolled in an approved program of study, undertaking clinical training and who is registered as a student with their respective Health Practitioner National Board.
Termination	The Termination of Pregnancy Act 2018 ⁴ states <i>termination means an intentional termination of a pregnancy in any way, including, for example, by (a) administering a drug; or (b) using an instrument or other thing.</i>
Termination healthcare	In this document <i>termination healthcare</i> refers to the provision of healthcare by a healthcare professional that supports a woman to terminate a pregnancy.
Vital signs	In this document <i>vital signs</i> includes respiratory rate (RR), blood pressure (BP), heart rate (HR), oxygen saturations (SpO ₂), temperature (T) and level of consciousness (LOC).
Young person	A <i>young person</i> refers to a woman aged less than 18 years.

1 Introduction

'Termination of pregnancy' under the *Termination of Pregnancy Act 2018* (Qld)⁴ (the ToP Act) refers to the intentional ending of a pregnancy in any way. The purpose of this guideline is to assist healthcare professionals provide care to women requesting termination of pregnancy (a termination).

1.1 Background

Prior to 3 December 2018, it was unlawful in Queensland under the *Criminal Code Act 1899*, to administer a drug or to perform a surgical or other medical procedure intending to terminate a pregnancy unless such conduct was authorised, excused, or justified by law.

Case law was relied on to provide an excuse from criminal responsibility and justify a termination where a surgical or medical treatment (where the intention was to adversely affect the pregnancy) was provided in good faith, with reasonable care, was to preserve the mother's life and was reasonable considering all the circumstances of the case.

2 Queensland law

As of 3 December 2018 the ToP Act applies to termination of pregnancy in Queensland.⁴ Termination performed by a registered medical practitioner, is no longer a criminal offence under the Criminal Code; nor is it a criminal offence for a woman to consent to, assist in or perform a termination on herself.⁴ The purposes of the ToP Act are to⁴:

- Enable reasonable and safe access by women to termination
- Regulate the conduct of registered and student health practitioners in relation to terminations

2.1 Performance of a termination

Table 1. Performance of a termination

Aspect	Definition
Context	<ul style="list-style-type: none"> • The term <i>performance of a termination</i> is not further specified or defined in the ToP Act⁴ • A consistent clinical interpretation of the term <i>performance of a termination</i> is important to identify: <ul style="list-style-type: none"> ○ The clinical boundaries that define the start and finish of the <i>performance of a termination</i> ○ Termination healthcare to which conscientious objection may be considered relevant or not ○ Termination healthcare that may be performed by a healthcare professional other than a registered health practitioner
Healthcare included in performance of a termination	<ul style="list-style-type: none"> • Expert clinical recommendation is that <i>performance of a termination</i> commences when the therapeutic intervention of termination starts and includes: <ul style="list-style-type: none"> ○ Dispensing, supplying or administering a termination drug on a medical practitioner's instruction ○ Feticide or a surgical procedure of termination performed by a medical practitioner ○ Feticide or a surgical procedure of termination assisted by a registered or student healthcare practitioner [refer to Table 3. Assisting with a termination] ○ At or after 22+1 weeks, determining if a termination should be performed [refer to Table 2. Medical practitioner responsibilities]
Healthcare not included in performance of a termination	<ul style="list-style-type: none"> • Expert clinical recommendation is that <i>performance of a termination</i> does not include clinical care provided before or after <i>performance of a termination</i> including, for example: <ul style="list-style-type: none"> ○ Clinical assessment, pre-operative preparation, referral or non-directive counselling, intrapartum or postpartum care after feticide or after administration of a termination drug ○ Refer to Table 14. Clinical assessment prior to termination ○ Refer to Table 35. Post-termination care considerations

2.2 Medical practitioner responsibilities

The legal responsibilities for the medical practitioner in relation to performance of a termination, are specified according to the gestational age of the woman's pregnancy.⁴

Table 2. Medical practitioner responsibilities

Aspect	Lawful action
Context	<ul style="list-style-type: none"> • Queensland Health considers that: <ul style="list-style-type: none"> ○ "Not more than 22 weeks" means less than or equal to 22+0 weeks ○ "More than 22 weeks" means at or after 22+1 weeks • Use clinical judgement when determining gestational age in individual circumstances
Less than or equal to 22+0 weeks gestation	<ul style="list-style-type: none"> • A medical practitioner may perform a termination on a woman upon request⁴
At or after 22+1 weeks gestation	<ul style="list-style-type: none"> • A medical practitioner may perform a termination if⁴: <ul style="list-style-type: none"> ○ They consider that in all the circumstances, the termination should be performed and ○ They have consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed • Both medical practitioners must consider⁴: <ul style="list-style-type: none"> ○ All relevant medical circumstances ○ The woman's current and future physical, psychological and social circumstances ○ The professional standards and guidelines that apply to the practitioner in relation to the performance of the termination • Consultation⁵ <ul style="list-style-type: none"> ○ The second medical practitioner is not required to examine the woman but may wish to do so ○ Between medical practitioners, consultation in person is not required and may occur by telephone, secure email or video-conference as is required to facilitate access to termination services

2.3 Registered and student health practitioners assisting

Assisting in the performance of a termination includes dispensing, supplying or procuring the supply, or administering a termination drug on a medical practitioner's instruction.^{5,6} 'Assisting' does not include the care provided to a woman before or after the performance of a termination.⁶

Table 3. Assisting with a termination

Aspect	Lawful action
Registered health practitioners	<ul style="list-style-type: none"> • The following registered health practitioners are from prescribed professions⁶ and may assist a medical practitioner in the performance of a termination⁷: <ul style="list-style-type: none"> ○ Another medical practitioner ○ Nurse ○ Midwife ○ Pharmacist ○ Aboriginal and Torres Strait Islander health practitioner ○ Other registered health practitioner prescribed by regulation • Does not apply to a termination the assisting practitioner knows or ought reasonably to know, is being performed by the medical practitioner other than in accordance with the ToP Act⁴
Student health practitioner	<ul style="list-style-type: none"> • Student health practitioners are permitted to assist in the performance of a termination⁷ to the extent necessary to complete the student's program of study under supervision of: <ul style="list-style-type: none"> ○ A medical practitioner performing the termination or ○ A registered health practitioner lawfully assisting in the performance of a termination or ○ The student's primary clinical supervisor

2.4 Conscientious objection

Refer to Definition of terms and Section 2.1 Performance of a termination.

Table 4. Conscientious objection

Aspect	Lawful action
Relevant to	<ul style="list-style-type: none"> • Registered health practitioners who have a conscientious objection to the performance of a termination and who are asked by a person to⁴: <ul style="list-style-type: none"> ○ Perform or assist with the performance of a termination ○ Make a decision whether a termination should be performed ○ Advise the person about the performance of termination on a woman • Registered student health practitioners who are asked by a registered health practitioner to assist with the performance of a termination, who have a conscientious objection to the performance of a termination or to assisting with the performance of a termination⁶
Disclosure of objection	<ul style="list-style-type: none"> • Registered and student health practitioners must disclose their conscientious objection to the requesting person⁴ • For example: <ul style="list-style-type: none"> ○ If a medical practitioner asks a nurse who holds a conscientious objection to assist with the performance of a termination, the nurse must disclose this to the medical practitioner ○ If a woman requests performance of a termination from a medical practitioner who holds a conscientious objection, the medical practitioner must disclose this to the woman ○ If a prescribed registered health practitioner asks a student health practitioner who holds a conscientious objection to assist with the performance of a termination, the student health practitioner must disclose this to the prescribed registered health practitioner⁶
Referral or transfer of care	<ul style="list-style-type: none"> • If a woman requests performance of a termination, a registered health practitioner who has a conscientious objection must refer the woman or transfer care, without delay, to^{4,5}: <ul style="list-style-type: none"> ○ Another registered health practitioner whom they believe can provide the requested termination healthcare and who does not have a conscientious objection OR ○ A health service provider at which, in the practitioner's belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection • Refer or transfer to avoid delays in care provision <ul style="list-style-type: none"> ○ Promptly (i.e. during the presentation in which the request is made) ○ To the nearest/most convenient registered health practitioner or service
Objection only in certain circumstances	<ul style="list-style-type: none"> • Where a registered or student health practitioner has a conscientious objection only in certain circumstances (e.g. a request beyond X weeks gestation) conscientious objection requirements apply only in that circumstance (i.e. for requests beyond X weeks gestation)
Care that is not a matter for conscientious objection	<ul style="list-style-type: none"> • The conscientious objection provision does not extend to⁵: <ul style="list-style-type: none"> ○ Administrative, managerial or other tasks ancillary to the performance of the termination ○ Hospitals, institutions or services, as the right to conscientiously object is a personal and individual right • Refer to Section 2.1 Performance of a termination

2.5 Emergency care involving termination

Table 5. Emergency care

Aspect	Lawful action
Medical practitioner	<ul style="list-style-type: none"> In an emergency, a medical practitioner may perform a termination if they consider it is necessary to save the woman's life or the life of (in a multiple pregnancy) another fetus⁴ If the pregnancy is greater than 22+1 weeks, they may perform the termination⁴: <ul style="list-style-type: none"> Without consulting another medical practitioner Without considering all relevant circumstances
Practitioners assisting	<ul style="list-style-type: none"> In an emergency, a registered or student health practitioner may assist a medical practitioner performing a termination in the circumstances outlined above⁴
Conscientious objectors	<ul style="list-style-type: none"> Conscientious objection does not limit any duty owed by a registered or student health practitioner to provide a service in an emergency at any gestation of pregnancy⁴ As for other health emergencies, the medical practitioner is required to consider what assistance they can provide based on their own safety, skills and what other options are available⁴

2.6 Safe access zones

The purpose of safe access zones is to protect the safety and well-being and respect the privacy and dignity of women and other persons accessing premises where performance of a termination occurs.⁴

Table 6. Safe access zone

Aspect	Lawful action
Safe access zone	<ul style="list-style-type: none"> <i>Termination services premises</i> means the premises at which terminations are performed⁴ <ul style="list-style-type: none"> Does not include a pharmacy Unless otherwise prescribed by regulation, the prescribed distance is 150 metres from the entrance to the <i>termination services premises</i>⁴
Prohibited conduct	<ul style="list-style-type: none"> Conduct in a safe access zone is prohibited if it relates to terminations (or could be reasonably be perceived to be so) and⁴: <ul style="list-style-type: none"> Would be visible or audible to another person entering or leaving the premises and Would be reasonably likely to deter a person from entering or leaving the <i>termination services premises</i>, requesting or undergoing a termination, or performing or assisting with the performance of a termination The conduct may be prohibited whether or not another person sees or hears the conduct or is actually deterred⁴ It is an offence to make an audio or visual recording that contains information that could identify a person entering or leaving a termination services premises without the person's consent, or to publish or distribute a recording without the person's consent⁴

2.7 Non-compliance with the ToP Act

Table 7. Non-compliance

Aspect	Lawful action
Offences	<ul style="list-style-type: none"> • Termination is considered a health matter • No penalty or offence is specified in the ToP Act for a registered or student health practitioner's failure to comply with the requirements of the ToP Act <ul style="list-style-type: none"> ○ Including the conscientious objection provision • As for other healthcare, the following may apply^{5,8}: <ul style="list-style-type: none"> ○ Professional and legal consequences for non-compliance with the ToP Act ○ Laws for duty of care, reasonable skill and care ○ Civil or criminal responsibility for harm that results from a failure to act with reasonable skill and care
Professional conduct	<ul style="list-style-type: none"> • Non-compliance with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards), policies and guidelines is subject to the same professional and legal consequences as for all other healthcare⁵

3 Clinical standards

Where service level capabilities, as defined in the Clinical Services Capability Framework (CSCF), are insufficient to provide termination healthcare, establish referral and transfer systems with other CSCF service level facilities.⁹

3.1 Service provision

Table 8. Service provision

Aspect	Considerations
Access to termination healthcare	<ul style="list-style-type: none"> • Women requesting termination require assessment by a registered health practitioner who is not a conscientious objector <ul style="list-style-type: none"> ○ Refer to Table 4. Conscientious objection • Where termination healthcare is not locally available, support women to access the service, as for any other healthcare not locally available • Provide care to women and families that acknowledges and respects their cultural beliefs and practices • If required, access and provide appropriate interpreter services <ul style="list-style-type: none"> ○ Refer to Queensland Clinical Guideline: <i>Standard care</i>¹⁰ • Provide documented information to consumers, external service providers and support agencies within the local Hospital and Health Service (HHS) on the choices available within the service, and on routes of access to these services • Facilitate access (including via patient travel subsidy scheme, when required) as early as possible and without delay to: <ul style="list-style-type: none"> ○ Reduce the likelihood of associated health risks ○ Support maternal preference for a termination procedure that may be impacted by gestational age limitations
Referral	<ul style="list-style-type: none"> • Document referral pathways within and between HHSs (e.g. between departments within a facility, between facilities, and between a facility and external agencies or general practitioners (GP)) <ul style="list-style-type: none"> ○ Consider engagement with statewide external service providers and agencies in the development of referral pathways and mechanisms • Provide documented referral pathways to external service providers, agencies and GPs • Inform healthcare professionals in contact with women seeking termination (e.g. emergency departments, GPs) about referral pathways • If there is a conscientious objection to the performance of a termination, act in accordance with Table 4. Conscientious objection • Where the woman considers but does not proceed to termination, provide information and access to appropriate referral pathways (e.g. access to a social worker, referral for antenatal care) • Refer to the Queensland Health <i>Guide to informed decision making</i>¹¹
Local service delivery	<ul style="list-style-type: none"> • Determine the local service delivery mechanisms and administrative reporting requirements within each service • A multidisciplinary and coordinated approach is required to avoid unnecessary delay in the provision of care • Where there are complex issues present [refer to Definition of terms], consider a case review (as for other complex healthcare) to assess the complexities specific to the individual woman • Educate providers and referrers about the service, the pathways, any service limitations and their professional responsibilities
Care setting	<ul style="list-style-type: none"> • The most appropriate care setting for termination is dependent on the: <ul style="list-style-type: none"> ○ Method of termination chosen ○ Gestation of the pregnancy^{12,13} ○ Preferences of the woman and her care provider ○ The service capabilities of the facility • Ensure there are local arrangements for the safe and sensitive handling, storage and management of fetal tissue

3.2 Workforce support

Table 9. Workforce support

Aspect	Considerations
Healthcare professionals	<ul style="list-style-type: none"> • For healthcare professionals involved in the provision of termination healthcare, provide: <ul style="list-style-type: none"> ○ Ongoing training and education¹² ○ Access to non-judgemental counselling and debriefing support
Student health practitioners	<ul style="list-style-type: none"> • Support access to information on: <ul style="list-style-type: none"> ○ Queensland Law and the ToP Act ○ Conscientious objection rights and responsibilities ○ Contemporary approach to termination healthcare provision ○ Sensitive communication and confidentiality ○ Other matters relevant to the clinical placement • If the student health practitioner holds a conscientious objection, support: <ul style="list-style-type: none"> ○ Alternative clinical learning ○ Access to non-judgemental counselling and debriefing support (if required)
Standard care	<ul style="list-style-type: none"> • Refer to Queensland Clinical Guideline: <i>Standard care</i> for care considered 'usual' or 'standard'. • Includes for example, privacy, consent, decision making, sensitive communication, medication administration, staff education and support and culturally appropriate care

4 Individual case considerations

Termination healthcare is provided in partnership with the woman (and family, where appropriate) and the healthcare professional. It is led by the woman's health needs, concerns and choices. Use clinical judgement when determining if all aspects of care are appropriate for the individual woman.

Registered and student health practitioners providing termination healthcare are advised to familiarise themselves with their legal responsibilities under the ToP Act.⁴ Refer to Section 2 Queensland law.

4.1 Consent

Table 10. Consent

Aspect	Consideration
Consent	<ul style="list-style-type: none"> • Follow usual consent processes and standards including: <ul style="list-style-type: none"> ○ Assessment of capacity ○ Discussion of available methods of termination ○ Risks and complications of each method of termination
Capacity to consent	<ul style="list-style-type: none"> • An adult can give consent (has capacity) if they¹⁴: <ul style="list-style-type: none"> ○ Understand the nature and effect of decisions about the matter ○ Freely and voluntarily makes decisions about the matter and ○ Can communicate the decisions in some way
Adults who lack capacity	<ul style="list-style-type: none"> • Termination of a pregnancy of an adult who lacks capacity is considered to be “special healthcare”^{14,15} • An attorney, legal guardian or substitute decisionmaker cannot give consent for another person to undergo a termination • The Queensland Civil and Administrative Tribunal may consent for an adult who lacks capacity to undergo a termination “only if the Tribunal is satisfied that it may be performed by a medical practitioner under the ToP Act”
Young person Gillick competent¹⁶	<ul style="list-style-type: none"> • A young person is considered <i>Gillick</i> competent when they achieve sufficient maturity and intelligence to enable them to understand fully what medical treatment is proposed¹⁶ • A <i>Gillick</i> competent young person can consent to medical procedures, in the same way as an autonomous adult with capacity • The decision about whether a young person is <i>Gillick</i> competent is a matter for the treating practitioner • Consider additional elements of informed consent when obtaining consent from a <i>Gillick</i> competent young person (e.g. the ability to freely and voluntarily make decisions without coercion) • The law requires that when a competent young person chooses not to include their parents/guardians in consultation, this must be respected, and confidentiality not breached • Involve appropriately skilled healthcare professionals for assessment of <i>Gillick</i> competency, psychosocial assessment and family court matters <i>where clinically indicated</i> • Refer to Queensland Health: <i>Guide to informed decision making in healthcare</i>¹¹
Young person <u>not</u> Gillick competent	<ul style="list-style-type: none"> • For a young person deemed not to have capacity (<i>Gillick</i> competent), the Supreme Court in its <i>parens patriae</i> jurisdiction¹⁵ may authorise the termination <ul style="list-style-type: none"> ○ The Supreme Court must act in the best interests of the young person ○ A young person's parents/guardian cannot provide consent to a termination • Involve appropriately skilled healthcare professionals for assessment of <i>Gillick</i> competency, psychosocial assessment and family court matters <i>where clinically indicated</i> • Escalate these cases to the Executive Director of Medical Services or equivalent (e.g. Medical Superintendent) for urgent attention

4.2 Young person less than 14 years

A young person less than 14 years may be considered *Gillick competent*. Assess individual circumstances. Refer to Table 9. Consent.

Table 11. Young person less than 14 years

Aspect	Consideration
Young person less than 14 years	<ul style="list-style-type: none"> • Each HHS determines its capability to provide termination healthcare for young people less than 14 years • Involve social worker support • If not considered <i>Gillick</i> competent: <ul style="list-style-type: none"> ○ Involve appropriately skilled healthcare professionals for assessment of <i>Gillick</i> competency, psychosocial assessment and family court matters ○ Refer to Table 9. Consent • Provide non-judgemental pre-termination psychological counselling by an appropriately qualified healthcare professional <ul style="list-style-type: none"> ○ Refer to Section 5.1 Psychological support ○ Include documented evidence of the pre-termination counselling in the medical record • Refer to the Queensland Health: <i>Guide to informed decision making in healthcare</i>¹¹

4.3 Suspicion of child abuse

Table 12. Suspicion of abuse

Aspect	Consideration
Suspicion of harm ¹⁷	<ul style="list-style-type: none"> • A reportable suspicion is where there is reasonable suspicion that a young person has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; <i>and</i> may not have a parent able and willing to protect them from harm • Registered nurses and doctors are mandatory reporters for children where there is reasonable suspicion of harm • Any Queensland Health staff member may report a reasonable suspicion of harm • A child under the Child Protection Act¹⁸ is a person under 18 years of age
Sexual offences ¹⁷	<ul style="list-style-type: none"> • It is a criminal offence⁸ for any adult who, without a reasonable excuse, fails to report a child sexual offense to police • It is an offence to fail to protect a child from a sexual offence in an institutional setting • A child under the Criminal Code⁸ is a person under 16 years of age or under 18 years with an impairment of mind
Reporting requirements ¹⁷	<ul style="list-style-type: none"> • Report any reasonable suspicions of harm, abuse, neglect or sexual offending against a young person to Child Safety Services in the Department of Child Safety, Youth and Women^{2,8,9,18} • A voluntary or mandatory report to an appropriate government authority such as Child Safety is considered a 'reasonable excuse' for not also reporting a child sexual offense to police

4.4 Special circumstances

Table 13. Special circumstances

Aspect	Consideration
Sexual assault	<ul style="list-style-type: none"> • Provide termination healthcare on the basis of the woman's request¹² • If the pregnancy is reported to have resulted from forced sexual activity, or the woman discloses domestic violence (or fear of violence) discuss with the woman her options for: <ul style="list-style-type: none"> ○ Social work support ○ Alerting authorities (Queensland Police Service) ○ Relocating, if in continued danger ○ Routine sexual health checks and treatment (as required) ○ A medical examination and documentation of findings ○ Possibility of the products of conception being used for forensic testing to assist legal proceedings • Support the woman's choices for ongoing healthcare and involvement • Refer to Queensland Health Policy: <i>Sexual health and safety guidelines: mental health, alcohol and other drug services</i>¹⁹
Suspected fetal abnormality	<ul style="list-style-type: none"> • If fetal abnormality suspected, discuss with the woman: <ul style="list-style-type: none"> ○ Chromosomal analysis ○ Histopathology ○ Autopsy
Female genital mutilation (FGM)	<ul style="list-style-type: none"> • If FGM, use clinical judgement and individually assess the clinical and psychological circumstances of each woman • If deinfibulation indicated, seek specialist advice • Refer to Queensland Clinical Guideline <i>Perineal Care</i>²⁰

4.5 Documentation of decisions

Refer to Queensland Clinical Guideline: *Standard care*.¹⁰

Table 14. Documentation

Aspect	Consideration
Less than or equal to 22+0 weeks	<ul style="list-style-type: none"> • Apply standard documentation principles • Refer to Queensland Clinical Guideline: <i>Standard care</i>¹⁰
At or after 22+1 weeks and/or complex case	<ul style="list-style-type: none"> • Both medical practitioners document: <ul style="list-style-type: none"> ○ Clinical opinion about the relevant medical circumstances ○ Clinical assessment about the woman's current and future physical, and psychological and social circumstances ○ Individual clinical assessment of the woman

5 Pre-termination assessment

Offer pre-termination assessment including counselling and psychosocial support services close to home where feasible.²¹

Table 15. Clinical assessment prior to termination

Aspect	Considerations
Review history	<ul style="list-style-type: none"> • Discuss request for termination services in a non-judgemental and supportive manner • Obtain medical, gynaecological, obstetric, and sexual health history^{12,13} including date of last menstrual period • Obtain psycho-social history²² including mental health issues, screening for domestic and family violence and reproductive coercion
Clinical exam and investigations	<ul style="list-style-type: none"> • Confirm diagnosis, gestational age and location of pregnancy²² • Undertake a physical exam as indicated by the history and signs and symptoms including: <ul style="list-style-type: none"> ◦ Vital signs^{12,23} and body mass index (BMI) if surgical termination • Undertake routine antenatal serum screening (if not already screened) including for: <ul style="list-style-type: none"> ◦ Haemoglobin, blood group and Rh status to identify Rh negative women requiring Rh D immunoglobulin^{13,24,25} ◦ Rubella titre²⁴
Ultrasound scan (USS)	<ul style="list-style-type: none"> • USS to confirm intrauterine pregnancy for all women prior to termination • If appropriate, ask women about their preference to see/hear USS images and audio
Sexual health check	<ul style="list-style-type: none"> • Perform a sexual health check and assess sexually transmitted infection(s) (STI) risk²⁶ including: <ul style="list-style-type: none"> ◦ Multiple or casual partners ◦ Condom use ◦ History of STI ◦ Symptoms (e.g. discharge, pain on urination, genital rashes) • Screen for STI as per local protocol; if no local protocol, consider²⁶ <ul style="list-style-type: none"> ◦ Chlamydia, gonorrhoea, trichomonas, syphilis, human immunodeficiency virus (HIV) • Presumptively treat women for symptomatic STI where follow-up is uncertain/unlikely
Pre-termination referral coordination	<ul style="list-style-type: none"> • Facilitate timely referral and coordination with other facilities/disciplines/agencies²⁷ for: <ul style="list-style-type: none"> ◦ Specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging) ◦ Psychosocial counselling/support <ul style="list-style-type: none"> ▪ Especially where risk factors are identified (e.g. young person, women with physical or intellectual disabilities, mental illness (past or current), rape or sexual assault, domestic violence (including sexual violence), fertility issues and religious or cultural beliefs/values) ◦ Mental health support/treatment²⁸ ◦ Termination procedure
Contraception	<ul style="list-style-type: none"> • Discuss contraceptive options at the time of initial consultation, termination procedure or immediately after^{12,27} • Refer to Table 36. Contraception provision
Opportunistic healthcare	<ul style="list-style-type: none"> • Consider opportunistic health screening or advice including: <ul style="list-style-type: none"> ◦ Cervical screening test ◦ Smoking cessation advice
Follow-up	<ul style="list-style-type: none"> • Arrange follow-up for review/assessment of^{12,27}: <ul style="list-style-type: none"> ◦ Physical recovery ◦ Emotional issues (and referral for counselling as necessary) ◦ Pathology from products of conception including results from fetal autopsy, as indicated ◦ Discussion of ongoing contraception • Refer to Table 37. Discharge preparation

5.1 Psychological support

The decision to terminate a pregnancy may be a difficult, and sometimes, a traumatic process.^{13,29} Consider the woman's psychological, spiritual and cultural beliefs when providing termination healthcare.

Table 16. Information and counselling

Aspect	Considerations
Information	<ul style="list-style-type: none"> • Support the decision-making process by providing accurate, impartial and easy to understand³ information including²¹: <ul style="list-style-type: none"> ○ Options to continue the pregnancy and parent the child¹³ ○ Options to continue the pregnancy and place the child for foster care/adoption/alternative arrangements ○ Documentation of discussions regarding all options for termination (including public and private facility options based on individual needs and circumstances) ○ Post-termination considerations (e.g. contraceptive options and non-judgemental counselling support) ○ Information about local support groups relevant to the circumstances ○ Birth registration requirements³⁰⁻³² [refer to Section 5.4.1 Birth registration]
Counselling	<ul style="list-style-type: none"> • Offer confidential, non-judgemental support and counselling^{12,28} provided by someone (e.g. social worker, psychologist, counsellor) who: <ul style="list-style-type: none"> ○ Is appropriately qualified and/or trained ○ Is experienced with the issues surrounding termination ○ Has no vested interest in the pregnancy outcome²⁸ • Where feasible, offer counselling 'close to home' to aid the establishment of longer-term counselling support • Involve family members as per the woman's preferences • Consider the requirement for formal mental health referral especially if: <ul style="list-style-type: none"> ○ History of mental illness or suicidal ideations ○ Clinical concern or the woman reports current acute needs²¹
Communication	<ul style="list-style-type: none"> • Appropriate communication is an important aspect of termination care <ul style="list-style-type: none"> ○ Use respectful language when referring to the pregnancy ○ Give time for questions to be asked and answered ○ Answer questions honestly and respectfully ○ Use straightforward and simple language ○ Acknowledge and reassure that it is normal to feel a range of emotions (e.g. grief, sadness, relief) ○ Involve the multi-disciplinary team if required • Do not: <ul style="list-style-type: none"> ○ Refer to the pregnancy as 'products of conception' or 'it' ○ Apply judgement for individual motives or reason for termination ○ Imply fault or blame about contraception use/lack of use ○ Try to persuade the woman to change her mind
Memory creation	<ul style="list-style-type: none"> • If appropriate, discuss with the woman (and if she chooses, her family and/or other children) options for 'memory creation' which may include: <ul style="list-style-type: none"> ○ Photographs ○ Hand/footprints ○ Holding or bathing ○ Copies of USS photographs

5.1.1 Psychological sequelae

Table 17. Psychological healthcare

Aspect	Considerations
Evidence summary	<ul style="list-style-type: none"> • There are significant limitations in the evidence examining the relationships between unplanned pregnancy, termination, birth and mental health³³ • Emotional responses following termination are complex and may change over time • Risk factors for post-termination psychological problems may include: previous or concurrent psychiatric illness, coercion, increasing length of gestation, ambivalence and lack of social support, poor relationships with others or religious affiliation • Adverse psychological sequelae may be no more likely following termination than following continuation of the pregnancy³⁴ • For the majority of mental health outcomes, there is no statistically significant association between termination of pregnancy and mental health problems^{21,33,35} • An unwanted pregnancy may lead to an increased risk of mental health problems, or other factors may lead to both an increased risk of unplanned pregnancy and increased risk of mental health problems³³⁻³⁵ • When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has a termination or goes on to give birth • Women with a past history of mental health problems may be at increased risk of further mental health issues after an unplanned pregnancy^{33,34}
Recommendation	<ul style="list-style-type: none"> • Consider the need for non-judgemental support and care for all women, and partners, who request a termination <ul style="list-style-type: none"> ○ Discuss with women the importance of seeking support if they experience mental distress/anxiety/health issues or suicidal ideations, particularly if there is a reported history of mental health issues ○ Involve members of the multidisciplinary team as appropriate • Offer the woman a referral to mental health services, where indicated³⁶

5.2 Method selection

A pregnancy may be terminated using a medical or surgical approach or a combination of the two.²⁷ The choice of method is dependent on the woman's preference, gestational age, local clinician expertise and the service capabilities, and availability of pharmacological agents.²⁷

Table 18. Methods of termination

Aspect	Consideration
Medical termination of pregnancy (MToP)	<ul style="list-style-type: none"> • Medications are used to induce the termination²⁷ • May be considered for all gestations of pregnancy • Mifepristone in combination with misoprostol (or misoprostol alone) are the recommended regimens for MToP <ul style="list-style-type: none"> ○ MS-2 Step is recommended for gestations 63 days or less ○ Refer to Section 6.5 MToP at 63 days gestation or less
Surgical termination of pregnancy (SToP)	<ul style="list-style-type: none"> • Surgical curettage is generally suitable up to 12 weeks gestation²² <ul style="list-style-type: none"> ○ Between 12–16 weeks (or greater) gestation, performed only by an experienced practitioner²² • Anaesthesia depends on service capabilities⁹ • Refer to Section 7 Surgical termination
Feticide	<ul style="list-style-type: none"> • Provided by a trained specialist • Usually for gestations greater than 22+1 weeks^{22,27} as is clinically appropriate • Refer the woman to the closest service with the capability to perform the procedure⁹ • Post feticide, a woman may be transferred to another facility for birth if⁹: <ul style="list-style-type: none"> ○ Considered clinically safe ○ There is a robust referral process ○ There is comprehensive documentation • Involve the woman and the receiving hospital in decisions about transfer
Selective reduction/selective feticide	<ul style="list-style-type: none"> • If selective reduction or selective feticide is required in multiple pregnancies, consider the woman's individual circumstances on a case by case basis⁵

5.2.1 Other considerations for method selection

Table 19. Considerations for selection

Aspect	Consideration
Service capability	<ul style="list-style-type: none"> • If there is limited capability for a preferred method, refer promptly to another service or provider⁹
Risks and complications	<ul style="list-style-type: none"> • Discuss the complications and risks associated with the differing methods of termination in a way the woman can understand • Advise of the overall safety of the procedures¹³
Acceptability of method	<ul style="list-style-type: none"> • Satisfaction with MToP and SToP reported as comparable^{37,38} • Support the woman to make the decision that is best for her circumstances and preferences • Consider additional psychological support for women at greater than 16 weeks gestation who receive inpatient care within the maternity services

5.3 MToP and SToP risks and complications

Complications and risks associated with termination of pregnancy are rare when performed by qualified medical practitioners.²² Serious complications are rare and morbidity is less common with terminations than with pregnancies that are carried to term.¹³

Table 20. Risks and complications

Complication	Comments
Retained products of conception	<ul style="list-style-type: none"> • Uncommon following SToP • Requirement for surgical evacuation of retained products increased following MToP³⁹
Infection	<ul style="list-style-type: none"> • Risk reduced if: <ul style="list-style-type: none"> ○ Prophylactic antibiotics prior to SToP¹³ ○ Refer to Section 7.3 Surgical curettage ○ Lower genital tract infection has been excluded • Prophylactic antibiotics not recommended for MToP^{12,40}
Cervical trauma	<ul style="list-style-type: none"> • Rates vary during SToP; risk of damage to the external cervical os at the time of surgical termination is no greater than 1 in 100¹³ • Decreased risk with¹³: <ul style="list-style-type: none"> ○ Experienced clinician ○ Use of preoperative cervical priming ○ Earlier gestations
Haemorrhage	<ul style="list-style-type: none"> • Risk is lower at earlier gestations <ul style="list-style-type: none"> ○ First trimester: less than 1 in 1000 terminations³² ○ Greater than 20 weeks: 4 in 1000 terminations³² ○ May be more common following MToP (bleeding may persist up to 45 days) but evidence is not conclusive^{13,22}
Uterine perforation	<ul style="list-style-type: none"> • Risk at the time of surgical termination is 1–4 in 1000³² • Decreased risk of uterine perforation associated with: <ul style="list-style-type: none"> ○ Experienced clinician ○ Use of pre-operative cervical priming^{32,41} ○ Earlier gestations
Uterine rupture	<ul style="list-style-type: none"> • Uterine rupture has been rarely reported in association with mid-trimester MToPs⁴² • More frequently associated with later gestational ages and previous uterine scar • Risk is less than 1 in 1000 terminations³²
Failure to achieve termination of the pregnancy	<ul style="list-style-type: none"> • All methods of first trimester termination carry a small risk of failure to terminate <ul style="list-style-type: none"> ○ Approximately 1–2 in 100 pregnancies across both surgical and medical procedures³² • More likely following early rather than late termination of pregnancy • Failed termination of pregnancy while uncommon may lead to fetal anomalies if the pregnancy persists³²
Future pregnancies	<ul style="list-style-type: none"> • There are no proven associations between termination of pregnancy and subsequent ectopic pregnancy, placenta praevia or infertility³²
Surgery, anaesthetic or sedation	<ul style="list-style-type: none"> • Standard risks common to all surgical procedures requiring anaesthetic or sedation • Consider: <ul style="list-style-type: none"> ○ Individual circumstances and general health of the woman ○ Service capabilities

5.4 Fetal considerations

Provide information to women (as appropriate to the clinical circumstances) about birth and death registration requirements and the management of fetal remains.

5.4.1 Birth registration

Table 21. Registration requirements

Gestation/Birth weight ³¹	Signs of life	Requirement
Less than 20 weeks AND less than 400 grams	Not live born	<ul style="list-style-type: none"> • Birth registration not required • Death certificate not required • Burial/cremation not required
Less than 20 weeks AND less than 400 grams	Live born	<ul style="list-style-type: none"> • Birth registration required • Death certificate required • Burial/cremation required
Greater than 20 weeks OR more than 400 grams	Not live born OR Live born	

5.4.2 Transport and management of fetal remains

Table 22. Management of fetal remains/tissue

Aspect	Consideration
Lawful disposal	<ul style="list-style-type: none"> • Where birth and death registration is required, burial or cremation of fetal remains is required within a cemetery or at a crematorium⁴³ • Where birth and death registration is not required: <ul style="list-style-type: none"> ○ Many local councils regulate how fetal remains may be disposed of outside of a cemetery or crematorium ○ Hospital facilities may be permitted to dispose of fetal remains by incineration or chemical disinfection⁴⁴
Requests to take fetal remains home/overseas	<ul style="list-style-type: none"> • Fetal remains that do not legally require burial or cremation may be released to the woman for private disposal provided that^{44,45}: <ul style="list-style-type: none"> ○ There is no risk of transmission of notifiable conditions ○ The woman has been informed how the fetal remains may be lawfully disposed • Establish local protocols to support requests to take fetal remains home (e.g. use of sensitive transport containers) • Provide information: <ul style="list-style-type: none"> ○ About safe and legal disposal ○ About safe management of fetal remains, including infection control⁴⁴ ○ About community queries regarding fetal remains that are to be transported within Australia or overseas
Individual preferences	<ul style="list-style-type: none"> • Recognise that a woman may wish to make her own arrangements for disposal • Respect cultural and/or religious beliefs • Advise women: <ul style="list-style-type: none"> ○ Of the options for lawful disposal ○ Of local council regulations for disposal on private property ○ Funeral services may assist with burial/cremation where birth registration is not required, and no death certificate has been issued ○ Memorial services may be offered at the facility • Consider the condition of the fetal remains and inform the woman appropriately • Offer social worker support • For births less than 20 weeks gestation, or less than 400 grams (i.e. not requiring registration), offer information on purchasing a commemorative certificate from Queensland Registry of Births Deaths Marriages

5.4.3 Other fetal considerations

Table 23. Fetal considerations

Aspect	Consideration
Live birth	<ul style="list-style-type: none"> • Provide individualised and holistic care to women according to circumstances • If appropriate to clinical circumstances, discuss with the woman before the procedure, the potential for live birth including: <ul style="list-style-type: none"> ○ Preferences for awareness of live birth (e.g. informed immediately at time of birth or information delayed) ○ Desire for engagement in any subsequent care ○ Expected fetal appearance and/or clinical course relevant to circumstances ○ Legal requirements for birth registration and management of fetal remains ○ Refer to Definition of terms and Section 5.4.1 Birth registration • Establish local procedures for the management of live birth • Offer counselling and support services to women, partners and healthcare professionals involved with care of a live born fetus • If a live birth occurs⁴⁶: <ul style="list-style-type: none"> ○ Support the woman's wishes and preferences ○ Handle baby gently and carefully and wrap to provide warmth ○ Offer opportunities to engage in care provision (e.g. cuddling/holding) as desired ○ Do not provide life sustaining treatment (e.g. gastric tubes, IV lines, oxygen therapy) ○ Provide sensitive emotional support and reassurance to parents throughout the process and afterwards ○ Document date and time end of life occurs
Fetal autopsy	<ul style="list-style-type: none"> • Offer fetal autopsy if clinically indicated (e.g. if fetal abnormality) • Refer to Queensland Clinical Guideline: <i>Stillbirth care</i>⁴⁷
Gestations greater than 16 weeks	<ul style="list-style-type: none"> • Discuss with women, as appropriate to clinical circumstance: <ul style="list-style-type: none"> ○ Possibility for live birth ○ Options for memory creation <ul style="list-style-type: none"> ▪ Refer to Table 15. Information and counselling ○ Autopsy, if indicated ○ Birth registration requirements <ul style="list-style-type: none"> ▪ Refer to Table 20. Registration requirements ○ Donation of breast milk to milk banks (where appropriate) or lactation suppression <ul style="list-style-type: none"> ▪ Refer to Table 37. Discharge preparation • Involve social workers (e.g. for support, discussion of any costs, funeral arrangements) • Offer information about community services (e.g. Harrison's Little Wings, Children by Choice, Mental Health Access Line, Pregnancy Counselling link)

6 Medical termination

Medical methods of termination are safe and effective.³ Where local protocols are not well established or do not exist, suggested regimens are provided in the following sections.

6.1 Practitioner requirements

Australian healthcare professionals must register with MS Health online to become licensed prescribers or dispensers of MS-2 Step (mifepristone, misoprostol) and/or mifepristone.^{48,49} MS-2 Step, mifepristone, and misoprostol are conditionally approved for use by Queensland Health as per the list of approved medicines (LAM).⁵⁰

6.2 MToP precautions

Table 24. Precautions for medical termination

Aspect	Consideration
Contraindications for MToP	<ul style="list-style-type: none"> • Hypersensitivity or allergy to prostaglandins or a product component³⁹ • Suspected or confirmed ectopic pregnancy³⁹ • Gestational trophoblastic disease • Intrauterine device (remove prior to termination)³⁹ • Obstructive cervical lesions (e.g. fibroids) • High suspicion of placenta accreta
Cautions for MToP	<ul style="list-style-type: none"> • If cardiovascular disease, monitor cardiovascular status as prostaglandins may cause transient blood pressure changes³⁹ • If high risk of uterine rupture <ul style="list-style-type: none"> ○ Consider individual circumstances⁵¹ ○ May not be suitable with history of caesarean section (CS), multiple pregnancies or uterine abnormalities⁵² • If previous traumatic pregnancy loss (e.g. miscarriage), counsel women on blood loss associated with MToP⁵³ <ul style="list-style-type: none"> ○ Vaginal bleeding is heavier with MToP compared with SToP and may be comparable to a miscarriage • If breastfeeding: MToP medications may cause diarrhoea in the child⁵⁴
Contraindications to mifepristone	<ul style="list-style-type: none"> • Chronic adrenal failure • Concurrent long-term corticosteroid therapy • Known or suspected haemorrhagic disorders or treatment with anti-coagulants⁵⁵

6.3 MToP in the outpatient setting

Table 25. Healthcare setting

Aspect	Considerations
Context	<ul style="list-style-type: none"> • To identify the most appropriate setting for MToP consider: <ul style="list-style-type: none"> ○ Local service capability ○ Individual circumstances ○ Woman's preferences ○ Geographic distances to be travelled if emergency care is required
Suggested criteria	<ul style="list-style-type: none"> • If no local criteria established, outpatient care may be suitable for women who meet all of the following: <ul style="list-style-type: none"> ○ Are less than or equal to 9 weeks gestation ○ Are accompanied by a support person, who has been adequately informed about what to expect, until the termination is complete²⁹ ○ Have immediate access to transport and telephone ○ Can communicate by telephone (e.g. have an interpreter available if required) ○ Have the capacity to understand and follow instructions ○ Can access a 24 hour emergency healthcare facility with minimal delay ○ Have follow-up arrangements in place

6.4 MToP pre-dosage care

Table 26. MToP pre-dosage care

Aspect	Consideration
Clinical care	<ul style="list-style-type: none"> • Perform a pre-termination assessment <ul style="list-style-type: none"> ○ Refer to Section 5 Pre-termination assessment • Obtain informed consent <ul style="list-style-type: none"> ○ Refer to Section 4.1 Consent • Exclude contraindications and review cautions <ul style="list-style-type: none"> ○ Refer to Section 6.2 MToP precautions • If greater than 10+0 weeks, consider the need for Rh D immunoglobulin prophylaxis <ul style="list-style-type: none"> ○ Refer to Table 35. Post-termination care considerations
Communication	<ul style="list-style-type: none"> • Provide information about: <ul style="list-style-type: none"> ○ The process (e.g. duration, timing of medication, symptoms, passage of tissue) ○ When and how to seek emergency care including specific contact details • If indicated, discuss collection of products of conception for examination
Medication side effects	<ul style="list-style-type: none"> • Provide information about possible medication side effects • Adverse events for combined use of mifepristone and misoprostol are dose dependent and increase with gestational age^{54,56} • Common side effects include^{22,23,51}: <ul style="list-style-type: none"> ○ Prolonged vaginal bleeding ○ Nausea, vomiting, diarrhoea ○ Headache ○ Abnormal thermoregulation (e.g. hot flushes, low grade temperature) ○ Abdominal pain and cramps • If woman is breastfeeding, refer to product information
Follow-up	<ul style="list-style-type: none"> • Confirm follow-up arrangements • Discuss options and preference for contraception • Refer to Section 8 MToP and SToP post-termination care

6.5 MToP at 63 days gestation or less

MS-2 Step composite pack is suitable for termination at 63 days or less gestation (9+0 weeks).⁴⁹

Table 27. MS-2 Step for MToP

Aspect	Consideration
MS-2 Step composite pack³⁹	<ul style="list-style-type: none"> Consists of: <ul style="list-style-type: none"> Mifepristone 200 mg (1 tablet containing 200 mg) Misoprostol 800 micrograms (4 tablets, each tablet containing 200 micrograms)
Efficacy	<ul style="list-style-type: none"> For women less than 49 days gestational age³⁹: <ul style="list-style-type: none"> Efficacy 97.3% Incomplete termination requiring aspiration 2.3% Rate of ongoing pregnancy 0.3% For women with a gestational age between 49 to 63 days: <ul style="list-style-type: none"> Efficacy 95.2% Incomplete termination requiring aspiration 4.8% Rate of ongoing pregnancy 0.6%
Pre-dosage care	<ul style="list-style-type: none"> Refer to Table 25. MToP pre-dosage care Provide written information about misoprostol medication self-administration⁵¹ Supply a prescription for analgesia and antiemetics
Dose⁴⁹	<p>Initial dose:</p> <ul style="list-style-type: none"> Mifepristone 200 mg oral <p>Subsequent dose:</p> <ul style="list-style-type: none"> 36–48 hours after mifepristone <ul style="list-style-type: none"> Misoprostol 800 micrograms buccal or sublingual
Follow-up	<ul style="list-style-type: none"> Follow-up at 14–21 days as per local protocols Confirm expulsion complete³⁹: <ul style="list-style-type: none"> Clinical examination (vital signs, abdominal cramping, pain, history of tissue passed) Serum β-hCG assay, or urine pregnancy test, if indicated USS if indicated No ongoing persistent vaginal bleeding Referral for surgical procedure or other follow-up if required Refer to Table 37. Discharge preparation

*Caution: refer to the Australian product information for complete drug information

6.6 MToP after 63 days gestation

A combination regimen with a prostaglandin analogue is more effective than use of either medication as a single analogue agent.³⁹

6.6.1 Care during MToP

Table 28. MToP considerations after 63 days gestation

Aspect	Considerations
Cautions	<ul style="list-style-type: none"> Seek expert advice from a higher level service as required Feticide required for gestations greater than 22 weeks
Pre-care	<ul style="list-style-type: none"> Refer to Table 25. MToP pre-dosage care Baseline vital signs, vaginal loss, pain prior to commencement IV access is recommended If Rh negative, recommend Rh D immunoglobulin from 10+0 weeks²⁴ Full blood count (FBC), group and hold as clinically indicated
Inpatient clinical care	<ul style="list-style-type: none"> Offer analgesia Offer antiemetics if required Vaginal examination as clinically indicated Bed rest for 30 minutes after each dose but may mobilise freely at other times Consider oxytocin IV at time of birth If the placenta is not spontaneously delivered within 60 minutes of the fetus (or earlier if excessive bleeding occurs) consider operative removal
Observations	<ul style="list-style-type: none"> 30–60 minutes after initial dose of misoprostol and after each subsequent dose <ul style="list-style-type: none"> Vital signs vaginal loss, contractions, assess pain

6.6.2 MToP regimen for women at risk of uterine rupture

Table 29. MToP with risk of uterine rupture

Risk of uterine rupture or with previous uterine surgery	
Cautions	<ul style="list-style-type: none"> Seek expert advice from a higher level service⁹ as required Feticide required for gestations greater than 22 weeks Consider IV access and monitor women closely for evidence of scar complications
Less than 34+0 weeks	<ul style="list-style-type: none"> Day 1: mifepristone 200 mg oral³⁹ Day 2: 36–48 hours after mifepristone <ul style="list-style-type: none"> Misoprostol 200 micrograms inserted into the posterior fornix of the vagina If undelivered at 4 hours after initial dose, then misoprostol 200 micrograms inserted into the posterior fornix of the vagina every 4 hours for 4 doses (may also be given sublingual or buccal) If undelivered at 24 hours after initial dose, then commence misoprostol 400 micrograms inserted into the posterior fornix of the vagina every 6 hours for a maximum of 4 further doses If undelivered at 48 hours after initial dose, then review by an obstetrician is indicated. Options may include: <ul style="list-style-type: none"> Continue with misoprostol 400 micrograms 6 hourly or Rest day then recommence or IV oxytocin is most effective if some effacement and dilation has occurred or Surgical delivery
34+0 weeks or more	<ul style="list-style-type: none"> Transcervical catheter Oxytocin infusion and artificial rupture of membranes Avoid misoprostol or dinoprostone

Refer to an Australian pharmacopoeia for complete drug information

6.6.3 MToP regimen for women not known to be at risk of uterine rupture

Table 30. MToP with no known risk of uterine rupture

Follow protocol according to gestational age	
9+0 to 12+6 weeks	<ul style="list-style-type: none"> • Day 1: mifepristone 200 mg oral³⁹ • Day 2: 36–48 hours after mifepristone²² <ul style="list-style-type: none"> ○ Misoprostol 800 micrograms vaginal, sublingual or buccal ○ Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses • If fetus undelivered, consider additional misoprostol dose or surgical procedure
13+0 to 24+6 weeks	<ul style="list-style-type: none"> • Day 1: mifepristone 200 mg oral³⁹ • Day 2: 36–48 hours after mifepristone²² <ul style="list-style-type: none"> ○ Misoprostol 400 micrograms vaginal or sublingual ○ Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses
25+0 to 33+6 weeks	<ul style="list-style-type: none"> • Day 1: mifepristone 200 mg oral³⁹ • Day 2: 36–48 hours after mifepristone²² <ul style="list-style-type: none"> ○ Misoprostol 200 micrograms vaginal or sublingual every 3–6 hours for six doses over 24 hours
34+0 weeks or more	<ul style="list-style-type: none"> • Pre-induction: <ul style="list-style-type: none"> ○ Dinoprostone or transcervical catheter • Induction <ul style="list-style-type: none"> ○ Misoprostol 50–100 micrograms sublingually or per vagina 3–6 hourly for five doses over 24 hours ○ Oxytocin infusion and consider artificial rupture of membranes after labour established

Caution: refer to the Australian product information for complete drug information

7 Surgical termination

Surgical curettage is generally suitable for gestations of pregnancy up to 14 weeks.²² Surgical procedures for pregnancies greater than 14–16 weeks gestation require a clinician with the relevant training and experience.^{22,57}

7.1 SToP pre-procedure care

Table 31. SToP pre-procedure care

Aspect	Considerations
Clinical care	<ul style="list-style-type: none"> • Perform a pre-termination assessment including baseline vital signs <ul style="list-style-type: none"> ○ Refer to Section 5 Pre-termination assessment • Obtain informed consent <ul style="list-style-type: none"> ○ Refer to Section 4.1 Consent • Consider the need for Rh D immunoglobulin <ul style="list-style-type: none"> ○ Refer to Table 35. Post-termination care considerations • Consider the need for cervical priming⁵⁸ <ul style="list-style-type: none"> ○ Refer to Table 31. Cervical priming
Communication	<ul style="list-style-type: none"> • Provide information about: <ul style="list-style-type: none"> ○ The termination process ○ What symptoms to expect post procedure including bleeding and pain⁵⁹ ○ Refer to Table 15. Information and counselling ○ Options for pain relief

7.2 Cervical priming for SToP

Table 32. Cervical priming for SToP

Aspect	Considerations
Rationale	<ul style="list-style-type: none"> • Cervical preparation decreases the length of SToP procedure • May also^{22,23}: <ul style="list-style-type: none"> ○ Reduce complications of uterine perforation and cervical injury ○ Make the procedure easier to perform ○ Make the procedure more comfortable for the woman
Options	<ul style="list-style-type: none"> • Pharmacological agents <ul style="list-style-type: none"> ○ Mifepristone and misoprostol ○ Misoprostol alone
Recommendation	<ul style="list-style-type: none"> • For women less than 18 years of age • For nulliparous women • After 12–14 weeks gestation²³ (although may be considered at any gestational age)

Caution: refer to the Australian product information for complete drug information

7.2.1 Misoprostol prior to SToP

Table 33. Misoprostol alone for cervical priming prior to surgical termination

Aspect	Considerations
Precautions	<ul style="list-style-type: none"> • Refer to Table 23. Precautions for medical termination
Dosage	<p>3–4 hours prior to surgery²²</p> <ul style="list-style-type: none"> • 400 micrograms inserted into the posterior fornix of the vagina <p>OR</p> <p>2–3 hours prior to surgery²²</p> <ul style="list-style-type: none"> • 400 micrograms oral, sublingual or buccal

Caution: refer to the Australian product information for complete drug information

7.2.2 Mifepristone and misoprostol prior to SToP

Table 34. Mifepristone and misoprostol for cervical priming prior to surgical termination

Aspect	Considerations
Precautions	<ul style="list-style-type: none"> Refer to Table 23. Precautions for medical termination
Day 1: Pre-dose care	<ul style="list-style-type: none"> May occur as an outpatient (or at home) following pre-termination assessment Provide contact details to the woman in case of emergency
Day 1: Dosage (24–48 hours prior to procedure)	<ul style="list-style-type: none"> Mifepristone 200 mg oral²²
Day 2 (Day of procedure)	<ul style="list-style-type: none"> <ul style="list-style-type: none"> If less than 14 weeks gestation²²: Misoprostol 400 micrograms sublingual 2–3 hours prior to procedure OR <ul style="list-style-type: none"> Misoprostol 400 micrograms vaginally 3–4 hours prior to the procedure <ul style="list-style-type: none"> If greater than 14 weeks gestation²²: <ul style="list-style-type: none"> Misoprostol 400 micrograms vaginally 3–4 hours prior to procedure

*Caution: refer to the Australian product information for complete drug information

7.3 Surgical curettage

Table 35. Considerations for surgical termination

Aspect	Consideration
Prophylactic antibiotics	<ul style="list-style-type: none"> Intra or perioperative prophylactic antibiotics recommended^{22,23} In the absence of local protocols consider: <ul style="list-style-type: none"> Doxycycline 400 mg orally, with food, 10–12 hour prior to procedure OR Doxycycline 100 mg orally 60 minutes prior to procedure THEN 200 mg orally 90 minutes after the procedure⁴⁰ If medication allergy refer to Therapeutic Guidelines for alternate antibiotic regime⁴⁰ Opportunistic healthcare including cervico-vaginal screening for STI <ul style="list-style-type: none"> Refer to Table 14. Clinical assessment prior to termination
Anaesthesia	<ul style="list-style-type: none"> Method may depend on service capabilities and the woman's choice May be performed with or without oral or intravenous tranquilliser Analgesics, local anaesthesia and/or mild sedation are usually sufficient
Oxytocic agents	<ul style="list-style-type: none"> May decrease the risks of haemorrhage but not routinely recommended for vacuum aspiration
USS	<ul style="list-style-type: none"> May be used to check completeness Routine use not required at less than 12 weeks³⁴
Examination of tissue	<ul style="list-style-type: none"> Examination of the products of conception by the surgeon may assist with recognition of gestational trophoblast⁶⁰ Histopathology if clinically indicated²² Refer to Table 35. Post-termination care considerations
Side effects	<ul style="list-style-type: none"> Pain: analgesia is usually required (e.g. non-steroidal anti-inflammatory drugs) Bleeding: expected duration 5–18 days²⁸ Nausea: usually related to prostaglandins or anaesthetic drugs²⁸
Risks and complications	<ul style="list-style-type: none"> Serious complications are rare²⁸ Risk rises with operator inexperience and gestational age²³
Follow-up	<ul style="list-style-type: none"> Recommend follow up (e.g. GP, telephone/video contact, face to face) to discuss: <ul style="list-style-type: none"> Bleeding Psychological well-being Contraception [refer to Table 36. Contraception provision] Refer to Section 8.2 Discharge preparation and follow-up

*Caution: refer to the Australian product information for complete drug information

8 MToP and SToP post-termination care

Most serious complications are detectable in the immediate post-procedure period. Refer to Table 19. Risks and complications. Appropriate and accessible follow-up care is essential.²³

Table 36. Post-termination care considerations

Aspect	Consideration
Inpatient post-procedural care	<ul style="list-style-type: none"> • Provide routine post-procedural care including assessment of vital signs, consciousness and observation of vaginal loss • Where possible provide inpatient care that is not within a maternity service environment
Rh prophylaxis*	<ul style="list-style-type: none"> • Indicated for women who are Rh D negative with no preformed anti-D antibodies within 72 hours of termination²⁴: <ul style="list-style-type: none"> ○ After SToP at any gestation ○ After MToP from 10+0 weeks gestation²⁴ • Dose: <ul style="list-style-type: none"> ○ First 12+6 weeks: 250 IU Rh D immunoglobulin IM injection ○ From 13+0 weeks: 625 IU Rh D immunoglobulin IM injection • If greater than 20 weeks gestation, recommend quantification of foeto-maternal haemorrhage (FMH)²⁴ <ul style="list-style-type: none"> ○ If FMH estimated at 6 mL or more, recommend additional Rh D immunoglobulin
Analgesia	<ul style="list-style-type: none"> • Individually determine analgesia requirements after surgical termination or during and after MToP as requirements vary • Offer medication for pain management¹² (paracetamol and/or ibuprofen often effective) • Advise women that severe pain may be indicative of uterine perforation or clot retention¹² <ul style="list-style-type: none"> ○ Seek advice if analgesia provided unable to manage pain effectively
Histopathology	<ul style="list-style-type: none"> • If clinically indicated or suspicion of fetal abnormality, consider histopathological examination and chromosomal analysis (microarray) of tissue obtained during termination procedures

*Caution: refer to the Australian product information for complete drug information

8.1 Contraception

Australia has a relatively high rate of unintended pregnancy (19.7 per 1000 women aged 15–44 years).⁶¹ Australia ranks amongst the highest countries for termination of pregnancy in the developed world with 1 in 4 women undergoing a termination procedure.^{62,63}

Table 37. Contraception provision

Aspect	Consideration
Context	<ul style="list-style-type: none"> • Prevention of unwanted future pregnancies is an important part of the provision of termination healthcare • Women who do not attend follow-up appointments for contraception are at higher risk of unintended pregnancy than women who have contraception provided at time of termination⁶⁴
Information	<ul style="list-style-type: none"> • Ideally, commence discussions about contraception during first contact • Discuss options based on woman's preference including short and long acting methods • Provide information on side effects, benefits and failure rates of methods • Offer information on benefits of condom use in preventing STI²⁶ • If contraception declined, offer information (as appropriate to the circumstances) about: <ul style="list-style-type: none"> ○ Types of contraception available ○ Accessing local services for contraceptive advice or support ○ The importance of prevention of future unwanted pregnancies
Long acting reversible contraception	<ul style="list-style-type: none"> • Significantly less likely to result in unintended pregnancy than short-acting user-dependent methods, such as the oral contraceptive pill^{63,64} • May be inserted, during a SToP, or immediately post MToP or SToP²² • Provide information on what to expect after insertion

8.2 Discharge preparation and follow-up

Table 38. Discharge preparation

Aspect	Consideration
Counselling and support	<ul style="list-style-type: none"> • Promote continuity of care to facilitate the development of longer-term support opportunities • Provide information on accessing support agencies/organisations appropriate to individual circumstances (e.g. GP, grief counselling or support groups) • Offer referral for counselling, especially where risk factors for long-term post-termination distress are evident (e.g. ambivalence before the termination, lack of a supportive partner, psychiatric history or membership of a religious or cultural group where termination is not an option) • Offer information and assistance as appropriate regarding birth registration and funeral arrangements <ul style="list-style-type: none"> ○ Refer to Table 20. Registration requirements ○ Refer to Table 15. Information and counselling
Lactation	<ul style="list-style-type: none"> • If appropriate, discuss the possibility of lactation including <ul style="list-style-type: none"> ○ Suppression (pharmacological and comfort measures) ○ Donation of breast milk to milk banks ○ Emotional response to lactation
Risk of infection	<ul style="list-style-type: none"> • To reduce risk of infection, recommend (until bleeding ceased) avoiding: <ul style="list-style-type: none"> ○ Vaginal intercourse ○ Insertion of tampons or other products into the vagina ○ Bathing or swimming
Subsequent pregnancy	<ul style="list-style-type: none"> • If there are no physical, psychological, health related or other barriers after a termination, conception can be attempted immediately following the termination • If appropriate offer information about pre-conceptual care (e.g. folic acid, smoking cessation, rubella immunisation if required)
Discharge	<ul style="list-style-type: none"> • Determine timing of discharge on an individual basis • Consider routine discharge criteria (e.g. vital signs, recovery from effects of sedation/anaesthesia) • Supply a prescription for analgesia and antiemetics • Provide written information regarding post-procedure symptoms and accessing emergency care¹² <ul style="list-style-type: none"> ○ Refer to Queensland Clinical Guidelines: <i>Patient information on post termination care</i>⁶⁵ • Provide a confidential letter to the woman that gives sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications (particularly for women living in rural and remote locations) • Seek consent for discharge letter distribution (e.g. to GP)
Follow-up	<ul style="list-style-type: none"> • After MToP, recommend follow-up within 14–21 days²² (e.g. GP, telephone/video contact, face to face) • After SToP, offer follow-up based on individual circumstances (e.g. if procedure complicated or additional support required) • If appropriate <ul style="list-style-type: none"> ○ Schedule follow-up to discuss pathology results, especially where there was histopathology/autopsy for fetal abnormality ○ Recommend referral to medical specialists (e.g. clinical genetics services) ○ Review emotional wellbeing of woman and family • Where follow up is difficult, or uncertain encourage woman to seek support from GP or local health service for <ul style="list-style-type: none"> ○ Passage of tissue ○ Ongoing bleeding and/or pain ○ Contraception

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