# Queensland Clinical Guidelines

*Translating evidence into best clinical practice*

Maternity and Neonatal **Clinical Guideline**

# Termination of pregnancy

Queensland Government

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**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.


Disclaimer

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The guideline is not a substitute for clinical judgement, knowledge and expertise, or medical advice. Variation from the guideline, taking into account individual circumstances, may be appropriate.

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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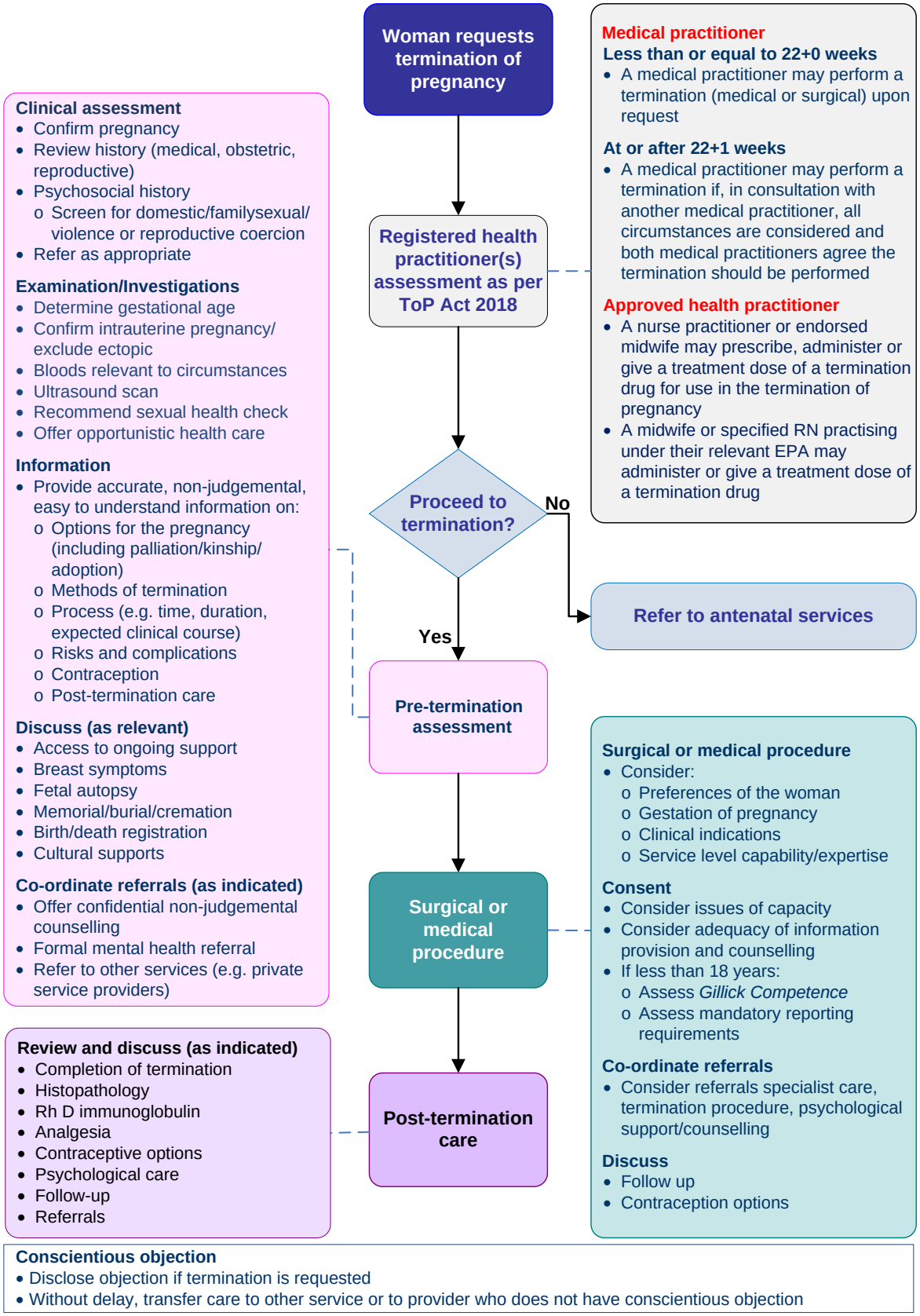
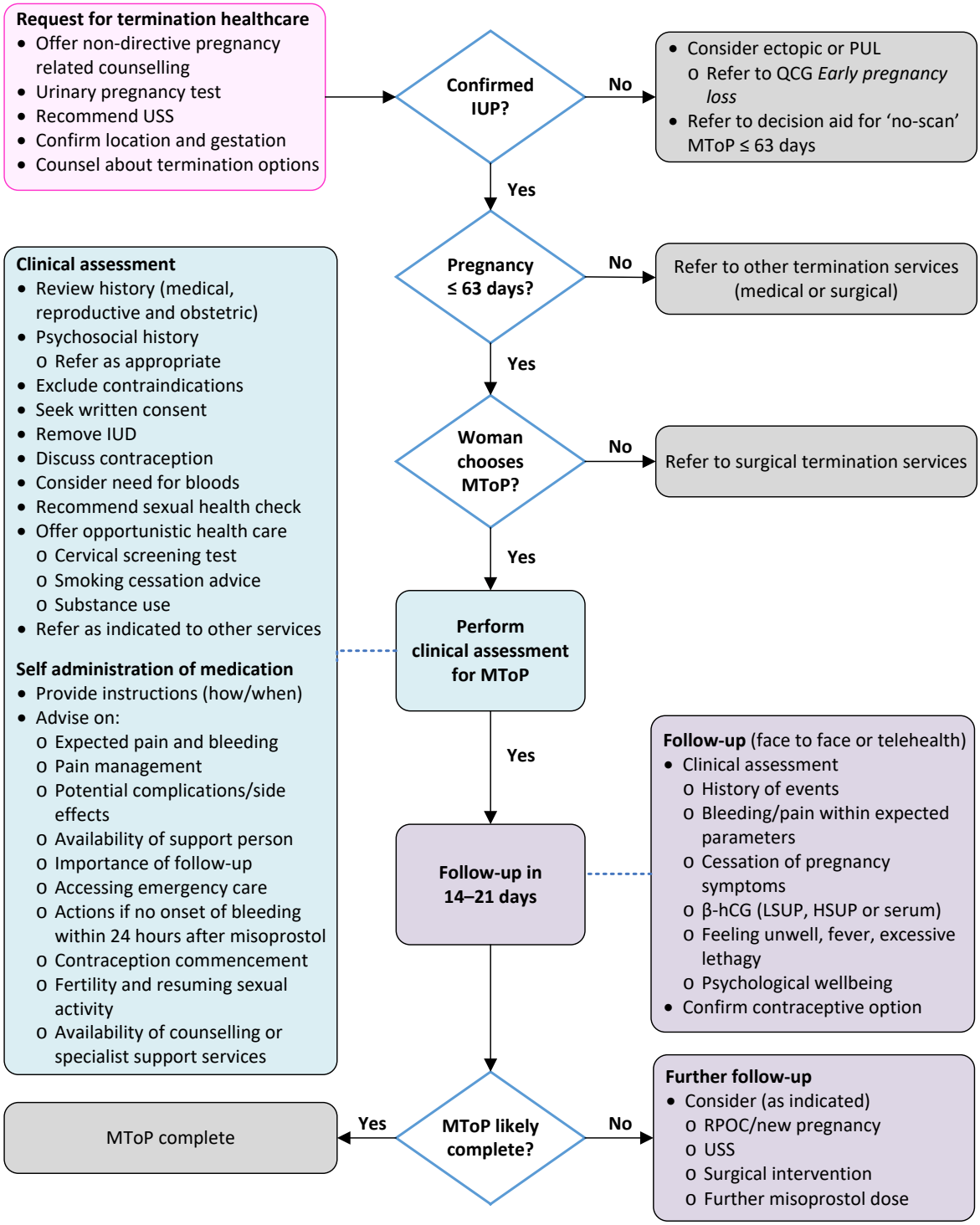
## Flow Chart: Summary of termination of pregnancy




**EPA:** extended practice authority, **Rh D**:Rhesus D, **RN:** Registered Nurse **ToP:** termination of pregnancy

Flowchart: F24.21-1-V6-R29

## Flowchart: Medical termination at or less than 63 days of pregnancy

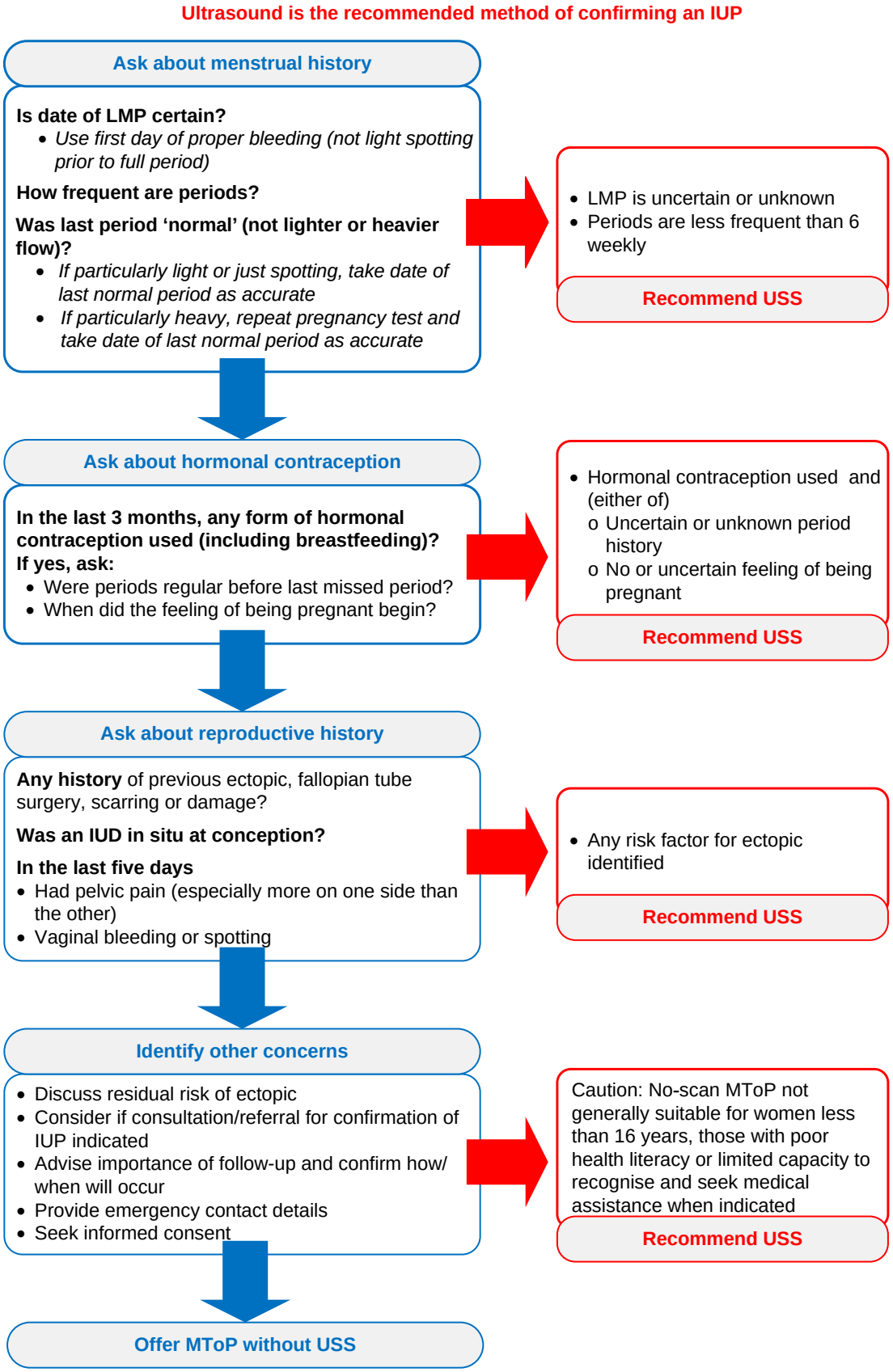



**Conscientious objection**
- Disclose objection if termination is requested
- Without delay, transfer care to other service or to provider who does not have conscientious objection

**β-hCG:** beta human chorionic gonadotrophin, **EPL:** early pregnancy loss, **HSUP:** high sensitivity urine pregnancy test, **IUD:** intrauterine device, **IUP:** intrauterine pregnancy, **LSUP:** low sensitivity urine pregnancy test, **MToP:** medical termination of pregnancy, **PUL:** pregnancy of unknown location, **QCG:** Queensland Clinical Guideline, **Rh D:** Rhesus D, **RPOC:** retained products of conceptions, **USS:** ultrasound scan, **≤:** less than or equal to

Flowchart: F24.21-2-V6-R29

## Flowchart: Decision aid for no-scan MToP at or less than 63 days of pregnancy




**IUD:** intrauterine device, **IUP:** intrauterine pregnancy, **MToP:** medical termination of pregnancy, **USS:** ultrasound scan,

Flowchart F24.21-3-V1-R29 .

Adapted from: RCOG (2020). Decision aid for early medical abortion without ultrasound

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**Abbreviations**

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|---|---|
| β-hCG | Beta human chorionic gonadotropin |
| EPA | Extended practice authority |
| GP | General Practitioner |
| HHS | Hospital and Health Services |
| MToP | Medical termination of pregnancy |
| STI | Sexually transmitted infection |
| SToP | Surgical termination of pregnancy |
| ToP Act | *Termination of Pregnancy Act 2018* (Qld) |
| USS | Ultrasound scan |

**Definition of terms**

| | |
|---|---|
| **Approved health practitioner** | In this guideline, refers to an endorsed midwife, nurse practitioner, medical practitioner and a midwife and registered nurse practising in accordance with their respective extended practice authority (EPA) and all acting in compliance with the requirements of the *Medicines and Poisons Act 2019* (Qld)[1] and Medicines and Poisons (Medicines) Regulation 2021 (Qld).[2] |
| **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 objection** | A registered health practitioner or student health practitioner who has an objection to performing or assisting with a lawful termination of pregnancy because it conflicts with their own personal beliefs, values or moral concerns.[3] |
| **Healthcare professional** | Healthcare provider involved in the care of a woman requesting termination of pregnancy (e.g. social worker, counsellor, Aboriginal and Torres Strait Islander health worker, medical practitioner, registered nurse or midwife). |
| **Live birth** | Describes a baby where there are signs of life after birth of the baby is completed regardless of gestation or birthweight.[4,5]<br>Signs of life may include[5]: beating of the heart, pulsation of the umbilical cord, breath efforts, definite movement of the voluntary muscles, any other evidence of life. |
| **Medical termination** | The *ToP Act*[6] states:<br>*medical termination means a termination caused by use of a termination drug* |
| **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. |
| **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 guideline, 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. Has the same meaning as 'prescribed student' in the *ToP Act.*[6] |
| **Termination** | The *ToP Act*[6] states<br>*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.* |
| **Termination healthcare** | In this guideline, *termination healthcare* refers to the provision of healthcare by a healthcare professional that supports a woman to terminate a pregnancy. |
| **Vital signs** | In this document *vital signs* includes respiratory rate (RR), blood pressure (BP), heart rate (HR), oxygen saturations ($SpO_2$), temperature (T) and level of consciousness (LOC). |
| **Woman/women** | Queensland Clinical Guidelines recognise that individuals have diverse gender identities. In QCG documents, although the terms *woman* and *women* are used, these guidelines are inclusive of people who are pregnant or give birth and who do not identify as female.[7,8] |
| **Young person/child** | Refers to a person aged less than 18 years. |

# 1 Introduction

Termination of pregnancy is a common reproductive health event with around one in four women undergoing a termination of pregnancy in their reproductive lifetime.[9] In Australia, most states do not routinely report data[10] but the estimated rate of termination of pregnancy is 15 per 1000 women between the ages of 15–49 years.[9,10] Since the approval of mifepristone in Australia, the proportion of surgical terminations has declined and the overall rate of termination of pregnancy has not increased.[9]

The purpose of this guideline is to assist healthcare professionals provide care to women requesting termination of pregnancy (a termination).

# 2 Queensland law

In Queensland, termination of pregnancy under the *Termination of Pregnancy Act 2018* (Qld) (the *ToP Act*) refers to the intentional ending of a pregnancy in any way.[6] When performed in accordance with Queensland legislation[1,2,6,11]

- A medical health practitioner may perform a *medical* or *surgical* termination of pregnancy (authorised under the ToP Act, Queensland Criminal Code, *Medicines and Poisons Act 2019* and the Medicines and Poisons (Medicines) Regulation 2021)
- A nurse practitioner or an endorsed midwife may perform a *medical* termination of pregnancy (authorised under the ToP Act and Medicines and *Poisons Act 2019* and the Medicines and Poisons (Medicines) Regulation 2021[2])
- A midwife or registered nurse practising under an extended practice authority (EPA) may perform a *medical* termination of pregnancy as this is specifically authorised under the *Medicines and Poisons Act 2019* and the Medicines and Poisons (Medicines) Regulation 2021[1]

## 2.1 Clinical performance of a termination

Table 1. Clinical performance of a termination

| Aspect | Explanation |
|---|---|
| **Context** | • A consistent clinical interpretation of the healthcare included in the term *performance of a termination* aids identification of:<br>o The clinical boundaries that define the start and finish of the *clinical performance of a termination*<br>o Termination healthcare to which conscientious objection may be considered relevant or not<br>o Termination healthcare that may be performed by a healthcare professional other than a registered health practitioner |
| **Healthcare included in the *clinical performance of a termination*** | • Expert clinical recommendation is that *clinical performance of a termination* commences when the therapeutic intervention of termination starts and includes:<br>o Dispensing, supplying, giving a treatment dose or administering a termination drug<br>o Feticide or a surgical procedure of termination<br>o At or after 22 weeks+1 day, determining if a termination should be performed<br>• For specific practitioner responsibilities related to the *clinical performance of a termination* refer to:<br>o Section 2.2 Termination by medical practitioner<br>o Section 2.3 Medical termination by approved health practitioners<br>o Section 2.4 Registered and student health practitioners assisting |
| **Healthcare not included in *clinical performance of a termination*** | • Expert clinical recommendation is that *clinical performance of a termination* does not include clinical care provided before or after *clinical performance of a termination* including, for example:<br>o Clinical assessment, pre-operative preparation, referral or non-directive counselling, intrapartum or postpartum care after feticide or after administration of a termination drug<br>o Refer to Table 21. Clinical assessment prior to termination<br>o Refer to Table 39. Post-termination care considerations |

## 2.2 Termination by medical practitioner

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.[6]

Table 2. Medical practitioner responsibilities

| Aspect | Lawful action |
|---|---|
| **Context** | • Queensland Health considers that:<br>o "Not more than 22 weeks" means less than or equal to 22 weeks+0 days<br>o "More than 22 weeks" means at or after 22 weeks+1 day<br>• Use clinical judgement when determining gestational age in individual circumstances |
| **Less than or equal to 22 weeks+0 days gestation** | • A medical practitioner may perform a termination on a woman[6] |
| **At or after 22 weeks+1 day gestation** | • A medical practitioner may perform a termination if[6]:<br>o They consider that in all the circumstances, the termination should be performed and<br>o They have consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed<br>• Both medical practitioners must consider[6]:<br>o All relevant medical circumstances, and<br>o The woman's current and future physical, psychological and social circumstances, and<br>o The professional standards and guidelines that apply to the medical practitioner in relation to the performance of the termination<br>• Consultation<br>o The second medical practitioner is not required to examine the woman but may wish to do so<br>o 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<br>• Refer to 2.5 Emergency care involving termination |

## 2.3 Medical termination by approved health practitioners

Table 3. Medical termination by approved health practitioner

| Aspect | Lawful action |
|---|---|
| **Approved health practitioners** | • The following registered health practitioners are approved health practitioners and may perform *a medical* termination[1]<br>o Medical practitioner<br>o Nurse practitioner<br>o Endorsed midwife<br>o Registered nurses authorised under an extended practice authority (EPA)<br>o Midwives authorised under an EPA |
| **Perform a medical termination** | • As defined in the *ToP Act*[6] perform a medical termination means to:<br>o Prescribe a treatment dose of a termination drug for use in the termination of pregnancy[6]<br>o Administer or give a treatment dose of a termination drug for use in the termination of pregnancy under an EPA<br>• As defined in the *Medicines and Poisons Act 2019* (Qld)<br>o Administer a medicine means to introduce a dose of the medicine into the body of a person or give a dose of the medicine to a person to be taken immediately<br>o Give a treatment dose of a medicine means to give one or more doses of the medicine to a person to be taken by a particular person, at a later time |
| **Authority given by legislation** | • The Therapeutic Goods Administration (TGA) has approved MS-2 Step (mifepristone and misoprostol) for medical termination of pregnancy in intrauterine pregnancies up to and including 63 days gestation (9 weeks)[12,13]<br>• Section 6A of the *ToP Act*[6] permits nurse practitioners and endorsed midwives to perform a medical termination of pregnancy, with an approved medication (i.e. MS-2 Step) if the practitioner is authorised to use the medicine under the *Medicines and Poisons Act 2019*[1]<br>• The Medicines and Poisons (Medicines) Regulation 2021[2] (MPMR) supports the *Medicines and Poisons Act 2019*[1], to regulate activities with scheduled medicines for therapeutic purposes in Queensland<br>o Nurse practitioners are permitted to perform a medical termination under the MPMR Schedule 7, Part 1, section 3<br>o Endorsed midwives are permitted to perform a medical termination under the MPMR Schedule 7, Part 2, section 8 |
| **Extended Practice Authority (EPA)**[14] | • Section 232 of the *Medicines and Poisons Act 2019*[1] enables the chief executive or their delegate to make an EPA and requires the EPA to be approved by regulation (section 232(4))<br>• The EPA can state the places or contexts an approved person may undertake additional regulated activities with medicines<br>• A midwife or registered nurse may be approved by their employer to practise under a relevant EPA, to administer or give a treatment dose of MS-2 Step, specified analgesia and antiemetics, without a prescription<br>• The midwife or registered nurse must have completed a prescribed education and training program approved by their employer and comply with any conditions specified |

## 2.4 Registered and student health practitioners assisting

Registered health practitioners and student health practitioners may assist a medical practitioner to perform a termination (medical or surgical) or they may assist a nurse practitioner or an endorsed midwife to perform a *medical* termination. Refer to Table 2. Medical practitioner responsibilities and Table 3. Medical termination by approved health practitioner.

Table 4. Assisting with a termination of pregnancy

| Aspect | Lawful action |
|---|---|
| ***Assisting*** | • Registered health practitioners (prescribed practitioners) and student health practitioners, as described below, may assist<br>• Includes assisting a medical practitioner in the clinical performance of a surgical termination of pregnancy[6]<br>• Defined in the *ToP Act*[6] to include dispensing, supplying or procuring the supply of, and administering a termination drug<br>• Refer to Table 1. Clinical performance of a termination |
| **Registered health professions** | • Registered health practitioners from the following prescribed health professions[15] may assist a medical practitioner in the performance of a termination[16] or assist a nurse practitioner or an endorsed midwife in the performance of a *medical* termination<br>o Medical<br>o Nursing<br>o Midwifery<br>o Pharmacy<br>o Aboriginal and Torres Strait Islander health practice<br>o Other registered health professions prescribed by regulation<br>• Does not apply to a termination the assisting prescribed practitioner knows or ought reasonably to know, is being performed by the medical practitioner, a nurse practitioner or an endorsed midwife other than in accordance with the *ToP Act*[6] |
| **Student health practitioner** | • Student health practitioners are permitted to assist in the performance of a termination[16] to the extent necessary to complete the student's program of study under supervision[2] of:<br>o A medical practitioner performing the termination (medical or surgical)<br>o An endorsed midwife or nurse practitioner performing a medical termination; or a registered nurse or midwife authorised under their EPA to perform a medical termination by administering, or giving a treatment dose of, a termination drug<br>o A registered health practitioner lawfully assisting in the performance of a termination or<br>o The student's primary clinical supervisor, who is a registered health practitioner who has responsibility for supervising the clinical work or training of the student health practitioner<br>o Under the Medicines and Poisons (Medicines) Regulation 2021, a student health practitioner can only assist (by dealing with medicines) under the direct supervision of a person authorised to administer and possess the medicine |

## 2.5 Emergency care involving termination

Table 5. Emergency care

| Aspect | Lawful action |
|---|---|
| **Medical practitioner** | • In an emergency, a medical practitioner may perform a termination (irrespective of gestational age) if they consider it is necessary to save the woman's life or the life of (in a multiple pregnancy) another fetus[6] |
| **Prescribed practitioners assisting** | • In an emergency, a registered health practitioner or student health practitioner may assist a medical practitioner performing a termination in the circumstances outlined above[6] |
| **Conscientious objection** | • Conscientious objection does not limit any duty owed by a registered health practitioner or student health practitioner to provide a service in an emergency at any gestation of pregnancy[6]<br>• 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 available[6] |

## 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 terminations are performed.[6]

Table 6. Safe access zone

| Aspect | Lawful action |
|---|---|
| **Safe access zone** | • *Termination services premises* means the premises at which terminations are performed[6]–does not include a pharmacy<br>• Unless otherwise prescribed by regulation, the prescribed distance is 150 metres from the entrance to the *termination services premises*[6] |
| **Prohibited conduct** | • Conduct in a safe access zone is prohibited if it relates to terminations (or could be reasonably be perceived to be so) and[6]:<br>o Would be visible or audible to another person entering or leaving the premises and<br>o Would be reasonably likely to deter a person from entering or leaving the *termination services premises*, requesting or undergoing a termination, or performing or assisting with the performance of a termination<br>• The conduct may be prohibited whether or not another person sees or hears the conduct or is actually deterred[6]<br>• 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 consent without reasonable excuse[6] |

## 2.7 Non-compliance with the ToP Act

Table 7. Non-compliance

| Aspect | Lawful action |
|---|---|
| **Consequences** | • No penalty or offence is specified in the *ToP Act* for a registered health practitioners or student health practitioner's failure to comply with the requirements of the *ToP Act*[6], including with regards to what steps to take if they have a conscientious objection<br>• As for other healthcare, the following may apply:<br>o Professional and legal consequences for noncompliance<br>o Laws for duty of care, reasonable skill and care<br>o Civil or criminal responsibility for harm that results from a failure to act with reasonable skill and care |
| **Professional conduct** | • 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 healthcare |

## 2.8 Conscientious objection

Table 8. Conscientious objection

| Aspect | Lawful action |
|---|---|
| **Relevant to** | • Registered health practitioners who have a conscientious objection to the performance of a termination and who are asked by a person to[6]:<br>o Perform or assist with the performance of a termination<br>o Make a decision whether a termination should be performed<br>o Advise the person about the performance of termination<br>• 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 termination[15] |
| **Disclosure of objection** | • Registered health practitioners and student health practitioners must disclose their conscientious objection to the requesting person[6]<br>• For example:<br>o 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<br>o 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<br>o 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 practitioner[15] |
| **Referral or transfer of care** | • If a woman requests performance of a termination, a registered health practitioner who has a conscientious objection must refer the woman or transfer care to[6]:<br>o Another registered health practitioner whom they believe can provide the requested termination healthcare and who does not have a conscientious objection OR<br>o 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<br>• Refer or transfer to avoid delays in care provision<br>o Promptly (i.e. during the presentation in which the request is made)<br>o To the nearest/most convenient registered health practitioner or service |
| **Objection only in certain circumstances** | • Where a registered health practitioner 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** | • The conscientious objection provision does not extend to:<br>o Administrative, managerial or other tasks ancillary to the performance of the termination<br>o Hospitals, institutions or services, as the right to conscientiously object is a personal and individual right<br>• Refer to Section 2.1 Clinical performance of a termination |

# 3 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 health practitioners and student health practitioners providing termination healthcare are advised to familiarise themselves with their legal responsibilities under the *ToP Act*.[6] Refer to Section 2.1 Clinical performance of a termination

## 3.1 Consent

Table 9. Consent

| Aspect | Consideration |
|---|---|
| **Consent** | • Follow usual consent processes and standards including:<br>o Assessment of capacity<br>o Discussion of available methods of termination<br>o Risks and complications of each method of termination |
| **Capacity to consent** | • An adult can give consent (has capacity) if they[17]:<br>o Understand the nature and effect of decisions about the matter<br>o Freely and voluntarily make decisions about the matter<br>o Can communicate the decisions in some way |
| **Adults with impaired capacity** | • Termination of a pregnancy of an adult who lacks capacity is considered to be "special healthcare"[17,18]<br>• An attorney, legal guardian or substitute decision-maker cannot give consent for another person to undergo a termination<br>• The Queensland Civil and Administrative Tribunal may consent for an adult with impaired capacity to undergo a termination "only if the Tribunal is satisfied that it may be performed by a medical practitioner under the *ToP Act*"[18] |
| **Young person Gillick competent[19]** | • A young person is considered *Gillick* competent when they achieve sufficient maturity and intelligence to enable them to understand fully what medical treatment is proposed[19]<br>• A *Gillick* competent young person can consent to medical procedures, in the same way as an autonomous adult with capacity<br>• The decision about whether a young person is *Gillick* competent is a matter for the treating practitioner<br>• Consider additional elements of informed consent when obtaining consent from a *Gillick* competent young person (e.g. the ability to freely and voluntarily make decisions without coercion)<br>• 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<br>• Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters where clinically indicated<br>• Refer to Queensland Health: *Guide to informed decision making in healthcare*[20] |
| **Young person <u>not</u> Gillick competent** | • For a young person deemed not to have capacity (*Gillick* competent), the Supreme Court in its *parens patriae* jurisdiction[18] may authorise the termination<br>o The Supreme Court must act in the best interests of the young person<br>o A young person's parents/guardian cannot provide consent to a termination<br>• Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters *where clinically indicated*<br>• Escalate these cases to the Executive Director of Medical Services or equivalent (e.g. Medical Superintendent) for urgent attention |

## 3.2 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 10. Young person less than 14 years

| Aspect | Consideration |
|---|---|
| **Young person less than 14 years** | • Each Hospital and Health Service (HHS) determines its capability to provide termination healthcare for young people less than 14 years<br>• Involve social worker support<br>• Consider cultural support for First Nations people<br>• If not considered *Gillick* competent:<br>o Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters<br>o Refer to Table 9. Consent<br>• Provide non-judgemental pre-termination psychological counselling by an appropriately qualified healthcare professional<br>• Refer to Section 6.3 Psychological support<br>o Include documented evidence of the pre-termination counselling in the medical record<br>• Refer to the Queensland Health: *Guide to informed decision making in healthcare*[20] |

## 3.3 Suspicion of child abuse

Table 11. Suspicion of abuse

| Aspect | Consideration |
|---|---|
| **Suspicion of harm**[21] | • 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; *and* may not have a parent able and willing to protect them from harm<br>• Registered nurses and doctors are mandatory reporters for children where there is reasonable suspicion of harm<br>o Midwives and endorsed midwives are not listed as mandatory reporters in the *Child Protection Act 1999*<br>• Any Queensland Health staff member may report a reasonable suspicion of harm<br>• A child under the *Child Protection Act 1999*[22] is a person under 18 years of age |
| **Sexual offences**[21] | • It is a criminal offence[11] for any adult who, without a reasonable excuse, fails to report a child sexual offence to police<br>• It is an offence to fail to protect a child from a sexual offence in an institutional setting |
| **Reporting requirements**[21] | • 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, Seniors and Disability Services[4,11,22,23]<br>• 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 offence to police (does not preclude also making a report to police)<br>• Seek advice or support from the service child protection liaison officer as required |

## 3.4 Special circumstances

Table 12. Special circumstances

| Aspect | Consideration |
|---|---|
| **Sexual assault** | • Provide termination healthcare on the basis of the woman's request[24]<br>• 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:<br>o Social work support<br>o Domestic violence counselling and support services<br>o Alerting authorities (Queensland Police Service)<br>o Relocating, if in continued danger<br>o Routine sexual health checks and treatment (as required)<br>o A medical examination and documentation of findings<br>o Possibility of the products of conception being used for forensic testing to assist legal proceedings<br>• Support the woman's choices for ongoing healthcare and involvement<br>• Refer to Queensland Health Policy: *Sexual health and safety guidelines: mental health, alcohol and other drug services*[25] |
| **Suspected fetal abnormality** | • If fetal abnormality suspected, discuss with the woman:<br>o Chromosomal analysis<br>o Histopathology<br>o Autopsy |
| **Female genital mutilation (FGM)** | • If FGM, use clinical judgement and individually assess the clinical and psychological circumstances of each woman<br>• If deinfibulation indicated, seek specialist advice<br>• Refer to Queensland Clinical Guideline: *Perineal Care*[26] |

## 3.5 Documentation of decisions

Refer to Queensland Clinical Guideline: *Standard care.*[27]

Table 13. Documentation

| Aspect | Consideration |
|---|---|
| **Less than or equal to 22 weeks+0 day** | • Apply standard documentation principles<br>• Refer to Queensland Clinical Guideline: *Standard care*[27] |
| **At or after 22 weeks+1 day and/or complex case** | • Both medical practitioners involved in the decision document:<br>o Clinical opinion about the relevant medical circumstances<br>o Clinical assessment about the woman's current and future physical, and psychological and social circumstances |

# 4 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 facilities.[23]

## 4.1 Service provision

Table 14. Service provision

| Aspect | Considerations |
|---|---|
| **Standard care** | • Refer to Queensland Clinical Guideline: *Standard care*[27] for care considered 'usual' or 'standard'.<br>• Includes for example, privacy, consent, decision making, sensitive communication, medication administration, staff education and support and culturally appropriate care |
| **Access to termination healthcare** | • Women requesting termination require assessment by a registered health practitioner who does not have a conscientious objection<br>o Refer to Table 8. Conscientious objection<br>• Where termination healthcare is not locally available, support women to access the service, as for any other healthcare not locally available<br>• Provide documented information to consumers, external service providers and support agencies within the local HHS on the choices available within the service, and on routes of access to these services<br>• Facilitate access (including via patient travel subsidy scheme, and telehealth) as early as possible and without delay to:<br>o Reduce the likelihood of associated health risks<br>o Support maternal preference for a termination procedure that may be impacted by gestational age limitations |
| **Referral** | • Document referral pathways within and between HHS (e.g. between departments within a facility, between facilities, and between a facility and external agencies or general practitioners (GP))<br>o Consider engagement with statewide external service providers and agencies in the development of referral pathways and mechanisms<br>• Provide documented referral pathways to external service providers, agencies and GPs<br>• Inform healthcare professionals in contact with women seeking termination (e.g. emergency departments, GPs) about referral pathways<br>• If there is a conscientious objection to the performance of a termination, act in accordance with Table 8. Conscientious objection<br>• 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)<br>• Refer to the Queensland Health *Guide to informed decision making*[20] |
| **Workforce** | • For healthcare professionals involved in the provision of termination healthcare, provide:<br>o Ongoing training and education[24], including bereavement training, trauma informed and culturally appropriate care<br>o Access to non-judgemental counselling and debriefing support<br>• For student healthcare practitioners, support access to information on:<br>o Queensland Law and the *ToP Act*[6]<br>o Conscientious objection rights and responsibilities<br>o Contemporary approach to termination healthcare provision<br>o Sensitive communication and confidentiality<br>o Other matters relevant to the clinical placement<br>o Alternative clinical learning if conscientious objection<br>o Access to non-judgemental counselling and debriefing support (if required) |

## 4.2 Local service delivery considerations

Table 15. Local service delivery

| Aspect | Consideration |
|---|---|
| **Governance** | • Determine the local service delivery mechanisms and administrative reporting requirements within each service<br>• A multidisciplinary and coordinated approach is required to avoid unnecessary delay in the provision of care<br>• Where there are complex issues present [refer to Definition of terms Complex case], consider a case review (as for other complex healthcare) to assess the complexities specific to the individual woman<br>• Educate providers and referrers about the service, the pathways, any service limitations and their professional responsibilities<br>• Local procedures are required for the safe and sensitive handling, storage and management of fetal tissue |
| **Clinician professional development** | • Support clinicians to access education and training relevant to termination of pregnancy, including:<br>o As specified in their EPA<br>o Medication safety and prescribing of termination medication<br>o Performance and interpretation of ultrasound scan (USS) (including bed-side USS)<br>o Advanced training (e.g. Nurse Practitioner qualification) |
| **Equipment and resources** | • Invest in resources (human and equipment) to support service provision, including (but not limited to)<br>o USS machines, sonographers or contracted services |
| **Care setting** | • The most appropriate care setting for termination is dependent on the:<br>o Method of termination chosen<br>o Gestation of the pregnancy<br>o Preferences of the woman and care provider<br>o The service capabilities of the facility<br>• Consider the proximity of termination services to birthing and postnatal areas as women may experience distress at hearing/seeing pregnant women and/or newborn babies<br>• Support the establishment of designated bereavement healthcare provider positions and facilities (e.g. bereavement rooms) |
| **Outpatient MToP**[13] | • Generally suitable for women who:<br>o Are less than or equal to 9 weeks gestation<br>o Will have a support person available until the termination is complete<br>o Can communicate by telephone (e.g. have an interpreter available if required)<br>o Can access 24-hour emergency care in the 14 days following start of the treatment<br>o Have capacity to understand and follow instructions<br>• Provide specific and clear information about:<br>o How and when to take medications<br>o Importance of completing the course<br>o Side effects of medications<br>o Signs and symptoms of concern<br>o When to seek help |
| **Telehealth consultations** | • Telehealth alone and in combined care models (telehealth and in-person consultation) for MToP less than 63 days gestation is safe, effective and acceptable to women[28-32]<br>o Of particular benefit for women living in rural, remote and regional areas |

### 4.2.1 Cultural considerations

Table 16. Cultural considerations

| Aspect | Consideration |
|---|---|
| **Equity of access** | • Consider the barriers/access needs of women:<br>o From culturally and linguistically diverse populations (e.g. information in a language other than English, interpreters, cultural supports)<br>o Rural and remote communities<br>o Who identify as First Nations people<br>• Support access to long-acting reversible contraception (LARC) at the time of termination healthcare, especially for financially disadvantaged women |
| **Cultural sensitivities** | • Remain cognisant of cultural sensitivities relevant to termination healthcare which may include (but are not limited to)<br>o Awareness that ToP is forbidden or taboo in some cultures<br>o A heightened need for privacy and confidentiality to prevent inadvertent or intentional disclosure to other community members<br>o The need to seek termination healthcare outside the local community (especially rural and remote) to maintain privacy and confidentiality<br>o The potential for unsafe methods of termination to be used if there are real or perceived barriers to access |
| **Cultural support workers** | • Acknowledge the duality of roles that may be experienced as both a member of the healthcare team and as a community member with obligations to the community (particularly for First Nations people)<br>• Support access to cultural supervision and training |
| **First Nations people** | • Respect the unique cultural identities and traditions of First Nation peoples<br>• Offer connection to Aboriginal and Torres Strait Islander Health Workers and Practitioners as appropriate to the circumstances<br>• Recognise that fear of underlying institutional racism or past trauma can prevent First Nation peoples from accessing services |

# 5 Method selection (medical or surgical)

A pregnancy may be terminated using a medical or surgical approach.

Table 17. Methods of termination

| Aspect | Consideration |
|---|---|
| **Medical** | • Medications are used to induce the termination<br>• May be considered for all gestations of pregnancy<br>• Recommended regimen is mifepristone in combination with misoprostol (or misoprostol alone)[33]<br>o MS-2 Step recommended at 63 days or less<br>• Refer to Section 8.1 Cautions |
| **Surgical** | • Less than 14 weeks gestation<br>o Vacuum aspiration is the recommended method[33]<br>• From 14 weeks gestation<br>o Dilation and evacuation is the recommended method[34]<br>o Experienced practitioner is required (and sometimes between 12–14 weeks gestation)[35]<br>• Anaesthesia depends on service capabilities and the woman's preferences[23] |
| **Choice of method** | • Offer information about both medical and surgical methods<br>• Recommendations may be influenced by:<br>o Health status[36-38]<br>o Gestational age<br>o Local clinician expertise and service capabilities<br>• Satisfaction with MToP and surgical termination of pregnancy (SToP) reported as comparable[39,40]<br>• Support the woman's choice of method[33] |

## 5.1 Incomplete termination

Table 18. Failure to achieve termination

| Complication | Comments |
|---|---|
| **First trimester failure** | • All methods of first trimester termination carry a small risk of failure with rate higher following medical compared to surgical[41]<br>• Aspiration required following MToP with gestational age[13]<br>o Less than 49 days 2.3%<br>o Between 49 to 63 days 4.8% |
| **Ongoing pregnancy following MToP** | • Rate of ongoing pregnancy rate by gestational age[13]<br>o Less than 49 days 0.3%<br>o Between 49 to 63 days 0.6%<br>• May lead to fetal anomalies if the pregnancy persists[42]<br>• Increased risk of complications later in the continuing pregnancy[43] |
| **Retained products of conception** | • Following<br>o SToP approximately 1% (for both first[44] and second trimester[45])<br>o MToP less than 63 days 4–5% women[46]<br>o MToP in second trimester 8–10%[45] |
| **Live birth** | • An uncommon outcome following a termination of pregnancy, more likely at later gestations<br>• Refer to:<br>o Definition of terms: Live birth<br>o Section 7 Fetal considerations |

## 5.2 Risks and complications

Complications and risks associated with termination of pregnancy are rare when performed by qualified medical practitioners.[35] Morbidity is less common with terminations than with pregnancies that are carried to term.[35]

Table 19. Risks and complications

| Complication | Comments |
|---|---|
| **Infection** | • Risk reduced if lower genital tract infection excluded pre-operatively[47]<br>• Recommend surgical antibiotic prophylaxis prior to procedure[34]<br>• Prophylactic antibiotics not routinely recommended for MToP[35] |
| **Cervical trauma** | • For SToP, decreased risk associated with[47,48]:<br>o Experienced clinician<br>o Use of preoperative cervical priming<br>o Earlier gestation (less than 1% in first trimester and 2-3% of second trimester surgical abortions<br>o Vaginal multiparity |
| **Haemorrhage** | • Risk is lower at earlier gestations[48]<br>o First trimester: approximately 1 per 1000 terminations<br>o Second trimester: estimates range from 0.3–10 per 1000 terminations<br>• Transfusion rates are overall low, but are higher following MToP (less than 0.1%) than for SToP (0.01%)[42] |
| **Uterine perforation** | • Risk reported as varying from 0.09 to 15 per 1000 cases[47]<br>• Decreased risk of uterine perforation associated with[47,48]:<br>o Experienced clinician<br>o Use of pre-operative cervical priming<br>o Earlier gestations<br>o Lower parity |
| **Uterine rupture** | • Uterine rupture has been rarely reported in association with mid-trimester MToP<br>• More frequently associated with later gestational ages and previous uterine scar[41]<br>• Incidence reported of up to 1.1% in second trimester termination[49] |
| **Future pregnancies** | • There are no proven associations between termination of pregnancy and subsequent ectopic pregnancy, placenta praevia or infertility[33,42] |
| **Asherman's syndrome** | • Pregnancy related intrauterine surgery is the most important predisposing risk factor and has been reported in up to 91% of cases[50] |
| **Surgery, anaesthetic or sedation** | • Standard risks common to all surgical procedures requiring anaesthetic or sedation<br>• Consider:<br>o Individual circumstances and general health of the woman<br>o Service capabilities |
| **Psychological** | • Refer to Section 6.3 Psychological support |

## 5.3 Information for women

Offer information in a way that is non-coercive, non-discriminatory, can be easily understood and is acceptable and accessible to the woman (including in languages other than English where required).[35] Not all aspects will be relevant for all women; use clinical judgement and tailor to individual need and circumstances.

Table 20. Information about termination

| Aspect | Considerations |
|---|---|
| **Types of termination available** | • Methods of termination relevant to:<br>o Woman's choice and preferences<br>o Gestation of the pregnancy<br>o Local service availability<br>o Individual clinical circumstances<br>• Benefits and disadvantages of each option<br>o Refer to Section 5.2 Risks and complications |
| **Assessments** | • History taking<br>• Clinical examinations<br>• Laboratory tests<br>• Ultrasound scans (USS)<br>• Opportunistic screening<br>• Support and counselling options |
| **Process and procedure of termination** | • Relevant to the method and clinical circumstances:<br>o Timeframes (to access and for completion)<br>o Expected pain and bleeding patterns and management<br>o Complications [refer to Section 5.2 Risks and complications]<br>o Appearance of and options to manage pregnancy tissue/fetal remains/live birth of baby<br>o Medication effects and side effects<br>o Expected clinical course and timing of follow-up |
| **Contraception** | • Options for contraception<br>• Timing of initiation/ovulation<br>• Refer to Table 40. Contraception provision |
| **Birth registration** | • Requirements for birth registration (as appropriate to the circumstances)<br>• Refer to Table 24. Registration requirements |
| **Fetal autopsy** | • Offer fetal autopsy if clinically indicated (e.g. if fetal abnormality)<br>• Refer to Queensland Clinical Guideline: *Stillbirth care*[51] |
| **Support needs** | • Offer early social worker involvement(e.g. for support, discussion of costs, funeral arrangements)[52]<br>• Offer information about community services (e.g. Harrison's Little Wings, Children by Choice, Mental Health Access Line, Pregnancy Counselling link, domestic violence supports)<br>• If appropriate, discuss options for 'memory creation' which may include:<br>o Photographs<br>o Hand/footprints<br>o Holding or bathing<br>o Copies of USS photographs<br>o Taking baby home |
| **Breast symptoms** | • Breast symptoms (engorgement, tenderness, leakage) may occur after termination[53]<br>o More likely to occur following second trimester termination<br>• Discuss lactation suppression or donation of breast milk to milk banks (where appropriate)<br>o Refer to lactation consultant as required<br>• Refer to Table 41. Discharge preparation |

# 6 Pre-termination assessment

Offer pre-termination assessment including counselling and psychosocial support services close to home where feasible.[54]

## 6.1 Clinical assessment

Table 21. Clinical assessment prior to termination

| Aspect | Considerations |
|---|---|
| **Review history** | • Discuss request for termination services in a non-judgemental and supportive manner<br>• Obtain medical and reproductive history[35] including date of last menstrual period<br>• Obtain psychosocial history[35] including mental health issues, screening for domestic and family violence and reproductive coercion |
| **Examination** | • Confirm diagnosis, gestational age and location of pregnancy[35]<br>• Undertake a physical exam as indicated by history and signs and symptoms |
| **Routine antenatal serum screening** | • Not routinely required for<br>o MToP less than 63 days gestation<br>o SToP in first trimester<br>• Recommend if:<br>o MToP more than 63 days gestation<br>o SToP in the second trimester<br>• Rh D status not required at less than 10 weeks gestation (MToP or SToP) |
| **Other investigations** | • Consider investigations based on history or opportunistically in conjunction with other serum screening<br>• If suspicion of underlying haematological, renal or hepatic disorders, recommend full blood count, ferritin, electrolytes and liver function tests |
| **Sexual health check** | • Recommend a sexual health check and assess for risk of sexually transmitted infection(s) (STI)[55]<br>• Screen for STI as per local protocol but do not delay access to termination procedures to undertake screening[33]<br>o If no local protocol, consider chlamydia, gonorrhoea, hepatitis B, syphilis, human immunodeficiency virus (HIV)[56]<br>• Presumptively treat women for symptomatic STI where follow-up is uncertain/unlikely |
| **Opportunistic healthcare** | • Offer opportunistic health screening or advice including:<br>o Cervical screening test (including self-collected specimens)<br>o Smoking cessation advice<br>o Substance use advice |
| **Pre-termination referral coordination** | • Facilitate timely referral and coordination with other facilities, disciplines, agencies, or healthcare providers:<br>o Specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging, mental health)<br>o Psychosocial counselling/support: 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)<br>o Termination procedure |

## 6.2 Ultrasound prior to MToP at or less than 63 days gestation

Table 22. Ultrasound

| Aspect | Considerations |
|---|---|
| **Context** | • USS can confirm gestation and location of pregnancy<br>• Ask women about their preference to see/hear USS images |
| **Evidence summary** | • Evidence is emerging that MToP without prior USS may be safe, effective, acceptable and improve access to termination healthcare[28-32,57-61]<br>• RANZCOG recommend prior to 14 weeks of pregnancy:<br>o *"The gestational age of the pregnancy should be determined prior to abortion; this could be by clinical means (history including last menstrual period, with or without examination) or by ultrasound"*<br>o *"Where the gestational age has been established by clinical means, the decision about USS prior to abortion should be made according to patient preference and access to services"*<br>• TGA product information for MS-2 Step recommends:<br>o *"that the duration of pregnancy (i.e. up to 63 days gestation) be confirmed by ultrasound. In the event that an ultrasound is not possible, extra caution should be exercised. Ultrasound is also useful to exclude ectopic pregnancy"* |
| **Less than 63 days gestation** | • Recommend USS as the preferred method of confirming an intrauterine pregnancy prior to MToP<br>• The risk of an ectopic pregnancy is increased if:<br>o Uncertainty about location of pregnancy<br>o Risk factors identified or signs and symptoms present [refer to Queensland Clinical Guideline: *Early pregnancy loss*[62]]<br>o Other clinical concerns are identified |
| **No-scan MToP** | • When USS is not possible, discuss the risks and benefits with the woman<br>o Use clinical judgement to identify the potential for ectopic pregnancy<br>o Consider consultation or referral with a more experienced practitioner for assessment of intrauterine pregnancy<br>o Consider the woman's psychological wellbeing, including cultural safety and financial hardship arising from the need to travel for USS<br>o Take into account how delay may affect the choice of termination method (e.g. if gestational age will exceed 63 days)<br>• Use an agreed screening tool to determine suitability for no-scan MToP<br>• Not recommended for women with poor health literacy who may have difficulty understanding or appreciating the importance of seeking medical assistance when indicated<br>• Refer to: Flowchart: Decision aid for no-scan MToP at or less than 63 days gestation |

## 6.3 Psychological support

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

Table 23. Information and counselling

| Aspect | Considerations |
|---|---|
| **Decision making** | • Support the decision-making process by providing accurate, impartial and easy to understand information including:<br>o Options to continue the pregnancy and parent the child<br>o Options to continue the pregnancy and place the child for foster care, adoption, cultural adoption or kinship arrangement<br>o Information about local support groups relevant to the circumstances<br>o Consider use of decision aids (e.g. RANZCOG Abortion decision aid[63]) |
| **Counselling** | • Offer confidential, non-judgemental support and counselling provided by someone (e.g. social worker, psychologist, counsellor) who:<br>o Is appropriately qualified and/or trained<br>o Is experienced with the issues surrounding termination<br>o Has no vested interest in the pregnancy outcome<br>o Is culturally acceptable to the woman<br>• Where feasible, offer counselling 'close to home' to aid the establishment of longer-term counselling support<br>• Involve family members as per the woman's preferences<br>• Refer to groups and organisations offering support and counselling (e.g. Children by Choice) |
| **Psychological sequelae** | • The evidence for an association between termination and subsequent psychological distress, is conflicting, and generally of lower methodological quality[64-66]<br>• Studies variously report:<br>o No difference in psychological distress between women who have a termination and women who give birth[67-69]<br>o Women experience less distress following termination than following adoption or unwanted birth[64,70]<br>o Psychological sequelae is more likely to be experienced by women who have experienced/are experiencing complex life circumstances (e.g. domestic violence, financial hardship, substance use, mental health issues, adverse life events[68])<br>o The experience of positive and negative emotions (relief, ambivalence, loss, guilt[71]) is influenced by a woman's resilience, access to social supports, and experience of abortion stigma[72]<br>• 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<br>o Involve members of the multidisciplinary team as appropriate<br>• Offer the woman a referral to mental health services, where indicated |

# 7 Fetal considerations

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

## 7.1 Birth registration

Table 24. Registration requirements

| Gestation/Birth weight[73] | Signs of life | Requirement |
|---|---|---|
| Less than 20 weeks **AND** less than 400 grams | Not live born | • Birth registration not required<br>• Death certificate not required<br>• Burial/cremation not required |
| Less than 20 weeks **AND** less than 400 grams | Live born | • Birth registration required<br>• Death certificate required<br>• Burial/cremation required |
| Greater than 20 weeks **OR** 400 grams or more | Not live born **OR** Live born | |

## 7.2 Feticide and selective reduction

Table 25. Feticide and selective reduction

| Aspect | Consideration |
|---|---|
| **Feticide** | • Provided by a trained specialist<br>• Recommended for gestations at or greater than 22 weeks+1 day[33]<br>• Refer the woman to the closest service with the capability to perform the procedure[23]<br>• Post feticide, a woman may be transferred to another facility for birth if[23]:<br>o Considered clinically safe<br>o There is a robust referral process<br>o There is comprehensive documentation<br>• Involve the woman and the receiving hospital in decisions about transfer |
| **Selective reduction/selective feticide** | • If selective reduction or selective feticide is required in multiple pregnancies, consider the woman's individual circumstances on a case by case basis |

## 7.3 Born with signs of life

Live birth following a termination of pregnancy is an uncommon outcome. Refer to Definition of terms Live birth

Table 26. Born with signs of life

| Aspect | Consideration |
|---|---|
| **Duty of care** | • Once removed or expelled from a woman's uterus and born alive, a fetus becomes a person (baby) and assumes legal status and rights independent of the rights of the parent<br>• If born alive, provide care in the best interests of the baby[74] and in accordance with best practice guidelines and good medical practice<br>o Provide care appropriate to the individual clinical circumstances |
| **Information sharing** | • If appropriate to clinical circumstances, discuss with the woman before the procedure, the potential for live birth including:<br>o Preferences for awareness of live birth (e.g. informed immediately at time of birth or information delayed)<br>o The woman's wishes and preferences for care of the baby, (e.g. to see, or to hold) which it is acknowledged may change during the course of the termination and following birth<br>o Desire for engagement in any subsequent care<br>o Expected appearance and/or clinical course and management relevant to circumstances<br>o Legal requirements for birth and death registration and management of remains |
| **Signs of life** | • Refer to Definition of terms: Live birth<br>• The attending clinician determines if there are signs of life using clinical judgement and established assessment techniques |
| **22 weeks+1 day or more gestation** | • Feticide is recommended at or after 22 weeks+1 day gestation<br>• If the fetus has a life limiting condition and feticide is declined, involve the multidisciplinary team to plan palliative care for the baby in accordance with best practice guidelines[75,76] |
| **Less than 22 weeks+1 day gestation** | • For a baby born alive at less than 22 weeks+1 day gestation, expert clinical opinion is that active treatment (e.g. oxygen therapy, intravenous line) is medically futile and not in the best interests of the baby as it may prolong suffering<br>• Handle gently and carefully, wrap and cuddle/hold to provide warmth and comfort<br>• Offer opportunities to engage in care provision (e.g. cuddling/holding) as desired |
| **Service support** | • Establish local procedures for the management of live birth<br>o Including management and recording of death certification<br>• Provide sensitive emotional support and reassurance to parents<br>• Offer counselling and support services to women, partners and healthcare professionals involved with care of a live born child |

## 7.4 Transport and management of fetal remains

Table 27. Management of fetal remains/tissue

| Aspect | Consideration |
|---|---|
| **Lawful interment** | • Where birth and death registration is required, burial or cremation of fetal remains is required within a cemetery or at a crematorium[77]<br>• Where birth and death registration is not required:<br>o Many local councils regulate how fetal remains may be managed outside of a cemetery or crematorium<br>o Hospital facilities may be permitted to incinerate or use chemical disinfection[78] |
| **Requests to take fetal remains home/overseas** | • Fetal remains that do not legally require burial or cremation may be released to the woman for private interment provided that[77,78]:<br>o There is no risk of transmission of notifiable conditions<br>o The woman has been informed how the fetal remains may be lawfully disposed<br>• Establish local protocols to support requests to take fetal remains home (e.g. use of sensitive transport containers)<br>• Provide information:<br>o About safe and legal interment<br>o About safe management of fetal remains, including infection control[78]<br>o About community queries regarding fetal remains that are to be transported within Australia or overseas |
| **Individual preferences** | • Recognise that a woman may wish to make separate arrangements for interment<br>• Respect cultural and/or religious beliefs<br>• Advise women:<br>o Of the options for lawful interment<br>o Of local council regulations for interment on private property<br>o Funeral services may assist with burial/cremation where birth registration is not required, and no death certificate has been issued<br>o Memorial services may be offered at the facility<br>• Consider the condition of the fetal remains and inform the woman appropriately<br>• Offer social worker support<br>• 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 and Marriages |

# 8 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. MS-2 Step, mifepristone, and misoprostol are conditionally approved for use by Queensland Health as per the list of approved medicines (LAM).[79]

## 8.1 Cautions with mifepristone and misoprostol

Table 28. Cautions

| Aspect | Consideration |
|---|---|
| **Contra-indications**[80] | • Lack of access to emergency medical care in the first 14 days after commencement (i.e. administration of mifepristone)<br>• Pregnancy not confirmed by USS or urine or serum ß-hCG<br>• Uncertainty about gestational age<br>• Suspected or confirmed ectopic pregnancy<br>• Intrauterine device (IUD) in place<br>• Asthma uncontrolled by therapy<br>• Chronic adrenal failure<br>• Concurrent long term corticosteroid therapy<br>• Suspected or known haemorrhagic disorders or treatment with anti-coagulants<br>• Hypersensitivity to mifepristone, misoprostol (or any prostaglandin), or any of the excipients used in MS-2 Step |
| **Cautions**[13] | • Populations not well studied, and therefore caution required if:<br>o Older than 35 years and smoking 15 or more cigarettes per day<br>o Cardiovascular, hepatic, renal or respiratory disease<br>o Hypertension<br>o Diabetes<br>o Severe anaemia<br>o Malnutrition<br>o Heavy smokers |
| **Special considerations** | • If comorbidities, seek medical practitioner advice<br>• If suspected acute adrenal failure, dexamethasone is recommended<br>• Long-term corticosteroids (including those inhaled for asthma) less efficacious for 3–4 days after administration of mifepristone<br>• Caution if medical history of:<br>o Epilepsy, as epileptic seizures reported with prostaglandin analogues<br>o Asthma, as bronchospasm reported with prostaglandin analogues<br>• If high risk of uterine rupture, consider[41]:<br>o Individual circumstances<br>o USS screening<br>o Transfer to higher level service<br>o SToP<br>• If previous traumatic pregnancy loss (e.g. miscarriage, traumatic MToP), offer SToP and counselling or referral for psychological support<br>• Consider individual clinical circumstances and advise care as appropriate (e.g. if insulin dependent diabetes additional blood glucose monitoring may be indicated due to nausea/vomiting, if regular medications include CYP450 or CYP3A4, consider earlier follow-up)<br>• If breastfeeding another child[81,82]<br>o Transfer levels of misoprostol and mifepristone into breastmilk are low<br>o Adjustment of feed timing with dose administration is probably not required (limited data) |

## 8.2 Effects of medication

Table 29. Medication effects

| Aspect | Consideration |
|---|---|
| **Information for women** | • Advise women about the effects of medications<br>• Adverse events for combined use of mifepristone and misoprostol are dose dependent and increase with gestational age[42]<br>o More common after misoprostol than mifepristone[42] |
| **Expected effects**[83] | • Cramping usually commences 1–4 hours after misoprostol dose, intensifies and then lessens as expulsion occurs<br>o May commence after mifepristone<br>o May be experienced for several days<br>• Bleeding usually:<br>o Starts after cramping<br>o Heavier than usual menstrual period<br>o Heavy with clots in the first 24 hours<br>o Lessens over 1–2 weeks but may continue up to next menstrual period |
| **Adverse effects** | • Common (more than 1 in 10) or very common (equal to or more than 1 in 100 to less than 1 in 10) effects[13,42,84]:<br>o Nausea, vomiting, diarrhoea<br>o Headache, dizziness, fainting<br>o Abnormal thermoregulation (e.g. hot flushes, low grade temperature)<br>o Breast tenderness<br>• If breastfeeding another child, misoprostol may cause diarrhoea in the child[81]<br>• Refer to product information for other less common adverse events |

## 8.3 Very early medical abortion (VEMA)

Table 30. Very early medical abortion

| Aspect | Consideration |
|---|---|
| **Definition** | • Refers to a medical termination of pregnancy (MToP) at very early gestation (6 weeks or less amenorrhoea)<br>• Definitive evidence of an intrauterine pregnancy (yolk sac or fetal pole on transvaginal scan) is not always visible |
| **Evidence**[60,85-87] | • Good quality randomised controlled trial evidence is lacking<br>• Ectopic pregnancy cannot be excluded<br>• Inconsistent correlation between ß-hCG and fetal structures although measurement before and after VEMA considered a reliable method of detecting successful completion or possible ongoing or ectopic pregnancy |
| **Recommendation** | • May be offered by experienced practitioners in individual circumstances<br>o Follow a local VEMA protocol that includes clear direction for follow-up and monitoring of outcome<br>• Not recommended if:<br>o Signs, symptoms or risk factors for ectopic pregnancy<br>o Follow-up uncertain or delayed<br>o Gestation estimated by dates is incongruent with quantitative serum ß-hCG measurement and first USS |

## 8.4 MToP at or less than 63 days gestation

MS-2 Step composite pack is suitable for termination at 63 days or less gestation (9+0 weeks).[13]

Table 31. MS-2 Step for MToP

| Aspect | Consideration |
|---|---|
| **MS-2 Step composite pack**[13] | • Consists of:<br>o Mifepristone 200 mg (1 tablet containing 200 mg)<br>o Misoprostol 800 micrograms (4 tablets, each tablet containing 200 micrograms) |
| **Pre-dosage care** | • Perform a pre-termination assessment<br>• Exclude contraindications and review cautions<br>o Refer to Section 8.1 Cautions<br>• Provide written information about medication self-administration<br>• Supply a prescription for analgesia and antiemetic<br>o Combination of paracetamol and Ibuprofen more effective than either used alone[33] |
| **Dosage**[13] | **Initial dose:**<br>• Mifepristone 200 mg oral<br><br>**Followed 36–48 hours later by:**<br>• Misoprostol 800 microgram buccal |

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

### 8.4.1 Follow-up after MToP at or less than 63 days gestation

Table 32. Follow-up after MToP at 63 days or less

| Aspect | Consideration |
|---|---|
| **Aims of follow-up** | • Assess physical and psychological wellbeing<br>• Assess completeness of the termination<br>• Identify if further treatment, referral or follow-up is indicated |
| **Timing** | • Recommend follow-up within 14–21 days[13]<br>• Earlier follow-up (e.g. telephone contact at 3–5 days) is also commonly incorporated as standard practice |
| **Assessment**[88] | • Refer to Table 41. Discharge preparation<br>• Assess clinical symptoms (e.g. abdominal cramping, bleeding, passing of clots/tissue, signs of infection and abatement of pregnancy symptoms such as nausea and breast tenderness)[89]<br>• Review urine or serum pregnancy test<br>• USS not routinely required |
| **Low sensitivity urine pregnancy test (LSUP)** | • Self-administered low sensitivity urine pregnancy test when combined with assessment (via telehealth or face to face) demonstrated as safe and effective follow-up for MToP at less than 63 days gestation[90-93]<br>o Detects ß-hCG above 1000 IU/L<br>o Most women will have levels below 1000 IU/L by two weeks post a complete termination[94,95] |
| **Completion** | • Generally defined as the absence of need for further intervention (medical or surgical treatment)[96]<br>• MisoREST trial reported that at USS 6 weeks after misoprostol start for miscarriage, 85% of women with suspected retained products of conception (RPOC) (endometrial thickness of 10 mm on USS at two weeks) had complete miscarriage[97] |

### 8.4.2 Completion uncertain after MToP at or less than 63 days gestation

Table 33. Completion uncertain at less than 63 days gestation

| Aspect | Consideration |
|---|---|
| **Definition** | • For retained products of conception[96]<br>o No uniformly accepted diagnostic criteria<br>o Optimal timing of assessment is uncertain<br>o Quantity necessitating additional treatment varies in reports |
| **Clinical signs/symptoms** | • Incomplete termination may be suggested by[83]:<br>o Absence of bleeding within 24 hours of misoprostol<br>o Bleeding less than four days duration<br>o Bleeding lighter than normal menses<br>o Ongoing pregnancy symptoms[89]<br>o Significant bleeding beyond three weeks post termination |
| **USS** | • If clinically well and ß-hCG dropping, USS within 2–3 weeks of misoprostol unlikely to inform management (thick endometrium or blood clots common findings during this period)<br>• A sonographic endometrial measurement of 10–15 mm or more, 2 weeks after primary treatment is commonly reported[96] |
| **Recommendation** | • Consider face-to-face assessment by a more experienced practitioner<br>• Serial urine or serum pregnancy test to monitor ß-hCG<br>• USS as indicated, usually not indicated within 2–3 weeks of misoprostol |

## 8.5 MToP after 63 days gestation

Mifepristone followed by a prostaglandin analogue is more effective than use of either medication as a single analogue agent.[41] Various regimens (dose, route, timing) have been found to be safe and effective and may be considered.[98,99] This guideline suggests the regimen recommended by Therapeutic Goods Administration.

Table 34. MToP after 63 days gestation

| Aspect | Considerations |
|---|---|
| **Cautions** | • Seek expert advice from a higher level service as required<br>• Feticide recommended for gestations greater than 22 weeks+1 day |
| **Information about birth** | • Discuss and incorporate wherever possible, personal preferences about care and contact with the fetus/baby after birth<br>• Offer information about expected clinical experience including:<br>o Signs and symptoms that delivery may be imminent<br>o Positions for birth<br>o Presence of support person<br>o Expected appearance of the fetus/baby |
| **Pre-care** | • Perform a pre-termination assessment<br>• Exclude contraindications and review cautions<br>o Refer to Section 8.1 Cautions<br>• Baseline: vital signs, vaginal loss, pain prior to commencement<br>• Full blood count (FBC), group and hold as clinically indicated<br>• IV access is recommended<br>• If Rh negative, recommend Rh D immunoglobulin from 10+0 weeks[100] |
| **Inpatient clinical care** | • Offer analgesia<br>• Offer antiemetics if required<br>• Vaginal examination as clinically indicated<br>• Bed rest for 30 minutes after each dose but may mobilise freely at other times<br>• Consider uterotonic IV at time of birth<br>• If the placenta is not spontaneously delivered within 60 minutes of the fetus (or earlier if excessive bleeding occurs) consider operative removal |
| **Observations** | • Vital signs vaginal loss, contractions, assess pain 30–60 minutes after initial dose of misoprostol and after each subsequent dose |

### 8.5.1 MToP regimen if risk of uterine rupture

Table 35. MToP with risk of uterine rupture

| **Risk of uterine rupture or with previous uterine surgery** | |
|---|---|
| **Cautions** | • Seek expert advice from a higher level service[23] as required<br>• Feticide recommended for gestations greater than 22 weeks+1 day<br>• Consider IV access and maintain clinical vigilance for evidence of scar complications |
| **Less than 34+0 weeks** | • Day 1: mifepristone 200 mg oral[13]<br>• Day 2: 36–48 hours after mifepristone<br>o Misoprostol 200 micrograms inserted into posterior fornix of the vagina<br>o 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)<br>• 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<br>• If undelivered at 48 hours after initial dose, then review by an obstetrician is indicated. Options may include:<br>o Continue with misoprostol 400 micrograms 6 hourly or<br>o Rest day then recommence or<br>o IV oxytocin is most effective if some effacement and dilation has occurred<br>o Surgical delivery |
| **34+0 weeks or more** | • Transcervical catheter<br>• Oxytocin infusion and artificial rupture of membranes<br>• Avoid misoprostol or dinoprostone |

*Caution: refer to an Australian pharmacopoeia for complete drug information*

### 8.5.2 MToP regimen if no known risk of uterine rupture

Table 36. MToP with no known risk of uterine rupture

| **Follow protocol according to gestational age** | |
|---|---|
| **9+0 to12+6 weeks** | • Day 1: mifepristone 200 mg oral[13]<br>• Day 2: 36–48 hours after mifepristone<br>o Misoprostol 800 micrograms vaginal, sublingual or buccal<br>o Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses<br>• If fetus undelivered, consider additional misoprostol dose or surgical procedure |
| **13+0 to 24+6 weeks**[41] | • Day 1: mifepristone 200 mg oral[13]<br>• Day 2: 36–48 hours after mifepristone<br>o Misoprostol 400 micrograms vaginal or sublingual<br>o 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**[41] | • Day 1: mifepristone 200 mg oral[13]<br>• Day 2: 36–48 hours after mifepristone<br>o Misoprostol 200 micrograms vaginal or sublingual every 3–6 hours for six doses over 24 hours |
| **34+0 weeks or more** | • Pre-induction:<br>o Dinoprostone or transcervical catheter<br>• Induction<br>o Misoprostol 50–100 micrograms sublingually or per vagina 3–6 hourly for five doses over 24 hours<br>o Oxytocin infusion and consider artificial rupture of membranes after labour established |
| **Clinical care** | • If after 5 doses the fetus is undelivered, consider a vaginal examination to assess progress<br>o If cervical changes, continue regimen and/or consider additional doses |

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

# 9 Surgical termination

## 9.1 Cervical priming prior to SToP

Table 37. Cervical priming prior to SToP

| Aspect | Considerations |
|---|---|
| **Evidence summary** | • Recommend cervical priming prior to SToP as:<br>o Decreases the length of SToP procedure[101]<br>o Reduces complications of uterine perforation and cervical injury<br>o Makes the procedure easier to perform<br>o Reduces incidence of incomplete termination[102,103]<br>• For misoprostol, oral route compared to vaginal, sublingual or buccal route, has longer absorption time, greater side effects and is less efficacious[104]<br>• Compared to misoprostol alone, there may be increased risk of preoperative expulsion with combined regimens, including with[102,103]:<br>o Mifepristone and misoprostol<br>o Misoprostol and osmotic dilators<br>o Mifepristone and osmotic dilators |
| **Cautions** | • Refer to Section 8 Medical termination<br>• Discuss with women (as relevant to individual circumstances)<br>o May cause bleeding and pain before the procedure<br>o Potential for pre-operative expulsion especially with combined regimens |
| **Up to 14 weeks gestation**[103] | • Recommended regimen<br>o 1–3 hours prior to procedure (usually after admission for procedure)<br>o Misoprostol 400 micrograms sublingual, vaginal or buccal |
| **From 14 weeks gestation** | • Optimal regimen uncertain, consider individual circumstances and if no local protocol, follow suggested regimen below<br>• Misoprostol as a single agent:<br>o 1–3 hours prior to procedure (usually after admission for procedure)<br>o Misoprostol 400 micrograms sublingual, vaginal or buccal<br>• Mifepristone and misoprostol in combination:<br>o 24–48 hours prior to the procedure mifepristone 200 mg oral (may be administered in the community)<br>o Then 3–4 hours prior to the procedure, misoprostol 400 micrograms sublingual, vaginal or buccal (usually after admission) |
| **Osmotic dilators**[102] | • Between 12+6 and 20 weeks gestation, use of osmotic dilators compared to misoprostol alone or mifepristone alone:<br>o Generally less acceptable to women<br>o No difference in duration of procedure performance<br>o No difference in baseline dilatation achieved<br>o May make the procedure easier to perform |

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

## 9.2 Surgical aspiration/evacuation

Table 38. Considerations for surgical termination

| Aspect | Consideration |
|---|---|
| **Clinical care** | • Perform a pre-termination assessment including baseline vital signs<br>• If greater than 10+0 weeks gestation and blood type Rh D negative, recommend Rh D immunoglobulin<br>o Refer to Table 39. Post-termination care considerations<br>• Refer to Section Cervical priming prior to SToP |
| **Prophylactic antibiotics** | • Intra or perioperative prophylactic antibiotics recommended[33]<br>• Offer opportunistic healthcare including cervico-vaginal screening for STI<br>• Refer to Table 21. Clinical assessment prior to termination<br>• In the absence of local protocols consider[105] :<br>o Doxycycline 400 mg orally, with food, 10–12 hour prior to procedure OR<br>o Doxycycline 100 mg orally 60 minutes prior to procedure THEN doxycycline 200 mg orally 90 minutes after the procedure<br>• If medication allergy refer to Therapeutic Guidelines for alternate antibiotic regime[105] |
| **Anaesthesia**[101,106] | • Method may depend on service capabilities, clinician expertise and the woman's choice and circumstances<br>• Offer available options (e.g. deep or light sedation, local anaesthesia, general anaesthesia, analgesics), |
| **Oxytocic agents**[34] | • For first trimester vacuum aspiration<br>o Routine use not recommended<br>• For second trimester procedures<br>o Ready and available for use<br>o Use determined by individual circumstances |
| **USS** | • For first trimester manual or vacuum suction<br>o Routine use not required[34,47]<br>o Determine use based on individual circumstances<br>• For dilation and evacuation[34]<br>o Intra-procedural use recommended<br>o Aids visualisation of instruments, fetal parts, verify uterus is empty, reduce risk of perforation and shorten procedure |
| **Examination of tissue** | • Examination of the products of conception by the surgeon may assist with confirmation of completeness[34]<br>• Routine histopathology not required; consider individual circumstances[47]<br>• Refer to Table 39. Post-termination care considerations |
| **Side effects** | • Pain: offer analgesia (e.g. non-steroidal anti-inflammatory drugs)[101]<br>• Bleeding: expected duration 5–18 days[35]<br>• Nausea: usually related to prostaglandins or anaesthetic drugs |
| **Risks and complications** | • Serious complications are rare[33]<br>• Risk rises with operator inexperience and gestational age[34]<br>• Intrauterine adhesions (IUA) (Asherman's syndrome)<br>o Pregnancy related intrauterine surgery is the most important predisposing risk factor and has been reported in up to 91% of IUA cases[50] |
| **Follow-up** | • Recommend follow-up based on individual circumstances<br>o Not routinely required for uncomplicated SToP less than 14 weeks gestation<br>• Refer to:<br>o Section 10.1 Contraception<br>o Section 10.2 Discharge preparation |

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

# 10 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.[34]

Table 39. Post-termination care considerations

| Aspect | Consideration |
|---|---|
| **Inpatient post-procedural care** | • Provide routine post-procedural care including assessment of vital signs, consciousness and observation of vaginal loss<br>• Where possible provide inpatient care that is not within a maternity service environment |
| **Rh prophylaxis**[107] | • Indicated for women who are more than 10+0 weeks gestation, and Rh D negative with no preformed anti-D antibodies within 72 hours of a medical or surgical termination[100]<br>• Refer to Queensland Clinical Guideline: *Rh D negative women and pregnancy*[107] |
| **Analgesia** | • Individually determine analgesia requirements after surgical termination[108] or during and after MToP as requirements vary<br>• Offer medication for pain management[24] (paracetamol in combination with ibuprofen often effective[109])<br>• Advise women that severe pain may be indicative of uterine perforation or clot retention[24]<br>o Seek advice if analgesia does not effectively manage pain |
| **Histopathology** | • If clinically indicated or suspicion of fetal abnormality, consider histopathological examination and chromosomal analysis (microarray) of tissue obtained during termination procedures |

## 10.1 Contraception

The most effective counselling strategies and interventions about contraception are uncertain.[110] Ideally, commence discussions about contraception during first contact and utilise multiple strategies (e.g. verbal, written, digital tools) to support individual circumstances and choice.[110]

Table 40. Contraception provision

| Aspect | Consideration |
|---|---|
| **Information** | • Discuss options based on woman's preferences and values including short and long acting methods<br>• Provide information on side effects, benefits and failure rates of methods<br>• Offer information on benefits of condom use in preventing STI[56]<br>• If immediate contraception declined, offer information (as appropriate to the circumstances) about:<br>o Types of contraception available (including emergency contraception)<br>o Accessing local services for contraceptive advice or support<br>o Prevention of future unwanted pregnancies |
| **If SToP** | • All forms of long-acting reversible contraception may be offered at the time of the procedure, including intrauterine devices (Copper bearing or Levonorgestrel varieties) injections or implants[41] |
| **If MToP**[111] | • Implants and injections may be offered on the day of mifepristone<br>• Intrauterine methods may be offered immediately after expulsion complete<br>o Timing according to individual circumstances and preferences |

## 10.2 Discharge preparation

Table 41. Discharge preparation

| Aspect | Consideration |
|---|---|
| **Counselling and support** | • Promote continuity of care to facilitate the development of longer-term support opportunities<br>• Provide information on accessing support agencies/organisations appropriate to individual circumstances (e.g. GP, grief counselling or support groups)<br>• 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)<br>• Offer information and assistance as appropriate regarding birth registration and funeral arrangements<br>o Refer to Table 24. Registration requirements<br>o Refer to Table 23. Information and counselling |
| **Lactation** | • More likely to occur after 18 weeks gestation<br>• If appropriate, discuss the possibility of lactation including<br>o Suppression (pharmacological and comfort measures)<br>o Donation of breast milk to milk banks<br>o Emotional response to lactation<br>• If breastfeeding another child, refer to midwife or lactation consultant as required |
| **Risk of infection** | To reduce risk of infection, recommend 'nothing in the vagina' for seven days post termination[83] |
| **Sexual activity** | • Sexual activity as desired after seven days |
| **Subsequent pregnancy** | • If there are no physical, psychological, health related or other barriers after a termination, conception can be attempted immediately following the termination<br>• If appropriate offer information about pre-conceptual care (e.g. folic acid, smoking cessation, rubella immunisation if required) |
| **Discharge** | • Determine timing of discharge on an individual basis<br>• Consider routine discharge criteria (e.g. vital signs, recovery from effects of sedation/anaesthesia)<br>• Supply a prescription for analgesia and antiemetics<br>• Provide written information regarding post-procedure symptoms and accessing emergency care[24]<br>o Refer to Queensland Clinical Guidelines: *Patient information on post termination care*[112]<br>• 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)<br>• Seek consent for discharge letter distribution (e.g. to GP) |
| **Other indications for follow-up** | • Follow-up according to method and circumstances<br>• As indicated:<br>o To discuss pathology results, (e.g. if histopathology or autopsy for fetal abnormality)<br>o Recommend referral to medical specialists (e.g. clinical genetics services)<br>o Review emotional wellbeing<br>• Where follow-up is difficult, or uncertain encourage the woman to seek support from GP or local health service |

## References


1. Medicines and Poisons Act 2019 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
2. Medicines and Poisons (Medicines) Regulation 2021. [Accessed 2024 July 07]. Available from: https://www.legislation.qld.gov.au.
3. Australian Medical Association. Position statement: conscientious objection [Internet]. 2019 [cited 2024 January 08]. Available from: https://www.ama.com.au.
4. Public Health Act 2005 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
5. Australian Government: Australian Institute of Health and Welfare. METeOR Metadata Online Registry: Live birth [Internet]. 2022 [updated 2024 January 08]. Available from: https://www.aihw.gov.au
6. Termination of Pregnancy Act 2018 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
7. Australian College of Midwives. Aims and scope. Women and Birth [Internet]. 2024 [cited 2024 March 3]. Available from: https://www.womenandbirth.org.
8. Australian Government Department of Health and Aged Care. First evaluation report: national stillbirth action and implementation plan [Internet]. 2023 [cited 2024 March 4]. Available from: https://www.health.gov.au.
9. Melville C. Abortion care in Australasia: a matter of health, not politics or religion. Australian and New Zealand Journal of Obstetrics and Gynaecology 2022;62(2):187-9. doi:org/10.1111/ajo.13501.
10. Keogh LA, Gurrin LC, Moore P. Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data. Medical Journal of Australia 2021;215(8):375-6. doi:10.5694/mja2.51217.
11. Criminal Code Act 1899 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
12. Australian Government: Department of Health and Aged Care. The Pharmaceutical Benefits Scheme: Medicine iitem 10211K [Internet]. 2024 [cited 2024 February 13]. Available from: https://www.pbs.gov.au/.
13. Therapeutic Goods Administration. Australian Product Information - MS-2 Step (mifepristone and misoprostol) [Internet]. 2023 [cited 2024 January 11]. Available from: https://tga.gov.au.
14. Queensland Government. Extended Practice Authorities [Internet]. 2024 [updated 2024 February 05; cited February 13]. Available from: https://www.health.qld.gov.au
15. Health and Other Legislation Amendment Bill 2021 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
16. Australian Health Practitioner Regulation Agency. Student Registration [Internet]. 2021 [cited 2024 January 08]. Available from: https://www.ahpra.gov.au.
17. Powers of Attorney Act 1998 (Queensland). [Accessed 2024 January 12]. Available from: https://www.legislation.qld.gov.au/.
18. Guardianship and Adminstration Act 2000 (Queensland). [Accessed 2024 January 12]. Available from: https://www.legislation.qld.gov.au.
19. *Gillick v West Norfolk & Wisbech Area Health Authority & Department of Health and Social Security* [1986] AC112. [Internet] [cited 2024 January 08]. Available from: https://www.legislation.qld.gov.au.
20. Queensland Health. Guide to informed decision-making in health care interim update version 2.2 [Internet]. 2023 [cited 2024 January 05]. Available from: https://www.health.qld.gov.au.
21. Queensland Health. Reporting concerns of child abuse and negelect to child safety and sexual offences against children to police V5.0: QH-GDL-948:2015 [Internet]. 2021 [cited 2024 January 08]. Available from: https://www.health.qld.gov.au.
22. Child Protection Act 1999 (Queensland). [Accessed 2024 January 8]. Available from: http://www.legislation.qld.gov.au.
23. Queensland Health. Clinical Services Capability Framework v3.2 [Internet]. 2015 [cited 2024 January 08]. Available from: https://www.health.qld.gov.au.
24. World Health Organization. Abortion care guideline. 2022. [cited 2024 January 08]. Available from: https://who.int.
25. Queensland Health. Sexual health and safety guidelines: mental health, alcohol and other drug services v1.1 [Internet]. 2017 [cited 2024 January 08]. Available from: https://www.health.qld.gov.au.
26. Queensland Clinical Guidelines. Perineal care. Guideline No. MN23.30-V5-R28. [Internet]. Queensland Health. 2023. [cited 2024 January 05]. Available from: https://www.health.qld.gov.au/qcg.
27. Queensland Clinical Guidelines. Standard care. Guideline No. MN22.50-V2-R27. [Internet]. Queensland Health. 2022. [cited 2024 January 08]. Available from: https://www.health.qld.gov.au/qcg.
28. Shapiro MP, Dethier D, Kahili-Heede M, Kaneshiro B. No-test medication abortion a systematic review. Obstetrics and Gynecology 2023;141(1):23-34. doi:10.1097/AOG.0000000000005016.
29. Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. BJOG: An International Journal of Obstetrics & Gynaecology 2019;126(9):1094-102. doi:10.1111/1471-0528.15684.
30. Gambir K, Kim C, Necastro KA, Ganatra B, Ngo TD. Self-administered versus provider-administered medical abortion. Cochrane Database of Systematic Reviews. [Internet]. 2020, Issue 3. Art No.: CD013181. DOI:10.1002/14651858.CD013181.pub2.
31. Seymour JW, Melville C, Thompson T-A, Grossman D. Effectiveness and safety of a direct-to-patient telehealth service providing medication abortion targeted at rural and remote populations: Cross-sectional findings from Marie Stopes Australia. Contraception 2022;115:67-8. doi:10.1016/j.contraception.2022.06.010.
32. Ireland S, Belton S, Doran F. 'I didn't feel judged': exploring women's access to telemedicine abortion in rural Australia. Journal of Primary Health Care 2020;12(1):49-56. doi:10.1071/HC19050.
33. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Clinical guideline for abortion care [Internet]. 2023 [cited 2024 January 05]. Available from: https://www.ranzcog.edu.au.
34. National Abortion Federation (NAF). Clinical policy guidelines for abortion care [Internet]. 2024 [cited 2024 January 08]. Available from: https://www.prochoice.org.
35. World Health Organization. Clinical practice handbook for quality abortion care [Internet]. 2023 [cited 2024 January 08]. Available from: https://www.who.int.
36. Guiahi M, Davis A. First-trimester abortion in women with medical conditions. Contraception 2012;86(6):622-30. doi:10.1016/j.contraception.2012.09.001.
37. Sert ZS, Bertizlioğlu M. Effect of obesity on the time to a successful medical abortion with misoprostol in first-trimester missed abortion. Archives of Gynecology and Obstetrics 2024;309(1):127-31. doi:10.1007/s00404-022-06875-9.
38. Henkel A, Blumenthal PD. Second-trimester abortion care for those with complex medical conditions. Curr Opin Obstet Gynecol 2022;34(6):359-66. doi:10.1097/GCO.0000000000000817.
39. Garhwal P, Rajoria L, Sharma M. A comparison of manual vacuum aspiration with medical method of abortion in termination of pregnancy up to 9 weeks of gestational age. International Journal of Reproduction, Contraception, Obstetrics and Gynecology 2017;6(9):3813-7. doi:10.18203/2320-1770.ijrcog20173665.
40. Murray M-E, Casson M, Pudwell J, Waddington A. Patients' motivation for surgical versus medical abortion. Journal of Obstetrics and Gynaecology Canada 2019;41(9):1325-9. doi:10.1016/j.jogc.2019.01.009.
41. Zwerling B, Edelman A, Jackson A, Burke A, Prabhu wtaoM. Society of Family Planning clinical recommendation: medication abortion between 14 0/7 and 27 6/7 weeks of gestation: Jointly developed with the Society for Maternal-Fetal Medicine. Contraception 2024;129:110143-. doi:10.1016/j.contraception.2023.110143.

42. American College of Obstetricians and Gynecologists. Medical abortion up to 70 Days of gestation ACOG Practice Bulletin. No 225. Obstetrics and Gynecology 2020;136(4):e31-47.
43. Creinin MD, Hou MY, Dalton L, Steward R, Chen MJ. Mifepristone antagonization with progesterone to prevent medical abortion: a randomized controlled trial. Obstet Gynecol 2020;135(1):158-65. doi:10.1097/aog.0000000000003620.
44. American College of Obstetricians and Gynecologists. Second-trimester abortion ACOG Practice Bulletin No. 135: . Obstetrics and Gynecology 2013;121(6):1394-406. doi:10.1097/01.AOG.0000431056.79334.cc.
45. Sonalkar S, Ogden SN, Tran LK, Chen AY. Comparison of complications associated with induction by misoprostol versus dilation and evacuation for second-trimester abortion. International Journal of Gynecology & Obstetrics 2017;138(3):272-5. doi:10.1002/ijgo.12229.
46. Tzur Y, Berkovitz-Shperling R, Goitein Inbar T, Bar-On S, Gil Y, Levin I, et al. Expectant vs medical management for retained products of conception after medical termination of pregnancy: a randomized controlled study. American Journal of Obstetrics and Gynecology 2022;227(4):599.e1-.e9. doi:10.1016/j.ajog.2022.06.025.
47. Boraas CM, Carroll A, Hesse SP, Norkett E, Ralph JA. Management of surgical abortion complications. Journal of Gynecologic Surgery 2022;38(5):335-8. doi:10.1089/gyn.2022.0065.
48. Kerns JL, Brown K, Nippita S, Steinauer J. Society of Family Planning clinical recommendation: management of hemorrhage at the time of abortion. Contraception (Stoneham) 2024;129:110292-. doi:10.1016/j.contraception.2023.110292.
49. Daniel Seow Choon K, Eek Chaw T, Hester Chang Qi QL, Mor Jack NG, Wan Shi T, Kok Hian T. Incidence and contributing factors for uterine rupture in patients undergoing second trimester termination of pregnancy in a large tertiary hospital - a 10-year case series. European Journal of Obstetrics & Gynecology and Reproductive Biololgy 2018;227:8-12. doi:10.1016/j.ejogrb.2018.05.016.
50. Hooker AB, de Leeuw RA, Emanuel MH, Mijatovic V, Brolmann HAM, Huirne JAF. The link between intrauterine adhesions and impaired reproductive performance: a systematic review of the literature. BMC Pregnancy and Childbirth 2022;22(1):1-837. doi:10.1186/s12884-022-05164-2.
51. Queensland Clinical Guidelines. Stillbirth care. Guideline No. MN23.24-V10-R28. [Internet]. Queensland Health. 2023. [cited 2024 January 05]. Available from: https://www.health.qld.gov.au/qcg.
52. Azri S, Larmar S, Cartmel J. Social work's role in prenatal diagnosis and genetic services: current practice and future potential. Australian Social Work 2013. doi:10.1080/0312407X.2013.848914.
53. Hagey J, Truong T, Deans E. Breast symptoms after pregnancy loss and abortion: an observational study. Obstetrics and Gynecology 2020; 135 103S-S. doi:10.1097/01.AOG.0000664260.95519.2e.
54. Steinberg JR, McCulloch CE, Adler NE. Abortion and mental health: findings from the national comorbidity survey-replication. Obstetrics and Gynecology 2014;123(201):263-70. doi:10.1097/AOG.0000000000000092.
55. Australasian Society for Infectious Diseases. Management of perinatal infections [Internet]. 2022 [cited 2024 April 10]. Available from: https://www.asid.net.au.
56. Queensland Health. Primary clinical care manual 11th edition [Internet]. 2022 [cited 2024 January 05]. Available from: https://www.publications.qld.gov.au.
57. Aiken A, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. BJOG 2021;128(9):1464-74. doi:10.1111/1471-0528.16668.
58. Rodriguez M, Edelman A, Hersh A, Gartoulla P, Henderson J. Medical abortion offered in pharmacy versus clinic-based settings. Cochrane Database of Systematic Reviews. [Internet]. 2021, [cited 2024 April 10]. Issue 6. Art No.: CD013566. DOI:10.1002/14651858.CD013566.pub2.
59. Grossman D, Grindlay K. Safety of medical abortion provided through telemedicine compared with in person. Obstet Gynecol 2017;130(4):778-82. doi:10.1097/AOG.0000000000002212.
60. Schmidt-Hansen M, Cameron S, Lord J, Hasler E. Initiation of abortion before there is definitive ultrasound evidence of intrauterine pregnancy: A systematic review with meta-analyses. Acta Obstet Gynecol Scand 2020;99(4):451-8. doi:10.1111/aogs.13797.
61. Schmidt-Hansen M, Pandey A, Lohr PA, Nevill M, Taylor P, Hasler E, et al. Expulsion at home for early medical abortion: A systematic review with meta-analyses. Acta Obstet Gynecol Scand 2021;100(4):727-35. doi:10.1111/aogs.14025.
62. Queensland Clinical Guidelines. Early pregnancy loss. Guideline No. MN22.29-V6-R27. [Internet]. Queensland Health. 2022. [cited 2024 January 12]. Available from: https://www.health.qld.gov.au/qcg.
63. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. RANZCOG Abortion decision aid [Internet]. n.d [cited 2024 January 15]. Available from: https://www.ranzcog.edu.au.
64. Sasaki N, Ikeda M, Nishi D. Long-term influence of unintended pregnancy on psychological distress: a large sample retrospective cross-sectional study. Archives of Women's Mental Health 2022;25(6):1119-27. doi:10.1007/s00737-022-01273-1.
65. Charles VE, Polis CB, Sridhara SK, Blum RW. Abortion and long-term mental health outcomes: a systematic review of the evidence. Contraception (Stoneham) 2008;78(6):436-50. doi:10.1016/j.contraception.2008.07.005.
66. Horvath S, Schreiber CA. Unintended pregnancy, induced abortion, and mental Health. Current Psychiatry Reports 2017;19(11):77-. doi:10.1007/s11920-017-0832-4.
67. Gilchrist AC, Hannaford PC, Frank P, Kay CR. Termination of pegnancy and psychiatric morbidity. British Journal of Psychiatry 1995;167(2):243-8. doi:10.1192/bjp.167.2.243.
68. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. Abortion and mental health: evaluating the evidence. American Psychologist 2009;64(9):863-90. doi:10.1037/a0017497.
69. Steinberg JR, Russo NF. Abortion and anxiety: what's the relationship? Social Science & Medicine 2008;67(2):238-52. doi:10.1016/j.socscimed.2008.03.033.
70. Biggs MA, Upadhyay UD, McCulloch CE, Foster DG. Women's mental health and well-being 5 years after receiving or being denied an abortion: a prospective, longitudinal cohort study. JAMA Psychiatry 2017;74(2):169-78. doi:10.1001/jamapsychiatry.2016.3478.
71. Petersen MN, Jessen-Winge C, Møbjerg ACM. Scandinavian women's experiences with abortions on request: A systematic review. Joanna Briggs Institute Database of Systematic Reviews & Implementation Reports 2018;16(7):1537-63. doi:10.11124/JBISRIR-2017-003344.
72. Biggs MA, Brown K, Foster DG. Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. PLoS One 2020;15(1):e0226417-e. doi:10.1371/journal.pone.0226417.
73. Births, Deaths and Marriages Registration Act 2003 (Queensland). [Accessed 2024 January 8]. Available from: https://www.legislation.qld.gov.au.
74. United Nations. Convention on the Rights of the Child [Internet]. 1989 [cited 2024 June 18]. Available from: https://www.humanrights.gov.au.
75. PalliativeCare Australia. Position statement: sustainable access to prescription opioids for use in palliative care [Internet]. 2019 [cited 2024 April 10]. Available from: https://www.palliativecare.org.au.
76. Paediatric Palliaitive Care Australia and New Zealand (PaPCANZ). A practical guide to palliative care in paediatrics. 4th ed. [Internet] 2023 [cited 2024 April 10]. Available from: https://www.paediatricpalliativecare.org.au.
77. Queensland Law Reform Commission. A review of the law in relation to the final disposal of a dead body: report no. 69 [Internet]. 2011 [cited 2024 January 12]. Available from: https://www.qlrc.qld.gov.au.
78. Queensland Government. Department of Environment and Science. Clinical and related waste: guideline number ESR/2015/1571 version 4.02 [Internet]. 2020 [cited 2024 January 12]. Available from: https://www.environment.des.qld.gov.au.

79. Queensland Health. List of approved medications (LAM) [Internet]. 2023 [cited 2024 January 11]. Available from: http://www.health.qld.gov.au.
80. Therapeutic Goods Administration. Australian Product Information - Mifepristone [Internet]. 2022 [cited 2024 January 11]. Available from: https://tga.gov.au.
81. Hale T (HalesMeds). Misoprostol. In: Medications and Mother's Milk. [Internet]: Springer; 2020. [cited 2024 April 17]. Available from: htpps://halesmeds.com.
82. Hale T (HalesMeds). Mifepristone. In: Medications and Mother's Milk. [Internet]: Springer; 2021. [cited 2024 April 17]. Available from: htpps://halesmeds.com.
83. Therapeutic Guidelines. Medical abortion [Internet]. 2024 [cited 2024 April 10]. Available from: https://www.tga.gov.au.
84. Misoprostol (obstetrics). In: Australian Medicines Handbook; 2024. [cited 2024 January 12]. Available from: https://www.amhonline.amh.net.au.
85. Heller R, Cameron S. Termination of pregnancy at very early gestation without visible yolk sac on ultrasound. The Journal of Family Planning and Reproductive Health Care 2015;41(2):90. doi:10.1136/jfprhc-2014-100924.
86. Jar-Allah T, Hognert H, Kocher L, Berggren L, Fiala C, Milsom I, et al. Detection of ectopic pregnancy and serum beta hCG levels in women undergoing very early medical abortion: a retrospective cohort study. The European Journal of Contraception & Reproductive Health Care 2022;27(3):240. doi:10.1080/13625187.2022.2025587.
87. Tai NQR, Reynolds-Wright JJ, Cameron S. Very early medical abortion: treatment with mifepristone and misoprostol before ultrasonographic visualisation of an intrauterine pregnancy. BMJ Sexual & Reproductive Health 2023;49(2):97-104. doi:10.1136/bmjsrh-2022-201677.
88. Schmidt-Hansen M, Cameron S, Lohr PA, Hasler E. Follow-up strategies to confirm the success of medical abortion of pregnancies up to 10 weeks' gestation: a systematic review with meta-analyses. American Journal of Obstetrics and Gynecology 2020;222(6):551-63.e13. doi:10.1016/j.ajog.2019.11.1244.
89. Society of Family Planning. Interim clinical recommendations: self-managed abortion [Internet]. 2022 [cited 2024 April 03]. Available from: https://www.societyfp.org.
90. Melville C, Goldstone P, Moosa N. Telephone follow-up after early medical abortion using Australia's first low sensitivity urine pregnancy test. Aust N Z J Obstet Gynaecol 2023;63(6):797-802. doi:10.1111/ajo.13731.
91. Millar SL, Cameron ST. Comparison of two low-sensitivity urine pregnancy tests for confirming the success of early medical abortion. BMJ Sexual & Reproductive Health 2018;44(1):54-7. doi:10.1136/bmjsrh-2017-101868.
92. Oppegaard KSD, Qvigstad EP, Fiala CMD, Heikinheimo OP, Benson LM, Gemzell-Danielsson KP. Clinical follow-up compared with self-assessment of outcome after medical abortion: a multicentre, non-inferiority, randomised, controlled trial. The Lancet (British edition) 2015;385(9969):698-704. doi:10.1016/S0140-6736(14)61054-0.
93. Whitehouse KC, Shochet T, Lohr PA. Efficacy of a low-sensitivity urine pregnancy test for identifying ongoing pregnancy after medication abortion at 64 to 70 days of gestation. Contraception 2022;110:21-6. doi:10.1016/j.contraception.2022.02.005.
94. Honkanen H, Ranta S, Ylikorkala O, Heikinheimo O. The kinetics of serum hCG and progesterone in response to oral and vaginal administration of misoprostol during medical termination of early pregnancy. Hum. Reprod 2002;17(9):2315-9. doi:10.1093/humrep/17.9.2315.
95. van der Lugt B, Drogendijk AC. The Disappearance of human chorionic gonadotropin from plasma and urine following induced abortion: disappearance of HCG after induced abortion. Acta Obstet Gynecol Scand 1985;64(7):547-52. doi:10.3109/00016348509156360.
96. Hamel CC, Wessel S, Carnegy A, Coppus SFPJ, Snijders MPML, Clark J, et al. Diagnostic criteria for retained products of conception—A scoping review. Acta Obstet Gynecol Scand 2021;100(12):2135-43. doi:10.1111/aogs.14229.
97. Lemmers M, Verschoor MAC, Oude Rengerink K, Naaktgeboren C, Opmeer BC, Bossuyt PM, et al. MisoREST: surgical versus expectant management in women with an incomplete evacuation of the uterus after misoprostol treatment for miscarriage: a randomized controlled trial. Hum Reprod 2016;31(11):2421-7. doi:10.1093/humrep/dew221.
98. Chaudhuri P, Mandal A, Das C, Mazumdar A. Dosing interval of 24 hours versus 48 hours between mifepristone and misoprostol administration for mid-trimester termination of pregnancy. International Journal of Gynecology & Obstetrics 2014;124(2):134-8. doi:10.1016/j.ijgo.2013.08.009.
99. Zhang J, Zhou K, Shan D, Luo X. Medical methods for first trimester abortion. Cochrane Database of Systematic Reviews. [Internet]. 2022, Issue Art No.: DOI:10.1002/14651858.CD002855.pub5.
100. National Blood Authority. Guideline for the prophylactic use of Rh D immunoglobulin in pregnancy care [Internet]. 2021 [cited 2024 January 12]. Available from: http://www.blood.gov.au.
101. Allen RH, Singh R. Society of Family Planning clinical guidelines pain control in surgical abortion part 1 — local anesthesia and minimal sedation. Contraception 2018;97(6):471-7. doi:10.1016/j.contraception.2018.01.014.
102. O'Shea LE, Lohr PA, Lord J, Hasler E, Cameron S. Cervical priming before surgical abortion between 14 and 24 weeks: a systematic review and meta-analyses for the National Institute for Health and Care Excellence-new clinical guidelines for England. Am J Obstet Gynecol MFM 2021;3(1):100283. doi:10.1016/j.ajogmf.2020.100283.
103. O'Shea LE, Lord J, Fletcher J, Hasler E, Cameron S. Cervical priming before surgical abortion up to 13+6 weeks' gestation: a systematic review and meta-analyses for the National Institute for Health and Care Excellence—new clinical guidelines for England. Am J Obstet Gynecol MFM 2020;2(4):100220. doi:10.1016/j.ajogmf.2020.100220.
104. Winikoff B, Dzuba IG, Creinin MD, Crowden WA, Goldberg AB, Gonzales J, et al. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. Obstetrics and Gynecology 2008;112(6),
105. Therapeutic Guidelines. Surgical prophylaxis for gynaecological surgery - termination of pregnancy [Internet]. 2024 [cited 2024 January 11]. Available from: https://www.tga.gov.au.
106. Renner R, Ennis M, McKercher A, Henderson J, Edelman A. Local anaesthesia for pain control in first trimester surgical abortion. Cochrane Database of Systematic Reviews. [Internet]. 2024, [cited 2024 April 11]. Issue 2. Art No.: CD006712. DOI:10.1002/14651858.CD006712.pub3.
107. Queensland Clinical Guidelines. Rh D negative women and pregnancy. Guideline No. MN23.74-V1-R28. [Internet]. Queensland Health. 2023. [cited 2024 January 05]. Available from: https://www.health.qld.gov.au/qcg.
108. Allen RH, Goldberg AB. Clinical guidelines: cervical dilation before first-trimester surgical abortion (<14 weeks' gestation). Contraception 2016;93:277-91. doi:10.1016/j.contraception.2015.12.001.
109. Reynolds-Wright JJ, Woldetsadik MA, Morroni C, Cameron S. Pain management for medical abortion before 14 weeks' gestation. Cochrane Database of Systematic Reviews. [Internet]. 2022, Issue Art No.: DOI:10.1002/14651858.CD013525.pub2.
110. Cavallaro FL, Benova L, Owolabi OO, Moazzam A. A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't? British Medical Journal: Sexual & Reproductive Health 2020;46(4):254-69. doi:10.1136/bmjsrh-2019-200377.
111. Schmidt-Hansen M, Hawkins JE, Lord J, Williams K, Lohr PA, Hasler E, et al. Long-acting reversible contraception immediately after medical abortion: systematic review with meta-analyses. Human Reproduction Update 2020;26(2):141-60. doi:10.1093/humupd/dmz040.
112. Queensland Clinical Guidelines. Consumer information: termination of pregnancy. Guideline No. C24.24-2-V3-R29. [Internet]. Queensland Health. 2024. [cited 2024 August 28]. Available from: https://www.health.qld.gov.au/qcg.

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