Government of **Western Australia**
Department of **Health**

INTERIM WA Abortion Care Clinical Guidelines

ONLINE CONSULTATION AND ENGAGEMENT VERSION

(PRIOR TO QUEENSLAND HEALTH LICENCE APPLICATION)

Consultation approval date: 28 October 2024

Contents

Applicability

This guideline must be considered by:

- Health professionals working within the Western Australian Department of Health and Health Service Providers.

Guideline statement

Abortion under the *Public Health Act 2016 (WA)*[1] means to perform an act with the intention of causing the termination of a person's pregnancy.

The purpose of this guideline is to assist healthcare professionals to provide care to people requesting an abortion. This can be either a woman, a girl, or a pregnant person.

This guideline is set by the Heath Network Directorate and Clinical Excellence Division in accordance with the Act. Registered health practitioners must have regard to the Public Health Act in the performance of abortions.

Relationship to parent policy

On 27 March 2024, the *Abortion Legislation Reform Act 2023* (WA)[2] came into effect in Western Australia.

The Reform Act repeals all provisions related to abortion within the *Health (Miscellaneous Provisions) Act 1911* (WA) and creates a new framework relating to abortion under Part 12 C of the *Public Health Act 2016* (WA), including to regulate the performance of abortion by registered health practitioners and prohibit the performance of abortion by certain persons. Consequential amendments have also been made to the Criminal Code, *Children's Court Act*, *Coroner's Act, Freedom of information Act 1992* and the *Guardianship and Administration Act*.

The new legislation aims to promote equity and reduce barriers for women, girls and pregnant people accessing abortion care services in Western Australia.
Key changes implemented by the legislation include:

- Raising the gestational age limit for when abortion can occur, without additional requirements, from 20 weeks to 'not more than 23 weeks.
- Removal of the mandatory counselling requirement prior to obtaining patient's consent to the abortion.
- Removal of the requirement for 2 medical practitioners to be consulted separately and consent before a patient can have an abortion for certain gestational periods. The legislation allows one health practitioner to be involved in an abortion (at not more than 23 weeks). The health practitioner is required to obtain informed consent in line with existing standards of care.
- For a patient who is more than 23 weeks pregnant (23 weeks and 1 day gestation or more), an abortion may be performed by a medical practitioner (the primary practitioner) if the primary practitioner having fully considered all relevant medical circumstances, current and future physical, psychological, and social circumstances and professional standards and guidelines, considers performing the abortion appropriate in all circumstances. The primary practitioner must have consulted with at least one other medical practitioner who, having also taken into account the above considerations, reasonably believes that performing the abortion is appropriate in all the circumstances.
- Registered health practitioners are able to conscientiously object to providing abortion services but are required to refer a patient requesting an abortion to a provider or service that can provide abortion care or provide the patient with information approved by the Chief Health Officer specifying

how the patient can access an abortion.

- Approval from a Ministerial Panel is no longer required for late term abortions.
- Babies born alive as a result of an abortion and subsequently die are no longer reportable deaths to the Coroner.

For copies of the Abortion Legislation Reform Act 2023, visit WALW - Abortion Legislation Reform Act 2023 - Home Page

Guideline details

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Corporate acknowledgement and endorsements

The WA Department of Health acknowledges the North Metropolitan Health Service, Women's and Newborns Health Service (NMHS/WNHS) Abortion Care Working Group and stakeholders who developed the *Draft Abortion Care Clinical Guidelines*, endorsed by the NMHS/WNHS Abortion Care Steering Committee in March 2024.

The *Draft Abortion Care Clinical Guidelines* (INTERIM WA guidelines) were provided to the WA Department of Health, Health Networks Directorate, Clinical Excellence Division for application and stewarding a statewide license with Queensland Health. The Clinical Lead, Women and Newborn Health Network has endorsed the INTERIM WA guidelines. Noting, addition of culturally appropriate Aboriginal and Culturally and Linguistically Diverse consumer perspectives for care considerations, would strengthen the guidelines.

On 1 November 2024, the Draft for Consultation Abortion Care Clinical Guidelines is this version released for consultation with WA health professionals. It builds on the INTERIM WA guidelines by including the cultural consideration statements for Aboriginal clients, and for Culturally and Linguistically Diverse clients. The WA Department of Health considers this version completed and prepared for submission to Queensland Health for the statewide license. The online consultation process will identify any areas for improvement, or editing, based on the feedback from WA health professionals who provide, or work in, services providing abortion care.

Disclaimer

These guidelines are intended as a guide and provided for information purposes only. The information has been prepared using a multidisciplinary approach with reference to the best information and evidence available at the time of preparation. No assurance is given that the information is entirely complete, current, or accurate in every respect.

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

These guidelines do 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 patient rights and informed decision making, including the right to decline intervention or ongoing management.
- advising patients 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; and
- documenting all care in accordance with mandatory and local requirements.

Recommended citation:

Department of Health WA Abortion Care Clinical Guidelines. © State of Queensland (Queensland Health) 2024

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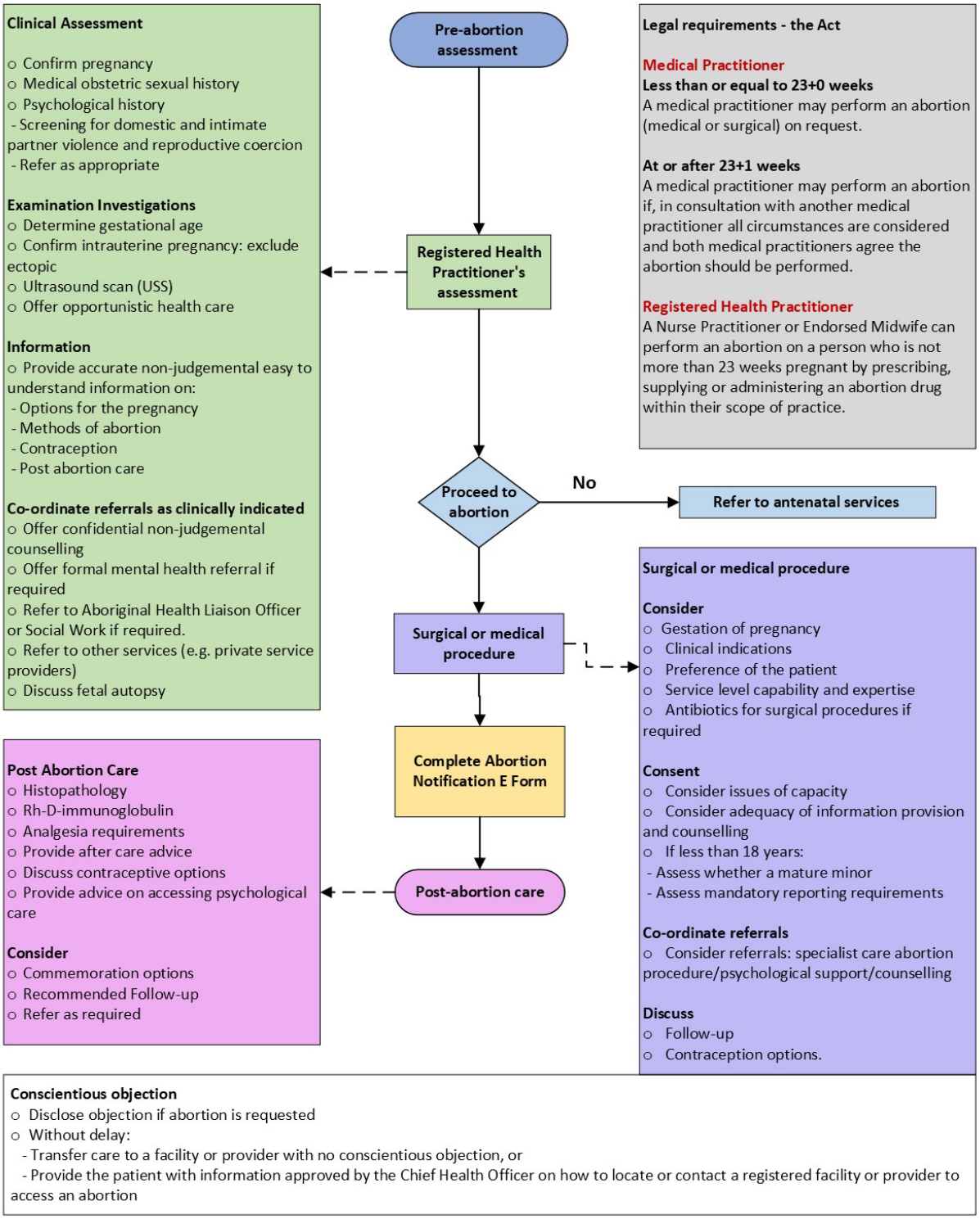
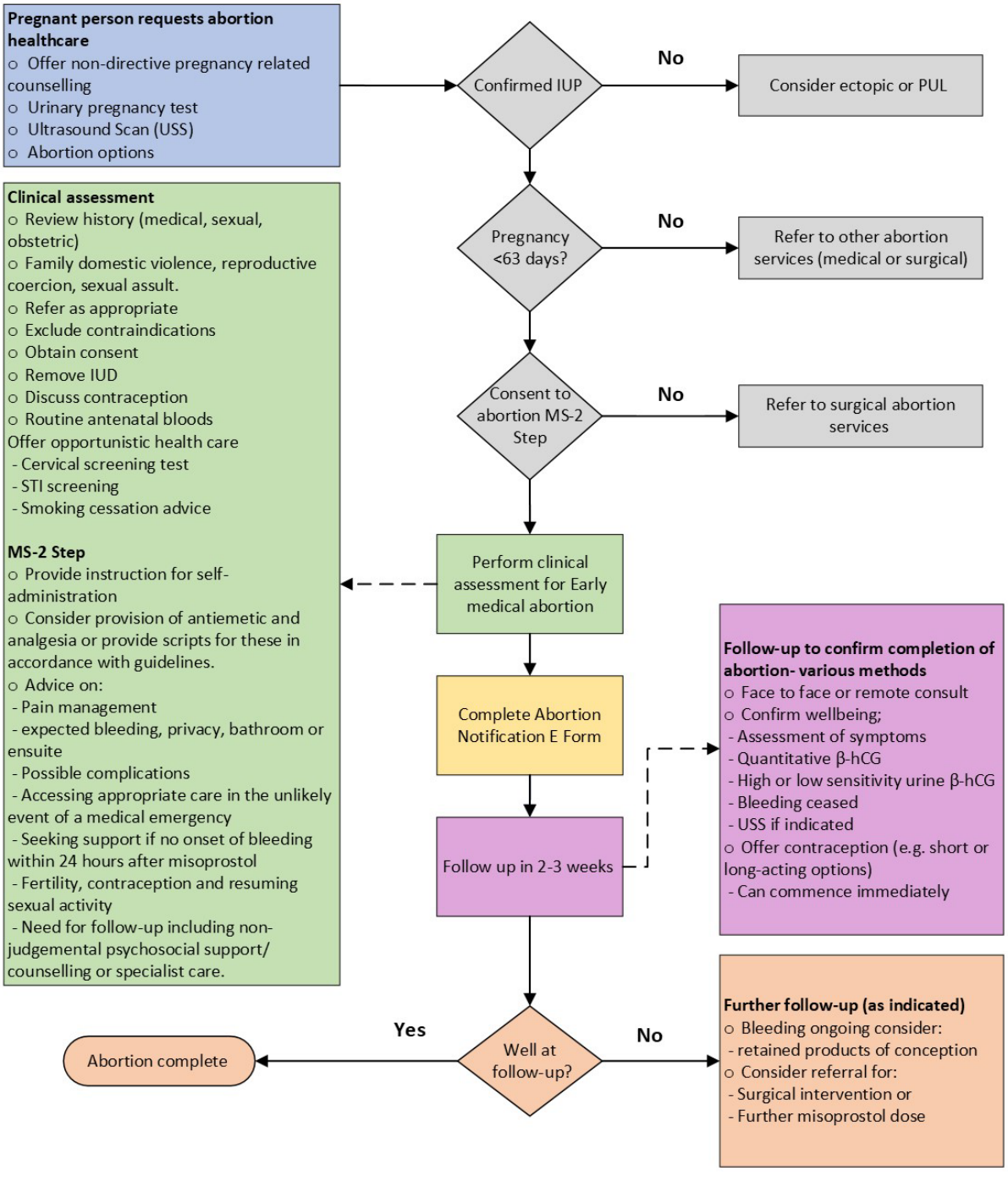
Summary of Abortion Healthcare under the Public Health Act 2016 (the Act)



Medical Abortion with MS – 2 Step



β-hCG: beta human chorionic gonadotrophin, IUD: Intrauterine device, IUP: Intrauterine pregnancy, MToP: medical termination of preganacy, PUL: Pregnancy of unknown location, Rh D: Rhesus D immunoglobulin, USS: Ultrasound scan, ≤: less than or equal to.

Section 1: Western Australian Law

1.1 Performing an abortion

Table 1. Performing an abortion

Aspect	Definition
Context	Performance of an abortion is defined in the Act[3] as follows: A person performs an abortion on another person (patient) if the person does any act with the intention of causing the termination of a pregnancy of the other person. The acts to which this applies includes the following: • Prescribing an abortion drug for another person (patient). • Supplying an abortion drug to another person. • Administering an abortion drug to the other person. • Carrying out a surgical or other procedure on the other person.
Healthcare included in performing an abortion	Expert clinical recommendation is that *performing an abortion* commences when the therapeutic intervention of abortion starts and includes: • Prescribing an abortion drug • Dispensing, supplying, or administering an abortion drug on a medical practitioner's and/or prescribing practitioners' instruction. • Feticide or a surgical procedure of abortion performed by a medical practitioner. • Feticide or a surgical procedure of abortion assisted by an authorised or student healthcare practitioner [refer to Table 3. Assisting with an abortion]. All health professionals, including community pharmacist's, must provide adequate pharmaceutical information to the patient and/or their support person to ensure the safe and effective use of the drugs in a manner that protects the patient's privacy.

Healthcare not included in performing an abortion	Expert clinical recommendation is that *performing an abortion* does not include clinical care provided before or after performing an abortion including, for example:
	• Clinical assessment, pre-operative preparation, referral, or non-directive counselling, intrapartum or postpartum care after feticide or after administration of an abortion drug.
	  • Refer to Table 17. Clinical assessment prior to abortion; and
	  • Refer to Table 38. Post-abortion care considerations.

1.2 Registered healthcare practitioner responsibilities

The legal responsibilities for the registered healthcare practitioner in relation to performing an abortion, are specified according to the gestational age of the pregnancy.[4]

Table 2. Registered health practitioner responsibilities

Aspect	Lawful action
Context	The Department of Health considers that: • 'Not more than 23 weeks' means less than or equal to 23+0 weeks. • 'More than 23 weeks' means at or after 23+1 weeks. Use clinical judgement when determining gestational age in individual circumstances
Less than or equal to 23+0 weeks gestation	Medical or Surgical Abortions: A medical practitioner is authorised to perform an abortion on a person (patient) who is not more than 23 weeks pregnant. A prescribing practitioner (Endorsed Midwives, Nurse Practitioners, Medical Practitioners, meaning a person who is authorised under the *Medicines and Poisons Act (2014)*[5] to prescribe an abortion drug) is authorised to perform a medical abortion on a person (patient) who is not more than 23 weeks pregnant if the prescribing practitioner performs the abortion by: • Prescribing an abortion drug for the person (patient); or • Supplying or administering an abortion drug to the person (patient). A registered health practitioner in a relevant health profession (other than pharmacy) is authorised to perform a medical abortion on a person (no more than 23 weeks gestation) by supplying or administering an abortion drug to the person if the registered health practitioner, in accordance with the *Medicines and Poisons Act (2014)*[6], supplies or administers the abortion drug to the person on the direction of a medical practitioner or prescribing practitioner. Medical Abortion: A pharmacist is authorised to perform an abortion on a person by supplying an abortion drug to the person if the pharmacist, in accordance with the *Medicines and Poisons Act (2014)*[7]: • dispenses the abortion drug to the person under a prescription issued by a medical practitioner or prescribing practitioner; or • otherwise supplies the abortion drug to the person on the direction of a medical practitioner or prescribing practitioner.
Equal or greater than 23+1 weeks gestation	A medical practitioner may perform an abortion on a person who is equal or greater than 23+1 weeks pregnant after consulting with another medical practitioner who has also assessed the person and both medical practitioners consider the abortion is appropriate in all the circumstances having regard to[8]: • All relevant medical circumstances; and • The person's current and future physical, psychological, and social circumstances; and • Professional standards and guidelines.

Aspect	Lawful action
	A registered health practitioner in a relevant health profession (other than pharmacy) is authorised to perform a medical abortion on a person (at or after 23+1 weeks gestation) by supplying or administering an abortion drug to the person if the registered health practitioner, in accordance with the *Medicines and Poisons Act (2014)*[9], supplies or administers the abortion drug to the person on the direction of a medical practitioner. A pharmacist is authorised to perform an abortion on a person by supplying an abortion drug to the person if the pharmacist, in accordance with the *Medicines and Poisons Act (2014)*[10]: • dispenses the abortion drug to the person under a prescription issued by a medical practitioner; or • otherwise supplies the abortion drug to the person on the direction of a medical practitioner.

1.3 Assisting by a registered health practitioner or student

A registered health practitioner in a relevant health profession, acting in the course of the practice of that profession, may assist in the performance of an abortion. A student in a relevant health profession may also assist.

Table 3. Assisting with an abortion

Aspect	Lawful action
Registered health practitioners	A registered health practitioner means a person registered under the *Health Practitioner Regulation National Law (Western Australia)*[11] to practice a health profession (other than as a student).
Relevant health profession	A relevant health profession means any of the following health professions: • Aboriginal and Torres Strait Islander health practitioner. • Medical. • Midwifery. • Nursing; or • Pharmacy.
Student health practitioner	Student health practitioners are permitted to assist in the performance of an abortion to the extent necessary to complete the student's program of study under supervision of: • A medical practitioner or prescribing practitioner performing the abortion; or • An authorised health practitioner lawfully assisting in the performance of an abortion; or • The student's primary clinical supervisor.

1.4 Conscientious objection

Refer to Definition of terms and Table 1 Performing an abortion.

Table 4. Conscientious objection

Aspect	Lawful action
Relevant to	Registered health practitioners and those they direct, including medical practitioners, Aboriginal and Torres Strait Islander health practitioners, midwives, nurses, pharmacists, and students who have a conscientious objection to the performance of an abortion and who are asked by the authorised health practitioner to[12]: • Perform or assist with the performance of an abortion. • Decide whether an abortion should be performed; or • Advise a person about the performance of abortion on a patient.
Disclosure of objection	When a registered health practitioner has been requested by a patient for information on abortion or has been asked to participate in an abortion and has a conscientious objection to abortion, the practitioner must disclose their conscientious objection to the patient immediately
Referral or transfer of care	A medical practitioner or prescribing practitioner (nurse practitioner or endorsed midwife) who will not participate in an abortion for any reason (including conscientious objection) must, without delay, refer the patient to a health practitioner or health facility which they believe can provide the requested service(s); or give the patient information that has been approved by the Chief Health Officer, about how the requested services can be accessed
Assisting in an abortion	Registered health practitioners who conscientiously object to assisting in an abortion must notify the practitioner requesting their assistance of their objection at the time the assistance request is made. A student who conscientiously objects to assisting in an abortion should notify the person supervising them of their objection at the time the supervisor makes the request. A student has a right to not participate in an abortion, and this right must be respected by their supervisor.
Duty to perform or assist when necessary to save life	Despite any conscientious objection in relation to abortions, a medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the patient. Despite any conscientious objection in relation to abortion, registered health practitioner is under a duty to assist in an emergency where an abortion is necessary to preserve the life of the patient.
Care that is not a matter for conscientious objection	The conscientious objection provision does not extend to: • Administrative, managerial, or other tasks ancillary to the performance of the abortion. Refer to Table 1 Performance of an abortion.

1.5 Emergency care involving abortion

Table 5. Emergency care

Aspect	Lawful action
Medical and registered health practitioner	• In an emergency, a medical practitioner is authorised to perform an abortion on a person who is more than 23 weeks pregnant[13]: ○ Without consulting another medical practitioner. ○ Without considering all relevant circumstances.
Practitioners assisting	In an emergency, a registered health practitioner is under a duty to assist a medical practitioner performing an abortion in the circumstances outlined above[14]
Conscientious objectors	Despite any conscientious objection in relation to abortions, a medical practitioner, is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the patient. Despite any conscientious objection in relation to abortion, a registered health practitioner is under a duty to assist a medical practitioner in an emergency where an abortion is necessary to preserve the life of the patient.

1.6 Safe access zones

The purpose of safe access zones is to protect the safety and well-being and respect the privacy and dignity of patients and other persons accessing premises where performance of an abortion occurs[15].

Table 6. Safe access zone

Aspect	Lawful action
Premises for performing abortions	Premises for performing abortions means premises where either or both of the following take place: • Abortions are performed by registered health practitioners. • Registered health practitioners assist in the performance of abortions; but • Does not include a pharmacy.
Safe access zone	Safe access zone means the area: • Within the boundary of premises for performing abortions; and • Within 150 metres outside the boundary.
Prohibited conduct	Prohibited conduct means: • Harassing, hindering, intimidating, interfering with, threatening, or obstructing a person, including by recording the person by any means without the person's consent and without a reasonable excuse, which may result in deterring the person from: ○ Entering or leaving premises for performing abortion; or ○ Performing, or receiving, an abortion at premises for performing abortions. And an act that could be seen or heard by a person in the vicinity of premises for performing abortions, that may result in deterring the person or another person from: • Entering or leaving the premises; or • Performing an abortion or receiving an abortion at the premises.

1.7 Non-compliance with the Act

Table 7. Non-compliance

Aspect	Lawful action
Offences	Performance of an abortion: Abortion is considered a health procedure and should be conducted by a registered health practitioner. An unqualified person must not perform an abortion, as this is a crime attracting a prison term. Prohibited behaviour in a safe access zone: A person commits an offence if: • The person intentionally engages in prohibited conduct. • The prohibited conduct occurs in a safe access zone and the person is reckless in relation to that circumstance. Maximum penalty for prohibited behavior in a Safe Access Zone is imprisonment for one year and a fine of $12 000.
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. As for other healthcare, the following may also apply: • Professional and legal consequences for non-compliance with the Act, including mechanisms available under the Health Practitioner Regulation National Law (WA) Act 2010[16] and the Health and Disability Services (Complaints) Act 1995[17]. • Laws for duty of care, reasonable skill, and care. • Civil or criminal responsibility for harm that results from a failure to act with reasonable skill and care.

Section 2 Clinical standards

2.1 Service provision

Table 8. Service provision

Aspect	Considerations

Access to abortion healthcare	• Patients requesting an abortion require assessment by a registered health practitioner who is not a conscientious objector.
	• Refer to Table 4. Conscientious objection.
	• Where abortion healthcare is not locally available, support patients to access the service, as for any other healthcare not locally available.
	• Provide care to patients and families that acknowledges and respects their cultural beliefs and practices. (See Appendix B and Appendix C for cultural considerations statements.)
	• If required, access and provide appropriate interpreter services.
	• Provide documented information to consumers, external service providers, support agencies and other Health Service Providers (HSP) on the choices available within the service, and on routes of access to these services.
	• Facilitate access (including via patient travel subsidy scheme, when required) as early as possible and without delay to:
	  ○ Reduce the likelihood of associated health risks; and
	  ○ Support the patient in their preference for an abortion procedure that may be impacted by gestational age limitations.
	• The patient accessing an abortion (and an escort) may be eligible for PATS if they do not have access to safe, private accommodation[18].

Referral	• Document referral pathways within and between HSP's (e.g. between departments within a facility, between facilities, and between a facility and external agencies or General Practitioners (GP)). • Consider engagement with Statewide external service providers and agencies in the development of referral pathways and mechanisms. • Provide documented referral pathways to external service providers, agencies, and GPs. • Inform healthcare professionals in contact with patients seeking abortion (e.g. emergency departments, GPs) about referral pathways. • If there is a conscientious objection to the performance of an abortion, act in accordance with Table 4. Conscientious objection. • Where the patient considers but does not proceed to abortion, provide information and access to appropriate referral pathways (e.g. access to a social worker, referral for antenatal care, cultural support).

Local service delivery	• Determine the local service delivery mechanisms and administrative reporting requirements within each service. • A multidisciplinary and coordinated approach is required to avoid unnecessary delay in the provision of care. • Where there are complex issues present, [refer to 'Definition of terms', consider a case review (as for other complex healthcare) to assess the complexities specific to the individual patient. • Educate providers and referrers about the service, the pathways, any service limitations, and their professional responsibilities.

Care setting	The most appropriate care setting for abortion is dependent on the:
	• Method of abortion chosen.
	• Gestation of the pregnancy.
	• Preferences of the patient and their care provider.
	• The service capabilities of the facility; and
	• For early Medical Abortion [refer Section 7 Medical Abortion]
	  ○ Access to working phone and reliable transport. Consider road access and weather conditions.
	  ○ Access to safe and private accommodation, including bathroom facilities and a support person.
	  ○ Make a risk assessment of the patient's ability to accurately follow instructions for taking medication; and their access to appropriate care in the unlikely event of a medical emergency; and
	  ○ Ensure there are local arrangements for the safe and sensitive handling, storage, and management of fetal tissue (if required), including individual and cultural requirements.

Cultural considerations	• Cultural respect is achieved when the health system is a safe environment for West Australians who identify as Aboriginal or from a Culturally and Linguistically Diverse community, and where cultural differences are respected. • The experiences of Aboriginal health care users, including having their cultural identity respected, is critical for assessing cultural safety. Aspects of cultural safety include good communication, respectful treatment, empowerment in decision making and the inclusion of family members[19]. • See Appendix B for the Aboriginal Cultural Considerations Statement. • See Appendix C for the Culturally and Linguistically Diverse Considerations Statement.

2.2 Workforce support

Table 9. Workforce support

Aspect	Considerations
Healthcare professionals	• For healthcare professionals involved in the provision of abortion healthcare, provide: o Ongoing training and education[20]. o Access to non-judgemental counselling and debriefing support.
Student health practitioners	• Support access to information on: o Western Australian Law and the *Public Health Act 2016*[21]: o Conscientious objection rights and responsibilities. o Contemporary approach to abortion healthcare provision. o Sensitive communication and confidentiality. o Cultural considerations. o Other matters relevant to the clinical placement. • If the student health practitioner holds a conscientious objection, support: o Alternative clinical learning. o Access to non-judgemental counselling and debriefing support (if required).
Standard care	Includes for example, privacy, consent, decision making, sensitive communication, medication administration, staff education and support and culturally appropriate care.

Section 3 Individual case considerations

Abortion healthcare is provided in partnership with the patient (and family, where appropriate) and the healthcare professional. It is led by the person's health needs, concerns and choices. Use clinical judgement when determining if all aspects of care are appropriate for the individual. Consider cultural aspects and minimising harm to the individual, family, and community.

Health practitioners providing abortion healthcare can access the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Clinical Guideline for Abortion Care (2023)[22] which provides evidence-based recommendations to healthcare practitioners who provide advice and abortion care in Australia and Aotearoa New Zealand.

Health practitioners providing abortion healthcare are also advised to familiarise themselves with their legal responsibilities under the Act[23].

3.1 Consent

See Consent to Treatment Policy (health.wa.gov.au)- WA Policy[24]

Table 10. Consent

Aspect	Considerations
Consent	Where a patient is seeking to abort a pregnancy, it is necessary to obtain written informed consent to the type of procedure recommended and selected. Consent procedures should be followed. To achieve this requires provision of suitable levels of information the patient needs to be able to weigh up all the factors relevant to them and the risks involved. If more than one step, or procedure, is involved then it is important to ensure the person is giving consent to each step or procedure. WA health practitioners must follow usual consent processes as set out in the WA Health Consent to Treatment Policy including: • Assessment of capacity. • Discussion of available methods of abortion. • Risks and complications of each method of abortion. • Access to a working phone, transport, road access, bathroom facilities and supports (for early medical abortion not completed in hospital). • Risk assess patient access to appropriate care in the unlikely event of a medical emergency; and • The right of the patient to choose where to receive treatment.
Capacity to consent	Persons over the age of 18 are presumed to have full lawful capacity to consent to medical treatment unless there is sufficient evidence to the contrary (Sec 43(1(a)) of the *Guardianship and Administration Act 1990*)[25]. Capacity to consent is usually evidenced by the person's demonstration of a sufficient understanding of their condition, the treatment options available (including the benefits and effect of treatment options), the consequences of the condition and those of having, or not having any treatment, and the risks associated with each treatment.

Aspect	Considerations
Adults who lack capacity	A person over 18 years of age who lacks the capacity to provide informed consent to a procedure for an abortion cannot consent to the performance of an abortion. Under the *Guardian and Administration Act 1990*[26], the State Administrative Tribunal (SAT) has "the jurisdiction to consent or refuse consent to the performance of abortion on persons who are unable to make reasonable judgements in respect of whether abortions should be performed on them." Therefore, where a patient does not have the capacity to make reasonable judgments about abortion treatment and care, the relevant parties can apply to the SAT to make a decision on their behalf. Where the patient is deemed to not have capacity and has a Guardian appointed under *the Guardianship and Administration Act 1990*, an application to SAT is still required. The Guardian cannot make the decision regarding the abortion on the patient's behalf. Abortion of a pregnancy of an adult who lacks capacity is a complex case and it is strongly recommended the health practitioner seek legal advice. In an emergency situation, where urgent treatment is required, and it is not practical for the health professional to obtain a decision of the SAT in respect to the performance of an abortion; an abortion may be performed to: • save the patient's life. • prevent serious damage to the patient's health; or • to save another fetus. But does not include psychiatric treatment, or sterilization of the patient as per S110ZH(b) of the *Guardianship and Administration Act 1990.*
Young person who is assessed as a mature minor[27]	A young person is considered a mature minor when they demonstrate sufficient maturity and intelligence to enable them to understand fully what medical treatment is propose.[28, 29] • A mature minor can consent to medical procedures, in the same way as an autonomous adult with capacity. • The decision about whether a young person is a mature minor is a matter for the treating practitioner. • Consider additional elements of informed consent when obtaining consent from a young person who is a mature minor (e.g. the ability to freely and voluntarily make decisions without coercion). • It is recommended that legal advice is sought if there is any doubt about the capacity of a young pregnant person to consent to the proposed treatment where no other person is representing them or presenting orders permitting the proposed treatment. The law requires that when a young person assessed as a mature minor chooses not to include their parents/guardians in consultation, this must be respected, and confidentiality not breached. • Involve appropriately skilled healthcare professionals for assessments of

Aspect	Considerations
	competency, psychosocial assessments and family court matters where clinically indicated. For more information and further factors to consider when assessing the maturity of a minor see WA Country Health Service Working with Youth: A legal resource for community-based health professionals (https://www.wacountry.health.wa.gov.au/~/media/WACHS/Documents/About-us/Publications/Working_with_Youth_-_WA_Health.PDF).
Young person who is not a mature minor	• For a young person/patient under the age of 18 who lacks capacity to make decisions about their day-to-day life or general medical treatment, it is necessary to consider seeking the consent of the pregnant person's parent(s) or guardian before undertaking the proposed treatment, if the pregnant person agrees to the involvement of the parent or guardian in the decision-making process[30]. • If the young person agrees to involve a parent or guardian, the parent or guardian may consent or refuse consent to the performance of the abortion on the patient. • If the minor does not wish for parent/legal guardian involvement or the registered health practitioner is of the view that the parent or legal guardian is not acting in the best interests of the child, the registered health practitioner can apply to the Supreme Court or the Family Court of WA to determine the course of action for the young person. • The young person can access free legal assistance through Legal Aid WA and information should be given to the young person regarding this assistance. • Where another person is seeking the treatment on behalf of a young pregnant person who apparently lacks capacity to give consent, the lawful basis upon which that person purports to represent the young pregnant person will be verified before proceeding with any treatment. • It is a matter for the treating physician to be reasonably satisfied that the person has authority to seek the treatment on behalf of the young person. • Legal advice should be sought in circumstances where legal authority is in question or authority of a court or tribunal is required for abortion.

3.2 Young person less than 14 years

A young person less than 14 years may be considered a mature minor. Assess individual circumstances. Refer to Table 10. Consent.

Table 11. Young person less than 14 years

Aspect	Consideration
Young person less than 14 years	A young person should not be presumed to lack capacity to consent to medical treatment by virtue of their age. In the majority of cases, a young pregnant person under the age of 14 years would require a parent or person having parental authority to provide consent to treatment. However, there may be circumstances where a person under 14 years is deemed to be a mature minor. Mandatory reporting requirements for sexual offences and suspected sexual abuse apply, irrespective of the treatment sought. The health practitioner should consider these requirements carefully[31]. See Table 12 Suspicion of Abuse.

3.3 Suspicion of child harm and exploitation

Table 12. Suspicion of abuse

Aspect	Consideration
Suspicion of harm[32]	Mandatory reporting requirements apply where a child has been, or is likely to be, the victim of a sexual abuse, irrespective of the treatment sought. Section 124(B) of the *Children and Community Services Act 2004*[33] places an obligation on certain people in WA, including doctors, nurses, and midwives, to report cases of child sexual abuse to the Department of Communities Mandatory Reporting Service. A child is a person less than 18 years of age, or who appears to be less than 18 years of age if the person's age cannot be proved[34]. Section 124(A) of the *Children and Community Services Act 2004,* defines sexual abuse in relation to a child, as including sexual behavior in circumstances where: • the child is subject to bribery, coercion, a threat, exploitation, or violence; or • The child has less power than another person involved in the behaviour; or • There is significant disparity in the developmental function or maturity of the child and another person involved in the behaviour. • A mandatory report must be made as soon as reasonably practicable to the Department of Communities after the reporter forms their belief regarding the sexual abuse of the child. The Mandatory Reporting Service can be contacted 24 hours a day 7 days a week by phone on **1800 708 704**[35] to: I. report immediate concerns for the safety of a child II. discuss with a specialist in child protection any grounds on which you have formed a belief that a child has been or is currently being sexually abused III. seek advice on reporting procedures.

Failure to report	• Failure to submit a written report to the CEO of the Department of Communities as soon as reasonably practicable, after the reporter forms their belief regarding sexual abuse of the child, is an offence with a fine ranging from $3000 to $6000.
Reporting requirements[36]	• The health practitioner must, if they form a reasonable belief that a child has been, or is at risk of harm, exploitation, or sexual abuse, report their belief to the Department of Communities. • If a child is at imminent risk of harm or exploitation, call police immediately on **000.** • It is important the health practitioner does not conduct their own investigations or test any allegations at all. The mandatory reporting requirement extends only to reporting a reasonable belief and the basis of that belief. • For additional information and guidance on Mandatory Reporting, child harm or exploitation and domestic and family violence see Department of Communities (wa.gov.au)or the Department of Communities Mandatory Reporting Guide: Western Australia May 2024 (https://www.wa.gov.au/system/files/2024-05/mandatory_reporting_guide_western_australia.pdf).

3.4 Sexual Assault, Family, Domestic and Intimate Partner Violence and Reproductive Coercion

Table 13. Special circumstances

Aspect	Consideration

Sexual assault	• If the pregnancy is reported to have resulted from forced sexual activity, or domestic and family violence (or fear of violence) is disclosed, sensitively discuss options for:
	  ○ Social work support.
	  ○ Relocating, if in continued danger.
	  ○ Routine sexual health checks and treatment as required, and.
	  ○ A medical examination and documentation of findings.
	• Provide abortion healthcare on the basis of the patient's request[37].
	• Ask the patient if they would like a referral to sexual assault counselling. This can be done through the Sexual Assault Resource Centre (SARC), Family Services or Sexual Health Quarters.
	• Contact SARC duty officer on (08) 6458 1820 for more individualised advice.
	• Ask the patient if they would like police involvement. Note that products of conception can be used as DNA evidence, and this can be requested by police and taken as evidence.
	• It is possible that the patient is at ongoing risk of harm. Follow the Statewide-Maternity-Shared-Care-Guidelines (https://kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Clinical-guidelines/Statewide-Maternity-Shared-Care-Guidelines.pdf) to screen for FDV and complete the appropriate risk assessment.
	• See Appendix D FDV Pathway
	• For more information, see the Sexual Assault Resource Centre
	• Support the person's choices for ongoing healthcare and involvement.
	• Following an abortion, Police may submit a written request for fetal tissue – cord

	blood or cord tissue. • Refer to local protocol for forensic specimen collection, storage, and movement requirements to ensure Chain of Evidence is maintained.
Family, domestic, or intimate partner violence and reproductive coercion	Family, domestic, and sexual violence is the use of a range of tactics by an abuser to create vulnerabilities, and to achieve power over a partner through coercive control. This includes physical violence or other forms of violence including emotional and psychological abuse. Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. It includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making, for example: • Controlling or sabotage of another person's contraception. • Pressuring another person into pregnancy • Controlling the outcome of another person's pregnancy, e.g. forcing someone towards abortion, adoption, care, kinship care or parenting. • Forcing or coercing a person into sterilisation, including tubal ligation, vasectomy, and hysterectomy. It is important to be aware that people seeking an abortion might have been exposed to reproductive coercion or family, domestic or sexual violence. If suspected or disclosed, please see Department of Communities Family and Domestic Violence Services and Resources (www.wa.gov.au) for information on support services. Advice can also be sought from the Women's Domestic Violence Helpline or the KEMH Women's Health Strategy and Programs Family and Domestic Violence Toolbox provides information on intimate partner violence and resources. Sexual Health Quarters *Safe to Tell* webpage has a number of resources, e-learning for clinicians and contact and referral information for patients experiencing reproductive coercion and/or intimate partner violence. Safe to Tell - Sexual Health Quarters (shq.org.au) The Royal Australian College of General Practitioners has clinical resources and training on identifying and responding to intimate partner violence RACGP - Intimate partner abuse and violence: Identification and initial response Additional training and resources for reproductive coercion and intimate partner violence include: Reproductive abuse | 1800RESPECT DV Alert Training: https://www.dvalert.org.au/workshops-courses/elearning-workshops/elearning

3.5 Female genital mutilation

Table 14. Female genital mutilation

Aspect	Consideration
Female genital cutting/ mutilation (FGC/M)	• If FGC/M is identified, refer to Female Genital Cutting/Mutilation Clinical Practice Guideline Female Genital Mutilation (https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Clinical-guidelines/Obs-Gyn-Guidelines/Female-Genital-Mutilation-FGM.pdf?thn=0 0). Use clinical judgement and individually assess the clinical and psychological circumstances of each patient. • Refer any patient who has been identified with FGC/M to Social Work to discuss Australian legal requirements. • If deinfibulation indicated, seek specialist advice.

3.6 Documentation of decisions

Table 16. Documentation

Aspect	Consideration
Less than or equal to 23 weeks	The authorised medical practitioner and other health practitioners are required to keep accurate health care records concerning the care and treatment of the patient. Documentation should include: • An assessment of the pregnancy. • A detailed and well documented informed decision-making process and informed consent. • Clinical process to determine successful completion of abortion. • Details of follow up appointments. • Location of the abortion. • Details of discussion of and provision of contraception; and • Completion of a 'Notification of abortion (termination of pregnancy) E-form (available at: https://www.health.wa.gov.au/Articles/A_E/Abortion)
At or after 23 weeks and/or complex case	Both medical practitioners together with a social worker, document: • A complete socioecological assessment of the patient and pregnancy. • Clinical opinion relevant to the patient's medical circumstances and their current and future physical, psychological, and social circumstances and the relevant professional standards followed. • Details of the second medical practitioner who assessed the patient. • A detailed and well documented informed decision-making process and informed consent. • Clinical process to determine successful completion of abortion. • Details of follow up appointments. • Location of abortion • Details of discussion of and provision of contraception; and

	• Completion of a 'Notification of abortion (termination of pregnancy) E-form (available at: https://www.health.wa.gov.au/Articles/A_E/Abortion

3.7 Suspected fetal abnormality

Table 17. Suspected fetal abnormality

Aspect	Consideration

Suspected fetal abnormality	• If fetal abnormality suspected, discuss with the patient:
	  ○ Chromosomal analysis.
	  ○ Histopathology; and
	  ○ Fetal autopsy.
	• Consider referral to Genetic Health WA and/or Maternal Fetal Medicine service at nearest available local health service.

Section 4: Pre-abortion assessment

Offer pre-abortion assessment including details of available counselling and local psychological support services.

Heath practitioners are advised to refer to current RANZCOG Abortion Care Guidelines, as well as the outlined information below, and adapt to individual patient circumstances.

Table 18. Clinical assessment prior to abortion -

Aspect	Consideration
Review history	Discuss request for abortion care in a non-judgemental and supportive manner: • Obtain medical, gynaecological, obstetric, and sexual health history[38, 39] including date of last menstrual period. • Obtain psycho-social history[40, 41] including mental health issues, screening for family and domestic violence (FDV), reproductive coercion and comply with mandatory reporting requirements.

Clinical exam and investigations	• Confirm gestational age and location of pregnancy[42].
	• Undertake a physical exam as indicated by the history and signs and symptoms including:
	  ○ Observations[43, 44] and body mass index (BMI).
	• Undertake routine testing (if not already screened) as indicated for the gestational age including as required for:
	  ○ Haemoglobin, blood group and Rh status to identify Rh negative patients requiring Rh D immunoglobulin[45, 46]

Ultrasound scan (USS)	• An USS is recommended prior to abortion up to 14 weeks gestation if there is uncertainty about gestational age by clinical means, or if there are symptoms or signs suspicious for ectopic pregnancy or other clinical concerns. • Where gestational age has been established by clinical means, the decision about USS prior to abortion should be made according to patient preferences and access to services. • After 14 weeks pregnant, all patients seeking an abortion should have an USS to confirm gestational age and position of placenta if previous uterine surgery. • Consider the persons age, context, and individual circumstances. Inform the patient that USS images and audio will not be shown to them unless requested.

Aspect	Consideration

Sexual health check	• Unintended pregnancy is a sexually transmitted infection(s) (STI) risk. Perform a sexual health check and assess other STI risks including:
	  ○ Condom use.
	  ○ History of STI.
	  ○ Symptoms (e.g. discharge, pain on urination, genital rashes).
	• Noting many STIs are asymptomatic in females and people with vaginas e.g. chlamydia and gonorrhoea, so if high suspicion of STI it is advised to treat on the day of assessment.
	• Gain consent for STI screening as per Department of Health Silver Book guidelines, including syphilis serology Quick guide to STI testing (health.wa.gov.au)[47].
	• Refer also to STI Guidelines Australia STI Guidelines Australia | Australian STI Guidelines website[48] (sti.guidelines.org.au).

Pre-abortion referral coordination	• Facilitate timely referral and coordination with other facilities, disciplines, or agencies[49] as required, for:
	  ○ Specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging).
	  ○ Psychosocial counselling/support:
	  ▪ Especially where risk factors are identified (e.g. young person, people with physical or intellectual disabilities, mental illness (past or current), rape or sexual assault, domestic violence (including sexual violence), fertility issues and religious or cultural beliefs/values).
	  ○ Mental health support/treatment[50].
	• Abortion procedure.

Contraception	• Discuss contraceptive options at the time of initial consultation, abortion procedure or immediately after[51, 52]. • Provide patient information on contraception options Contraceptives-methods-poster (https://kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Patients-resources/Contraceptives-methods-poster.pdf) • Refer to Table 39. Contraception provision.

Additional healthcare	• Consider additional health screening or advice including:
	  ○ Cervical screening test.
	  ○ appropriate for support for any drug and alcohol issues; and
	  ○ Screening for Family Domestic Violence (FDV) or reproductive coercion (see Table 13.

Aspect	Consideration
Follow-up	• Arrange follow-up for review/assessment of [53, 54]: ○ Physical recovery. ○ Emotional issues (and referral for counselling as necessary). ○ Pathology from products of conception including results from fetal autopsy, as indicated; and ○ Discussion and provision of ongoing contraception[55]. • Refer to Table 40. Discharge preparation.

4.1 Psychological support

The decision to abort a pregnancy may be a difficult and sometimes distressing process[56]. Consider the person's psychological, spiritual, and cultural beliefs when providing abortion care. The patient may be clear in their decision, require supportive listening or further psychological support.

Table 19. Information and counselling

Aspect	Consideration
Information	Support the decision-making process by providing accurate, impartial, and easy to understand information including: • Options to continue the pregnancy and parent the child or adoption for the child. Pregnant and considering adoption for your child (wa.gov.au) • Documentation of discussions regarding all options for abortion including public and private facility options and abortion methods based on individual needs and circumstances. • Post-abortion considerations (e.g. contraceptive options and non-judgemental unintended pregnancy counselling support). • Information about local support groups relevant to the circumstances • Birth registration requirements[57] [refer to Table 24 Birth registration]. Refer to RANZCOG Decision Aid to support the decision-making discussion Abortion-Decision-Aid.pdf (ranzcog.edu.au)[58]
Counselling	There is no mandatory counselling requirement prior to obtaining patient's consent to the abortion. The support needs of every person considering abortion of pregnancy will be different. For most, and particularly those accessing early medical abortion, the decision is made early, negative consequences are minimal and there is little disruption to their ongoing lives[59]. However, it may be helpful for patients to access non-judgemental and unbiased counselling both pre and post abortion. Unplanned pregnancy counselling services offer independent and non-judgemental counselling to assist with decision making and post-abortion counselling. These services are free and optional. A list of services is available on the WNHS website with contracts to provide non-judgemental supportive counselling with respect to consideration of pregnancy options and unplanned pregnancy. King Edward Memorial Hospital - Abortion counselling and support (https://www.kemh.health.wa.gov.au/Pregnancy-and-Birth/Abortion/Abortion-counselling)

Aspect	Consideration
Communication	Appropriate communication is an important aspect of abortion care, be sure to: • Allow space to identify if the patient has alternate gender identity. • Use respectful language when referring to the pregnancy. • Refer to the possible father or attending male as 'partner in pregnancy,' unless the person refers otherwise. • Give time for questions to be asked and answered. • Answer questions honestly and respectfully. • Use straightforward and simple language. • Acknowledge and reassure that it is normal to feel a range of emotions (e.g. grief, sadness, relief); and • Involve the multi-disciplinary team if required. DO NOT: • Refer to the pregnancy as 'products of conception' or 'it.' • Refer to the pregnancy as a 'baby' (unless the person does). • Apply judgement for individual motives or reason for abortion. • Imply fault or blame about contraception use/lack of use; or • Try to persuade the patient to change their mind.
Memory creation	If appropriate, discuss with the patient (and if they choose their family and/or other children) options for 'memory creation' which may include: • Photographs. • Hand/footprints. • Holding or bathing; and/or • Copies of USS photographs. • See Table 25 Management of Fetal remains/tissue.

Psychological sequelae

Table 20. Psychological healthcare

Aspect	Considerations
Evidence summary	• There are significant limitations in the evidence examining the relationships between unplanned pregnancy, abortion, birth, and mental health.[60] • Emotional responses following abortion are complex and may change over time. • Adverse psychological sequelae may be no more likely following abortion than following continuation of the pregnancy[61]. • For the majority of mental health outcomes, there is no statistically significant association between abortion of pregnancy and mental health problems[62, 63, 64]. • An unintended pregnancy may lead to increased risk of mental health problems, but it is likely that there are variables in common with risk of mental health problems and unintended pregnancy[65, 66]. • When a patient has an unplanned pregnancy, rates of mental health problems will be largely unaffected whether they have an abortion or go on to give birth. • Patients with a past history of mental health problems may be at increased risk of further mental health issues after an unplanned pregnancy[67].

Recommendation	• Consider the need for non-judgemental support and care for all women and pregnant people, and partners, who request an abortion and discuss:
	  ○ The importance of seeking support if they experience mental distress/anxiety/health issues or suicidal ideations, particularly if there is a reported history of mental health issues.
	  ○ Involve members of the multidisciplinary team as appropriate; and
	  ○ Offer the patient a referral to mental health services, where indicated[68].

4.2 Method selection

A pregnancy may be aborted using a medical or surgical approach or a combination of the two[69].

The choice of method is dependent on the patient and/or practitioner preference, clinical necessity, clinical services availability, service capability, gestational age, transport, support, and a risk assessment of their access to appropriate care in the unlikely event of a medical emergency. For early medical abortion, consideration must be given to the availability of bathroom facilities and supports, a working phone and access to emergency healthcare if required.

Table 21. Methods of abortion

Aspect	Consideration

Medical abortion of pregnancy	• Medications are used to induce the abortion[70].
	• May be considered for all gestations of pregnancy as a sole option or combined with other methods.
	• Mifepristone in combination with misoprostol (or misoprostol alone) are the recommended regimens for medical abortion.
	  ○ These medications are indicated for gestations 63 days or less by the TGA and are taken by patients at home[71];
	  ○ Medical abortions for gestations greater than 63 days are conducted in a hospital or clinic setting as an in-patient.
	  ○ Refer to Table 30 Medical Abortion Considerations after 63 days.

Surgical abortion of pregnancy	Vacuum aspiration or surgical dilatation and curettage is generally suitable up to 12 weeks gestation. Greater than 12 weeks gestation, a surgical dilation and evacuation is performed by an experienced practitioner[72]. • Anaesthesia depends on service capabilities. • Refer to Table 37 Considerations for Surgical Abortion.

Feticide	• Provided by a trained practitioner.
	• Usually performed prior to medical abortion where there is a risk of an unplanned livebirth.
	• Strongly recommended by RANZCOG for all abortions 22 weeks gestation and above as is clinically appropriate[73].
	• Post feticide, a person may be transferred to another facility for passage of pregnancy if:
	  ○ Considered clinically safe.
	  ○ There is a robust referral process.
	  ○ There is comprehensive documentation.
	• Involve the person and the receiving hospital in decisions about transfer.

Selective reduction/selective feticide	• If selective reduction or selective feticide is required in multiple pregnancy, consider the patient's individual circumstances on a case-by-case basis.

Other considerations for method selection

Table 22. Considerations for selection

Aspect	Consideration
Previous uterine surgery	• The method of abortion for pregnant people with previous uterine surgery should be a decision between the person and their clinician as there is increased risks of complications at time of procedure. • RANZCOG recommends that for gestations over 14 weeks an USS is performed to assess for placenta accreta spectrum to assist in planning the appropriate method and location for the abortion to take place.
Service capability	• Service capability and capacity should be considered when discussing method selection, to confirm the patient's preferred method of abortion is available. • Should there be a change to the patient's planned abortion care, due to changes in service capability or capacity, contact the patient immediately and discuss available options.
Risks and complications	• Discuss the complications and risks associated with the differing methods of abortion in a way the patient can understand. • Advise of the overall safety of the procedures[74]. • Make a risk assessment of patient's ability to accurately follow instructions for taking medication, and their access to appropriate care in the unlikely event of a medical emergency. • For early medical abortion <63 days, consider access to working phone and reliable transport, road access and weather conditions, as well as access to safe accommodation, including privacy and bathroom facilities and support for the whole time of the procedure.
Acceptability of method	• Studies show patient's experience (measured in satisfaction levels) with medical and surgical abortion is comparable[75, 76]. • Support the patient to make the decision that is best for their circumstances and preferences. • Consider additional psychological support for the patient where there is a need, for those who receive inpatient care within a maternity setting.

Section 5: Medical and Surgical abortion risks and complications

Complications and risks associated with abortion are rare when performed by qualified medical practitioners[77]. Serious complications are rare, and morbidity is less common with abortion than with pregnancies that are carried to term[78].

Table 23. Risks and complications

Aspect	Consideration
Retained products of conception	• Less common following surgical abortion than a medical abortion and are more common after the first trimester (2–10% of those undergoing abortion in the second trimester)[79]. • Requirement for surgical evacuation of retained products increased following medical abortion, especially with increasing gestation[80].

Infection	Infection occurs in 0 to 2 percent of cases of surgical and less than 1 percent of cases in medical abortion[81].
	• Risk reduced if:
	  ○ Prophylactic antibiotics prior to surgical abortion[82].
	  ▪ [refer to Table 37 Considerations for Surgical Abortion].
	  ○ Lower genital tract infection has been excluded.

Cervical trauma	• Rates vary during surgical abortion, however, risk of damage to the external cervical os at the time of surgical abortion is no greater than 1 in 100[83].
	• Decreased risk with[84]:
	  ○ Experienced clinician.
	  ○ Use of preoperative cervical priming; and
	  ○ Earlier gestations.
	• Increased risk with:
	  ○ Age <18; and
	  ○ Second trimester procedures.

Haemorrhage (requiring transfusion)	• Risk is lower at earlier gestations: ○ First trimester: less than 1 in 1000 abortions[85]; • Greater than 20 weeks: 4 in 1000 abortions[86].

Uterine perforation	• Risk at the time of surgical abortion is 1–4 in 1000[87].
	• Decreased risk of uterine perforation associated with:
	  ○ Experienced clinician.
	  ○ Use of pre-operative cervical priming[88].
	• Earlier gestations.

Uterine rupture	• Uterine rupture is a rare but well described serious complication[89]. • More frequently associated with later gestational ages and previous uterine scar. • Risk is less than 1 in 1000 abortions for second trimester medical abortions[90].

Aspect	Consideration
Continuing pregnancy	• Abortion carries a small risk of continued pregnancy (less than 5%) necessitating another procedure or further intervention. • More likely following early, rather than late abortion and more likely in medical rather than surgical abortions[91]. • A continued pregnancy following an unsuccessful abortion, while uncommon, may lead to fetal anomalies if the pregnancy persists[92].
Future pregnancies	• There are no proven associations between abortion and subsequent ectopic pregnancy, placenta praevia or infertility[93].
Surgery, anaesthetic, or sedation	• Standard risks common to all surgical procedures requiring anaesthetic or sedation. • Consider: ○ Individual circumstances and general health of the patient. • Service capabilities.

Section 6: Fetal considerations

Provide information to the patient (as appropriate to the clinical circumstances) about birth and death registration requirements with the Registry of Births Deaths and Marriages and the management of fetal remains. For information on the state-wide cremation service and funeral requirements see PathWest Perinatal Pathology PathWest - (health.wa.gov.au)

Consider the safety of the pregnant person and if there are concerns regarding access to a birth or death certificate, advise and support the pregnant person to contact the Registry of Births Deaths and Marriages to discuss options. For information on the Bereavement Centre, see PathWest Bereavement Centre

6.1 Birth registration

Table 24. Registration requirements

Gestation/Birth weight[23]	Signs of life	Requirement
Less than 20 weeks AND less than 400 grams[94].	Not live born	• Birth registration not required. • Death registration not required. • Burial/cremation not required. Cremation available through Pathwest at KEMH if desired. • Parent may request a recognition of pregnancy loss certificate.
Less than 20 weeks AND less than 400 grams[95].	Live born who subsequently die	• Birth registration required. • Death registration required. • Burial/cremation required. Births resulting in live born who subsequently dies at any gestation require a private cremation or burial. • Parent may request birth certificate.
Greater than 20 weeks OR more than 400 grams[96].	Not live born	• Birth registration required. • Death registration required. • Burial/cremation required. Cremation available for all births **not** live born under 28 weeks gestation through Pathwest at KEMH. • Parent may request birth certificate.
Greater than 20 weeks OR more than 400 grams[97].	Live born who subsequently die	• Birth registration required. • Death registration required. • Burial/cremation required. Births resulting in live born who subsequently die at any gestation, or stillborn at greater than 28 weeks gestation, require a private cremation or burial. • Parent may request birth certificate.

Note:

- Babies born alive following an abortion are not reportable to the Coroner.
- Midwives are not required to complete a Notice of Case Attendance form for abortions attended; and
- Birth notifications following an abortion are not to be sent to the Chief Health Officer[98].

6.2 Transport and management of fetal remains

Table 25. Management of fetal remains/tissue

Aspect	Consideration

Lawful disposal	• Where birth and death registration is required, burial or cremation of fetal remains is required within a cemetery or at a crematorium[99].
	• Where birth and death registration is not required:
	  ○ Fetal remains and any products of conception (POC) are to be sent to Perinatal Pathology for disposal and cremation.
	  ○ Fetal remains and POC must not be disposed on in anatomical waste bins.

Requests to take fetal remains home	• Fetal remains that do not legally require burial or cremation may be released to the patient for private disposal provided that[100]:
	  ○ There is no risk of transmission of notifiable conditions.
	  ○ The patient has been provided with the Patient Information Sheet detailing how the fetal remains may be disposed and has signed the consent form Patient Information Sheet and Consent Form Authorisation and Release of a Human Fetus or Placenta (health.wa.gov.au)
	
	See Release of Human Tissue and Explanted Medical Devices Policy (health.wa.gov.au) for further information.

Individual preferences	• Recognise that a patient may wish to make their own arrangements for disposal within the legal requirements.
	• Respect cultural and/or religious beliefs.
	• Refer patients to Pastoral care (if available) for information on:
	  ○ The options for disposal.
	  ○ Funeral services that may assist with burial/cremation where birth registration **is not** required, and no death certificate has been issued.
	  ○ Memorial services offered through KEMH.
	  ○ Information on memory making and commemorative options
	  ○ Funeral services that may assist with burial/cremation where birth registration **is** required.
	• Consider the condition of the fetal remains and inform the patient appropriately.
	  ○ Offer social worker or pastoral care support if required.

6.3 Other fetal considerations

Table 26. Fetal considerations

Aspect	Consideration
Live birth	• Provide individualised and holistic care to patients according to circumstances. • If appropriate, discuss the potential for live birth with the patient. • Refer to Definition of terms. • Establish local procedures for the management of live birth, including palliative and comfort care[101]. • Offer counselling and support services to patients, partners and healthcare professionals involved with care of a live born fetus.
Fetal autopsy	• Offer post-mortem examination if clinically indicated (e.g. if fetal abnormality). • Refer to Stillbirth Centre of Research Excellence: *Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death Section 4 Perinatal Autopsy Including Placental Assessment* for more information[102].

Gestations greater than 20 weeks	• Discuss with patient (as appropriate to clinical circumstance) the following:
	  ○ Possibility for live birth.
	  ○ Options for memory creation.
	  ○ Refer to Table 18. Information and counselling.
	  ○ Post-mortem examination, if indicated.
	  ○ Birth registration requirements [see Table 24 Birth Registration requirements].
	  ○ Donation of breast milk to milk banks (where appropriate) or lactation suppression.
	  ▪ Refer to Table 40. Discharge preparation.
	• Involve social workers (e.g. for support, discussion of any costs, funeral arrangements).
	• Offer information about community services (e.g. Red Nose Grief and Loss)

Section 7: Medical abortion

Medical methods of abortion are safe and effective[103]. The below protocol is in line with RANZCOG Clinical Guideline for Abortion Care.

7.1 Practitioner requirements

MS-2 Step (mifepristone, misoprostol)[104] can be prescribed by any medical practitioner with appropriate qualifications and training, without the need for certification, including Nurse Practitioners and Endorsed Midwives for the medical abortion of an intrauterine pregnancy up to 63 days of gestation, in accordance with the Therapeutic Goods Administration (TGA) regulations and the Public Health Act regulations.

It is recommended that practitioners prescribing MS-2 Step have completed the MS-2 Step training. ms2step.com.au | This site is intended for healthcare professionals only.

7.2 Medical abortion precautions

Table 27. Precautions for medical abortion

Aspect	Consideration
Contraindications for medical abortion	• Hypersensitivity or allergy to prostaglandins or a product component[105]. • Suspected or confirmed ectopic pregnancy[106]. • Gestational trophoblastic disease. • Intrauterine device (remove prior to abortion)[107]. • Obstructive cervical lesions (e.g. fibroids). • High suspicion of placenta accreta.

Cautions for medical abortion	• If cardiovascular disease, monitor cardiovascular status as prostaglandins may cause transient blood pressure changes[108].
	• If high risk of uterine rupture:
	  ○ Consider individual circumstances.
	  ○ May not be suitable with history of caesarean section (CS), multiple pregnancies or uterine abnormalities[109].
	• If previous traumatic pregnancy loss (e.g. miscarriage), counsel on blood loss associated with medical abortion[110]:
	  ○ Vaginal bleeding is heavier with medical abortion compared with surgical abortion and may be comparable to a miscarriage.
	• If breastfeeding: abortion medications may cause diarrhoea in the child[111].

Contraindications to mifepristone	• Chronic adrenal failure. • Concurrent long-term corticosteroid therapy. • Known or suspected haemorrhagic disorders or treatment with anti-coagulants[112].

7.3 Early medical abortion in the outpatient setting

Heath practitioners are advised to refer to current RANZCOG Abortion Care Guidelines[113], as well as the outlined information below, and adapt to individual patient circumstances.

Table 28. Healthcare setting

Aspect	Consideration
Context	To identify the most appropriate setting for early medical abortion consider: • Local service capability. • Individual circumstances. • The patient preference; and • Discuss where the person will stay during the abortion (3-4 days). Consider access to working phone and reliable transport, road access and weather conditions, as well as access to safe accommodation, including privacy and bathroom facilities and support for the whole time of the procedure. • Support a decision to access services outside of the patient's local community if requested. • If the patient is eligible for an early medical abortion and does not have access to safe accommodation, they (and an escort) may be eligible for assistance for travel and accommodation through PATS[114]. • Help with travel and accommodation through PATS is also available for patients having a surgical abortion of pregnancy. • Access PATS information through the WA Country Health Website WA Country Health Service - Patient Assisted Travel Scheme - PATS (wacountry.health.wa.gov.au/Our-patients/Patient-Assisted-Travel-Scheme-PATS)
Suggested criteria	If no local criteria established, outpatient care may be suitable for patients who meet all of the following: • Are less than or equal to 9 weeks gestation. • May be accompanied by a support person, who has been adequately informed about what to expect, until the termination is complete[115]; • Have access to private facilities required to have an early medical abortion, including a shower and toilet. • Have immediate access to transport and telephone. • Can communicate by telephone (e.g. have an interpreter available if required). • Have the capacity to understand and follow instructions. • Can access appropriate care in the unlikely event of a medical emergency; and • Have follow-up arrangements in place – for example consider phone coverage and access to a working phone, reliable transport, and road access.

7.4 Early Medical Abortion pre-dosage care

Table 29. Early medical abortion pre-dosage care

Aspect	Consideration

Clinical care	• Perform a pre-abortion assessment:
	  ○ Refer to Section 4 Pre-abortion assessment.
	• Obtain informed consent:
	  ○ Refer to Table 10 Consent.
	• Exclude contraindications and review cautions:
	  ○ Refer to Early medical abortion precautions.
	• Provision of contraception at time of early medical abortion e.g. subdermal contraceptive implant or follow up appointments for IUD insertion and bridging contraception.
	  ○ Refer to Table 39 Contraception
	• Consider the provision of analgesia and antiemetics or scripts for these as per RANZCOG Guidelines.

Communication	• Provide information about: ○ The process (e.g. duration, timing of medication, symptoms, passage of tissue). • Discuss where the patient will stay during the abortion (3-4 days) considering their access and support (e.g. a working phone with coverage, reliable transport, roads, access to safe accommodation, including privacy and bathroom facilities and support for the whole time of the procedure). • Make a risk assessment of the patient's situation, ability to accurately follow instructions and their access to appropriate care in the unlikely event of a medical emergency. • If indicated, discuss collection of products of conception for examination.

Medication side effects	• Provide information about possible medication side effects.
	• Common side effects include[116, 117, 118]
	  ○ Prolonged vaginal bleeding.
	  ○ Nausea, vomiting, diarrhoea.
	  ○ Headache.
	  ○ Abnormal thermoregulation (e.g. hot flushes, low grade temperature); and
	  ○ Abdominal pain and cramps.
	• If a patient is breastfeeding, refer to product information.

Follow-up	• Confirm follow-up arrangements. • Discuss options and preference for contraception. • Refer to Section 9. Medical and Surgical post-abortion care.

7.5 Early Medical Abortion at 63 days gestation or less

MS-2 Step composite pack is suitable for abortions at 63 days or less gestation (9+0 weeks)[119].

Table 30. MS-2 Step for Early medical abortion

Aspect	Consideration

MS-2 Step composite pack[120]	• Consists of:
	  ○ Mifepristone 200 mg (1 tablet containing 200 mg).
	  ○ Misoprostol 800 micrograms (4 tablets, each tablet containing 200 micrograms).

Efficacy	• For patients less than 49 days gestational age[121]:
	  ○ Efficacy: 97.4%.
	  ○ Incomplete abortion, requiring aspiration: 2.3%.
	  ○ Rate of ongoing pregnancy: 0.3%.
	• For patients with a gestational age between 49 to 63 days[122]:
	  ○ Efficacy: 95.2%.
	  ○ Incomplete abortion, requiring aspiration: 4.8%.
	  ○ Rate of ongoing pregnancy: 0.6%.

Pre-dosage care	• Refer to Table 29. Early medical abortion pre-dosage care. • Provide written information about misoprostol medication self-administration[123]. • Supply a prescription for analgesia and antiemetic.
Dose[124]	**Initial dose:** • Mifepristone 200 mg oral. **Subsequent dose:** 36–48 hours after mifepristone: • Misoprostol 800 micrograms buccal or sublingual.

Follow-up	• Follow-up at 14-21 days as per protocol.
	• Confirm expulsion complete[125]:
	  ○ clinical history (abdominal cramping, pain, history of tissue passed).
	  ○ serum β-hCG assay, or urine pregnancy test.
	  ○ no ongoing persistent vaginal bleeding beyond 21 days.
	• Referral for surgical procedure or other follow-up if required.
	• Refer to Table 40. Discharge preparation.

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

20230628-MS2STEP-PI.pdf (mshealth.com.au)

7.6 Medical abortion after 63 days gestation

A combination regimen with a prostaglandin analogue is more effective than use of either medication as a single analogue agent[126].

Care during medical abortion

Table 31. medical abortion considerations after 63 days gestation

Aspect	Consideration
Cautions	• Feticide advised for gestations greater than 22 weeks. • If mifepristone use is contraindicated, seek expert advice on misoprostol-only regimen. • If misoprostol use is contraindicated, consider cervical ripening with transcervical balloon and oxytocin.
Pre-care	• Refer to Table 29 Early medical abortion pre-dosage care. • Baseline observations, vaginal loss, pain prior to commencement. • IV access is recommended. • If Rh negative and gestational age of 10+0 weeks and over, recommend Rh D Immunoglobulin[127]. • Full blood count (FBC), Iron Studies and Group and Hold. • USS
Inpatient clinical care	• Offer analgesia. • Offer antiemetics if required. • Vaginal examination as clinically indicated. • Bed rest for 30 minutes after each dose but may mobilise freely at other times. • Consider oxytocin IM at time of birth. • If the placenta is not spontaneously delivered within 30 minutes of the fetus (or earlier if excessive bleeding occurs) or if blood loss is 300mls or above, notify Senior Medical Officer to consider operative removal.

Observations	• Prior to initial dose of misoprostol and then every 4 hours, unless the patient's condition dictates more frequent observations:
	  ○ Observations, vaginal loss, contractions, assess pain.
	• Post birth, every 15 minutes for the first hour after delivery and then as often as dictated by the patient's clinical condition.
	  ○ Observations, vaginal loss, and conscious state.

Medical abortion for patients at risk of uterine rupture

See Table 21 Considerations for selection. There is a small increase in risk of uterine perforation or rupture for both surgical and medical methods in the second trimester for patients with previous uterine surgery. Refer to local protocol for medical management of abortion in the second trimester[128].

For patients >20 weeks with previous uterine surgery, seek expert opinion on medical abortion protocol and management[129].

Refer to an Australian pharmacopoeia for complete drug information.

Medical abortion regimen for patients not known to be at risk of uterine rupture.

The following medical regime is in accordance with RANZCOG Clinical Guidelines for Abortion Care (2023)[130].

Table 32. Medical abortion with no known risk of uterine rupture

Follow protocol according to gestational age	
Up to 10 weeks weeks	• Day 1: mifepristone 200 mg oral • Day 2: 24–48 hours after mifepristone: ○ Misoprostol 800 micrograms vaginal, sublingual, or buccal.

10+1 – 20 weeks	• Day 1: mifepristone 200 mg oral
	• Day 2: 36–48 hours after mifepristone
	  ○ Misoprostol 800 micrograms vaginal or 600 micrograms sublingual.
	  ○ Repeat doses of misoprostol 400 micrograms (vaginally, sublingually, or buccally) every three hours until expulsion of pregnancy.

Greater than 20 weeks	For medical abortions after 20 weeks pregnant an adjusted regime with lower doses of misoprostol and longer intervals is recommended, in accordance with local guidelines.

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

Section 8: Surgical abortion

Surgical curettage is generally suitable for gestations up to 12 weeks. Gestations beyond this require a clinician with the relevant training and experience[131].

8.1 Surgical abortion pre-procedure care

Table 33. Surgical abortion pre-procedure care

Aspect	Considerations

Clinical care	• Perform a pre-abortion assessment including baseline observations:
	  ○ Refer to Section 4 Pre-abortion assessment.
	• Obtain informed consent:
	  ○ Refer to Table 10 Consent.
	• Consider the need for Rh D immunoglobulin:
	  ○ Refer to Table 38. Post-abortion care considerations.
	• Consider the need for cervical priming[132]:
	  ○ Refer to Table 34. Cervical priming for surgical abortion.

Communication	• Provide information about:
	  ○ The abortion process.
	  ○ What symptoms to expect post procedure including bleeding and pain; and
	  ○ Refer to Table 18 Information and counselling.

8.2 Cervical priming for surgical abortion

Table 34. Cervical priming for surgical abortion

Aspect	Considerations

Rationale	• Cervical preparation decreases the length of surgical abortion procedure.
	• May also[133]:
	  ○ Reduce complications of uterine perforation and cervical injury.
	  ○ Make the procedure easier to perform.
	  Make the procedure more comfortable for the patient.

Options	• Pharmacological agents:
	  ○ Mifepristone and misoprostol.
	  ○ Misoprostol alone.
	• Osmotic dilators:
	  Dilapan-S dilators.

Recommendation	• Recommended:
	  ○ For patients less than 18 years of age.
	  ○ For nulliparous pregnant people.
	  ○ After 12–14 weeks gestation[134] (although may be considered at any gestational age).

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

Misoprostol prior to surgical abortion

The following medical regime is in accordance with RANZCOG Clinical Guidelines for Abortion Care (2023)[135].

Table 35. Misoprostol alone for cervical priming prior to surgical abortion up to 14 weeks gestation.

Aspect	Considerations
Precautions	• Refer to Table 27. Precautions for medical abortion.
Dosage	Dosage and timing of misoprostol prior to surgery may vary based on practitioner preference, gestation, and risk factors for difficult dilatation. Misoprostol can be administered buccally, sublingually, and vaginally. Avoid the oral route due to increased risk of gastrointestinal side effects. Suggested dosing: **1–3 hours prior to surgery** • 400 micrograms vaginally, sublingually, or buccally • If misoprostol is unable to be used, then suggest mifepristone 200mg orally 24-48 hours prior to procedure.

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

Mifepristone and misoprostol prior to surgical abortion

The following recommendation is in accordance with RANZCOG Clinical Guidelines for Abortion Care (2023)[136]

Table 36. Mifepristone and misoprostol for cervical priming prior to surgical abortion from 14 – 24 weeks gestation.

Aspect	Considerations
Precautions	• Refer to Table 27. Precautions for medical abortion. • There may be an increased risk of pre-operative expulsion of pregnancy with mifepristone and misoprostol prior to surgical abortion[137].
Pre-dose care	• May occur as an outpatient (or at home) following pre-abortion assessment. • Provide contact details to the patient in case of emergency.
Recommendation	• For patients having a surgical abortion from 14-24 weeks gestation, it is reasonable to offer either osmotic dilators alone (or in combination with mifepristone), misoprostol alone, or a combine regimen of mifepristone and misoprostol. • It is noted that the addition if misoprostol to osmotic dilators may lead to increased side effects at later gestations without obvious benefit.

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

See Appendix A for considerations for osmotic dilators for cervical priming prior to surgical abortion.

8.3 Surgical abortion of pregnancy

Table 37. Considerations for surgical abortion.

Aspect	Considerations

Methods	• Suction evacuation:
	  ○ commonly performed up to 12+0 weeks gestation.
	  ○ experienced practitioners up to 16+0.
	• Dilatation and evacuation (D&E):
	  ○ usually performed after 12+0 weeks (depending on practitioner experience and equipment availability).
	• Upper gestational limit dependent on practitioner experience[138].

Prophylactic antibiotics	• Intra or perioperative prophylactic antibiotics recommended, for those who have not been appropriately investigated[139, 140]. • In the absence of local protocols consider RANZCOG Best Practice Statement: Prophylactic antibiotics in obstetrics and gynaecology 2021[141]. • If medication allergy refer to Therapeutic Guidelines for alternate antibiotic regime[142, 143]; • Consider opportunistic healthcare including cervico-vaginal screening for STI and syphilis serology. • Refer to Table 17. Clinical assessment prior to abortion.
Anaesthesia	• Method may depend on service capabilities and the patient's choice. • May be performed with or without oral or intravenous anxiolytic. • Analgesics, local anaesthesia and/or mild sedation are usually sufficient.
Oxytocic agents	• May decrease the risks of haemorrhage but not routinely recommended for suction evacuation.
USS	• May be used to check completeness. • Routine use not required at less than 12 weeks[144]. • Routine use with dilatation and evacuation (D&E) to reduce rate of uterine perforation[145].
Examination of tissue	• Examination of the products of conception by the surgeon may assist with recognition of gestational trophoblast[146]. • Examination and identification of fetal parts by practitioner is advised with D&E for confirmation of complete evacuation[147]. • Histopathology if clinically indicated: • Refer to Table 38. Post-abortion care considerations.

Aspect	Considerations
Contraception	• Consider provision of contraception at time of surgical abortion - i.e., insertion of IUD or subdermal contraceptive implant[148]
Side effects	• Pain: analgesia is usually required (e.g. non-steroidal anti-inflammatory drugs). • Bleeding: expected duration 5–18 days[149]. • Nausea: usually related to prostaglandins or anaesthetic drugs[150].
Risks and complications	• Serious complications are rare[151]. • Risk rises with operator inexperience and gestational age[152].
Follow-up	• Recommend follow up (e.g. GP, telephone/video contact, face to face) to discuss: ○ Bleeding. ○ Psychological well-being. ○ Contraception [refer to Table 39. Contraception provision]. • Refer to Table 40 Discharge preparation.

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

Section 9: Medical and Surgical post-abortion care

Most serious complications are detectable in the immediate post-procedure period. Refer to Table 23. Risks and complications. Appropriate and accessible follow-up care is essential[153].

Table 38. Post-abortion care considerations

Aspect	Considerations
Inpatient post-procedural care	• Provide routine post-procedural care including assessment of observations, consciousness, and observation of vaginal loss. • If possible, consider providing inpatient care that is not within a maternity service environment.
Rh prophylaxis*	• Recommend Rh D immunoglobulin (Anti-D) to all Rh D negative patients within 72 hours of abortion >10 weeks gestation[154], unless the fetus is known to be Rh negative. • Anti-D prohylaxis not recommended for medical abortion performed under 10+0 gestation[155]. • Gestations up to 12+6 weeks (SToP) —250 IU Rh D immunoglobulin via intramuscular (IM) injection[156]. • Gestations 13+0 weeks or more—625 IU Rh D immunoglobulin via intramuscular (IM) injection[157]. • If greater than 20 weeks gestation, recommend quantification of feto-maternal haemorrhage (FMH)[158]. • If FMH estimated at 6 mL or more, recommend additional dose according to FMH quantification.
Analgesia	• Individually determine analgesia requirements after surgical abortion or during and after medical abortion, as requirements vary. • Offer medication for pain management[159] (paracetamol and/or ibuprofen often effective). • Advise patients that severe pain may be indicative of uterine perforation or clot retention[160]. • Seek advice if analgesia provided unable to manage pain effectively.
Histopathology	• If clinically indicated or suspicion of fetal abnormality, consider histopathological examination and chromosomal analysis (microarray) of tissue obtained during abortion procedures.

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

9.1 Contraception

Australia has a relatively high rate of unintended pregnancy 40-50%[161]. Australia ranks amongst the highest countries for abortion in the developed world, with 1 in 4 people undergoing an abortion procedure[162].

Table 39. Contraception provision

Aspect	Considerations
Context	• Prevention of unwanted future pregnancies is an important part of the provision of abortion healthcare. • Patients who do not attend follow-up appointments for contraception are at higher risk of unintended pregnancy than patients who have contraception provided at time of abortion[163].

Information	• Ideally, commence discussions about contraception during first contact.
	• Discuss options based on the patient preference including short and long-acting methods.
	• Provide information on side effects, benefits and failure rates of methods using WNHS Contraception information sheet Contraceptives-methods-poster.pdf (health.wa.gov.au)
	• Offer information on benefits of condom use in preventing STI.
	• If contraception declined, offer information (as appropriate to the circumstances) about:
	  ○ Types of contraception available.
	  ○ Accessing local services for contraceptive advice or support; and
	  ○ The importance of prevention of future unwanted pregnancies.

Long-acting reversible contraception	• Significantly less likely to result in unintended pregnancy than short-acting user- dependent methods, such as the oral contraceptive pill[164], [165]. • May be inserted, during a surgical abortion, at time of early medical abortion, i.e. subdermal implant, or at post medical or surgical abortion follow up[166]. • Provide information on what to expect after insertion.

9.2 Discharge preparation and follow-up

Table 40. Discharge preparation

Aspect	Considerations

Counselling and support	• Promote continuity of care to facilitate the development of longer- term support opportunities.
	• Provide information on accessing support agencies/organisations appropriate to individual circumstances (e.g. GP, grief counselling or support groups).
	• Offer referral for counselling, especially where risk factors for long- term post-abortion distress are evident (e.g. ambivalence before the abortion, lack of a supportive partner, psychiatric history, membership of a religious or cultural group where abortion is not an option, or faith or cultural complexities relating to abortion).
	• Offer information and assistance as appropriate regarding birth registration and funeral arrangements:
	  ○ Refer to Table 24. Registration requirements.
	  ○ Refer to Table 18. Information and counselling.

Aspect	Considerations

Lactation	• If appropriate, discuss the possibility of lactation including:
	  ○ suppression (pharmacological and comfort measures).
	  ○ donation of breast milk to milk banks.
	  ○ emotional response to lactation.

Risk of infection	• To reduce risk of infection, recommend (until bleeding ceased) avoiding:
	  ○ Vaginal intercourse.
	  ○ Insertion of tampons or other products into the vagina.
	  ○ Bathing or swimming.

Subsequent pregnancy	• If there are no physical, psychological, health related or other barriers after an abortion, conception can be attempted immediately following the abortion. • If appropriate offer information about pre-conception care (e.g. folic acid, smoking cessation, rubella immunisation if required).
Discharge	• Determine timing of discharge on an individual basis. • Consider routine discharge criteria (e.g. observations, recovery from effects of sedation/anaesthesia). • Supply a prescription for analgesia and/or antiemetics (relevant to method of abortion). • Provide written information regarding post-procedure symptoms and accessing appropriate care in the unlikely event of a medical emergency[167]. Provide a confidential discharge summary to the patient that gives sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications (particularly for people living in rural and remote locations). • Seek consent for discharge summary distribution (e.g. to GP) and for discharge/medical information to be uploaded to My Health Record. Ensure this information is clearly understood as clinics in remote communities are often staffed by friends or family of the patient.

Aspect	Considerations

Follow-up	• After medical abortion, recommend follow-up within 14-21 days[168] (e.g. GP, telephone/video contact, face to face).
	• Various methods recommended to confirm completion of medical abortion[169]:
	  ○ Assessment of symptoms.
	  ○ Quantitative β-hCG.
	  ○ low sensitivity urine β-hCG.
	  ○ USS if indicated.
	• After surgical abortion, offer follow-up based on individual circumstances (e.g. if procedure complicated or additional support required).
	• If appropriate:
	  ○ Schedule follow-up to discuss pathology results, especially where there was histopathology/autopsy for fetal abnormality.
	  ○ Recommend referral to medical specialists (e.g. clinical genetics services).
	• Where follow up is difficult, or uncertain encourage the patient to seek support from GP or local health service for:
	  ○ Passage of tissue.
	  ○ Ongoing bleeding and/or pain.
	  ○ Contraception.

Definitions

The following definition(s) are relevant to these guidelines.

Abbreviations

Term	Definition
β-hCG	Beta human chorionic gonadotropin
FMH	Feto-maternal haemorrhage
GP	General Practitioner
PATS	Patient Assisted Travel Scheme
Rh D	Rhesus immunoglobulin
SARC	Sexual Assault Resource Centre
STI	Sexually transmitted infection(s)
USS	Ultrasound scan

Definition of terms

Term	Definition
Aboriginal and Torres Strait Islander Health Practitioner	A person registered under the Health Practitioner Regulation National Law to practice in the Aboriginal and Torres Strait Islander health practice profession (other than as a student).
Abortion	The *Public Health Act 2016*defines abortion as any act done with the intention of causing the termination of a pregnancy.
Abortion healthcare	In this document abortion healthcare refers to the provision of healthcare by a healthcare professional that supports a patient to abort a pregnancy.
Chief Health Officer (CHO)	The person designated as the Chief Health Officer under Part 2, Division 1, section 11 of the *Public Health Act 2016*.
Coercive control	The use of non-physical tactics and/or physical tactics to make a person subordinate and maintain dominance and control over every aspect of life, effectively removing personhood.
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 patient requesting an abortion of pregnancy. This may include (but is not automatically a requirement of or limited to) issues related to a woman or pregnant person's medical, social, or economic circumstances, capacity to consent, mental health, congenital anomalies, age, or gestation of pregnancy at which termination of pregnancy is requested.
Conscientious objector	A registered health practitioner who declines to advise or provide or participate in a lawful treatment, procedure, or practice, because it conflicts

	with their own personal beliefs and values[170, 171].
Early medical abortion	Early medical abortion refers to medical abortion of pregnancy under 9 weeks (63 days).
Family violence	This term includes the impact violence has on kinship and family ties and the broader community. It can also refer to violence across and within families such as child abuse and elder abuse. Such violence can also involve stressors that lead to self-harm and suicide.
Healthcare professional	Any healthcare provider involved in the care of a patient requesting termination of pregnancy (i.e., includes social worker, counsellor, Aboriginal health worker, liaison officer as well as medical officer and authorised nurse or midwife).
Long-acting reversible contraception	At the time of a surgical termination of pregnancy all forms of long-acting reversible contraception may be inserted including intrauterine devices (Copper bearing or Levonorgestrel varieties) injections or subdermal implants. At the time of medical termination of pregnancy implants and injections may be utilised immediately.
Live birth	Describes a fetus where there are signs of life after birth of the fetus is completed, regardless of gestation or birthweight[172]. Signs of life may include: beating of the heart, pulsation of the umbilical cord, breath efforts, definite movement of the voluntary muscles, any other evidence of life[173, 174]
Multidisciplinary team	Membership of the multidisciplinary healthcare team is influenced by the needs of the patient, 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, psychologist, counsellor, or Aboriginal liaison officer.
Observations	In this document observations includes respiratory rate (RR), blood pressure (BP), heart rate (HR), oxygen saturations (SpO2), temperature (T) and level of consciousness (LOC).
Obstetrician	Local facilities may, as required, differentiate the roles and responsibilities assigned in this document to an 'Obstetrician' according to their specific practitioner group requirements; for example, to gynaecologists, general practitioner obstetricians, specialist obstetricians, consultants, senior registrars, and obstetric fellows.
Patient	Refers to a person receiving or registered to receive medical treatment (in this instance the person requesting the abortion). For noting, in this guideline a patient can otherwise be referred to as a girl, woman/women, young person, young pregnant person, consumer or client.
Patient Assisted Travel Scheme	Referred to as PATS, a subsidy program that provides financial help for travel and accommodation expenses when travelling long distances to see an

	approved medical specialist. The patient accessing termination of pregnancy (and an escort) may be eligible for assistance with travel and accommodation if they do not have access to safe, private accommodation. The patient will be covered under the PATS program until the patient is discharged by a suitably qualified medical practitioner. Any further follow up appointments required for this procedure will also be eligible for PATS.
Performing an abortion	Refer to Section 1.1 Performing of an abortion.
Pregnant person	An inclusive term used in the clinical setting prior to the client revealing preferred pronouns.
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.
Reproductive control	Behaviours that interfere with women or pregnant person's reproductive autonomy as well as any actions that pressurise or coerces a patient into initiating or terminating a pregnancy.
Student health practitioner	In this document, refers to a person enrolled in an approved program of study, undertaking clinical training and who is authorised as a student with their respective Health Practitioner National Board.
Young person	A young person refers to a woman or pregnant person aged less than 18 years.

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National Safety and Quality Health Service standards

National Safety and Quality Health Service standards							
Clinical Governance	Partnering with Consumers	Preventing and Controlling Healthcare Associated Infection	Medication Safety	Comprehensive Care	Communicating for Safety	Blood Management	Recognising & Responding to Acute Deterioration
☒	☒	☒	☒	☒	☒	☒	☒

Appendices

Appendix A: Osmotic dilators for surgical priming prior to surgical abortion.

Aspect	Considerations

Types of osmotic dilators	• Dilapan-S:
	  ○ Synthetic osmotic dilators made of a polyacrylate based proprietary hydrogel (Aquacryl).
	  ○ Achieves close to maximum dilation effect at 4-6 hours – most suited for same day evacuation.
	  ○ More predictable dilatation compared to Laminaria[175].
	• Laminaria:
	  ○ Non-synthetic osmotic dilators made up of dehydrated and sterilised stems of the seaweed Laminaria Japonica and Laminaria Digitata.
	  ○ Achieve maximum dilation effect at 12-24 hours.
	  ○ Dilators should not be left in place for more than 24 hours[176].
	  ○ Theoretical risk of allergy and infection due to organic material[177].

Indication	• Osmotic dilators are a suitable non-pharmacological method of cervical priming prior to surgical abortion after 14+0 weeks gestation. • Osmotic dilators are the preferred method of cervical priming after 19+0 weeks.
Timing	• Offer insertion of osmotic dilators (with or without adjuvant mifepristone or misoprostol) the day before the surgical abortion. • Osmotic dilators can be used in setting of ruptured membranes, with appropriate antibiotic cover[178]. • Osmotic dilators can be used in setting of placenta praevia[179]. • There is no clear evidence to guide the appropriate number of osmotic dilators required for cervical ripening. The number of osmotic dilators inserted tend to increase with gestation but is often based on provider experience and preference[180]. • For gestations over 20+0, further insertion of osmotic dilators may be required if adequate dilatation is not achieved. • A surgical abortion following same day insertion of osmotic dilator, usually 4-6 hours prior to procedure, should only be performed by experienced practitioners. Consider Dilapan-S over Laminaria, and use of adjuvant mifepristone or misoprostol, when considering dilation and excavation of same-day insertion of osmotic dilators[181].

Aspect	Considerations
Combination with mifepristone or misoprostol	• Practitioners may combine use of osmotic dilators with mifepristone or misoprostol for improved cervical ripening and reduced duration between cervical ripening and surgical abortion to accommodate time constraints of patient and health service, especially after 19+0 week gestation. • Combined use of mifepristone AND misoprostol may increase risk of pre-procedural expulsion of fetus[182]. • Mifepristone can be given the same day of osmotic dilator insertion, if used as adjuvant cervical priming agent. • Buccal or sublingual misoprostol should be given 3 hours before surgical abortion if used as adjuvant cervical ripening agent[183].
Anaesthesia	• Method may depend on service capabilities and the patient choice. • May be performed with or without oral or intravenous anxiolytic. • Analgesics, local anaesthesia and/or mild sedation are usually sufficient.
Prophylactic antibiotics	• Prophylactic antibiotics are not required during insertion of the synthetic osmotic dilator, Dilapan-S. • The product information for Laminaria recommends prophylactic antibiotic with insertion of Laminaria[184].
Precautions	• Migration and fragmentation of osmotic dilators may result in retained dilators in the uterus. Although rare, retained osmotic dilators can lead to infection and bleeding complications. • Advise patient to collect and bring with them on the day of procedure any osmotic dilators that have been spontaneously expelled.

Appendix B: Aboriginal Clients: Cultural Considerations

WA Health recognises that a culturally safe and responsive health system is imperative to ensuring Aboriginal and Torres Strait Islander (Aboriginal[1]) West Australians receive the healthcare required to significantly improve health and social and emotional wellbeing outcomes. To ensure the unique rights and needs of Aboriginal people are recognised, the provision of culturally secure and respectful care[185] will embrace a strengths-based paradigm[186], kinship and Aboriginal culture as a protective factor. For Aboriginal girls and women, childbearing maintains culturally significant ancestral and familial connections[187]. A decision to terminate a pregnancy is impactful. This can be immediately or in the long-term.

Recognition of intergenerational, institutional, collective, and historical trauma is important. In addition, racism, cultural load[188], and the differences between mainstream systems and more holistic Aboriginal understandings of social and emotional health and wellbeing[189], need to be understood and respected.

Women's Business

Aboriginal women continue their support and nurturing of a young girl until she becomes a woman, when she then provides the same role to younger generations of girls. This special knowledge is preserved through women's business[190].

For Aboriginal women or girls, to terminate a pregnancy by having an abortion can be regarded as a sensitive and complex topic. To be supportive, where possible, offer access to female medical health practitioners. Where this is not possible, offer the Aboriginal women or girls to nominate a female support person to be present for all parts of the health care journey, if she feels she needs this level of support.

The power of kinship and spiritual safety

There is significant power in Aboriginal kinship connections which supports the holistic strengthening of women's wellbeing. Strong kinship systems are known to improve the maternal health of Aboriginal girls and women[191].

Culturally Safe Practices

Provide culturally safe practices and support for girls and women who identify as Aboriginal is critical. Improving cultural safety can improve access to, and the quality of health care. This manifests as a health system that demonstrates respect for Aboriginal cultural values, strengths, and differences, and also addresses racism and inequity. Importantly, it requires self-understanding, truly knowing and accepting our own culture and its influence on how we think, feel, and behave. The impact of one's dominant culture on another is complex - and often goes unquestioned - but lies at the heart of cultural safety.
This can be supported via formal professional development and training of all staff in cultural awareness.

Cultural responsiveness

Cultural responsiveness is the active approach taken by individuals, organisations, and systems to promote and maintain cultural safety. It is a negotiated process of what constitutes culturally safe health care as decided by the woman receiving the care. It requires strengths-based approaches and recognises that if culture is not factored into health care and treatment, the quality and probable impact of that care and treatment is likely to be diminished[192].

Having a yarn can be helpful when a girl or woman is thinking about their care options and deciding the best way forward. To ensure a culturally safe and responsive practice is provided, below is a list of considerations for guidance. It is essential to:

[1] Use of the word "Aboriginal" Using the term – Aboriginal Within Western Australia, the term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of Western Australia. "Aboriginal and Torres Strait Islander" may be referred to in the national context, and "Indigenous" may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

- Ensure that all support is provided with confidentiality for the Aboriginal woman, or girl (noting Section 3.2 of the Guidelines). Ensure this is said openly to provide assurance, reduce shame and stigma. Ensure your organisational Code of Conduct is adhered to.
- Yarn with the Aboriginal woman or girl about what is best for them. If consented to, include support people such as a partner, the young girl's parent/s, or others.
- Respect an Aboriginal girl's or woman's cultural identity while providing good communication, empowerment in decision making and inclusion of supportive people valued in her care.
- Offer support from female culturally appropriate staff, such as an Aboriginal Health Practitioner or an Aboriginal Liaison Officer. Or offer co-care with female health practitioners from mainstream health support services or an Aboriginal Community Controlled Health Organisation.
- Be mindful of coercion. Remind a woman they are in control of their decisions and body. Provide additional information particularly if terminology is not new to the woman or girl. Offer support and if appropriate, ask if they would like a referral for aftercare support.
- Understand cultural determinants of health[193], the strength and importance of family, kin, the impact for a girl or woman being 'off-country' particularly the differences of cultural practice, or if unaccompanied by family and other support people.

In WA, practitioners operate with the Australian Health Practitioner Regulation Agency (AHPRA) registration system. The creation of a culturally safe notification process, led by Aboriginal and Torres Strait Islander Peoples, is a major milestone[194] in the implementation of the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025[195] and aligns to:

- AHPRA Aboriginal-and-Torres-Strait-Islander-Employment-Strategy-2020-2025[196]
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health[197]

In WA, each Health Service Provider provides direction to staff by:

1. having a Code of Conduct
2. implementing policy and strategic direction, such as but not limited to:
    a. WA Health and Wellbeing Framework 2015 - 2030[198]
    b. National Agreement on Closing the Gap[199], in particular the priority reforms[200]
    c. WA Aboriginal Empowerment Strategy[201]
    d. Aboriginal Health Impact Statement and Declaration Policy[202]
3. providing education and training to uplift cultural competency of staff.

Appendix C: Culturally Diverse Clients: Cultural Considerations

The WA Department of Health (WA DoH), Clinical Excellence Division has a Cultural Diversity Unit (CDU) within the Health Networks Directorate. The CDU develops and promotes policies, practices and services that strengthen the cultural competency of WA health staff, and improves accessibility, safety, and quality of services for people of culturally and linguistically diverse (CaLD) backgrounds. This includes improving health literacy and better health outcomes for CaLD communities.

Many resources for health professionals can be found on the WA DoH website: Multicultural health[203] and within the 'Resources and services' section is a link to the 2015 Resource toolkit for refugee and migrant women accessing maternity services[204]. The toolkit is to support clinicians to deliver timely, safe, quality, and competent care for refugee and migrant women.

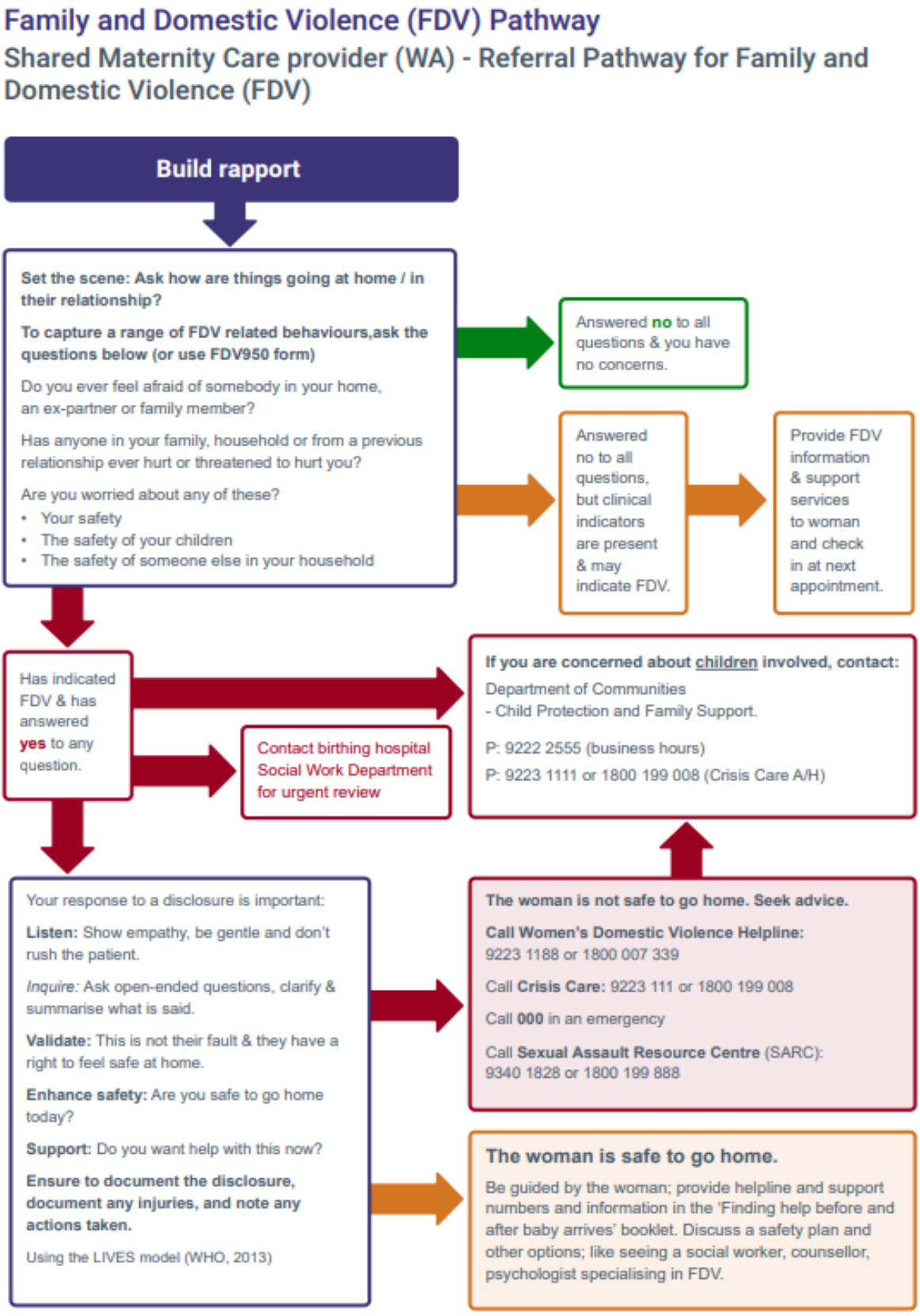
Whilst dated, the principles and overarching guidance in the toolkit remains relevant and useful for clinicians to refer to. However, abortion is not mentioned in the toolkit.

Therefore, the following checklist has been provided by the WA DoH in consultation with CaLD community organisations to assist those caring for women and families requiring abortion care.

MULTICULTURAL ABORTION CARE CONSIDERATIONS CHECKLIST

- The individual seeking care has been provided with opportunity to codesign the plan of care.
- To the extent that the individual wants support and consents to appropriate community representation from spouse, family members, and community leaders is enabled.
- Care is provided in the context of cultural needs and with sensitivity to the individual's own level of engagement and interpretation of the cultural community societal norms (mores).
- General community policy has been adapted to meet the individuals own cultural needs.
- Care providers consider the specific needs of CaLD groups when developing and evaluating operational policy.
- Communication is clear and accessible for the individual and as appropriate, their spouse, family members, and community leaders. It is important to note that often it is only the men in the family who learn English and the person requiring abortion care may not want a man to be aware. It is therefore essential that all care is described and planned in language that is accessible to the individual requiring the service and if needed always via professional interpretation services.
- The health care providers caring for this person have had cultural awareness training supported by as a minimum:
    - a multicultural competency and capacity framework
    - access to professional language services.

Appendix D: Family and Domestic Violence (FDV) Pathway



Appendix E: Acknowledgements

Acknowledgements - Queensland

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Cultural Consideration Statement development

The Western Australian, Department of Health gratefully acknowledge the contribution of the following for the development of the cultural considerations statement for this guideline version:

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Appendix C - Culturally Diverse Clients: Cultural Considerations

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