Northern Territory Clinical Guideline

Approval Date: 8 December 2022

Termination of Pregnancy

Contents

NORTHERN TERRITORY GOVERNMENT

Applicability

This guideline must be considered by:

- Health professionals in the Northern Territory public and private maternity and neonatal services, primary health services and remote health services.

This guideline must be/must not be used for the following:

- N/A

Guideline statement

'Termination of pregnancy' under the *Termination of Pregnancy Law Reform Act 2017 (NT)* (the Act)[1] means intentionally terminating a person's pregnancy.

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

This guideline is set by the Northern Territory (NT) Chief Health Officer (CHO) in accordance with section 18(g) of the *Termination of Pregnancy Law Reform Act 2017 Act* (the Act) and regulation 6 of the *Termination of Pregnancy Law Reform Regulations 2017* (the Regulations). Medical practitioners must have regard to this guideline in the performance of terminations.

Relationship to parent policy

The Termination of Pregnancy Law Reform Act 2017 (the Act) commenced on 1 July 2017. The Act enabled reasonable, safe and equitable access to termination of pregnancy in the NT and allowed termination of pregnancy to be lawfully performed in the NT, both within and outside of hospital settings.

A 2018 review of the Act, resulted in recommendations to support improved access to termination services, streamline administrative processes and further align to national professional standards and legislation. The Act was subsequently amended on 16 December 2021 and included amendments to:

- Remove the requirement for two suitably qualified medical practitioners to assess a woman who is between 14 and 23 weeks gestation.
- Increase the gestational upper limit for one medical practitioner performing a termination from 14 weeks to 24 weeks gestation.
- Allow terminations after 24 weeks gestation following consultation between two authorised medical practitioners.
- Remove the requirement for medical practitioners to additionally verify their credentials to the Northern Territory Chief Health Officer (NT CHO), in addition to fulfilling professional registration requirements.

The Act is supported by the *Termination of Pregnancy Law Reform Regulations* (the Regulations). The Regulations empower the CHO in relation to:

- The setting of standards and guidelines in relation to the performance of a termination of pregnancy or the provision of termination of pregnancy services.
- Provision of prescribed information by practitioners within 28 days (20 penalty units); and
- Confidentiality of information relating to the termination of a woman's pregnancy and intentionally disclosing this information (100 penalty units).

The Chief Health Officer's prescribed information does not include any personal information that identifies the patient and assists in assessing if the Act is achieving its goals.

For copies of the Act and Regulations visit legislation.nt.gov.au

Guideline details

Cultural acknowledgement

We acknowledge the Traditional Custodians of the land on which we work and pay our respect to the Aboriginal Elders past, present and emerging.

Disclaimer

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

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

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

Recommended citation:

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NT Health acknowledges and thanks Queensland Health for developing and providing this evidence based clinical guideline, which NT Health have adapted for the Northern Territory legislation, context and people. For further information, contact Queensland Clinical Guideline, RBWH Post Office, Herston Qld 4029, email Guidelines@health.qld.gov.au. For permissions beyond the scope of this licence, contact: Intellectual Property Officer Queensland Health, GPO Box 48, Brisbane Qld 4001, email ip_officer@health.qld.gov.au.

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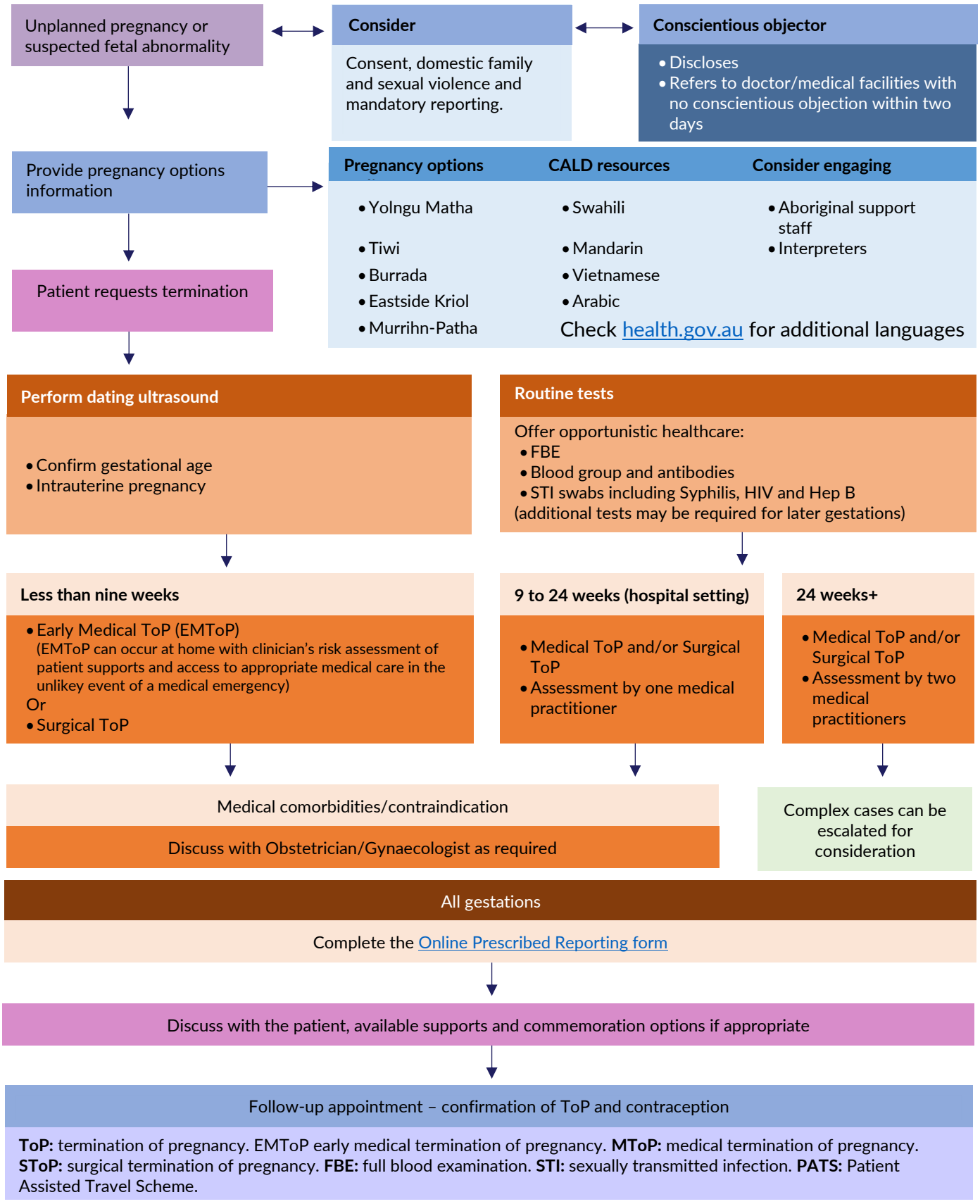
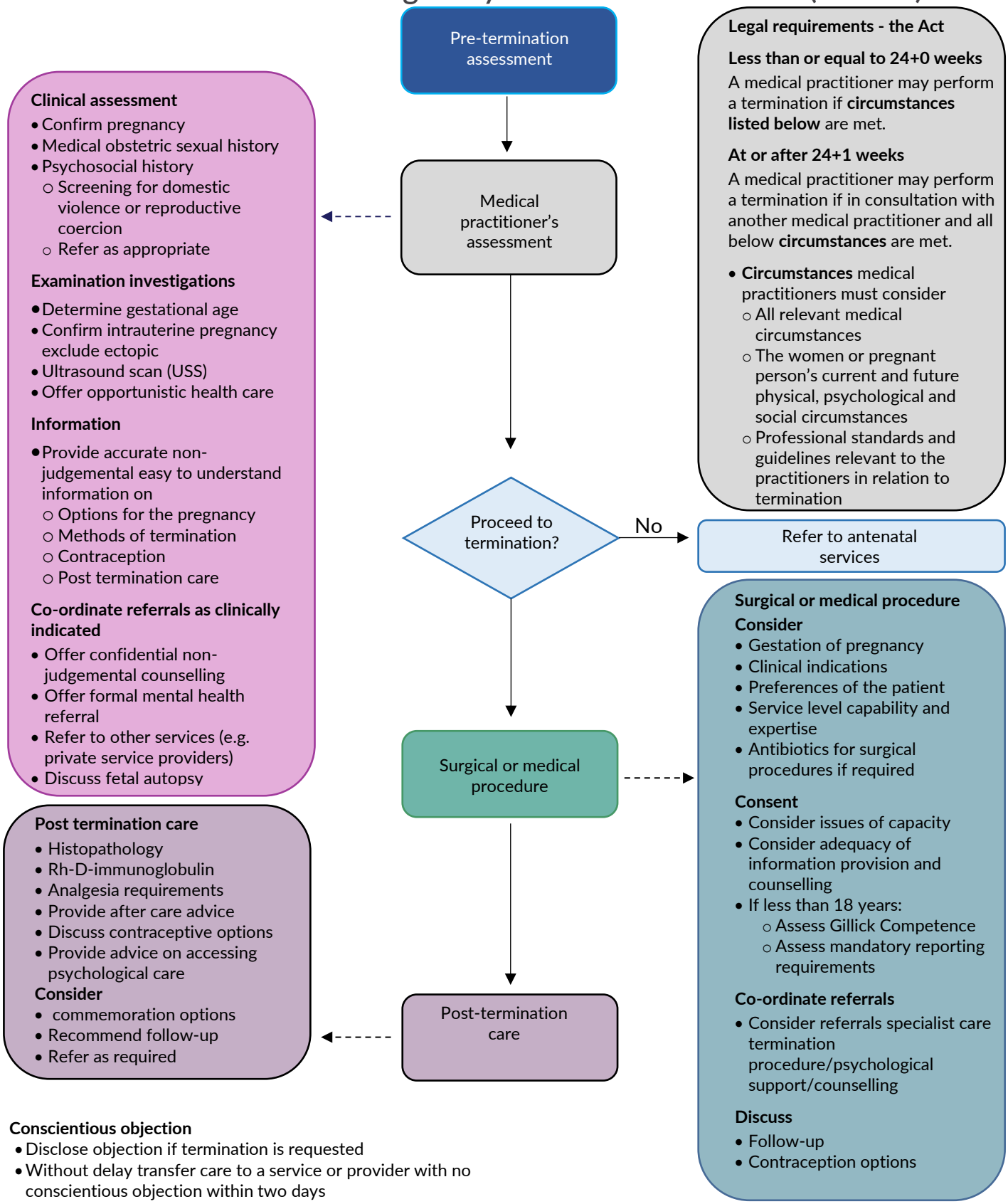
Website: health.nt.gov.au

Termination of pregnancy (ToP) service pathway summary



ToP: termination of pregnancy. EMToP early medical termination of pregnancy. **MToP:** medical termination of pregnancy. **SToP:** surgical termination of pregnancy. **FBE:** full blood examination. **STI:** sexually transmitted infection. **PATS:** Patient Assisted Travel Scheme.

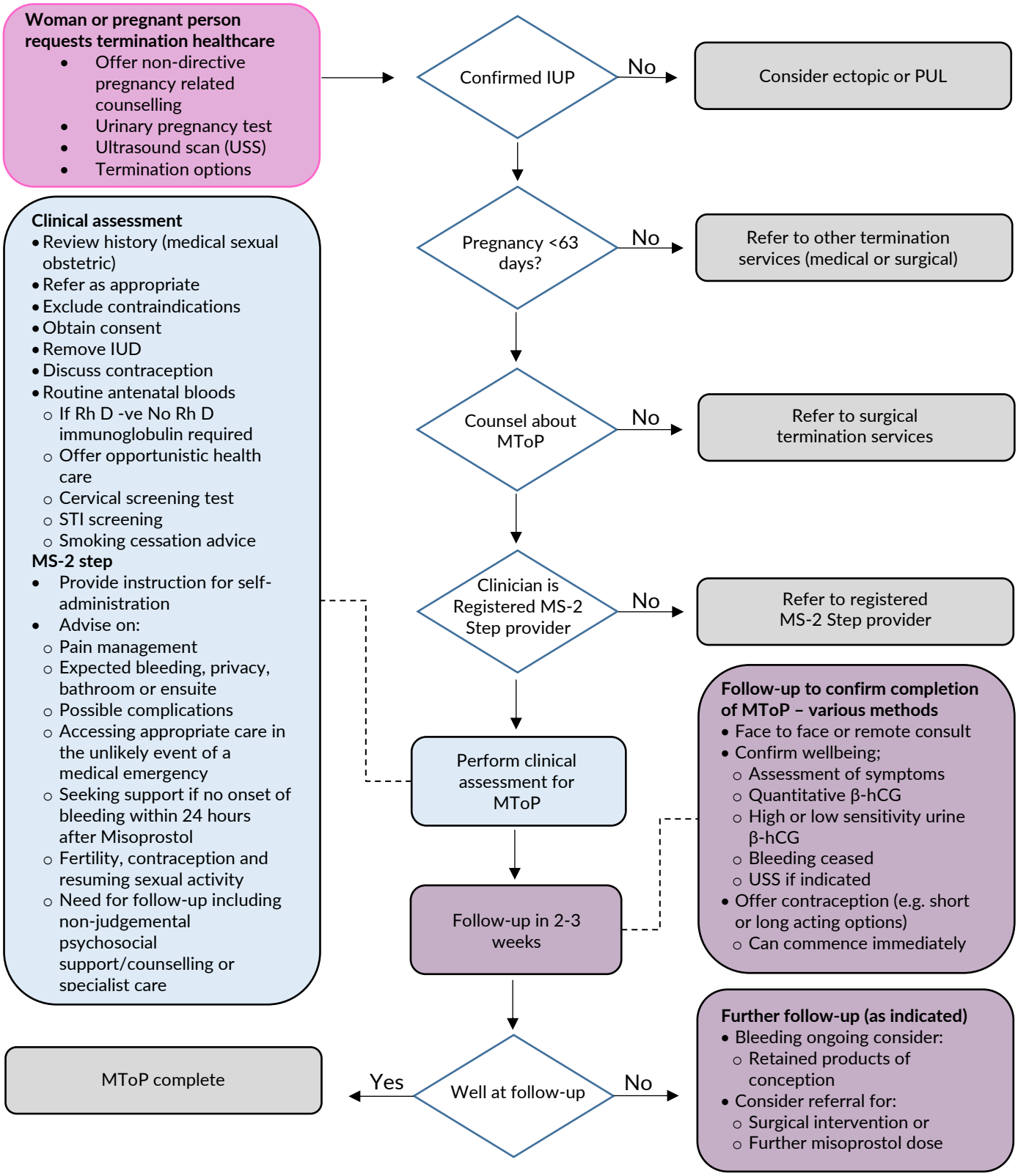
More Flow Chart: Summary of termination of pregnancy healthcare under the Termination of Pregnancy Law Reform Act 2017 (the Act).



Conscientious objection

- Disclose objection if termination is requested
- Without delay transfer care to a service or provider with no conscientious objection within two days

Flowchart: Medical termination with MS-2 Step



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

Northern Territory Law

Performing a termination

Table 1. Performing a termination

Aspect	Definition
Context	Performing a termination is defined in the Act as follows: A medical practitioner who does any of the following, intending to induce an abortion, performs a termination: • Performs a surgical procedure. • Prescribes, supplies or administers a termination drug. • Any other action. An Aboriginal health practitioner, a midwife nurse or pharmacist assisting in the performance of a termination by supplying or administering, under the direction of a medical practitioner, a termination drug, knowing it is intended to induce an abortion. A pharmacist must be certified in accordance with TGA licensing conditions through MS Health before ordering termination of pregnancy medication. A pharmacist can assists in the performance of a termination by supplying, under the direction of an authorised medical practitioner, a termination drug, knowing it is intended to induce an abortion. The pharmacist must provide adequate pharmaceutical information to the patient and/or her support person to ensure the safe and effective use of the drugs in a manner that protects the person's privacy.
Healthcare included in *performing a termination*	Expert clinical recommendation is that *performing a termination* commences when the therapeutic intervention of termination starts and includes: • Dispensing, supplying or administering a termination drug on a medical practitioner's instruction. • Feticide or a surgical procedure of termination performed by a medical practitioner. • Feticide or a surgical procedure of termination assisted by an authorised or student healthcare practitioner [refer to Table 3. Assisting with a termination].
Healthcare not included in *performing a termination*	Expert clinical recommendation is that *performing a termination* does not include clinical care provided before or after performing a termination including, for example: • Clinical assessment, pre-operative preparation, referral or non-directive counselling, intrapartum or postpartum care after feticide or after administration of a termination drug; • Refer to Table 17. Clinical assessment prior to termination; and • Refer to Table 39. Post-termination care considerations.

Medical practitioner responsibilities

The legal responsibilities for the medical practitioner in relation to performing a termination, are specified according to the gestational age of the pregnancy.[4]

Table 2. Medical practitioner responsibilities

Aspect	Lawful action
Context	NT Health considers that: • 'Not more than 24 weeks' means less than or equal to 24+0 weeks. • 'More than 24 weeks' means at or after 24+1 weeks. Use clinical judgement when determining gestational age in individual circumstances
Less than or equal to 24 weeks gestation	A medical practitioner may perform a termination on a woman who is not more than 24 weeks pregnant, if the medical practitioner considers the termination is appropriate in all the circumstances, having regard to: • All relevant medical circumstances; and • The person's current and future physical, psychological; and • Social circumstances; and • Professional standards and guidelines.
At or after 24 weeks gestation	A medical practitioner may perform a termination on a woman who is more than 24 weeks pregnant after consulting with another medical practitioner who has also assessed the woman and both medical practitioners[5] consider the termination is appropriate in all the circumstances having regard to: • All relevant medical circumstances; and • The person's current and future physical, psychological and social circumstances; and • Professional standards and guidelines.

Authorised and student health practitioners assisting

Assisting in the performance of a termination includes prescribing, supplying or administering a termination drug under the direction of a medical practitioner.

Table 3. Assisting with a termination

Aspect	Lawful action
Authorised health practitioners	An authorised health practitioner means a person authorised under one of the following health professions within the meaning of the Health Practitioner Regulation National Law (other than as a student): • Aboriginal health practice; • Medical; • Midwifery; • Nursing; or • Pharmacy.
Student health practitioner	Student health practitioners are permitted to assist in the performance of a termination[7] to the extent necessary to complete the student's program of study under supervision of: • A medical practitioner performing the termination; or • An authorised health practitioner lawfully assisting in the performance of a termination; or • The student's primary clinical supervisor.

Conscientious objection

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

Table 4. Conscientious objection

Aspect	Lawful action
Relevant to	Authorised medical practitioners and those they direct including; authorised Aboriginal health practitioners, authorised midwifes, authorised nurses or authorised pharmacists who have a conscientious objection[13] to the performance of a termination and who are asked by the authorised medical practitioner to:[4] • Perform or assist with the performance of a termination; • Make a decision whether a termination should be performed; or • Advise a person about the performance of termination on a patient.
Disclosure of objection	Authorised health practitioners must disclose their conscientious objection to the requesting person[4]. For example: • If a medical practitioner asks for assistance from a nurse who holds a conscientious objection, the nurse must disclose this to the medical practitioner; and • If a patient requests performance of a termination from a medical practitioner who holds a conscientious objection, the medical practitioner must disclose this.

Referral or transfer of care	This section applies if a patient requests a medical practitioner to advise on a proposed termination or perform a termination on them, and the medical practitioner has a conscientious objection.
	The medical practitioner must:
	• Inform the patient of their conscientious objection in relation to the termination contemplated by the patient; and
	• Refer the patient, within a clinically reasonable time, to another medical practitioner known by the medical practitioner not to have a conscientious objection in relation to terminations; and
	• Refer or transfer to avoid delays in care provision:
	  ○ Promptly (i.e. during the presentation in which the request is made); and
	  ○ To the nearest/most convenient authorised health practitioner or termination service provider.

Duty to perform or assist when necessary to save life	Despite any conscientious objection in relation to terminations, a medical practitioner is under a duty to perform a termination in an emergency where the termination is necessary to preserve the life of the patient. Despite any conscientious objection in relation to terminations, an Aboriginal health practitioner, a midwife or a nurse is under a duty to assist a medical practitioner in an emergency where a termination 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 termination. Refer to Section 2.1 Performance of a termination.

Emergency care involving termination

Table 5. Emergency care

Aspect	Lawful action

Medical practitioner	• In an emergency, a medical practitioner is under a duty to perform a termination in an emergency where the termination is necessary to save the patient's life.
	• If the pregnancy is greater than 24 weeks, they may perform the termination:[4]
	  ○ 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 a termination in the circumstances outlined above[4].
Conscientious objectors	Despite any conscientious objection in relation to terminations, a medical practitioner, Aboriginal health practitioner, a midwife or a nurse is under a duty to perform a termination in an emergency where the termination is necessary to preserve the life of the patient.

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 a termination occurs.[4]

Table 6. Safe access zone

Aspect	Lawful action
Premises for performing terminations	Premises for performing terminations means premises where either or both of the following take place: • Terminations are performed by medical practitioners. • Health practitioners assist in the performance of terminations; but • Does not include a pharmacy.
Safe access zone	Safe access zone means the area: • Within the boundary of premises for performing terminations; 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, that may result in deterring the person from:
	  ○ Entering or leaving premises for performing terminations; or
	  ○ Performing, or receiving, a termination at premises for performing terminations.
	And An act that could be seen or heard by a person in the vicinity of premises for performing
	terminations, that may result in deterring the person or another person from:
	• Entering or leaving the premises; or
	• Performing a termination, or receiving a termination at the premises.

Non-compliance with the Act

Table 7. Non-compliance

Aspect	Lawful action
Offences	Termination is considered a health procedure. A person commits an offence if: • The person intentionally engages in prohibited conduct; and • The prohibited conduct occurs in a safe access zone and the person is reckless in relation to that circumstance. Maximum penalty: 100 penalty units or imprisonment for 12 months. As for other healthcare, the following may also apply: • Professional and legal consequences for non-compliance with the Act. • Laws for duty of care, reasonable skill and care. • Civil or criminal responsibility for harm that results from a failure to act with reasonable skill and care.
Professional conduct	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.

Clinical standards

Service provision

Table 8. Service provision

Aspect	Considerations

Access to termination healthcare	• Patients requesting termination require assessment by an authorised health practitioner who is not a conscientious objector.
	• Refer to Table 4. Conscientious objection.
	• Where termination 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.
	• If required, access and provide appropriate interpreter services.
	• Provide documented information to consumers, external service providers and support agencies within the local Hospital and Health Service (HHS) on the choices available within the service, and on routes of access to these services.
	• Facilitate access (including via patient travel subsidy scheme, when required) as early as possible and without delay to:
	  ○ Reduce the likelihood of associated health risks.
	  ○ Support the patient in their preference for a termination procedure that may be impacted by gestational age limitations.
	• The patient accessing termination of pregnancy (and an escort) may be eligible for PATS if they do not have access to safe, private accommodation.

Aspect	Considerations
Referral	• Document referral pathways within and between HHS's (e.g. between departments within a facility, between facilities, and between a facility and external agencies or general practitioners (GP)). • Consider engagement with territory wide 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 termination (e.g. emergency departments, GPs) about referral pathways. • If there is a conscientious objection to the performance of a termination, act in accordance with Table 4. Conscientious objection. • Where the patient considers but does not proceed to termination, provide information and access to appropriate referral pathways (e.g. access to a social worker, referral for antenatal care, 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 termination is dependent on the: • Method of termination chosen; • Gestation of the pregnancy; • Preferences of the patient and their care provider; • The service capabilities of the facility; • Access to a working phone, reliable transport, road access and weather conditions; • Access to safe and private accommodation, including ensuite 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.

Workforce support

Table 9. Workforce support

Aspect	Considerations
Healthcare professionals	• For healthcare professionals involved in the provision of termination healthcare, provide: ○ Ongoing training and education.[9] ○ Access to non-judgemental counselling and debriefing support.
Student health practitioners	• Support access to information on: ○ Northern Territory Law and the Act. ○ Conscientious objection rights and responsibilities. ○ Contemporary approach to termination healthcare provision. ○ Sensitive communication and confidentiality. ○ Cultural considerations. ○ Other matters relevant to the clinical placement. • If the student health practitioner holds a conscientious objection, support: ○ Alternative clinical learning. ○ 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.

Individual case considerations

Termination 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 termination healthcare are advised to familiarise themselves with their legal responsibilities under the Act.[4]

Consent

See Consent to Treatment - NT Health Policy

Table 10. Consent

Aspect	Considerations
Consent	Where a patient is seeking to terminate 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. NT health practitioners must follow usual consent processes as set out in the NT Health Consent to Treatment Policy including: • Assessment of capacity. • Discussion of available methods of termination.

Aspect	Considerations
	• Risks and complications of each method of termination. • Access to a working phone, transport, road access, a private ensuite and supports. • Risk assessing 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 5(2) of the *Guardianship of Adults Act 2016*). 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.
Adults who lack capacity	A person over 18 years of age who lacks the capacity to provide informed consent to a procedure for termination of pregnancy cannot consent to termination of pregnancy. The process to obtain a decision on the termination or pregnancy for an adult who lacks capacity depends on the individual circumstances. Under normal circumstances a guardian, health care decision maker under an Advance Personal Plan or next of kin cannot provide consent to a termination of pregnancy. The exception is if the termination occurs as a result of healthcare action primarily to treat an illness or injury. Termination of a pregnancy of an adult who lacks capacity is a complex case and it is strongly recommended the medical practitioner seek legal advice. Medical practitioners employed by NT Health should contact Legal Services, via the NT Health email: DoHLegal.THS@nt.gov.au. Under emergency circumstances section 10 of the Act and the provisions of the *Emergency Medical Operations Act 1973* apply.
Young person who is *Gillick* competent[11]	A young person is considered *Gillick* competent when they demonstrate sufficient maturity and intelligence to enable them to understand fully what medical treatment is proposed.[10,11] • A *Gillick* competent young person can consent to medical procedures, in the same way as an autonomous adult with capacity. • The decision about whether a young person is *Gillick* competent is a matter for the treating practitioner. • Consider additional elements of informed consent when obtaining consent from a *Gillick* competent young person (e.g. the ability to freely and voluntarily make decisions without coercion). • The law requires that when a young person assessed as *Gillick* competent chooses not to include their parents/guardians in consultation, this must be respected, and confidentiality not breached.

Aspect	Considerations
	• Involve appropriately skilled healthcare professionals for assessment of *Gillick* competency, psychosocial assessment and family court matters where clinically indicated.
Young person who is not *Gillick* competent	• For a young person 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 female or pregnant person's parent(s) or guardian before undertaking the proposed treatment. • It is recommended that legal advice is sought if there is any doubt about the capacity of a young female pregnant person to consent to the proposed treatment and no other person is representing them or presenting orders permitting the proposed treatment. • Where another person is seeking the treatment on behalf of a young female pregnant person who apparently lacks capacity to give consent, the lawful basis upon which that person purports to represent the young female 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 termination.

Young person less than 14 years

A young person less than 14 years may be considered *Gillick* competent. 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 female pregnant person under the age of 14 years should not be presumed to have capacity to give consent to medical treatment. In the majority of cases, a young female pregnant person under the age of 14 years would require a parent or person having parental authority to provide consent to treatment. Mandatory reporting requirements for sexual offences and suspected sexual abuse apply irrespective of the treatment sought. The medical practitioner should consider these requirements carefully.

Suspicion of child harm and exploitation

Table 12. Suspicion of abuse

Aspect	Consideration
Suspicion of harm[12]	Mandatory reporting requirements apply where a child has been or is likely to be the victim of a sexual offence, irrespective of the treatment sought. The medical practitioner should consider these requirements carefully. Section 26(1) of the *Care and Protection of Children Act 2007* places an obligation on all persons in the NT to report cases of child harm and exploitation to Territory Families, Housing and Communities. All Territorians are mandatory reporters for children where harm or exploitation is suspected. 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. Section 26(2) applies to health practitioners in cases where a child has been or is likely to be the victim of a sexual offence. A person is guilty of an offence if the person believes any of the following: • A child aged 14 to 16 years has been or is likely to be a victim of a sexual offence and the age difference between the child and the alleged sexual offender is more than two years. • A child aged less than 14 years has been or is likely to be a victim of a sexual offence; or • A child has been or is likely to be a victim of an offence against section 128 of the Criminal Code Act 1983 (see definitions and search terms); and • does not, as soon as possible after forming that belief, report to Territory Families Housing and Communities and/or police: I. that belief; II. any knowledge of the person forming the grounds for that belief; and III. any factual circumstances on which that knowledge is based. • All NT Health staff members are required to report a reasonable belief of harm 24/7 child protection reporting line **1800 700 250**. • Health practitioners have additional reporting requirements where a child is between 14 and 16 years of age and they are in a sexual relationship with a person who is more than 2 years older.
Sexual offences[12]	• It is an offence if any person in the Northern Territory does not report to Territory Families, Housing and Communities if they believe that a child has, or is likely to suffer harm or exploitation.
Reporting requirements[12]	• Report any reasonable suspicions of harm and exploitation against the child or young person to Territory Families, Housing and Communities 24/7 reporting line **1800 700 250**. • You must, if you form a reasonable belief that a child has been or is at risk of harm or exploitation, report your belief to TFHC. • If a child is at imminent risk of harm or exploitation, call police immediately and follow up with a notification to TFHC.

Aspect	Consideration
	• It is important you do not conduct your own investigations or test any allegations at all. The mandatory reporting requirement extends only to reporting your reasonable belief and the basis of that belief. • For additional information and guidance refer to Mandatory Reporting – Child harm or exploitation and domestic and family violence NT Health Policy.

Sexual Assault and Domestic and Family Violence

Table 13. Special circumstances

Aspect	Consideration

Sexual assault	• The Northern Territory has the highest rates of domestic and family violence in Australia.
	• Provide termination healthcare on the basis of the patient request.[9]
	• 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.
	  ○ Alerting authorities (Northern Territory Police Service).
	  ○ Relocating, if in continued danger.
	  ○ Routine sexual health checks and treatment (as required).
	  ○ A medical examination and documentation of findings; and
	  ○ The possibility of the products of conception being used for forensic testing to assist legal proceedings.
	• Support the person's choices for ongoing healthcare and involvement.
	• Refer (with the person's consent) to Sexual Assault Referral Centre.

Mandatory Reporting of Domestic and Family Violence	All adults are required to notify police of domestic and family violence incidents that meet the threshold for mandatory reporting. Section 124A of the *Domestic and Family Violence Act 2007 (DFVA)* requires every adult in the Northern Territory to make a report to police (**131 444**) if they believe on reasonable grounds either or both of the following: • Another person has caused or is likely to cause serious physical harm to someone else, with whom the other person is in a domestic relationship; and/or • The life or safety of another person is under serious or imminent threat because domestic violence has been, is being or is about to be committed. For additional information and guidance refer to Mandatory Reporting – Child harm or exploitation and domestic and family violence NT Health Policy.

Suspected fetal abnormality

Table 14. Suspected fetal abnormality

Aspect	Consideration
Suspected fetal abnormality	• If fetal abnormality suspected, discuss with the patient: ○ Chromosomal analysis. ○ Histopathology; and ○ Fetal autopsy.

Female genital mutilation

Table 15. Female genital mutilation

Aspect	Consideration
Female genital mutilation (FGM)	• If FGM, use clinical judgement and individually assess the clinical and psychological circumstances of each patient. • If deinfibulation indicated, seek specialist advice.

Documentation of decisions

Table 16. Documentation

Aspect	Consideration
Less than or equal to 24 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. • Clinical opinion relevant to the person's medical circumstances and their current and future physical, psychological and social circumstances and the relevant professional standards followed. • A detailed and well documented informed decision making process. • Clinical process to determine successful completion of termination. • Details of follow up appointments. • Location of the termination. • Details of discussion of and provision of contraception; and • Complete the Termination of Pregnancy Online Prescribed Reporting form within 28 days of procedure.
At or after 24 weeks and/or complex case	Both authorised medical practitioners document: • An assessment of the 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 authorised medical practitioner who assessed the patient. • A detailed and well documented informed decision making process. • Clinical process to determine successful completion of termination.

Aspect	Consideration
	• Details of follow up appointments. • Location of the termination. • Details of discussion of and provision of contraception; and • Complete the Termination of Pregnancy Online Prescribed Reporting form within 28 days of procedure.

Pre-termination assessment

Offer pre-termination assessment including counselling, psychosocial support services close to home where feasible.[14] Provide 'Having a termination of pregnancy in the NT' information booklet. This resource is available in several languages and can be accessed at health.gov.au. Audio resources in Aboriginal languages are also available by emailing womenshealth.doh@nt.gov.au

Table 17. Clinical assessment prior to termination

Aspect	Consideration
Review history	Discuss request for termination healthcare in a non-judgemental and supportive manner: • Obtain medical, gynaecological, obstetric, and sexual health history[9,15] including date of last menstrual period; • Obtain psycho-social history[15,16] including mental health issues, screening for domestic and family violence (DFV), reproductive coercion and comply with mandatory reporting requirements.

Clinical exam and investigations	• Confirm diagnosis, gestational age and location of pregnancy.[8]
	• Undertake a physical exam as indicated by the history and signs and symptoms including:
	  ○ Vital signs[9,15,16] and body mass index (BMI) if surgical termination.
	• 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[9,17,18] Rubella titre.[17]

Ultrasound scan (USS)	• Perform USS to confirm intrauterine pregnancy and assess gestational age. • Consider the persons age, context and individual circumstances and if appropriate, ask the person about their preference to see or hear USS images and audio.

Sexual health check	• Perform a sexual health check and assess sexually transmitted infection(s) (STI) risk including:
	  ○ Condom use.
	  ○ History of STI.
	  ○ Symptoms (e.g. discharge, pain on urination, genital rashes).
	• Screen for STI as per local protocol; if no local protocol, consider:
	  ○ Chlamydia, gonorrhoea, trichomonas, syphilis, human immunodeficiency virus (HIV).
	• Offer syndromic treatment to the patient with symptoms suggestive of STI, where there is increased risk of loss to follow-up.

Aspect	Consideration
Pre-termination referral coordination	• Facilitate timely referral and coordination with other facilities, disciplines or agencies[19] 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;[20] ○ Termination procedure.
Contraception	• Discuss contraceptive options at the time of initial consultation, termination procedure or immediately after.[9,19] • Refer to Table 40. Contraception provision.
Additional healthcare	• Consider additional health screening or advice including: ○ Cervical screening test. ○ Smoking cessation advice; and ○ Screening for Domestic Family Sexual Violence (DFSV).
Follow-up	• Arrange follow-up for review/assessment of:[8,19] ○ Physical recovery. ○ Emotional issues (and referral for counselling as necessary). ○ Pathology from products of conception including results from fetal autopsy, as indicated; and ○ Discussion of ongoing contraception. • Refer to Table 41. Discharge preparation.

Psychological support

The decision to terminate a pregnancy may be a difficult and sometimes, a distressing process.[9,21] Consider the person's psychological, spiritual and cultural beliefs when providing termination healthcare. The patient may be clear in their decision, require supportive listening or further psychological support.

Table 18. Information and counselling

Aspect	Consideration
Information	Support the decision-making process by providing accurate, impartial and easy to understand[3] information including[14]: • Options to continue the pregnancy and parent the child (provide 'Pregnancy options in the Northern Territory' information booklet). • Documentation of discussions regarding all options for termination (including public and private facility options based on individual needs and circumstances); • Provide 'Having a termination of pregnancy (abortion) in the Northern Territory' information booklet. • Post-termination considerations (e.g. contraceptive options and non-judgemental counselling support). • Information about local support groups relevant to the circumstances. • Birth registration requirements[22-24] [refer to Section 5.4.1 Birth registration].
Counselling	The support needs of every person considering termination of pregnancy will be different. For most, and particularly those accessing early medical termination, the decision is made early, negative consequences are minimal and there is little disruption to their ongoing lives. Confidential, non-judgemental support and counselling[8,20] should be available as needed and provided by someone (e.g. social worker, psychologist, counsellor) who: • Is appropriately qualified and/or trained. • Is experienced with the issues surrounding termination; and • Has no vested interest in the pregnancy outcome.[20]
Communication	Appropriate communication is an important aspect of termination care, be sure to: • Allow space to identify if client has alternate gender identity. • Use respectful language when referring to the pregnancy. • Give time for questions to be asked and answered. • Answer questions honestly and respectfully. • Use straightforward and simple language. • Acknowledge and reassure that it is normal to feel a range of emotions (e.g. grief, sadness, relief); 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 termination. • Imply fault or blame about contraception use/lack of use; or • Try to persuade the patient to change their mind.

Aspect	Consideration
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.

Psychological sequelae

Table 19. Psychological healthcare

Aspect	Considerations
Evidence summary	• There are significant limitations in the evidence examining the relationships between unplanned pregnancy, termination, birth and mental health.[25] • Emotional responses following termination are complex and may change over time. • Risk factors for post-termination psychological problems may include: previous or concurrent psychiatric illness, coercion, increasing length of gestation, ambivalence and lack of social support, poor relationships with others or religious affiliation. • Adverse psychological sequelae may be no more likely following termination than following continuation of the pregnancy.[26] • For the majority of mental health outcomes, there is no statistically significant association between termination of pregnancy and mental health problems.[14,25,27] • An unwanted pregnancy may lead to an increased risk of mental health problems, or other factors may lead to both an increased risk of unplanned pregnancy and increased risk of mental health problems.[25-27] • When a patient has an unplanned pregnancy, rates of mental health problems will be largely unaffected whether they have a termination 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.[25,26]

Recommendation	• Consider the need for non-judgemental support and care for all women and pregnant people, and partners, who request a termination 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.[28]

Method selection

A pregnancy may be terminated using a medical or surgical approach or a combination of the two.[19]

The choice of method is dependent on the patient preference, gestational age, access to a working phone, transport, support and a risk assessment of their access to appropriate care in the unlikely event of a medical emergency. For EMToP availability of a private ensuite and supports, local clinician expertise and the service capabilities, and availability of pharmacological agents.[19]

Table 20. Methods of termination

Aspect	Consideration

Medical termination of pregnancy (MToP)	• Medications are used to induce the termination.[19]
	• May be considered for all gestations of pregnancy.
	• Mifepristone in combination with misoprostol (or misoprostol alone) are the recommended regimens for MToP:
	  ○ These medications are recommended for gestations 63 days or less;
	  ○ Refer to Section 6.5 EMToP at 63 days gestation or less.

Surgical termination of pregnancy (SToP)	Surgical curettage is generally suitable up to 12 weeks gestation and then done after that by experienced practitioners.[15] • Anaesthesia depends on service capabilities.[6] • Refer to Section 7 Surgical termination.

Feticide	• Provided by a trained practitioner.
	• Usually performed prior to MToP where there is a risk of an unplanned livebirth.
	• Strongly recommended for MToP at gestations greater than 22 weeks[14,19,29] as is clinically appropriate.
	• May be offered prior to a SToP, based on a person's preference.
	• Refer the person to the closest service with the capability to perform the procedure.
	• 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 21. Considerations for selection

Aspect	Consideration
Service capability	• If there is limited capability for a preferred method, refer promptly to another service or provider.[6]
Risks and complications	• Discuss the complications and risks associated with the differing methods of termination in a way the patient can understand. • Advise of the overall safety of the procedures.[9] • 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. • Consider phone coverage and access to a working phone; reliable transport and road access; weather conditions; access to safe accommodation, including privacy and ensuite facilities and support for the whole time of the procedure.
Acceptability of method	• Satisfaction with MToP and SToP reported as comparable.[29,30] • Support the patient to make the decision that is best for their circumstances and preferences. • Support the decision to choose treatment outside the community or in a hospital setting if requested or if there is lack of safety or confidentiality. • Consider additional psychological support for the patient where there is a need, for those who receive inpatient care within the maternity services.

MToP and SToP risks and complications

Complications and risks associated with termination of pregnancy are rare when performed by qualified medical practitioners.[15] Serious complications are rare and morbidity is less common with terminations than with pregnancies that are carried to term.[9]

Table 22. Risks and complications

Aspect	Consideration
Retained products of conception	• Uncommon following SToP. • Requirement for surgical evacuation of retained products increased following MToP, especially with increasing gestation.[31]

Infection	• Risk reduced if:
	  ○ Prophylactic antibiotics prior to SToP.[9]
	  ▪ [refer to Section 7.3 Surgical curettage].
	  ○ Lower genital tract infection has been excluded.

Cervical trauma	• Rates vary during SToP; risk of damage to the external cervical os at the time of surgical termination is no greater than 1 in 100.[9]
	• Decreased risk with[9]:
	  ○ Experienced clinician.
	  ○ Use of preoperative cervical priming; and
	  ○ Earlier gestations.

Aspect	Consideration

	• Increased risk with:
	  ○ Age <18; and
	  ○ Second trimester procedures.

Haemorrhage	• Risk is lower at earlier gestations:
	  ○ First trimester: less than 1 in 1000 terminations;[24]
	  ○ Greater than 20 weeks: 4 in 1000 terminations.[24]
	• May be more common following MToP (bleeding may persist up to 45 days) but evidence is not conclusive.[9,15]

Uterine perforation	• Risk at the time of surgical termination is 1–4 in 1000.[24]
	• Decreased risk of uterine perforation associated with:
	  ○ Experienced clinician.
	  ○ Use of pre-operative cervical priming.[24,32]
	  ○ Earlier gestations.

Uterine rupture	• Uterine rupture has been rarely reported in association with mid-trimester MToPs.[33] • More frequently associated with later gestational ages and previous uterine scar. • Risk is less than 1 in 1000 terminations.[24]
Continuing pregnancy	• All methods of first trimester termination carry a small risk of continued pregnancy: ○ Approximately 1–2 in 100 pregnancies across both surgical and medical procedures.[24] • More likely following early rather than late termination of pregnancy. • A continuing pregnancy following unsuccessful termination of pregnancy while uncommon may lead to fetal anomalies if the pregnancy persists.[24]
Future pregnancies	• There are no proven associations between termination of pregnancy and subsequent ectopic pregnancy, placenta praevia or infertility.[24]

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.

Fetal considerations

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

Birth registration

Table 23. Registration requirements

Gestation/Birth weight[23]	Signs of life	Requirement
Less than 20 weeks AND less than 400 grams.	Not live born	• Birth registration not required. • Death registration not required. • Burial/cremation not required but check local procedures if requested.
Less than 20 weeks AND less than 400 grams.	Live born	• Birth registration required. • Death registration required. • Death reportable to the Coroner. • Burial/cremation required .
Greater than 20 weeks OR more than 400 grams.	Not live born	• Birth registration required. • Death registration not required. • Burial/cremation required. • Death not reportable to the Coroner.
Greater than 20 weeks OR more than 400 grams.	Live born	• Birth registration required. • Must report death to Coroner. • Death registration required. • Burial/cremation required.

Transport and management of fetal remains

Refer to Management of the Deceased and Human Tissue NT Health Policy.

Table 24. 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. • Where birth and death registration is not required: ○ Hospital facilities may be permitted to dispose of fetal remains by incineration or chemical disinfection, in line with the Management of the Deceased and Human Tissue NT Health Policy.

Requests to take fetal remains home/overseas	• Fetal remains that do not legally require burial or cremation may be released to the the patient for private disposal provided that:[50]
	  ○ There is no risk of transmission of notifiable conditions.
	  ○ The patient has been informed how the fetal remains may be disposed.
	• Establish local protocols to support requests to take fetal remains home (e.g. use of sensitive transport containers).

Individual preferences	• Recognise that a patient may wish to make their own arrangements for disposal.
	• Respect cultural and/or religious beliefs.
	• Advise patients:
	  ○ Of the options for disposal;
	  ○ Funeral services may assist with burial/cremation where birth registration is not required, and no death certificate has been issued;

Aspect	Consideration
	○ Memorial services may be offered at the facility. • Consider the condition of the fetal remains and inform the patient appropriately. • Offer social worker support or support group. • For births less than 20 weeks gestation, or less than 400 grams (i.e. not requiring registration), offer information on commemorative options.

There is also an obligation regulation 6 of the Births, Deaths and Marriages Registration Regulations 1996 (NT) to report certain particulars when a child has died within 28 days after birth and additional reporting requirements if the death occurs within 24 hours of birth, however notification to the Registrar of Births, Deaths and Marriages is not required where the death is reported to the coroner.

Other fetal considerations

Table 25. 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. • Offer counselling and support services to patients, partners and healthcare professionals involved with care of a live born fetus. • If a live birth occurs:[50] ○ Handle baby gently and carefully and wrap to provide warmth. ○ Offer opportunities and support the family's wishes to engage in care provision (e.g. cuddling/holding). ○ Do not provide life sustaining treatment (e.g. gastric tubes, IV lines, oxygen therapy). ○ Provide sensitive emotional support and reassurance to parents throughout the process and afterwards; and ○ Document date and time end of life occurs.
Fetal autopsy	• Offer fetal autopsy if clinically indicated (e.g. if fetal abnormality). • Refer to local policy for Stillbirth and Neonatal death guidelines.
Gestations greater than 16 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. ○ Autopsy, if indicated. ○ Birth registration requirements. ○ Refer to Table 23. Registration requirements. ○ Donation of breast milk to milk banks (where appropriate) or lactation suppression. ▪ Refer to Table 41. Discharge preparation.

Aspect	Consideration
	• Involve social workers (e.g. for support, discussion of any costs, funeral arrangements). • Offer information about community services (e.g. Amber NT).
Sexual assault	• Police may submit a written request for foetal tissue – cord blood or cord tissue. • Samples are received by SARC Darwin staff and store in SAIK fridge to maintain Chain of Evidence.

There is also an obligation regulation 6 of the Births, Deaths and Marriages Registration Regulations 1996 (NT) to report certain particulars when a child has died within 28 days after birth and additional reporting requirements if the death occurs within 24 hours of birth, however notification to the Registrar of Births, Deaths and Marriages is not required where the death is reported to the coroner.

Medical termination

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

Practitioner requirements

Australian healthcare professionals must register with MS Health online to become licensed prescribers or dispensers of MS-2 Step (mifepristone, misoprostol) and/or mifepristone.[34,35] MS-2 Step, mifepristone, and misoprostol are approved for use in the NT as per the Medicines, Poisons and *Therapeutic Goods Act 2012*.

MToP precautions

Table 26. Precautions for medical termination

Aspect	Consideration
Contraindications for MToP	• Hypersensitivity or allergy to prostaglandins or a product component.[31] • Suspected or confirmed ectopic pregnancy.[31] • Gestational trophoblastic disease. • Intrauterine device (remove prior to termination).[31] • Obstructive cervical lesions (e.g. fibroids). • High suspicion of placenta accreta.

Cautions for MToP	• If cardiovascular disease, monitor cardiovascular status as prostaglandins may cause transient blood pressure changes.[31]
	• If high risk of uterine rupture:
	  ○ Consider individual circumstances.[36]
	  ○ May not be suitable with history of caesarean section (CS), multiple pregnancies or uterine abnormalities.[37]
	• If previous traumatic pregnancy loss (e.g. miscarriage), counsel on blood loss associated with MToP:[38]
	  ○ Vaginal bleeding is heavier with MToP compared with SToP and may be comparable to a miscarriage.
	• If breastfeeding: MToP medications may cause diarrhoea in the child.[39]

Contraindications to mifepristone	• Chronic adrenal failure. • Concurrent long-term corticosteroid therapy. • Known or suspected haemorrhagic disorders or treatment with anti-coagulants.[40]

EMToP in the outpatient setting

Table 27. Healthcare setting

Aspect	Consideration
Context	To identify the most appropriate setting for EMToP consider: • Local service capability. • Individual circumstances. • The patient preference; and • Discuss where the person will stay during the termination (3-4 days) and risk assess the patient's access to phone coverage and access to a working phone; reliable transport and road access; weather conditions; access to safe accommodation, including bathroom and toilet and support for the whole time of the procedure. • Support a decision to access services outside of the patient's local community if requested.

Aspect	Consideration
	• If the patient is eligible for an early medical termination and does not have access to safe accommodation they (and an escort) may be eligible for assistance for travel and accommodation through PATS. • Help with travel and accommodation through PATS is also available for patients having a surgical termination of pregnancy.
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.[21] • Have access to private facilities required to have an EMToP 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; weather conditions.

EMToP pre-dosage care

Table 28. EMToP pre-dosage care

Aspect	Consideration

Clinical care	• Perform a pre-termination assessment:
	  ○ Refer to Section 5 Pre-termination assessment.
	• Obtain informed consent:
	  ○ Refer to Section 4.1 Consent.
	• Exclude contraindications and review cautions:
	  ○ Refer to Section 6.2 EMToP precautions.
	• Consider the need for Rh D immunoglobulin prophylaxis:
	  ○ Refer to Table 39. Post-termination care considerations.

Communication	• Provide information about: ○ The process (e.g. duration, timing of medication, symptoms, passage of tissue). • Discuss where the patient will stay during the termination (3-4 days) considering their access and support (e.g. a working phone with coverage, reliable transport, roads and weather conditions, access to safe accommodation, including privacy and ensuite 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.

Aspect	Consideration
	• If indicated, discuss collection of products of conception for examination.
Medication side effects	• Provide information about possible medication side effects. • Adverse events for combined use of mifepristone and misoprostol are dose dependent and increase with gestational age.[39,41] • Common side effects include:[15,16,36] ○ 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 8. MToP and SToP post-termination care.

EMToP at 63 days gestation or less

MS-2 Step composite pack is suitable for termination at 63 days or less gestation (9+0 weeks).[35]

Table 29. MS-2 Step for EMToP

Aspect	Consideration
MS-2 Step composite pack[31]	• 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:[31] ○ Efficacy 97.3%. ○ Incomplete termination requiring aspiration 2.3%. ○ Rate of ongoing pregnancy 0.3%. • For patients with a gestational age between 49 to 63 days: ○ Efficacy 95.2%. ○ Incomplete termination requiring aspiration 4.8%. ○ Rate of ongoing pregnancy 0.6%.
Pre-dosage care	• Refer to Table 28. MToP pre-dosage care. • Provide written information about misoprostol medication self-administration.[36] • Supply a prescription for analgesia and antiemetic.
Dose[48]	**Initial dose:** • Mifepristone 200 mg oral. **Subsequent dose:** • 36–48 hours after mifepristone:

Aspect	Consideration
	○ Misoprostol 800 micrograms buccal or sublingual.
Follow-up	• Follow-up at 7–21 days as per local protocols. • Confirm expulsion complete:[31] ○ clinical history (abdominal cramping, pain, history of tissue passed); ○ serum β-hCG assay, or urine pregnancy test, if indicated; ○ no ongoing persistent vaginal bleeding beyond 21 days. • Referral for surgical procedure or other follow-up if required. • Refer to Table 41. Discharge preparation.

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

MToP after 63 days gestation

A combination regimen with a prostaglandin analogue is more effective than use of either medication as a single analogue agent.[31]

Care during MToP

Table 30. MToP considerations after 63 days gestation

Aspect	Consideration
Cautions	• Seek expert advice from a higher level service as required. • 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 28. MToP pre-dosage care. • Baseline vital signs, 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.[17] • Full blood count (FBC), group and hold as clinically indicated.
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 IV at time of birth. • If the placenta is not spontaneously delivered within 60 minutes of the fetus (or earlier if excessive bleeding occurs) consider operative removal.
Observations	• 30–60 minutes after initial dose of misoprostol and after each subsequent dose: ○ Vital signs, vaginal loss, contractions, assess pain.

MToP regimen for patients at risk of uterine rupture

Table 31. MToP with risk of uterine rupture.

Risk of uterine rupture or with previous uterine surgery	
Cautions	• Seek expert advice from a higher level service[6] as required. • Feticide advised for gestations greater than 22 weeks. • Consider IV access and monitor patients closely for evidence of scar complications.

Less than 34+0 weeks	• Day 1: mifepristone 200 mg oral.[31]
	• Day 2: 36–48 hours after mifepristone:
	  ○ Misoprostol 200 micrograms inserted into the posterior fornix of the vagina.
	  ○ If undelivered at 4 hours after initial dose, then misoprostol 200 micrograms inserted into the posterior fornix of the vagina every 4 hours for 4 doses (may also be given sublingual or buccal).
	• If undelivered at 24 hours after initial dose, then commence misoprostol 400 micrograms inserted into the posterior fornix of the vagina every 6 hours for a maximum of 4 further doses.
	• If undelivered at 48 hours after initial dose, then review by an obstetrician is indicated. Options may include:
	  ○ Continue with misoprostol 400 micrograms 6 hourly; or
	  ○ Rest day then recommence; or
	  ○ IV oxytocin is most effective if some effacement and dilation has occurred; or
	• Surgical delivery.

34+0 weeks or more	• Transcervical catheter. • Oxytocin infusion and artificial rupture of membranes. • Avoid misoprostol or dinoprostone.

Refer to an Australian pharmacopoeia for complete drug information.

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

Table 32. MToP with no known risk of uterine rupture

Follow protocol according to gestational age	

9+0 to12+6 weeks	• Day 1: mifepristone 200 mg oral.[31]
	• Day 2: 36–48 hours after mifepristone:[15]
	  ○ Misoprostol 800 micrograms vaginal, sublingual or buccal;
	  ○ Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses.
	• If fetus undelivered, consider additional misoprostol dose or surgical procedure.

13+0 to 24+6 weeks	• Day 1: mifepristone 200 mg oral.[31] • Day 2: 36–48 hours after mifepristone:[15] ○ Misoprostol 400 micrograms vaginal or sublingual.

Follow protocol according to gestational age	
	○ Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses.
25+0 to 33+6 weeks	• Day 1: mifepristone 200 mg oral.[31] • Day 2: 36–48 hours after mifepristone:[15] ○ Misoprostol 200 micrograms vaginal or sublingual every 3–6 hours for six doses over 24 hours.
34+0 weeks or more	• Dinoprostone or transcervical catheter. • Induction: ○ Misoprostol 50–100 micrograms sublingually or per vagina 3–6 hourly for five doses over 24 hours. ○ Oxytocin infusion and consider artificial rupture of membranes after labour established.

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

Surgical termination

Surgical curettage is generally suitable for gestations up to 12 weeks.[15] Gestations beyond this require a clinician with the relevant training and experience.[15,42] Where local protocols are not well established or do not exist, suggested regimens are provided in the following sections.

SToP pre-procedure care

Table 33. SToP pre-procedure care

Aspect	Considerations
Clinical care	• Perform a pre-termination assessment including baseline vital signs: ○ Refer to Section 5 Pre-termination assessment. • Obtain informed consent: ○ Refer to Section 4.1 Consent. • Consider the need for Rh D immunoglobulin: ○ Refer to Table 39. Post-termination care considerations. • Consider the need for cervical priming:[43] ○ Refer to Table 34. Cervical priming for SToP.
Communication	• Provide information about: ○ The termination process. ○ What symptoms to expect post procedure including bleeding and pain; and ○ Refer to Table 15. Information and counselling.

Cervical priming for SToP

Table 34. Cervical priming for SToP

Aspect	Considerations
Rationale	• Cervical preparation decreases the length of SToP procedure. • May also:[22,16] ○ 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[16] (although may be considered at any gestational age).

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

Misoprostol prior to SToP

Table 35. Misoprostol alone for cervical priming prior to surgical termination.

Aspect	Considerations
Precautions	• Refer to Table 26. Precautions for medical termination.
Dosage	Dosage and timing of misoprostol prior to surgery may vary based on practitioner preference, gestation and risk factors for difficult dilatation at SToP. Misoprostol can be administered buccally, sublingually and vaginally. Avoid the oral route due to increased risk of gastrointestinal side effects. Example of suggested dosing: **3–4 hours prior to surgery**[15] • 400 micrograms inserted into the posterior fornix of the vagina. OR **2–3 hours prior to surgery**[15] • 400 micrograms sublingual or buccal.

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

Mifepristone and misoprostol prior to SToP

Table 36. Mifepristone and misoprostol for cervical priming prior to surgical termination

Aspect	Considerations
Precautions	• Refer to Table 26. Precautions for medical termination. • There may be an increased risk of pre-operative expulsion of pregnancy with mifepristone and misoprostol prior to SToP.[51]
Day 1: Pre-dose care	• May occur as an outpatient (or at home) following pre-termination assessment. • Provide contact details to the patient in case of emergency.
Day 1: Dosage (24–48 hours prior to procedure)	• Mifepristone 200 mg oral.[15]

Day 2 (Day of procedure)	• If less than 14 weeks gestation:[15]
	  ○ Misoprostol 400 micrograms sublingual 2–3 hours prior to procedure; or
	  ○ Misoprostol 400 micrograms vaginally 3–4 hours prior to the procedure.
	• If greater than 14 weeks gestation:
	  ○ Misoprostol 400 micrograms vaginally 3–4 hours prior to procedure.

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

Osmotic dilators prior to SToP

Table 37. Osmotic dilators for cervical priming prior to surgical termination.

Aspect	Considerations
Types of osmotic dilators	• Dilapan-S: ○ Synthetic osmotic dilators made of a polyacrylate based proprietry hydrogel (Aquacryl). ○ Achieves close to maximum dilation effect at 4-6 hours – most suited for same day evacuation. ○ More predictable dilatation compared to Laminaria.[51] • 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.[52] ○ Theoretical risk of allergy and infection due to organic material.[51]
Indication	• Osmotic dilators are a suitable non-pharmacological method of cervical priming prior to SToP 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)[53] the day before the SToP. • Osmotic dilators can be used in setting of ruptured membranes, with appropriate antibiotic cover.[51] • Osmotic dilators can be used in setting of placenta praevia.[51] • 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.[51] • For gestations over 20+0, further insertion of osmotic dilators may be required if adequate dilatation is not achieved.[53] • A SToP following same day insertion of osmotic dilator, usually 4-6 hours prior to SToP, should only be performed by experienced practitioners. Consider Dilapan-S over Laminaria, and use of adjuvant mifepristone or misprostol, when considering dilation and excavation of same-day insertion of osmotic dilators.[52]
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 SToP to accommodate time constraints of patient and health service, especially after 19+0 week gestation.[53] • Combined use of mifepristone AND misoprostol, may increase risk of pre-procedural expulsion of fetus.[51] • 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 SToP if used as adjuvant cervical ripening agent.[51]

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.[52]
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.

Surgical termination of pregnancy

Table 38. Considerations for surgical termination.

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.[26]

Prophylactic antibiotics	• Intra or perioperative prophylactic antibiotics recommended, for those who have not been appropriately investigated.[15,16]
	• In the absence of local protocols consider:
	  ○ doxycycline 400 mg orally, with food, 10–12 hour prior to procedure; or
	  ○ doxycycline 100 mg orally 60 minutes prior to procedure THEN 200 mg orally 90 minutes after the procedure; or
	  ○ 2g oral metronidazole; add 1g oral azithromycin (if high risk of chlamydia and not screened for STI). [44,55]
	  ○ If medication allergy refer to Therapeutic Guidelines for alternate antibiotic regime;[44,55]
	  ○ opportunistic healthcare including cervico-vaginal screening for STI.
	  ▪ refer to Table 17. Clinical assessment prior to termination.

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.[26] • Routine use with dilatation and evacuation (D&E) to reduce rate of uterine perforation. [26]
Examination of tissue	• Examination of the products of conception by the surgeon may assist with recognition of gestational trophoblast.[45] • Examination and identification of fetal parts by practitioner is advised with D&E for confirmation of complete evacuation.[54] • Histopathology if clinically indicated: ○ Refer to Table 39. Post-termination care considerations.
Side effects	• Pain: analgesia is usually required (e.g. non-steroidal anti-inflammatory drugs). • Bleeding: expected duration 5–18 days.[20] • Nausea: usually related to prostaglandins or anaesthetic drugs.[20]
Risks and complications	• Serious complications are rare.[20] • Risk rises with operator inexperience and gestational age.[16]

Follow-up	• Recommend follow up (e.g. GP, telephone/video contact, face to face) to discuss:
	  ○ Bleeding.
	  ○ Psychological well-being.
	  ○ Contraception [refer to Table 40. Contraception provision].
	• Refer to Section 8.2 Discharge preparation and follow-up.

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

MToP and SToP post-termination care

Most serious complications are detectable in the immediate post-procedure period. Refer to Table 22. Risks and complications. Appropriate and accessible follow-up care is essential.[16]

Table 39. Post-termination care considerations

Aspect	Considerations
Inpatient post-procedural care	• Provide routine post-procedural care including assessment of vital signs, consciousness and observation of vaginal loss. • Where possible provide inpatient care that is not within a maternity service environment.
Rh prophylaxis*	• Recommend Rh D immunoglobulin (Anti-D) to all Rh D negative patients within 72 hours of termination (medical after 10 weeks of gestation or surgical),[16-18] unless the fetus is known to be Rh negative. • Anti-D prohylaxis not recommended for medical terminations performed under 10+0 gestation.[18] • Gestations up to 12+6 weeks (SToP) —250 IU Rh D immunoglobulin via intramuscular (IM) injection. • Gestations 13+0 weeks or more—625 IU Rh D immunoglobulin via intramuscular (IM) injection. • If greater than 20 weeks gestation, recommend quantification of feto-maternal haemorrhage (FMH).[17]

Aspect	Considerations
	• If FMH estimated at 6 mL or more, recommend additional Rh D immunoglobulin.
Analgesia	• Individually determine analgesia requirements after surgical termination or during and after MToP as requirements vary. • Offer medication for pain management[8,9] (paracetamol and/or ibuprofen often effective). • Advise patients that severe pain may be indicative of uterine perforation or clot retention.[8,9] • 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 termination procedures.

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

Contraception

Australia has a relatively high rate of unintended pregnancy (19.7 per 1000 woman aged 15–44 years).[46] Australia ranks amongst the highest countries for termination of pregnancy in the developed world with 1 in 4 people undergoing a termination procedure.[47,48]

Table 40. Contraception provision

Aspect	Considerations
Context	• Prevention of unwanted future pregnancies is an important part of the provision of termination 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 termination.[49]

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.
	• 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.
	  ○ 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.[48,49] • May be inserted, during a SToP, or immediately post MToP or SToP.[15] • Provide information on what to expect after insertion.

Discharge preparation and follow-up

Table 41. 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-termination distress are evident (e.g. ambivalence before the termination, lack of a supportive partner, psychiatric history or membership of a religious or cultural group where termination is not an option).
	• Offer information and assistance as appropriate regarding birth registration and funeral arrangements:
	  ○ Refer to Table 23. Registration requirements.
	  ○ Refer to Table 18. Information and counselling.

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 a termination, conception can be attempted immediately following the termination. • 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. vital signs, recovery from effects of sedation/anaesthesia). • Supply a prescription for analgesia and/or antiemetics (relevant to method of ToP). • Provide written information regarding post-procedure symptoms and accessing appropriate care in the unlikely event of a medical emergency:[8] ○ Refer to Surgical Termination of Pregnancy – Pre and Post-operative Care RDH PRH Guidelines or appropriate local procedures. • Provide a confidential letter 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 letter distribution (e.g. to GP). Ensure this information is clearly understood as clinics in remote communities are often staffed by friends or family of the patient.

Follow-up	• After MToP, recommend follow-up within 14–21 days[15] (e.g. GP, telephone/video contact, face to face).
	• Various methods recommended to confirm completion of MToP: [15]
	  ○ Assessment of symptoms.
	  ○ Quantitative β-hCG.
	  ○ High or low sensitivity urine β-hCG.
	  ○ Bleeding ceased.
	  ○ USS if indicated.
	  ○ Bleeding ceased.
	• After SToP, 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 this guideline.

Abbreviations

Term	Definition
β-hCG	Beta human chorionic gonadotropin
CSCF	Clinical Services Capability Framework
EMToP	Early medical termination of pregnancy
FMH	Feto-maternal haemorrhage
GP	General Practitioner
HHS	Hospital and Health Services
MToP	Medical termination of pregnancy
PATS	Patient Assisted Travel Scheme
Rh D	Rhesus immunoglobulin
SAIK	Sexual assault investigation kit
SARC	Sexual Assault Referral Centre
STI	Sexually transmitted infection(s)
SToP	Surgical termination of pregnancy
The Act	Termination of Pregnancy Law Reform Act 2017
USS	Ultrasound scan

Definition of terms

Term	Definition
Aboriginal	Refers to Aboriginal and Torres Strait Islanders
Aboriginal health practitioner	A person registered under the Health Practitioner Regulation National Law to practise in the Aboriginal health practice profession (other than as a student).
Authorised	In relation to a medical practitioner, Aboriginal health practitioner, midwife, nurse or pharmacist authorised or directed under the Medicines, Poisons and Therapeutic Goods Act 2012 to supply or administer a termination drug.
Chief Health Officer (CHO)	The person appointed under section 67 of the *Public and Environmental Health Act 2011* to be the Chief Health Officer.
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.
Credentialed	Having the verified qualifications, training, experience, professional standing and other relevant professional attributes of a medical practitioner used for the purpose of forming a view about the competence, performance and professional suitability of the medical practitioner.

Term	Definition
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 termination 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	An authorised medical practitioner, authorised Aboriginal health practitioner, authorised midwife, authorised nurse or authorised pharmacist directed to assist in the performance of a termination who refuses to advise or provide or participate in a lawful treatment or procedure because it conflicts with their own personal beliefs, values or moral concerns.[1,2]
EMToP	Early medical termination of pregnancy refers to medical termination of pregnancy under 9 weeks.
Family violence	Aboriginal communities have supported the use of the term 'family violence' to indicate the impact violence has on kinship and family ties and the broader community. However, family violence 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 implants. At the time of medical termination of pregnancy implants and injections may be utilised immediately.
Live birth	Describes a baby where there are signs of life after birth of the baby is completed regardless of gestation or birthweight.[1] 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.
Multidisciplinary team	Membership of the 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, counsellor or Aboriginal liaison officer.
Obstetrician	Local facilities may, as required, differentiate the roles and responsibilities assigned in this document to an 'Obstetrician' according to their specific practitioner group requirements; for example, to gynaecologists, general practitioner obstetricians, specialist obstetricians, consultants, senior registrars and obstetric fellows.
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.

Term	Definition
	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 a termination	Refer to Section 2.1 Performing of a termination.
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 coerce 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.
Termination	The *Termination of Pregnancy Law Reform Act 2017* states termination means "intentionally terminating a women's pregnancy"
Termination healthcare	In this document termination healthcare refers to the provision of healthcare by a healthcare professional that supports a patient to terminate a pregnancy.
Vital signs	In this document vital signs includes respiratory rate (RR), blood pressure (BP), heart rate (HR), oxygen saturations (SpO2), temperature (T) and level of consciousness (LOC).
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: Aboriginal and Culturally Diverse Clients – Cultural Considerations

The vast majority of Australians (81%) believe a woman has the right to choice regarding termination of pregnancy (Australian Survey of Social Attitudes (AuSSA)). However the issue can raise strong opinions across some groups in society stemming from historic, cultural, religious, political and personal beliefs and practices.

In this context, there may be cultural and kin based and family responsibilities and attitudes towards termination of pregnancy that should be explored with a client and support team to minimise risk to the individual, family and community.

NT Health is dedicated to maximising cultural responsiveness, in particular through the integration of Aboriginal cultural rights, views and values with support from the Aboriginal workforce.

Having a diverse health team including Aboriginal Health Practitioners (AHP) and/or or Aboriginal Health Worker (AHW)s and other cultural advisors and interpreters can assist in providing culturally appropriate care.

NT Health are committed to following key principles in regard to termination of pregnancy:

- Access to safe termination of pregnancy is a human right - A person has the right to make their own decision about whether or not to progress with a pregnancy.
- Safe access to termination of pregnancy is an evidence based intervention which prevents maternal mortality and morbidity and contributes to gender equality and social justice.
- Every care must be taken to ensure the person requesting a termination of pregnancy understands the procedure and is not being pressured into a decision.

Interpreters

Where language is a barrier involve an interpreter.

For most non-English languages call the Translating and Interpreting Service on 13 14 50.

For Aboriginal languages call the Aboriginal Interpreter Service 1800 334 944 or email ais@nt.gov.au.

NOTE: some translators or interpreters may not wish to assist due to their own beliefs. If unsure seek advice from a local cultural advisor who does not have a conscientious objection to termination of pregnancy or contact the manager of the interpreter service.

Aboriginal Resources

Aboriginal Cultural Security Framework 2016 - 2026.pdf (nt.gov.au)

Aboriginal Cultural Security Policy.pdf (nt.gov.au)

Aboriginal and Torres Strait Islander Health Practitioner Cultural Statement.pdf

Pregnancy Options in Aboriginal Languages

Pregnancy options information has been translated into AUDIO resources (to avoid literacy limitations and to seek to provide confidentiality). Languages available to date are Tiwi, Murrihn Patha, West-side Kriol, Burrada and Yolŋu Matha (with other language groups to follow).

Northern Territory Clinical Guideline – Termination of Pregnancy

Adapted from the Pregnancy Options for Women in the NT booklet these resources were developed in consultation with relevant Aboriginal stakeholders and with the assistance of the Aboriginal Interpreter Service.

They may be used as a decision tool for patients or an educational aid for Aboriginal support staff.

Due to the sensitive nature of termination of pregnancy, these files are considered women's business and available on request by emailing womenshealth.doh@nt.gov.au

Culturally Diverse Resources

The NT Health website publishes two booklets to help women or pregnant people in the NT make decisions about an unplanned pregnancy or an unexpected problem with a pregnancy:

Pregnancy Options for women in the Northern Territory; and

Having a termination of pregnancy in the Northern Territory.

These two booklets are available at www.health.nt.gov.au in Swahili, Chinese, Vietnamese, Arabic, Greek, Thai and Punjabi.

Values Workshop

Currently available at Royal Darwin Hospital (and other locations on request within capacity), these workshops provide a safe and non-judgmental space to facilitate person-centred discussion about reproductive health among health providers with divergent views.

For more information or to apply for the workshop please contact STOPReferrals.DoH@nt.gov.au

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Appendix C: Acknowledgements

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