# Abortion: Principles of Assessment and Care

## 1. Purpose

This document outlines the procedure at the Women's for clinicians undertaking a clinical assessment of women following a request for an induced medical or surgical abortion.
This procedure is related to The Women's Position Statement: Abortion (Appendix 1), Abortion: Medical Abortion up to 9 Weeks of Pregnancy, Consent To Treatment Policy, Consent To Treatment Guideline, Child Protection Management Guideline.

## 2. Definitions

**Women and pregnant people:** This document refers to women and pregnant people to describe those with pelvic anatomy that includes a vagina, a uterus, ovaries, and/or fallopian tubes. It is recognised that not all people with such anatomy identify as women. We encourage the reader to consider the specific needs of nonbinary individuals and transgender men and adopt trans-inclusive practice.
**Medical abortion** refers to the administration of medications to end a pregnancy. The medications for medical abortion are marketed as MS2Step, under licence from MS Health as part of Marie Stopes International. MS2Step is a composite pack and consists of Mifepristone 200 mg tablet and Misoprostol 4x 200 microgram tablets. The pack is indicated for use in eligible women and pregnant people for the purpose of a medical abortion of a developing intrauterine pregnancy, up to 63 days of gestation.
**Surgical abortion** refers to the use of transcervical uterine evacuation procedure to end a pregnancy. These include:

- Vacuum aspiration/suction curettage up to 13+6 weeks gestation may be performed by those with training in general obstetrics and gynaecology, and may be performed by other suitably qualified and trained proceduralist.
- Dilatation and evacuation from 14+0 to 23+6 weeks gestation is more technically demanding and warrants specific training and expertise. Methods for cervical priming/preparation should be considered and are recommended at these gestations.

## 3. Responsibilities

All staff involved in the care of women and pregnant people seeking an abortion will promote and protect the following principles as outlined in the The Women's Position Statement: Abortion (Appendix 1).
The Women's is a pro-choice organisation that provides access to abortion services to support women's choice and ability to exercise their reproductive rights.
Access to abortion is fundamental to women's sexual and reproductive healthcare, is a human right and an important public health issue.
The Women's is committed to providing public abortion services, as we believe that every individual – regardless of their age, gender identity, sexuality, ethnicity, religion, social class, and ability – should have access to reproductive healthcare.
The Women's provides abortion services consistent with the Abortion Law Reform Act 2008 and supports a person's right to access healthcare within this legal framework.
Abortion services must be provided by registered health practitioners and are regulated in the same way as all other health procedures and services. We provide support and counselling services, which are an integral part of abortion healthcare.
The Women's strongly supports a person's right to accurate, unbiased sexual and reproductive health information, including options counselling, to support their informed decision-making, health and wellbeing.
The Women's is committed to preventing violence against women. We acknowledge that many women who experience reproductive coercion require timely access to abortion services.

All Abortion and Contraception Service (ACS) Nurses, Social Workers and Medical Practitioners work within the legal framework as determined by the Abortion Law Reform Act 2008 and are required to complete the relevant steps outlined when caring for a woman or pregnant person who has requested an abortion.

# 4. Procedure

## *4.1 Pre- abortion clinical assessment*

### i. Explore pregnancy options and confirm decision to proceed with an abortion

All women and pregnant people attending the abortion service require sensitive and careful discussion to determine the degree of certainty of their decision and their understanding of the implications of the decision.

- Provide objective information about pregnancy options (ongoing pregnancy, adoption/foster arrangements, abortion),
- It is important to see the woman or pregnant person on their own at some stage during the consultation to assess for safety and autonomy in the decision making process. This provides the opportunity to screen for intimate partner violence and reproductive coercion and to assess that the person has made a voluntary informed decision for an abortion,
- Sensitively enquire about the experience of making the abortion decision and identify available supports,
- Acknowledge and reassure that it is normal to feel a range of emotions that may also be conflicting e.g. grief, sadness, relief,
- Facilitate access to objective, person-centered, supportive counselling and decision making support as indicated,
- Decision for an ongoing pregnancy, if the decision is to continue the pregnancy refer to Pregnancy Booking Clinic or an external provider as appropriate.

### *ii.* The clinical history

**Table 1**

| Domain | Component |
|---|---|
| Current pregnancy history | Last normal menstrual period (LNMP)<br>Confirm gestation and location of this pregnancy |
| Obstetric history | Previous pregnancy and outcomes, including mode of delivery and history of post-partum haemorrhage (PPH) |
| Gynaecological history | Usual menstrual pattern<br>Known gynaecological issues<br>STI screen according to risk<br>Check cervical screening status |
| Contraceptive history | Current use, subjective assessment of contraceptive method<br>Provide evidence-based information about the safety, efficacy, advantages and disadvantages of all methods |
| Medical/ surgical history | Chronic disease, hospitalisations and operations<br>BMI |
| Medications and allergies | Routine medications and allergies |
| Tobacco, alcohol, illicit | Identify frequency and impact of use |

| | |
|---|---|
| drug use | |
| Psycho-social history | Mental health history<br>Identify availability and level of social support<br>Sensitively screen for family violence (FV) and reproductive coercion. Prompt questions may include:<br>• Do you feel safe and supported in your decision?<br>• What is it like for you to make the decision to have an abortion? |

## iii. Choice of method:

The request for an abortion and choice of method is considered in a non-judgmental and supportive manner.
Available options depend on gestation, personal preference, medical criteria and service capacity.
Provide reassurance that abortion is a safe procedure for which major complications and mortality are extremely rare at all gestations. Uncomplicated procedures have little bearing on future fertility or pregnancy (see Risks).
Provide accurate information about the procedure or available choices in a range of formats that are easy to understand to support decision making and informed consent (Table 2).
For each available method include information on:

- what to expect before, during and after the procedure,
- risks, side effects and complications,
- expected pain, bleeding and management options,
- how to recognise complications, how and where to seek help,
- the range of emotions commonly experienced with an abortion,
- recommended follow up care,
- plan for contraception (as desired).

**Table 2**

| Characteristics of abortion procedures | |
|---|---|
| Medical abortion | Surgical abortion |
| Available up to 63 days of pregnancy<br>Avoids anaesthesia and surgery<br>Mimics the process of a natural miscarriage<br>Medications are self- administered and abortion occurs at home<br>Takes time to complete abortion, and the timing may not be predictable<br>Pain and bleeding expected. Potential gastrointestinal side effects due to misoprostol<br>IUD can be inserted once complete abortion is confirmed, usually during follow up<br>Support person required during the abortion<br>Longer period of bleeding, average 16 days, may be up to 30 days<br>Need to be active in follow-up care<br>Severe complications are rare<br>Risk of teratogenicity - requires commitment to completion once treatment is commenced<br>Contraindications (i.e. extra-uterine pregnancy, unknown gestation, chronic adrenal failure, haemorrhagic disorders, hypersensitivity to medications)<br>*See PGP Abortion: medical management* | Availability depends on service capacity<br><br>Timing of abortion controlled by the clinic<br><br>Generally involves two separate hospital visits, one for clinic consultation and second for procedure<br><br>Actual procedure quick, complete within 10 to 15 minutes<br><br>On day of procedure, may be at the hospital for up to 5-6 hours<br><br>Predictable timeframe and high degree of certainty about the outcome<br><br>May require cervical preparation in advance of the procedure<br><br>Able to have long acting reversible contraception (LARC) inserted at time of procedure<br><br>Overnight support is required after an anaesthetic<br><br>Shorter period of bleeding<br><br>Severe complications are rare<br><br>No known absolute contraindications |

Adapted from World Health Organisation 2012, Clinical practice handbook for safe abortion, Geneva.

## iv. Risks and complications

Serious complications are rare at all gestations irrespective of technique. The efficacy and safety of both methods are similar. While the absolute risk of major complications is low, it is known that complications increase with increasing gestation. Accurate estimates of complications are difficult to obtain due to poor reporting and lack of standardised criteria.

**Table 3**

| Abortion risk and complications: | |
|---|---|
| Complication | Risk |
| Haemorrhage and heavy bleeding | Defined as blood loss greater than 500ml or severe bleeding requiring transfusion, is low across all methods and gestations. The risk is lower for early abortions, 1-3:1000 in first trimester, 1-10:1000 in second trimester. |
| Infection | Uncommon, usually caused by a pre-existing bacterial infection. Opportunistic screening for bacteria of the lower genital tract or prophylactic antibiotics reduces this risk. |
| Retained products of conception (RPOC)/ incomplete abortion | Uncommon. Routine follow-up ultrasound is **not** recommended if asymptomatic. Occurs in approximately 1-4:100 for medical abortion, and may require surgical management. Approximately 1:100 for surgical abortion. |
| Ongoing pregnancy/ failed abortion | Less than 1:100 pregnancies across both methods; more common in early abortions and requires surgical management. |
| Cervical trauma | For surgical abortion only, risk no greater than 1:100, decreased risk with earlier gestations, cervical priming and experienced practitioner. |
| Uterine perforation and damage to surrounding structures | For surgical abortion only, risk is 1–4:1000, decreased risk with cervical priming, earlier gestations and experienced practitioner. |
| Future reproductive outcome | There are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. There may be an association between abortion and subsequent risk of preterm birth, this increases with the number of abortions or later gestation. |

## v. Pain management

Almost all women and pregnant people will experience some pain and cramping with surgical and medical abortion methods. The degree of pain varies with age, parity, history of dysmenorrhoea, level of anxiety or fear and the chosen method.
Quality abortion care involves supportive, reassuring and patient centered communication techniques to reduce anxiety and perceptions of pain. It is important to establish accurate expectations.
Provide information on pharmacological methods pre and post abortion. Simple analgesia is usually sufficient, e.g. paracetamol 1 g QID and ibuprofen 400mg TDS
Non-pharmacological therapeutic techniques such as rest, heat packs and lower back massage may be helpful.

## vi. Psychological support

For some people, the decision to end a pregnancy will be clear, for others it may be a difficult choice to make. A range of mixed and conflicting emotional responses may be experienced during the decision making process. These are normal responses. There are many factors that can impact on a woman or pregnant person's decision. These may include the circumstances that led to the unwanted pregnancy, their relationship with the partner in the pregnancy, reproductive coercion from partner, family or friends, family situation, ambivalence, access to decision making support, financial circumstances, increasing length of gestation, discomfort with abortion due to moral or religious reasons, the timing of the pregnancy and how this fits with life goals and plans.
Refer to ACS Social Work as indicated.

## vii. ACS Social Work

ACS Social Work services are delivered within a clearly articulated intersectional feminist, violence and trauma informed practice framework which aims to promote access to choice in reproductive care, reproductive health literacy, bodily autonomy and reproductive rights in a public health setting.
The Abortion and Contraception Service Social Work Team are able to provide:

- intake and support service to women and pregnant people seeking abortion care at the Women's,
- evidence-based options counselling to support patient-centered decision making. Throughout the counselling process, Social Workers support women and pregnant people to examine their own values and beliefs on pregnancy, parenting and abortion to come to the decision that is best for them,
- access to resources - fact sheets and decision making tools. See: *https://www.thewomens.org.au/health-information/unplanned-pregnancy-information*,
- information and referral to assist with additional issues that impact on health and wellbeing such as mental health, drug and alcohol use, trauma, family violence or interpersonal safety concerns, housing, financial matters, visa concerns, legal issues,
- provide emotional and practical support during outpatient and inpatient episodes of care, including safety and support planning around admission and discharge,
- post-procedure counselling,
- secondary consultation to nursing and medical staff,
- liaison with Victoria Police and Foresnic Services.

## viii. Contraception:

The abortion consultation is an ideal time to discuss ongoing contraception as the woman or pregnant person has proven fertility, is likely to be motivated to explore options and is currently accessing health care. Ovulation occurs within 1 month of first trimester abortions in 90% of cases. People seeking contraception need accurate, evidence-based information about the safety, efficacy, advantages and disadvantages of all methods and be supported to make a choice based on their personal needs, preferences and medical suitability. Long acting reversible contraception (LARC) methods are highly effective and safe across the reproductive life course. Opportunity for "LARC first" conversation. *See: https://www.familyplanningallianceaustralia.org.au/larc/*

At the time of **surgical abortion:**

- Etonogestrel implant (Implanon NXT ®), levonorgestrel intrauterine device (IUD) (Mirena® or Kyleena®) or copper IUD may be inserted intraoperatively.
- Depot medroxyprogesterone acetate injection (DMPA) may be administered intraoperatively.
- Combined oral contraceptives can be started the day following surgical abortion.

At the time of **medical abortion:**

- Etonogestrel (Implanon NXT ®) and levonorgestrel (Microlut ®) may be initiated immediately, that is on the day of mifepristone.
- Depot medroxyprogesterone acetate (DMPA) can be initiated at the time of misoprostol administration.
- Combined oral contraceptives can be started the day following misoprostol.
- Levonorgestrel IUD (Mirena® or Kyleena®) and copper IUD may be inserted once it has been determined the abortion is complete, that is, at follow up visit with β serum or low sensitivity urine hCG assessment.

## ix. Baseline investigations:

- Pelvic Ultrasound: accurate assessment of gestational age and presence of intrauterine pregnancy, i.e. through visualisation of a yolk sac. Exclude ectopic pregnancy.
- Blood investigations:
  - Baseline quantitative β hCG for medical abortion
  - Blood group and antibody status for surgical abortion
  - Full blood count (FBC)
- •STI screen: according to risk, minimum requirement includes:
  - Microscopy for bacterial vaginosis
  - Urine PCR for chlamydia, gonorrhoea and mycoplasma genitalium
  - Syphilis serology

For further information *see Melbourne Sexual Health Service, STI Tool,* https://www.mshc.org.au/HealthProfessional/STITool/tabid/1040/Default.aspx#.Xthydq2P46s

## x. Consent to treatment and decision making competence

*Refer to PGP Consent To Treatment Guideline and Consent To Treatment Policy*
Consent is valid when

- it is provided voluntarily (without fear or coercion),
- it is informed, accompanied by adequate information to understand the risks and benefits involved,
- given by a person with decision-making capacity.

A person has decision making capacity if they are able to do the following:

- understand the information relevant to the decision and the effect of the decision,
- retain that information to the extent necessary to make the decision,
- use or weigh that information as part of the process of making the decision,
- communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

Adult patients are presumed to have decision-making capacity unless there is evidence to the contrary.
If concerns exist, refer to ACS Social Work at the earliest opportunity in order to receive appropriate support, case management and advocacy with consideration of the patient's decision making capacity.
Centre for Women's Mental Health (CWMH) provide services to meet patient's mental health needs including assessment, treatment and secondary consultation and may be requested to provide an assessment of the person's capacity to give consent.
Where a patient is unable to consent to the abortion procedure, referral must be made to The Office of the Public Advocate, through VCAT, which can consent to an abortion procedure.
The patient's next of kin is unable to give consent. *See:*
*https://www.vcat.vic.gov.au/resources/application-for-order-appointment-of-an-administrator-andor-guardian*

## xi. Consent: Young person, aged under 18 years

A 'mature minor' is a young person who has decision-making capacity for the decision in question and referred to as 'Gillick Competent'. Young people can give valid informed consent when they achieve sufficient maturity and capability to fully understand the treatment being proposed. Capacity to consent is assessed and not assumed. There is no lower age limit. Young people can be supported to make their own decision. Provide clear information on confidentiality and limitations. Assess for availability of adult support networks and encourage the young person to access these if safe to do so.
The treating Medical Practitioner provides assessment of competence, discuss with Lead Clinician as required.

## Additional circumstances:

## xii. Suspicion of child abuse

*See: Child Protection Management Guideline*
Registered Medical Practitioners, Registered Psychologists, Registered Nurses and Midwives and are required to report to Child Protection where they have formed a reasonable belief, that a child has been or is at risk of significant harm, as a result of physical or sexual abuse, and the child's parents have not protected or are unlikely to protect the child from that abuse.
Discuss with Lead Clinician as required. See: https://providers.dhhs.vic.gov.au/making-report-child-protection

## xiii. Pregnancy as a result of sexual assault and forced sexual activity

*See: Termination of Pregnancy: Women Seeking, Following Sexual Assault Guideline*

Pathways for women accessing the Women's for abortion as a result of sexual assault are available through ACS Social Work and Centre Against Sexual Assault (CASA) House.

## *Methods of abortion:*

Medical and surgical methods of abortion are offered.
**Medical abortion** *See PGP Abortion: medical management up to 9 weeks of pregnancy. Complete EPIC, RWH, ACS Medical abortion care plan*
**Surgical abortion** *Complete EPIC, RWH, ACS Surgical abortion care plan*

## *Post abortion care and follow up:*

### i. Rhesus (Rh) isoimmunisation:

Following an early medical abortion (less than 63 days) the risk of Rhesus sensitisation is minimal. Current international guidelines do not recommend Rhesus testing and anti-D administration for a medical Abortion. In 2020, The Royal Australian College Obstretics and Gynaecology (RANZCOG) advise that a clinican my appropriately decide not to administer anti-D to 10 weeks gestation and for medical management of abortion. See: https://ranzcog.edu.au/news/covid-19-anti-d-and-abortion
Rhesus testing and anti D administration for Rhesus negative women is recommended for surgical abortion.

### ii. Follow –up:

Post-procedure follow up following medical abortion is an important component of care to ensure completeness of the procedure. Routine follow up may not be necessary after an uncomplicated surgical procedure.
Follow up consultation may be face to face, via telehealth or telephone consultation.
**Medical abortion:**

- telephone follow up at day 3 to 5
- telephone or clinic consultation at day 7 to 21 post misoprostol.

Clinical history and βhCG determination (serum or urine) can accurately predict completeness of the procedure. Serum βhCG levels fall more than 50 percent within 24 hours of pregnancy expulsion and may remain detectable at low levels for 4 to 6 weeks. An 80 percent decline in serum βhCG levels from day of misoprostol to 8 to 16 days later is considered appropriate. Lower sensitivity urine pregnancy (LSUP) tests detect hCG levels greater than 1000 mIU/mL. Negative LSUP test from day 14 is appropriate.
**Surgical abortion:** Where indicated, follow up may be offered six weeks post procedure to assess adjustment to LARC, discuss bleeding patterns and check for IUD string (where appropriate).
Follow up with GP or ACS clinic as required.
The purpose of follow up is to:

- provide support and reassurance,
- assess physical and psycho-social wellbeing,
- ensure completeness of the abortion procedure,
- ensure the contraception plan is enacted.

## iii. Post procedure complications

Post procedure complications are rare. The most common immediate complications are ongoing pregnancy/ failed abortion, incomplete abortion/RPOC and infection (see table 3). Assess clinical signs and symptoms to monitor completeness of the procedure. If asymptomatic, ultrasound is not a clinically useful tool to assess the need for further intervention and/or surgical management. Blood or thickened endometrium are common findings post abortion regardless of symptoms. Assess clinical signs such as resolution of symptoms or signs of pregnancy, absence of heavy or persistent bleeding and abdominal pain and use an objective measure (serum β or low sensitivity urine pregnancy (LSUP) test) provide assurance of complete abortion.
Assess and treat clinical features suggestive of infection. These include fever >37.5ºC, abdominal tenderness, guarding and rebound, foul odour or pus visible in the cervical os and uterine tenderness. Features suggestive of sepsis require urgent intervention.
*See PGP Abortion: management of presentation post procedure*

## iv. Discharge summary/communication with Primary Care Provider:

Seek permission to communicate with primary care provider e.g. General Practitioner and provide with sufficient information about the procedure to allow another practitioner to manage any complications.

## Evaluation, monitoring and reporting of compliance to this procedure

Compliance to this guideline or procedure will be monitored, evaluated and reported through VHIMS and consumer feedback.

## References


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- WHO 2012, Safe abortion: technical and policy guidance for health systems, WHO, Geneva.
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# Legislation/ Regulations related to this procedure

The Abortion Law Reform Act 2008

# Appendices

Appendix 1: The Women's Position Statement: Abortion

Appendix1

the women's
the royal women's hospital
victoria australia

## The Women's Position Statement: Abortion

### About the Women's

The Women's is a leader in women's sexual and reproductive health services and is a public provider of abortion services in Victoria. We are part of a broader health system that includes public and private providers of abortion services.

Our publicly funded abortion service is an important component of our commitment to ensure women's access to safe, high-quality healthcare. We provide priority of access to people with highly complex psychosocial needs, including those who experience violence and reproductive coercion.

The Women's is committed to increasing access to abortion services by building the clinical capacity and expertise of other hospitals, health services and the primary care sector to also provide abortion and contraception services. This is critical to ensure that women can access abortion services that are safe, timely and close to their home and social support networks.

### The Women's Position

The Women's is a pro-choice organisation that provides access to abortion services to support women's choice and ability to exercise their reproductive rights.

Access to abortion is fundamental to women's sexual and reproductive healthcare, is a human right and an important public health issue.

The Women's is committed to providing public abortion services, as we believe that every individual – regardless of their age, gender identity, sexuality, ethnicity, religion, social class, and ability – should have access to reproductive healthcare.

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The Women's strongly supports a person's right to accurate, unbiased sexual and reproductive health information – including options counselling – to support their informed decision-making and health and wellbeing.

The Women's is committed to preventing violence against women. We acknowledge that many women who experience reproductive coercion require timely access to abortion services.

Statement endorsed by

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