RACGP

Curriculum and syllabus for Australian general practice (7th edition)

Pregnancy and reproductive health

RACGP Curriculum and syllabus for Australian general practice (7th edition): Pregnancy and reproductive health.

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular circumstances when so doing. Compliance with any recommendations cannot of itself guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional and the premises from which the health professional operates.

Accordingly, The Royal Australian College of General Practitioners Ltd (RACGP) and its employees and agents shall have no liability (including without limitation liability by reason of negligence) to any users of the information contained in this publication for any loss or damage (consequential or otherwise), cost or expense incurred or arising by reason of any person using or relying on the information contained in this publication and whether caused by reason of any error, negligent act, omission or misrepresentation in the information.

Recommended citation

The Royal Australian College of General Practitioners. Curriculum and syllabus for Australian general practice (7th edition). Pregnancy and reproductive health. East Melbourne, Vic: RACGP, 2026.

The Royal Australian College of General Practitioners Ltd

100 Wellington Parade

East Melbourne, Victoria 3002

Tel 03 8699 0414

Fax 03 8699 0400

www.racgp.org.au

ABN 34 000 223 807

Published September 2026

© The Royal Australian College of General Practitioners 2026

This resource is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence. In summary, you must not edit or adapt it or use it for any commercial purposes. You must acknowledge the RACGP as the owner.

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

Contents

Pregnancy and reproductive health 4
- Context 4
  - References 4
- Learning outcomes 6
- Key areas of learning 7
- Opportunities for learning 10
  - Words of wisdom 10
  - Learning strategies 11
  - Case example 13
- Learning resources 14
- Assessment 15

Pregnancy and reproductive health

Context

GPs play a central role in delivering comprehensive, person-centred, culturally sage, and trauma-informed pregnancy and reproductive healthcare across the life course, supporting patients to achieve their reproductive life goals. This includes pre-conception care, antenatal, postnatal, and inter-conception care including breastfeeding, contraception; and, fertility assessment. It also includes management of unintended pregnancy, and abortion care – with a strong focus on patient safety, wellbeing, and shared decision-making. People bring diverse strengths, values, cultural knowledge, and lived experiences that shape their reproductive goals, decision-making, and care needs. Recognising and working in partnership with these strengths supports safe and effective care.

In Australia, 292,318 babies were born in 2024, with births occurring at older average maternal ages and lower fertility rates than in previous decades.[1] GPs are often the first point of contact for pregnancy care, providing early assessment, first and second-trimester care, antenatal shared care, continuity across pregnancy and the postnatal period, inter-conception care, and coordination with maternity and specialist services, including the management of miscarriage.[2,3] GPs also play an important role in identifying and managing pregnancy-related complications such as early pregnancy bleeding, mental health conditions, intimate partner violence, and cardiometabolic complications including gestational diabetes and hypertensive disorders of pregnancy, and late pregnancy complications such as abruption. GPs also need to attend to long-term health risks.[1,4]

Fertility concerns are common in general practice, with around 15% of couples experiencing infertility.[4] GPs are well placed to initiate timely assessment for both patients, identify contributing health conditions, provide counselling and initial management, and determine when referral is required, including earlier assessment for those at increased risk.[4,5]

Unintended pregnancy remains common, with around one in four Australian women experiencing an unintended pregnancy and an estimated 88,000 abortions occurring annually.[6,7] GPs play a critical role in providing non-directive counselling and delivering or coordinating abortion care, particularly medical abortion, within state and territory legal frameworks.[8–10]

Contraception care is a core component of general practice, encompassing counselling, prescribing, long-acting reversible contraception procedures, and ongoing review.[11–13] Equitable access to culturally safe pregnancy and reproductive healthcare remains variable, particularly for rural and remote communities and Aboriginal and Torres Strait Islander peoples.[14–19] In these contexts, GPs play a vital role in providing continuity of care and coordinated, locally responsive services.

Trauma-informed, culturally safe communication and multidisciplinary collaboration support continuity of care and partnership with patients, families, and communities across primary, secondary, and community settings; improving outcomes for patients, babies, and families.

References

1. Australian Bureau of Statistics. Births, Australia [Internet]. Canberra: ABS; 2024. Available from: https://www.abs.gov.au/statistics/people/population/births-australia/2024 [Accessed 22 Apr 2026].
2. Fitzgerald KC, Kang M, Black KI. Australian GPs' experiences, practices, and perspectives on postpartum care, contraception, and breastfeeding. Fam Pract. 2025;42(4):cmaf055.
3. The Royal Australian College of General Practitioners. Maternity care in general practice. East Melbourne: RACGP; 2019. Available from: https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/maternity-care-in-general-practice [Accessed 22 Jan 2026].
4. Hunt S, Vollenhoven B. Assessment of female fertility in the general practice setting. Aust J Gen Pract. 2020;49(6):304–308.
5. Katz DJ, Teloken P, Shoshany O. Male infertility – the other side of the equation. Aust Fam Physician. 2017;46(9):641–646.
6. Taft AJ, Shankar M, Black KI, et al. Unintended and unwanted pregnancy in Australia. Med J Aust. 2018;209(9):407–408.
7. Keogh LA, Gurrin LC, Moore P. Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data. Med J Aust. 2021 Oct 18;215(8):375-376
8. Mazza D, Burton G, Wilson S, Boulton E, Fairweather J, Black KI. Medical abortion. Aust J Gen Pract. 2020 Jun;49(6):324-330.
9. Deb S, Subasinghe AK, Mazza D. Providing medical abortion in general practice: General practitioner insights and tips for future providers. Aust J Gen Pract. 2020 Jun;49(6):331-337.

10. Therapeutic Goods Administration. Amendments to restrictions for prescribing of MS-2 Step (Mifepristone and Misoprostol). Canberra: TGA; 2023. Available from: https://www.tga.gov.au/news/media-releases/amendments-restrictions-prescribing-ms-2-step-mifepristone-and-misoprostol [Accessed 22 Jan 2026].
11. Mazza D, Assifi AR, McGeechan K, et al. Increasing the uptake of long-acting reversible contraception through family practice: the Australian Contraceptive ChOice pRoject (ACCORd) cluster randomized controlled trial 3-year follow-up. Am J Obstet Gynecol. 2025;233(4):299.
12. Templeton-Smith M. LARCs as first-line contraception. Aust J Gen Pract. 2017;46:710–715.
13. Pearson S, Boerma C, McNamee K, Bateson D. Long-acting reversible contraceptives: new evidence to support clinical practice. Aust J Gen Pract. 2022;51:246–252.
14. Munns A. Community midwifery: a primary health care approach to care during pregnancy for Aboriginal and Torres Strait Islander women. Aust J Prim Health. 2021;27(1):57–61.
15. Jones E, Lattof SR, Coast E. Interventions to provide culturally appropriate maternity care services: factors affecting implementation. BMC Pregnancy Childbirth. 2017;17:267..
16. Singh R, Mazza D, Moloney L, Shankar M, Subasinghe AK. General practitioner experiences in delivering early medical abortion services to women from culturally and linguistically diverse backgrounds: A qualitative-descriptive study. Aust J Gen Pract. 2023;52(8):557-564.
17. Rolfe MI, Donoghue DA, Longman JM, et al. The distribution of maternity services across rural and remote Australia: does it reflect population need? BMC Health Serv Res. 2017;17:163.
18. Thackrah RD, Wood J, Thompson SC. Cultural respect in midwifery service provision for Aboriginal women: longitudinal follow-up reveals the enduring legacy of targeted program initiatives. Int J Equity Health. 2020;19:210.
19. Wood SM, Alston L, Chapman A, et al. Barriers and facilitators to women's access to sexual and reproductive health services in rural Australia: a systematic review. BMC Health Serv Res. 2024;24:1221.

Learning outcomes

Please note: Whilst contraception is mentioned in this unit, the 'Sexual health and gender diversity' unit has the specific learning outcomes, key areas of learning and learning resources regarding contraception

The GP is able to:

- discuss sensitively topics related to pregnancy and reproductive care with patients and their partners, including presentations with potentially significant emotional impact such as fertility challenges, unplanned pregnancy, miscarriage, and abortion care
- consider cultural safety, emotional wellbeing, the possibility of reproductive coercion, and the socioeconomic context for each patient who presents for fertility, pre-conception, inter-conception, pregnancy, or abortion care
- identify and provide preventive health advice for patients planning pregnancy, including appropriate vaccinations and pre-conception screening (including genetic carrier screening and haemoglobinopathy screening), inter-conception care, and first-trimester screening options
- determine an appropriate clinical management pathway for patients with reproductive health challenges, standard and complex pregnancies, pregnancy complications, and unplanned pregnancies
- structure initial and ongoing antenatal and postnatal visits to address patient agendas and also requirements for that stage of care
- identify long term risks associated with complications of pregnancy including gestational diabetes and hypertensive disorders of pregnancy, and how to monitor and manage these
- assess fertility concerns, support optimisation of reproductive health, and refer as appropriate in line with patient preferences
- demonstrate self-awareness of personal values or beliefs (eg cultural or religious) that may impact ability to deliver patient-centred reproductive or pregnancy care and demonstrate respectful, effective transition of care when required
- respect autonomy in reproductive healthcare decision-making.

Key areas of learning

Conduct a pre-conception consultation, including a discussion of:

- genetic diseases and the available pre-conception tests, including reproductive carrier screening, and those that may be done early in pregnancy including first trimester screening, non-invasive prenatal testing (NIPT), and pre-eclampsia risk assessment
- screening and any ethical considerations
- managing chronic diseases prior to and during pregnancy
- preventive health, including advice about diet, supplements, medication, lifestyle, smoking, alcohol and substance avoidance, weight management, and immunisations.

Assess, investigate, and formulate a management plan (with the patient) including referral as appropriate for subfertility and infertility:

- assessment for causes of female and male infertility
- ways to optimise fertility
- support services
- when to refer and assisted reproductive technologies, including in vitro fertilisation (IVF considerations (psychological support, legal aspects, etc).

If a patient has an unplanned pregnancy provide supportive, non-directive care, including exploring options in line with the patient's values, preferences, and circumstances.

Identify what needs to be covered in a request for a termination of pregnancy consultation, including (using non-stigmatising language):

- non-directive pregnancy counselling
- sensitively exploring safety, including family violence and reproductive coercion
- counselling about medical and surgical abortion options
- facilitating timely access to medical termination of pregnancy, either by provision or referral
- discussion and as needed, be able to manage of complications of termination as they present
- understanding the legal aspects of termination.

Identify what needs to be covered in an antenatal consultation, including:

- recognising when patients may benefit from additional medical, cultural, or social support
- managing routine pregnancy as per guidelines including routine investigations, screening tests, lifestyle advice, supplements, and immunisations.
- managing normal symptoms of pregnancy, such as physiological changes, nausea, vomiting, back pain, and pubic symphysis pain
- managing (and referring if appropriate) intercurrent problems of pregnancy, such as gestational diabetes, reflux, iron deficiency of anaemia, infections during pregnancy (eg urinary tract infections, pelvic inflammatory disease, vaginal thrush), and perinatal anxiety and depression
- types of antenatal care and types of delivery.

Identify and know when and where to refer complications of pregnancy, including:

- bleeding in early pregnancy
- foetus small for gestational age / growth restriction
- ultrasound abnormalities
- premature labour
- deep vein thrombosis
- undocumented breech presentation
- gestational diabetes
- thyroid disorders in pregnancy.

Recognise and respond appropriately to pregnancy-related emergencies, including timely referral:

- bleeding in early pregnancy (threatened miscarriage, miscarriage, and ectopic pregnancy)
- bleeding after 20 weeks
- puerperal infection
- injury affecting pregnancy
- hypertension
- pre-eclampsia and / or eclampsia
- premature labour
- mental health including suicidal ideation, thoughts of harm, and psychosis

Diagnose, investigate appropriately, and manage presentations associated with pregnancy loss or termination of pregnancy, including:

- persistent bleeding
- retained products of contraception
- infection.

Assess and manage presentations in pregnant patients, that may be unrelated to their pregnancy.

Identify what needs to be covered in a six-week postnatal consultation, including:

- breastfeeding establishment including physiology, supply and demand, and problems including mastitis, breast pain, nipple trauma, and thrush
- sleep issues
- mental health, including postnatal depression, anxiety, and psychosis
- postpartum bleeding
- complications such as those from perineal and abdominal (caesarean) wounds, or deep vein thrombosis
- postnatal contraception and inter-conception planning
- cervical screening, if required
- advice on the need for babies to be checked.

Inter-conception and life-long after-care after complications during pregnancy such as gestational diabetes and hypertensive disorders of pregnancy.

- Lifestyle risk factors for chronic disease including smoking, nutrition, alcohol, and physical activity.
- Inter-conception optimisation of health conditions.
- Screening for overt diabetes and persistent hypertension.

Be able to undertake the following procedures according to recognised best practice:

- female pelvic examination
- pelvic speculum examination, including cervical screening
- urine pregnancy testing
- collection of pathology specimens (vaginal swabs)
- doppler foetal heart rate.

Opportunities for learning

Words of wisdom

- Challenges in both attempting to conceive (ie infertility) and pregnancy (ie miscarriage) can produce significant emotional distress, people may experience feelings such as self-blame, and feeling shock, anger, grief, depression, and anxiety. Be mindful of the language you use in these consultations as you can unintentionally say something that the patient takes to heart or misinterprets. Communicate with empathy, remind them it is not their fault and be clear with your advice and explanations.

- When a patient presents with a positive pregnancy test, be mindful that not all pregnancies are planned. It is best to explore your patient's feelings about the pregnancy before assuming they will be happy about it. Simply asking 'How do you feel about the pregnancy?' can be a powerful question and help you navigate the consultation and build patient rapport.

- Many patients will feel relieved to know that GPs can provide medical abortions. Be able to counsel patients, and prescribe and provide, or facilitate access to medical abortion for patients seeking termination of pregnancy of appropriate gestation. More than one consultation may be required. Consider the use of telehealth especially for follow up. Be aware of your local services should additional pregnancy counselling be required. Offer the choice of surgical termination of pregnancy and be aware of how this can be accessed locally. Understand your state or territory laws and regulations for termination of pregnancy.

- In the first routine antenatal consultation there is a lot to discuss and it can be overwhelming in a standard consultation. Think about how you will structure your consultation. What are the most important things that need to be covered? Then arrange investigations and have the patient return to discuss them. The return consultation should be longer to allow time to cover everything. It can be helpful to direct your patient to websites, reading material and other information to access in between these consultations, so they can return with their questions. However, consider your patient's health literacy and the best ways you can help to support their understanding and decision-making.

- Pregnancy is a time of increased risk for reoccurrence or exacerbation of mental health issues and domestic violence. Have this in the back of your mind for all antenatal consultations and start conversations early with the patient. Think about how you might bring these topics up for discussion in a sensitive, non-judgemental way. Remember to create space for patients to raise concerns. Try normalising statements such as: 'Pregnancy can be an emotional and tough time, and lots of people feel anxious or depressed. Is that something you would like to talk about?' or consider using a screening tool such as the Edinburgh Perinatal Depression Scale. Allow the patient to be part of the decision-making process about risk minimisation by continuing or recommencing treatment, arranging psychological support, discussing support networks, and so on, as appropriate.

Learning strategies

On your own

Make a list of differential diagnoses of vaginal bleeding in pregnancy (first, second, and third trimesters) and the post-partum period.

- *What are the important points in the history, examination, and investigation that will help you identify the probable diagnosis?*
- *What are the key points or red flags that will be most important to identify?*

Reflecting on a consultation or hypothetical scenario of a patient attending with an unplanned pregnancy requesting an abortion, consider the following:

- *What are the important components of the history, examination, and investigation needed to assess a patient's suitability for a medical abortion?*
- *Think about what should be discussed and how time should be managed in the consultation.*
- *What are the key points to discuss with the patient about how to take the medical abortion tablets and what to expect?*
- *What follow-up care will the patient require after a medical abortion?*
- *What written information resources can you provide to support your patient?*
- *How would things change if the patient presented at 11 weeks gestation?*

Review a post-partum visit. Make a list of the number of issues which could be discussed.

- *Which of these were discussed?*
- *If some were only partly covered, or not covered, how could you plan care to address these in future?*
- *How was breastfeeding addressed?*

With a supervisor

Undertake a speculum examination (in a non-pregnant patient) with your supervisor present and ensure you are comfortable with how to perform the procedure, how to discuss the procedure with your patient and gain consent, and what you see whilst performing the examination.

- *What feedback did you receive from your supervisor about how you went?*

Plan how you would manage a routine first antenatal consultation. Include details of what should be discussed and how time should be managed. Discuss this with your supervisor.

- *What changes or other ideas did your supervisor suggest?*
- *What preventive measures should be offered? When should they be offered? How would you ensure your approach is culturally safe and responsive across diverse contexts (eg age, Aboriginal and Torres Strait Islander identity, cultural background)?*
- *Consider the TGA's Australian categorisation system for prescribing medicines in pregnancy. How would you describe the different drug safety categories to a patient? What approaches does your supervisor have? How would you communicate the importance of staying on medications (such as asthma preventers)?*

Discuss the subtle clues that may help identify postnatal depression, how to broach the subjects that may reveal this, how to perform and interpret an Edinburgh Postnatal Depression Scale.

- *How would you sensitively ask a patient about perinatal depression and anxiety?*
- *What tips did your supervisor give you?*

In a small group

Role-play the following pregnancy consultations. Have group members rotate through the roles of patient, doctor and observer.

a. Interpretation of an early pregnancy ultrasound where the pregnancy is yet to be sighted (first trimester) ie pregnancy of unknown viability.
b. Nausea and vomiting in pregnancy (first and second trimester). Discuss what is considered 'normal' versus nausea and vomiting of concern (ie hyperemesis gravidarum) and how to manage both.
c. Positive oral glucose tolerance test (OGTT) in pregnancy. Also discuss rationale and value of long-term, post-partum follow up for Gestational Diabetes Mellitus (GDM).
d. Pubic symphysis pain (usually in the third trimester).
e. Bleeding a week after taking medical abortion pills.

- *How did your questions and explanations compare to the rest of the group?*
- *As a group, agree on the 'must not miss' history and examination points for each situation.*
- *Consider writing your own cases and use them to provide feedback to each other.*

Discuss how to provide a termination of pregnancy and what services are available in each of your local areas.

- *How would you support patients to choose between medical and surgical abortion options?*
- *Do these local services differ? How do you refer to them?*
- *What are the possible structural and practical barriers that may impact access to these services? What is the cost?*
- *What are the legal issues to consider?*

Organise a teaching session with your group. Allocate each member a topic or case to research and present to the group. When teaching your peers, remember to include the important resources you used. Here are some topics and cases that you might like to consider:

- *What is a biopsychosocial assessment? How does this relate to the pregnant patient?*
- *What is intergenerational trauma? How might this relate to how Aboriginal and Torres Strait Islander patients access healthcare when pregnant?*
- *A 35-year-old female presents with an inability to fall pregnant after 12 months. What are the key history, examination, investigation and management areas for this patient? What if the patient was 25 years old? What if she was 45 years old? What are your considerations for her partner?*
- *What fertility treatment is available in Australia? In urban areas? In rural or remote areas? What are the costs involved?*
- *How does your pregnancy history and assessment change for diverse cultural and community contexts?*
- *Outline the different mental health screening questionnaires and discuss which are better suited for the antenatal and postnatal patient and why. Practise using them with your group.*

With a friend or family member

With the permission of a friend or family member, role-play a consultation of breaking the bad news of a high-risk first trimester screening result. Video this consultation and review it with your supervisor or another doctor.

- *Think about more than the clinical aspects of the case. What was your body language like? Did you say 'Um'? Did you use jargon? Did the patient fully understand what had happened? How do you know this?*
- *Ask the 'patient' how you went.*

If appropriate, ask a friend or family member what they thought of the Australian healthcare system during their pregnancy or fertility journey.

- *Identify what was done well and what could be improved.*
- *Reflect on how general practice can help contribute to pregnancy and fertility care, including detection, investigation, collaboration with non-GP specialists, and follow up care. Consider how people's experiences may be affected by culture, ethnicity, being Aboriginal or Torres Strait Islander, living in rural or remote communities, and so on.*

Review a local hospital patient information sheet with your friend or family member and practise explaining a condition or procedure to them. For example, explain pre-conception genetic carrier screening, first trimester screening (including what happens if identified as high risk), gestational diabetes (positive OGTT), public versus private antenatal care, etc.

- *What was challenging about these conversations?*
- *What questions did the 'patient' ask? Reflect on why these questions were asked. What could you change about the way you delivered the information to reduce these questions?*
- *Was the handout useful? Would you use a different one in the future?*

Case example

Julie, a 35-year-old patient, presents with vaginal spotting for two days. She has no past medical history. Julie believes she is pregnant as her period is late and she had a faint positive pregnancy test at home four days ago. This is her first pregnancy.

In a case-based discussion, questions relating to each role could be:

Communicator

- How do you communicate the uncertainty of this situation to Julie?
- How would you ensure Julie feels safe to discuss intimate sexual history in the consultation?
- How would you explore if the pregnancy was planned? And how Julie feels about the pregnancy?
- How would you explore if Julie has emotional support through this uncertain time?

Clinician

- What further information do you need to make a diagnosis? What are the 'must not miss' parts of the patient's history?

- When would you consider performing a speculum examination in this case? Would this change your management?
- What would be the emergency features or red flags in the history and examination that you would be concerned about?
- How do you approach vaginal bleeding in women of reproductive age?
- What are your differential diagnoses for vaginal bleeding in women?
- What is your management plan for women with vaginal bleeding in suspected pregnancy?
- What if this were Julie's third pregnancy – and the previous two were miscarriages. Would that change your approach?
- How would you manage this situation if you couldn't easily access investigations? What if it was a weekend?
- How would Rhesus status change management?
- How would this management plan change if Julie were experiencing bleeding and in her third trimester?
- What if Julie doesn't want to continue with the pregnancy and wants an abortion?
- What if Julie identifies as Aboriginal or Torres Strait Islander? How would you ensure your approach is culturally safe and responsive?
- What if Julie were from a remote area? Would that change your management? What factors would you consider in planning care in this context? What strengths or supports might Julie have that could inform her care and decision-making?

Health advocate and leader

- What can be barriers and enablers to accessing carefor women in early pregnancy? And what methods can you use to assist care access?
- What are some of the equity issues that impact decisions about screening during pregnancy for Down syndrome?

Professional

- How would Julie be triaged in your practice to ensure she is seen today?
- How will you ensure Julie, and any investigation results, are followed up?
- What legal aspects should be considered if Julie were 15 years old? Or had an intellectual disability?
- How might your own personal beliefs and values influence the care you provide?
- How might the demographics and personal circumstances of the GP impact the consultation?

Scientist, educator and researcher

- What are potentially relevant guidelines for the care of Julie?
- If you were developing an education session for practice staff and nurses on triage of pregnancy bleeding, what would be your learning objectives?
- What is one specific researchable question relevant to the care of Julie in general practice?

Learning resources

The curriculum website includes learning resources within each unit.

Assessment

Content in this unit will be assessed in a variety of ways.

Workplace based assessments

Mini-CEX	RCA	MSF	CBD	Reflective exercise	Audit	Mid and end term assessment

Fellowship examinations

AKT	KFP	CCE

KEY

- Expected to be assessed here always
- Often assessed here but not in every example / case / assessment
- May at times be here or contribute to the assessment

ABBREVIATIONS

Mini-CEX – Mini-clinical evaluation exercise
RCA – Random case analysis
MSF – Multi source feedback
CBD – Case-based discussion
AKT – Applied knowledge test
KFP – Key feature problem
CCE – Clinical competency exam