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South Australian
Abortion Action Coalition
Better abortion access

Barriers to best care

While each individual experience of abortion is unique, all women seeking an abortion in South Australia will encounter a law that constrains the possibilities for medical practitioners and health services to provide them with best care. Considered an act of liberalisation in 1969, Section 82A of the current Criminal Law Consolidation Act 1935 (SA) has become a barrier, rather than an enabler, of good health care.

The regulation of abortion within the State's criminal law not only reinforces the stigma associated with seeking or providing an abortion, it also produces significant barriers to best care. These barriers do not prevent women from seeking abortions, but they do place unnecessary limits on the capacity of doctors to provide them. Doctors and other health practitioners have the capacity to provide better care for women and repealing section 82A will enable them to do this in four key ways.

Barrier 1: The prescribed hospital clause

The current law requires that all abortions must be performed in a 'prescribed hospital'. Originally intended to ensure the safe provision of surgical abortion, the global emergence of safe and effective Early Medication Abortion (EMA) in 1988 means that the current interpretation of 'prescribed hospital' is out-of-step with evidence-based, best care practices.[1] [2] The law does not enable GPs to prescribe EMA for their patients from their general practice setting as occurs in other states. Furthermore, SA women are not able to use telemedicine services for EMA. To access EMA women in SA must attend a 'prescribed hospital' for two or more visits.

Across other Australian jurisdictions, EMA services are provided according to best practice guidelines of leading health authorities.[3] These guidelines enable women to take the prescribed medication at home with support and follow up care available, if required.

The impact of the current legal requirement for all abortions to be performed in a 'prescribed hospital' is felt most by women living in regional SA where abortion services are scarce. The majority of women living in regional SA who have an abortion within the current law need to travel and this involves delays, stress and financial burden. For some women, this can mean a 700km round-trip, often for the purpose of taking a tablet.[4] The solution of accessing EMA from a GP is not available to them.

In more distressing circumstances, these legal constraints can mean that women who have accessed an EMA experience the commencement of their abortion on the way home from the 'prescribed hospital'. These experiences are totally avoidable.

Barrier 2: Requirement for examination and certification by two doctors

In SA, abortion is the only health procedure that requires examination and certification by two legally qualified medical practitioners in order to make the procedure lawful. By delegating this decision-making authority to not one, but two, medical practitioners, the current law compromises women's right to self-determination. Not only is abortion one of the safest health procedures in Australia,[5] [6] it should always be a decision made by the person who is pregnant.

This requirement enforces the inefficient over use of scarce medical resources. This can contribute to delay in access when a second doctor may not be available to certify the procedure. Some medical practitioners identify the location of abortion in the criminal law as a reason for their reluctance to be the second examiner.

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Barrier 3: Provision of abortion is limited to medical practitioners

International research demonstrates that abortion can be safely and effectively provided by appropriately trained health care providers, not only by medical practitioners.[7] The World Health Organisation advises that EMA is the responsibility of women with the support of trained health care providers. These providers can include not only doctors, but also nurses, midwives and pharmacists. By precluding these providers from supporting women in this way, the current law constrains the possibilities for best care.

Barrier 4: Gestational limits

More than 90% of SA women who have an abortion do so within the first 14 weeks of pregnancy.[8] For a small but significant population the decision may be made after this stage. These decisions emerge out of varied and complex lived experiences. For more than half, the delay derives from the little recognised fact that pregnancy is not always easily identifiable or, for women who are pre- and peri-menopausal, pregnancy is not considered likely or possible.

Domestic violence, mental and physical health problems, injury, trauma and addiction often frame the personal circumstances of women's decision to have an abortion beyond 14 weeks. In the case of foetal anomaly, the complexities of making the decision to have an abortion is bound up with the timing of tests. The timing restrictions set out in the current law prescribe an upper time limit of 28 weeks. Interpretation of the law means that abortion is provided in SA only up to 24 weeks. Certain tests may only be available after 20 weeks. If an anomaly is identified, further tests may be ordered to give women as much information as possible for decision making. While health care practitioners can provide women this important information, the current law restricts them from giving women this information with time to decide.

Best care practices require that women be able to make decisions about their reproductive health as the experts of their situation with the support of their health practitioner. When the law limits women's access to the information and time needed to act autonomously with the support of their health practitioners, the law needs to change.

Best care happens when women have convenient access to abortion services, and when we trust women and health care professionals. Best care is timely care that happens when it is needed. Repealing Section 82A will enable more trained health practitioners to respect women's decision making capacities and provide better care for them — no matter where they live.

1 Mulligan E and Messenger H, 2011, 'Mifepristone in South Australia: The first 1343 tablets', *Australian Family Physician*, 40.5, 342.

2 Gatter M, Cleland K and Nucatola DL, 2015, 'Efficacy and Safety of Medical Abortion Using Mifepristone and Buccal Misoprostol Through 63 Days', *Contraception*, 91.4, 269.

3 Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2016. Termination of Pregnancy. https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/ Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20 Gynaecology/Termination-of pregnancy-(C-Gyn-17)-Review-July-2016.pdf

4 Scheil W, Jolly K, Scott J, Catcheside B, Sage L and Kennare R, 2016, Pregnancy Outcome in South Australia 2014. Adelaide: Pregnancy Outcome Unit, SA Health. http://www.sahealth.sa.gov.au/wps/wcm/connect/d8b1db004f29bbbda841ee9ea2e2f365/16148.1+Pregnancy+Outcomes+Report+A4_final.pdf?MOD=AJPERES&CACHEID=d8b1db004f29bbbda841ee9ea2e2f365

5 Mulligan E and Messenger H, op cit

6 World Health Organisation. 2014. *Trends in Maternal Mortality: 1990 to 2013: Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1

7 World Health Organisation 2015. *Health worker roles in providing safe abortion care and post abortion contraception.* http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/

8 Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R, 2016, op cit.

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