saaac
South Australian
Abortion Action Coalition
Better abortion access

Better abortion access

Best quality abortion care is enabled when abortion is a woman's decision, is affordable to all, and is accessible regardless of a woman's location.[1] Care is best when provided by well trained and committed practitioners using the most up to date, evidence-based methods suited to the particular circumstances. Abortion should be regulated like other health care. It should not be in the criminal law.

Currently the provision of abortion in South Australia is defined and restricted by Sections 81, 82 and 82A of the Criminal Law Consolidation Act. Because of the way the legislators shaped these sections in 1969, the law is no longer fit for purpose, and creates several important barriers to best care. The availability of early medication abortion, for example, was not imagined when the requirement for abortion services to be provided in a 'prescribed hospital' was written. Similarly, the requirement to be resident in SA for two months prior to having an abortion is out of step with current health care arrangements by which patients from Broken Hill, Mildura, Alice Springs, Darwin and neighbouring regions come to Adelaide for specialised health care that isn't available in their own region (and SA is reimbursed for the costs of that care).

This sort of mismatch between the specific provisions in the criminal law and modern health care practice mean that access to best care for abortion is compromised, particularly for those who don't live in Adelaide. Some of the provisions, and the regulations that enforce them, are also demeaning to women's autonomy and their status as citizens.

It is time to repeal the criminal law relating to abortion, and to regulate this essential health care, like any other health matter, through the Health Care Act. The fact sheets in this pack explain the problems caused by the current law, the ways that necessary regulation can be achieved through existing health law and regulations (with two important additions), and they also bust some common myths about who has abortions and why.

The ten Fact Sheets in this collection provide essential background information for understanding abortion care in South Australia and the problems faced in obtaining care.

The fact sheets refer to women having abortions. We (SAAAC) acknowledge that other people who do not identify as women, including trans men, trans masculine people and non-binary people, can also experience pregnancy and abortion.[1]

If you have any questions about the information in the fact sheets, or would like to discuss the proposal, please contact SAAAC through our website:

saabortionactioncoalition.com or email
saabortionactioncoalition@gmail.com

saaac
South Australian
Abortion Action Coalition
Better abortion access

1 IPPF, *How to talk about abortion*: *A guide to rights based messaging*, (London: IPPF, 2015), http://www.ippf.org/resource/how-talk-about-abortion-guide-rights-based-messaging.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Best care and how to extend it

Abortion should be a woman's decision, be affordable to all, and accessible regardless of a woman's location. It should be provided by well trained and committed practitioners utilising the most up to date, evidence-based methods suited to the particular woman's circumstances. Abortion should be regulated like other health care. It should not be in the criminal law.

Metropolitan abortion services

Adelaide has excellent public sector abortion services. Provision of these services is generally free of charge, and therefore a patient's income or socioeconomic status is not a constraint upon access; this is unique in Australia. Nearly all abortions in South Australia are performed in metropolitan public hospitals, and the majority are performed at the Pregnancy Advisory Centre, which operates as part of the Queen Elizabeth Hospital.

The Pregnancy Advisory Centre (PAC) is a free-standing specialist clinic which has maintained global best practice standards of abortion provision since 1992. The PAC has been collecting data on the outcomes of abortion procedures since its inception. These data show that the PAC has improved its performance across this period. The effectiveness of the PAC's quality improvement approach is illustrated by its extremely low rate of adverse events.[1]

Abortion services are not readily accessible in regional and rural areas

However, abortion services are not as readily accessible to women in regional and rural South Australia, nor in areas across state borders where people regularly rely upon and are referred to SA health services (eg Broken Hill, Alice Springs). A legislative requirement that women must hold SA residency in order to access abortion services results in access being denied to interstate patients.

Medication and surgical methods of abortion

Since 2008, the PAC (and, subsequently, some public hospitals in SA) have been providing abortion using both medication and surgical methods. About one third of women treated by the PAC choose early medication abortion, which is available to women up to nine weeks into their pregnancy. Data collected internationally and at the PAC shows that early medication abortion is as safe as surgical abortion[2 3] and does not need to be provided in a hospital clinic. Early medication abortion has the potential to improve access for women, particularly those in rural and remote areas.

South Australian law obstructs widespread availability of Early Medication Abortion (EMA) and late gestation abortion

But the SA law, which was developed to provide excellent hospital or clinic based care for surgical abortion, has become an obstruction to the widespread availability of early medication abortion. The requirement that abortions be performed in a hospital compromises wider access to early medication abortion.

saaac
South Australian
Abortion Action Coalition
Better abortion access

Abortion is available in SA only up to 24 weeks gestation (although the law sets a limit of 28 weeks). This creates an arbitrary gestational limit, not guided by medical evidence and is out of step with patient centred health care. The need for late gestation abortion is relatively rare, arising from exceptional circumstances including serious health risks and foetal abnormality or death.

Safe access zone legislation is needed to protect patients and staff

The PAC is regularly frequented by protesters who oppose abortion. In many countries, the provision of abortion is (uniquely among medical services) heavily affected by protests. This interference is distressing for patients and staff, and at its most extreme compromises the safety of those accessing and/or providing abortion services. Currently, four Australian jurisdictions, as well as numerous international territories, have introduced safe access zone legislation, which creates a physical space around a clinic or hospital where protesters may not enter and/or where their speech and action is restricted.

The two doctor requirement is unnecessary

The law in SA currently states that in order for a woman to have an abortion two doctors must form the opinion that she meets criteria set out in the criminal law. This requirement — made nearly fifty years ago — is completely out of step with consent processes for all other medical procedures in SA and demeans women's decision making authority. The two doctor requirement is an unnecessary use of doctors' human resource.

1 Mulligan E, 2006, 'Striving for excellence in abortion services', *Australian Health Review*, 30.4, 468-473.

2 Kulier R, Kapp N, Gülmezoglu AM, Hofmeyr GJ, Cheng L, Campana A. *Medical methods for first trimester abortion*. Cochrane Database of Systematic Reviews 2011, Issue 11. Art No: CD002855. DOI: 10.1002/14651858.CD002855.pub4.

3 Mulligan E and Messenger H, 2011, 'Mifepristone in South Australia: the first 1343 tablets', *Australian Family Physician*, 40.5, 342-345.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Public opinion

Public opinion in Australia has been moving in a strong pro-choice direction since the 1970s. Rigorous studies conducted in the twenty first century have consistently shown that about 80% of Australians support the statement that 'A woman should have the right to choose whether or not she has an abortion'.[1] Most people have been surprised to find that abortion is still defined in the criminal law.

- Differences of sex, age, location, or political party affiliation make little impact on attitudes toward abortion.[2]
- While religion is associated with a significant difference in attitudes toward abortion, no religious group falls below 80% in support of allowing abortion in some circumstances, nor rises above 10% in opposition to it in all circumstances. People not identifying with any religion have the highest rate of support for access to abortion in any circumstance (78%), a position supported by a majority of respondents belonging to the Church of England (60%), Uniting Church (57%), and Presbyterian churches (53%). 45% of Catholic respondents support the availability of abortion in any circumstances, and only 7% believe it should not be available at all.[3]
- In a 2013 Newspoll surveying 600 Victorian women about that state's abortion laws, 78% of women with a religious affiliation and 95% of women without agreed that the law should provide women with the right to decide whether or not to have an abortion.[4]
- The most recent major report on Australian public opinion of abortion was conducted by Lonergan Research in 2015, and surveyed 1015 NSW residents. The overwhelming majority — some 87% of respondents — believed that women should be able to have an abortion, with over half agreeing that women should be able to obtain one at any time under any circumstances. A mere 6% indicated opposition to abortion regardless of circumstances.[5]
- More than 78% of people believed medical practitioners should be required to provide unbiased and independent information on options for unplanned pregnancies, including abortion, regardless of their personal views on the matter.[6]
- 76% of respondents were unaware that abortion was still a crime in NSW, and 73% supported the removal of abortion from the NSW Crimes Act. 81% supported the creation of safe access zones around healthcare locations providing abortion services and advice. There was majority support for abortion access, decriminalisation, and safe access zones was the majority across geographic, demographic, and political boundaries.

- Australian surveys have rarely investigated public opinion about abortion with respect to gestational stage. The results of a Victorian survey conducted by Crosby Textor in 2008 challenged the belief that Australians strongly oppose women accessing abortion in the second and third trimesters. The survey demonstrated that individuals have nuanced views depending on the reasons for which women seek abortion. 69% indicated that abortion should be lawful in at least some circumstances for the second trimester and 48% for the third. A majority of respondents indicated that in a wide range of clinical and social circumstances doctors should not face professional sanctions for terminating a pregnancy after 24 weeks' gestation.[7]

1 Victorian Law Reform Commission, 2008, *Law of Abortion Final Report*, Melbourne: VLRC.

2 Betts K, 2009, 'Attitudes to abortion: Australia and Queensland in the twenty-first century,' *People and Place*, 17:3, 25-39.

3 ibid.

4 O'Rourke A, 2016, 'The discourse of abortion law debate in Australia', *Women's Studies International Forum*, 56, 37-44.

5 O'Brien N, 2015, 'Make it legal and accessible: poll on women's right to choose in NSW', *The Sydney Morning Herald*, September 27 2015. http://www.smh.com.au/nsw/polling-shows-overwhelming-support-for-a-womans-right-to-choose-20150925-gjvfyu

6 ibid.

7 De Crespigny L et al, 2010 'Australian attitudes to early and late abortion', *Medical Journal of Australia*, 193:1, 9-12.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Health professionals' opinion on abortion

As advocates for patient welfare and rights, the majority of Australian health professionals are in support of access to abortion services. However, they admit that restrictive laws impact upon their ability to provide the best standard of care for their patients.

Health professionals are bound to act in the best interest of their patients' health, autonomy and rights, and this includes the provision of, and referral on to, safe abortion services. Despite the overwhelming support for providing access to abortion services, the presence of abortion in the South Australian criminal law negatively impacts upon health professionals' willingness and ability to provide the best standard of care for women.[1]

In their formal position on Ethical Issues in Reproductive Medicine in 2013, the Australian Medical Association (AMA) emphasised the role of abortion services in providing holistic healthcare: *'to regulate and control fertility should be regarded as a principal component of the physical, mental, and social well-being of women of reproductive age.'*[2]

In examining the opinions of health practitioners on abortion, it is particularly important to consider the professional opinion of those practitioners who are in a position to actually provide abortion services—obstetricians/gynaecologists and general practitioners.

The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) has issued a formal statement in support of access to abortion services. RANZCOG cites the potential dangers arising from restricted access. *'Non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies'*. They make note of equity issues. *'Access to termination services should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation… in the same way it is for other health services.'*[3]

A large peer-reviewed study of practicing obstetricians/gynaecologists (OBGYNs) demonstrated that 89% supported the availability of abortion within the public health system, and 73% provided abortion services as part of their practice.[4] Of those who reported religious/conscientious objection to abortion, 32% still provided abortions in certain circumstances.[5] Several respondents reported not accepting a fee for provision of abortion services, stating that it is a 'needed procedure'.

General practitioners (GPs) account for the majority of abortion-providing doctors in Australia and GPs as a professional group overwhelmingly support access to abortion services. A large Australia-wide survey found that 84% of Australian GPs believed all women should have access to abortion services.[6] However, more than a third (37%) reported that they do not feel they fully understand the abortion laws in their state or territory.[7] Health professionals are cautious of the laws that govern their practice; in the case of abortion, these laws impede best practice.

saaac
South Australian
Abortion Action Coalition
Better abortion access

The impact of South Australian laws on practice

In SA, abortion is currently defined as an offence in the criminal law, but there are circumstances in which abortion is deemed lawful. Nonetheless, the presence of a vital medical procedure in the criminal law impacts upon practitioners providing this service.

Australian research has demonstrated that the continued status of abortion as a potential criminal offence in some jurisdictions (as is the case in SA) *affects the willingness of medical practitioners to provide abortion services*, and the manner in which abortion services are provided.[8] Sustainable service provision is undermined by laws that discourage otherwise willing practitioners.

Researchers have shown that abortion providers in NSW and Queensland adopt *restrictive practices to manage the perceived risk of prosecution*, even though these practices are neither medically indicated nor explicitly required by the law. This occurs even where medical practitioners indicate that these restrictions are 'usually unnecessary, time consuming, emotionally distressing for the woman concerned and often detrimental to her physical and/or mental health'.[9] Complete removal of abortion from the criminal law would mean that practitioners need not be restricted by fear of prosecution and uncertain legal interpretations, but rather guided by current medical evidence regarding safe and best practice for abortion provision.

Research has demonstrated that the majority of Australian OBGYNs and GPs support ready and free access to abortion services for women, and are willing to provide this essential service. By repealing the laws that restrict best practice in South Australia, we wouls allow health professionals to continue to advocate for their patients and provide best quality care.

1 Quantum Market Research, Marie Stopes International. 2004. 'General Practitioners: Attitudes to Abortion', May 27, 2010. https://issuu.com/mariestopes/docs/gps_attitudes_to_abortion_research/7.

2 Australian Medical Association, 2013, Ethical Issues in Reproductive Medicine. Position statement. https://ama.com.au/position-statement/ethical-issues-reproductive-medicine-2013.

3 The 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-%20Gynaecology/Termination-of-pregnancy-(C-Gyn-17)-Review-July-2016.pdf?ext=.pdf.

4 De Costa CM, Russell DB and Carrette M, 2010 'Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Medical Journal of Australia*, 2010; 193:1, 13–16. https://www.mja.com.au/journal/2010/193/1/views-and-practices-induced-abortion-among-australian-fellows-and-specialist.

5 ibid.

6 Quantum Market Research, Marie Stopes International, 2004. Op cit.

7 ibid.

8 De Costa CM, Russell DB, Carrette M, 2010, Op cit.

9 ibid.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Understanding the need for late gestation abortion

Most abortions in South Australia occur in the first trimester of pregnancy but a small number of women need an abortion later in pregnancy. SA abortion law imposes a limit on the gestational age at which abortion may be performed, which is out of step with medical evidence, public opinion, and patient-centred health care.

SA has excellent services for the care of women needing second trimester abortion but each year a small number of women experience distress associated with the current gestational 'cut-off' and some are denied an abortion because of it. Others face the pressure of having to make a hurried decision to comply with the gestational limit.

Abortions in the second or third trimester are rare in Australia and in other countries such as the UK. [2 3 4]

SA data consistently shows the majority of abortions (91.9%) occur within the first 14 weeks, or first trimester of pregnancy. Abortions occurring at or over 20 weeks gestation account for less than 2% of all abortions; and 50–55% of these abortions occur for reasons of fetal anomaly.

Women require abortions after 20 weeks gestation for the same reasons as first trimester abortions; because they decide they do not want to continue with the pregnancy. Research shows delays occur for a range of reasons and women do not delay seeking an abortion 'needlessly'. Australian and overseas studies identify factors affecting the timing of the decision for abortion.[5 6 7 8]

Symptoms of pregnancy are not clear

Later presentation for abortion may occur because the pregnancy has gone unrecognised by the woman, or has failed to be diagnosed by doctors. Some women continue to menstruate in pregnancy. When effective contraception is being used, pregnancy symptoms, may be discounted. Long-acting methods of contraception, such as implants and IUDs suppress menstruation. Younger women or menopausal women, women with irregular bleeding or women with medical conditions, which make pregnancy unlikely, may not realise that they are pregnant.

Difficult personal circumstances

Women may be delayed in seeking abortion due to anxiety about confiding in their parents or partner, failure of anticipated emotional or economic support (from family, partner, or employer), or a change in socio-economic circumstances. Women experiencing domestic violence, mental or physical health problems, trauma, or addiction also experience barriers in organising care.

Reproductive coercion

A recognised form of domestic violence, reproductive coercion includes a range of abusive, controlling behaviours by the woman's partner, such as contraceptive sabotage, or forcing a woman to continue with an unwanted pregnancy. As this usually occurs in the context of violent relationships, women can find it extremely difficult and dangerous to access abortion services, causing significant delays in presentation.

Difficulty accessing abortion

Some women make a decision to have an abortion earlier in their pregnancy, but experience delays in access. Some women are given misinformation—sometimes deliberately—about abortion availability. Women living in rural, regional or remote locations experience delays because of long waiting times for appointments, specialist referrals, and travel times. Diagnosis of fetal anomaly occurs later in pregnancy, with the timing of tests and procedures which screen for and diagnose serious foetal anomalies dictating the timing of a woman's decision to abort. There is a range of screening tests in the first trimester. Some indicators then require further diagnostic tests but results may not be available until after 14 weeks gestation. If a decision is made to proceed to abortion it is usually then performed in the second trimester.

The next screening test is a morphology scan at 19–20 weeks gestation. Until this point in the pregnancy, many serious anomalies will not be detectable. If abnormalities are identified on this scan, further investigations are often required including second ultrasound, genetic testing, foetal MRI, and referral to other specialists. Some complex clinical conditions can take even more time before a confident clinical picture or the safest time for abortion is determined. About 30% of abortions for foetal anomaly are therefore performed at 20+ weeks.

Illness or injury during pregnancy

While relatively rare, sometimes a woman experiences the need for a late gestation abortion due to illness or injury, such as serious trauma (eg from a car accident), the need for urgent cancer treatment or deterioration in other conditions.

The Royal Australian & New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recognises special circumstances of late presentation or diagnosis and support the availability of legal abortion without a gestational cut-off, so that women and their specialists can decide as late as necessary, avoiding the regret and suffering caused when decisions are made under the pressure of arbitrary (non-clinical) limits.[9] A 2008 peer-reviewed online survey showed a high level of support for access to lawful abortion and that a majority of Australians support laws which enable women to access abortion services after 24 weeks gestation.[10]

Repealing laws restricting abortion from the criminal law will enable assessment by the woman's specialist multidisciplinary team, and her own informed consent, to proceed with an abortion.

1 South Australia Criminal Law Consolidation Act 1935 (Division 17: Abortion, Sections 81, 82 & 82A, pp. 46–47. https://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT%201935/CURRENT/1935.2252.UN.PDF

2 Scheil W, Jolly K, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2013. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2015.

3 Government of Western Australia, Department of Health, Reports on Induced Abortion in Western Australia. http://ww2.health.wa.gov.au/Reports-and-publications/Reports-on-induced-abortions-in-Western-Australia

4 Department of Health [UK], Abortion Statistics: England and Wales, 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/570040/Updated_Abortion_Statistics_2015.pdf

5 Foster D and Kimport K, 2013, 'Who seeks abortions at or after 20 weeks?', *Perspectives on Sexual and Reproductive Health*, 45. 4, 210–218. http://onlinelibrary.wiley.com/doi/10.1363/4521013/abstract

6 Ingham R, Lee E, Clements S and Stone N, nd, *Second trimester abortions in England and Wales*, Centre of Sexual Health Research, University of Southampton. https://www.bpas.org/media/1202/second_trimester_abortions__ingham.pdf

7 Conlon C, 2006, *Concealed Pregnancy: A sase study approach from an Irish Setting*, Crisis Pregnancy Agency Report No 15. http://crisispregnancy.ie/wp-content/uploads/2012/05/15.-Concealed-pregnancy-a-case-study-approach-form-an-Irish-setting.pdf

8 Children by Choice, 2016, Pregnancy, Domestic Violence and Reproductive Coercion, Healthed Clinical Articles. http://www.healthed.com.au/clinical-articles/pregnancy-domestic-violence-and-reproductive-coercion/

9 RANZCOG, 2016, Late termination of pregnancy. https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Late-Termination-of-Pregnancy-(C-Gyn-17a)-New-May-2016.pdf?ext=.pdf

10 De Crespigny L, Wilkinson D, Douglas T, Textor M and Savulescu J, 2010, 'Australian attitudes to early and late abortion', 193.1, 9–12. https://www.mja.com.au/journal/2010/193/1/australian-attitudes-early-and-late-abortion

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
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 assessed supports 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 denies 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.

saaac
South Australian
Abortion Action Coalition
Better abortion access

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 with this important information, the current law restricts them from giving women 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.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Early medication abortion (EMA)

Abortion using prescription medication is a safe, legal, and effective alternative to surgical termination. However, South Australia's legislation was written before early medication abortion was available, and restrictive interpretation of these laws currently limits access for women. It is time to repeal these laws, and allow SA women access to essential abortion services that are available in other Australian states, and worldwide.

What is EMA?

EMA is the termination of a pregnancy using prescription medication. It is safe and effective for early pregnancy up to nine weeks. EMA is sometimes referred to as medical termination of pregnancy or MTOP. The medications used are mifepristone (also known as RU486) and misoprostol. This is not the same as emergency contraception which works to prevent pregnancy.

What do the medications contain? How do they work?

Mifepristone and misoprostol are medications that mimic naturally produced hormones. That is to say they are not noxious or poisonous, but rather synthetic copies of physiological, normal hormones. They abort a pregnancy by blocking the hormones that would otherwise sustain it. Mifepristone and misoprostol have been approved by the Therapeutic Goods Administration Australia[1] and are subsidised by the Pharmaceutical Benefits Scheme[2]. The World Health Organisation has included both on the list of WHO Essential Medications.[3]

Why is EMA important?

Early medication abortion provides an alternative to surgical abortion. This is significant for women who cannot or do not wish to undergo a surgical procedure and/or general anaesthetic. Importantly, it is an opportunity to improve access to women in rural and remote areas, who may have to travel long distances to reach metropolitan centres that perform surgical abortions, but could access early medication abortion closer to home. In one study termination providers reported that when given a choice, one third of women will opt for an EMA.[4]

How does current legislation in SA affect EMA?

SA's abortion reforms were enacted in 1970—long before the development of mifepristone and misoprostol. These laws still regulate our practice. They are outdated, and do not support best care.

Two specifications of the criminal law particularly could restrict access to EMA in SA:

1. The requirement for two medical practitioners to assess and approve an abortion.
2. The requirement for an abortion to be 'carried out in a hospital'.

saaac
South Australian
Abortion Action Coalition
Better abortion access

This wording in the legislation could be interpreted to mean that doctors are prevented from prescribing EMAs in the community. Even in hospitals, two doctors are required to assess a woman seeking an abortion — doubling staffing requirements and reducing efficiency. The two medications are ideally given 48 hours apart and current interpretation of the law in SA means that women must visit the hospital twice to be given medication.

The impact of these constraints is felt most by rural women, who are already in resource-poor settings, and often must travel to metropolitan services at great personal cost. Reforming SA's abortion laws will also create the opportunity for rural women to access abortion care from their GP and safely via telemedicine — utilising available technology to provide best-practice care for abortion, in the same way it is already utilised for many other medical practices.

It is time to repeal South Australian law, and allow women better access to essential abortion services.

1 Australian Government, Department of Health, Therapeutic Goods Administration, 2014, Australian Public Assessment Report: Mifepristone/misoprostol, 19 November 2014. https://www.tga.gov.au/auspar/auspar-mifepristone-misoprostol.

2 Australian Government, Department of Health, The Pharmaceutical Benefits Scheme, 2013, Public Summary Document: Mifepristone, tablet 200mg, Mifepristone Linepharma™, and GyMiso®, March 2013. http://www.pbs.gov.au/info/industry/listing/elements/pbac-meetings/psd/2013-03/mifepristone.

3 World Health Organisation, 2015, 19th WHO Model List of Essential Medicines, April 2015. http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf

4 Mulligan E and Messenger H, 2011, 'Mifepristone in South Australia: the first 1343 tablets', *Australian Family Physician* 40.5, 342-345.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

How the current law affects services

Abortion in South Australia is governed by the Criminal Law Consolidation Act 1935 (SA) Division 17, Sections 81, 82 and 82A.[1] The law was amended in 1969 with the addition of Section 82A Medical Termination of Pregnancy. This reform enabled development of high quality abortion services in public and private hospitals. Expectations of women's rights, community attitudes to abortion and methods of abortion have significantly changed since1969. Nearly fifty years later, this law is outdated and contributes to numerous problems for women and service providers when accessing and providing contemporary best practice health care.

Section 82A, Medical Termination of Pregnancy, outlines the conditions under which abortion is legal:

1(a) If the pregnancy of a woman is terminated by a legally qualified medical practitioner in a case where he and one other legally qualified medical practitioner are of the opinion, formed in good faith after both have personally examined the woman —

1(a)(i) That the continuance of the pregnancy would involve greater risk to the life of the pregnant woman, or greater risk of injury to the physical or mental health of the pregnant woman, than if the pregnancy were terminated; or

1(a)(ii) That there is a substantial risk that, if the pregnancy were not terminated and the child were born to the pregnant woman, the child would suffer from such physical or mental abnormalities as to be seriously handicapped

and where the treatment for the termination of the pregnancy is carried out in a prescribed hospital, or a hospital of a prescribed class …

1(a) Medical practitioner requirements

The current law does not give a right to decide to have an abortion. Rather, it maintains the position of the medical profession as the gatekeepers of women's reproductive lives by denying women full agency for their decision. It specifies the circumstances in which medical practitioners can perform an abortion. The requirement that two legally qualified medical practitioners examine the woman is difficult and expensive and an unnecessary use of financial and medical resources. It can contribute to delay in access where two doctors might not be available. The current law does not allow for contemporary models of health care to be implemented in a society that experiences workforce and financial constraints in the broader healthcare sector.

1(a)(i) Relative risk assessment

Medical and surgical abortion is highly effective with a low rate of complications making it safer than continuing a pregnancy and childbirth.

Prescribed hospital requirement

The prescribed hospital requirement is a significant impediment to the availability and standard of care because it limits the premises where abortions can be provided. For women who need an early medication abortion two visits to a prescribed hospital, 48 hours apart, for the taking of tablets, are currently required. Best clinical practice standards recommend that the woman be given medication to take at home at a time of their convenience.[2]

The two visit requirement is exceptionally burdensome for women who travel from regional or rural areas to Adelaide to access abortion services, negatively impacting work, family and other commitments. Developments in modern health care provision using telemedicine enable women elsewhere in Australia to obtain the requisite assessment and information for suitability for a medical abortion thus ensuring timely access.[3] The law precludes women in regional and rural South Australia from accessing care and advice via telemedicine (eg for follow-up) to improve their overall health outcomes.

Two month residency requirement

(2) Subsection (1)(a) does not refer or apply to any woman who has not resided in South Australia for a period of at least two months before the termination of her pregnancy.

This clause arose from SA politicians' concern when the law was first introduced in 1969 that SA would become the 'abortion capital of Australia'. This residency clause is completely out of step with the normal practice of health care provision in Adelaide for people from Broken Hill, Mildura, Alice Springs, Darwin and remote Northern Territory for care that is not available in their local area. Abortion care for women from these areas needs to be included in the reciprocal health care agreements that manage and fund these arrangements.

Conscientious objection

(5) no person is under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this section to which he has a conscientious objection, but in any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it

The AMA Code of Conduct 2016 states that access to medical care must not be impeded based on conscientious objection, and that information must be provided so that care can be sought elsewhere.[4] Mandatory referral should be made to another medical practitioner who does not hold a conscientious objection.

Certification and mandatory reporting

(4) The Governor may make regulations:

(a) for requiring any such opinion as is referred to in subsection (1) to be certified by the legally qualified medical practitioners or practitioner concerned in such form and at or within such time as may be prescribed and for requiring the preservation and disposal of any such certificate made for the purposes of this Act; and

(b) for requiring any legally qualified medical practitioner who terminates a pregnancy, and the superintendent or manager of the hospital in which the termination is carried out, to give notice of the termination and such other information relating to the termination as may be prescribed to the Director-General of Medical Services; and

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be prescribed, of notices or information given pursuant to the regulations; and

(d) declaring a particular hospital or a class of hospitals to be a prescribed hospital or a prescribed class of hospitals for the purposes of this section; and

(e) for providing for, and prescribing, any penalty, not exceeding two hundred dollars, for any contravention of, or failure to comply with, any regulations.

Although not mandated by Section 82A the form COR19 is required by regulation to be completed by the doctor performing an abortion and signed by them and a second doctor who has also examined the woman.

The COR 19 documents personal detail not required for any other health service and includes specific details of the abortion care and treatment provided. Data from the COR 19 forms the basis of reports released by the Pregnancy Outcomes Unit annually and tabled in SA Parliament.

The COR19 does not meet the requirements for the analogous situation of the ethical collection and use of data for research as outlined in the NHMRC Statement on the Ethical Conduct in Human Research.[5] It is argued by service providers that information required to be completed on the COR 19 is a gross invasion of women's privacy.

Doctors identify the regulation of abortion in the criminal law as a reason for their reluctance to provide a second opinion for the notification form. The COR19 form intimidates doctors who can be reluctant to provide the second opinion because of the potential for criminal liability.

saaac
South Australian
Abortion Action Coalition
Better abortion access

Child destruction clause

(7) The provisions of subsection (1) do not apply to, or in relation to, a person who, with intent to destroy the life of a child capable of being born alive, [defined in (8) as a foetus of 28 weeks gestation] by any wilful act causes such a child to die before it has an existence independent of its mother where it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

There is strong opinion that removal of the child destruction clause would eliminate the ambiguity currently perceived by medical practitioners. South Australia and Tasmania expressly provide for a defence to the crime of child destruction: in these jurisdictions it is a complete defence if the act that caused the death of the child was done in good faith for the preservation of the mother's life.[6]

The interpretation of this clause and its relationship to the 'born alive rule', have given rise to Departmental concern and consequent service limitations to 24 week gestation limit for abortion in SA.

Service providers have advised women that the opinion of Crown Law is that even procedures meeting the requirements of Clause 1 may be criminal if the pregnancy is 'capable of being born alive'.

Hence, services are not offered beyond 24 weeks gestation.

Gestation becomes the determining factor rather than the health of the woman.

The 2008 Victorian Law Reform Commission Report, strongly recommended removal of all references to child destruction from abortion laws.[7] The Victorian parliament heeded this advice in 2008 when they repealed the sections of their criminal code relating to abortion.[8]

Conclusion

The repeal of all sections in the criminal law relating to abortion will improve access, bring abortion provision into the twenty-first century and show respect for women's autonomy.

1 https://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT%201935.aspx

2 O'Rourke A, Belton S and Mulligan E, 2016, 'Medical Abortion in Australia: What Are the Clinical and Legal Risks? Is Medical Abortion Over-regulated?' *Journal of Law and Medicine*, 24.1, 221-238.

3 See Tabbott Foundation www.tabbot.com.au; Mulligan E, 2016, *The advent of telemedicine abortion has had a broad impact on Australian abortion services.* https://www.eiseverywhere.com/file_uploads/68f39018a2692eca05bb104e0298c9ec_130_EaMulligan.pdf.

4 AMA Code of Ethics 2016. https://ama.com.au/position-statement/code-ethics-2004-editorially-revised-2006-revised-2016

5 NHMRC. 2007. Australian Code for Responsible Conduct of Research. https://www.nhmrc.gov.au/_files_nhmrc/file/publications/r39_australian_code_responsible_conduct_research_150811.pdf

6 Criminal Law Consolidation Act 1935 (SA) s 82A(7); Criminal Code (Tas) s 165(2). Also see 1929 UK Act s 1(1).

7 Victorian Law Reform Commission, 2008. Law of Abortion. Final Report. http://www.lawreform.vic.gov.au/projects/abortion/law-abortion-final-report-pdf.

8 www.legislation.vic.gov.au/Abortion-law-reform-Act-2008.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Enabling legislation to support access

While defining abortion in the criminal law is outdated and unnecessary the law has an important role to play in supporting women's access to abortion care. Repealing South Australia's outdated abortion laws and treating abortion like all other health procedures, regulated under the Health Care Act 2008 (SA),[1] will remove barriers to providing best care and improve women's access to timely services which are able to respond to their needs and values.

Enacting enabling legislation for safe access to abortion premises and timely referral to an abortion provider will ensure women have access to this health care like any other.

The South Australian Abortion Action Coalition (SAAAC) proposes an abortion law reform bill which would:

1. Repeal abortion entirely from criminal law in SA by repealing all of Division17 and Division 18 CLCA, 1935 (SA)[2];
2. Abolish all references to abortion in criminal law.

SAAAC proposes additional provisions in the Health Care Act to:

1. Ensure there is an obligation for medical practitioners who have a conscientious objection to abortion to refer to practitioners who do not;
2. Ensure safe access to premises at which abortions are provided.

These advances will enable abortions to be provided, under health law and ethics:

1. On the informed consent of the woman rather than the opinion of two doctors;
2. In the most appropriate location, rather than only in those hospitals prescribed by the law;
3. By appropriately trained health professionals, including nurses and midwives, unrestricted by outdated and uncertain legal interpretations,[3] and in accordance with World Health Organisation recommendations;
4. Incorporating technological advances and guided by medical evidence for the provision of safe and best practice abortion care;
5. To women from interstate locations such as Broken Hill, Alice Springs, Mildura or Darwin who usually access specialist health services in Adelaide.

saaac
South Australian
Abortion Action Coalition
Better abortion access

The key advances recognised by other Australian states' modernised legislative environments include:

The right to safe access

Anti-abortion protests at the entrance and adjacent to the Pregnancy Advisory Centre in Woodville are commonplace and cause concern and distress to clients and staff. The introduction of safe access zone legislation in Victoria,[4] Tasmania,[5] the ACT[6] and the NT[7] demonstrates governments' commitment to ensure citizens' right to provide and access health services without hindrance.

Safe access zones (sometimes called exclusion or bubble zones) create a defined area around the entrance to an abortion service within which behaviour is controlled to enable the right of entry to clients and staff free from harassment and intimidation of any kind.

The obligation to refer

Doctors are ethically and professionally bound to ensure that their own conscientious objection to a health service does not impede access for people needing such a service. The Victorian,[8] Tasmanian and NT abortion laws specifically require that doctors who have a personal conscientious objection to abortion refer to a practitioner who they know will support the woman's request for abortion.

Penalties apply to medical professionals who do not refer women in a timely manner.

1 Health Care Act 2008
https://www.legislation.sa.gov.au/LZ/C/A/HEALTH%20CARE%20ACT%202008.aspx

2 Criminal Law Consolidation Act 1935
https://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT%201935.aspx

3 De Costa CM, Russell DB and Carrette M, 2010, 'Views and practices of induced abortion among Australian Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists', *Medical Journal of Australia* 193, 13-16.
https://www.mja.com.au/journal/2010/193/1/views-and-practices-induced-abortion-among-australian-fellows-and-specialist

4 Public Health and Wellbeing (Safe Access) Bill 2015
http://www.parliament.vic.gov.au/static/www.legislation.vic.gov.au-bills.html

5 Reproductive Health (Access to Terminations) Act 2013
http://www.thelaw.tas.gov.au/tocview/index w3p;cond=ALL;docid=72%2B%2B2013%2BAT%40EN%2B20161018140000;histon=;pdfauthverid=;prompt=;rec=;rtfauthverid=;term=reproductive%20health;webauthverid=

6 Health (Patient Privacy) Amendment Bill 2015
http://www.legislation.act.gov.au/b/db_52769/20150917-61888/pdf/db_52769.pdf

7 Termination of Pregnancy Law Reform Bill 2017
http://www.austlii.edu.au/au/legis/nt/bill/toplrb2017373/

8 Abortion Law Reform Act 2008
http://www.legislation.vic.gov.au/domino/web_notes/LDMS/LTObject_Store/LTObjSt1.nsf/d1a8d8a9bed958efca25761600042ef5/69d6c3a5305f935bca2577610017c10d/$FILE/08-58a003.pdf

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Rural and remote access

South Australian law makes abortion more difficult and costly for rural and remote women. Of all abortions provided in South Australia 18% are for women who reside in rural, regional or remote SA, however, just 2% of all abortions are provided outside metropolitan Adelaide.[1] Technological advances such as early medication abortion (EMA) with mifepristone (RU486)[2] and provision by telemedicine[3] and/or nurses and midwives[4] could improve accessibility for country women[5] but SA law restricts this.[6]

The current law:

- Restricts (surgical) abortion treatment to 'prescribed hospitals'
- Requires examination by two doctors
- Requires residence in South Australia for eight weeks prior to abortion

Early medical abortion (EMA)

EMA has been safely provided to Australian women since 2007. At gestations of nine weeks or less EMA is a simple method to provide at a GP practice or community health service and/or via telemedicine.[7]

The Therapeutic Goods Administration directs that women, having been provided with instructions by a doctor, can take the whole EMA package of medication with them to take in the timing and comfort of their own home and support networks, with the back up of a 24 hour telephone help/advice line.

Protocols with the best outcomes for this method recommend two doses of medication 24–48 hours apart.

Current advice from SA Health to service providers is that the abortion legislation requires women to attend at a prescribed hospital and be supervised taking each dose. Therefore, country women who attend the PAC must stay in Adelaide for at least two days.

Women living close enough to drive to Adelaide services must make two trips, risking the pregnancy starting to abort while they are still travelling home after taking the second dose of misoprostol tablets.

Women have told service providers:

"The misoprostol took twenty minutes to take effect with severe cramping and bleeding. As I live more than an hour away from Adelaide I was in terrible pain the majority of the way home."

And that services closer to their homes would save them from undertaking a *"700km round trip"* and enable them to *"get help… and not have to travel so far"*.

The requirement for women to see two doctors, and for abortions to be provided in a prescribed hospital, precludes confidential provision of EMA by a single GP, or nurse/midwife at their usual place of practice.

The current legislation also means that the Tabbott Foundation, a telehealth provider of abortion services, does not provide EMA by telemedicine for South Australian women[8], again excluding this safe, convenient and private service as an option for rural and remote women.

saaac
South Australian
Abortion Action Coalition
Better abortion access

Abortion services are reliant on the availability of a skilled and willing medical practitioner to provide abortions — many rural and regional centres are without one, let alone a second medical practitioner, to examine the woman and sign approval for the abortion to proceed.

Finding a second practitioner at the same service as the provider is rarely possible meaning that a woman must attend at another health service — adding cost, causing delay and compromising her privacy in a small community.

Alternatively, she must travel to Adelaide, incurring travel, accommodation and other costs associated with leaving her work and/or family responsibilities, and in many cases without support from a family member or friend.

South Australian residency requirement

The current legislation requires women to have resided in South Australia for a period of two months prior to the abortion procedure. This affects women who live in or near centres such as Broken Hill, Mildura, Alice Springs and Darwin, and may normally come to Adelaide for services unavailable in these centres.

Specialist expertise in the safe provision of abortions in the second trimester has been developed in SA, but service providers cannot offer this excellent care to women from these locations. Best practice requires that patients receive appropriate specialist care even if this is not available in their closest health service.[9]

When women don't inform providers of their residency interstate in order to protect their access to abortion services, the health care team is unaware of travel plans post discharge and is thus unable to provide accurate plans for follow up.
It is possible that other women simply do not get the service they need and continue an unwanted pregnancy.

Repealing SA abortion law would mean that country women:

- Need only find one trained health professional to provide an abortion.
- Could choose to have a medical abortion at home or closest regional centre.
- Would only need to travel to Adelaide for abortion procedures requiring more specialised care.

1 Reports of Pregnancy Outcome in South Australia 2007–2014, Government of South Australia, Adelaide. http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/pregnancy+outcome+statistics

2 Goldstone P, Michelson J and Williamson E, 2012 'Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study', *Medical Journal of Australia*, 197(5) 282–286.

3 Raymond EG, Chong E, Hyland P 2016, 'Increasing access to abortion with telemedicine', *JAMA Intern Med* 176(5) 585–586

4 Kopp Kallner H, Gomperts R, Salomonsson E et al, 2014 'The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse midwives: a randomised controlled equivalence trial' 2014, *British Journal of Obstetrics and Gynaecology*. http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.12982/full

5 Shankar M, Black KJ, Goldstone P et al, 2017 'Access, equity and costs of induced abortion services in Australia: a cross sectional study', *Australian and New Zealand Journal of Public Health*, 41(3), 309-314. http://onlinelibrary.wiley.com/doi/10.1111/1753-6405.12641/full

6 'Criminal Law Consolidation Act 1935 SA' 1935, Australia. http://www.legislation.sa.gov.au/LZ/C/A/CRIMINAL%20LAW%20CONSOLIDATION%20ACT%201935.aspx

7 Barnar S, Kim C, Park MH and Ngo TD, 2015 'Doctors or mid level providers for abortion', Cochrane Database Syst Rev. 2015(7):CD011242

8 http://www.tabbot.com.au/about/terms-of-service.html

9 RANZCOG 2016, Termination of Pregnancy (Guideline C-Gyn 17). https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/ Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Termination-of-pregnancy-(C-Gyn-17)-Review July-2016.pdf?ext=.pdf

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com Twitter @SA_AAC

saaac
South Australian
Abortion Action Coalition
Better abortion access

Myths and realities

MYTH: Abortion wouldn't be necessary if contraceptives were more widely available.

No form of contraception is 100% effective. The World Health Organisation estimates that even if all contraceptive users utilised contraception perfectly in every sexual encounter, there would still be six million unintended pregnancies every year.[1] Recent research suggests that more than three quarters of women's reproductive lives are characterised by efforts to avoid unintended pregnancy.[2] [3] Most women who are trying to avoid becoming pregnant are using at least one form of contraception, and more than half of the women presenting to abortion services in Australia each year were using contraception at the time they became pregnant.[4]

MYTH: There are too many abortions.

When it comes to this aspect of women's health, only one number matters — the one showing that all women who need an abortion are able to have one. Currently, only a very small number of women wanting an abortion are unable to access one in South Australia. Like all other health services, abortion is regulated under the Health Care Act 2008 (SA). Unlike other medical services, however, abortion also remains in SA's criminal law — its presence there creates barriers to access and care. These barriers do not prevent women from seeking abortions, but they do place unnecessary limits on the ability and willingness of their doctors to provide them. The removal of abortion from the criminal law will support health practitioners in fulfilling their promise to provide all women with the best care — first time, every time.

MYTH: Abortion is an issue that affects only a few women.

One in three Australian women will have an abortion in their lifetime.[5]

MYTH: Abortion harms women.

According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, serious complications after abortions are rare; in fact, safe and legal abortion is less hazardous to a woman's health than childbirth.[6] Contrary to popular misconceptions, adverse effects on a woman's psychological and emotional health are also rare.[7] Multiple studies confirm that for the majority of women, psychological wellbeing frequently improves following an abortion. This should not be surprising, as many women report their abortion experiences to be characterised by feelings of relief.[8]

Abortion is a healthy choice for women and families. Despite the myths, abortion has no link to long-term mental health problems, no link to infertility, and no link to breast cancer.[9]

MYTH: Providing abortions is undesirable, or 'dirty', work.

Even though abortion providers experience stigma and opposition, providing abortion services is satisfying and rewarding work that these practitioners freely elect and train to perform.[10] [11]

MYTH: Only women need access to abortion services.

People who may need access to safe abortion are not only women. Trans-men, gender queer and others of diverse gender identities who do not necessarily identify as women, can and do get pregnant. Such individuals, however, face wide-ranging challenges in accessing safe abortion information and services, a result not only of the stigma surrounding abortion itself, but additional barriers they face in realising their sexual and reproductive health rights.[12] [13]

saaac
South Australian
Abortion Action Coalition
Better abortion access

MYTH: Only certain types of women have abortions.

All kinds of women have abortions for all kinds of reasons. Women are just as likely to have an abortion if they already have children than if they don't have any children. More women over 35 have abortions than women under 20.[14] Women are just as likely to have abortions if they earn high levels of income as those who have a low income.

MYTH: All religious people oppose abortion.

The majority of Australians who identify with a religious faith support women's access to abortion in any circumstances.[15]

MYTH: Women who seek abortions need counselling.

Multiple studies of women's decision-making in pregnancy confirm that the overwhelming majority of women requesting abortion services are confident and firm in their decision.[16] These studies also assert that pregnancy counselling is better able to provide support when the woman makes the choice to access the counselling, rather than when it is necessitated by law.

MYTH: Abortion is a controversial issue.

The controversy that often accompanies discussion about abortion belies the fact that the vast majority of Australians actually support women's access to safe and legal abortion services.[17] [18] The time is overdue for the law to reflect this reality.

1 World Health Organisation, *Safe Abortion: Technical and Policy Guidance for Health Systems, 2nd ed*, WHO, Geneva, 2012. http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

2 Marie Stopes International, *What Women Want: when faced with an unplanned pregnancy*, MSI & WebSurvey, Melbourne, November 2006.

3 Guttmacher Institute, *Unintended Pregnancy in the United States*, Fact Sheet, September 2016. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

4 Abigail W, Power C and Belan I, 2008 'Changing patterns in women seeking terminations of pregnancy: A trend analysis of data from one service provider 1996-2006' *Australia and New Zealand Journal of Public* Health Volume 32, Number 3, pp. 230-237(8)

5 Children by Choice. https://www.childrenbychoice.org.au/factsandfigures/australian-abortion-statistics

6 Royal Australian and New New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A resource for health professionals*, RANZCOG, March 2005. https://www.ranzcog.edu.au/Statements-Guidelines

7 American Psychological Association, Task Force on Mental Health and Abortion, *Report of the Task Force on Mental Health and Abortion*, APA, Washington, 2008. http://www.apa.org/pi/women/programs/abortion/mental-health.pdf

8 Bonevski B and Adams J, 2001, *Psychological Effects of Termination of Pregnancy: A summary of the literature*, Newcastle Institute of Public Health, Newcastle, 2001.

9 World Health Organisation, 2000, *Induced abortion does not increase the risk of breast cancer* Fact Sheet 240, June 2000. Reproduced on the Australian Women's Health Network website at http://awhn.org.au/policy-statements-and-fact-sheets/.

10 Baird B, 2014, "Happy Abortionists' Considering the Place of Doctors in the Practice of Abortion in Australia since the Early 1990s', *Australian Feminist Studies*. 29:82, :419-434

11 Coombe BA, 2013, *"It's busy but I love it": The Experience of Nurses providing abortion care in a specialist setting.* M Nurs Sc Thesis, University of Adelaide. http://hdl.handle.net/2440/86640.

12 Abortion Rights Coalition of Canada, *Transgender Inclusivity*, ARCC, December 2015. http://www.arcc-cdac.ca/postionpapers/101-transgender-inclusivity.pdf

13 Riggs D, Coleman K, and Due C, 2014, Healthcare experiences of gender diverse Australians: a mixed-methods, self-report survey, *BMC Public Health*, 14:230.

14 Abigail W, Power C and Belan I, 2008 op cit

15 Betts K, 2009, 'Attitudes to abortion: Australia and Queensland in the twenty-first century,' People and Place, 17:3, 25-39.

16 Victorian Law Reform Commission, *Law of Abortion: Final Report*, VLRC, Melbourne, 2008.

17 Betts K, 2009, op cit 22-28.

18 De Crespigny L et al, 2010 'Australian attitudes to early and late abortion', *Medical Journal of Australia*, 193:1, 9-12.

South Australian Abortion Action Coalition
saabortionactioncoalition@gmail.com
saabortionactioncoalition.com
Twitter @SA_AAC