*Policy Document*

# Access to Safe Termination of Pregnancy

## Position Statement

AMSA believes that:

1. Access to safe and legal termination of pregnancy is a core aspect of the universal human right to health;
2. Access to safe termination of pregnancy should be provided free of discrimination and stigma, and preserve the safety and dignity of the individual, to prevent detrimental mental and physical effects;
3. Safe termination of pregnancy should be accessible to all and efforts should be made to minimise barriers such as cost, language, cultural background, stigma, discrimination, rurality and specialist training;
4. The decision to take a pregnancy to full term, or not, belongs to the pregnant individual in consultation with their treating physician, and should be respected;
5. Individual beliefs about termination of pregnancy should be respected but not impede on universal access to safe termination services.

## Policy

AMSA calls upon:

1. The Commonwealth Government of Australia and other National Governments to:
    a. Collect reliable data on unintended pregnancy and termination of pregnancy rates, the number and nature of termination procedures performed and associated complications;
    b. Reduce legal restrictions that limit access to safe, legal termination of pregnancy globally
    c. Improve provision of care for people who suffer morbidity as the result of termination of pregnancy;
    d. Implement evidence-based recommendations and clinical practice guidelines regarding the the provision of safe termination of pregnancy in accordance with WHO guidelines;
    e. Support the provision of comprehensive family planning services to reduce the number of unintended pregnancies, including access to affordable contraception and medically accurate sexual health education.

2. The Australian State and Territory governments to:
    a. Ensure access to safe and legal termination of pregnancy is available across all states and territories;
        i. Ensure that political restrictions, crises, and/or emergency powers do not impede on access to safe termination of pregnancy

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b. Improve the accessibility of skilled and multidisciplinary care for individuals seeking reproductive healthcare and termination of pregnancy, including but not limited to:
    i. Family planning services, including providing affordable access to contraception to minimise the number of unintended pregnancies;
    ii. Nation-wide at-home access to medical termination of pregnancy services, when criteria for early medical terminations are met;
    iii. Telehealth consultations, as a more accessible alternative to face-to-face consultations for termination services;
c. Ensure that safe access zones are implemented and maintained around all clinics that provide terminations of pregnancy;
d. Implement initiatives to promote the destigmatisation of termination of pregnancy, and communicate the availability of termination services;
e. Improve research about termination of pregnancy, including the number and nature of procedures performed, associated complications, and provider availability;
f. Improve access to termination services in rural and remote areas through measures such as:
    i. Increasing funding for staff, facilities and equipment;
    ii. Increasing opportunities for training and upskilling of providers in regional and rural areas;
    iii. Providing support to people who need to travel to access termination of pregnancy where not available locally, such as financial aid or transport and accommodation;
g. Provide medically accurate information regarding termination procedures that can be easily accessed by the public, ensuring information is culturally responsive and appropriate.
h. Ensure the provision of comprehensive and medically accurate sexual health curriculum in schools, with clear and consistent educator guidelines to reduce the incidence of unintended pregnancy and improve public understanding of accessing reproductive healthcare.
i. Ensure that termination services are affordable and equitable, through service cost subsidy, and additional support for patients with financial hardship.

3. AMA, RANZCOG, RACGP, ACRRM and other medical and health organisations working in this field to:
    a. Publicly support and collaborate with organisations and initiatives that work to improve access to reproductive health services and safe termination of pregnancy;
    b. Provide adequate training for healthcare workers to gain competency in caring for individuals seeking termination of pregnancy, including pre- and post-termination care;
    c. Ensure adequate ongoing professional support is given to healthcare workers providing termination services, including the provision of clear and accessible referral pathways;
    d. Improve provider training surrounding sexual and reproductive health for transgender, nonbinary and gender-expansive individuals
    e. Acknowledge the additional barriers to safe termination of pregnancy faced by those in vulnerable communities including, but not limited to,

Aboriginal and Torres Strait Islander peoples, transgender and gender-expansive individuals, culturally and linguistically diverse persons, those from rural and remote regions and advocate for more equitable access to appropriate care.

4. Healthcare service providers to:
    a. Provide care that is professional, non-judgemental, and respectful of patients' autonomy in making reproductive decisions;
    b. Ensure that where a healthcare worker conscientiously objects to termination of pregnancy, a referral is provided to another safe, willing and accessible provider;
    c. Advocate for destigmatisation of termination of pregnancy, and promote a working environment where healthcare professionals can provide termination services without fear of discrimination;
    d. Engage in further research and development of safer and more effective methods of contraception and termination of pregnancy;
    e. Ensure that patients are adequately screened for mental health risk factors as part of pre- and post-termination care, and referred on to mental health services as necessary;
    f. Provide reliable and comprehensive information about contraceptive methods to patients seeking treatment;
    g. Support patients who may be experiencing reproductive coercion or sexual violence by:
        i. Ensuring, with proper screening, that patients are seeking treatment or termination of pregnancy via their own autonomy
        ii. Providing interventions that address reproductive coercion and sexual violence and their consequences, such as education about support services, and confidential contraception;
    h. Improve the experience of transgender, nonbinary and gender-expansive patients in accessing termination of pregnancy services through the use of gender-neutral documentation, language and educational materials
    i. Acknowledge and minimise the additional access barriers faced by those from vulnerable communities including, but not limited to, Aboriginal and Torres Strait Islander peoples, transgender and gender diverse individuals, culturally and linguistically diverse persons, and those from rural and remote regions.

5. Medical schools to:
    a. Ensure all students are taught a patient-centred, evidence-based approach to reproductive health services, including termination of pregnancy, contraception, assisting those experiencing sexual violence, and medically accurate sexual health advice;
    b. Inform students of the current termination of pregnancy services available, including treatment options and facilities, relevant legislation, and psychological and social support services;
    c. Provide opportunities for students to discuss and develop personal and professional views with regards to termination of pregnancy;
    d. Ensure that students understand their future professional obligation to provide patients with referrals to other willing and safe providers, should they conscientiously object to termination of pregnancy;

e. Provide opportunities for students to engage in professional scenarios involving core reproductive health services and safe termination of pregnancy;
f. Ensure that students are educated about the mental health challenges surrounding termination of pregnancy;
g. Ensure students have an understanding of how to communicate and understand the differing needs of patient populations who may have further limited access to termination services, including but not limited to:
    i. The transgender and gender diverse community
    ii. Aboriginal and Torres Strait Islander peoples;
    iii. Those living in rural or remote communities.

## Background

*Note:* Throughout this policy, we have included gender-specific terms such as 'woman' and 'maternal' in accordance with the terminology used by our references. However, we acknowledge that transgender, non-binary and gender expansive people may seek a termination of pregnancy.

### What is Safe Termination of Pregnancy?

Termination of pregnancy (TOP), also referred to as abortion, refers to ending a pregnancy by using medicines or surgery to remove an embryo or fetus from the uterus [1]. Approximately 30% of all pregnancies end in induced termination [2]. Between 2015 and 2019, on average, 73.3 million induced safe and unsafe terminations of pregnancy occurred worldwide each year [3].

A medical termination involves the use of drugs mifepristone and misoprostol, which act to stop a pregnancy from progressing, promote cervical opening and induce uterine contraction to allow evacuation of the uterine contents [4]. Surgical TOP involves physical removal of the pregnancy from the uterus, typically using suction aspiration (vacuum) method [5]. In Australia, some providers support patients who are no more than 8 weeks pregnant to undergo medical terminations in their own home, via "tele-abortion", without needing to visit a clinic [6].

Medical and surgical terminations are considered safe when they are carried out using recommended evidence-based techniques appropriate to the pregnancy duration, and are performed by a trained provider in an appropriate environment [7, 8]. However, each year millions of people with unwanted pregnancies often resort to unsafe terminations when safe services are restricted or unavailable [1, 3], and 45% of terminations do not meet World Health Organization safety criteria [2, 9].

### Rights to Safe Termination of Pregnancy

The Universal Declaration of Human Rights states that health and equality are core human rights, emphasising the importance of maintaining one's autonomy in healthcare decisions. [10]. Reproductive health is an essential component of an individual's overall health and wellbeing, and all people, regardless of gender, are entitled to exercise autonomy over matters of personal reproductive health. This involves decisions relating to the timing and number of children to have, and the decision to take a pregnancy to term or not. Failure to provide access to services such as safe termination of pregnancy is a violation of an individual's right to healthcare as defined in international human rights treaties [11].

Access to safe termination of pregnancy is recognised as a fundamental human right and an important public health priority by several global health leaders including, but not limited to, the Australian Medical Association (AMA) [12], Royal Australian and

New Zealand College of Obstetricians and Gynaecologists (RANZCOG) [13], the Public Health Association of Australia (PHAA) [14], the World Health Organization (WHO) [1], the International Federation of Gynecologists and Obstetricians (FIGO) [15-17], and the International Federation of Medical Students' Associations (IFMSA) [18].

Additionally, advancing reproductive health and rights, including access to safe termination of pregnancy, has been identified as a significant global health priority in the Sustainable Development Goals [19]. It is specifically addressed in Target 3.7, which prioritises universal access to sexual and reproductive healthcare services, including family planning, in order to ensure good health and wellbeing; and Target 5.6, which prioritises universal access to sexual and reproductive health and reproductive rights in order to achieve gender equality [15].

There is a wide range of ethical and religious beliefs regarding TOP around the world. As healthcare providers, provision of access to safe TOP is an ethical obligation based on public health and human rights grounds. The decision to terminate a pregnancy should be an informed autonomous decision with assistance from healthcare professionals where appropriate., Harm minimisation strategies and the removal of barriers to accessing safe care is paramount to upholding individual autonomy and gender equality.

## Why is Access to Safe Termination of Pregnancy Important?

Unsafe terminations of pregnancy can lead to immediate, severe health risks such as infection, haemorrhage, incomplete abortion, trauma to the uterus or genital tract and death. In addition, it may result in long term complications that affect physical and mental health such as, anaemia, prolonged weakness, chronic pain, pelvic inflammatory disease, and secondary infertility [3, 7, 20]. Each year on average, up to 13.2% of global maternal deaths can be attributed to unsafe terminations [21].

Additionally, surveys conducted between 2002 and 2008 estimate that, of 20 million women who have unsafe terminations, 40% experience complications that require medical care, but only 25% receive the treatment that they need [20]. In 2012, approximately 7 million women in developing countries were admitted to hospitals as a consequence of unsafe terminations. And, each year, an estimated 8.3 million Disability-Adjusted Life Years (DALYS) are lost globally due to the long-term impact of unsafe terminations on women's health [20]. Thus, unsafe TOP is a clear cause of maternal morbidity and mortality.

Further, unsafe terminations of pregnancy and their associated complications also have financial implications for women and their communities [7]. Estimates from 2006 showed that the yearly cost for treating unsafe termination complications in developing countries was US $553 billion [3]. Long-term disability resulting from unsafe terminations resulted in $922 million in loss of income, and there are also significant costs associated with post-termination care and treating post-termination infertility [9, 22]. Indirect costs stemming from unsafe terminations include loss of productivity among women and other household members due to illness or disability, negative impacts on family health and education, and strain on potentially already limited healthcare resources [23].

Despite these statistics, unsafe TOP is one of the most preventable causes of mortality. When performed by skilled providers in contemporary medical practice, TOP is one of the safest procedures, with minimum morbidity and a negligible risk of death [24]. Provision of safe services without the fear of legal or social repercussions substantially reduces the number of unsafe terminations and its related morbidity and mortality [24, 25].

## Global Trends in Safety of TOP

Advancements in provision of TOP and post-termination care have led to a substantial decrease in termination-related deaths worldwide. It is estimated that the annual number of deaths per 100,000 terminations fell by 42% between 1990 and 2015 [9]. And, based on observations by obstetricians and gynaecologists providing care, it has been hypothesised that the severity of complications related to unsafe termination also declined in the two decades preceding 2010 [20].

The development and application of clinical guidelines and standards by organisations such as the WHO, has likely resulted in this improved provision of safe termination [26]. However, despite improvement in the safety of TOP, numerous legal, social and economic barriers to access force people to seek unsafe alternatives, risking dangerous consequences to their physical and mental health [9]. Broader access to safe TOP services is essential. As such, reliable data is needed to measure and monitor the true trends in unintended pregnancy and termination, particularly in developing countries, in order to understand and reduce these access barriers [2, 26].

## Termination of Pregnancy in Australia

Data on the number of terminations of pregnancy in Australia is extremely limited due to the lack of a national data collection system and absence of a specific Medicare 'termination of pregnancy' code [27, 28]. Comprehensive data collection on TOP across Australia is necessary to help inform and shape future policy reforms. South Australia is currently the only state that routinely collects and publishes TOP data, which is often extrapolated to provide a national estimate. The most recent report, based on data from 2017, found that 389.6 per 1,000 women aged 15-44 (approximately 39%) would have an induced termination in their lifetime [29].

It is therefore extremely important to facilitate provision of safe TOP to people in Australia. Fortunately, in Australia, terminations are required to be authorised or performed by qualified healthcare professionals, such as general practitioners and gynaecologists, and safe, hygienic conditions mean complications are extremely rare [4, 8, 30]. Despite this, many women still face significant barriers to accessing safe TOP services in Australia, many of which are discussed further below [4].

## Components of Safe Termination of Pregnancy

### Legal Considerations

The UN has asserted that access to safe TOP and prevention of maternal mortality is a human right [31]. A country's laws should reflect this and allow individuals to safely and confidentially access a TOP [1]. Australian laws provide the option of termination to the vast majority of people who seek one, however there is variation amongst states, as outlined in Table 1. In previous years, all Australian states apart from Western Australia have decriminalised TOP meaning that it is now regulated under health laws rather than criminal laws [32]. Safe access zones are legislated around clinics, aiming to help shield patients and providers from sidewalk counsellors who misinform, show images and icons meant to manipulate and upset, and film and photograph women against their will. This allows for the clinics to be safe spaces, free from harassment and intimidation [33].

| State or territory | Access | Safe access zones |
|---|---|---|
| Queensland | Legal up to 22 weeks and thereafter with two doctors' approval | 150 m |
| New South Wales | Legal up to 22 weeks and thereafter with two doctors' approval | 150 m |
| Australian Capital Territory | Accessed through the GP up to 16 weeks (a medical abortion can only be accessed up to 8 weeks). May be accessed through a hospital at a later gestational age. | Set at the discretion of the ACT health minister |
| Victoria | Legal up to 24 weeks and thereafter with two doctors' approval | 150 m |
| South Australia | Legal if two doctors deem that the pregnancy will endanger the person's physical and/ or mental health or for serious foetal abnormality. | 150 m |
| Tasmania | Legal up to 16 weeks and thereafter with two doctors' approval | 150 m |
| Western Australia | Legal up to 20 weeks but very restricted thereafter. This is the only state in which TOP is still regulated through criminal law rather than through health law. | 150 m |
| Northern Territory | Legal up to 14 weeks with one doctor's approval and up to 23 weeks with two doctors approval. | 150 m |

Table 1. State legislation in Australia regarding legal access to termination of pregnancy [31].

Globally, there is huge variation in a person's access to TOP. In almost all developed countries, TOP has been made legal; the circumstances under which it is permitted varies but it is generally allowed due to many social and economic grounds. In contrast, the vast majority of developing countries have set their laws so that TOP is highly restricted [1, 34]. Despite legal barriers, restrictions on access to TOP is likely to increase the rate of unintended pregnancies whilst making no difference on the actual rate of terminations. In a meta-analysis conducted by *The Lancet* [2], it was found that the rate of unintended pregnancies in countries where TOP was broadly legal was 58 / 1000 women in 2015-2019 whereas the rate was 80 / 1000 women in countries where TOP was prohibited. Whilst there are numerous factors that can lead to higher rates of unintended pregnancy such as persons' access to contraception, it is clear that unintended pregnancies will happen regardless of the legal status of TOP. Furthermore, the rate of terminations was 40 / 1000 women whether TOP was

broadly legal or it was prohibited. This indicates the high levels of unsafe terminations that are likely to occur when access is restricted. Global data indicates that regardless of legal restrictions, the likelihood of an individual terminating a pregnancy is similar; however, lack of legal access increases the number of people who seek unsafe alternatives [24].

Mental Health

The effect of TOP on one's mental health varies greatly between individuals and their surrounding circumstances. The most current literature shows that continuing with an unwanted or unintended pregnancy poses a higher risk to the individual's mental health than a TOP. These mental health impacts are compounded if the person is denied a termination. Further, unwanted pregnancies have been associated with deficits to the subsequent child's social, emotional and cognitive processes [35].

Some pro-life groups argue that TOP predisposes people to '*Post Abortion Syndrome',* an unfounded condition which they define as severe mental health disturbances following a termination. There is no reputable evidence to support these claims [36]. Conversely, research suggests that the vast majority of people will have no long term psychological impacts from properly performed terminations of pregnancy [37]. The main source of risk for psychological trauma and ongoing mental health issues stems from negative stigma, the stress induced by a lack of access, pre-existing mental health issues, or external pressure to receive a termination [38]. As such, medical professions must consider the social impact of a termination on the patient and the circumstances surrounding each individual when trying to access TOP. Patients should initially be screened for the risk factors outlined above and appropriate services should be offered if necessary.

Pre-TOP Care

There are a plethora of important aspects to treating a patient seeking a termination of pregnancy, many of which occur before the procedure takes place. In accordance with WHO recommendations, Pre-termination care, should include [1]:

- An accurate estimate of the gestational age, so that the most appropriate mode of termination can be decided
- A thorough medical history and exam
- Lab testing if required (a hCG blood test if signs of pregnancy are unclear, haemoglobin if there is a risk of haemorrhage)
- Ultrasound if required for gestational age or to rule out ectopic pregnancy
- Information and counselling [1, 39]:
    - Many women seeking TOP have already made their decision. As such, counselling about one's options is not mandatory. However, physicians should be trained in providing this counselling if the patient requests it, providing the patient with more autonomy to make an informed decision.
    - The patient must be fully informed about the procedure in a way that is understandable and accessible to them. They must comprehend the potential complications of the procedure and when to seek help post-TOP. This should include a discussion about their mental health and the potential that it may be impacted.
    - A discussion about future contraceptive needs
    - Screening and counselling about STIs if appropriate.

Post-TOP Care

The required amount of post-TOP care varies for each patient. For those with complications or who have undergone unsafe procedures, post-TOP care involves

reducing morbidity and mortality [1]. For those who have undergone a safe and uncomplicated procedure they may need no follow up care, given that they were adequately informed before the procedure about when to seek help. Services that should be available for patients if required include [1]:

- Contraceptive information and/or prescriptions (this should be available in the facility the procedure is performed)
- Mental health services
- Clear, written information about how to care for themselves post-TOP.

Education and Training of Providers

Universal access to safe TOP relies on adequate numbers of trained providers. Providers require the appropriate support and supervision to develop competency in providing termination services to the general population [1]. Currently, there is a paucity of education and training surrounding TOP in the medical curricula, at both the medical school and specialist training levels. In Australia, many general practitioners regard medical termination as beyond their scope of practice, or as a complicated and difficult service to provide [40]. They also report feeling inadequately supported in their training and professional development. This has resulted in fewer general practitioners choosing to become authorised providers of medical terminations, despite approval by the Australian government [40].

Similarly, students worldwide report that most medical school curricula include little education on TOP, often with only a single lecture on the topic. Surveys of medical students conducted in Australia and internationally indicate a lack of self-confidence in their ability to provide pre- and post-termination care, and dissatisfaction with current education on TOP [41-45]. Many students expressed a desire for more training that focused on developing their capacity to provide appropriate care to patients seeking terminations of pregnancy, including counselling and communication skills [45]. Ensuring that adequate training and professional development opportunities are included in the medical curricula is an essential step to building and maintaining a workforce that can care for patients seeking TOP.

Training at both medical student and specialist levels is especially important for TOP due to the additional considerations presented by the possibility of conscientious objection in Australia. Professionals are able to refuse to provide TOP services if they have a personal moral objection to the procedure. Conscientious objection allows doctors to uphold personal values and integrity, however it can also unfairly restrict access to patients seeking care [46]. Hence, in Australia a range of conditions are applied to conscientious objection. For example, professionals who conscientiously object to TOP are obligated to inform the patient that TOP is an available service, and provide a referral to another professional who provides the services [46-48]. Equipping healthcare professionals with knowledge about their rights to conscientious objection, as well as responsibilities to the patient, are essential for ensuring that patient care and access to TOP is not compromised.

## Barriers to Safe Termination of Pregnancy

Stigma

TOP stigma is “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood” [49]. Internally, people may experience TOP stigma in the form of negative feelings such as guilt and shame, especially about their sexual activity or failure to contracept [50]. These people are at higher risk of anxiety, depression, increased physiological distress, and social withdrawal and avoidance [51].

Externally, people often face stigma from their friends, family, sexual partners and broader society about their decision to terminate their pregnancy [50,51]. Legal

barriers such as gestational limits, condemnation by certain cultures and religious institutions, the 'pro-life' rhetoric attributing personhood to the foetus, and associations of pregnancy termination to alcoholism, drug abuse and sexual promiscuity can all contribute a criminalising view of TOP [50,51,52]. Such stigma, in place of respectful acknowledgment that TOP is simply a way for people to gain reproductive control, can thus deter pregnant people from seeking the help they need [51].

Providers can also face stigma from multiple sources, such as politics or public discourse, for their provision of termination of pregnancy. Such stigma may significantly impact providers' quality of professional life, contributing to lower job satisfaction, more burnout and more compassion fatigue, with common secondary stress responses being loss of sleep or intrusive thoughts [51,53].

Cost

TOP costs can be substantial and may present a financial challenge for many people trying to access these services. These costs may be direct (termination of pregnancy) or indirect (travel, accommodation, GP referrals, medical tests, childcare and lost wages). TOP in South Australia and the Northern Territory are low cost as provision is largely public, whereas it is mostly private in all other states [54]. Beyond the first trimester, the cost of surgical TOP rises at key gestation intervals, though Medicare rebates remain unchanged [55]. Those without Medicare, such as people studying or holidaying in Australia, on visas or awaiting a decision on their visa status, are not eligible for rebate [55].

Although mifepristone and misoprostol are listed on the PBS for early medical TOP, it has little to no impact on the costs of private clinics, which dominate in all states except SA and NT [54,56]. Many people report requiring financial assistance or foregoing regular payments for bills, food and groceries in order to afford the high out-of-pocket costs [54]. Those who need financial assistance are also more likely to be domestic or sexual assault victims, identify as Aboriginal or Torres Strait Islander or have mental health issues [54].

Gender Identity

There are recognised research gaps in the evidence base surrounding TOP experiences for transgender, nonbinary and gender-expansive (TGE) people, particularly in Australia. However, it is well understood that many TGE people who are assigned female at birth do not undergo surgery to remove their internal reproductive organs. As such, these individuals can experience pregnancy and may require access to termination services throughout their lifetime [57]. In the US, a survey of 450 TGE adults who were assigned female sex at birth reported that 6% had experienced at least one unplanned pregnancy, and 32% of these pregnancies had ended in termination [58].

There are well established barriers to safe healthcare for TGE people, including discrimination based on gender identity, limited provider understanding or knowledge, refusal of care and discrepancies between gender identity and sex/gender indicated on medical or administrative documents [57, 59]. It is recognised that these barriers likely also limit access to reproductive healthcare and termination services. A US study involving researchers, healthcare providers, advocates and TGE community members also identified a range of additional barriers to contraception and termination for TGE people who were assigned female at birth, including inability to afford services, a lack of gender-affirming clinicians, insurance coverage difficulties, and misconceptions about unplanned pregnancy and risk [60].

To improve accessibility to safe TOP care for TGE patients, and the experience of TGE people in accessing these services, interventions at both provider and institutional level are needed. Specifically, it is recommended that providers use

gender-neutral or gender affirming documentation and language, provide gender-affirming patient educational materials, incorporate greater privacy into clinics. Provider training surrounding sexual and reproductive health for TGE individuals also needs to be improved [57, 60].

Reproductive Coercion and Sexual Violence

Reproductive coercion describes a collection of behaviours that interfere with an individual's autonomy to make decisions regarding their reproductive or sexual health [61]. Reproductive coercion may be exercised using violence, threats, or exercise of power or control by someone who is, was, or wishes to be involved intimately with an individual [61]. Common coercive behaviours can include pressuring a partner to have unprotected or unwanted sex, sabotage of contraceptive methods, attempts to impregnate a partner against their will and controlling outcomes of a pregnancy. Specifically, an individual may be coerced to continue with a pregnancy they do not wish to have, or forced to terminate a pregnancy that they wish to continue [61]. Reproductive coercion therefore provides a significant barrier to access to safe termination of pregnancy in the event of unwanted pregnancy.

Along with reproductive coercion, domestic violence and sexual assault have also been recognised as significant risk factors for unintended pregnancy and termination. The Centre for Disease Control and Prevention estimates that almost 3 million women in the US have experienced rape-related pregnancy (RRP) in their lifetime [62]. Of these, women who were raped by a current or former intimate partner were more likely to report RRP (26%) compared to those raped by an acquaintance (5.2%) or a stranger (6.9%) [63]. Research has indicated that women who experience sexual and physical violence are up to 3.3 times more likely to experience unintended pregnancy than those who experience no violence [64].

A 2020 Queensland study involving 3117 women found a clear relationship between women experiencing sexual or domestic violence and attempts to access information about unplanned pregnancy options, indicating a need for these services [65]. Unfortunately, however, due to the controlling nature of violent or coercive situations, many women who experience domestic violence and sexual assault are more likely to terminate their pregnancies at later gestational ages, if at all [66]. This can pose significant barriers to women depending on the regulations regarding late termination of pregnancy where she lives, and is likely to significantly increase the cost [65]. In circumstances where a termination is desired but denied due to legal restrictions, women are more likely to resort to unsafe termination methods [65, 67].

Overall, current research suggests that there are clear associations between intimate-partner or domestic violence, rape-related pregnancies, reproductive coercion, unintended or unwanted pregnancy and a lack of access to termination services [63, 65]. As autonomy in healthcare decisions is considered a universal right, it is therefore the responsibility of healthcare providers to provide interventions that address reproductive coercion and sexual assault and their consequences. These can include education about planning and support services, harm-reduction strategies, provision of discreet and confidential contraception methods and screening for intimate-partner and domestic violence [61].

Aboriginal and Torres Strait Islander Peoples

Limited data is available regarding TOP specific to the Indigenous community. However, it is recognised that Indigenous Australians suffer poorer baseline health outcomes and have a lower life expectancy (all-cause mortality) than their non-Indigenous counterparts. They experience a burden of disease 2.3 times higher than non-Indigenous Australians, 64% of which is attributable to chronic conditions [68]. Sexual health outcomes are likewise poorer, with studies recording up to 50 times more cases of sexually transmitted infections (chlamydia, gonorrhoea and syphilis) in remote Indigenous communities than in non-Indigenous Australians [69]. Maternal

mortality is also higher in Indigenous communities: between 2012-2018, the maternal mortality ratio for Aboriginal and Torres Strait Islander women was 4 times higher than for non-Indigenous women (20.2 and 5.5 per 100,000 women respectively) [70]. As such, Indigenous Australians are placed at greater risk of poor health outcomes when prevented from accessing safe TOP, relative to the general population.

Common barriers to TOP are often amplified within Indigenous communities, where factors such as gender roles and sexuality, financial costs, education and geographical location play a significant role. Additional issues arise where people have intersecting identities (for example, Indigenous background and LGBTQIA+ identifying), as the healthcare system is ill-experienced and thus ill-equipped to provide sensitive and appropriate care [71]. Indigenous Australians are also nearly 10% less likely to have seen a GP within the past 12 months if they reside in a remote area [72]. Transient medical infrastructure in rural settings (with locum models of care) limits consistency of care, which is a particular issue for groups with more complex health and sociocultural needs.

These barriers are compounded by cultural and communication factors unique to Indigenous populations. Medical practitioners often do not have sufficient understanding of decision-making practices in Indigenous families and communities, which may differ to a more individual Western approach. In Australia, current health safety and quality standards do not ensure culturally safe care for Indigenous patients [73]. Indeed, where practitioners lack sufficient understanding of cultural practices and beliefs, such as 'shame', 'payback', 'women's business' and 'family lines', this can pose a significant barrier to Indigenous individuals accessing appropriate care. Indigenous-led models of care are required, focused on acknowledging and breaking down the inherent power dynamic between the practitioner and patient and reflecting on barriers to achieving safe, patient-focused care [73]. Cultural safety programs provided in medical school or to doctors in the community may be of benefit in maintaining culturally aware practice. Public health information is likewise insufficiently tailored to those who may not be fluent in either spoken or written English [74]. It is critical that clear information, including information in local Indigenous languages, is available in order to facilitate patient-centred models of care as well as informed consent.

Due to limited access to medical care as a whole, and therefore also to safe access to termination, Indigenous Australians may face significant delays in time to treatment. This may result in termination no longer being a viable alternative, and cause significant short- and long-term medical complications and social challenges for the parent, child or both.

Rural and Remote Regions

People residing in rural or remote areas in any part of the world face additional challenges in accessing health care and TOP. In Australia, life expectancy has been shown to decrease as remoteness increases, and those living in rural or remote regions are more likely than their metropolitan peers to report barriers to accessing GPs and specialists [75].

Poor servicing of rural and remote areas is widely recognised as a significant concern by a number of bodies, including the AMA. The AMA has released a statement [76] with suggestions for reducing this gap in resource distribution, and calls for increased funding of rural medicine with a focus on staff, facilities and equipment, as well as increased training in rural areas and the formation of regional training networks. Having increased staffing levels and better resourced hospitals would be invaluable to those seeking terminations in rural environments, and facilitate significant improvements in health outcomes.

Telehealth is increasingly used worldwide to improve access to TOP for those who are either located rurally or otherwise isolated from medical services. It involves a telehealth consult to allow the practitioner to perform a patient assessment, as well as to ensure the patient understands the procedure, followed by the medications being posted to the patient's home address for them to administer themselves with follow-up. However, in South Australia, medical terminations of pregnancy can only be performed while the patient is in hospital [77]. This prevents people from accessing medical terminations in the home environment either from a GP or via a telehealth consult, and disproportionately affects those in rural areas. Additionally, a new restriction on Medicare Benefits Scheme (MBS) item numbers for telehealth GP consults came into effect in July 2020 [77]. It restricts the eligibility to claim to those who visited their GP in the prior 12 months or were referred by a specialist. Unfortunately, this has the effect of discriminating against those who find it difficult to regularly visit their GP, again disproportionately disadvantaging those in rural and remote regions.

## Prevention of Unintended Pregnancy

Currently, it is estimated that over a quarter of pregnancies in Australia are unplanned, and that around 30% of these pregnancies are terminated [78]. While the need for safe access to terminations will always remain, there is benefit in trying to prevent unplanned pregnancies prior to conception where possible. Essential in this endeavour is ensuring people have access to safe, effective and affordable contraception, and the tools to access medically accurate advice about family planning and contraceptives to empower individuals to manage their sexual and reproductive health.

Increased use of modern contraceptives has played a significant role in reducing the rates of unintended pregnancy, both globally and in Australia [79]. Currently it is estimated that over 70% of Australian women between the ages of 16-59 use contraception [80]. Most modern contraceptive options are highly effective, with many commonly used methods such as the hormonal IUD and combined oral contraceptive pill being over 99% effective at preventing pregnancy when used perfectly. By comparison, 85% of women in their 20s will become pregnant within one year with no form of contraception [81]. Thus, ensuring access to safe, affordable contraceptives is an effective way to prevent a large number of unintended pregnancies. This also includes providing culturally appropriate care for individuals who are part of vulnerable communities and might face additional barriers when accessing reproductive healthcare, including culturally and linguistically diverse persons, people of Aboriginal and Torres Strait islander descent or who are part of the gender diverse community [82,83,84]. Despite the successes of modern contraception, it is important to recognize that no contraception is without a failure rate and that associated side effects, user error and random chance may still result in an unwanted pregnancy and termination despite taking these precautions. Thus, the need for affordable and accessible contraception does not negate the need for safe access to termination of pregnancy.

Currently, sexual health education in Australia is delivered primarily by high school programs, with these programs being one of the most popular sources of knowledge for all students [85]. The benefits of providing comprehensive and medically accurate sex education in high school are well recognised, with lower rates of pregnancy reported in teenagers receiving comprehensive sex education, when compared to teenagers who received either no sexual health education or abstinence-only education [86]. Despite this, sexual health education remains inconsistent and poorly organised within the Australian education sector, with 16% of educators reporting no training in sexuality education, and one third reporting that their teaching was not assessed against curriculum standards. This was largely due to a lack of support from their schools and a lack of clarity around assessment criteria [87]. Hence it is paramount to ensure that measures are put in place to ensure all young people have

access to comprehensive, consistent and medically accurate sexual health education, which includes information about how to access contraception and terminations, and their rights when seeking care. Currently in Australia, contraception and terminations are available to minors without the need for parental consent if they are deemed to be Gillick competent [88]. By empowering young people to manage their own sexual health, comprehensive sexual health education may help to prevent the need for terminations in some cases and help individuals avoid the physical, social and mental stress that may be associated with an unplanned pregnancy.

Despite the advances in sexual health education and contraceptive use made in recent years it is important to acknowledge that these measures are not 100% effective in preventing all instances of unwanted pregnancy. In addition to contraceptive failure and lack of sexual health education, unwanted pregnancies can occur for a large variety of reasons, as discussed previously. Not all of these reasons can be predicted or effectively controlled with preventative measures, and thus the need for safe access to termination of pregnancy remains an essential component of reproductive healthcare

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## Policy Details

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