

**Women's Health Issues Paper  
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**Women and Abortion**

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## **Women and Abortion**

(Women's Health Issues Paper No. 6)

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## Introduction

Termination of pregnancy, or abortion, is one of the safest and most common medical procedures when performed by a qualified health professional.<sup>1</sup> All women should be able to obtain accurate information about abortion; make their own decision about abortion free from coercion or pressure; and access safe, legal and affordable abortion services.

The decision to terminate a pregnancy should be made by those most closely involved with the situation. Women's decisions regarding their fertility, including unintended pregnancies, are based on their life situations, personal views and beliefs. The decision to continue or terminate a pregnancy can be difficult for many women and women should not be made to feel guilty or judged for their decision.<sup>2</sup> Research indicates that the best outcome is achieved when women are in control of the decision about pregnancy termination.<sup>3</sup> As outlined by the Public Health Association of Australia, control of fertility is crucial to a woman's ability to maintain her health.<sup>4</sup>

The purpose of an Issues Paper is to bring together the evidence on a particular topic and provide a gender analysis of that topic. This Issues Paper outlines the legal context governing abortion in Victoria, and in other states in Australia. It considers attitudes, myths, access to services and key issues regarding termination of pregnancy.

## About abortion

Termination of pregnancy can be carried out in the first trimester of pregnancy (up to 12 weeks), the second trimester (12 – 24 weeks) or, in rare circumstances, in the third trimester (24 – 36 weeks), however almost all terminations occur during the first trimester.<sup>5-6</sup> The procedure can be either surgical or medical and both are safe and common procedures.<sup>1, 7</sup>

### Surgical abortion

Surgical abortion is the most widely used termination procedure.<sup>6</sup> It is performed under general anaesthetic or local anaesthetic with sedation. First trimester terminations are usually performed as a day procedure using vacuum aspiration. This removes the lining and the contents of the uterus. Dilatation and curettage also falls within the definition of surgical abortion, as does dilatation and evacuation, which is an effective surgical technique for abortions after 14 weeks gestation.<sup>1, 6, 8</sup>

### Medical abortion

Medication may be used to induce a termination of pregnancy and this method has been proven to be safe and effective.<sup>1, 9-10</sup> Drugs for this purpose may include one, or a combination of, mifepristone (anti-progesterone, also known as RU486), misoprostol (prostaglandin), and methotrexate.<sup>1, 6, 8</sup> The method induces miscarriage and avoids a surgical procedure and anaesthesia. It can be used up to 24 weeks gestation, and is generally preferable to surgical abortion in very early gestation (up to 49 days).<sup>7, 11</sup>

Medical termination is used in Europe, the United Kingdom, the United States and New Zealand.<sup>12</sup> While mifepristone is not widely available in Australia, some medical practitioners have successfully obtained 'authorised prescriber' status with the Therapeutic Goods Administration (TGA) to import and use the drug in specific circumstances, where surgical abortion is not appropriate on medical grounds.<sup>13</sup> In addition to this, some medical

practitioners are using other medication, such as the combination of methotrexate and misoprostol for early termination or for treating ectopic pregnancy.<sup>6</sup>

Many women prefer medical to surgical abortion.<sup>6</sup> It can make abortion 'easier, more accessible, safer, less traumatic, less medicalised and less expensive'.<sup>11</sup> Some women consider it a more 'natural' method that does not involve surgery.<sup>11</sup> For women living in rural and remote areas, the amount of time, cost and number of clinic visits may be reduced by medical rather than surgical termination.<sup>11</sup> As there are few abortion service providers outside metropolitan areas, rural women are disproportionately disadvantaged by the limited availability of medical abortion.<sup>9</sup> Furthermore, the ability to be able to choose between medical or surgical termination procedures has been shown to be important for both women and service providers.<sup>7, 11, 14</sup>

### **Terminations after 20 weeks gestation<sup>i</sup>**

Terminations after 20 weeks gestation are rare.<sup>15</sup> The decision to terminate a pregnancy after 20 weeks can be a difficult one as the circumstances that surround the pregnancy can often be highly complex. The reasons for termination at this stage are often characterised by the medical profession as either 'psychosocial', that is, there is serious risk to the mother's physical or mental health, or termination as a result of a diagnosis of foetal abnormalities.<sup>16</sup>

The British Medical Association has identified some of the key reasons for terminations after 20 weeks gestation.<sup>17</sup> These are as follows:

- Failure to recognise the pregnancy earlier:  
Some women do not recognise that they are pregnant until late into the pregnancy. These are often younger women, whose bodies are still developing, and pre and peri menopausal women, who do not expect to be pregnant at this stage of their lives.
- Delay in seeking abortion due to personal circumstances:  
Delays in seeking abortion are often due to the woman's apprehension (including difficulty in confiding in parents or partner), failure of anticipated emotional or economic support (from family, partner, or employer), or an unanticipated change in the woman's socio-economic circumstances (in relation to her partner, or others dependent on her as a carer).
- Diagnosis of foetal abnormality:  
Many abnormalities are not diagnosed until the latter part of the second trimester and the woman needs time to consider the information provided, to come to terms with it and make a decision about how to proceed.
- Difficulty in accessing abortion:  
Some women make a decision to have an abortion earlier in pregnancy but experience delays in accessing the service.

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<sup>i</sup> In gathering information for this paper, a number of sources of data were considered that use different timelines of gestation (such as 20 weeks, 22 weeks or 24 weeks). For the purposes of this paper, we use 'terminations after 20 weeks gestation', except when discussing the Abortion Law Reform Act (Vic) 2008 which distinguishes terminations carried out after 24 weeks gestation.

In 2006 in Victoria, terminations after 20 weeks gestation for congenital malformations (foetal abnormalities) comprised of 17 percent of stillbirths.<sup>18</sup> Many abnormalities are not able to be diagnosed until this stage.<sup>17</sup> Terminations in such instances may be particularly distressing as the pregnancy may have been planned and welcome. Terminations of pregnancy after 20 weeks gestation for maternal psychosocial indications comprised 25 percent of the stillbirth rate in Victoria in 2006.<sup>18</sup>

## Number of abortions

In Australia, it is estimated that around 70,000 to 80,000 women undergo an abortion each year.<sup>19</sup> One large national survey found that 22.6 percent of Australian women aged between 16 and 59 years have had an abortion.<sup>20</sup> South Australian data shows that approximately 91 percent of abortions occur in the first 14 weeks of gestation.<sup>5</sup> In Victoria in 2004, it is estimated that there are around 19 'induced abortions'<sup>ii</sup> per 1,000 women.<sup>21</sup>

Exact numbers, however, can be difficult to obtain. There is no routinely collected national or Victorian data on elective abortions.<sup>5</sup> Currently, only South Australia, Western Australia and the Northern Territory collect accurate abortion statistics. National statistics, available through the Health Insurance Commission, reflect abortions from which a Medicare rebate has been claimed. They do not report on abortions in which no rebate is claimed nor do they capture women who have abortions as public patients in a public hospital. Approximately one quarter of all abortions in Victoria are performed in the public health system.<sup>22</sup> Data published by the Australian Institute of Health and Welfare reports on the number of abortions performed in public hospitals although there are also limitations associated with this data.<sup>23</sup>

Accuracy of data is also limited by a lack of consistency and clarity in Medicare item numbers used to record terminations. For procedures undertaken in the first and second trimester, two different item numbers may be used. Abortive procedures in the third trimester may be coded differently again. The Medicare item numbers that are used to record terminations also reflect other experiences such as miscarriage, foetal death or some gynaecological conditions unrelated to pregnancy.<sup>5, 19</sup> Abortions performed after 24 weeks are not included in the data, as there is no rebate through the Medicare Benefits Schedule.<sup>24</sup>

Nevertheless, the following table gives some indication of the age range of women seeking abortion. It shows the estimated number of induced abortions by 5-year age group in 2004 in Australia.<sup>21</sup>

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<sup>ii</sup> 'Induced abortions' carried out in Victoria include 'separations with a diagnosis of O04.5–O04.9 Medical abortion, complete or unspecified and an abortion-related procedure reported to the National Hospital Morbidity Database plus nonhospital Medicare services for MBS-item 35643 Evacuation of the contents of the gravid uterus by curettage or suction curettage reported to the Medicare data are included.'

## Estimated number of induced abortions by age group, 2004

	Less than 15	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45 and over	Total
<b>Estimated number of induced abortions</b>	296	13,262	21,504	17,072	15,258	10,432	4,889	497	83,210
<b>Rates per 1,000 women aged 15-44 years</b>	n.p.	20.1 Includes under 15 years	31.3	25.3	20.0	14.2	7.0 Includes over 45 years	n.p.	19.3

These numbers may be underestimated because the inclusion of Victorian private hospitals in the National Hospital Morbidity Database is limited.<sup>23</sup> More information on the limitations of termination statistics in Australia is available in the Parliamentary Research Brief, *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection.*<sup>19</sup>

### Current legal context

Abortion law in Australia varies across state and territory jurisdictions but the procedure is generally not considered illegal if undertaken to protect the mother's physical and mental health. Rates of abortion are generally unaffected by the legality of abortion.<sup>25</sup>

#### Victoria

Following a long and committed campaign by abortion law reform advocates in Victoria, the Abortion Law Reform Act was passed in October 2008, bringing the law relating to termination of pregnancy into line with existing clinical practice and community attitudes.<sup>26</sup> The Act:

1. Removes abortion from the Crimes Act 1958;
2. Outlines the grounds on which abortion may take place; and
3. States the obligations of registered health practitioners with a conscientious objection to abortion.

The grounds for termination of pregnancy are that any woman who is no more than 24 weeks pregnant can obtain an abortion from a registered medical practitioner. After 24 weeks, the abortion can be performed only if the medical practitioner reasonably believes it is appropriate in all the circumstances, that is, having regard to all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances. They must also have consulted at least one other medical practitioner who also believes it appropriate.

#### Other states

In 2002, the Australian Capital Territory became the first Australian jurisdiction to legalise abortion by removing it from the criminal law.<sup>27-28</sup> Although abortion is criminalised in most Australian jurisdictions, it is generally lawful for mental and physical health reasons.<sup>27</sup>

In New South Wales and Queensland, the common law provides that abortion is lawful where a woman's mental or physical health is in danger.<sup>16, 27</sup> This also applies in South Australia and the Northern Territory, where abortion is also lawful if there is a significant chance the child will be disabled.<sup>16</sup> In Queensland at the time of writing, however, there is a significant degree of legal uncertainty resulting from criminal charges that have been laid against a young woman for 'procuring her own miscarriage'.<sup>13</sup> As a result of this decision, many abortion service providers are wary of legal consequences and have ceased to provide terminations, with women travelling interstate to obtain the service.<sup>13, 29</sup>

In Tasmania, abortion is lawful where the pregnant woman gives her informed consent or where the continuation of the pregnancy would cause the woman physical or mental harm.<sup>16</sup> In Western Australia, amendments to the *Health Act 1911* permit lawful abortion when four criteria are met, including that the woman seeking the abortion must have given informed consent and received independent counselling.<sup>30</sup>

Across all jurisdictions, the length of gestation may affect the lawfulness of the termination, or may require the approval of a second medical practitioner. More information about the specific legal framework in different states (as at 1 January 2008) is available in the Victorian Law Reform Commission's *Law of Abortion Final Report*.<sup>16</sup>

## **Access to abortion**

Although a number of social, psychological, cultural and economic factors contribute to unwanted pregnancy, access to accurate, timely and unbiased information about sexual relationships and contraception is critical in supporting both women and men to make informed decisions about their sexual and reproductive health.<sup>25</sup> Evidence demonstrates that comprehensive sex education and access to a variety of effective contraceptive choices help lower the rate of unintended pregnancies.<sup>31</sup>

Access to safe abortion services is a necessary part of any system of reproductive health services.<sup>32</sup> Before 1971, abortion was a major cause of maternal death in Australia and access to safe abortion has reduced the high rates of women suffering poor health outcomes and even death as the result of 'backyard abortions'.<sup>33</sup>

## **Geographical considerations**

Only a limited number of public hospitals in Victoria offer termination of pregnancy services and these are clustered around metropolitan Melbourne.<sup>34</sup> Access to abortion services is an issue particularly for women from rural and regional areas where services are limited or non-existent. Although it is difficult to ascertain exact numbers, the region of Greater Melbourne is serviced by only a handful of private clinics and public hospitals. In many rural and regional areas of Victoria, the situation is more critical with no apparent private clinics and limited access to terminations in public hospitals.<sup>34</sup> Women in these areas who experience anti-choice attitudes by medical practitioners find their options even further reduced.

Even where a service exists, women in rural and regional areas may travel elsewhere to access termination services to ensure privacy and confidentiality.<sup>34</sup> Travelling to metropolitan areas to access services can place further emotional and financial strain on women making the decision to terminate.<sup>35</sup> It takes time, can be expensive, and can require arrangements to

be made regarding childcare, school or employment.<sup>34, 36</sup> In one Victorian study, 9.3% of respondents travelled more than 100 kilometres to access the termination service.<sup>34</sup> Many other women may have to travel interstate to access abortion services.<sup>18</sup>

### **Financial considerations**

Financial barriers can also limit a woman's access to abortion. Most abortions are provided in private clinics, although a substantial proportion of abortions are provided at public hospitals.<sup>16</sup> This means that out-of-pocket expenses for women can increase considerably. Some public hospitals provide a small number of abortions at no cost. Out-of-pocket expenses vary with private providers and range from around \$200 to \$400. Fees can increase for terminations after 12 weeks.<sup>37</sup>

### **Access to terminations after 20 weeks gestation**

For many women, obtaining a termination after 20 weeks gestation is complex and difficult as few services in Victoria offer late term abortion.<sup>38</sup> The provision of information and services about abortion in these circumstances must be made accessible, affordable and timely.<sup>2</sup>

Only one clinic in Victoria offers late term termination for psychosocial reasons.<sup>16</sup> Following a diagnosis of foetal abnormality or maternal psychosocial indications, women who have attended Catholic hospitals throughout their pregnancy may face barriers to obtaining information and support about late term termination.<sup>38</sup> Other women may face overly restrictive hospital administrative procedures that require a panel to make the decision.<sup>16, 38</sup> The Victorian Abortion Law Reform Act 2008, however, requires that for abortions after 24 weeks gestation, two registered medical practitioners must believe that the termination is appropriate in all the circumstances, having regard to all relevant medical circumstances and the woman's current and future physical, psychological and social circumstances.<sup>26</sup> Lack of understanding about the law relating to abortion after 24 weeks gestation among medical practitioners adds to further delay.<sup>39</sup>

It should also be noted that many terminations in Victoria after 20 weeks gestation are performed on women from other states and territories. For example, in 2006 in Victoria, terminations of pregnancy after 20 weeks gestation for maternal psychosocial indications comprised 25 percent of the stillbirth rate in Victoria in 2006. More than half of these procedures were performed on women not residing in Victoria, due to the unavailability of appropriate services in those states.<sup>18</sup>

## **Attitudes to abortion**

### **Community attitudes**

A degree of stigma continues to surround the issue of abortion. This stigma manifests itself in many ways, including disapproval from family and friends, the perpetuation of myths about abortion despite evidence to the contrary, and the avoidance of legal or policy reform due to a perception of political risk.<sup>40-42</sup> It inhibits access to and awareness of abortion, yet abortion is broadly supported in Australia. According to the Australian Survey of Social Attitudes in 2003, 81.2 percent of Australians agree that women should have the right to choose an abortion. This was independent of their gender or religious affiliation. Only 9 percent of the 5000 adults questioned disagreed with a woman's right to choose, and the remaining 10

percent were undecided.<sup>43</sup> In an Australian Election Study in 2004, only 4 percent of Australians agreed with the statement 'abortion should not be allowed under any circumstances'.<sup>16</sup> A study commissioned by Marie Stopes International surveyed 2,500 general practitioners nationally and found that 85 percent of Australian GPs believe women should have access to abortion.<sup>44</sup>

### **The views of women seeking abortion**

In a 2006 Australian study by Marie Stopes International, 90 percent of women believed that abortion should be able to be obtained in all or some circumstances.<sup>45</sup> The study also states that 'a comparison of women's views before and after their unplanned pregnancy suggests the experience leads women to become more pro-choice'.<sup>45</sup>

A study carried out by the Centre for Women's Health, Gender and Society at the University of Melbourne sought the views of women on their experience of unplanned pregnancy and abortion:

Reasons given for contemplating or undergoing abortion can be summarised as relating to the woman herself, the potential child, existing children, and the woman's partner and other significant relationships, most of which contribute to what it means to a woman to be a good mother.<sup>5</sup>

Other studies have also found that the decision to terminate a pregnancy for many women centres on concerns about 'wanting to be a good mother and provide a good home'.<sup>15, 46</sup> The reasons that women give for terminating a pregnancy are varied and complex and it is vital that women should be able to 'make their own reproductive decisions with dignity and freedom from stereotypes and stigma'.<sup>47</sup>

## **Myths about abortion**

### **Abortion and mental health**

The suggestion of a causal link between abortion and subsequent mental health issues for women has been discounted by research.<sup>48-49</sup> One example is the New Zealand research by Fergusson, Horwood and Ridder in 2006, which demonstrated the link between abortion and poor mental health outcomes.<sup>50</sup> The research has since been discredited on a range of grounds, including the exclusion of the wantedness of a pregnancy or intimate partner violence as contributing factors to mental ill-health.<sup>51-52</sup> Other research has shown that women who experience long-term psychological symptoms following an abortion 'display certain characteristics and demographic similarities that are more likely to predispose them to severe psychological effects' regardless, such as previous psychiatric history and poor social support.<sup>53</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists also cite studies that show that termination of pregnancy 'rarely causes immediate or lasting negative consequences in healthy women'.<sup>6</sup>

Studies have shown that that poorer mental health status is associated with pregnancy and parenting in the teenage years and much of the available literature rejects that abortion causes poor mental health.<sup>51</sup> Unintended pregnancies can have negative life consequences for the mother and child in terms of education, employment, financial security, and health.<sup>54</sup>

### **Abortion and breast cancer**

The existence of a link between abortion and breast cancer has been suggested in some studies<sup>55-56</sup>, however it is generally understood that such a link cannot be proven, and results are inconsistent and inconclusive.<sup>6</sup> A key study of 1.5 million Danish women has shown no increased risk of breast cancer as a result of abortion.<sup>57</sup> The World Health Organisation has published a factsheet explaining that induced abortion does not increase breast cancer risk.<sup>58</sup> The Cancer Council of New South Wales has also issued a factsheet discounting the link between breast cancer and abortion.<sup>59</sup>

### **Abortion and fertility**

Abortion is a safe, common medical procedure that does not affect a woman's future fertility.<sup>1, 36, 48</sup> The Royal Australian and New Zealand College of Obstetricians and Gynaecologists state that 'overall, in countries where termination of pregnancy is available within the law, a woman who has an uncomplicated termination is not at increased risk of being infertile in the future.'<sup>6</sup>

## **Current issues in Victoria**

### **Conscientious objection**

Section 8 of the Abortion Law Reform Act 2008 sets out the action that must be taken by registered health practitioners who have a conscientious objection to abortion.<sup>26</sup> Any health practitioner who is asked to advise a woman about abortion, or perform, direct, authorise or supervise an abortion, and who has a conscientious objection to abortion must:

- Inform the woman that they have a conscientious objection; and
- Refer the woman to another health practitioner, in the same profession, who the practitioner knows does not have a conscientious objection to abortion.

In cases where an abortion is necessary to preserve the life of the pregnant woman, health practitioners are obliged to assist, regardless of their objection.

Section 8 of the Abortion Law Reform Act ensures that a health practitioner with a conscientious objection to abortion is not discriminated against. It also ensures that the beliefs of the health practitioner do not affect the ability of their patients to access healthcare.<sup>60</sup>

One American study shows that 86 percent of physicians believe that doctors are obligated to present all options to their patients and 71 percent believe that they must refer the patient to another clinician who does not object to the requested procedure. Sixty three percent of physicians believe that it is ethically permissible for doctors to explain their moral objections to patients.<sup>61</sup> The Abortion Law Reform Act reflects these themes. The referral stipulated by the Act is to another health practitioner in the same profession – it is not a direct referral to an abortion service provider. A woman may or may not go on to terminate her pregnancy – 'the physician cannot reasonably be understood to be a party to, or complicit in, a subsequent decision that is the sole province of the patient's subsequent exercise of autonomy in consultation with a referral physician.'<sup>62</sup> The purpose of section 8 is to ensure

that women receive timely, accurate information from a professional who does not hold an objection to the health service she seeks.<sup>63</sup>

### **Pregnancy counselling**

Counselling can be an integral part of the abortion process and may or may not include support in decision-making.<sup>16</sup> Counselling should be available to women if they want it either before or after a termination and should be covered as part of good practice guidelines rather than by legislation. An Australian study in 2006 found that three out of every four women with an unintended pregnancy did not wish to speak to a pregnancy counsellor before deciding. Eighty one percent of women said that it was important that a pregnancy counsellor refer for all three options: abortion, adoption and parenting.<sup>45</sup> The study also showed that the more difficulty women had making their decision when faced with an unintended pregnancy, the more important they felt it was to have a counsellor who would refer for all three options. Of the women who obtained counselling, 46 percent said that the most important thing was that it was non-judgemental and 24 percent said the unbiased nature of the counselling was the most helpful aspect of the service.<sup>45</sup>

There are some serious concerns about the accuracy of information provided by some pregnancy counselling services. Some services are run by anti-choice organisations but use misleading advertising that implies that women are offered non-directive pregnancy advice.<sup>16</sup> These services are free, making them exempt from *Trade Practices Act* prohibitions of false and misleading advertising.<sup>27</sup>

In 2005, the *Transparent Advertising and Notification of Pregnancy Counselling Services Bill* was introduced into federal Parliament which attempted to regulate these services. Although this Bill was not passed, it was referred to the Senate Community Affairs Legislation Committee who stated in their report:

The omission of key information can result in Australian women not being fully informed on all the options for dealing with an unplanned pregnancy and not feeling fully supported and empowered to arrive at an independent decision which is in the best interests of herself and her family. The limited timeframe available to make a decision about whether or not to continue with an unplanned pregnancy increases the importance of access to complete, accurate and unbiased information.<sup>64</sup>

In the absence of legislation or regulation, the deceptive nature of these services continues to be an issue for women seeking information about abortion services, or support about making a decision about their pregnancy. A government-run telephone hotline that provides non-directive counselling on pregnancy options, including contact information for termination clinics, is in the process of being set up.

### **Anti-choice activity**

Anti-choice activity affects women's safe access to abortion services.<sup>41</sup> It can include picketing outside termination clinics, harassment of patients and at a more extreme level, violent activity such as vandalism, arson and assault or murder.<sup>41, 65</sup> The issue of protesters outside abortion clinics is a significant one for women seeking abortion services, as well as their friends and family who accompany them, and the staff who work at those clinics.<sup>27</sup> In

addition to this, most clinics offer a range of fertility control services, not just abortion. Harassing and intimidating behaviour seriously compromises the safety and wellbeing of both staff and patients.<sup>16</sup> It aims to obstruct access to clinics through the use of fear, intimidation and the circulation of misleading and incorrect information to women as they enter a clinic.<sup>27</sup>

The legal remedies available to restrict this activity can be limited. Some abortion service providers in Victoria are protected by permanent injunctions, others by council by-laws, and others have no such protection. In the United States, specific legislation known as 'buffer zone' or 'bubble zone' legislation has been enacted which ensures that termination clinics are prohibited areas for anti-choice activity (although not all clinics use such legislation).<sup>27</sup> Similar legislation has not been enacted in Victoria.

### **Good practice in abortion service provision**

Termination of pregnancy should be regulated in the same way as all health services and should be part of health services planning, service delivery and health workforce training. At present in Australia, there are no good practice guidelines as such that exist for abortion care, although the Royal Australian and New Zealand College of Obstetrics and Gynaecologists published *Termination of pregnancy: a resource for health professionals* in 2005.<sup>6</sup> This contains information about termination of pregnancy including methods and risks. In the United Kingdom, similar but more detailed guidance containing information about professional practice, the legal and ethical aspects of abortion, and the organisation of services has been published by the Royal College of Obstetricians and Gynaecologists.<sup>8</sup> Good practice guidelines are provided in British Columbia, Canada. The BC Women's Hospital and Health Centre and the Provincial Health Services Authority published *Best practices in abortion care: Guidelines for British Columbia* in 2004.<sup>66</sup> The guiding principles of that document are reproduced here:

- 1. Reproductive health is vital to the well-being of women and their families. Quality reproductive health services, including reproductive health screening and treatment, contraceptive information and methods, and abortion, are core components of the health care system in British Columbia.*
- 2. Access to the full range of reproductive health services, including abortion, must be available for women regardless of where they live in the province.*
- 3. The planning and provision of abortion services for women must take place within a woman-centred care model that recognises and respects the rights of women to control their reproductive lives and to make decisions that are based on their personal knowledge and experiences.*
- 4. Although abortion procedures are not complicated from a medical or technical point of view, the 'elective' nature of abortion requires that it be provided with particular care to ensure the future reproductive health of women is not compromised.*

The World Health Organization recommend that planning for abortion services must encompass the establishment of norms and standards governing the provision of quality

abortion care; the definition of provider skills, training, supervision and certification processes; the monitoring and evaluation of services; and adequate financing.<sup>1</sup> In Australia, abortion services have often been marginalised within the wider medical community because of a lack of clarity under the law and the opposing views of some doctors. This impacts on the monitoring of quality improvement systems, the adoption of improved techniques (such as medical abortion), and training and professional development.<sup>67</sup> This makes the World Health Organization's recommendations more pertinent.

The provision of termination of pregnancy may not always be a compulsory element of gynaecology or general practice training and in Australia, there is also limited scope for opportunities for professional development.<sup>67</sup> This inevitably adds to a shortage of service providers and a similar situation is reported in the United States and the United Kingdom.<sup>41, 68-69</sup> For a younger generation of health professionals, this was felt to be because younger doctors lack experience of the life-threatening consequences of backyard abortions, and have 'little awareness of the damaging effect of unintended pregnancies on women and their families'.<sup>41, 68</sup> This inevitably results in a feeling of isolation and stress for those health professionals working in this field. This is compounded by the stigma that is attached to abortion service provision, as well as anti-choice activity targeted towards service providers.<sup>41, 70</sup> The need to identify and manage the stress that is particular to this field of work should therefore form part of good practice guidelines.<sup>71</sup>

All of these issues affect women's ability to access abortion services in Australia. The work that health professionals do in this area must be recognised and valued through the application of guidelines, education and ongoing professional development and support. Built into this should be the guiding principle of women-centred practice and an understanding that the right of women to control their own reproductive capacity is central to their empowerment.<sup>72-73</sup>

## Conclusion

Access to safe abortion services is a necessary part of any comprehensive system of reproductive health services. Although change to the law has now been achieved in Victoria which makes abortion lawful, there remain ongoing issues relating to the ability of women to access services. These issues include geographical and financial considerations, limited training and development opportunities for health professionals working in the field, and ongoing anti-choice activity. Stigma and myths surrounding abortion influence all of these issues. Women should be able to access abortion services free from harassment and intimidation.

Abortion services must be complemented by a broader strategy to prevent unintended pregnancy. The changes to the laws in Victoria must be accompanied by measures to improve access to termination services and awareness raising about the options available to women, as well as initiatives that address unintended pregnancy. The importance of shared responsibility by both men and women to prevent unintended pregnancy and of unbiased, relevant and accurate information and support for women is imperative.

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