Submission No. 857
Received 30 June 2016

Submission to:
Health, Communities, Disability Services, and Domestic Violence Prevention committee on the Abortion Law reform (Womens Right to Choose) Amendment Bill 2016 and Inquiry into laws governing termination of pregnancy in Queensland.

Submitters Name: Sue Kruske on behalf of the Institute of Urban Indigenous Health
[redacted]

This submission is based on our experience providing primary health care services to Aboriginal and Torres Strait islander people in 18 clinics community controlled Aboriginal and Torres Strait Islander health clinics in the SE corner of Queensland. We will not address in detail each of the 5 terms of reference the committee has identified as we believe there are others with more detailed knowledge of many of these areas who will provide you with this information.

The submission will however focus on the link between the current ongoing legal uncertainty and the complete lack of public hospital access for disadvantaged and medically complex women seeking TOP in SE Queensland and the impact this has for our patients and families who seek this health care.

There is ample evidence available for the committee that:

- access to safe legal abortion is an essential component of reproductive and maternal health services (1) and is accepted as such by most first world countries; and all jurisdictions in Australia other than Queensland and NSW
- strictly enforced criminalisation of abortion leads to unsafe abortion with associated increased maternal morbidity and mortality (1). Women die from unsafe “backyard” abortions
- the legalisation of abortion does not increase the abortion rate, in fact countries with very open access to abortion (eg Holland, Germany, Sweden) have abortion rates much lower than Australia’s (2)
- that more than 90% of abortions in Australia occur in the first 12 weeks of pregnancy (3)
- abortion is a very safe procedure with no long term health impacts. No evidence supports links with breast cancer, depression, infertility despite some claims to the contrary (4)
- that the vast majority of the small numbers of abortions at later gestations are performed for serious maternal illness or significant fetal abnormalities which need to be considered on a case by case basis (4)
- women of all ages, nationalities, cultural backgrounds, religions and levels of education and income have abortions
- that the majority of Australians believe that a woman with the support of her doctor, should have the right to have an abortion under certain or any circumstances (5)
- 90% of gynaecologists believe that abortion should be available through the public hospital system (6)

- that while routine data collection on abortion in Australia is inconsistent it is estimated that 1 in 4 Australian women will have an abortion at some time over their 35- 40 years of potential fertility (4)
- that women considering abortion need access to non biased supportive counselling but that many women make the individual decision without formal counselling being required.

We would also draw your attention to these 2 well referenced, evidence based policy documents written by national medical and public organisations which include recommendations on the need for decriminalisation across all jurisdictions- both to protect women and doctors from prosecution and to support women making reproductive choices. These documents also advocate for improved data collection, robust clinical guidelines, a mix of private and public TOP provision to ensure equitable access, optional counselling for women with unintended pregnancy and prevention through comprehensive sex and relationship education and improved contraception access programs.

1. Public Health Association of Australia Abortion policy
   https://www.phaa.net.au/documents/item/256

2. Royal Australasian College of Obstetricians and Gynaecologists Termination of Pregnancy Statement-C Gyn-17

   https://www.ranzcog.edu.au/college-statements-guidelines.html#gynaecology

   Both the documents are attached to this submission.

   IUIH would like to provide the following points to the committee

- Clinical staff at our clinics report that women are referred for TOP under a wide range of circumstances and that significant difficulties frequently arise for disadvantaged women, young women and those with medical conditions requiring referral to public hospitals.
- IUIH are in regular contact with Children By Choice a Brisbane based organisation that provides unbiased counselling, support and limited financial assistance to women with unplanned pregnancies, to discuss the needs of specific Aboriginal and Torres Strait Islander women from across Qld who are seeking abortion but cannot afford the fees of private clinics.
- The numbers of ATSI women seeking TOP across our sector in SE Qld, and more broadly across the state, is unknown. However the impact is enormous for individual women and their families if unable to readily access this reproductive choice in the many circumstances (including overwhelming family or other social stressors, physical or mental ill health conditions, domestic violence, substance use, sexual assault) which lead to TOP being sought.
- Data on TOP is generally sparse with SA and WA being the only states to record and report on this. WA data suggests that Aboriginal women have an abortion rate half that of non indigenous women (3).It is not known whether this relates to differences in individual choices, wider community beliefs or simply lack of access to abortion services for our women.

- "Children by Choice" report that 8-15 % per month of calls to their organisation for counselling and support are from indigenous women from across Queensland.
- The reality is that TOP services are readily available in Queensland through private day surgeries, and for medical abortion, by private gynaecologists and a limited number of GPs. These medical providers work around the current outdated criminal legislation to provide what they assess to be lawful procedures (as allowed by section 282). As a result, many people think that TOP is already legal. But the issue of equality of access is highlighted by the following-it is estimated that only 1% of TOPs in Queensland are provided in the public system.
- Despite the existence of Queensland Health clinical guidelines (7) published in 2013- which state that women requesting terminations should be assessed and that hospitals should have published referral pathways and criteria for public provision of termination of pregnancy- in reality most public hospitals simply refuse to follow the guidelines, to accept referrals, much less provide a TOP. This is the case, even in the face of cases of serious physical or mental health disorders necessitating termination (eg cancer), pregnancy as the result of rape, pregnancies where there is significant substance abuse or women in situations of domestic violence.
- It is unclear as to the exact reasons why hospital administrators and medical practitioners within Queensland Health settings continue to refuse to provide TOP services to high needs women. It can only be assumed that they are not adhering to clinical guidelines because they are afraid of the legal implications.
- The resultant problem is that the legal uncertainty and clouding has led to a two tier system of access, where women in regional or metropolitan centres with knowledge and financial means can readily access TOP, while women facing socioeconomic disadvantage have extremely high hurdles to jump in order to access the same services. This is particularly relevant to teenagers, women with physical mental health problems including substance abuse and those with medical conditions including cancer.
- Aboriginal and Torres Strait Islander women already face significant health and socioeconomic disadvantages and the majority of our patients rely on the public health system to provide procedures that are not available in primary care. If a woman requires or chooses a surgical TOP she is left with no option if she can't afford the $400-$500 of a private clinic in Brisbane (the costs are much higher than this for women living in rural and regional areas or for second trimester procedures). This doesn't include transport costs, time off work, childcare etc.
- The most disadvantaged Aboriginal and Torres Strait Islander women, already living in poverty, face higher rates of domestic violence, psychological stress, chronic ill health, homelessness, overcrowded housing, interaction with child protection authorities including child removal to out of home care. For those women who make the difficult and often courageous choice to terminate a pregnancy, often to be able to "keep their head above water" and care for their living children and families, why should this not be legally and readily available to them as it is to those in more advantaged situations?

A recent example from one of the clinics in our sector highlights some of the issues:

Submission No. 857
Received 30 June 2016

A 15 year old Aboriginal young woman presented requesting referral for abortion at 7 weeks gestation. She had a developmental delay, is trauma affected, using amphetamines and had an unplanned pregnancy; the circumstances of the pregnancy are not clear but possibly involving coercion or assault. With discussion and family support, the GP agreed with her decision to terminate the pregnancy and contacted the local public hospital to arrange prompt referral for the required surgical procedure. However, the gynaecology registrar at the hospital declined to accept the referral, stating - somewhat bizarrely – that they would only consider it if a definite fetal abnormality was found.

In Queensland, fetal abnormality is not even grounds for lawful TOP; it would need to be on the grounds of the impact of the abnormality on the mothers health. Clearly this doctor does not understand the law and seemed oblivious of the Qld Health guidelines. The expectation therefore seems to have been that this young woman could carry this pregnancy to term or find the funds to attend a private clinic. If the latter isn't possible, or if it the endless hurdles to find the necessary funds mean that this young woman disengages from service providers during the first trimester; it is likely that she will proceed with the pregnancy.

In summary,

- IUIH believes that decriminalisation of abortion in Queensland , in line with every other jurisdiction in Australia, is well overdue. Whilst it is clear that a TOP can be readily accessed by many women, the necessary addition of public hospital provision (as one part of the service pathway mix) will only ever occur with the absolute legal clarity that decriminalisation brings. The "stone walling" by public gynaecology services, regardless of womens individual circumstances, needs to end.
- The procedure can best be regulated through existing health regulations with the support of clear evidenced best practice clinical guidelines which could be drawn up and endorsed by both Queensland Health and the relevant medical colleges (RANZCOG and RACGP for early medical abortion)
- IUIH supports policy from other organisations
  -that unbiased professional counselling should be available but not mandatory for women considering TOP
  -that improved data collection on TOP is necessary to monitor trends and evaluate interventions aimed at reducing the need for TOP

References:

1. WHO (2012) safe abortion: technical and policy guidance for health systems- 2nd edition. http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/
2. Sedgh, G et al (2007) Induced abortion: estimated rates and trends worldwide, *The Lancet*, Vol 370: 1338-45
3. Family Planning NSW. Reproductive and Sexual Health in Australia. Ashfield, Sydney:FPNSW, 2013.
4. VLRC (2008), 'Law of abortion: final report', Victorian Law Reform Commission. http://www.lawreform.vic.gov.au/content/law-abortion-final-report-html-version

5. Monash University Centre for Population and Urban Research (2009)Attitudes to abortion: Australia and Queensland in the 21st century **http://arrow.monash.edu.au/hdl/1959.1/481991**
6. de Costa C, Russell D, 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 Med J Aust ; 193 (1): 13-16. https://www.mja.com.au/journal/2010/193/1/views-and-practices-induced-abortion-among-australian-fellows-and-specialist
7. Therapeutic termination of pregnancy Document number: MN13.21-V1-R18 April 2013 Author: Queensland Maternity and Neonatal Clinical Guidelines Program https://www.health.qld.gov.au/qcg/documents/g-ttop.pdf

Submission No. 857
Received 30 June 2016

Public Health Association
AUSTRALIA

Public Health Association of Australia:

Policy-at-a-glance – Abortion Policy

Key message:

1. Rates of unplanned pregnancy and abortion could be reduced by increased education, fertility awareness, uptake of effective contraception and respectful relationships. This may be assisted through a comprehensive national sexual and reproductive health strategy.

2. While the primary public health goal in the area of unintended pregnancy is prevention, even with good prevention strategies abortion services will always be needed.

3. Abortion is a common part of many women's reproductive experience with one quarter to one third of all Australian women having an abortion at some point in their life.

4. In the Australian setting, abortion is an extremely safe procedure. Internationally, access to safe, legal abortion significantly reduces maternal mortality.

5. Abortion should be regulated in the same way as other health procedures, without additional barriers or conditions. Regulation of abortion should be removed from Australian criminal law.

6. States and territories should actively work toward equitable access (including geographic and financial access) to abortion services, with a mix of public and private services available.

Summary: Abortion is a safe, common medical procedure which should be regulated in the same way as other medical procedures. Both medical and surgical abortion should be included in health service planning.

Audience: Australian, State and Territory Governments, policy makers and program managers.

Responsibility: PHAA's Women's Health Special Interest Group (SIG)

Date policy adopted: September 2014

Contact: [redacted] Women's Health SIG Convenors

Submission No. 857
Received 30 June 2016

Public Health Association
AUSTRALIA

ABORTION POLICY

The Public Health Association of Australia notes that:

1. Access to safe, legal abortion is essential to optimal reproductive health outcomes and to minimizing maternal morbidity and mortality globally[1].

2. The primary public health goal in the area of unintended pregnancy is prevention. Improved access to and uptake of contraception is associated with lower rates of unintended pregnancy and abortion[1].

3. Even with good access to and uptake of contraception, there will always be a need for abortion services. Contraceptive failure, sexual violence and other factors can lead to unintended pregnancies[1] while new or progressing maternal illness or diagnosis of fetal anomaly or illness may lead to consideration of abortion in intended pregnancies.

4. When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, particularly if performed within the first 14 weeks of pregnancy, induced abortion is a very safe medical procedure[1].

5. Abortion is one of the most commonly performed gynaecological procedures with an estimated 25-30% of Australian women having an abortion at some stage in their lives[2].

6. The registration in 2012 of therapeutic agents capable of medically (as distinct from surgically) inducing abortion presents an opportunity to develop service models which may improve geographic and economic access to abortion, particularly early abortion.

7. There are good quality comprehensive evidence based guidelines to support abortion service delivery[3].

8. While there are diverse views on many aspects of abortion, the majority of Australians support of women's access to safe, legal abortion[4].

9. There is a lack of systematic data collection on abortion in Australia[5].

10. The law pertaining to abortion is still located in the criminal statutes and codes in some states and territories[6]. This creates uncertainty and places women and health professionals at risk of criminal sanctions for obtaining or delivering health care.

11. Australian and international experience shows that removing legal barriers to abortion does not affect abortion rates[7].

12. Laws which criminalise and/or restrict abortion are not associated with lower abortion rates, but are associated with higher maternal mortality and unsafe abortion rates internationally[1,6].

13. Internationally, barriers to safe and timely abortion may include legal restrictions, inability to pay, lack of social support, delays in seeking health-care, providers' negative attitudes, and poor quality of services. These barriers may be particularly pronounced for young women and for women experiencing violence, resulting in abortion being accessed later than would otherwise be the case[1].

The Public Health Association of Australia affirms the following principles:

14. A comprehensive sexual and reproductive health strategy[8] can be expected to deliver the best health outcomes by addressing elements including:
    - school-based education for safe, respectful relationships
    - increasing health literacy with respect to contraception and prevention of unintended pregnancy
    - a social determinants framework which takes account of factors such as partner violence and access to financial resources
    - service development and planning which ensures equitable access to good quality services
    - workforce development for health professionals, educators and others
    - monitoring, evaluation and research

15. The criminal law is an inappropriate vehicle - both in principle and practice - for regulating the provision of abortion.

16. Increasing gestation increases the complexity and risks of abortions as well as the costs to women and to the health system: therefore timely and affordable access to abortion services is extremely important.

17. Both medically and surgically induced abortion should be available throughout Australia including in rural and remote regions where geographical distance and limited services often hinder health care provision.

18. Australian overseas aid should support the provision of pre and post abortion care and abortion provision where appropriate.

The Public Health Association of Australia believes that the following steps should be undertaken by legislators, policymakers, funding bodies and health services:

19. Organisations should support and collaborate in the development of a comprehensive national sexual and reproductive health strategy.

20. Organisations working at public health and individual health care levels should address fertility control and informed decision making. This should include education and information about access to abortion services and choice of method where available.

21. Women should be supported at both individual and population levels in their right to choose the fertility control options that are most appropriate to their individual circumstances and without coercion.

22. Research, training and workforce development should be adequately funded, as for other areas of health practice, to promote evidence based quality care, adequacy of and access to service provision and service improvement.

23. Regulation of abortion should be removed from the criminal laws and codes of the States and Territories of Australia. Abortion should be regulated, as are all other medical services, under existing health care legislation.

24. Barriers and restrictions to access such as requirements for multiple opinions or mandated counselling should not be applied through legislation, regulation or policy. Care should be delivered in accordance with evidence based standards of best practice and informed consent.

25. Abortion services should be included in service planning for all state and territory health authorities

26. Service development and funding arrangements should increase access to medically induced abortion in the interests of improving access to earlier abortion and increasing women's capacity to choose the care most appropriate to their circumstances. This is especially important in rural and remote areas where surgical abortion is not readily available.

27. A mix of private and public services should be available in all jurisdictions as for other reproductive health services; adequate public services must be available for women experiencing financial disadvantage and limited access, so that cost is not a barrier to access.

28. Routine, complete and systematic data collection on abortion should be implemented in Australia to increase understanding of how services may be improved, including how to improve strategies to reduce unintended pregnancies.

29. Medicare rebates for abortion procedures should be sufficient to prevent cost presenting a barrier to access.

30. Counselling offered to women considering abortion should always be non-judgmental, professional and provide advice on all options including referral pathways.

31. Abortion service providers should always offer optional, comprehensive pre and post-abortion counselling.

32. Any health professional with a conscientious objection to personal participation in abortion care should inform their patients of this and refer patients wanting to consider or discuss abortion to another health professional without such objection (this does not have to be an abortion service provider). Registration, professional and educational bodies should reinforce this responsibility.

33. Legal protection should safeguard clients and staff of legal abortion services from harassment.

The Public Health Association of Australia resolves to undertake the following actions:

34. The Board, Women's Health Special Interest Group and State/Territory Branches of the Association will endeavour to keep federal, state and territory members of parliament aware of the importance to health of safe affordable accessible abortion services and the adverse health consequences of restriction of access. They will advocate for:
    - The development of a comprehensive sexual and reproductive health strategy, addressing the domains identified in the Melbourne Proclamation[9] and the Association's earlier call to action and sexual and reproductive health background paper[10]
    - the removal of abortion from criminal codes in all states and territories and the treatment of abortion as a health issue in legislation and regulation
    - the availability of abortion within public health services with equivalent quality of care and equity of access to other health services
    - improved timely access to safe appropriate abortion procedures, both medical and surgical, for Australian women, especially those experiencing disadvantage.

ADOPTED 1989, REVISED AND RE-ENDORSED IN 1996, 2005, 2008, 2011 & 2014
First adopted at the 1989 Annual General Meeting (AGM) of the Public Health Association of Australia (PHAA). Revised and re- endorsed at the 1996,2005, 2008, 2011 & 2014 PHAA AGM.

References

[1] WHO (2012) Safe abortion: technical and policy guidance for health systems – 2nd ed.
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

[2] Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2005) Termination of Pregnancy A Resource for Health Professionals, p.5 https://www.ranzcog.edu.au/termination-of-pregnancy-booklet.html

[3] Royal College of Obstetricians and Gynaecologists (2011) The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7 http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

[4] Victorian Law Reform Commission (2008) *Law of Abortion Final Report.* Victorian Law Reform Commission, Melbourne: pp 57-68 http://www.lawreform.vic.gov.au/all-projects/abortion

5 AIHW NPSU: Grayson N, Hargreaves J & Sullivan EA 2005. *Use of routinely collected national data sets for reporting on induced abortion in Australia*. AIHW Cat. No. PER 30. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 17).

[6] Children by Choice (Qld) maintains a current list of state & territory law and practice with links to legislation http://www.childrenbychoice.org.au/info-a-resources/facts-and-figures/australian-abortion-law-and-practice

[7] Sedgh, G. et al (2007) Induced abortion: estimated rates and trends worldwide, *The Lancet, Vol* 370: 1338–45

[8] Public Health Association of Australia (2008): Time for a national sexual and reproductive health strategy for Australia: a call to action http://www.phaa.net.au/documents/SRH_call_to_action.pdf and background paper http://www.phaa.net.au/documents/SRH_background_paper.pdf

[9] PHAA, SHFPA, MSI (2012) Melbourne Proclamation
http://www.phaa.net.au/documents/DR0208%20Melbourne%20Proclamation.pdf

[10] PHAA 2008 background paper http://www.phaa.net.au/documents/SRH_background_paper.pdf

Submission No. 857
Received 30 June 2016

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

College Statement
C-Gyn 17
1st Endorsed: March 2005
Current: March 2013
Review: March 2016

C-Gyn 17

Termination of Pregnancy

RANZCOG recognises that termination of pregnancy is an important health issue.[1, 2, 3] The College is committed to improving the health and well being of all women, and to the advancement of knowledge of the health effects of pregnancy and pregnancy termination. The College acknowledges that people may have strong personal beliefs about termination of pregnancy.

The College supports moves to develop a national sexual and reproductive health strategy, which would have the potential to support the following dimensions of sexual and reproductive health including termination of pregnancy care:

- Education and the development of health literacy including access to and uptake of contraception.
- Equitable access to optimal sexual and reproductive health services, including termination services.
- Monitoring and research.
- Workforce development and succession planning.

Prevention of unintended pregnancy and development of health literacy

The prevention of unintended pregnancy should be a priority. RANZCOG supports broad community education (including in schools), with regard to sexual and reproductive health including relationships, safe sex and contraception. RANZCOG specifically supports ready access to as wide a range of safe and reliable contraceptive measures as possible. Professional and community education about long acting reversible contraception is encouraged.

Access

Non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies.[3] 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. Equitable access to services should be overseen and supported by health departments in each jurisdiction, in the same way it is for other health services. Women have the right to access any medical services without their privacy being infringed or being subjected to harassment.

Services

A woman's physical, social, emotional and psychological needs should be taken into account in the course of counselling and decision-making. Pregnancy termination services should be provided subject to all appropriate standards for clinical assessment, procedural safety and aftercare. In general this will be in an approved facility, but some components of early medical termination of pregnancy may take place as an outpatient and/or at home, provided 24 hour back up is arranged.

The availability of a range of medical and surgical methods of termination is seen as ideal. Pre- and post-termination counselling by appropriately qualified personnel should be routinely available. Confidentiality of all possible identifying information of women undergoing termination of pregnancy is essential.

Women should be provided with accurate information including that termination of pregnancy is a safe procedure for which major complications and mortality are rare.

Special considerations

Decisions around timing of termination of pregnancy become more complex in the presence of some specific fetal conditions, late recognition of pregnancy, advancing gestational age, multiple pregnancy and pre-existing maternal disease. The College supports a multidisciplinary approach in assisting women in such circumstances and the availability of late termination of pregnancy for the rare situations where both managing clinicians and patient believe it to be the most suitable option in the circumstances.

Monitoring and research

In order to better understand the individual and public health impacts of termination of pregnancy, the College supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.

Workforce

A cornerstone of the provision of good health care is the availability of well trained health professionals. Issues relating to termination of pregnancy should be included in the education of all health professionals, particularly those who are primarily involved in women's health care. No member of the health team should be expected to perform termination of pregnancy against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained. A systematic approach is required to ensure recruitment and training of sufficient health professionals to provide safe clinical care.

Legislation

Legislation regarding termination of pregnancy varies across jurisdictions. It is essential that health practitioners are aware of the legislation that applies in the jurisdiction in which they practice. Uniformity and clarity of legislation would benefit both health practitioners and the women for whom they care.

References

1. Chan A, Keane R. Prevalence of Induced Abortion in a Reproductive Lifetime. American Journal of Epidemiology 2003; 159 (5): 475-80.

2. World Health Organization. Safe abortion: technical and policy guidance for health systems (Second edition) Geneva: WHO; 2012. Available at: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

3. World Health Organization. Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. Geneva; 2004. Available at: http://whqlibdoc.who.int/publications/2004/9241591803.pdf

Other suggested reading

Abortion Supervisory Committee. Report of the Abortion Supervisory Committee 2010. Wellington: Ministry of Justice.

AIHW NPSU: Grayson N, Hargreaves J & Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. AIHW Cat. No. PER 30.

Enhancing Sexual Wellbeing in Scotland - A Sexual Health and Relationships Strategy. A Proposal to the Scottish Executive 2003. Available at: http://www.scotland.gov.uk/Resource/Doc/47063/0013758.pdf

International Federation of Gynaecology and Obstetrics (FIGO). Recommendations on Ethical Issues in Obstetrics and Gynaecology by The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health: Ethical aspects of induced abortion for non-medical reasons, pp. 102. London: FIGO; 2009.

Marston C, Cleland J. Relationships between contraception and abortion: a review of the evidence. International Family Planning Perspectives 2003; 29 (1): 6-13.

National Institute for Health and Clinical Excellence. Long-acting reversible contraception: The effective and appropriate use of long-acting reversible contraception. London; 2005. Available at: http://www.nice.org.uk/nicemedia/live/10974/29912/29912.pdf

Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. RCOG Press November 2011. Available at: http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

Victorian Law Reform Commission. Law of Abortion: Final Report 2008. Available at: http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Abortion_Report.pdf

Links to other related College Statements

(C-Gyn 17a) Late termination of pregnancy
http://www.ranzcog.edu.au/component/docman/doc_download/2866-late-termination-of-pregnancy-c-gyn-17a.html?Itemid=946

(C-Gyn 21) The use of mifepristone for medical termination of pregnancy
http://www.ranzcog.edu.au/component/docman/doc_download/929-c-gyn-21-the-use-of-mifepristone-for-medical-termination-of-pregnancy.html

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology
http://www.ranzcog.edu.au/component/docman/doc_download/894-c-gen-15-evidence-based-medicine-obstetrics-and-gynaecology.html?Itemid=341

(C-Gen 2) Guidelines for consent and the provision of information regarding proposed treatment
http://www.ranzcog.edu.au/component/docman/doc_view/899-c-gen-02-guidelines-for-consent-and-the-provision-of-information-regarding-proposed-treatment.html?Itemid=341

Useful websites

International Federation of Gynecology and Obstetrics
http://www.figo.org

Royal College of Obstetricians and Gynaecologists
http://www.rcog.org.uk

Disclaimer

This College Statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

This College statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that College statements are accurate and current at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the date of the statements.

Submission No. 857
Received 30 June 2016

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

College Statement
C-Gyn 17
1st Endorsed: March 2005
Current: March 2013
Review: March 2016

C-Gyn 17

Termination of Pregnancy

RANZCOG recognises that termination of pregnancy is an important health issue.[1, 2, 3] The College is committed to improving the health and well being of all women, and to the advancement of knowledge of the health effects of pregnancy and pregnancy termination. The College acknowledges that people may have strong personal beliefs about termination of pregnancy.

The College supports moves to develop a national sexual and reproductive health strategy, which would have the potential to support the following dimensions of sexual and reproductive health including termination of pregnancy care:

- Education and the development of health literacy including access to and uptake of contraception.
- Equitable access to optimal sexual and reproductive health services, including termination services.
- Monitoring and research.
- Workforce development and succession planning.

Prevention of unintended pregnancy and development of health literacy

The prevention of unintended pregnancy should be a priority. RANZCOG supports broad community education (including in schools), with regard to sexual and reproductive health including relationships, safe sex and contraception. RANZCOG specifically supports ready access to as wide a range of safe and reliable contraceptive measures as possible. Professional and community education about long acting reversible contraception is encouraged.

Access

Non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies.[3] 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. Equitable access to services should be overseen and supported by health departments in each jurisdiction, in the same way it is for other health services. Women have the right to access any medical services without their privacy being infringed or being subjected to harassment.

Services

A woman's physical, social, emotional and psychological needs should be taken into account in the course of counselling and decision-making. Pregnancy termination services should be provided subject to all appropriate standards for clinical assessment, procedural safety and aftercare. In general this will be in an approved facility, but some components of early medical termination of pregnancy may take place as an outpatient and/or at home, provided 24 hour back up is arranged.

The availability of a range of medical and surgical methods of termination is seen as ideal. Pre- and post-termination counselling by appropriately qualified personnel should be routinely available. Confidentiality of all possible identifying information of women undergoing termination of pregnancy is essential.

Women should be provided with accurate information including that termination of pregnancy is a safe procedure for which major complications and mortality are rare.

Special considerations

Decisions around timing of termination of pregnancy become more complex in the presence of some specific fetal conditions, late recognition of pregnancy, advancing gestational age, multiple pregnancy and pre-existing maternal disease. The College supports a multidisciplinary approach in assisting women in such circumstances and the availability of late termination of pregnancy for the rare situations where both managing clinicians and patient believe it to be the most suitable option in the circumstances.

Monitoring and research

In order to better understand the individual and public health impacts of termination of pregnancy, the College supports the monitoring and collection of statistics relating to termination of pregnancy, including the occurrence of complications of these procedures.

Workforce

A cornerstone of the provision of good health care is the availability of well trained health professionals. Issues relating to termination of pregnancy should be included in the education of all health professionals, particularly those who are primarily involved in women's health care. No member of the health team should be expected to perform termination of pregnancy against his or her personal convictions, but all have a professional responsibility to inform patients where and how such services can be obtained. A systematic approach is required to ensure recruitment and training of sufficient health professionals to provide safe clinical care.

Legislation

Legislation regarding termination of pregnancy varies across jurisdictions. It is essential that health practitioners are aware of the legislation that applies in the jurisdiction in which they practice. Uniformity and clarity of legislation would benefit both health practitioners and the women for whom they care.

References

1. Chan A, Keane R. Prevalence of Induced Abortion in a Reproductive Lifetime. American Journal of Epidemiology 2003; 159 (5): 475-80.

2. World Health Organization. Safe abortion: technical and policy guidance for health systems (Second edition) Geneva: WHO; 2012. Available at: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

3. World Health Organization. Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2000. Geneva; 2004. Available at: http://whqlibdoc.who.int/publications/2004/9241591803.pdf

Other suggested reading

Abortion Supervisory Committee. Report of the Abortion Supervisory Committee 2010. Wellington: Ministry of Justice.

AIHW NPSU: Grayson N, Hargreaves J & Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. AIHW Cat. No. PER 30.

Enhancing Sexual Wellbeing in Scotland - A Sexual Health and Relationships Strategy. A Proposal to the Scottish Executive 2003. Available at: http://www.scotland.gov.uk/Resource/Doc/47063/0013758.pdf

International Federation of Gynaecology and Obstetrics (FIGO). Recommendations on Ethical Issues in Obstetrics and Gynaecology by The FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health: Ethical aspects of induced abortion for non-medical reasons, pp. 102. London: FIGO; 2009.

Marston C, Cleland J. Relationships between contraception and abortion: a review of the evidence. International Family Planning Perspectives 2003; 29 (1): 6-13.

National Institute for Health and Clinical Excellence. Long-acting reversible contraception: The effective and appropriate use of long-acting reversible contraception. London; 2005. Available at: http://www.nice.org.uk/nicemedia/live/10974/29912/29912.pdf

Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. RCOG Press November 2011. Available at: http://www.rcog.org.uk/files/rcog-corp/Abortion%20guideline_web_1.pdf

Victorian Law Reform Commission. Law of Abortion: Final Report 2008. Available at: http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Abortion_Report.pdf

Links to other related College Statements

(C-Gyn 17a) Late termination of pregnancy
http://www.ranzcog.edu.au/component/docman/doc_download/2866-late-termination-of-pregnancy-c-gyn-17a.html?Itemid=946

(C-Gyn 21) The use of mifepristone for medical termination of pregnancy
http://www.ranzcog.edu.au/component/docman/doc_download/929-c-gyn-21-the-use-of-mifepristone-for-medical-termination-of-pregnancy.html

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology
http://www.ranzcog.edu.au/component/docman/doc_download/894-c-gen-15-evidence-based-medicine-obstetrics-and-gynaecology.html?Itemid=341

(C-Gen 2) Guidelines for consent and the provision of information regarding proposed treatment
http://www.ranzcog.edu.au/component/docman/doc_view/899-c-gen-02-guidelines-for-consent-and-the-provision-of-information-regarding-proposed-treatment.html?Itemid=341

Useful websites

International Federation of Gynecology and Obstetrics
http://www.figo.org

Royal College of Obstetricians and Gynaecologists
http://www.rcog.org.uk

Disclaimer

This College Statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

This College statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that College statements are accurate and current at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the date of the statements.