Reimagining medical abortion in Australia: what do we need to do to meet women's needs and ensure ongoing access?

There is much to be done to make high quality, accessible medical abortion a reality in Australia

The overturning of *Roe v Wade* in the United States has renewed impetus in Australia to ensure the availability of high quality, accessible abortion services. But decriminalisation and the availability of medical abortion do not in and of themselves mandate service delivery or ensure access. Numerous barriers continue to exist. These include issues such as inconsistent abortion laws, over-regulation, lack of regional level planning and accountability for service delivery, sparse and inconsistent services across the country, inadequate numbers of skilled providers, a lack of training opportunities for the current and future workforce, and consumer concerns such as high costs and difficulty navigating services.

With each state and territory having different abortion laws,[1] practitioners are concerned about compliance when practising across borders or undertaking locums. Women are also forced to travel between states to get the abortion care they require because of differences in gestational limits or lack of availability of providers. Uniformity in legislation across the country is necessary, involving both decriminalisation and removal of grounds-based restrictions, gestational limits, third party authorisation, and provider restrictions. Laws must also ensure that access to abortion care is protected against barriers created by conscientious objection.[2]

Medical abortion remains over-regulated in Australia and out of step with current international models of care and evidence-based recommendations. The World Health Organization guidelines[3] outline, for example, regimens for medical abortion involving mifepristone and different dosages of misoprostol both before 12 weeks' gestation and beyond. However, the current composite pack of mifepristone and misoprostol available in Australia is only registered for use up to nine weeks' gestation[4] and does not offer practitioners or indeed women the availability of additional doses of misoprostol when required.

Over-regulation contributes to stigma and is a barrier to primary care provision. Canada has completely deregulated mifepristone providing evidence not only of continued safety but also a marked increase in the number of providers.[5] Moves are underway in Australia to remove many of the restrictions that were applied at the time of registration of mifepristone. Once approved, mifepristone will be able to be prescribed like any other drug and dispensed by any pharmacist. But more is required than just deregulation to increase the current low number and maldistribution of primary care providers in Australia. There are currently only 3885 general practitioners registered to provide medical abortion, of which 2478 are based in metropolitan areas.[6] Some 30% of Australian women live in an area with not even one GP provider.[7] This increases to 50% for those living in remote Australia.[7]

A high functioning integrated health system is required to optimise care. Although GPs play a central role in primary care provision, the WHO guidelines[3] make recommendations supporting provision by a broader range of health professionals than currently exists in Australia. This includes task sharing and nurse and other health service professional provision of a range of abortion services, including vacuum aspiration for induced abortion, management of incomplete abortions and miscarriage, medical abortions in the first trimester, management of uncomplicated incomplete abortions or miscarriage with misoprostol, and self-managed abortion.

Secondary and tertiary care facilities need to better support primary care provision in their region. It is necessary to have greater accountability for local level planning, service delivery, and creation and transparency of referral pathways that support primary care delivery and provide specialist service options where there is complexity or special needs.[8]

Focus is also required on workforce capacity building and creating a pipeline of providers of abortion services. This involves exposure to and education on abortion at all stages of a health care professional's career pathway: while a student, during hospital residency and rotations, during discipline-based training (eg, general practice, midwifery, pharmacy and gynaecology training), and for practising clinicians through opportunities for further skill acquisition and peer support and networking.

Student curricula need to focus on clinical delivery of abortion services, not only ethical and legal dimensions.[9] With the majority of abortion service provision currently occurring outside of hospitals in private community-based services, student placements and skills-focused training in high volume community-based clinics need to be supported. This could occur through support of local family planning clinics, general practice clinics with special expertise in women's health (eg, the newly established endometriosis general practice clinics[10]), or through local commissioning of both clinical services and training at a regional level through primary health networks. At a minimum, all GP trainees could be

Danielle Mazza

Monash University, Melbourne, VIC.

danielle.mazza@monash.edu

MJA 218 (11) • 19 June 2023
doi:10.5694/mja2.51979

offered training in medical abortion and long-acting reversible contraception insertion and removal through these clinics that need to receive specific funding to provide such training. Training incentives for local providers could also be established in specific areas of need.

Deliberate leadership development through fellowships is another strategy increasingly used in countries such as the US (eg, the Reproductive Health Education in Family Medicine [RHEDI] Fellowship Program; https://rhedi.org). These fellowships provide salary support for trainees to learn core skills in clinical care, advocacy and leadership, education skills, and research skills. This could help make trainees the leaders in sexual reproductive health in the future, ensuring the sustainability of the workforce.

Communities of practice can be a valuable resource for practitioners in the community, providing peer support, resources and information on best practice. Examples of communities of practice include the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) initiative in Australia — a multidisciplinary online community supporting primary care providers to deliver contraception and abortion care.[11] By incorporating these workforce capacity building approaches into professional education at all levels, we will ensure that Australia is well equipped to provide high quality abortion care throughout the country in the future.

It is also important to address the needs and preferences of consumers in the provision of abortion care. Although medical abortion may be enabling for many women, it is not the preferred option for many[12] and is not suitable for everyone, particularly young people who may need more support and consideration. Choice of either medical or surgical abortion must therefore be maintained. Women seeking abortion often have poor knowledge of their options. In addition, they face lack of transparency as to where services are provided, high costs, and few local services providing abortion.[13] National information hotlines, such as My Options in Ireland[14] and 1800 My Options (www.1800myoptions.org.au) in Victoria, can help women (and primary care practitioners who are not themselves providers or who have conscientious objection) navigate to services. As is the case in Ireland, they could also provide a 24-hour support line. Making abortion cost-neutral to the patient, as is also the case in Ireland[14] (for related consultations, necessary ultrasounds and investigations, medical abortion medication, follow-up low sensitivity urine pregnancy test, and post-abortion contraception if desired) and in other countries such as England, Scotland and Sweden, would also remove barriers to women requiring this essential service. No cost abortions have recently become available in the Australian Capital Territory,[15] setting an example that hopefully the rest of Australia will follow.

Improving women's health literacy is also crucial in enabling them to make informed decisions about their reproductive health. With the increasing trend of relying on information gleaned through social media and the internet, a national digital hub could promote evidence-based information through social media campaigns, use animations to assist women with low health literacy, provide information in multiple languages and help counter misinformation commonly peddled on TikTok and Instagram, for example. Video-based information can be an effective way of increasing young women's knowledge and has been demonstrated to achieve outcomes such as increasing women's uptake and preference for long-acting reversible contraception.[16]

The coronavirus disease 2019 (COVID-19) pandemic mainstreamed telehealth abortion service provision across the world, and, in Australia, is supported by much welcomed sexual and reproductive health telehealth Medicare item numbers that have no patient restrictions.[17] Knowledge of the availability of telehealth approaches to medical abortion among both GPs[18] and consumers remains limited and more needs to be done to promote the availability of this option, which is so effective for improving access.

Self-management in abortion, where women are supported to have a safe at-home abortion, is endorsed by the WHO[3] and is gaining momentum in countries with restrictions to abortion access such as the US; for instance, Plan C is an example of an organisation that supports women in self-managing their abortions (www.plancpills.org). However, it is important to consider both the benefits and potential drawbacks of self-management in abortion care. Even though self-management can provide greater access to safe and effective medical abortion, particularly for those who face barriers to accessing in-person care, it is important to ensure that vulnerable populations are not left behind and that health care services continue to provide comprehensive and accessible reproductive health services, including abortion care, for those who need it. Advanced provision of medical abortion medication as well as the use of mifepristone for menstrual regulation[19] are likely next steps, but rigorous evaluation and careful consideration of the potential benefits and risks are necessary before these approaches can be advocated.

In conclusion, there is much to be done to make high quality, accessible medical abortion a reality in Australia, but the steps needed are clear. The WHO guideline provides the evidence and the policy, workforce and clinical framework for moving forward.[3] The gains that have been made through the availability of telehealth access should be built upon. Regional level planning, integration, delivery and accountability need to become a given. Countries such as Ireland and Canada provide examples of the models of care and policies required, and strangely the US, whose legal system is restricting much needed provision in the health care sector, has showcased how consumer empowerment and literacy can be harnessed to overcome what can seem like insurmountable barriers.

Open access: Open access publishing facilitated by Monash University, as part of the Wiley - Monash University agreement via the Council of Australian University Librarians.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

© 2023 The Author. *Medical Journal of Australia* published by John Wiley & Sons Australia, Ltd on behalf of AMPCo Pty Ltd.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

1 Children by Choice. Australian abortion law and practice. https://www.childrenbychoice.org.au/organisational-information/legislation/australian-abortion-law-and-practice/ (viewed May 2023).

2 World Health Organization. Towards a supportive law and policy environment for quality abortion care: evidence brief. Geneva: WHO, 2022. https://www.who.int/publications/i/item/9789240062405 (viewed May 2023).

3 World Health Organization. Abortion care guideline. Geneva: WHO, 2022. https://www.who.int/publications/i/item/9789240039483 (viewed May 2023).

4 MS Health. Product information: MS-2-Step (Mifepristone and Misoprostol) tablets. Therapeutic Goods Administration, 2014. https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2014-PI-01965-1 (viewed Apr 2023).

5 Schummers L, Darling EK, Dunn S, et al. Abortion safety and use with normally prescribed mifepristone in Canada. *N Engl J Med* 2022; 386: 57-67.

6 MS Health Impact report 2022. Melbourne: MS Health, 2023. https://mshealth.us11.list-manage.com/track/click?u=14f86febead535ec671efe982&id=3439df9683&e=10f9b94107 (viewed Apr 2023).

7 Subasinghe AK, McGeechan K, Moulton JE, et al. Early medical abortion services provided in Australian primary care. *Med J Aust* 2021; 215: 366-370. https://www.mja.com.au/journal/2021/215/8/early-medical-abortion-services-provided-australian-primary-care

8 Srinivasan S, Botfield JR, Mazza D. Utilising HealthPathways to understand the availability of public abortion in Australia. *Aust J Prim Health* 2022; doi: https://doi.org/10.1071/PY22194 [Epub ahead of print].

9 Cheng HC, de Costa C. Abortion education in Australian medical schools. *Aust N Z J Obstet Gynaecol* 2021; 61: 793-797.

10 Department of Health and Aged Care; Hon Ged Kearney MP. Australia's first endometriosis and pelvic pain clinics now available nationally [media release]. 22 March 2023. https://www.health.gov.au/ministers/the-hon-ged-kearney-mp/media/australias-first-endometriosis-and-pelvic-pain-clinics-now-available-nationally (viewed Apr 2023).

11 Mazza D, James S, Black K, et al. Increasing the availability of long-acting reversible contraception and medical abortion in primary care: the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) cohort study protocol. *BMJ Open* 2022; 12: e065583.

12 Baraitser P, Free C, Norman WV, et al; SACHA Study Team. Improving experience of medical abortion at home in a changing therapeutic, technological and regulatory landscape: a realist review. *BMJ Open* 2022; 12: e066650.

13 Shankar M, Black KI, Goldstone P, et al. Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Aust N Z J Public Health* 2017; 41: 309-314.

14 Mishtal J, Reeves K, Chakravarty D, et al. Abortion policy implementation in Ireland: Lessons from the community model of care. *PLoS One* 2022; 17: e0264494.

15 ACT Government; Yvette Berry MLA, Rachel Stephen-Smith MLA. No cost abortions now available in ACT [media release]. 20 Apr 2023. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/yvette-berry-mla-media-releases/2023/no-cost-abortions-now-available-in-the-act (viewed May 2023).

16 Mazza D, Buckingham P, McCarthy E, Enticott J. Can an online educational video broaden young women's contraceptive choice? Outcomes of the PREFER pre-post intervention study. *BMJ Sex Reprod Health* 2022; 48: 267-274.

17 Mazza D. Increasing access to women's sexual and reproductive health services: telehealth is only the start. *Med J Aust* 2021; 215: 352-353. https://www.mja.com.au/journal/2021/215/8/increasing-access-womens-sexual-and-reproductive-health-services-telehealth-only

18 Mazza D, Seymour JW, Sandhu MV, et al. General practitioner knowledge of and engagement with telehealth-at-home medical abortion provision. *Aust J Prim Health* 2021; 27: 456-461.

19 Cameron S, Li HWR, Gemzell-Danielsson K. Is contragestion the future? *BMJ Sex Reprod Health* 2023; doi: https://doi.org/10.1136/bmjsrh-2022-201758 [Epub ahead of print]. ■