



MELBOURNE
SCHOOL OF
POPULATION
HEALTH

UNDERSTANDING WOMEN'S EXPERIENCES OF UNPLANNED PREGNANCY AND ABORTION

FINAL REPORT

Doreen Rosenthal, Heather Rowe, Shelley Mallett,
Annarella Hardiman, Maggie Kirkman

KEY CENTRE FOR WOMEN'S HEALTH IN SOCIETY



ACKNOWLEDGEMENTS

The project was funded by grants from the Australian Research Council (ARC Linkage Grant LP0667968) and the Victorian Health Promotion Foundation (VicHealth) to Professor Doreen Rosenthal, Dr Heather Rowe, and Dr Shelley Mallett of the Key Centre for Women's Health in Society at the University of Melbourne, and Annarella Hardiman of the Royal Women's Hospital.

We are especially grateful to the women who participated in the research and the staff of the Pregnancy Advisory Service at the Royal Women's Hospital for their cooperation.

We thank the project reference group members, Dr Susie Allanson, Ms Dee Basinski, Dr Chris Bayly, Dr Robyn Gregory, Ms Meg Gulbin, and Prof Jenny Morgan, for their assistance.

Suggested citation: Rosenthal, D., Rowe, H., Mallett, S., Hardiman, A., and Kirkman, M. (2009). *Understanding Women's Experiences of Unplanned Pregnancy and Abortion, Final Report*. Key Centre for Women's Health in Society, Melbourne School of Population Health, The University of Melbourne: Melbourne, Australia.

Published by The Key Centre for Women's Health in Society, Melbourne School of Population Health, The University of Melbourne, Australia, 2009.

<http://www.kcwhs.unimelb.edu.au/publications/reports>

ISBN 9780734039880

UNDERSTANDING WOMEN'S EXPERIENCES OF UNPLANNED PREGNANCY AND ABORTION

FINAL REPORT

Doreen Rosenthal, Heather Rowe, Shelley Mallett,
Annarella Hardiman, Maggie Kirkman

The Report was prepared and written
by Dr Maggie Kirkman, Project Director.

CONTENTS	Page
Acknowledgements	Inside cover
Summary	3
Recommendations	5
Background	6
Abortion statistics	6
Legislation	6
Service provision	7
Why women have abortions	7
Why this project was necessary	8
Aims	9
What we did: setting, methods, ethics	10
The Pregnancy Advisory Service	10
Method: Audit	10
Method: Interviews	11
Ethics	11
What we found	12
<i>The audit</i>	12
Demographic characteristics	12
Circumstances of pregnancy	14
Access problems	14
Special needs	14
Primary reason for seeking abortion	14
<i>Results: Interviews</i>	16
Women who participated in the interviews	16
Services for women	16
Women's reasons for contemplating or seeking abortion	17
Abortion is a difficult solution to a problem	17
Conclusions	24
References	25
Appendices	27
Papers and activities resulting from the project	27
The Melbourne Declaration	28
Participants in the consultation day	29

SUMMARY

The Key Centre for Women's Health in Society at the University of Melbourne, in collaboration with the Pregnancy Advisory Service of the Royal Women's Hospital and VicHealth, undertook a project about abortion with two components: an audit of electronic data collected by the Pregnancy Advisory Service for all their service users over one year and in-depth interviews with subsets of these women. This report of the project includes recommendations arising from the project about data collection, future research, and policy and service development.

Audit of Records of the Women's Pregnancy Advisory Service

The audit was designed to characterise the demographic and psychosocial circumstances of women contacting Victoria's largest public Pregnancy Advisory Service about their pregnancy and to inform development of a protocol for systematic data collection. An audit was conducted of electronic records at the Royal Women's Hospital for 12 months from 1 October 2006 to 30 September 2007. De-identified data were extracted from a comprehensive electronic database used for recording consultations. Summary statistics and measures of association were calculated.

During the audit 5462 women had a consultation with the Women's Pregnancy Advisory Service. Records were created for 3827 of these women, many of whom had more than one consultation. Over half of the women receiving pregnancy support from the Pregnancy Advisory Service were

18 to 29 years old; 12% lived outside the metropolitan area; 51% held a Health Care Card; 16% reported violence; and 71% described partners as involved and supportive. Almost 80% made contact within two weeks of discovering their pregnancy and 72% were referred by a General Practitioner. The most common single reason for seeking abortion was family completion or the desire to delay pregnancy. More than 40% of women already had at least one child. Twenty seven women reported that their pregnancy was the result of sexual assault; 10% had mental health problems; and minorities had special needs and faced barriers in gaining access to reproductive health care.

The investigators concluded that the Women's Pregnancy Advisory Service responds to demand from women with diverse social and personal circumstances. The results of the audit provide evidence for recommendations about policy and service development.

Interviews With Women

There is little research on women's experiences of abortion, despite considerable public debate on the topic and the fact that a substantial proportion of women have an abortion at some time in their lives. The research interviews aimed to provide insights into women's perspectives on the experience of dealing with a pregnancy during which they contemplated or underwent an abortion.

Sixty women who had contacted the Pregnancy Advisory Service at the Royal Women's Hospital seeking information, advice, or appointments in relation to an unplanned or unwanted pregnancy were recruited into the study. Recruitment targeted three categories: women aged 16-18, from rural or regional areas, and presenting at 12-18 weeks gestation. The first two groups are known to be disadvantaged in gaining access to reproductive health services, and women who present for termination after 12 weeks gestation prompt concern about personal or service restrictions on earlier presentation.

Telephone interviews were conducted and recordings transcribed. Thematic analysis and discourse analysis were carried out on the transcripts.

Women said that, when seeking advice about an unwanted pregnancy, they should have ready access to services that are not anti-abortion, that provide non-directive counselling relevant to the three possible outcomes, and do not evince judgemental attitudes.

Women described complex influences on their decisions to have an abortion (or to continue a pregnancy) that were usually contingent and multiple, conveyed throughout the interview rather than in a brief statement. 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.

The women's primary discourse about "contemplating or having an abortion" was found to be that "Abortion is a solution, however difficult, to a complex problem". This discourse encompassed being a responsible woman and (actual or potential) mother who took others' needs into account, including those of the potential child. Most women found the decision to have an abortion difficult for reasons concerning the fetus, herself, and others.

Women's accounts revealed the complex personal and social contexts within which reproductive events must be understood.

It can be concluded from both components of the project that there is a need for increased ease of access to coordinated services which reduce inequalities, are sensitive and responsive to women's needs, and reduce stigma and shame. The audit and the interviews reinforce knowledge of unplanned pregnancy and abortion as common reproductive events experienced by women in diverse circumstances.

~ ABORTION AND THE LAW IN VICTORIA ~

For almost 40 years, the Royal Women's Hospital has provided abortion in accordance with a 1969 judicial ruling determining when an abortion is not unlawful. Medical staff satisfied themselves in each case that abortion was performed for the woman's health and was legal under the common law. On 10 October 2008 the Victorian Law Reform Bill was passed in the Victorian Parliament. The Abortion Law Reform Act 2008 confirms the lawfulness of abortion in Victoria.

RECOMMENDATIONS

Recommendation 1

We recommend that the Department of Human Services establish a **data-collection system** to inform accessible and affordable service delivery for women throughout Victoria who are dealing with an unplanned or unwanted pregnancy. The data would:

- a be consistent with data currently collected to ensure appropriate service provision in other medical procedures, such as cardiac surgery;
- b include geographic distribution;
- c be relevant to public and private provision of services;
- d contribute to planning for equitable and timely delivery of services;
- e be freely available.

Recommendation 2

We recommend further **research** directed at priority areas including:

- a women's perceptions of best practice in pregnancy advisory services;
- b women's perceptions of best practice in abortion services;
- c women who have difficulty gaining access to timely and comprehensive pregnancy advice and support;
- d women who have difficulty gaining access to timely and affordable abortion;
- e the impact of previous reproductive history on women's experience of unplanned pregnancy and abortion;
- f women's experience of violence and its association with unplanned pregnancy and abortion;
- g understanding and thus contributing to prevention of unplanned pregnancy.

Recommendation 3

We recommend that a coordinated system of pregnancy **support** services be established and maintained throughout Victoria for women who are dealing with an unplanned or unwanted pregnancy. Pregnancy support services must provide professional, impartial, and comprehensive services, including:

- a information about all pregnancy options, including parenting, adoption or other alternative care arrangements, and abortion;
- b counselling by trained professional staff about pregnancy options and decision-making;
- c impartial and unconditional support, referral, and advocacy in relation to all options;
- d risk assessment and professional advocacy as required;
- e crisis intervention;
- f post-abortion support and counselling.

Recommendation 4

We recommend that accessible, affordable, and timely **services** be established and maintained throughout Victoria for women seeking abortion.

- a Service provision will be designed to reduce delay and inequity of access, consistent with best practice.
- b Adequacy of both public and private service will be ensured.
- c Equitable regional distribution of services will be established.
- d Service provision will accommodate changes to practice, such as provision of medical abortion.

Recommendation 5

We recommend appropriate **recruitment and training** of health professionals in relevant disciplines to ensure an adequate workforce to implement best practice.

BACKGROUND

There is considerable public debate about abortion but no comprehensive understanding of why women terminate a pregnancy, nor adequate information about characteristics of women who seek abortions and their needs for pregnancy advisory services. The ramifications of unplanned pregnancy for individuals, families, and the community of are acknowledged to be substantial, yet there has been little research conducted in this area beyond attempts to estimate incidence on the basis of uncertain data. This report summarises a project designed to fill this important gap. It begins by reviewing previous research and statistics.

Abortion Statistics

Many women in Australia and around the world have abortions. There are no routinely-collected national data that give accurate figures for elective abortions in Australia (Grayson, Hargreaves, & Sullivan, 2005), partly because abortion legislation is inconsistent (de Crespigny & Savulescu, 2004). Medicare claims for abortive procedures in the years 1995-2004 averaged about 75,700 annually, with numbers decreasing over this period (Pratt, Biggs, & Buckmaster, 2005). However, these data do not distinguish elective abortion from miscarriage, fetal death, or some other gynaecological conditions unrelated to pregnancy. Medicare claim figures thus overestimate abortions among women making Medicare claims. On the other hand, women using private providers of abortion services may not seek Medicare rebates, and a recent study revealed that up to 34% of private non-hospital abortions were not recorded as Medicare claims (Nickson, Smith, & Shelley, 2004).

The most accurate data on elective abortions in Australia are available for South Australia. The Pregnancy Outcome Unit, South Australian Department of Health, reports a 29% lifetime prevalence of legal induced abortion in South Australia for women born around 1955 (Chan & Keane, 2003). A large representative national survey found that 22.6% of women aged 16-59 years in Australia report ever having had an abortion (Smith, Rissel, Richters, Grulich, & de Visser, 2003).

In the US, 20 out of every 1,000 women of reproductive age had an abortion in 2004, with variations according to demographic subgroups (Henshaw & Kost, 2008). In 2006, for women resident in England and Wales, the age-standardised abortion rate was 18.3 per 1,000 women aged 15-44 (Department of Health, 2007). Worldwide in 2003, the induced abortion rate was estimated at 29 per 1000 women aged 15-44 years (Sedgh, Henshaw, Singh, Ahman, & Shah, 2007). Almost half (48%) of these abortions were unsafe, and more than 97% of all unsafe abortions were in developing countries; most unsafe abortions are illegal (Sedgh et al., 2007).

Little is known about the incidence of early abortions versus later abortions but, in South Australia in 2006, 91% of abortions occurred in the first 14 weeks of gestation (Chan, Scott, Nguyen, & Sage, 2007).

There is scant Australian research examining which women have abortions and why they do so. A study of women using private clinics in NSW more than a decade ago (Adelson, Frommer, & Weisberg, 1995) found a wide range of explanatory factors including age and financial concerns. Women in their twenties accounted for more than half the abortions and many women were married or in stable partnerships.

Legislation

Abortion legislation varies around Australia. In Victoria, while the research was being conducted, abortion was regulated in the criminal law, although a judicial ruling in 1969 defined broad criteria enabling lawful abortion in certain circumstances (see Victorian Law Reform Commission, 2008). On 10 October 2008 the Victorian Parliament passed a Bill based on recommendations from the Victorian Law Reform Commission (2008) that removes abortion from the Crimes Act. The Bill is now known as the Abortion Law Reform Act 2008.

Service Provision

Unplanned pregnancies can have adverse consequences for both mother and child in education, employment, and health (Wulf & Donovan, 2002). Provision of services for unplanned pregnancy and abortion continues to be an important clinical and public health concern worldwide (Sedgh et al., 2007). It is essential that women have prompt access to pregnancy advisory services, because abortion performed at earlier gestational age reduces not only distress but also the risk of mortality and morbidity (Bartlett, Zane, & Berg, 2004), although absolute complication rates are low.

In Australia, services to women with an unplanned or unwanted pregnancy vary from State to State, including public and private distribution of services for unplanned pregnancy support and abortion (Grayson et al., 2005). Women in States and Territories that do not provide adequate abortion services face additional costs and reduced support. An analysis of clients of one major public provider demonstrated that demand for the service exceeds its capacity, and that some economically disadvantaged women must seek private-service abortion (Black, Fisher, & Grover, 1999).

It is evident that women living in stable relationships with adequate financial support seek abortion (e.g. Adelson et al., 1995; Kero, Hogberg, Jacobsson, & Lalos, 2001). Nevertheless, unwanted pregnancy and women's access to abortion are affected by personal and social factors such as age, economic status, place of residence, intimate and familial relationships, and culture (Nickson, Shelley, & Smith, 2002), as well as marital status (Bankole, Singh, & Haas, 1999). An American study found that financial restrictions as well as delayed recognition of pregnancy contributed to difficulties in obtaining an early abortion (Finer, Frohworth, Dauphinee, Singh, & Moore, 2006); minors experienced more delays than adults. A Swedish qualitative study of women seeking repeat abortion concluded that they were experiencing personal, interpersonal, and social difficulties that made them vulnerable to unwanted pregnancies

and other problems (Törnborn & Möller, 1999). Throughout Australia, there are clear differences in the use of reproductive health services by women from rural or metropolitan areas (Mirza, Kovacs, & Kinfu, 2001), with women from rural areas having limited access to services. Women in Victoria seeking abortion services frequently travel long distances; this is particularly so for teenagers (Nickson, Smith, & Shelley, 2006).

The Federal Government established the National Pregnancy Support Helpline in 2006 to provide free, confidential, professional telephone counselling for unplanned pregnancy (Australian Government Department of Health and Ageing, 2006). No usage or user satisfaction data have yet been published.

Why Women Have Abortions

Abortion is a passionately-debated topic, attracting controversy, stigma, and prejudice. For example, one Australian politician's comments were quoted in the national newspaper, including the following: "I can't believe that women in this day and age are so dumb to get pregnant willy-nilly" (Maiden, 2005). This politician implied that women conceive carelessly and resort to abortion to compensate for their stupidity.

Why, then, do women have abortions?

This question is often answered without consulting women themselves: in terms, for example, of social determinants, varieties of associated factors, physicians' assessments, inadequacy of contraceptive practices, moral and cultural constructs, and opinions of people other than women seeking abortion (Addor, Narring, & Michaud, 2003; Bowes & Macleod, 2006; Cagnacci & Volpe, 2001; Ekstrand, Larsson, Von Essen, & Tyden, 2005; Kozinszky, Boda, & Bártfai, 2001; Liamputtong, 2003; Mitchell, Halpern, Kamathi, & Owino, 2006; Misago, Fonseca, Correia, Fernandes, & Campbell, 1998; Mogilevkina, Hellberg, Nordstrom, & Odland, 2000; Savonius, Pakarinen, Sjöberg, & Kajanoja, 1995; Sihvo, Bajos, Ducot, & Kaminski, 2003).

These factors may provide causes of or at least associations with abortion for populations, but they do not tell us how *women* explain why they seek an abortion.

Poverty or low educational attainment may be more likely attributes of those who have abortions than those who do not (e.g. Kozinszky et al., 2001), yet women of all socioeconomic levels both terminate and continue their pregnancies. Knowledge of women's own reasons is an essential aspect of understanding abortion.

We conducted a review (Kirkman, Rowe, Hardiman, Mallett, & Rosenthal, under review) of empirical research on women's reasons for seeking abortion and found 19 eligible papers from peer-reviewed, English language publications 1996-2007, indexed in eight databases. Although we identified three categories of reason – 'Woman-focused', 'Other-focused', and 'Material' – it was evident that women's reasons were complex and contingent, taking into account their own needs, responsibility to existing and potential children, and other people including the male partner. Ambivalence was often evident in women's awareness of reasons for continuing the pregnancy, but abortion was chosen because it was assessed as having fewer adverse effects on the life of the woman and significant others.

Research conducted with women in Victoria in the 1990s identified their complex decision-making when dealing with a problem pregnancy, including concern about their mothering capacity, "abortion role models", and relationship stability (Allanson, 2007). There is no published recent Australian research investigating reasons women give for contemplating or seeking abortion.

Why This Project Was Necessary

Perhaps because of its political sensitivity, abortion has long been neglected in State and Federal health policy development, in planning and coordinating the delivery of services, and in the education of health professionals (National Health & Medical Research Council, 1996b). Nevertheless, abortion continues to be a significant political issue, especially in Victoria where a Bill to remove abortion from the Crimes Act was passed while this project report was in preparation.

Contemporary Australian debates about political, philosophical, health, and social aspects of unplanned pregnancy and abortion are conducted in the absence of accurate information. If we are to engage in informed discussion on delivery of appropriate health services and strategies to prevent unplanned pregnancy and adverse outcomes for women and children, it is essential that comprehensive evidence is available. It was therefore timely for three leading organisations to initiate a project which would contribute to increasing community and government knowledge about unplanned pregnancy and inform strategies aimed at prevention of unwanted pregnancy as well as the support needs of women dealing with unplanned and unwanted pregnancy and abortion.

AIMS

The project had two components: an audit of data collected by the Pregnancy Advisory Service at the Royal Women's Hospital, Melbourne, and research incorporating interviews with women who had contacted the Pregnancy Advisory Service about their pregnancies.

Audit

The first part of this project was a 12-month audit of the data collected by the Pregnancy Advisory Service at the Royal Women's Hospital. Its aims were:

- ~ to document the health and social circumstances of women presenting at Victoria's largest public Pregnancy Advisory Service;
- ~ to improve understanding of women's service needs in order to inform best practice;
- ~ to develop recommendations for a protocol for systematic data collection about unplanned pregnancies and abortions;
- ~ to identify factors such as geographic location and demographic characteristics which affect women's access to pregnancy prevention and abortion services;
- ~ to contribute to an evidence base for informed public policy and debate.

Interviews

The second part of the project investigated abortion from the woman's perspective. The broad aim of this research was to understand what it means to women to contemplate or undergo an abortion. Specific objectives were:

- ~ to investigate how women experience and interpret what is often referred to as an "unwanted" pregnancy;
- ~ to investigate how women define the factors that contributed to their decisions or actions following access to a pregnancy advisory service;
- ~ to investigate how women assess the effects on their health and wellbeing of their decisions or actions in relation to termination;
- ~ to contribute to the understanding of the circumstances of particular sub-populations of women presenting for termination, specifically young women, women from rural and regional areas, and women at mid-trimester;
- ~ to improve understanding of women's service needs.

WHAT WE DID: SETTING, METHODS, ETHICS

The Pregnancy Advisory Service

The project was conducted through the largest public hospital solely for women in Victoria. The Pregnancy Advisory Service, located at the Royal Women's Hospital (the Women's) in Melbourne, is Victoria's largest public pregnancy support service. It takes up to 9000 calls per year. An internal analysis of telephone calls answered by the hospital switchboard in 2005 revealed that 19,843 calls were directed to the Women's Pregnancy Advisory Service in nine months. Of those calls, 66% lasted one minute or less, suggesting that the callers hung up after receiving the busy signal or an out-of-hours message. The Women's Pregnancy Advisory Service is not resourced to meet state-wide demand for pregnancy information and support. In the absence of coordinated state-wide services, many women and health professionals throughout Victoria and even from interstate approach the Women's for assistance.

Women with an unplanned or unwanted pregnancy contact the service, usually by telephone, for information on their options, including abortion and continuing the pregnancy, and for assessment, support, counselling, advocacy, and referral. Services are provided by qualified health professionals, including social workers and counsellors.

The Women's Pregnancy Advisory Service, as the major public provider of services, has particular experience with women who are marginalised, such as those with financial and social barriers to access, young and homeless women, those experiencing domestic violence or sexual assault, and newly-arrived migrant women. Women from throughout Victoria contact the service for assistance; some have abortions at the Women's or elsewhere and others continue their pregnancies. Women seeking abortion after a diagnosis of fetal abnormality are not interviewed by the Pregnancy Advisory Service but referred to other services within the hospital.

To improve service, a database was developed by staff of the Women's Pregnancy Advisory Service in 2005 for service provision, continuity of care, research, and monitoring.

Method: Audit

We conducted an audit of the electronic records of all clients of the Pregnancy Advisory Service for 12 months from 1 October 2006 to 30 September 2007. The electronic records are of information collected by the counsellor/advocates as they speak to women, usually over the phone but sometimes in person. A record is created for all women who become hospital out-patients or in-patients and are given a Unit Record Number.

The database was designed as a clinical tool to aid staff in their service provision and record-keeping, and as a link to hospital patient records. Women are routinely asked a range of questions. It is not always possible to record a response in the data base. Information on routine and occasional questions is recorded as it is disclosed during the assessment interview. There may be details of demographic and social characteristics, referral, circumstances of pregnancy, special needs, and a single reason for considering abortion. Data are recorded using fixed-choice options, numerical data, or free text.

Complete data are not entered for every woman and "missing" data require special consideration. For example, it is the practice to ask all women about their pregnancy history, but information is entered in this category only if women report a previous pregnancy. In other cases, data entry depends on staff judgement about whether a topic should be raised, or on women disclosing information. Nothing is known about these matters for women where information is not recorded. Aggregate data are therefore to be construed as minimum figures. The percentage of each characteristic was calculated using as denominator the number of records that contained information on that item.

After consultation with staff of the Women's Pregnancy Advisory Service, two composite variables—"Violence" and "Mental Health"—were constructed, because the women's needs meant that staff entered information in a variety of ways about whether women were (or have been) at risk of violence or had problems with mental health. For the purposes of the audit, a score in a relevant drop-down box or the presence anywhere in a record of the words "violence", "coercion", "DV",

"safety", "risk", "assault", or "abuse" scored positive for "Violence". A score in a relevant drop-down box or the words "mental health", "suicide", "depression", "anxiety", "PND", "chaotic", or "self-harm" scored positive for "Mental Health".

Data were de-identified for analysis at the Key Centre for Women's Health in Society, where we calculated summary statistics and some measures of association using SPSS (SPSS, 2006). Dr Heather Rowe and Dr Maggie Kirkman conducted the audit.

Method: Interviews

The research team identified in-depth interviews as the most appropriate means of seeking to understand the women's perspective.

We chose to interview three categories of women because of their significance to the experience of unplanned and unwanted pregnancy. Young women are repeatedly shown to be disadvantaged in avoiding pregnancy and in gaining access to abortions (e.g. Creatsas & Elsheikh, 2002; Nickson et al., 2006; Skinner & Hickey, 2003), so we included women aged 16 to 18. We invited women who live in rural and regional areas of Victoria to participate, because they also have restricted access to all reproductive health services (Nickson et al., 2006). The third group comprises women at 12 to 18 weeks gestation; we wanted to gain insight into the experiences of women who present in their second trimester.

Volunteers were sought who had approached the Pregnancy Advisory Service about their own pregnancy, fitted at least one of the categories of interest (aged 16-18, living in a rural or regional area, 12-18 weeks gestation), did not have an evident cognitive impairment or psychiatric problem, and who had adequate English for an interview. From February 2007, women who were assisted by the Pregnancy Advisory Service and met the selection criteria were asked—once their needs had been met—if they would be willing to be invited for an interview. Women were not asked about the research if the counsellor/advocate considered it inappropriate in the light of the woman's immediate needs. Those who agreed to be contacted were telephoned by

a researcher between six and twelve weeks later, seeking informed consent. Recruitment continued until 60 women (with at least 20 in each of the three selected categories) had been interviewed (February 2008).

Interviews were conducted by telephone and usually lasted about 20 minutes (range 10-40 minutes). Dr Maggie Kirkman conducted 59 of the interviews; Dr Shelley Mallett conducted one interview. The interviewer began each interview by asking what services should be available for women with a pregnancy that might be unplanned or unwanted, and concluded by asking if the woman had any messages she wanted to convey to other women or the community in general. Women were encouraged to talk about their own experiences and what the pregnancy and decision about abortion meant to them. They were asked how they came to consider abortion, whether they planned to have future children and, if so, what the right circumstances would be. To avoid conveying a judgemental attitude or prompting women to feel that they had to defend themselves, we did not ask women directly why they had an abortion or continued the pregnancy.

All identifying details were changed on the transcripts and each woman was given a pseudonym. Most women were sent a postal order for \$30 (some declined the offer).

Thematic and discourse analyses were performed on the interview transcripts by Dr Maggie Kirkman, in consultation with the research team. Themes and discourses were independently verified by Dr Deborah Keys on a subset of transcripts. Throughout the analysis, explanation and meaning were derived from each interview as a whole rather than from isolated extracts.

Ethics

Audit: The project was approved by the Chair of the Human Research Ethics Committee of the Royal Women's Hospital as meeting the NHMRC requirements for quality assurance/audit.

Interviews: The research was approved by the Research and Ethics Committees of the Royal Women's Hospital.

WHAT WE FOUND

The Audit

A striking finding of the audit is the large number of calls taken by the Women's Pregnancy Advisory Service.

During the one-year audit, 5462 women made contact with the Pregnancy Advisory Service; 3827 of these women had a hospital record created for them and were then provided with services such as advocacy, counselling, appointments, or referral. The remaining 1635 women rang or visited the service but were not registered with the hospital for various reasons, including that there were no appointments available to them at the Women's, or they chose to go elsewhere for further services after being told of their options. Records were not created in the database for these women and no further information was noted.

Where relevant data were recorded (for 3598 women: 94%), most contacts (3224: 90%) were from women requesting an abortion. A minority (306: 9%) were ambivalent or undecided about abortion, 39 women said that they were considering continuing their pregnancy, and 2 were considering adoption.

The Women's clinical report for 2007 indicates that the hospital has been providing about 3000 elective abortions annually through the Pregnancy Advisory Service pathway in recent years. This suggests that about 800 women in the audit either sought an abortion elsewhere or continued their pregnancies.

About 44% of the registered users made contact (or were contacted in return) more than once. Although 53% of women had only one contact and 98% had six or fewer contacts recorded for them, a few women had up to 17 contacts.

Most of the results of the audit relating to aspects of the women contacting the Pregnancy Advisory Service are summarised in Table 1. We describe them below categorised by demographic characteristics, circumstances of pregnancy, access problems, special needs, and primary reason for seeking abortion.

Demographic characteristics

The women who received pregnancy support from the Women's Pregnancy Advisory Service were aged from 13 to 49, with a mean age of 26.6 years. As found in routinely-collected data, women in their twenties constitute the largest group, although there are small proportions at both extremes of the reproductive age range.

A small percentage of women preferred to use one of 48 languages other than English; 134 (4%) were recorded as using an interpreter.

More than 1 in 10 women lived in rural or regional Victoria or interstate.

Socioeconomic disadvantage was common among the women: Just over half were holders of Health Care Cards, compared with 23% of the Australian population in 2004-2005 (Australian Bureau of Statistics, 2006). Approximately 2% identified themselves as Aboriginal or Torres Strait Islander, compared with an estimate of 0.6% of the Victorian population in 2006 (Australian Bureau of Statistics, 2008).

The high representation of socio-economic disadvantage among clients of the Women's Pregnancy Advisory Service, women from outside the Melbourne metropolitan area, women who identify as Aboriginal or Torres Strait Islander, and women who require the services of an interpreter does not necessarily reflect women seeking pregnancy support and abortion services in the community as a whole. The Women's Pregnancy Advisory Service gives priority to women most in need of a publicly-funded health service; the demand for such a service from all over the state suggests the need for increased access to public abortion services in Victoria.

General practitioners are frequently the first point of contact: almost three quarters of the women were referred to the Women's Pregnancy Advisory Service by a General Practitioner. One woman in 10 self-referred.

Table 1: Characteristics of women contacting the Women's Pregnancy Advisory Service during audit (n=3827)

Characteristic	Number (%) of records in which data recorded	Number	Percent
Demographic characteristics			
<i>Age (years)</i>	3706 (96.8%)		
Under 18		262	7.1%
18–29		2205	59.5%
30–39		1051	28.4%
Over 40		188	5.1%
<i>Preferred language</i>	3827 (100%)		
Other than English		264	6.9%
<i>Postcode</i>	3610 (94%)		
Metropolitan/Greater Melbourne		3178	88.1%
Rural/regional/interstate/overseas		432	11.9%
Aboriginal or Torres Strait Islander	3827 (100%)	81	2.1%
<i>Health cover</i>	3827 (100%)		
Medicare card holder		3484	91.0%
Health care card holder		1965	51.3%
Private health insurance		89	2.3%
International visitor		60	1.6%
<i>Referred by</i>	3128 (81.7%)		
GP		2257	72.2%
Self		327	10.5%
Friend		119	3.8%
Other hospital		103	3.3%
Royal Women's Hospital		80	2.6%
Other health professional		55	1.8%
Community Health Centre		42	1.3%
Other		145	4.6%
Circumstances of pregnancy			
<i>Estimated gestational age on contact</i>	3607 (94.3%)		
Mean 7.9 weeks; SD 2.8 weeks			
4–11 weeks		3249	90.1%
12–18 weeks		334	9.3%
19–30 weeks		24	0.6%
Has at least one child	3827 (100%)	2205	42.4%
<i>Previous pregnancy</i>	1945 (50.8%)		
Termination of pregnancy		752	38.7%
<i>Partner in pregnancy</i>	3363 (87.9%)		
Aware and supportive		2370	70.5%
Not aware		368	10.9%
Aware but unsupportive		292	8.7%
Aware attitude unknown		139	4.1%
*Other		194	5.8%
Access problems	3827 (100%)	663	17.3%
Special needs			
Experience of violence	3827 (100%)	601	15.7%
Mental health problems	3827 (100%)	362	9.5%
One or more special individual need	3827 (100%)	236	6.2%
Housing problems	2109 (55.1%)	117	5.5%

*Other = separation; partner abusive; complex circumstances

Circumstances of pregnancy

Most women present in the first trimester of pregnancy, many have children, describe partners who support them in their decision to have an abortion (or, in a few cases, continue their pregnancy), and some report becoming pregnant while using apparently reliable forms of contraception.

Details of the current pregnancy were recorded for the majority of women. Most women (2579/3257: 79%) contacted the Women's Pregnancy Advisory Service within two weeks of discovering their pregnancy; a small minority (96/3257: 2.9%) did not make contact until at least 6 weeks later. The overwhelming majority of pregnancies were in the first trimester and less than 1% were over 18 weeks gestation.

Almost half of the women already had at least one child. Previous pregnancy was recorded for only half of the total number of women and it is not the practice of Pregnancy Advisory Service staff to ask routinely about contraception, which is among matters dealt with in the medical consultation. These items are therefore not representative of all clients, but 752 women reported having had a previous abortion and 434/1107 (39%) reported that their current pregnancy occurred while they were using contraception, including condoms, intrauterine devices, implants, injectibles, or oral contraceptives.

The majority of women described the men who were their biological partners in the pregnancy as supportive, which Pregnancy Advisory Service staff understand as supporting the woman in her current situation and associated needs.

Access problems

About one in five of all women were noted as experiencing difficulties in gaining access to pregnancy support services. Difficulties included financial or health problems, geographical isolation, lack of transport or childcare, being at school, safety fears, alcohol or drug problems, and language or interpreter concerns.

Special needs

Items relating to violence were recorded for 16% of all women; 27 women reported that the pregnancy was the result of sexual assault. The finding that almost one in six of all women contacting the Women's Pregnancy Advisory Service disclosed experiences of violence confirms Australian evidence that violence is commonly implicated in the lives of women who have unplanned pregnancies and abortions (Taft, Watson, & Lee, 2004; Whitehead & Fanslow, 2005) and is more prevalent than in women in the general community (Hegarty, Gunn, Chondros, & Small, 2004).

Mental health problems were recorded for almost 1 in 10 women. A variety of other special individual needs was recorded for 236 women, including medical, drug, or alcohol problems, and intellectual or physical disability.

Housing difficulties, experienced by 117 women, related to unstable or unsafe accommodation, homelessness, being institutionalised, or being in transitional accommodation. It is evident that the Pregnancy Advisory Service responds to demand from women with diverse social and personal circumstances.

Primary reason for seeking abortion

The database permitted only one reason for seeking an abortion to be recorded for each woman. The results are set out in Table 2.

Several of the most commonly endorsed fixed-choice responses ("does not want children now", "too young", "not at the right time", "has young baby") can be interpreted as "wrong time", which together constitute the largest single category (54%). Almost one fifth had completed their families. Financial, relationship, or medical reasons in combination account for 19% and rape for almost 1% of cases.

Table 2: Primary reason for considering abortion (n=3018>)

Reason ^	n	Percent
Does not want children now	701	23.2%
Already enough children	547	18.1%
Too young	339	11.2%
Not the right time	325	10.8%
Has young baby	263	8.7%
Financial reasons	189	6.3%
New or unstable relationship	103	3.4%
Medical reasons	101	3.3%
Relationship problems	98	3.2%
Violent partner	47	1.6%
Partner not involved	44	1.5%
Too old	31	1.0%
Single parent	31	1.0%
Alone, isolated, unable to cope	23	0.8%
Pregnancy result of rape	23	0.8%
Mental health	23	0.8%
Never wants children	14	0.5%
Cultural reasons*	11	0.4%
Current partner not "partner in pregnancy" #	9	0.3%
Travelling	1	0.03%
Other	95	3.1%

> A reason was recorded for 3018/3827 (78.9%) of women

^ Database permitted only one reason to be recorded for each woman

* For example, risk of harm because of violation of cultural norms of sexual activity

The biological partner in the woman's pregnancy

~ FENELLA ~

Aged 21, from a rural or regional area, no children, abortion

When Fenella discovered her pregnancy, she immediately decided that:

It just wasn't right for me and my partner at the time. ... Having a kid would have been awesome but it just would have been too hard. ... Like if we had have been together longer and like we weren't in uni and things, it might have been different, but just debt, debt. It wasn't really an option.

She considers herself to be "still a kid myself". Building up the justification for her decision, Fenella also described herself as "a madwoman" while she was pregnant. "So it would have been hard on the relationship. ... I hate to think how it would have been if the whole nine months was like that." She sees a dilemma confronting young women: "A lot of people turn their noses down at young mothers, but a lot of people turn their noses down or have, you know, avid views on abortion. So it's a sort of a lose-lose situation."

Fenella and her partner did not tell their families, who would have been upset by the pregnancy, but:

I think the abortion would have been the worst thing. Because, like, you think, "Oh, it's my grandchild, ... what could have been?" ... They wouldn't have seen how hard it would have been for us, but ... it's easy when it's not your body. ... [But] it's my decision. I'm the one who's going to have to live with it for the next, you know, 20 years.

It was not only the family's "religious background" that kept Fenella from telling them, but also "the pressure. ... They would have probably left it up to me, but I think it would have hurt them and made it harder for me. And we'd have to tell the story again and it gets upsetting." At times Fenella has felt "a bit sad" seeing "little babies", but concludes, "There was never any doubt in my mind that I was doing the right thing."

Results: Interviews

Women who participated in the interviews

A total of 136 eligible women gave permission to be contacted. These comprised 85 from rural or regional areas, 50 aged 16-18, and 42 at 12-18 weeks gestation. Women could be categorised in more than one way. Of the 136, 64 (42 rural, 22 aged 16-18, 19 at 12-18 weeks gestation) could not be reached after repeated attempts and 12 (8 rural, 3 at 12-18 weeks gestation, 2 aged 16-18) declined to participate or did not keep appointments.

The 60 women who were interviewed were aged from 16 to 38. There were 35 from a rural or regional area, 25 aged 16-18, and 20 who were 12-18 weeks gestation when they contacted the Pregnancy Advisory Service. Twenty-two of the women already had children. Five women had chosen to continue their pregnancies; the rest had had an abortion. Four of the five women continuing their pregnancies presented in the second trimester, two were from rural or regional areas, and none was aged 16-18.

At least five women had planned their pregnancy or said that they wanted to have a baby now. Four of them chose to have an abortion: Alison decided not to bring a baby into an abusive relationship; Kristen was told that *placenta praevia* put her own and her baby's health at risk and did not want to deprive her first child of attention; Zoë realised that she had conceived "for the wrong reasons" (to save a failing relationship); and Narelle's partner told her, after she was pregnant, that he was not prepared to take on responsibility for the child she already had. Melanie continued her planned pregnancy despite contemplating abortion after her partner left her.

Services for women

The interviewer began each interview by asking what services should be available for women with a pregnancy that might be unplanned or unwanted. The women did not, on the whole, reflect on the nature and extent of services available or desirable, apart from as they had experienced them personally. This should

not be construed as an expression of lack of care for others; abortion is one of those matters where you do not think about the details until you confront the problem, "What do I do now?" Alison, for example, could not suggest how people could be made more aware of services "because, I suppose, you don't know until you need to look." Women suggested there should be more publicity about services, and that counselling and abortions should be available to all women, at a reasonable price.

There was almost universal, unsolicited praise for the Women's Pregnancy Advisory Service because of its non-directive support and provision of information. However, the heavy demand on the service meant that some women spent hours on the phone trying to get through.

There were three broad levels of assistance sought by women. Some contacted the Pregnancy Advisory Service confident in their decision to have an abortion, seeking only an appointment and information. Others, such as Belinda, wanted to "talk through with somebody about it, and make sure I was positive about everything"; the rest sought help with making a decision.

Women said that, when seeking advice about an unwanted pregnancy, they should deal with a service that is not anti-abortion; that counsels for the three possible outcomes; and does not make women feel "degraded" or "uncomfortable".

Some women described enforced waiting for abortion as very difficult. Caroline had struggled to decide what to do about her unplanned pregnancy. Once she had concluded that abortion was the most responsible outcome for her, Caroline said, "Knowing what I had to do, I couldn't wait for the day. Like, once your decision's made, you want it done straight away." Long waiting lists and insufficient services, even at the Women's, often made a swift conclusion impossible.

One advantage of a large public hospital such as the Women's was seen to be the absence of anti-abortion protestors. Women could be coming in to hospital "for anything," with no-one able to guess

~ HANNA ~

Aged 18, no children, abortion

Hanna exemplifies other young women's explanations for terminating an unplanned pregnancy. She described herself as too young and "selfish" for motherhood; she wants to complete her studies and travel, to experience freedom and independence, and to earn enough money to be financially secure. The only advantage of her unexpected pregnancy was that she now knows she is fertile; the only reason for continuing the pregnancy would be to see what the baby looked like. Hanna found it difficult to cope with the changes to her body when she was pregnant, and does not feel ready to give up her freedom or her body. Before having children, she wants a stable relationship and does not want to stay with her current partner

because we have to; ... I just don't feel like he's the person I want to have kids with. ... And I don't want to get a divorce. Because my parents got divorced when I was 13 and I didn't like it.

Hanna assessed herself as immature and unready for motherhood:

I felt like the child was going to take so much away from me. Like I wouldn't have my body, I wouldn't have my freedom, I wouldn't have money, I wouldn't have—like everything was just, "I wouldn't, I wouldn't," and it was all about me. And that's how I knew, like, look, it's not right. I'm very selfish at the moment. I have to worry about my dogs; that's enough for me. I don't need kids right now.

Hanna thinks abortion is more responsible than adoption.

the procedure. When Daisy went to a private clinic, she found the protesters "really scary". Once inside, she was happy with the care she received there.

After having an abortion, the support of women who had been through similar experiences was valued by a few women and desired by others. Those who avoided formal post-abortion counselling, such as Emma, said that pregnancy and abortion were too personal to discuss.

In summary, women thought there should be ready access to information about options and services, non-directive counselling, and non-judgemental abortion services. At present, this is not always the case.

Women's reasons for contemplating or seeking abortion

All women seeking abortion at the Women's and elsewhere are routinely assessed at medical consultation to ensure that their circumstances are consistent with legal requirements. Our interviews sought to understand the women's perspectives.

In every case, women described making decisions about their pregnancy that took account of their life circumstances. Reasons were usually contingent and

multiple, explained throughout the interview rather than in a brief statement.

The three groups of women were remarkably similar in their reasons for contemplating or undergoing abortion, which can be summarised as relating to the woman herself, the potential child, existing children, and her sexual partner and other significant relationships. The reasons are interrelated.

Reasons relating to the woman

Half of the women identified their youth and immaturity as important reasons for not committing to motherhood. Not all of them were 18 or younger – the oldest were 22 – and not all of the youngest women gave this explanation. Prue had had fantasies about the baby, but said that she "wouldn't be mature enough" – at 17 – and thought it was better to have an abortion than be a bad mother. Sara, at 22 (from a rural area), regretted having her first child before she was ready and did not want to compound the problem by having a second.

The women who were not ready for motherhood often talked about the things they wanted to do before committing to a family, including study, travel, recreation, and just experiencing more of the world. Ophelia said, at 18, that

~ SARA ~

Aged 22, from a rural or regional area, 1 child, abortion

Despite being on the Pill, Sara gave birth to a daughter soon after her marriage, urged on by the enthusiasm of her husband and extended family. She knew she was not ready to be a mother and found it "claustrophobic" at home with her daughter. She said, "I feel like I was too young to share my body. And obviously, having a baby, your body's not your own any more." Throughout her first pregnancy, Sara was

quite depressed that I'd done this to myself, that I was very silly and all the rest of it, even though people tried to say that, you know, "You're married and you've got a home and that's okay, and your husband's got a good job", it still wasn't right for me.

So Sara was determined not to do it again:

Because I'm still trying to come to terms with being a mother. ... Sixteen months later, I'm still having trouble coping. ... And although I wouldn't change having my baby, it would have made life a lot easier if I had've had her long in the future. Not right now.

she wanted to live "a young life" before becoming a mother.

Reasons concerning the potential child

In contemplating abortion, women were explicit in their concerns about the potential child, including that they were not in a position to be adequate mothers, a child deserves to be wanted, the child would suffer from financial restrictions, there was not the father that a child ought to have, and they did not want the child to be born into an abusive relationship or to parents who have mental health or drug problems. Women wanted to be able to provide for a child materially, emotionally, and socially.

Kaylene (aged 37), for example, said she did not want to give a child a "miserable" life, and Ruth (17) "didn't want to have a kid that I could give nothing to". Felicity, aged 22, said that she had an abortion

Because, well, first of all for the child's sake. I mean, there was no father in the picture, ... not to mention the fact that, you know, I couldn't offer it everything at this point. I wasn't financially secure. My living situations weren't ideal. So, and my age.

Abigail (aged 23) did not recognise her pregnancy until the second trimester. She had been drinking alcohol, not realising she was pregnant, and feared that she had damaged the fetus. Furthermore, Abigail said, "I believe every child should have a mum and a dad. You know, you don't just have a child because you can".

Reasons concerning existing children

When women already had children, they were torn between not wanting to overstretch the family's capacity, and envisaging the potential baby pursuing the same developmental goals as their children.

Existing children sometimes contributed to the woman-focused reasons for abortion when women felt that they were not yet ready to deal with another child. Some women said they had an abortion because the pregnancy occurred too soon after a birth; another baby would have been too much for the woman to manage as well as unfair to the existing baby. Lauren had an abortion and felt "selfish" for wanting a break from child-bearing after dealing with a child with a congenital illness.

Corinne has two children in foster care because of her difficulties in caring for them adequately when she was drug dependent. She does not want another child until she has recovered further and has consolidated her relationship with her existing children, whom she describes as her priority.

Narelle had wanted to have the baby but had an abortion when her partner refused to accept the child she has. Bonnie contemplated an abortion partly because she already has a 1-year-old child and the second one is too close, but she decided to continue her pregnancy.

Reasons related to the sexual partner and other significant relationships

When women considered the needs of children in deciding on abortion, they thought not only of their personal capacity

~ CAROLINE ~

Aged over 18, from a rural or regional area, three children, abortion

There's just not room. Like we both work full time. I have morning shift, he has afternoon shift. And financially we, like, couldn't change cars and move and all the things that it takes for a fourth. Not only financially but emotionally. ... Our lives are very full. ... There's always enough love, but sometimes it's not enough. So I had to put my family's future first.

Caroline found the decision to have an abortion a difficult one but concluded that, "It was the mature decision." To continue the pregnancy would have been "selfish".

Caroline's partner was about to have vasectomy.

as mothers, but also of the suitability of their partner as a husband or father, or their lack of a partner and hence father for the child. Women often felt they needed adequate support to be good mothers.

Tiffany (aged 17) did not "want to bring up a child that doesn't exactly have a proper dad". Polly, at 33, was breaking up with her partner, because he did not want children and she did, when she found she was pregnant. She had an abortion rather than be a single mother. She said, "surrounded by family and friends, there was a temptation to go ahead. But my mother was a single mother and I've just always vowed I'd never be a single mother." Polly's mother struggled emotionally and financially. Polly was also concerned about the ability of the father to contribute financially to support a child whom he did not want and with whom he would be unlikely to form a bond. The instability

of relationships, problems with previous partners, and "new" relationships were among the partner-related reasons given for having or considering abortions.

Women also considered their family and social milieu when making the decision to seek an abortion. For example, Emily did not want her parents to know that she was sexually active at 16; Ophelia thought that it would "ruin" her relationships with her family if they knew she was pregnant; Hanna would have felt "ashamed" to be seen to be pregnant at her university, and confessed to feeling that way about others; and Sara thinks young motherhood is stigmatised in small towns like her own. Meryl had a series of compelling reasons for and against abortion; one of her reasons for finally deciding to continue her pregnancy was that her mother is terminally ill and she wants her to know her first grandchild.

~ MERYL ~

Aged 27, no children, presented in second trimester, continuing her pregnancy

Meryl was finding it hard to make up her mind about her unplanned pregnancy and made an appointment to see a counsellor at the Women's Pregnancy Advisory Service. Meryl had an abortion in her teens when she had a problem with drugs, which she is now managing. Her partner's disinclination to be a father weighed on the side of abortion this time, whereas her mother's ill-health and her own current health problems which could affect her fertility weighed in favour of continuing the pregnancy.

It took me a long time to decide what I wanted to do. ... I didn't want to tell my parents if I was going to have an abortion. ... They didn't know about my first abortion and it's just something that I guess they don't need to know about. ... I still haven't told too many people about it. Yeah, I'm sort of trying to get used to the idea with my boyfriend, and knowing what to do in the future with him, before I start telling people.

It's very hard to go through it by yourself. You know, it took me such a long time because I didn't have anyone to talk to. ... I guess that's the main thing: to speak to someone about it. ... It was so nice to have someone to talk to about it, who wasn't rushing me. ... She took the time to talk to me about all the sort of different things that were going on in my life.

Jacinta approached the Pregnancy Advisory Service in her second trimester. She said that her family and friends wanted her to have an abortion for reasons given by other women: She was too young to be having a second child at 20, she had no partner, and was not financially independent. However, she did not want to have an abortion and contacted the Pregnancy Advisory Service to seek support in making her own decision. Jacinta was continuing her pregnancy.

Other reasons

There were only two other reasons identified: Esther's concern not to add to the world's overpopulation, and the previous abortions of a few of the women after rape, which women identified as a sufficient reason in itself.

~ YVETTE ~

Aged 28, from a rural or regional area, 1 child, abortion

Yvette did not plan her pregnancy and thinks she must have missed a contraceptive pill. At first she liked the idea of having a baby with her new partner after leaving a violent marriage, but was concerned about many things, including making her partner feel "trapped" and the stress caused by continuing court battles with her ex-husband over their young son. The violence had begun in pregnancy and the child had later witnessed attacks on his mother. After a few weeks of ambivalence, Yvette started to wake each morning with a "panic attack" and concluded that she had to make a decision or it would be too late for an abortion. Yvette described the decision as "tough", and said "abortion is something I never thought I'd do; ... I really never thought I'd be put in that predicament, to tell you the truth". She felt guilty for a few weeks after the abortion, wondering whether "this person was supposed to be here," but was reassured by her GP that she had made the right decision and "started to come good again." She is now relieved not to be pregnant as she deals with lawyers and court appearances. Yvette wants to make sure her life is settled so that her next child will be born into a secure family.

Abortion is a difficult solution to a problem

The interviews also gave insight into how women explained what abortion meant to them. In reconciling the many aspects of their complex lives, women appeared to construct abortion as "A solution, however difficult, to a complex problem". Here we briefly describe the components of this discourse.

The problem

Women's reasons for seeking abortion indicate some of their problems. They described problems associated with their pregnancy that related to themselves, the potential child, existing children, and their sexual partners and other significant relationships. The pregnancy had often occurred at what women described

as the wrong time, such as too soon after another birth, before the woman felt ready to take on the responsibility of motherhood, or in the absence of a committed relationship.

Components of the problem as women perceive it can also arise from attitudes to sex and pregnancy, usually because they are pre-marital. Tracy, for example, who is 31, said that her parents "would be probably disappointed that I got pregnant and then disappointed that I had it aborted", and Prue (18) said that her pregnancy as a young single woman made her feel like "the scum one of the family" who had "let her family down".

Daisy said, "unplanned pregnancy isn't a good thing"; Bianca envisaged it as potentially "ruining your life".

~ NARELLE ~

Aged 32, presented in her second trimester, 1 child, abortion

Narelle planned her pregnancy and was then told by her partner that he was unwilling to take on responsibility for Narelle's pre-school child from a previous relationship (in which her partner had also left during pregnancy). She did not want to be stereotyped as a single mother of two children from different fathers, with perhaps, later on, a third partner and child. Narelle's partner's family wanted her to have the baby and give it to them. She said, "What do you think I am? Your personal incubator? ... It's not that I can't cope with another baby. ... It's that I don't want to wreck my life to make you happy."

It was difficult for Narelle to decide on abortion, which was "a traumatic time," delaying her presentation at the Pregnancy Advisory Service until the second trimester, but she was sure it was the right decision. Afterwards, she "felt ten feet tall and bulletproof", having stood up to her now-ex-partner and his family. Narelle's feelings have been "up and down" since then; the loss of the pregnancy and (especially) the loss of her partner have been difficult to deal with. Narelle wants her next child to be born into a stable relationship, and is staying "strong" now for the sake of her daughter.

Abortion is a solution

Women who chose to have an abortion (and some who continued their pregnancies) represented abortion as a solution. This encompassed being a responsible woman and mother who took others' needs into account, including those of the potential child, as well as being consistent with a woman's desire to act in her own best interests. Most women assessed abortion as the best solution at the time, even if it might not have been the only possible solution.

Tracy was shocked to find herself pregnant before she and her partner were ready, and thought, "Oh my god! What do I do?" Almost at once, "it was like, 'Oh, I don't have to worry about this, because there are other ways around this'." Even Melanie, who was continuing her pregnancy, constructed abortion as a solution if you are not ready for motherhood: "You've just got to put everything into perspective because, I mean, it's not just a phase; it's a lifetime thing to have a baby."

Felicity said, "I just pretty much had my mind made up from the moment I found out. It just sort of was a hard thing to do, if that makes sense." Felicity constructed

her decision to have an abortion as both inevitable and difficult; she called it "logical". By representing abortion as "logical", women position themselves as using reason to identify the appropriate solution; by apologising for their relief at achieving the solution, women position themselves as having warm feelings and being aware that they ought, as women, to sacrifice their own needs for others.

Abortion is difficult

Although abortion is constructed as a solution to a problem, it is not, on the whole, an easy one. Most women found the decision to have an abortion difficult for reasons concerning the fetus, herself, and others.

Consideration of **the fetus** can both suggest the necessity for an abortion (because the woman feels unable to care appropriately for the potential child) and, at the same time, make it a difficult solution. Alison thought that she would be putting herself and the child at risk were she to have a baby with her abusive partner. Nevertheless, she said, "I feel like I just wish I was sort of stronger and been able to keep it." Wendy was one of the women who were pressured by others not to have

~ HANNA ~

Aged 18, no children, abortion

The perfect answer, the perfect choice for me was an abortion. It was the best choice and probably the most accurate choice I'll ever make in my entire life. ... The relief that I felt once I woke up, after the abortion: it was amazing. ... It's like, you know, when you have all these debts and you finally pay it off, it's like, like your chest is, like, just empty, and you've got this weight literally lifted off your shoulders. I've never felt that before. I'd never, ever felt like a weight lifting off my shoulders. ... I really, I really felt really good about it.

~ DEBORAH ~

Aged 18, no children, abortion

Deborah had been excited by her pregnancy and the “new life”.

When I found out, it was like so exciting, to be honest. It was just like, “Whoa! Wow! This is amazing!” But then it’s just like: reality check! How ridiculous it would be to go through with it, because I’m so young and everything else in my life.

She decided to have an abortion. Deborah thinks abortion “is a big deal” even though it was the right decision.

You can’t deny your basic instinct as a human, you know? I wanted to keep it and I would have fought for that baby, like. But sometimes, you know, you’ve got to—there’s just such a conflict between what you feel inside and what is right.

an abortion with comments like, “Oh, but what about a baby; wouldn’t it be cute?” These women said that such comments made it more difficult for them. Amy and Georgia both preferred an abortion to becoming teenage mothers, but each felt “cruel”, seeing themselves as responsible for the potential child and making “a hard decision” [Georgia] that was best for all concerned. Brittany said, “I was thinking about the baby and myself, because I needed to, like—I want to, like, bring up a child, like, that I know that I’m going to be able to look after and everything.”

Abortion is difficult for reasons relating to **the woman** herself, including her sense of being “selfish” for taking her own needs and interests into account or conversely, as Caroline said, “sacrificing my wants and needs for the welfare of my family”. Polly was concerned, at 33, that she might not have another chance at pregnancy and worried that an abortion might damage her fertility, but her circumstances meant that she could not care for a child. Many women were just “disappointed” in themselves for getting pregnant in the first place. Some found it difficult to decide on abortion. Prue, for example, said, “It was a hard decision to make and sometimes I regret it. And like, you know, that’s what you have to do.” So now Prue feels that she must achieve all the things she felt she would lose by becoming a mother, setting goals for herself and aware that “I’m trying to justify the decision,” in what can be understood as an adaptive way of managing a difficult solution.

Other researchers have found complex feelings around abortion as well as confidence that it was the right solution (e.g. Kero et al., 2001). Kero and Lalos (2000) identify incompatible values—social and personal responsibility versus ethical feelings about ending a life—that render the confusing experience of abortion both logical and understandable.

Women’s accounts of considering or undergoing abortion incorporated the complex ways in which **other people** contribute to their difficulties. The abusive **partners** of a few women are obvious examples; Alison’s pushed her into a pregnancy she did not want:

And he didn’t want me to get rid of it at all but then, you know, we’d have fights and he would—he’d, you know, blow up and then he’d be like, ‘Right, okay, you’re getting rid of the baby and dah, dah, dah, dah’, and then the next day it would be like, ‘You’re not getting rid of the baby’. [Alison, 33, no children, abortion]

Other men are adamantly anti-abortion, such as Hanna’s boyfriend who threatened to prevent her from having one. Rebecca’s ex-partner, with whom she already has one child, did not want her to have an abortion but also wanted no responsibility for the baby.

In contrast, there are women like Caroline who understand pregnancy in the context of a loving relationship in which having a baby “is the most loving thing I can do. That it’s the greatest way I can show my partner that I love him and this is our bond”.

~ OPHELIA ~

Aged 18, no children, abortion

Ophelia had problems with her boyfriend's mother:

I think because she didn't really understand my life, because at some stage she was going to tell my parents behind my back. ... She's come from a very easy-going background, right, and she's always been allowed to do whatever she wanted and all that kind of stuff. And ... she had my boyfriend when she was 16, 17. And her parents didn't find anything wrong with that. And so I think, like, she just doesn't understand how devastated and upset and betrayed my parents would feel.

It was difficult for them to agree on abortion for the sake of the family as a whole.

Women's **extended family**, especially parents, can make abortion difficult because of the views they have expressed for decades, their attitudes stereotyping women who have abortions, or their over-solicitousness of their daughters contemplating abortion. Some women feared their parents' wrath and were surprised by their support, but still felt that they had disappointed them.

Several other women felt guilty about having abortions because they had family members on assisted conception programs. Prue said, "Because my sister had to go through IVF to get pregnant, ... the decision to terminate was really horrible". Her sister, when told later, was understanding and supportive.

Some, but not all, women who already had **children** found abortion difficult because they imagined the fetus growing up like their sons and daughters. Rebecca said, "It is the hardest decision you'll ever have to make in your life, and it's harder when you've already got a child".

Other people in general, or "**society**", can make abortion difficult because of the perceived discourses about abortion and women who have them. Daisy said, "I didn't even tell my family or my friends because I'm scared that they're going to look down on me for it, because it's perceived to be such a bad thing". Women's expectations of judgement against them were sometimes evident in their expressed surprise that they had not encountered it. According to Stephanie, for example, "most people that I spoke to were really helpful and didn't seem judgemental or anything like that".

Religious doctrine could also contribute to women's difficulties. Bianca thought her father would "disown" her if he knew she had had an abortion, because "in our religion, abortions are, you know, not on".

The most overt expression of social attitudes that make abortion difficult for women is anti-abortion protest. Daisy found the protestors outside the private clinic to be "scary", but accepted it as "freedom of speech". Other women specifically chose a public hospital in order to avoid protestors, the fear of whom contributed to their sense of engaging in a stigmatised activity.

~ KAYLENE ~

Aged 37, from a rural or regional area, presented in her second trimester, two children, abortion

Kaylene had her second, most recent, abortion at the Women's and recalled her shock, 17 years earlier, when she arrived for her first abortion at a private abortion clinic. She had become pregnant soon after the birth of her first child and was "gobsmacked" by the protestors:

I asked a couple of them, ... "Do you know what life's about when you have a child and the responsibility and everything else in life to go with it?" ... They said, "No, we don't have kids, but you're still killing". And I'm like, "No, you don't understand. I'd rather give a better life to a child and have my own sanity as well than have a child that ends up in welfare and I end up, you know, wherever, and on anti-depressant-type things".

CONCLUSIONS

This report presents the results of a two-part project on abortion: a 12-month audit of electronic records of women contacting the Pregnancy Advisory Service at the Royal Women's Hospital and interviews with 60 women who had contemplated or undergone abortion in Victoria.

Now that Victorian legislation formally acknowledges abortion as part of women's health care, the findings and recommendations of this research will assist the health system to recognise service needs, identify gaps, and ensure the equitable provision of timely and affordable services across the state. Law reform was not intended to change the frequency of abortion; equitable service distribution would be expected to improve accessibility and timeliness of abortion services, and therefore promote Victorian women's reproductive health, without changing the numbers of abortions.

The audit is the first of its kind to report on the social and personal circumstances of all clients of a large public Pregnancy Advisory Service in contemporary Australia. It indicates that reliable and comprehensive information can be collected during a consultation without compromising care. Although the findings are not representative of all Victorian women who contact pregnancy advisory services, cautious interpretation allows them to make an important contribution to information available on the public record. The results of the audit will, we hope, inform the development of continuous systematic data collection. The goal of data collection would not be to monitor women or doctors but to provide opportunities for evidence-based preventative initiatives, service improvements, and policy development.

For the **interviews**, we selected women who were from regional or rural areas, aged 16 to 18, or in the second trimester of pregnancy. Nevertheless, the women's accounts contained little that distinguished among the three categories. Participants in this study described complex lives within which they made decisions about abortion. Being young or living a long way from reproductive services constitute only part of the story, and a second-trimester presentation can arise from influences also affecting those who present earlier.

Each woman's story is different, yet women have much in common. In considering their own needs, desires, and capacities, the well-being of potential children, and their responsibility for children and adults already in their lives, these women were making considered decisions to terminate or continue their pregnancies, based on multiple and contingent factors. Each woman assessed her capacity to be a good mother and to provide adequately for the potential child; women thought about their relationships and the man concerned; and those with children considered their needs. Some women said explicitly and others implied that their pregnancy occurred at the "wrong time"; had it happened at a more propitious time, they could have continued. Women represented themselves as making responsible decisions about child-bearing.

Together, the aggregate data and interviews give insights into women's experiences of contemplating or undergoing abortion. They provide evidence to inform policy-making, service provision, further research, and public debate. The project as a whole should enable more sensitive understanding of this complex aspect of women's reproductive lives.

~ ESTHER ~

Aged 38, from a rural or regional area, no children, abortion

Esther made her decision to have this and previous abortions:

For everyone concerned. For the people around me, for myself, for the person-to-be, the child, you know, and for the planet. All, for all of those reasons, it can be a decision that's—even though it's an awful decision to make, it can be the greatest, the greatest way to show your love.

REFERENCES

- Addor, V., Narring, F., & Michaud, P.-A. (2003). Abortion trends 1990-1999 in a Swiss region and determinants of abortion recurrence. *Swiss Medical Weekly*, 133, 219-226.
- Adelson, P.L., Frommer, M.S., & Weisberg, E. (1995). A survey of women seeking termination of pregnancy in New South Wales. *The Medical Journal of Australia*, 163, 419-422.
- Allanson, S. (2007). Abortion decision and ambivalence: Insights via an abortion decision balance sheet. *Clinical Psychologist*, 11, 50-60.
- Australian Bureau of Statistics. (2006). *National Health Survey: Summary of Results Australia 2004-05*. Cat. no. 43640, Canberra: ABS.
- Australian Bureau of Statistics. (2008). *Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006*. Cat. no. 47050, Canberra: ABS.
- Australian Government Department of Health and Ageing. (2006). *National Pregnancy Support Helpline*. <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-pregnancy-helpline> (consulted 3.9.08).
- Bankole, A., Singh, S., & Haas, T. (1999). Characteristics of women who obtain induced abortion: A worldwide review. *International Family Planning Perspectives*, 25, 68-77.
- Bartlett, L.A., Zane, S.B., & Berg, C.J. (2004). Risk factors for legal induced abortion-related mortality in the United States. *Obstetrics & Gynecology*, 103, 729-737.
- Black, K., Fisher, J., & Grover, S. (1999). Public hospital pregnancy termination services: are we meeting demand? *Australian & New Zealand Journal of Public Health*, 23, 525-527.
- Bowes, T., & Macleod, C. (2006). The characteristics of women seeking termination of pregnancy at an urban-based government hospital in the Eastern Cape. *Curationis*, 29(4), 12-18.
- Cagnacci, A., & Volpe, A. (2001). Is voluntary abortion a seasonal disorder of mood? *Human Reproduction*, 16, 1748-1752.
- Chan, A., & Keane, R.J. (2003). Prevalence of induced abortion in a reproductive lifetime. *American Journal of Epidemiology*, 159, 475-480.
- Chan, A., Scott, J., Nguyen, A.-M., & Sage, L. (2007). *Pregnancy outcome in South Australia 2006*. Adelaide: Pregnancy Outcome Unit, South Australian Department of Health.
- Creatas, G., & Elsheikh, A. (2002). Adolescent pregnancy and its consequences. *European Journal of Contraception and Reproductive Health Care*, 7, 167-172.
- de Crespigny, L.J., & Savulescu, J. (2004). Abortion: time to clarify Australia's confusing laws. *Medical Journal of Australia*, 181(4), 201-203.
- Department of Health. (2007). *Abortion Statistics, England and Wales: 2006*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_075697, consulted 26.6.07.
- Ekstrand, M., Larsson, M., Von Essen, L., & Tyden, T. (2005). Swedish teenager perceptions of teenage pregnancy, abortion, sexual behavior, and contraceptive habits—a focus group study among 17-year-old female high-school students. *Acta Obstetrica et Gynecologica Scandinavica*, 84, 980-986.
- Finer, L.B., Frohworth, L.F., Dauphinee, L.A., Singh, S., & Moore, A.M. (2006). Timing of steps and reasons for delays in obtaining abortions in the United States. *Contraception*, 74, 334-344.
- Grayson, N., Hargreaves, J., & Sullivan, E. (2005). *Use of routinely collected national data sets for reporting on induced abortion in Australia*. AIHW Perinatal Statistics Unit Sydney. Perinatal Statistics Series Number 17(AIHW Cat. No. PER 30).
- Hegarty, K., Gunn, J., Chondros, P., & Small, R. (2004). Association between depression and abuse by partners of women attending general practice: Descriptive, cross sectional survey. *British Medical Journal*, 328, 621-624.
- Henshaw, S.K., & Kost, K. (2008). *Trends in the characteristics of women obtaining abortions, 1974 to 2004*. New York: Guttmacher Institute.
- Kero, A., Hogberg, U., Jacobsson, L., & Lalos, A. (2001). Legal abortion: a painful necessity. *Social Science & Medicine*, 53, 1481-1490.
- Kero, A., & Lalos, A. (2000). Ambivalence – a logical response to legal abortion: a prospective study among women and men. *Journal of Psychosomatic Obstetrics and Gynecology*, 21, 81-91.
- Kirkman, M. (2002). What's the plot? Applying narrative theory to research in psychology. *Australian Psychologist*, 37, 30-38.
- Kirkman, M., Rowe, H. J., Hardiman, A., Mallett, S., & Rosenthal, D. (Under review). Reasons women give for abortion: A review of the literature.
- Kozinszky, Z., Boda, K., & Bártfai, G. (2001). Determinants of abortion among women undergoing artificial termination of pregnancy. *European Journal of Contraception and Reproductive Health Care*, 6, 145-152.

- Liamputtong, P. (2003). Abortion—it is for some women only! Hmong women's perceptions of abortion. *Health Care for Women International*, 24, 230-241.
- Maiden, S. (2005, 4 February). Willy-nilly pregnant women 'dumb'. *The Australian*. http://www.democrats.org.au/speeches/?speech_id=1526&display=1, consulted 9.2.05.
- Mirza, T., Kovacs, G., & Kinfu, Y. (2001). Serving rural Australia with reproductive health expertise. *Australian Journal Of Rural Health*, 9, 241-245.
- Misago, C., Fonseca, W., Correia, L., Fernandes, L.M., & Campbell, O. (1998). Determinants of abortion among women admitted to hospitals in Fortaleza, North Eastern Brazil. *International Journal of Epidemiology*, 27, 833-839
- Mitchell, E.M.H., Halpern, C.T., Kamathi, E.M., & Owino, S. (2006). Social scripts and stark realities: Kenyan adolescents' abortion discourse. *Culture, Health & Sexuality*, 8, 515-528.
- Mogilevkina, I., Hellberg, D., Nordstrom, M.-L., & Odland, V. (2000). Factors associated with pregnancy termination in Ukrainian women. *Acta Obstetrica et Gynecologica Scandinavica*, 79, 1126-1131.
- National Health & Medical Research Council. (1996a). *An information paper on termination of pregnancy in Australia*. Canberra: Commonwealth of Australia: Australian Government Publishing Service.
- National Health & Medical Research Council. (1996b). *Termination of pregnancy in Australia: a review of health care services*. Canberra: Commonwealth of Australia: Australian Government Publishing Service.
- Nickson, C., Shelley, J., & Smith, A.M.A. (2002). Use of interstate services for termination of pregnancy in Australia. *Australian and New Zealand Journal of Public Health*, 26, 421-425.
- Nickson, C., Smith, A.M.A., & Shelley, J. (2006). Travel undertaken by women accessing private Victorian pregnancy termination services. *Australian and New Zealand Journal of Public Health*, 30, 329-333.
- Nickson, C., Smith, A.M.A., & Shelley, J.M. (2004). Intention to claim a Medicare rebate among women receiving private Victorian pregnancy termination services. *Australian and New Zealand Journal of Public Health*, 28, 120-123.
- Pratt, A., Biggs, A., Buckmaster, L. (2005). *How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*. Parliament of Australia: Research brief no.9 2004-5. <http://www.aph.gov.au/library/pubs/rb/2004-05/05rb09.pdf>.
- Savonius, H., Pakarinen, P., Sjöberg, L., & Kajanoja, P. (1995). Reasons for pregnancy termination: negligence or failure of contraception? *Acta Obstetrica et Gynecologica Scandinavica*, 74, 818-821.
- Sedgh, G., Henshaw, S., Singh, S., Aahman, E., & Shah, I. (2007). Induced abortion: estimated rates and trends worldwide. *Lancet*, 370, 1338-1345.
- Sihvo, S., Bajos, N., Ducot, B., & Kaminski, M. (2003). Women's life cycle and abortion decision in unintended pregnancies. *Journal of Epidemiology and Community Health*, 57, 601-605.
- Skinner, S.R., & Hickey, M. (2003). Current priorities for adolescent sexual and reproductive health in Australia. *Medical Journal of Australia*, 179, 158-161.
- Smith, A.M.A., Rissel, C.E., Richters, J., Grulich, A.E., & de Visser, R.O. (2003). Sex in Australia: Reproductive experiences and reproductive health among a representative sample of women. *Australian & New Zealand Journal of Public Health*, 27, 204-209.
- SPSS. (2006). *SPSS for Windows, Release 15.0*. Chicago: SPSS Inc.
- Taft, A.J., Watson, L.F., & Lee, C. (2004). Violence against young Australian women and association with reproductive events: a cross-sectional analysis of a national population sample. *Australian & New Zealand Journal of Public Health*, 28, 324-329.
- Törnborn, M., & Möller, A. (1999). Repeat abortion: A qualitative study. *Journal of Psychosomatic Obstetrics & Gynecology*, 20, 21-30.
- Victorian Law Reform Commission. (2008). *Law of abortion: Final report*. Melbourne: VLRC. http://www.lawreform.vic.gov.au/wps/wcm/connect/Law+Reform/resources/file/ebede602dfadc52/VLRC_Abortion_Report.pdf, consulted 29.5.08.
- Whitehead, A., & Fanslow, J. (2005). Prevalence of family violence amongst women attending an abortion clinic in New Zealand. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, 45, 321-324.
- Wulf, D., & Donovan, P. (2002). *Women and societies benefit when childbearing is planned*. Issues in brief. Series No. 3. New York: Alan Guttmacher Institute.

APPENDICES

Papers and Activities Resulting from the Project

Conference

The investigators convened a conference, *Abortion in Victoria: Where are we now? Where do we want to go?* held on 30 November 2007, inspired by the research project. In addition to the University of Melbourne, organisations sponsoring the conference were Women's Health Victoria, the Royal Women's Hospital, and Family Planning Victoria. The conference attracted intense interest and resulted in The Melbourne Declaration, a widely-circulated document about women's reproductive health; the Declaration is appended to this report.

Victorian Law Reform Commission

Progress results of the audit were sought by the Victorian Law Reform Commission to inform their investigation into abortion law reform; the research was cited in the report presented to parliament in 2008.

Publications

Rowe, H., Kirkman, M., Hardiman, A., Mallett, S., & Rosenthal, D. (2009). Considering abortion: a 12-month audit of records of women contacting a Pregnancy Advisory Service. *Medical Journal of Australia*, 190, 69-72.

Kirkman, M., Rowe, H., Hardiman, A., & Rosenthal, D. (Submitted). Abortion is a difficult solution to a problem: A discursive analysis of interviews with women considering or undergoing abortion in Australia.

Kirkman, M., Rowe, H., Rosenthal, D., Mallett, S., & Hardiman, A. (Submitted). Understanding abortion from women's perspective: Reasons for contemplating or undergoing abortion in Victoria, Australia.

Kirkman, M., Rowe, H., Hardiman, A., Mallett, S., & Rosenthal, D. (Submitted). Reasons women give for abortion: A review of the literature.

Conference Presentations

Kirkman, M., Rowe, H., Hardiman, A., Mallett, S., & Rosenthal, D. (2008). *Understanding women's experiences of contemplating or undergoing abortion*. Invited presentation to the conference "Abortion in Queensland", convened by Children by Choice, Family Planning Queensland, and Caroline de Costa, Brisbane, 17 October 2008.

Kirkman, M., Mallett, S., Rowe, H., Hardiman, A., and Rosenthal, D. (2008). On being a good mother: Reasons women give for contemplating or undergoing abortion. *Program and Abstracts of the Meeting of the International Marcé Society, 'Policy, planning and effective delivery of perinatal mental health care'*, Sydney, 11-13 September 2008: 29.

Rowe, H., Kirkman, M., Hardiman, A., Mallett, S., and Rosenthal, D. (2008). Evidence for planning improved services for Australian women contemplating abortion after unplanned or unwanted pregnancy. *Program and Abstracts of the Meeting of the International Marcé Society, 'Policy, planning and effective delivery of perinatal mental health care'*, Sydney, 11-13 September 2008: 42.

Kirkman, M., Rowe, H., Mallett, S., Hardiman, A., & Rosenthal, D. (2008). Understanding women's experiences of unplanned pregnancy and abortion. Invited presentation. Program and Abstracts of the 34th Annual Scientific Meeting of the Australian Society for Psychosocial Obstetrics and Gynaecology. Adelaide, 1-2 August 2008: 17.

Rowe, H., Kirkman, M., Hardiman, A., Mallett, S., Rosenthal, D. (2008). Contributing to the evidence base about unplanned and unwanted pregnancy and abortion in Australia. *Program and Abstracts of the Population Health Congress 2008*. Brisbane, 6-9 July 2008: 107.

Kirkman, M., Mallett, S., Rowe, H., Rosenthal, D., & Hardiman, A. (2008). Women's experiences of unplanned or unwanted pregnancy and abortion. *Program and Abstracts of the 3rd International Congress on Women's Mental Health*. Melbourne 17-20 March 2008: 67.

Rowe, H., Kirkman, M., Hardiman, A., Mallett, S., & Rosenthal, D. (2008). Considering abortion: 12-month audit of all women contacting a pregnancy advisory service. *Program and Abstracts of the 3rd International Congress on Women's Mental Health*. Melbourne, 17-20 March 2008: 56.

Kirkman, M., Rosenthal, D., Rowe, H., Mallett, S., & Hardiman, A. (2007). *Understanding women's experiences of unplanned pregnancy and abortion: A research collaboration between the Key Centre for Women's Health in Society and the Royal Women's Hospital*. 'Abortion in Victoria: Where are we now? Where do we want to go?' University of Melbourne, 30 November 2007.

ABORTION IN VICTORIA

The Melbourne Declaration

Endorsed by the participants of the 'Abortion in Victoria: Where are we now? Where do we want to go?' Conference, held at The University of Melbourne, 30 November 2007.

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Effort should be made to improve sexual health and reduce the need for abortion.

1. We welcome the identification by the Victorian Department of Human Services of sexual and reproductive health as a health promotion priority. We support a multi-layered approach, including education, better services, improved technology and community debate about sexuality and fertility.
2. Contraception should be accessible and affordable to all Victorian women.

Abortion services should be accessible to all women.

3. Abortion should be removed from The Crimes Act 1958 (Vic).
4. Regional public health services must take responsibility for access by women in their region to abortion services. If abortion services are not available within their local facilities, then arrangements should be made with the nearest available services.
5. A government funded statewide pregnancy information service should be developed, implemented and advertised to ensure timely, professional, accessible and comprehensive information, referral and advocacy for women wanting to discuss pregnancy options.

6. Health professionals (including pharmacists) who have a conscientious objection to contraception or abortion should make their objection known and refer to services which can assist.
7. Abortion should be funded through Medicare and the public health system.
8. Data on all abortions carried out in Australia should be collected and collated to inform service development and health promotion strategies.

Abortion services should conform to world's best practice.

9. Victorian best practice guidelines for the provision of abortion services should be developed, implemented and regularly reviewed.
10. Decisions on the availability of methods of abortion should be based on best medical evidence. The option of medical abortion with mifepristone and prostaglandin should be available to women where medically appropriate.

11. All services, including those providing abortion, should respond to the individual needs of women. They should provide counselling and social support where required, and should not impose restrictive requirements such as mandatory counselling or cooling off periods.
12. Medical workforce training and succession planning should be addressed systematically and sustainably.
13. Impartial, accurate, evidence-based information must be provided to enable women to make an informed decision. Legislation along the lines of the Commonwealth Transparency of Advertising and Notification of Pregnancy Counselling Services Bill should be enacted.

Women having abortions and abortion providers should be free from harassment.

14. Buffer zone legislation must be introduced to prevent picketing and other forms of harassment in the vicinity of abortion services.

The Conference was hosted by **The Key Centre for Women's Health in Society (University of Melbourne), The Royal Women's Hospital, Family Planning Victoria and Women's Health Victoria.**



Participants in Consultation Day at the Key Centre for Women's Health in Society 5 December 2008

Dr Susie Allanson

Clinical Psychologist, Private Fertility Control Clinic; Honorary Clinical Fellow, University of Melbourne

Ms Dee Basinski

Senior Project Officer, VicHealth

Dr Chris Bayly

Associate Director Women's Services, Royal Women's Hospital, Melbourne

Ms Brigid Coombe

Director, Pregnancy Advisory Centre, Central Northern Adelaide Health Service

Dr Robyn Gregory

CEO, Women's Health West, Victoria

Ms Annarella Hardiman

Manager, Pregnancy Advisory Service, Royal Women's Hospital, Melbourne (Partner Investigator)

Dr Christine Healy

GP, private abortion provider, past president of the Abortion Providers' Federation of Australasia

Ms Lynne Jordan

CEO, Family Planning Victoria

Dr Maggie Kirkman

Key Centre for Women's Health in Society, Melbourne School of Population Health, The University of Melbourne (Research Director)

Prof Doreen Rosenthal

Key Centre for Women's Health in Society, Melbourne School of Population Health, The University of Melbourne (Principal Investigator)

Dr Heather Rowe

Key Centre for Women's Health in Society, Melbourne School of Population Health, The University of Melbourne (Chief Investigator)

Those who commented on the draft report but did not attend the meeting:

Ms Marilyn Beaumont

Executive Director, Women's Health Victoria

Ms Melissa Brown

Senior Program Adviser, Maternity Services, Department of Human Services, Victoria

Ms Julie Jenkin

Head, Maternity Services, Department of Human Services, Victoria

Prof Jenny Morgan

Professor of Law, The University of Melbourne

Prof Jeremy Oats

Clinical Director, Department of Women's Services, Royal Women's Hospital, Melbourne

