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Strategies to reduce abortion stigma in the healthcare workforce

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The University of Melbourne acknowledges the Traditional Owners of the unceded land on which we work, learn and live: the Wurundjeri Woi-wurrung and Bunurong peoples (Burnley, Fishermans Bend, Parkville, Southbank and Werribee campuses), the Yorta Yorta Nation (Dookie and Shepparton campuses), and the Dja Dja Wurrung people (Creswick campus).

The University also acknowledges and is grateful to the Traditional Owners, Elders and Knowledge Holders of all Indigenous nations and clans who have been instrumental in our reconciliation journey.

We recognise the unique place held by Aboriginal and Torres Strait Islander peoples as the original owners and custodians of the lands and waterways across the Australian continent, with histories of continuous connection dating back more than 60,000 years. We also acknowledge their enduring cultural practices of caring for Country.

We pay respect to Elders past, present and future, and acknowledge the importance of Indigenous knowledge in the Academy. As a community of researchers, teachers, professional staff and students we are privileged to work and learn every day with Indigenous colleagues and partners.

In making this Acknowledgment of Country we commit to respectful and responsible conduct towards all others according to the Traditional lores of this land, particularly at times of formal ceremony.

Abortion context in Australia

Abortion is common and safe

- Approx 1 in 3 women* in their lifetime[1]
- 80,000 services/year[1]

(Somewhat) favorable political and legal context

- 2023 deregulation: can be prescribed by all doctors and Nurse Practitioners[2]
- (Some) state governments very committed
- Cohort of committed providers

1. Keogh et al. Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data (2021);
2. *https://www1.racgp.org.au/newsgp/clinical/ms-2-step-access-set-to-expand*Millar 2025 (https://theconversation.com/who-can-access-abortion-in-australia-243699)

Workforce challenges

- Too few trained and willing abortion providers, particularly in regional areas [1,2,3]
- Only about 10% of GPs prescribe abortion medication [4]
- Conscientious objectors do not always refer, despite obligation to do so [5,6]
- Abortion obstruction across the health system [6]

1. Melville C. Abortion care in Australasia: A matter of health, not politics or religion. Aust. N. Z. J. Obstet. Gynaecol. 62, 187–189 (2022). 2. Sifris R & Penovic T. Barriers to abortion access in Australia before and during the COVID-19 pandemic. Womens Stud. Int. Forum 86, 102470 (2021). 3. Makleff S et al. Typologies of interactions between abortion seekers and healthcare workers in Australia: a qualitative study exploring the impact of stigma on quality of care. BMC Pregnancy Childbirth 23, 646 (2023). 4. Bateson D et al. Medical abortion in primary care. Aust. Prescr. 44, 187–192 (2021). 5. Haining et al (2022) Abortion law in Australia: Conscientious objection and implications for access, *Monash University Law Review*, vol. 48, iss. 2. 6. Keogh et al (2019a) Conscientious objection to abortion, the law and its implementation in Victoria, Australia: Perspectives of abortion service providers. *BMC Medical Ethics*, vol. 20, iss 1.

Obstruction and delays

Reception / booking

- Denial of care (‘we don’t do that’)
- Delays services unnecessarily

Provider

- No information about abortion
- Misinformation about abortion
- Creates unnecessary delays
- Tells patient to continue pregnancy

Pathology / sonography / hospital

- Refuse to provide abortion care
- Give false or inaccurate information

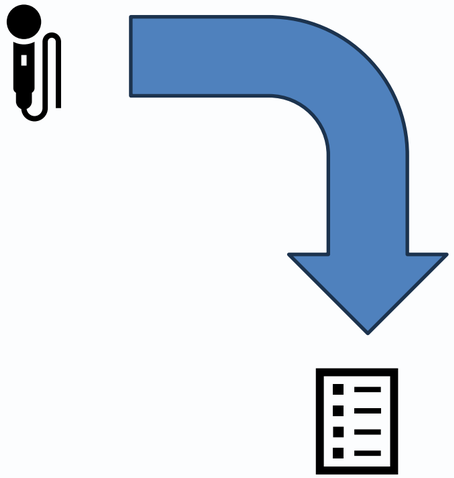
Pharmacy

- Will not supply medication abortion
- Do not provide alternative locations

Vallury et al. Systemic delays to abortion access undermine the health and rights of abortion seekers across Australia (2023); Millar E. Who can access abortion in Australia? The Conversation (2024); Wickramasinghe et al. Experiences of abortion care in Australia: a qualitative study examining multiple dimensions of access (2024); Keogh et al. Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers (2019).

Stigmatising	Supportive
1.1 Creating barriers to abortion access	2.1 Actively helping people access care
1.2 Judging, blaming, or punishing abortion seekers	2.2 Actively validating abortion decision
1.3 Not responding to emotional or information needs	2.3 Interactions responsive to emotional and information needs
1.4 Making assumptions about intentions and preferences	2.4 Aligning abortion provision with client's preferences
1.5 Minimized interactions that compromise quality and safety	2.5 Providing holistic and high-quality care to ensure a safe service

24 interview with abortion seekers



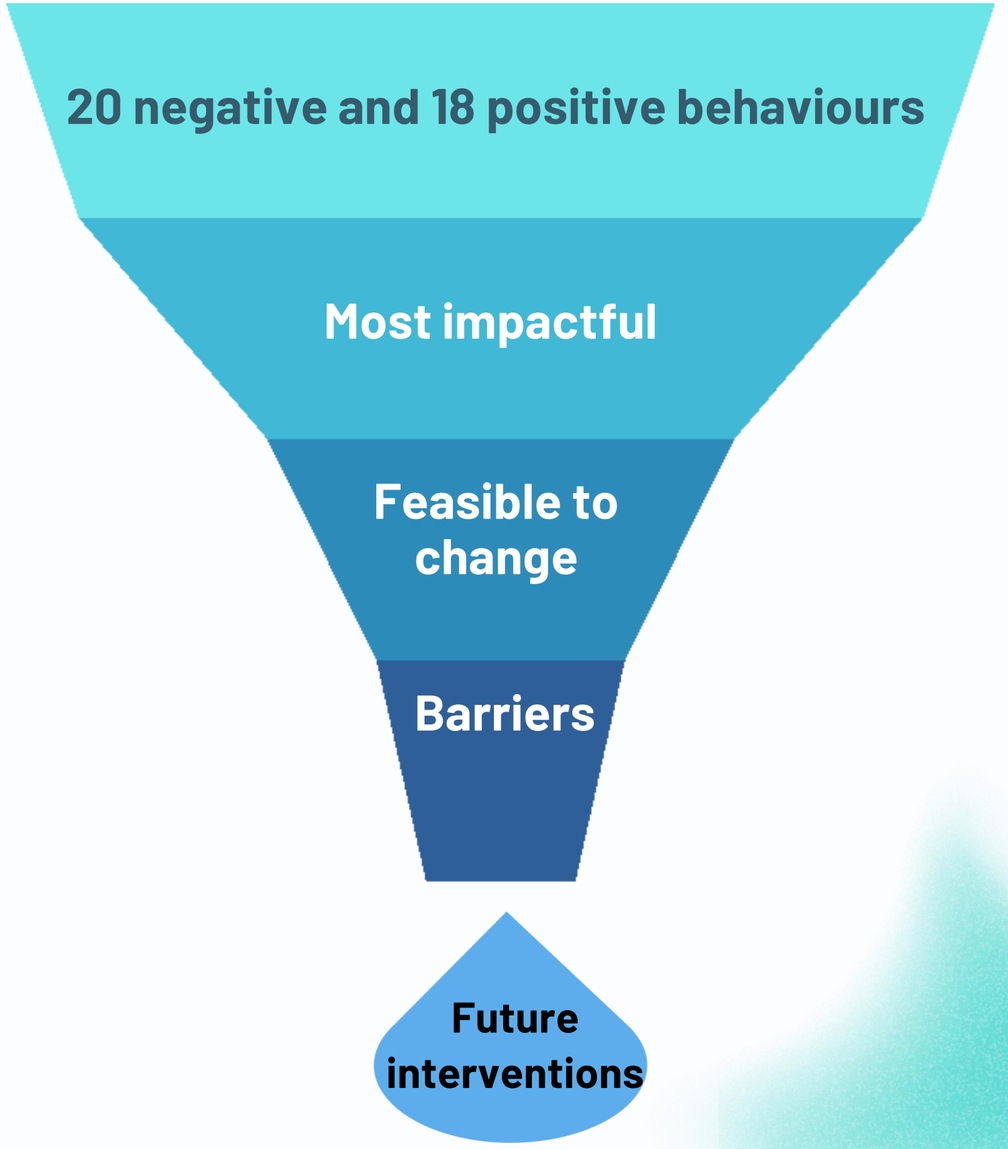
- Re-analysed qualitative data to identify:
  - Types of stigmatising behaviours
  - Where they happen (e.g., booking, referral, sonography, pathology, counselling)
- Refined list to:
    - 18 stigmatising behaviours
    - 20 non-stigmatising behaviours
- Developed survey to gain healthcare worker perspectives on these behaviours

Study objectives and methods

To inform future interventions to reduce stigma, obstruction and delays in abortion care by identifying:

1. **Impactful:** Healthcare worker behaviours most impactful on abortion seekers (top 5)
2. **Changeable**: Healthcare worker behaviours that are most amenable to change
3. **Barriers:** What limits change
4. **Ideas:** How to promote behaviour change

Online survey and recruitment



Sample (n=299)

Demographics

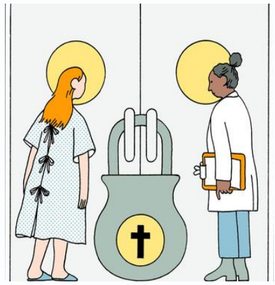
- 90% women
- 70% over age of 35
- 77% not at all religious

Interaction with abortion seekers

- 67% of participants interacted with abortion seekers **frequently**

Participants' roles

- 42% doctors
- 31% nurses/midwives
- 14% non-clinical
- 13% allied health

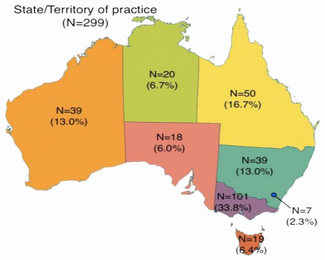


Conscientious objection

- 3% objected in some cases
- 1% objected in all cases

Location

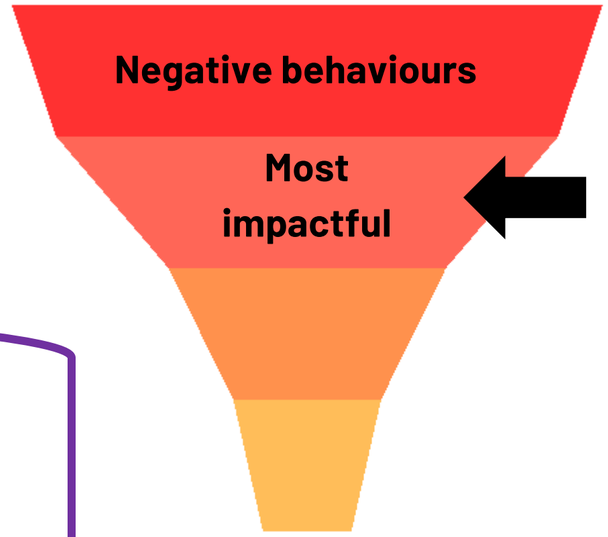
- 38% Metropolitan
- 25% Regional
- 22% Rural or Remote



State/territory

- All represented
- Mix of public and private systems

Top 5 negative behaviours (n=285/299)



1. Clinician does not refer, delays referral, inappropriate referral

   (81%; n=230)

2. Provider gives false/inaccurate abortion information

   (69% n=195)

3. Pharmacist doesn't supply MS2STEP /doesn't give alternative location

   (59%; n=168)

4. Receptionist obstructs or delays

   (56%; n=160)

5. Communicates in cold, unfriendly, judgemental way

   (43%; n=122)

Obstruction

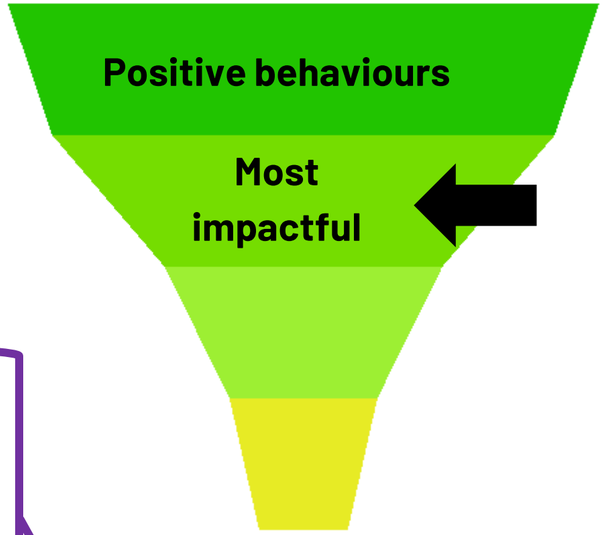
Stigmatising communication

Why are these negative behaviours important?

“They manage shame and eliminate barriers to access.”

“I recall a patient considering abortion coming back to my practice crying. The sonographer tried to persuade her not to abort, saying she was committing a crime against god. And [the sonographer was] making her listen to the foetal heartbeat and see sonography images.”

Top 5 positive behaviours (n=267/299)



1. Providers normalise/validate abortion (64%; n=172)
2. Providers communicate in professional, friendly, non-judgmental way (58% n=156)
3. Referring clinician helps patient navigate access (45%; n=121)
4. Referring clinician shares information about all options, pathways to care, next steps (40%; n=107)
5. Provider gives non-directive pregnancy options counselling without judgement (40%; n=106)

Non judgemental communication

Access and information

Why are these positive behaviours important?

“Focus on areas to make the patient feel heard, respected and listened to.”

“Duty of care should be to offer patients options. Judgements should not be a factor.”

Barriers to behaviour change

Individual

- Lack of education/ training about abortion
- Personal beliefs
- Lack of interest

"[It's] hard to reach clinicians with education after they are qualified. Those clinicians who most need the extra education and training are least likely to attend."

Community and organisations

- Social norms
- Health literacy
- Unclear pathways to care

"The greatest barrier is the referral process. A woman needing to attend three different GP's before finding a fourth who would refer her to an appropriate service is unacceptable, yet not an uncommon experience."

Health system, laws, governance

- Conscientious objection
- Unsustainable funding model
- No accountability
- No enforcement

"Some clinicians may misuse conscientious objection laws, failing to provide timely referrals as required."

Recommendations to address abortion stigma

Normalise abortion care

- Standardised guidelines and resources
- Medical education
- Clinician training
- Values clarification

Improve referral pathways

- Centralised repository
- Conscious hiring
- Regular updates for all staff about referral pathways

Incentivise quality / Penalise obstruction

- Sustainable funding models
- Stigmatising behaviour within quality metrics for audits/accreditation
- Require MS2STEP stocking
- Reporting of obstruction

Strengths and limitations

Strengths

- Data from range of disciplines, locations
- Oversampling of regional, rural, remote respondents
- Identified priority behaviours from abortion seeker and healthcare worker perspectives:

1. Reduce obstruction / Promote access
2. Reduce stigma / Promote respectful communication and care

Limitations

- Attrition later in the survey (10%)
- Over-representation of Victorian respondents

Implications for future interventions

Train and educate

- Improve training / education across career stages
- Improve communication skills
- Non-directive pregnancy options counselling

Promote access

- Improve understanding of referral pathways
- Upskill reception staff
- Improve funding models

Reduce stigma

- Normalise abortion as ‘routine’ health care
- Institutional approaches (e.g. values clarification)
- Enforce breaches of professionalism (e.g., obstruction)

“Consider both carrot and stick when designing behavioural change for health professionals. We want an opportunity to be better, but we also need a kick up the arse.”

Questions?

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Survey respondents

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