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Developing a tool to document obstruction experiences along the abortion care pathway

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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 in Australia

- Gradually decriminalised in all states/territories
- Estimated 80,000 abortions/yr
- 1 in 3 to 1 in 4 women* will experience an abortion in her lifetime

*Terminology used in national data

Chan A, Sage LC. Estimating Australia's abortion rates 1985–2003. Med J Aust 2005; Keogh et al. Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data Med J Aust 2021. Melville, Abortion care in Australasia: A matter of health, not politics or religion, Aust N Z J Obstet Gynaecol 2022. Millar E. Who can access abortion in Australia? The Conversation (2024).

Ongoing barriers to abortion access

- No obligation for public provision
- Gestational age limits vary
- Distance to abortion care/ pharmacies
- Gap in medical education and training
- Stigma (providers and care-seekers)
- Costs

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). Parliament of Australia. Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia (2023).

Conscientious objection vs obstruction

- Conscientious objection = refusal on grounds of conscience[1]
- Despite referral requirements[2] some objectors do not refer[3]
- Obstruction has many forms beyond referral [3,4]
- Obstruction is not always conscience-based [5]

1. Wicclair, M.R. (2011) *Conscientious Objection in Health Care: An Ethical Analysis*. Cambridge University Press. **2.** Haining et al (2022) Abortion law in Australia: Conscientious objection and implications for access, *Monash University Law Review*, vol. 48, iss. 2. **3.** 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. **4**. 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 and Childbirth* (2023). **5.** Brown, J., et al. (2021) *Factors influencing practitioners' who do not participate in ethically complex, legally available care: scoping review.* BMC Med Ethics, 22(1).

Obstruction across pathways to care

Front desk | Sonography | Pathology | Pharmacist | Emergency

GP | Public hospital | Abortion prescriber / provider | Nurse/midwife, counsellor

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 and Childbirth* (2023); Keogh et al. Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers, BMC Medical Ethics (2019).

Rationale

Knowledge gap:

We lack information about nature, scope, patterns, geography of obstruction

Assumptions:

1. Abortion seekers are being obstructed across the health system
2. Healthcare workers hear about patient obstruction experiences
3. Some healthcare workers are willing to report obstruction

Project aim:

To develop an online tool for healthcare workers to report cases of obstruction of abortion care (anonymity for patient and obstructor)

Methods

Data capture tool iteratively developed

- Multiple-choice and open-ended (Qualtrics)

One-month pilot (June-July 2025)

- Victorian health professionals (clinical and non-clinical) provided consent
- Asked to report each time saw obstructed patient
- n=15 users of tool

Evaluation of usability, feasibility, scalability

- n=13 respondents

Tool adapted from Care Post Roe tool (UCSF, USA); OSF Pre-registration: https://osf.io/e4jb7

Evaluation: What respondents liked

Importance: “Good to capture this. As we so often hear about [obstruction] but have little avenue to do anything if abortion seeker doesn’t want to proceed with any formal complaints.”

Empowerment, validation, catharsis and/or relief:

“Having this survey gave me […] a great sense of relief and helped to make it feel like I was contributing to change.”

“Having somewhere to put the frustrations of hearing about obstruction on a daily basis was so therapeutic.”

Evaluation findings: Use of tool

What proportion of your obstructed clients did you report?

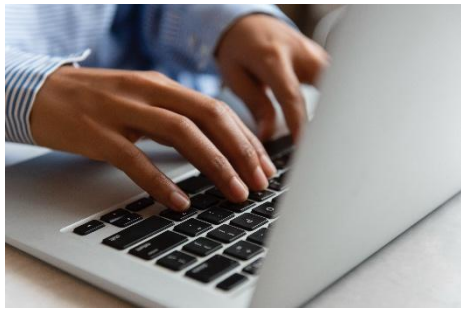
- 54% (n=7) reported 81-100% of obstructions
- 23% (n=3) reported 61-80% of obstructions
- 23% (n=3) reported ≦ 40% of obstructions

Reasons for occasional non-use

- (n=2) Did not see any/many obstructed patients (on leave, first point of care)
- (n=1) Difficult when workload increased

How many times used tool in pilot?

- 69% (n=9) used tool ≦ 10 times
- 31% (n=4) used tool 11 - 50 times



Evaluation findings: Ease and format

- **Easy to use** (100%)
- **No technical complications** (100%)
- **Logically ordered** (100%)
- **Fit into workday** (92%)
- **No concerns about wording or framing** (92%)
- **Would not change format** (84%)
  - Good combination of open-ended + tick-box
  - One wanted more tick boxes to “prompt me to include more details”

*Percents are calculated among those who answered each question

Challenges capturing nuance

"A lot of abortion seekers report **how the obstruction made them feel**, and I thought this was an important thing to capture."

"I loved the survey, but once I started responding I felt there was all of these **nuanced ways that obstruction was happening and impacting abortion seekers** that was difficult to adequately capture."

Risk of under- and mis-reporting

- Possibility that multiple providers would report same obstruction (n=1)
- “Standard” delays in care may be attributed to obstruction
- Data could be skewed towards more significant obstruction

“We don’t [know] the majority of the obstruction that happens. We will never know because people don't report that to us.”

“We are never going to see the full extent, but the more that this tool could be rolled out to all providers would be fantastic. Because it also prompts people to start thinking about it as well.”

Suggestions for future implementation

National vs state specific survey

- 72% (8/11) suggest same survey nationally (comparison; interstate tracking)
- 28% (3/11) suggest different surveys for different states (different laws/criteria)

Confidential vs anonymous

- 75% agreed study ID should be kept (confidential) to provide context for data
- 25% concerned study ID could be a barrier

> "[The Study ID] could be a barrier. It wasn't for me, but remembering or feeling like the responses are being tracked might stop some participation."

Need to link survey to action

"They could capture all of this and build this body of **data to go on for health advocacy and health policy**."

"We can provide this feedback to **health departments**, or it can go to **AHPRA**, or it can be used to particularly **target areas** in the state that obviously seem to have a higher rate of obstruction."

- Risk: identifying problems without providing solutions (n=1)

Key Findings

- Tool is feasible, acceptable, has potential for wide implementation
- Some minor adjustments will improve tool
- Tool provides ‘real-time’ data, but won’t measure prevalence
- Structural barriers remain to consumer reporting of obstruction

Implications

- Data about nature and geographic patterns of obstructive behaviours must link to action
- Opportunities to inform response (e.g., policy reform, training, education, support, routine monitoring)
- Need more nuanced definition of obstruction
  - Individual and system levels
  - Subtle to over
  - Intentional to unintentional

Questions?

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