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Submission Cover Sheet

Inquiry into Abortion and reproductive choice in the ACT

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Inquiry into abortion and reproductive choice in the ACT

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Endorsed by Deep End GPs of the Canberra Region
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(The following document is endorsed as per their personal views, and does not represent the views of any organsations for which they work).

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Table of Contents

Introduction

I am writing this as a GP who has been working in the ACT and surrounding regions for over a decade and providing non-directive pregnancy counselling and medical termination of pregnancy for 3 years. I work, or have worked, in private practice, for an NGO, and for a community health service. I am a member of the Women's Sexual and Reproductive Health Coalition for the NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care (SPHERE), as well as being a member of SPHERE's GP Advisory Circle. I am a part of a community of practice of local GPs who provide medical abortion, as well as a social media group for Australian GPs who provide medical abortion.

This submission has been written with the support of Canberra Deep End GPs. We are a community of practice of GPs and other specialists in the region who provide services for those experiencing deep urban poverty. Canberra has a large number of people who live in overt or hidden proverty and who have particular needs for health care that are not always met by mainstream services. The Deep End primary care practitioners work in youth health, drug and alcohol care, Aboriginal and Torres Strait Islander health care, refugee health care, prison health, people with chronic mental illness, and victims and victim-survivors of family and domestic violence.

Please also see the end of the document for specific information regarding medical and surgical abortion access and processes that have implications for this section.

For an additional reference and preferably to be removed from any public publishing of submissions, the end of the document also contains the paper I, Dr Melanie Dorrington, wrote for the Canberra Maternity Services Advisory Committee in October 2021 regarding abortion access whilst working as the acting GP Policy Advisor for ACT Health. This was in response to CHS advising that the unofficial short-term provision of abortion >16 weeks' gestation at Centenary Hospital for Women and Children during COVID lock down was ceasing and 'normal referral pathways' were to be returned to.

Brief Summary

We would like to begin by acknowledging and commending the ACT government for their recent announcement of free abortion access up to 16 weeks' gestation, including for people without Medicare. We look forward to engagement with the government to assist in determining how this access will function for the community. We hope that there will also be public access to abortion beyond 16 weeks, and for those not suitable to access abortion in the community, within the hospital system.

We believe there are significant access and affordability gaps within the ACT for abortion. There are also various limitations with regards to accessing different forms of contraception.

Pregnant people should be able to access clear, non-directive, non-judgmental information provided in their language in a trauma-informed way. With that information they should then be able to access a clinically appropriate means of abortion of their choice, without being impeded by various barriers, as described within this document. People should also have a choice of provider. No one should have to travel to outside of the ACT, our nation's capital, to access an abortion, at whatever gestation they are, given that we have no legal restrictions in this manner.

Abbreviations:

Explanation for some abbreviations used:

MTOP: Medical Termination Of Pregnancy

STOP: Surgical Termination Of Pregnancy

MSI: Marie Stopes International

GCA: Gynaecology Centres Australia

MS2-step: the combination pack of medical abortion medications, mifepristone and misoprostol

RPOC: Retained Products of Conception

CHWC: Centenary Hospital for Women and Children

FDV: family and domestic violence

WHO: World Health Organisation

KPIs: Key Performance Indicators

Items for comment:

1. The accessibility of abortion and reproductive choice for people in the ACT, including abortion medication, and taking into consideration barriers for:

    a. non-English speakers;

    b. victims of domestic and family violence, including coercive control;

    c. people with a disability;

    d. young people and minors; and

    e. other vulnerable demographics;

Comments:

I am aware of the significant barriers to accessing abortion care within the ACT, and surrounding regions, even for the most health literate. While the providers of surgical abortion (Marie Stopes International, MSI, and Gynaecology Centres Australia, GCA) are easily found on the internet, not everyone seeking abortion wants or can afford a surgical termination. For those who are <9 weeks gestation for whom medical abortion is an option, there is no clear information regarding how to access this outside of MSI, where costs are the same as a surgical termination. For those who can access surgical termination, these are only available locally until 14 weeks gestation (though some can be accessed to 16 weeks at MSI). Beyond this gestation or outside of the service level of MSI & GCA, travel to Sydney is required. The ACT (and with GCA in Queanbeyan) services areas of SNSW and parts of Western NSW with regards to accessing abortion, especially surgical abortion, as there are no private or public providers of surgical abortion in these areas, and even more limited prescribers of medical abortion than within the ACT.

Even for local health professionals there is no information available regarding eligibility criteria for MSI or GCA. There is no information or referral pathway in place for those who require travel to Sydney - this would be accessible to patients calling MSI, but there is no information available for health care professionals who need to support their patients with such access. When Canberra Health Services resumed declining to provide abortion care for what they term “social terminations” after COVID lockdown, they suggested that GPs revert to usual referral pathways, not recognising that this is an area where there are no clear referral pathways or information.

Accessibility is also inhibited by the limited number of medical abortion prescribers in the ACT (I believe there are likely around 13 GPs working in mainstream practice in ACT and the surrounding region). There is a limited timeframe in which a pregnant person can access these services, given that an ultrasound is required for the significant majority to demonstrate an intrauterine pregnancy, and assist in demonstrating appropriate gestation, with the former not possible until around 6 weeks gestation. Blood tests are also required before and after the medication. Accessing these services across locations and days adds more barriers. ACT/SNSW HealthPathways does have a small list of MS2Step prescribers, which is available to healthcare workers, should a patient present to their usual GP.

Finally, there are limitations to accessibility relating to dispensing through pharmacies, including

- There are a limited number of pharmacists who have undertaken training to dispense MS2step.

- While some pharmacies have dispensing pharmacists, they do not necessarily always have a dispensing pharmacist available during opening hours.

- Not all dispensing pharmacies keep MS2step in stock, and those who do generally keep limited quantities, which means that it won't always be accessible when a patient presents with a script, potentially increasing difficulties with access.

- Pharmacists tend not to list that dispensing of MS2step is available from their pharmacy. ACT/SNSW HealthPathways has a list of some pharmacies that dispense MS2Step, though, as just explored, this would not mean that a patient could present in their own time and be able to immediately access the medication.

Ironically, searching for GPs who do advise of provision of medical abortion on their websites has become more difficult following the ACT government's announcement of funded abortion. Most local community facing websites with information on abortion direct patients to MSI or GCA. Due to capacity at these 2 clinics, there are clinically significant delays when appointments can be made. The Junction Youth Health Service, in supporting young people access abortion, have spent long periods waiting on the phone to book an appointment - this is not something that there is flexibility for in mainstream general practice. Recently I have had several patients report to me delays in accessing early medical abortion via these more obvious access points, being offered appointments that would have them beyond the 9-week gestation, which would mean surgical would be their only option. The only other option they have reported being presented to them is teleabortion through the same clinic, and that they are not being advised of alternative options in the community. Patients find my services through their own GP or calling Sexual Health and Family Planning ACT (SHFPACT), who hold a list of GP MS2step prescribers (GPs have notified of SHFPACT of these services for this reason; noting this is not a function SHFPACT receive any funding for). Patients should be able to choose with clear and available information, as clinically appropriate, whether they have a medical or surgical termination, and they should have a choice of provider

For patients who have difficulties with general literacy, health literacy, IT literacy, or are non-English speaking, finding and navigating services may be too much of a barrier to access any abortion services that are currently available. It must also be considered that these options are time limited, and funds may need to be found to pay for services, and travel to Sydney is likely to be a barrier too far to navigate. It is very difficult to find information on abortion in languages other than English. The Victorian 'BetterHealth' website (https://www.betterhealth.vic.gov.au/health/HealthyLiving/abortion-translated) has information translated into several languages, and the GCA website has information about surgical abortion translated into Chinese. There are limited resources available to health professionals or prescribers of termination to provide to patients. Some migrant populations can be conservative with regards to abortion, and with limited access to information and health care services already, if someone cannot seek emotional or financial support from their family and community, or needs to hide accessing abortion from their family and community, it can make their lives more difficult.

People with a disability who rely on support from others to access healthcare will have even greater barriers to accessing timely appointments, which is likely to reduce their chance of accessing MTOP (should it be their choice), and they may not be appropriate for a STOP at local private clinics. It also means they may need to disclose to more people than they would want to in order to access services as quickly as they require.

Evidence suggests that people who discover later pregnancies tend to be younger, have more chaotic lives, and be more vulnerable, including in situations of FDV, including reproductive coercion. These are also factors that impede accessibility to services, especially if it requires travel. Please see a quote in this section for evidence of reasons for later abortions. These are people who deserve the same rights to access abortion than those who are able to discover their pregnancies earlier and should not be forced to travel to Sydney and pay thousands of dollars to access the abortion of their choice.

In my extensive experience as a doctor in general practice, the reasons that pregnant people seek abortion generally come down to feeling they do not have the material, and/or physical, and/or emotional resources to complete a pregnancy, go through labour, and have another child in their household. A US study of around ten thousand pregnant people who sought an abortion, whether or not they were able to access it, (The TurnAway Study, https://www.ansirh.org/research/ongoing/turnaway-study) found that the concerns people had about pregnancy, labour or having a child (reasons they sought an abortion) were borne out for those who were not able to access abortion and completed their pregnancy. We need to trust our community that they are the expert in their lives, and if they feel that this is not something that they are prepared for / ready for / have capacity for, we should respect that and assist them in managing their lives by providing abortion.

We need to consider the implications of a denied abortion - including the morbidity and mortality associated with pregnancy and childbirth. There are people who will remain with an abusive partner if they are pregnant and abortion is not an option due to fears such as where they will live and how they will financially support themselves if they leave. For those who do leave an abusive partner they are never able to fully remove themselves from that connection once a child is shared and many abusive partners use the connection through children to continue their abuse. There are higher risks of living in poverty for the pregnant person and their children, and they will have more struggles regarding housing, and access to food and transport. There are implications for any existing or subsequent children in terms of their development, and barriers they also face regarding poverty. When considering the alternatives to improving access to abortion I strongly suggest reading the evidence that has come out of "The Turnaway Study" from the US, by Dr Diana Greene Foster and associates in "The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having - or Being Denied - an Abortion", Diana Greene Foster, PhD, (2020), New York (https://www.goodreads.com/book/show/49680209-the-turnaway-study), or their publications and information on their website https://www.ansirh.org/research/ongoing/turnaway-study.

> From Greene Foster (2020):
> "…five profiles that describe 80% of the women having abortions at of after 20 weeks: women raising children alone; women who are depressed or using illicit substances; women who have conflict with a male partner; women who have trouble deciding what to do with their pregnancies followed by difficulty accessing care; and finally, teenagers who had never had a child."
> "The more time you need to raise money, find a provider, or find a way to get to a clinic, the more likely it is that you will be denied care."
> "In some tiny percentage of cases, this deadline for abortion (20/40, 15/40, 12/40) may speed up women's decision-making. However, our findings suggest that several of the reasons women delay seeking abortion (eg, late discovery of pregnancy, conflict with the man involved) cannot be reduced by shortening the window for abortion care."
> "The quiet truth about abortion between 20 and 24 weeks is that it is often a problem of late recognition of pregnancy followed by real obstacles - financial, travel-related, and

> legal - to getting an abortion. Making abortion more difficult to access does not mean that only the morally deserving get their abortions. It means that only adult women who don't have any physical or mental health issues and have money and social support get their abortions."

The above study also demonstrated that people who have an unintended, unwanted pregnancy who smoke, use drugs, or misuse alcohol and are denied an abortion do not have a reduction in use of these substances through the pregnancy. This has an impact on the health of the child from that pregnancy, as well as on child & family services being involved with the family.

Victoria and Queensland each have state funded phone lines (1800 options and children by choice) where pregnant people can call to have counselling and be assisted to find local options for abortion, or whatever their preference is in relation to their unintended, and potentially unwanted, pregnancy. It would be of benefit in the ACT to have a phone line that was government funded to provide the information on all options and service providers to assist patients access the most appropriate services for their preferences. Such a phone line should be funded to use the Translating and Interpreting Service, if needed, for non-English speakers, as well as for Auslan.

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2. The affordability of abortion and reproductive choice in the ACT, including:

    a. access to bulk billing general practitioners;

    b. indirect costs such as transport, leave from work, childcare; and

    c. options for low-income patients.

Comments:

We believe there are around 13 GPs within ACT and the surrounding area that are prescribers of MS2step. This is part of the access difficulty, but a person also needs to physically access the medication via a pharmacy, and attend for blood tests and imaging, which all impact on affordability. Affordability is not just the cost of the services, but costs associated with travel and potentially time off work, or extra childcare to meet some, or all, of these requirements.

Bulk-billing is not a feasible business plan for general practice, and the ACT government cannot expect GPs to be paid less for certain consultations, including providing abortion care which requires at least 3 consultations (though the 1st may be with the patients usual GP). Having said this, in *certain cases* there may be a number of prescribing GPs who will consent to providing this service without an out-of-pocket expense (this would lead to a loss of income for the GP and practice of >$100). However, when complications occur then more medical appointments may be required, and there can be additional work in terms of obtaining time sensitive investigations and results. As we are all aware, the Medicare rebates do not incentivise long appointments. It should not be expected that those GPs willing to provide services, which do not have adequate patient rebates, accept not being adequately financially compensated for their time and care. This also includes Medicare rebates for services such as insertion of long-acting reversible contraception (implanons and IUDs).

The ACT has a population of people without access to Medicare, including asylum seekers, people who have come to Australia on spousal visas, and people on temporary visas. International students may be able to access consultations using their health care insurance, but may not be able to access abortion services. We commend the recent announcement for funding including those without Medicare, and hope that this will extend to all abortion related care, including when provided in the hospital system.

Consultations are required to establish pregnancy (organising blood test for B-hCG level within a few days of taking the mifepristone, and ultrasound to ascertain the pregnancy as being intrauterine), and discussion of options (eg MTOP, STOP, keeping baby, fostering, adoption); a medical consultation will be required to review clinical information and consent for MTOP (if that is the choice); then a B-hCG is required to be repeated 1-2 weeks following the mifepristone, with a subsequent consultation to review how the patient is, review the B-hCG and ensure no signs/suspicions of infection, retained products, or ongoing pregnancy. Should there be issues with infection, RPOC, ongoing pregnancy, or haemorrhage, a patient will need an extra review, possible medication, possible imaging, blood tests, possible need for STOP/D&C. Most of this would be undertaken with the prescribing GP, and could incur more costs for the patient. There are also costs associated with organising ongoing contraception.

When a pregnant patient undergoes a medical termination of pregnancy, they are generally unwell on the day they take the misoprostol; side effects include nausea, vomiting, cramping, bleeding, diarrhoea, fever, fatigue/lethargy, and malaise. These generally subside within 24hrs. Patients require an adult to be with them when undergoing this due to the risk of haemorrhage and possibly needing urgent medical assistance. I generally advise patients to expect to have 1 day where they are unable to care for their children, go to work, etc; and a second day where they remain limited in their capacity. There are cost implications to this.

If someone does not have access to Medicare, the costs can be prohibitive, given that the MS2-step is $353.84 without PBS as opposed to $42.50 as a general patient fee on the PBS (Pharmaceutical Benefits Scheme (PBS) |). For non-Medicare patients, a STOP is generally the most affordable option given that for an MTOP, on top of the MS2-step, most patients also require scripts for anti-emetics and possibly analgesia, as well as to pay for at least 2 B-hCGs and 1 ultrasound; whereas going through GCA or MSI for a STOP encompasses the whole management, and can include free contraception insertion at the same time.

- Indirect costs of MTOP through general practice
    - Potential travel for medical consultations (there is an item number so that these consultations are possible via telehealth/telephone, however due to needing to ensure the patient has a clear understanding of the process, it can be helpful to the clinician to meet the patient face to face)
    - Travel/time for blood tests and ultrasound
    - Travel to access medication (it may not be available at a nearby pharmacy, or a patient may need to wait for it to become available or for a certain pharmacist to be working, as pharmacists require training to be able to dispense)
    - Childcare requirements during consultations, investigations, and also for at least 24hrs of undergoing MTOP; potentially more if complications
    - Medication – MS2step, antiemetic, analgesia
    - Menstrual products for heavy bleeding
    - Time off work for various appointments, and to line up with childcare and availability of support person

The financial and other associated costs involved in all aspects of accessing abortion are exponentially more when a person discovers their pregnancy at a later gestation, or is trying to save money to access care and inadvertently goes beyond gestation for local access. As mentioned at point 1, this typically affects those who are more likely to have difficulty with access (younger, more chaotic lives, and more vulnerable including in situations of FDV including reproductive coercion). Funding of abortion service provision cannot end at a specific gestation. The hospital services need to be able to provide abortion care at gestations beyond which it can safely be provided within community health services, or we still end up with inequity.

There are no specific options for low-income patients. MSI have a small amount of funding to support a small number of financially vulnerable patients at times. Women's Health Service does provide MTOP to a small number of vulnerable/disadvantaged patients, however there is limited access to appointments with their GP staff specialists (0.3FTE), and so this is not a substantive option.

It is important to note that those with greatest financial difficulty in accessing an abortion will also feel the greater impact of not having the abortion, with increased risk of unemployment and living in poverty.

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3. Legal protections for abortion rights in the ACT; including:

    a. comparison with other Australian jurisdictions;

    b. interactions with non-ACT legislative instruments (e.g.: with Commonwealth law);

    c. potential implications for IVF providers; and

    d. effectiveness of exclusion zones around abortion facilities.

Comments:

Our understanding is that legally we, in the ACT, do have the best standing in Australia for abortion rights. Unfortunately, the benefit of having no gestational limit via law is limited when there is simply no provision of care beyond a certain gestation.

There is no constitutional right for accessing human rights within Australia, which is how the WHO recognise abortion care. The is a risk that Federal law changes could impact rights within the ACT, as has happened previously when the Health Minister restricted access to mifepristone.

We are not aware of current implications for IVF providers with regards to abortion rights. However, if there were legislative changes regarding a gestation from which an embryo is treated as a human life, then it would potentially impact how embryos are managed when not required by the parents.

Whilst exclusion zones around abortion facilities do seem effective, it doesn't assist concern regarding personal attack for those who provide the clinical care.

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4. Access to information to support a variety of possible reproductive choices, including choosing to give birth.

Comments:

Pregnant patients are the ones with the best information on their situation to determine whether they have capacity to go through a pregnancy (noting that pregnancy has morbidity and mortality associated with it, and abortion has much less morbidity and essentially no mortality).

There are risks associated with people not being able to access abortion when they seek one, specifically relating to living in poverty and impacts on development of children they already have as well as the child of the unwanted pregnancy.

Most pregnant patients, even when denied an abortion, will not choose to foster or adopt their child. There are many complex factors that go into being able to go through a pregnancy and birth a child (with social expectations of being excited about being pregnant, and subsequently *raising* a child), as well as the poor system of fostering and adoption within Australia that would raise concerns about risks of child abuse and not being able to try to protect the child

If a pregnant person has decided they do not want to, or simply cannot, continue their pregnancy, the only information they require is the options of surgical and medical abortion (depending on gestation), and how to access whichever is their choice.

The ACT requires a sexual and reproductive health strategy that includes accessible, safe, and free abortions. KPIs should be created, which will require data collection, as this is a key way to improve information and demonstrate that access to services leads to a reduced need for abortion.

Training for health professionals around abortion care needs to improve - including medical students, GP registrars and O&G registrars.
Clinicians training in O&G at CHWC should be routinely trained in abortion care. If there are staffing issues with providing abortion care in CHWC, then this is an HR / recruitment issue that needs to be addressed.

Education aimed at school students to improve their understanding of contraception and abortion should also be provided to improve sexual and reproductive health.

Access to all services related to an unintended and/or unwanted pregnancy should be facilitated by a “one stop shop”. Not that all services are delivered under the one roof, but that one service, like the 1800 OPTIONS line in Victoria and Children by Choice in QLD, has the information available to provide and discuss options with pregnant patients. A helpline should be able to provide counselling, and relevant information, as required/requested, on pregnancy and birth, adopting, fostering, and access to abortion and facilitate referral to these services. These services need to be patient-centred, non-directive, have access to interpreting services and be trauma-informed.

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5. Any other related matters.

Comments:

People who find themselves with an unwanted pregnancy do not need to be blamed, punished, victimised or politicised. They need access to health care services.

In any community/political discussion regarding abortion, the pregnant patient needs to be at the centre of the discussion. If they have determined that they are not able/wanting to go through a pregnancy, they need to be supported in this decision. There is evidence to support that this is what is best for the pregnant person as well as any current or future children in the Turnaway Study. The harms of being denied an abortion need to be considered whenever any limitations on access to abortion are raised.

Reducing the need for abortion care requires improved contraception access and care, improved access to healthcare services with higher patient rebates, improved parental leave and pay, improved government supports for low-income families, single parents, and children with special needs and improved reproductive autonomy (which includes tackling intimate partner violence and reproductive coercion). It is important to note that not all people have a contraceptive option that works for them for a variety of reasons (contraindications, side effects, acceptability, etc), and all contraception has failure rates.

The ACT should aim to collect data on abortion, as there is paucity of this nationwide, only SA and WA collect data.

MSI in ACT currently relies on the services of 1 GP obstetrician providing abortion services. This is not feasible long term, and I believe that the majority of ACT residents would find it absurd that to service such a large region there are so few providers of care. Currently patients are reporting appointment time delays of over 4 weeks, which would mean they would not be able to access a preferred medical termination of pregnancy.

Appendix information regarding abortion:

1. A medical abortion using MS2step:

- Only available until 9 weeks gestation; noting that a person isn't pregnant for the 1st 2 weeks of this time, and if a patient has regular periods they may recognise an unplanned pregnancy at the earliest just after 4 weeks gestation.

- A GP must have undertaken online training to prescribe

- The GP must have an appointment available within an appropriate time frame

- A pharmacist must have undertaken online training to dispense

- A pharmacy must have stock on hand + a dispensing pharmacist available to provide the medication to a patient

- There are no accessible lists for the public to know who provides medical abortion in general practice; there are lists held by SHFPACT and within HealthPathways (the latter for health professionals only, but not everyone uses the site), and costs are not available for comparison with MSI.

- Few GPs advertise their provision of medical abortion medication due to fears of repercussions and stigma from community, patients, and/or colleagues

- Patients must also access blood tests and ultrasound prior to a GP being able to provide a prescription, and access to all of this is required within 5 weeks

2. A surgical abortion

- Available in ACT only via MSI

- Available in surrounding NSW only via GCA in Queanbeyan (no other services in SNSW or Murrumbidgee)

- Only available until 14 weeks (for some patients possibly 16 weeks) gestation at these local services

- There are medical/surgical/anaesthetic reasons for which a person within the gestational limit may not be an appropriate candidate for a surgical termination at the local sites

- If a surgical abortion is not possible for gestational or other reasons at MSI or GCA, the pregnant patient must travel to Sydney to access abortion

3. 2nd trimester abortion

- There is no access to public or private 2nd trimester abortion in the ACT or surrounding region, unless there is a physical health reason for the pregnant patient or fetus

- To undertake the abortion in Sydney, the pregnant person requires time + money + transport + support + possibly childcare to travel to and from Sydney, pay the expense of the abortion (potentially over $7,000), potentially require an overnight stay, and someone (a support person) staying with them, in Sydney

- There are no clear guidelines available that would make clear to a GP or community member whether they can access a termination locally or would need to travel

- During COVID lockdown CHWC provided abortions more broadly so that patients wouldn't need to travel for these, however this access was removed as soon as travel was safer again. This access was not notified to local GPs or the community more broadly

4. Process of medical abortion via General Practice

- Confirm intrauterine pregnancy of appropriate gestation (blood test + ultrasound) - this will require a GP appointment to organize referral forms, this can be with any GP

    - Ultrasound has had delays of up to 3 weeks in recent times

- Consultation for prescription of medication after appropriate eligibility demonstrated with aforementioned tests, this needs to be with a prescribing GP

- Take 1st medication (mifepristone), generally recommended 6pm on day 0

- Take 2nd medication (misoprostol), generally recommended 6am on day 2

- On average around 4 hours after taking the misoprostol the abortion itself occurs with heavy bleeding and painful cramping. These symptoms do improve over this day. The expected side effects, apart from cramping and bleeding, include nausea, vomiting, diarrhoea, fever, and malaise. On this day 2 of the process the person undergoing the abortion is expected to be limited in what they do, and requires a support person (adult) who is able to assist caring for them, and to assist seeking medical attention if there is an urgent need, for example bleeding concerning for haemorrhage. Day 3 there may still be some heavy bleeding and cramping restricting activity, eg unlikely to be able to work still

- Due to a variety of hormonal factors and potentially grief as well, this is also an emotional time.

- Around day 7 a repeat blood test is required to determine appropriate decreasing pregnancy hormone level

- Around 2 weeks post abortion (can occur after 7 days) a GP consultation is required to review the patient and the final blood test

- Further medical assessments are required if there are concerns regarding level of bleeding, pain, or signs/symptoms of infection

- Obviously during this process contraception is discussed, and preferably organised and started

Additional resources:

https://insightplus.mja.com.au/2022/29/embedding-womens-reproductive-rights-into-primary-care/#comment-466767

https://www.mja.com.au/journal/2022/216/9/access-abortion-services-australia-we-must-do-better