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Australian Institute of
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AIHW

# Appendix G

## Termination of pregnancy: topic overview and data strategy

Caution: Some people may find parts of this content confronting or distressing, including content relating to pregnancy loss and termination of pregnancy. Please carefully consider your needs when reading the following information.

# G.1 Topic overview

**The following topic overview is a summary of the key data gaps based on findings from literature reviews, data scoping and stakeholder consultation activities. Section G.2 identifies existing data sources and options for new data collection.**

Achieving equitable access to termination of pregnancy (TOP) (also called 'abortion') is central to the realisation of universal access to reproductive health, autonomy and rights. "Lack of access to safe, affordable, timely and respectful abortion care, and the stigma associated with abortion, pose risks to women's physical and mental well-being throughout the life-course" (WHO 2024a).

There is a lack of regularly collated and reported data regarding TOP utilisation, accessibility and quality in Australia (Community Affairs References Committee 2023). More comprehensive and nuanced data collection would "enable evidence-based policy, which is essential to end inequities in abortion care access" in Australia (Fair Agenda in Community Affairs References Committee 2023). The Senate Inquiry into reproductive health and AIHW consultations have indicated that the lack of comprehensive national TOP data is both fuelled by, and exacerbates, abortion stigma and exceptionalism.

## Background

Termination of pregnancy involves intentionally ending a pregnancy by removal or expulsion of the embryo or foetus and placenta from the uterus. It routinely involves taking medications (medication termination of pregnancy or MTOP, referred to as early medication abortion (EMA) prior to 9 weeks gestation and a 'medical induction' after 9 weeks) or undergoing a procedure (surgical termination of pregnancy or STOP). 'TOP care' herein refers to facilitating access to and/or provision of MS-2 Step or STOP and related care, including provision of information, counselling or decision-making support, practical and psychosocial supports, screening for violence and coercion, necessary tests, referrals, and post-abortion care and follow-up.

In 2017-18 there were an estimated 88,287 TOPs (17.3 per 1000 women aged 15-44 years) in Australia (Keogh at al. 2021). The proportion of TOP undertaken using MTOP is increasing. In South Australia, 61% of abortions were undertaken using MTOP in 2023, compared with 43% between 2016 and 2020 (Slade et al. 2024; South Australian Abortion Reporting Committee SA 2024). In the same year in South Australia, around 90% of TOP were undertaken before 14 weeks gestation (South Australian Abortion Reporting Committee 2024).

Termination of pregnancy has been decriminalised in all Australian jurisdictions, yet differing gestational limits and restrictions, inequitable geographical distribution of care, out-of-pocket costs, religiosity, conscientious objection, and the separation of TOP from mainstream health and education systems mean quality TOP care is not universally accessible (Community Affairs References Committee 2023; Vallury et al. 2023). Being denied a wanted TOP is associated with poorer mental and physical health, financial and child development outcomes (ANSIRH 2022).

Research has found that, in Australia, people are more likely to report experiencing TOP if they are using less effective contraceptive methods, engage in risky alcohol or drug use, experience partner violence, were born in Oceania, North-East Asia or Australia (compared to other regions), aspire to employment or further education, are unpartnered, and aged between 20 and 24 years of age (Edvardsson et al. 2024; South Australian Abortion Reporting Committee 2024; Taft et al. 2019).

## Priority populations

Research and consultations identified a range of accessibility issues faced by different communities in accessing quality TOP care in Australia.

Presenting for TOP-related care or pregnancy decision making support at relatively higher gestational ages is symptomatic of experiencing barriers to healthcare access and reduces patient choice of methods, increasing costs and complication rates. Population groups more likely to experience TOP at higher gestational ages include teenagers and people living in rural or remote areas, living in the most socioeconomically disadvantaged areas, who have difficulty paying for an abortion, who are unaware of MTOP, and First Nations people (Shankar et al. 2017; Slade et al. 2024).

Understanding experiences of different groups within the population is necessary to inform policy and ensure equitable healthcare access and outcomes in Australia. Recognising the intersectionality among different population groups is also important to understand the complexity of these experiences. The following priority populations have been identified through the stakeholder consultation process and literature review, but this is not intended to be an exhaustive list. A full list of priority populations considered within the framework and data strategy is available in the Sexual and Reproductive Health Monitoring Framework and Data Strategy document, Section 2.3.

### First Nations people

The accessibility of culturally safe TOP care for First Nations people is impacted by a lack and inequitable distribution of safe and affordable TOP services, limited integration between community controlled and mainstream health services and challenges navigating access pathways, and concerns about the safety (confidentiality) of local services (AHMRC 2023; AIHW Stakeholder Consultations 2025). Histories of forced TOP and poor healthcare experiences have eroded many First Nations peoples' trust in healthcare systems, leading to healthcare avoidance and delays (AHMRC 2023; Coombe et al. 2020). For First Nations people living in rural and remote areas, barriers to access are compounded.

## People living in regional, rural and remote areas

People living in rural, regional and remote and/or socioeconomically disadvantaged areas have the poorest access to TOP care, relative to people living in urban and socio-economically advantaged areas, with lack of providers a significant barrier (Family Planning Australia 2024; Sarder et al. 2024; South Australian Abortion Reporting Committee 2023). Scarce abortion services create an overreliance on individual providers, community champions and informal networks, with implications for service continuity, reliability and sustainability (Noonan et al. 2024). Rates of medication abortion have increased substantially more in rural than in urban settings: while access to MTOP is critical, limited access to STOP undermines patient agency and choice (Edvardsson et al. 2025). Concerns about confidentiality, stigma, professional obstruction (including conscientious objection), and opportunities for provider training disproportionately impact abortion seekers in rural and remote areas, driving delays in access to care, increased costs (direct and indirect) and travel times, and impacting patient outcomes (Noonan et al. 2024; Vallury et al. 2023).

## People who are culturally and linguistically diverse, including recent migrants

Language barriers, health literacy (including a lack of familiarity with the Australian healthcare system), affordability (including health insurance restrictions), cultural norms, and reproductive coercion and abuse are critical determinants of TOP accessibility for pregnant people from some migrant and refugee communities (Kanan 2025; Singh et al. 2023; Subasinghe & Deb 2024). Among Australian GPs, a lack of training, resources and access to interpreters are cited as barriers to achieving cultural competency and effective communication with people from multicultural backgrounds in relation to the provision of TOP (Singh et al. 2023). Pregnant people who do not hold a Medicare card, including many international students and temporary workers, face compounded barriers to accessing TOP, with affordability a significant concern (Community Affairs References Committee 2023; Vallury et al. 2023).

## Young people

In Australia, adolescents have been found to be more likely to present for TOP care at higher gestations, indicating barriers to accessing abortion care (Shankar et al. 2017; Slade et al. 2024). AIHW consultations revealed that affordability and distance to services can particularly impact young people who rely on others to access both money and transport and can increase vulnerability to reproductive coercion and abuse (AIHW Stakeholder Consultations 2025). Young people in Australia have also been found to be most likely to experience anticipated abortion stigma, which has been linked with healthcare avoidance, delays, social isolation and mental health concerns (Vallury et al. 2023).

# Critical data gaps and priority areas for data development

Through the literature review and consultation process, the AIHW identified 4 overarching data gaps relating to access to Termination of Pregnancy in Australia, along with a series of priority areas for data collection and development to begin to address these.

Table G.1 Critical data gaps and priority areas for data development

| Critical Data Gaps | Priority Areas for Data Development |
|---|---|
| Comprehensive, nuanced national statistical data on TOP numbers, disaggregated[1] by method, gestation, and patient and provider demographic and geographical characteristics. | Link, collate, analyse and publish TOP data from existing datasets (hospital, MBS and PBS, ABS, jurisdictional TOP notifications) in a timely way to:<br>• Facilitate routine publishing of TOP numbers/rates, types, gestation, and patient and provider characteristics (likely limited to public and Medicare patients).<br>• Describe and monitor geographical accessibility of TOP care and methods choice.<br>• Establish national data standards, including agreed definitions, for use across primary and tertiary, public and private settings to facilitate routine, consistent data collection and reporting.<br>• Collect data that allow counts of procedures for TOP to be distinct from those for pregnancy loss management.(a) |

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[1] Age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socioeconomic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.)

| Critical Data Gaps | Priority Areas for Data Development |
|---|---|
| TOP accessibility across (priority) population groups, including access to choice of methods and the distribution of TOP services and providers (all types). | • Research barriers to and experiences of TOP care among diverse population groups, including for people more likely to present for care at (relatively) higher gestations and groups who are currently not (sufficiently) represented in TOP data.<br>• Develop methods to monitor access to/realisation of TOP methods choice, and determinants of access to/ realisation of method choice, across population groups.<br>• Identify and monitor the rates and costs associated with accessing TOP care without MBS or PBS-subsidies, and the geographical distribution, demographic characteristics and experiences of people accessing non-subsidised care.<br>• Develop a system for recording self-managed and unsafe abortion (attempts), which is critical to understanding barriers to TOP access and service gaps. |
| Routine measurement and monitoring of patient experiences, quality-of-care and complication rates. | Establish mechanisms for monitoring patient experiences and quality of TOP care, including:<br>• stigma,<br>• obstruction and conscientious objection, and<br>• complication rates,<br>• with the lowest possible geographical disaggregation, across provider types. |
| An understanding of provider capability, capacity, and wellbeing/support. | • Establish a mechanism for monitoring workforce capability and capacity, including timely identification and reporting of skills and service gaps.<br>• Identify organisational/service and systems level factors influencing provider capability, capacity and wellbeing. |

NOTE: Where "disaggregation" is used, this is referring to disaggregation by geographic and demographic characteristics, including regarding all priority populations listed in the monitoring framework.

a) Stakeholder consultations identified the separation of MBS item numbers for pregnancy loss and TOP procedures as a priority for data development. As the MBS is not designed to provide explicit data on reasons or causes for procedures, expanding the level of detail for pregnancy loss and TOP procedures would be at odds with the purpose of the MBS. The AIHW will explore alternate methods of collecting distinct counts of pregnancy loss and TOP procedures.

# G.2 Data strategy for termination of pregnancy

The context and scope of each section of this table is described in Appendix J.

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Routinely link, collate, analyse,and publish disaggregated TOP data from existing (and emerging) datasets in a timely way. | Number (total population, per person), rate.<br>TOP method/type.<br>Gestation.<br>Location (patient, providers, pharmacy).<br>Demographic characteristics (patient, provider).<br>Other services accessed (ie. Pregnancy options counselling).<br>Unmet need. | Collation of health records and jurisdictional (incl. mandatory notification) datasets<br>Data linkage<br>Medicare records<br>Pharmacy/ prescription data | MBS<br>PBS<br>NHMD<br>NPMDC<br>Jurisdiction notification systems<br>SRH service provider data | Partially available - refer to Appendix J | Explore data linkage opportunities (National Health Data Hub).<br>Explore data collected by State and territory and private SRH services.<br>Explore feasibility of developing and collating jurisdictional TOP notification datasets.<br>Establish data standards for consistent data collection and collate existing notification data. | **Services data:** Explore feasibility of collating/ establishing a data collection with private services and outpatient data, including for non-subsidised patients and services where MBS/PBS rebates are not accessed (e.g. under the ACT public funding model). | 2.2; 2.3<br>4.3<br>6.1; 6.3<br>O7 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Describe and monitor geographical accessibility of TOP care, disaggregated. | Location of services (all types, including wraparound care like ultrasound and counselling) and providers (all types).<br>Wait times, out of pocket costs, distance (patient to providers), travel times and travel costs (disaggregated by patient, service & provider characteristics & location).<br>Unmet need. | Provider mapping<br>Health records<br>National surveys<br>Pharmacy/ prescription data | MBS<br>PBS<br>NHMD | Partially available - refer to Appendix J | Explore additional analysis of national administrative data collections.<br>Explore feasibility of developing and collating jurisdictional TOP notification datasets. | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection (medical termination of pregnancy (MTOP) only).<br>**Services collection:** Explore feasibility of establishing a data collection with private services and outpatient data, including for non-subsidised patients and services where MBS/PBS rebates are not accessed (ie. Under the ACT & WA public funding models).<br>**Other suggestions:**<br>• Explore potential use of jurisdictional contraception provider maps (Vic, Qld) data.<br>• Explore feasibility of developing geo-mapped database of healthcare providers and data on service availability and accessibility. | 4.1; 4.2; 4.3<br>6.1; 6.2; 6.3<br>O7; O10 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Establish national data standards, including agreed definitions, for use across settings to facilitate consistent data collection and reporting. | Data consistency, accuracy, comparability. | Develop data standards and definitions | n.a. | n.a. – data currently inconsistent | Establish data standards for consistent data collection. | Establish or work within an existing national working group. | 13.3 |
| Research on barriers to and experiences of TOP care among diverse population groups, including for people more likely to present for care at relatively higher gestations and groups not currently represented in TOP data. | Barriers to TOP care unique to and shared across population groups.<br>Cultural safety.<br>Unmet need, including among priority populations.<br>See quality of care measures below. | Health records<br>Primary research<br>Jurisdictional TOP notification data<br>National surveys | MBS<br>PBS<br>PLIDA<br>NHMD<br>NPMDC | Limited / fragmented - refer to Appendix J | Explore additional analysis of National administrative data collections.<br>Expand/add questions to national surveys/ longitudinal studies.<br>Explore data linkage opportunities (National Health Data Hub). | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Other suggestions:**<br>• Research into the experiences of population groups currently underrepresented in data collections.<br>• Qualitative research studies to understand barriers and cultural safety. | 1.1; 1.2<br>3.1<br>5.1; 5.2<br>7.1; 7.3<br>8.2<br>9.1; 9.3; 9.4; 9.5; 9.6 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Develop mechanisms to monitor access to/realisation of preferred TOP method choice, and determinants of access to/realisation of method choice, across population groups. | Accessed preferred TOP type/method.<br>Access to/offered for example choice of provider (type), service (type), model of care, location, analgesia. | National surveys<br>Patient surveys<br>Jurisdictional TOP notification data | Jurisdiction notification systems<br>SRH service provider data | No data currently exists | Explore data collected by State and territory SRH services data.<br>Establish data standards for consistent data collection. | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Other suggestions:**<br>• Explore feasibility of standardising and collating jurisdictional TOP notification data.<br>• Explore potential for PREMs in data collection.<br>• Establish data standards for consistent data collection. | 3.1<br>7.3<br>9.3; 9.4; 9.5<br>O5; O15 |
| Identify and monitor rates and costs associated with accessing TOP care without MBS or PBS subsidies.<br>Geographical distribution, demographic characteristics and experiences of people accessing non-subsidised care. | Number of MTOP and STOP performed outside of MBS and PBS systems.<br>Out of pocket costs.<br>Characteristics of those accessing TOP via private/non-subsidised care.<br>Impact of access to subsidised care on decision making, pregnancy outcomes, and quality of care. | Health records<br>Pharmacy data<br>National surveys<br>Primary research studies | Admitted patient data<br>Health expenditure database (to be confirmed) | Very limited / fragmented - refer to Appendix J | Explore data collected by State and territory and private SRH services.<br>Establish data standards for consistent data collection and collate existing notification data. | **Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection.<br>**Services data:** Explore feasibility of establishing a data collection with private services and outpatient data, including for non-subsidised patients and private services where MBS/PBS rebates are not accessed (ie. Under the ACT & WA public funding models). | 6.1<br>4.1; 4.3<br>8.1<br>O5 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Develop a system for recording self-managed and unsafe TOP (attempts). | Number (total population, per person).<br>Type. Gestation. Location (patient, providers, pharmacy).<br>Demographic characteristics (patient, provider). | National register<br>National surveys<br>Primary research studies<br>Patient experience surveys | No data currently exists | No data currently exists | n.a. | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Other suggestions:**<br>• Primary research studies, including regarding experiences of health professionals working with populations more likely to attempt self-induction.<br>• Explore the feasibility of developing an online portal/register for anonymous reporting by clinicians/services. | 2.2; 2.3<br>O5; O6; O7; O12; O13 |
| Establish mechanisms for monitoring patient experiences and quality of TOP care, including:<br>• stigma,<br>• obstruction and conscientious objection, and<br>• complication rates,<br>with the lowest possible geographical disaggregation, across provider types. | Quality of care: alignment with clinical guidelines.<br>PREMs.<br>Timeliness and delays.<br>Safety (including cultural safety) and inclusivity.<br>Complaints processes and outcomes. | Clinical audits<br>Workforce surveys<br>Patient experience surveys<br>Health records (hospital wait times, primary care, private & outpatient)<br>National surveys<br>Complaints data | NHMD (wait times only)<br>NHDH (time from pregnancy test to TOP) | Very limited / fragmented - refer to Appendix J | n.a. | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Workforce survey:** Explore the value of a national audit of healthcare providers or workforce survey.<br>**Other suggestions:**<br>• Primary research studies to understand cultural safety, inclusiveness, and complaints experiences.<br>• Explore potential for PREMs in data collection.<br>• Explore the feasibility of collating and monitoring complaints processes, characteristics, and outcomes. | 4.2<br>5.1; 5.2<br>8.1; 8.2; 8.4<br>9.1; 9.4<br>17.1<br>O13; O14; O15 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| | Stigma: experiences and impacts in healthcare (individuals, providers). | Workforce surveys<br>Clinical audits<br>Primary research | No data currently exists | No data currently exists | n.a. | **National survey:** Develop an ongoing nationally representative SRH survey.<br>**Other suggestions**:<br>- Potential value in conducting primary research into stigmatising interactions with health care providers (by provider and service type, location, patient and provider characteristics). | 9.6<br>11.2; 11.3<br>15.1; 15.2; 15.3 |
| | Conscientious objection: Number, location, patient and provider characteristics, requirements met (referrals made), impact (delays, outcomes). | National register<br>Patient experience surveys<br>Complaints data<br>Pregnancy Options Counselling service data | No data currently exists | No data currently exists | n.a. | Explore the feasibility of developing a register of patient interactions with unsupportive health professionals, with consideration to the outcomes of current Victorian pilot. | 4.2; 4.3<br>5.1; 5.2<br>6.1; 6.2; 6.3<br>11.2; 11.3<br>17.2<br>O5; O16 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| | Complications & adverse events: numbers, types, patient, service & provider characteristics. | Health records | Admitted patient data only (NHMD) | Very limited / fragmented - refer to Appendix J | Explore data linkage opportunities. | **Services data:** Explore feasibility of establishing a data collection with private services and outpatient data, including for non-subsidised patients and private services where MBS/PBS rebates are not accessed (ie. Under the ACT & WA public funding models). | O12 |
| Establish a mechanism for monitoring workforce capability and capacity, including timely identification and reporting of skills and service gaps | Service, provider and skills distribution.<br>Training availability, type, uptake and participant characteristics.<br>Unmet training needs.<br>Proportion of providers (all relevant types) working to full scope.<br>Existence of institutional models for assessing and monitoring staffing needs to ensure quality care.<br>Providers not offering TOP, reasons.<br>Provider confidence in offering quality TOP care.<br>Supportive professional environments. | Training and skills audit<br>Training provider data<br>Workforce survey | No data currently exists | No data currently exists | n.a. | **Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey.<br>**Other suggestions**:<br>• Explore potential value of collating data from training providers. | 10.1; 10.2; 10.3; 10.4<br>11.1; 11.2; 11.3<br>O11 |

| Priority area for development | What to monitor (areas of measurement) [(a)] | How to measure it [(b)] | Potential data sources [(c)] | Current status [(d)] | Options for development of existing data sources | Options for new data collections: establish a new collection or standardise and collate existing data | MF domains, subdomains and outcomes |
|---|---|---|---|---|---|---|---|
| Identify organisational/ service and systems level factors influencing provider capability, capacity and wellbeing. | Service-level workforce policies and practices.<br>Existence of clear TOP care cascades/care pathways at service level.<br>Access to/utilisation of professional networks and communities of practice.<br>Staff report feeling supported to provide TOP care/access TOP-related training by management<br>Provider-provider stigma and professional isolation.<br>Community/service level opposition to TOP provision. | Workforce surveys<br>Clinical audits<br>Workplace policies | No data currently exists | No data currently exists | n.a. | **Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. | 7.1; 7.2<br>10.2; 10.3; 10.4<br>11.1; 11.2; 11.3<br>15.1<br>17.1 |

Note: The focus of this work is on addressing gaps in information and data and to not duplicate work currently being undertaken or in development.

(a) The aim is to report priority populations for all areas of measurement where possible. This includes age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socio-economic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.).

(b) In the absence of comprehensive prevalence/primary data, multiple supplementary data sources may need to be used.

(c) Only nationally representative data collections with established time-series data are included in this table (see section 4.1. Data sources assessment criteria for more information). Other data sources out-of-scope for this table, that may be considered for future research include: Jurisdictional TOP notification data, ACT Women's Health Survey, Victorian Women's Health Survey. 45 and Up survey, PATH Survey, Australian Women's Midlife Years survey.

(d) 'Very limited/fragmented data' indicates that only one or two data points/questions are available in the current source; whereas 'Partially available' means that it includes data that could partially answer some of the priority areas for development but still requires significant development/expansion. Refer to Appendix J for a summary of existing national data sources that capture some SRH data across the initial priority areas.

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