CSIRO PUBLISHING

RESEARCH PAPER
https://doi.org/10.1071/SH22059

SEXUAL HEALTH

Termination of pregnancy in Queensland post-decriminalisation: a content analysis of client records from an all-options pregnancy counselling organisation

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Handling Editor:
Marian Pitts

ABSTRACT

Background. Termination of pregnancy (ToP) was decriminalised in Queensland, Australia, in December 2018. Although approximately 14 000 terminations are performed in Queensland annually, decriminalisation had addressed a known barrier to ToP access by supporting the legal right to access and enabling safe and regulated public pathways to ToP care. The post-decriminalised ToP experience in Queensland is unknown. Therefore, this study explored the reported reasons clients access information and support from an all-options pregnancy counselling service in Queensland with the aim of identifying the facilitators and barriers accessing ToP that remain post-decriminalisation in Queensland. **Methods.** A two-part qualitative conventional and directed content analysis approach guided by the Socioecological Model was used to examine counsellor notes on interactions with clients (n = 1933) between December 2018 and June 2020 at an all-options pregnancy counselling service in Queensland. **Findings.** Key reasons for contacting the service were for financial assistance, ToP information, and support for decision making. Facilitators and barriers affecting ToP access interconnected across the Socioecological Model levels highlighting affordability, violence, stigma, knowledge, and information as key factors influencing ToP access post-decriminalisation in Queensland. **Conclusions.** Inclusive multisectoral action to support reproductive autonomy is needed in Queensland. Following decriminalisation, cost, stigma, and intimate partner violence continue to impede access to safe, compassionate, and timely abortion care. Future models of care must eliminate these barriers by developing public models of service provision, investing in workforce development, fully utilising the capacity of that workforce, and creating stronger connections between sexual and reproductive health and intimate partner violence services.

Keywords: abortion, access, Australia, barriers, Queensland, reproductive health, unplanned pregnancy, unwanted pregnancy.

Received: 28 March 2022
Accepted: 4 July 2022
Published: 28 July 2022

Cite this:
Cleetus M *et al.* (2022)
Sexual Health, **19**(6), 491–500.
doi:10.1071/SH22059

Introduction

Approximately 10 000–14 000 abortions (hereafter referred to as Termination of Pregnancy (ToP) to align with the terminology used in Queensland) occur annually in Queensland, Australia,[1] a state of over 1.8 million km^2 with a vastly dispersed population.[2] This geographical distribution and Queensland's diverse multicultural population, create challenges for ToP healthcare delivery.[3] The 2014 national introduction of Early Medical Abortion (EMA),[4] and Queensland decriminalisation of ToP in December 2018[5], have started to address some of these challenges. Prior to decriminalisation, accessing and providing ToP was a criminal offence, unless performed to prevent negative physical and or mental health outcomes.[6] Most ToPs were surgical[7] and despite Australia having a system of universal public health care ,[8] most ToPs were provided in the parallel private health care sector on a fee-for-service basis. As part of the decriminalisation of ToP in Queensland, all public hospitals were required to establish pathways to enable publicly-funded access to ToP with the procedure to be provided internally or via partnerships with private

providers. However, these pathways are not well publicised, readily changeable, and have strict eligibility criteria. As a result, many seek advocacy and support to navigate these pathways. Where they are unable to do so, ToP remains a costly health care experience in the private sector. Unplanned pregnancies, ToP criminalisation and negative ToP experiences can attribute to global health inequalities such as gendered power imbalances, poor wellbeing, ostracisation, and mortality from unsafe ToP practices.[9–13] Comprehensive ToP care is a women's centred approach that facilitates the nuance of individual needs, treatment, compassionate counselling, and contraceptive, sexual and reproductive services.[14] Therefore, accessing comprehensive ToP care from early pregnancy through to the post-ToP period is a matter of reproductive justice that is centred around choice, power, and the intersectionality of the personal, political, legal, social, and structural environments surrounding women and pregnant people.[13–16]

The impact of social determinants in hindering reproductive justice for women and pregnant people accessing ToP in Australia is well established, and includes political and legal factors, feelings of shame and stigma, and interpersonal and health care delivery constraints.[17,18] Qualitative studies highlighting these factors have focused on New South Wales[17–19] and Victoria,[20] both Australian jurisdictions where legislation and service provisions differs to Queensland.[21] A few Australian quantitative studies provide valuable insights into ToP health consumer characteristics and demographics.[22,23] However, these studies do not examine the nuances of the post-decriminalisation context and overlook the perspective of priority groups at increased risk of social disadvantage and often left out of current ToP discourse such as persons experiencing violence, persons in rural locations, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations including migrant, refugee and asylum seekers, and lesbian, gay, bisexual, transgender, queer, intersex (LGBTQIA+), and additional gender, sexual and romantic minority identities (collectively referred hereafter as 'priority populations'). Previous Queensland research has focused on the effectiveness of and demand for EMA and the historical impacts of criminalisation.[7,21] Only two studies have explored ToP experiences in Queensland, but without exploring the legal context of these experiences.[17,18] Reproductive justice is the intersection of reproductive rights and social justice[15] and Australia's *National Women's Health Strategy 2020–2030*[24] recognises that a combination of biomedical, behavioural, social, economic, and physical factors influences the health experiences, outcomes, and empowerment of Australian women. Likewise, the current *Queensland Sexual Health Framework*[25] recognises that understanding these factors is pivotal to improving sexual health outcomes and supporting the needs of priority populations through a whole-of-government approach. Therefore, a greater understanding of the intersectionality of factors influencing ToP access in Queensland, post-decriminalisation is needed.

The overall aim of this study was to describe the experiences of women and pregnant people (hereafter referred to as clients) when accessing ToP services in Queensland, since decriminalisation. Specifically, this study sought to understand clients reported reasons for contacting an all-options pregnancy counselling, information, and referral service and identify the barriers and facilitators that influenced their access to ToP health care that remain post-decriminalisation.

Materials and methods

A combination of conventional and directed content analysis and basic descriptive analysis was conducted on client data collected by counsellors from an all-options pregnancy counselling service in Queensland between December 2018 and June 2020. This approach was informed by a previous study conducted using the same dataset[3] and content analysis literature.[26] Ethical approval was granted by the University of Queensland Human Research Ethics Committee (Approval Number: 202001309).

Study setting

This study was conducted in partnership with Children by Choice (CbyC), a Queensland charity providing a state-wide non-judgemental all-options pregnancy counselling, information, and referral service.[27] Our methodology was underpinned by the organisational values of CbyC, which include a pregnant person-centred framework built on a commitment to reproductive autonomy, and recognition that these concepts are inherently both personal and political.[28] The CbyC values align with reproductive justice[15] and that women have the right to comprehensive and sustainable ToP care.[10,11,14,16]

Data collection

Data for this study comprised of client data, which was routinely collected by counsellors during face-to-face, phone or email consultations between 3 December 2018 and 30 June 2020. These data were then extracted by a CbyC senior counsellor, and de-identified before sharing with the other investigators. Consent for the use of these data for research purposes was obtained from clients before each counsellor interaction as per the Children by Choice Privacy Policy.[29] This data set included demographic data fields (age, gender, postcode, population group, mental health, violence, and pregnancy related details such as gestation) and written notes documented by counsellors to specific 'free-text' questions including reasons for contacting CbyC, presenting issues, and personal experiences accessing ToP. Data included

only information clients disclosed as part of routine consultation.

Data analysis

Basic descriptive analyses were conducted on the demographic data using IBM Statistical Package for the Social Sciences (SPSS) Statistics for Windows (ver. 25). The free-text data were stored and managed in NVivo 12 and analysed using a two-step qualitative process.

Reasons for accessing the service were coded using conventional content analysis, whereby recorded reasons were coded inductively and then quantified to determine the frequency of each reason.[26] A directed content analysis[26] was then applied to code the counsellor 'free text' notes into identified barriers and facilitators to accessing ToP. ToP care is a dynamic 'ecosystem' influenced by a complex intersection of factors that recognise the disparities between power, choice, and the intersectionality of individual and systems environments surrounding clients.[15,16] The Socioecological Model (SEM) was applied to provide a framework to guide the free text analysis as the SEM level categories align with these dynamic factors. The SEM levels: structural (laws, policies, systems, affordability, culture, and beliefs), health care and settings (professional attitudes and behaviours), interpersonal (social connections), and intrapersonal (knowledge, beliefs, income, and biology) provided the pre-determined categories used for coding the barriers and facilitators for accessing ToP care.[30,31] By putting health consumer experiences at the centre, the SEM aids in the identification of disparities across the diverse range of factors that might affect ToP experiences in Queensland.[30,31]

Coding was conducted by the first author, and reviewed by two other authors (JD, ML) with minor discrepancies resolved by discussion. In this paper, quotations from counsellor notes are provided to exemplify themes, with the client age, gestation and counselling mode identified.

Results

Participant characteristics and demographics

From December 2018 to June 2020, a total of 1993 clients from a range of priority populations and diverse locations across Queensland contacted the service. Clients often had multiple interactions (range 1–71) with 8729 total interactions during this period. The demographic characteristics of these clients are in Table 1. Ages ranged between 12 and 61 years (median, 27 years) with clients from asylum seeker/refugee backgrounds being notably older, on average, compared to other clients. Of note, 43% reported exposure to violence, and 30% held a healthcare concession card.

The study results identified a range of reasons for contacting the service both pre- and post-termination and highlighted barriers and facilitators influencing access to termination that remain, despite decriminalisation.

Reasons for contacting the service

Reasons for contacting the service identified in the records of 1353 clients were coded into two categories: (1) pre-ToP (1135, 83.8%); and (2) post-ToP (218, 16.1%). Table 2 summarises the reasons for contacting the service identified within each category.

Table 1. Collective characteristics and demographics of women and pregnant people at first contacts. $N = 1993$.

Population group	*n*	%	Gestation week at ultrasound (median)	Age in years (median)
Exposure to violence: intimate partner violence, family violence, reproductive coercion, and other violence	859	43	4–40 (9)	12–61 (27)
Concession or healthcare card holder	602	30	4–21 (8)	13–49 (26.5)
Culturally and linguistically diverse	220	11	4–21 (10)	14–49 (30)
Aboriginal and Torres Strait Islander peoples	153	8	4–20 (9)	13–42 (25)
Student	138	7	4–40 (8)	13–39 (22)
No income	110	6	2–34 (9)	13–42 (26)
Overseas visitor	108	5	4–24 (10)	19–37 (28)
New Zealander	103	5	4–29 (9)	17–44 (26)
Secondary homelessness	88	4	6–19 (10)	16–42 (25)
Disability	30	2	4–40 (13)	13–40 (25)
Attempted self-induced termination of pregnancy	25	1	4–30 (18)	16–41 (26)
Primary homelessness	16	1	5–19 (9)	20–37 (25)
Asylum seeker and refugee background	15	1	5–21 (9)	20–49 (29)
Incarcerated	3	0.003	13 (13)	16–31 (18)

Table 2. Reasons for contacting an all-options pregnancy counselling service organised by the time period of Termination of Pregnancy (ToP) access.

Category	Total references coded *n* (%)	Themes	Total references coded per theme
Pre-ToP	1135 (83.8)	Seeking financial assistance to access ToP costs	840
		Information on ToP and navigating the healthcare system	180
		Counselling and support for decision making	98
		Accommodation and logistical support for either short or long distance travelling for ToP	9
		Support to access ToP due to COVID-19 barriers	8
Post-ToP	218 (16.1)	Grief and acceptance counselling following ToP (particularly following coercion and exposure to violence) and spontaneous miscarriage	129
		Feedback on ToP and health care experience	64
		Information and other: failed medical ToP, contraception, financial and accommodation support, embryo, and fertility information	15
		Depression and self-judgement: shame and stigma	10

Common reasons clients contacted CbyC pre-ToP were for financial assistance, information, and support for decision making or navigating the healthcare system. Counsellors frequently noted clients expressing distress due to financial constraints surrounding ToP costs, along with feelings of isolation and difficulty making decisions due to a lack of personal and healthcare system support. This was demonstrated in written communication from a client to a CbyC counsellor as summarised below.

> The client is a 30 year old single parent with mental health concerns and no informal support network. She is 9 weeks' pregnant and seeking help to access an abortion. Client has no capacity to make loan repayments if that was their only pathway to access an abortion. In the last year, the client has paid for two abortions, the cost of which prevented her from affording contraception. The client reports being scared for her physical and mental health and discloses considering harming herself to end the current pregnancy if she cannot access an abortion. (Summary of email correspondence)

Post-ToP, the most common reason clients contacted CbyC, was for support around grief and acceptance for both recent and historical ToP. This included situations where the client had experienced coercion towards ToP and/or other forms of violence. A notable theme associated with these clients was an underlying internalised stigma due to personal belief systems. These strong beliefs created a sense of shame following ToP. During an interaction with a client who reported a loss of community, friends, and acceptance after being raped by a religious leader, one counsellor documented:

> Strong themes of shame and guilt. Examined possible links to capacities for empathy and reflection. Considered possibility of sitting with discomfort when making values-based decisions, e.g., sex before marriage, ToP. [Shows] more connections between past experiences and present experiences . . . [Client] reported feeling depressed and anxious all the time, not sleeping, not caring about studies . . . . (26 years. Gestation unknown. Telephone interaction).

Barriers and facilitators to accessing ToP

The barriers and facilitators of ToP access interconnected across all the SEM levels (Fig. 1). Intrapersonal environment identified strong themes of distress, knowledge, identity, and demographic factors such as financial precarity, rural status, and health. The interpersonal environment was dominated by themes of violence and conflict as well as the support social equity provides. Healthcare and setting environments showed strong themes surrounding knowledge and information. While affordability dominated accessibility factors overall and in the structural environments surrounding ToP access in Queensland. The following sections will discuss in more depth these factors aligned with the Intrapersonal, Interpersonal, Healthcare and Settings, and Structural levels.

Intrapersonal

Experiencing pregnancy itself was an emotional and stressful situation that created uncertainties and barriers to ToP access for many clients. Emotional distress along with common early signs and symptoms of pregnancy, such as nausea, affected clients' income and therefore their capacity to pay for ToP and associated health care appointments. This resulted in delayed access and reduced viability of EMA, especially if the symptoms were severe as noted by a counsellor below following a telephone consultation:

> [Client] reports extreme hyperemesis and became distressed when she thought she may not get a [EMA] in

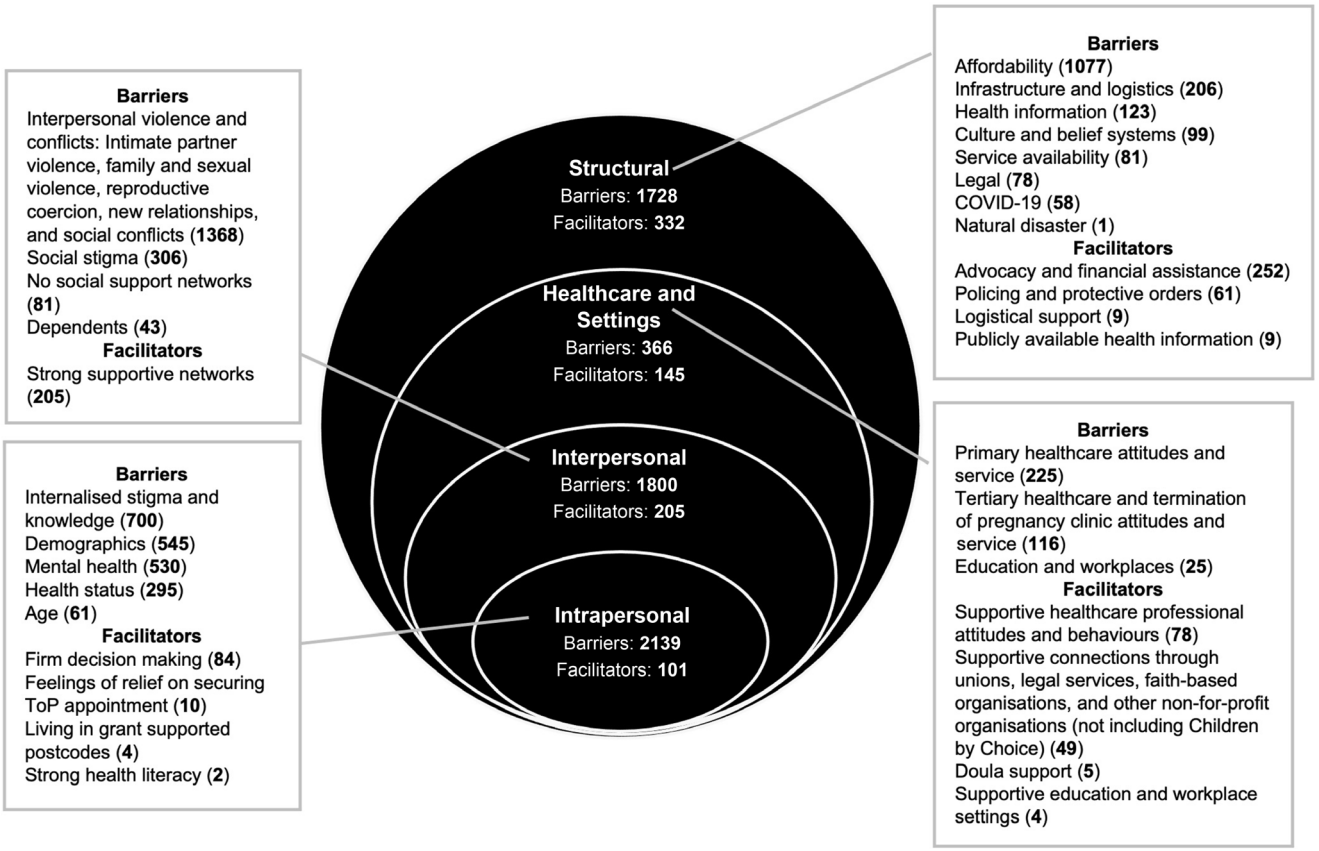

Fig. 1. Socioecological Model of factors influencing access to Termination of Pregnancy (ToP) in Queensland and the number of references coded in NVivo 12 for each factor.

next days as did not feel well enough to access [ultrasound]/bloods [tests]. (Age unknown. 8 weeks' gestation Telephone interaction.)

The interconnection of low levels of knowledge and experience navigating the healthcare system, combined with ambivalence and difficulty in decision making, often delayed clients from seeking support, which in turn created barriers to ToP access.

Wasn't sure about decision which delayed her contact with us – then was trying to save for procedure not realising the cost would increase. (Age and gestation unknown. Email correspondence).

Conversely, clients with greater health literacy were in a better position to exercise their reproductive autonomy, and more confident to make informed choices and navigate the healthcare system:

[Client] is firm in her decision to terminate as she wants to support her current children and does not feel she will be able to do this and continue a pregnancy. (26 years. 12 weeks' gestation. Telephone interaction).

Interpersonal

Reproductive coercion, intimate partner violence (IPV), sexual assault, and conflicts surrounding pregnancy and ToP dominated the interpersonal environments of clients seeking pregnancy counselling (Fig. 2). Exposure to IPV and associated uncertainties reduced clients' financial and reproductive autonomy, which hindered ToP access. The below summary of an email correspondence demonstrates the impact IPV had on one woman's choice and access.

A client of unknown age at 18 weeks' gestation reported that the MIP [Man involved in pregnancy (MIP)] called them 'a murderer' for choosing a ToP and that he stole the money she had saved for ToP. (Summary of email correspondence).

However, clients' reproductive autonomy was supported by factors such as resilient social networks and support from formal organisations. Often support was needed in navigating emotions, decisions, and travelling to appointments and healthcare facilities, as well as minding dependents:

Father and stepmother live in [major city] and will transport, adult brother will look after baby. Mother

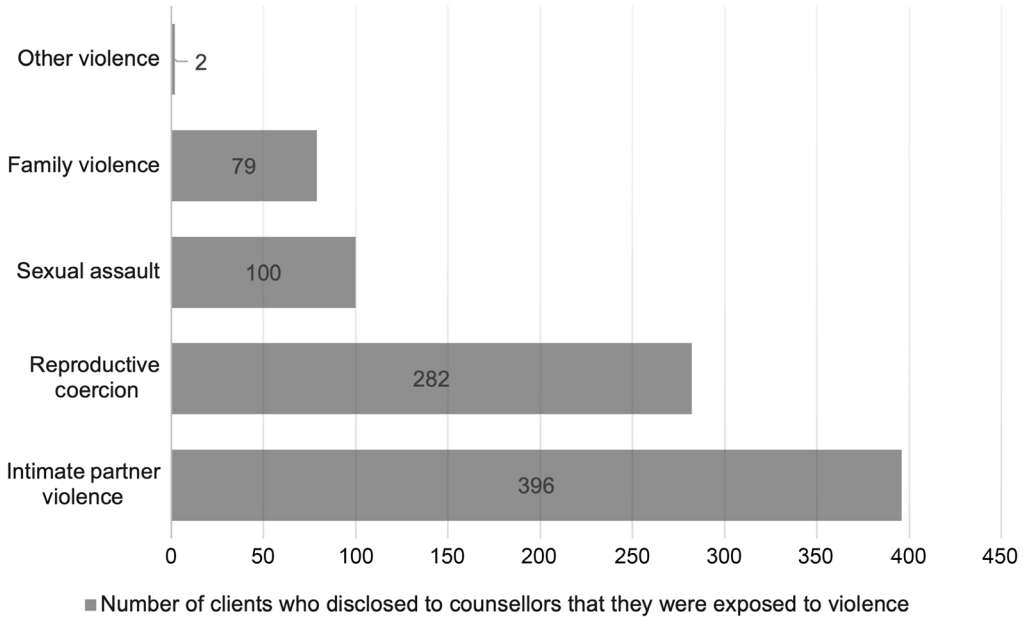

Fig. 2. Frequency of the types of violence disclosed by the clients to counsellors.

lives in [regional town]. States all supportive. (27 years. 5 weeks' gestation. Telephone interaction).

Health care and settings

Healthcare practitioner (HCP) stigma and conscientious objections to providing ToP information and referral were identified as key barriers for clients navigating the healthcare system. HCP refusal to refer caused major frustration and delays in accessing ToP. Clients commonly reported being told by HCPs that 'We don't do social abortion.' ToP access was further hindered by misinformation around gestational limits, and the availability of public pathways:

> ...she had been to or contacted about 6 doctors for a referral to public system. They had all refused ... One wanted her to go to [another clinic] instead, others said they didn't refer for abortions. [Client] was frustrated.... (33 years. 14 weeks' gestation. Telephone interaction).

Unsupportive healthcare professionals also created informational barriers, with clients reportedly receiving incorrect or misleading advice.

> [Client] advised she saw a [General Practitioner (GP)] for ToP referral and doctor advised her ToP cannot be done after 10w, that it is unsafe, and she might die, that [major tertiary hospital] doesn't do it anyway...hospital advised her they do provide ToP. [Client] indicated feeling upset after GP appointment. (29 years. Gestation unknown. Telephone interaction).

In contrast, helpful, informative, and non-judgmental support from HCPs in both the primary and tertiary healthcare sector were identified as access facilitators. Advocacy and support provided by organisations and educational facilities assisted access to ToP by providing child-minding, logistical support, accommodation, and pregnancy counselling as well as strengthening interpersonal stability through domestic and family violence organisations. The below summary of an email correspondence demonstrates how financial help from organisations can assist women and pregnant people's access.

> She [Client] has some funds to contribute and we will endeavour to find the balance. (20 Years. 21 Weeks. Email correspondence).

Structural

The structural environment was identified as the largest and most powerful influence on the ToP experiences of clients with affordability, the primary structural barrier. With ToP-associated costs ranging from AUD$200 to AUD $17 000 depending on the location, situation, and gestation, for those lacking the financial means, this resulted in distress, considerable mental burden, and delayed access to services. This was particularly noted for clients seeking ToP beyond 15-weeks' gestation, where delays resulted in additional cost and limited-service availability. These factors often intersected with client rurality due to poor service availability, logistical factors, and additional financial burden due to travel costs. One counsellor documented an interaction between a client and a tertiary HCP that demonstrated the

complex intersection of socioecological factors influencing access:

> [HCP] reports her frustration that [primary health clinic] would not provide [client's] details until now and noting due to that and [remote location], short timeframe to access termination in [regional hospital]. [Client] trying to follow up [major tertiary hospital] foeticide option as alternative, as cost to [regional hospital] has been quoted AUD$17K. (23 Years. 20 weeks' gestation. Telephone interaction).

Financial precarity and accessibility was exacerbated by the coronavirus disease 2019 (COVID-19) pandemic due to lockdowns affecting service availability and loss of employment. This caused additional distress, and curtailed client choices about method of ToP as illustrated by the below summary of an email correspondence from a client at 12 weeks' gestation:

> A 38 year old woman at 12 weeks' gestation emailed describing how the healthcare clinic she contacted was unable to provide an appointment time for a surgical termination due to COVID-19. The client reported feeling anxious as she did not want a medical termination. (Summary of email correspondence).

These delays and barriers generated frustration along with reports of unsafe ToP and self-harm, including researching black market pills and online methods on self-ToP or attempting self-harm to procure a miscarriage as these quotes highlight:

> When quoted the price [client] considered suicide. Has also thought about self-abortion as an option. (24 years. 18 weeks' gestation. Telephone interaction).

> Mum said [client] has already tried to cut her wrists and is attempting to self-abort through self-harm. (16 years. Gestation unknown. Telephone interaction).

The leading factor facilitating access to ToP was the counsellors advocating for financial assistance including CbyC's financial assistance program. This advocacy alleviated stress from the lack of structural support through affordable health care and restored choice and empowerment to clients to meet their reproductive needs. However, some clients lacked the financial history and stable income required to qualify for a no interest loan scheme (NILS):

> Financial distress due to loans repayment. Not eligible for NILS loan. Currently residing with extended family (secondary homelessness), planning to return to work. Separated from [MIP] although supported in decision he is unable to assist financially with cost. History [of IPV] secondary to [MIP] alcoholism. Has been declined [remote hospital public pathway] due to advancing gestation – [client] reports they are still in discussion re policy/procedure and can only provide surgical 9–12w currently. (27 years. 15 weeks' gestation. Telephone interaction).

While diverse organisations facilitated nuanced care and support for clients experiencing barriers from stigma and belief systems, the interconnection of social and internalised stigma was identified as a pivotal factor across the SEM levels (Fig. 1) with reports of stigma rooted deep in culture, health care, the workplace, educational settings, and the intrapersonal environment. ToP-related shame, guilt, and competing religious beliefs featured strongly for many clients:

> Concerned God won't forgive her for ToP. (20 years. 5 weeks' gestation. Telephone interaction).

Cultural influence including feelings of grief surrounding the stolen generation was identified as an access barrier for Aboriginal and Torres Strait Islander peoples.

> Trauma/violence/loss and grief/culturally related also to stolen generation loss of family – only generally disclosed and declines referral for Mental Health or Alcohol and Drug services but encouraged to attend [Aboriginal and Torres Strait Islander Community Health Service] if wanting to consider these issues. (36 years. 15 weeks' gestation. Telephone interaction).

Discordance between personal beliefs and social network norms induced fear, stigma, and reluctance to disclose the pregnancy or ToP to family and friends. This reluctance to disclose the pregnancy or ToP, limited client's access to financial, emotional, child-minding, and logistical support.

> [Client] said she does not want anyone to know as it will 'ruin' her career and her marriage . . . she shares a bank account with husband and needs to slowly pay back loan so he does not notice . . . her and partner have fertility issues hence this would not be 'good situation' . . . firm in her decision to terminate and wanted to focus on healing from the sexual assault. (32 years. 5 weeks' gestation. Telephone interaction).

Discussion

The study set out to describe the reasons women and pregnant people contact an all-options pregnancy counselling, information and referral service and the barriers and facilitators that influenced their access to ToP care, 2 years on from law

reform that removed ToP from the Queensland Criminal Code. Decriminalisation of ToP in Queensland eliminated a major legal barrier, but other access barriers remain, especially for vulnerable clients, and exacerbated by COVID-19.[32] These barriers intersected across the broader intrapersonal, interpersonal, healthcare, and structural environments surrounding clients hindering the right to choose, and access comprehensive ToP care. The intrapersonal environment lay at the centre of client experiences and identified personal barriers such as pregnancy-related stressors, individual knowledge, agency, and the ability to afford and access timely ToP care. Personal factors have been reported from the individual and HCP perspective both nationally[17–22,33] and internationally[9,34] as barriers to accessing ToP and despite recent legislative changes our study highlights that they continue to impact access, rights and justice for people seeking ToP in Queensland.

The interpersonal environments similarly intersected across this study in the accounts of reproductive coercion, IPV, sexual assault, and conflict amongst clients, demonstrating the complexity of ensuring access to ToP health care. Pregnancy is a time when IPV may escalate or change,[35] and IPV also hinders reproductive autonomy and financial security for people seeking ToP in Australia.[23] Likewise, the process of making a decision about a pregnancy may create opportunities to connect a pregnant person with supportive services, and act as a catalyst for them to escape a violent relationship.[36] Our study suggests that these factors remain a barrier despite ToP decriminalisation.

The healthcare and setting environments impacting clients continues to be an area for improvement post-decriminalisation of ToP in Queensland. With approximately one in six women experiencing IPV and one in five women reporting experiences of sexual violence,[37] ToP services must adopt supportive and rigorous approaches to identifying violence[3] and domestic violence services must be skilful in all-options pregnancy counselling and knowledgeable about ToP and contraception access. Healthcare settings often acted as a powerful force influencing reproductive autonomy in this study. Client experiences of being stigmatised and provided with misinformation by HCPs highlights the need for training of HCPs from all disciplines to increase access to compassionate and affordable ToP care.[20,38,39] Education should focus on increasing the number of EMA providers in primary care,[40] as there is clear evidence that EMA is safe, acceptable to people accessing ToP (including via telehealth), as well as being a cost-effective alternative to surgical options.[17,41,42] Beyond early pregnancy, however, confusion over perceived gestational limits, the lack of skilled providers,[34,43] and additional HCP stigma limits access to ToP in tertiary settings.[44,45] Nurse/midwife led models of care should also be used to increase ToP access, however, current regulatory frameworks limit the expansion of this model of care.[39] Regardless of the professional cadre of the provider, investment in workforce development must address the right to affordable health care, including ToP. Also, for HCPs in any discipline who choose not to provide ToP, there is a need for greater awareness of the obligations of conscientious objectors; that is, to disclose their objection to the client and refer on to another HCP who does provide the needed service. CbyC's recently published map of abortion and contraception services in Queensland enables HCPs to make these referrals more easily,[46] but funding is needed to ensure the sustainability of this resource.

Chief among the structural barriers identified in this study was financial precarity, consistent with national[18,33] and global[9,34] evidence. Post-decriminalisation, ToP remains provided largely in the private fee-for-service sector, with limited accessibility to public care. This slow establishment of public provision further contributes to the financial stressors identified in our findings. Australia is a high-income country and internationally recognised as a safe provider of ToP,[11] and with a well-resourced universal healthcare system.[8] In that context, reports of clients considering or undertaking self-induced ToP or self-harm because of an unplanned pregnancy or difficulty accessing a legal ToP should be unacceptable to all of us.

COVID-19 has exacerbated many of the barriers identified in this study. For example, the number of IPV cases being reported have increased[47] creating additional barriers to accessing contraception and ToP care.[48] The impact of COVID-19 has further highlighted the need for services that are responsive and focused on supporting reproductive autonomy of a group already facing inequities.[3] This should include providing special consideration for the comprehensive needs of health consumers, including their right to choose, providing readily available education programs on ToP, sexual and reproductive health, and equitable access to contraceptive options despite other competing demands on the health system.

Limitations of this study

Although this study centred on health consumers, the client notes collected from counsellors did not always identify the in-depth nuances of personal experiences of ToP in Queensland and failed to encapsulate the voices of health consumers in first person. We were unable to determine if any clients included in this study identified as LGBTQIA+, as this information was not routinely collected by CbyC. The needs of experiences of LGBTQIA+ people experiencing unplanned pregnancy or seeking ToP must be explored in future research.

Conclusion

To our knowledge, this study is the first to examine the socioecological barriers and facilitators to accessing comprehensive ToP care in Queensland post-decriminalisation.

Findings from this study show that despite decriminalisation, the intersectionality of power and choice affecting reproductive rights in Queensland continues, especially for priority populations. Professional, non-judgemental, all-options pregnancy counselling and support services play a vital role in supporting clients to navigate the healthcare system and this study has further highlighted the positive role such services continue to play in advocating for improved ToP access and de-stigmatising reproductive health care in Queensland.

The decriminalisation of ToP was necessary, but not sufficient to protect women and pregnant people's reproductive autonomy. Inclusive, multisectoral action to eliminate barriers to ToP access is still needed in Queensland. Investment in workforce development and service planning in both primary and tertiary healthcare sectors, and in partnership with health consumers, is urgently needed to address barriers to ensure access to safe, compassionate, and timely ToP. Future policies and health care must take into consideration the broad factors affecting ToP access and specifically focus on preventative models of care that remove cost burden, integrate comprehensive sexual and reproductive education for both professionals and consumers, identification of violence, and elimination of stigma.

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Data availability. The data that support this study were obtained from Children by Choice by permission. Data will be shared upon reasonable request to the corresponding author with permission from Children by Choice.

Conflicts of interest. The authors declare no conflicts of interest.

Declaration of funding. This research did not receive any specific funding.

Acknowledgements. The authors thank and acknowledge all clients of CbyC whose data were used in this study and the CbyC staff for their support.

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