Majority support for access to abortion care including later abortion in South Australia

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Abstract

Objective: To measure public opinion about access to abortion in South Australia.

Methods: An online survey conducted in 2019. SPSS statistical package version 22 was used for data analysis, with data weighted by age, gender, and region.

Results: The majority (65%) of the 1,012 respondents supported the ready availability of abortion care and an additional 25% supported availability in certain circumstances. Most (70%) were unaware that abortion remains in criminal law and 80% supported decriminalisation. Support for safe access zones (88%) and the application of existing protections (69%) and obligations (94%) for conscientious objectors was high. A majority (63%) considered that later abortion should be available 'when the woman and her healthcare team decide it is necessary'.

Conclusions: These results confirm the trend of increasing support for access to abortion and add two new insights. There was majority support for using existing general protections for the rights and obligations of those with a conscientious objection to abortion. Second, there was strong support for decisions about later abortion to be decided through normal clinical consultation. These results indicate general community approval of abortion being normalised as healthcare, with the safeguards and accountabilities that status entails.

Implications for public health: These results invite repeal of special laws about abortion care, to enable better access.

Key words: abortion law reform, public opinion on abortion, population survey, women's sexual health

Majority support for decriminalisation of abortion among the Australian public has been reported for several decades.[1–3] For example, in 2015, more than 72% of 1,015 residents of New South Wales supported the decriminalisation of abortion while 58% endorsed that women should be able to obtain an abortion readily when they wanted one.[2] Recent reforms in Queensland[4] and New South Wales[5] leave only South Australia with abortion care regulated under criminal law. Although this state provides fully subsidised Government-funded abortion services, the current law specifies that women are required to access abortion within a 'prescribed hospital', with the permission of two physicians, after living in the state for more than two months and before 24 weeks gestation.[6] These provisions limit equitable access in important ways, particularly for rural and remote women who are forced to travel long distances, even for early medication abortion (EMA). EMA is normally an accessible and safe alternative to surgical abortion, but access is restricted under SA laws.[7] Current laws also do not provide for safe access zones to protect women from harassment or threatening behaviour when attending abortion clinics.

The aim of this paper is to report the results of a survey conducted in 2019 to inform debate on a bill to reform South Australian abortion law. This is the first survey of South Australian knowledge and attitudes towards abortion. The data provides updated evidence about community views following significant publicity about legislative change to decriminalise abortion in other states.

Methods

Participants and recruitment

Participants were recruited during May 2019 through Dynata, a commercial market research agency, using panel-based sampling. Dynata maintains a database of voluntary market research participants who accumulate points for completing online surveys. Points can be redeemed for cash or gift cards. Dynata members aged 18 years or older and living in South Australia were invited to complete the survey via email. Demographic details (age, gender, region) were self-reported. Sampling continued for three weeks and was stopped when responses slowed and additional recruitment did not improve the demographic representativeness of the sample.

Measures

Most items in the survey were based on those in a previous survey of knowledge and attitudes towards abortion conducted in 2015 in New South Wales[2] and in the Australian Election Study since 1979[3] (Supplementary

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Table 1). Participants were asked to report whether they were aware that abortion remained in criminal law in South Australia. They were then asked a series of questions regarding their attitude toward abortion, including: a) whether abortion should be decriminalised; b) whether women seeking abortions should be protected from harassment or threatening behaviour; and c) whether safe access zones should be established around abortion clinics. Two novel questions were: d) whether current conscientious objection and responsibility to refer provisions should continue to apply or be strengthened or removed; and e) a question about later abortion. The survey was piloted using the first 100 panel participants. Following piloting, the wording of the question on later abortion was amended to clarify and enforce online that the response options were mutually exclusive.

The remaining 912 participants were asked their opinion about the circumstances under which abortion after 20 weeks gestation should be available (response options were: 'in all circumstances when the woman and her healthcare team decide it is necessary', 'in some circumstances', or 'under no circumstances'). Only those respondents who indicated support 'in some circumstances' were asked to indicate whether they would endorse later abortion in the case of serious foetal abnormality; major health risk for the woman; rape, incest, or domestic violence; or failure to diagnose pregnancy at the normal time.

Analysis

Data analysis was conducted using SPSS statistical package version 22.[8] Data were weighted by age, gender and region (metropolitan or regional/rural) according to the 2016 Australian Census population estimates for South Australia.[9] Weighted percentages were calculated and compared by age group (younger [18 to 44 years] vs older [45 years and above]), gender (male vs female; 'other' excluded from comparison), and location (metropolitan vs regional) using chi-square tests (α set at 0.05). Where significant group differences were found for outcome variables with more than two levels (responses), post hoc chi-square analysis was conducted with each response (compared to any other response) because group differences were expected to vary between responses. Additionally, post hoc analysis comparing those who reported that later abortion should not be permitted in any circumstances to the rest of the sample was conducted to provide additional context for their views. A Bonferroni correction was applied to account for multiple comparisons.

Table 1: Survey results compared by gender, location, and age group with weighted percentages (full Chi-square test results available in Supplementary Table 3).

	n (weighted %)							
	All (n=1,012)	Gender			Location		Age group	
		Female (n=534)	Male (n=470)	Other (n=8)	Metro (n=742)	Regional (n=270)	18-44 yrs (n=482)	45+ yrs (n=530)
Which of these statements best describes your current views about abortion?								
Women should be able to obtain an abortion readily when they want one[b]	655 (64.7)	354 (66.7)	296 (62.7)	5 (57.1)	500 (67.6)	155 (58.4)	309 (64.1)	346 (65.2)
Abortion should be allowed only in special circumstances	245 (24.6)	128 (24.2)	117 (25.5)	0 (0)	169 (23.2)	76 (27.9)	108 (21.8)	137 (26.6)
Abortion should not be allowed under any circumstances[c]	47 (4.5)	22 (3.9)	24 (5.0)	1 (14.3)	30 (3.8)	17 (6.0)	29 (6.3)	18 (3.2)
Don't know/not sure	65 (6.2)	30 (5.3)	33 (6.8)	2 (28.6)	43 (5.4)	22 (7.6)	36 (7.7)	29 (5.1)
Before today, I was aware that abortion is currently listed as a criminal offence under the SA Criminal Law[a]	303 (30.3)	114 (26.8)	156 (33.7)	3 (42.9)	224 (30.5)	79 (29.8)	140 (28.8)	163 (31.4)
I think abortion should be decriminalised (removed from the criminal law) and regulated under health law as a health service[b,c]	795 (79.4)	429 (81.7)	362 (77.4)	4 (50)	597 (81.3)	198 (75.0)	357 (74.2)	438 (83.1)
I think that women attending clinics for abortion care should be protected from any form of harassment or threatening behaviour[a]								
Strongly agree or agree	926 (91.7)	499 (94.2)	422 (89.6)	3 (71.4)	682 (92.0)	244 (91.1)	438 (90.8)	488 (92.4)
Disagree or strongly disagree	33 (3.3)	12 (1.9)	21 (4.6)	0 (0)	21 (2.8)	12 (4.1)	20 (4.5)	13 (2.4)
Don't know	53 (5.0)	23 (3.9)	27 (5.8)	3 (28.6)	39 (5.1)	14 (4.8)	24 (4.7)	29 (5.2)
I think that safe access zones should be introduced around abortion clinics to protect patients and staff from harassment and threatening behaviour								
Strongly agree or agree	885 (87.7)	480 (90.4)	402 (85.8)	3 (28.6)	655 (88.4)	230 (86.1)	416 (86.4)	469 (88.7)
Disagree or strongly disagree	54 (5.3)	23 (4.1)	31 (6.4)	0 (0)	37 (5.1)	17 (5.7)	27 (5.6)	27 (4.9)
Don't know	73 (7.0)	31 (5.5)	37 (7.8)	5 (71.4)	50 (6.5)	23 (8.2)	39 (8.0)	34 (6.4)
I think the conscientious objection provisions should …								
Continue to apply[c]	502 (50.5)	256 (48.8)	244 (52.5)	2 (28.6)	373 (51.0)	129 (49.4)	220 (45.5)	282 (54.2)
Be strengthened[c]	187 (18.1)	94 (16.9)	91 (19.2)	2 (28.6)	128 (16.8)	59 (21.2)	105 (22.1)	82 (15.2)
Be reduced or removed	323 (31.4)	184 (34.2)	135 (28.3)	4 (42.9)	241 (32.2)	82 (29.4)	157 (32.4)	166 (30.6)
I think the responsibility for health practitioners to provide information about alternative sources of care should…								
Continue to apply[c]	581 (58.3)	321 (60.9)	258 (56.1)	3 (28.6)	424 (58.0)	157 (58.5)	261 (54.0)	320 (61.2)
Be strengthened[c]	369 (35.7)	186 (33.9)	181 (37.7)	1 (28.6)	271 (35.6)	98 (36.1)	194 (40.4)	175 (32.5)
Be reduced or removed	62 (6.0)	27 (5.3)	31 (6.2)	4 (42.9)	47 (6.4)	15 (5.4)	27 (5.6)	35 (6.0)

Notes:

a: Significant difference between men and women to p<0.05 ('other' excluded from analysis)

b: Significant difference between metro and regional to p<0.05

c: Significant difference between age groups to p<0.05

Ethics

In accordance with the National Health and Medical Research Council statement on ethical conduct, review by an HREC for an anonymous public opinion survey was not required.[10]

Results

Weighted variables were used for all analyses because, without weighting, older people and people living outside of metropolitan areas were slightly underrepresented (Supplementary Table 2). After weighting was applied, the 1,012 participants were representative of the South Australian population by sex (50.4% female, 48.9% male, 0.7% other), region (69.1% metropolitan, 30.9% regional/rural/remote), and age (8.5% 18–24 years, 17.1% 25–35 years, 16.2% 35–44 years, 17.5% 45–55 years, 16.7% years, 24.0% over 65 years; see Supplementary Table 2).

More than 64% of respondents endorsed that abortion care should be readily available, and an additional 24.6% felt that abortion should be available in certain circumstances (Table 1). Participants living in regional areas were slightly less likely to consider that abortion should be readily available than those living in metropolitan areas (58.4% vs 67.6%, χ^2=7.82, p=0.006), and younger people were more likely than older people to report that abortion should not be allowed in any circumstances (6.3% vs 3.2%, χ^2=5.65, p=0.02). There were no differences by gender. Most respondents (69.7%) were not aware that abortion remains in criminal law in South Australia and 79.4% supported decriminalisation, although support was slightly lower among younger people (74.2%) and people living in regional areas (75.0%).

Almost all participants (91.7%) agreed that women attending clinics for abortion care should be protected from harassment. More than 87% supported the establishment of safe access zones to limit threatening behaviour in these environments, with no significant differences between groups (all p>0.05). Half the participants felt that the current level of protection for practitioners' conscientious objection should continue to apply, although 31.4% felt that these provisions should be reduced or removed. Similarly, 58.3% of participants supported the continuation of the current requirement that health practitioners who conscientiously object should provide information about alternative sources of care. A further 35.7% felt that this requirement should be strengthened.

Results of survey questions pertaining to later abortion (i.e. after 20 weeks gestation; n=912) are displayed in Table 2. A majority (63.1%) of participants considered that later abortion should be available in any circumstance deemed necessary by the woman and her healthcare team, although younger people were less likely to endorse this response than older people (57.3% vs 67.3%, χ^2=9.50, p=0.002). Very few participants (6.8%) felt that later abortion should be completely banned; those who did (n=67) were far less likely than other respondents (n=945) to support decriminalisation (33.3% vs 83.1%, χ^2=127.7, p<0.001) or to support the establishment of safe access zones (61.9% vs 81.9%, χ^2=80.7, p<0.001).

Among participants who believed later abortion should be available in some circumstances (n=202), major illness or health risk to the woman was the most supported circumstance (76.5%), followed by serious foetal abnormality (71.2%), situations of rape, incest or domestic violence (62.7%) and failure to diagnose pregnancy at the normal time (24.4%).

Discussion

These results confirm the trend in recent studies of increasing levels of support for the availability of abortion, including most recently the 2019 Australian Election Survey.[3]

Table 2: Results of survey questions about abortion later in pregnancy compared by gender, location, and age group with weighted percentages (full Chi-square test results available in Supplementary Table 3).

		Gender			Location		Age group	
	(n=912)	Female (n=485)	Male (n=419)	Other (n=8)	Metro (n=675)	Regional (n=237)	18-44 yrs (n=434)	45+ yrs (n=478)
A very small number of abortions are needed later in pregnancy (after 20 weeks gestation) when the woman and her health care team decide it is necessary. In which circumstances do you consider abortion after 20 weeks to be acceptable?								
In all circumstances where the woman and health care team decide it is necessary[b]	568 (63.1)	310 (64.7)	255 (61.8)	3 (42.9)	426 (63.8)	142 (61.5)	250 (57.3)	318 (67.3)
In some circumstances	202 (21.9)	102 (20.9)	99 (23.1)	1 (14.3)	147 (21.6)	55 (22.7)	107 (25.1)	95 (19.6)
Under no circumstances	67 (6.8)	39 (7.5)	27 (6.1)	1 (14.3)	44 (6.1)	23 (8.6)	37 (8.1)	30 (6.0)
Don't know	75 (8.1)	34 (6.9)	38 (9.0)	3 (28.6)	58 (8.5)	17 (7.2)	40 (9.4)	35 (7.1)
				Gender		Location		Age group
	(n=202)	Female (n=102)	Male (n=99)	Other (n=1)	Metro (n=147)	Regional (n=55)	18-44 yrs (n=107)	45+ yrs (n=95)
[If 'In some circumstances'] In which of these circumstances do you consider abortion after 20 weeks to be acceptable?								
When there is serious fetal abnormality	142 (71.2)	78 (77.3)	63 (65.0)	1 (100)	99 (67.6)	43 (79.0)	70 (64.9)	72 (77.1)
When there is major illness, injury or health risk in the woman, for example cancer, mental illness, drug addiction[a,b]	153 (76.5)	85 (83.5)	68 (70.9)	0 (0)	113 (77.7)	40 (73.0)	73 (66.7)	80 (84.8)
In situations of rape, incest or domestic violence[a]	125 (62.7)	71 (69.8)	53 (55.3)	1 (100)	86 (58.7)	39 (71.4)	64 (59.4)	61 (65.7)
Failure to diagnose pregnancy at the normal time (for example, through medical error, or in women at puberty or menopause)	46 (24.4)	23 (24.0)	22 (23.3)	1 (100)	29 (20.3)	17 (33.3)	20 (19.8)	26 (28.6)

Notes:

a: Significant difference between men and women to p<0.05 ('other' excluded from analysis)

b: Significant difference between age groups to p<0.05

However, our results add two important insights in the context of current national law reforms and practice changes.

First, our survey was the first to frame questions about protection for health professionals' conscientious objection to abortion in terms of the standard requirements prescribed in Australian health law and policy. This standard both protects the rights of health professionals to refuse to provide any aspect of healthcare to which they have a conscientious objection, while simultaneously requiring them to provide information to patients about where they can access the care they seek.[11-13] The results indicate that there is majority support for a balanced approach to the rights and obligations of conscientious objectors, as already defined in general health law and policy, and little support for special protections for those with a conscientious objection to abortion.

Second, surveys about access to later abortion typically ask people to give their opinion about access to care in various circumstances affecting the woman or the pregnancy.[1,2] Our survey additionally asked respondents to consider whether normal processes of clinical consultation that generally apply to healthcare provision are appropriate for abortion care. The majority supported abortion being undertaken 'when the woman and her healthcare team decide that it is necessary'. This suggests that the community largely accepts that women and their healthcare providers are best placed to make these decisions, within the legal, policy and ethical frameworks that govern and regulate healthcare. Taken together, these results indicate that much of the community approve of abortion being normalised as healthcare, with the safeguards and accountabilities that status entails.

Limitation

There are important limitations to this work. Older people and people living outside of metropolitan areas were slightly underrepresented, though weighting was applied to the analyses to account for this limitation. The sampling methodology precluded assessment of the survey response rate. As such, the results may reflect those with strong views about abortion rather than the South Australian population more generally. In addition, the use of online recruitment and survey software introduces a sampling bias in favour of those with relatively better digital literacy.

Conclusions and implications

These results are consistent with those of other Australian surveys and confirm the trend for strong and increasing support for abortion care to be available when needed, including abortion at later gestation. This study adds insights into the community's response to abortion care being removed from the criminal law and normalised in the general framework of health law, regulation and ethics. That is, participants considered the standard approach to healthcare decision making (a collaboration between practitioner and patient) to be appropriate. They also supported the application of standard healthcare protocols and ethics when considering practitioners' rights to conscientious objection and their obligation to refer. The only special law supported in this study was the establishment of safe access zones to protect against disruption of abortion care by third parties. We suggest that this framing of abortion as an aspect of healthcare, governed by the laws and codes of healthcare practice, invites repeal of special laws relating to abortion care (except to ensure it is not disrupted), in favour of normalising abortion care as healthcare.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary Table 1: Survey questions.

Supplementary Table 2: Sample characteristics.

Supplementary Table 3: Results of chi-square analysis by gender, region, and age group (weighted and corrected).