Governing Abortion Talk: The Influence of Medication Abortion Policy on Discourse in Australia

Domina Augustine

University of Sydney

Abstract

This paper critically examines the enduring influence of historical medication abortion policy in Australia on contemporary access to abortion, with particular attention to the role of discursive practices. Drawing on the Post-structural Interview Analysis (PIA) methodology, grounded in Bacchi and Goodwin's "Post-structural Policy Analysis", this article illuminates how language shaped by restrictive knowledge practices continues to perpetuate inaccessibility to medication abortion. The central argument presented is that policy not only regulates access at a structural level but also fundamentally shapes the epistemological frameworks through which medication abortion is understood and represented. These discursive representations—rooted in historically restrictive policy —have permeated public and institutional narratives, producing a discourse that limits the scope of abortion care and reinforces barriers to access. The paper contends that addressing inequities in abortion access requires more than policy reform; it necessitates a critical interrogation and transformation of the knowledge practices that sustain restrictive discourses. Visibility on discursive representations and their foundation in restrictive knowledge practices is essential for enabling expansive abortion care in Australia.

Keywords: medical abortion; Australia; social policy; discourse

Introduction

Abortion in Australia is no longer criminalised, yet it continues to lag behind internationally in terms of equitable access to abortion services (Costa, 2007; Sifris, 2023) . Currently, the majority of abortion care is provided outside the public healthcare system, primarily through a limited number of private providers, often at considerable cost—ranging from $600 under Medicare to over $1,000 without Medicare coverage (*MSI Australia | Abortion, Contraception & Vasectomy Provider*, n.d.) Additionally, there are only three public hospitals in New South Wales (NSW) that provide abortion services (Davey et al., 2024). This leaves many people, including those already marginalised and experiencing complex disadvantage, with few options to access abortion care.

Medication abortion (commonly referred to as abortion pills) holds considerable potential to expand access and enhance greater autonomy for individuals seeking abortion care, including the possibility of self-managed abortions (Belfrage, 2023). However, its use for elective or 'social' abortions—those not medically indicated—has been fraught with ongoing controversy and stringent regulatory restrictions (Costa, 2007; LaRoche et al., 2020). Despite being long endorsed by the World Health Organisation (WHO) as a safe, cost-effective, and convenient first-line approach to abortion care, these medications remain highly regulated, commercially controlled, and socially stigmatised within the Australian context. In addition, in the Australian context, access to medication abortion has been delayed and denied, contributing to a prevailing notion that abortion care that is autonomous from the medical system, is almost unthinkable (Baird, 2015).

A Note on Language

Abortion publics: This paper will intentionally use gender inclusive language to encompass all people seeking abortions, beyond cis-gendered females. Gender inclusive language enables us to discuss and understand abortion publics as expansive, therefore it is imperative to use expansive language for abortion seekers.

Self-managed abortion: is an abortion induced by the pregnant person themselves at home, or with the help of other, non-medical assistance (Belfrage, 2023). It is usually, but not limited to abortion pills.

Autonomy: is a relational process that transcends conditionality, resisting and challenging the widespread and violent control over pregnant people's bodies (Belfrage, 2024).

Key definitions

There are different abortion methods with multiple labels to describe them. For simplicity, this paper will refer to only "medication abortion", "surgical abortion" and "abortion".
Abortion: For this paper, the use of abortion is to be understood as both surgical and/or medication abortion methods. Other methods of abortion are prevalent, including alternative methods of self-managed abortions. However, for this paper, the use of the word abortion will be the concept within a medical situ only (exclusive of alternative methods).

Medication abortion: or abortion pills typically involve the administration of two distinct medications in succession: mifepristone and misoprostol.

Surgical abortion: is a day-surgery procedure done by a trained doctor within the first trimester of pregnancy (*MSI Australia | Abortion, Contraception & Vasectomy Provider*, n.d.).

Policy Landscape

Australian policy on medication abortion has followed a markedly different trajectory from that of many comparable countries, where medication abortion became widely accessible as early as the 1990s (Costa, 2007). This delayed timeline has positioned Australia as a global outlier, with the consequences of this divergence continuing to shape dominant discourses and patterns of access to abortion today. As Baird (2015) outlines, the regulatory landscape surrounding medication abortion in Australia has been shaped by a history of political resistance, regulatory hesitation, and pharmaceutical inaction.

During the 1990s, while countries such as France, the UK, and the US approved the use of mifepristone (one of the pills needed for a medication abortion), Australia imposed a de facto ban on its importation and use—legislated via a 1996 amendment to the Therapeutic Goods Act—effectively restricting access to medication abortion until 2006 (Baird, 2013, 2015; Costa, 2007). Even after the ban was lifted, pharmaceutical companies remained reluctant to manufacture or distribute the drug, leaving a significant gap in provision. It was not until 2013 that MS Health, secured the exclusive license to import and distribute mifepristone (Baird, 2015). This milestone enabled general practitioners to prescribe—and pharmacists to dispense—the medication, conditional upon the completion of mandated training.

Despite this formal approval, uptake remained limited. By 2019, only approximately one in ten GPs and one in six pharmacies had undertaken the training required to provide medication abortion services (Baird, 2015). Yet, as Noonan et al. (2023) note, no comprehensive data exists on whether trained providers are actively delivering abortion care, nor is there any legal obligation compelling trained practitioners to do so. In 2023, efforts to improve accessibility led to the removal of the mandatory training requirement, reflecting a shift in regulatory strategy aimed at lowering barriers to provision (Baird, 2015).

Further progress was marked by a recent amendment to New South Wales abortion legislation, influenced by research on "abortion deserts" by Noonan (2024) and Belfrage (2024). This amendment authorised nurse practitioners and endorsed midwives to prescribe medication abortion, representing an important, though partial, step toward broader accessibility (Liu et al., 2024).

This policy trajectory illustrates how Australia's historically restrictive approach has entrenched medication abortion as a politically and pharmaceutically regulated commodity. The dominant discourse continues to reflect and reinforce this legacy, facilitating ongoing control over abortion provision through political and economic monopolies, and subtly undermining the practical

realisation of abortion seekers' legal rights (LaRoche et al., 2020). Despite the formal decriminalisation of abortion, access remains fragmented and uneven across the country.

This article seeks to extend existing understandings of abortion access in New South Wales by critically analysing how policy decisions shape dominant discourses. In doing so, it highlights the importance of discourse not merely as a reflection of policy, but as an active force in producing the conditions under which abortion care is accessed, provided, and understood.

Literature Review

Barbara Baird, one of Australia's leading abortion scholars, argues in "Abortion is Healthcare" (2023) that competing discursive elements continue to shape abortion debates, positioning abortion simultaneously as a social and medical issue. The medicalisation of abortion—particularly with the advent of medication abortion—has introduced new layers of complexity. While medication abortion holds the potential to broaden access to care, Baird (2015) notes that some healthcare professionals still express ambivalence about its legitimacy, reflecting broader tensions within the healthcare system. This hesitation points to the enduring constraints of neoliberal health policies that govern abortion provision in Australia, where market logic and institutional conservatism limit progressive reform (Baird, 2015, 2023).

Building on this, Berro Pizzarossa and Nandagiri (2021) critically examine the power dynamics that shape abortion access, highlighting the problematic framing of abortion as something to be "accessed"—a framing that implicitly positions abortion seekers as passive recipients of care, rather than autonomous agents. Within this dominant medicalised model, access becomes conditional and dependent on conformity to institutional norms. The result is a dynamic in which abortion seekers are compelled to defer to medical authority in the hope of receiving care, reinforcing asymmetrical power relations between provider and patient. The cumulative effects of these dynamics systematically exclude abortion from the broader healthcare framework, facilitating ongoing institutional denial of access.

Further, Nandagiri and Berro Pizzarossa (2023) elaborate on how abortion is increasingly framed as a "regulated transgression." In this framing, only "permissible" abortions—those performed within sanctioned clinical settings using approved methods—are legitimised, while non-clinical, self-managed abortions are constructed as "illicit" and subject to disciplinary oversight. These regulatory distinctions not only constrain reproductive autonomy but also reflect the medical and legal systems' role as gatekeepers, determining which reproductive acts are deemed acceptable. Alternative forms of abortion, such as those undertaken outside the formal health system, are thus discursively positioned as socially and politically deviant—rendered, in effect, unthinkable (Nandagiri & Berro Pizzarossa, 2023; Veldhuis et al., 2022).

Together, these scholars underscore the complex positionality of abortion, revealing how access is contingent upon receiving a metaphorical "permission slip"—not only from medical institutions, but also from legal and social systems (Baird, 2023; Nandagiri & Berro Pizzarossa, 2023). This article situates itself within this social domain, focusing specifically on the discursive practices that both produce and perpetuate the ongoing denial and inaccessibility of abortion care. Through the use of a post-structural methodology, this study seeks to identify and interrogate the discursive patterns from outdated historical policy that continue circulate within contemporary abortion narratives. By doing so, it aims to challenge dominant discourse and open up space for alternative understandings—understandings that might contribute to a reimagining of abortion not as a regulated exception, but as an integral, autonomous, and expansive component of reproductive healthcare.

Research Aims and Questions

Post-structuralism as a theoretical framework

In the hope of repositioning abortion seekers and the wider public, the aim of this paper is to create change by bringing attention to deep seated ways of thinking, to advocate and provide an opportunity to think differently, and therefore, an opportunity to re-imagine abortion care. To explore the potential for expansive abortion care in Australia, this article seeks to understand how abortion—particularly medication abortion—is positioned in contemporary Australian society. The central research question of inquiry is:

> What dominant discourses operate in contemporary understandings of "medication abortion" in NSW?

To unpack this further, the subsequent questions developed were:

1. What are the assumptions, presuppositions, taken-for granted concepts circulating in knowledges about abortion generally and medication abortion specifically?
2. How might these impact change? How might this contribute to the aspirations for autonomy?

To address the research questions and build on the existing literature, this study adopts a post-structuralist theoretical framework, with discourse analysis as the primary methodological tool. As articulated by Carol Bacchi and Susan Goodwin (2016a), post-structuralism provides a critical lens to examine the intersections of power, knowledge, and social structures in the construction of political issues. Bacchi and Goodwin's framework "What's the Problem Represented to Be?", explores the discursive framing of issues such as abortion within political and societal discourse – the production and operation of knowledge and power (Bacchi & Goodwin, 2016a; Guédon, 1977; Schneck, 1987). Central to this approach is the understanding that "truths" are not fixed or

objective but are instead socially constructed through language and power relations. In extension, problems are understood as socially constructed through discursive practices that influence how individuals understand and respond to them (Bacchi & Goodwin, 2016a).

Building on Michel Foucault's theoretical perspectives, post-structuralism emphasises the relationship between discourse and power, asserting that discourses serve as mechanisms through which power is exercised and societal norms are reproduced (Bacchi & Goodwin, 2016a; Schneck, 1987). Language, therefore, is not merely a tool for communication but functions as a medium through which social behavior is regulated and existing power structures are maintained, hence defined as discursive practices (Bacchi & Goodwin, 2016a). Bacchi and Goodwin's framework invites scholars to interrogate dominant discourses that often marginalise alternative perspectives and limit individual agency, providing a means to critically engage with the social and political construction of problems, thereby opening up possibilities for rethinking and reshaping how issues like abortion are understood and addressed.

Method

During May and June, a series of brief, informal vox pop interviews were conducted on the University of Sydney campus, primarily engaging students from the Social Work program, who generally expressed pro-abortion views. These interviews aimed to elicit public perceptions and baseline knowledge regarding abortion access and medication abortion in Australia. The format was intentionally conversational, designed to capture spontaneous responses that reflect broader social understandings rather than in-depth curated responses.

The interview questions that were developed and asked were as follows:

1. Do you think abortion is freely available in Australia today?

2. If you (or someone you know) needed to access an abortion tomorrow, how would you go about it?

3. Have you heard of medication abortion or "abortion pills"? What do you know about them?

It is important to note that these interviews were conducted under journalistic rather than social science ethical protocols, as they were designed for media purposes rather than research. A total of 14 recordings were transcribed and used for discursive analysis.

Post-structural Interview Analysis (PIA) methodology

For the analysis of the vox pops transcripts, Post-structural Interview Analysis (PIA) was used. It is a discursive method designed to excavate the ways in which meaning, identity, and power are constructed through language. PIA functions as a method of discourse analysis grounded in post-structuralist theory, particularly the work of Michel Foucault (2008), and is closely aligned with Post-structural Policy Analysis (Bacchi & Goodwin, 2016a). This framework of policy analysis offers a critical lens to interrogate how policy problems are not merely identified but actively produced and represented within political and institutional discourse, emphasising the role of discourse in shaping public policy and influencing the exercise of power (Bacchi & Goodwin, 2016a).

PIA, as formulated by Bacchi and Jennifer Bonham (2016), extends this analytical tradition by focusing on how interview data can reveal the discursive construction of subjectivities, normative assumptions, and relations of power. Rather than treating interviews as transparent accounts of personal experience, PIA attends to the ways in which respondents position themselves in relation to dominant discourses, and how their language both reflects and potentially disrupts broader socio-political narratives.

In PIA, the focus is on what is said —how meaning is produced in relation to power, social norms, and cultural assumptions. Through their words, interviewees may position themselves in particular ways, either conforming to or challenging the prevailing discourses on a subject (Bacchi & Bonham, 2016). By analysing the ways in which interviewees either conform to or resist these discourses, PIA opens up space for alternative voices and perspectives, encouraging a more nuanced understanding of how social issues are framed and experienced (Bacchi & Goodwin, 2016b).

PIA directs attention to the "what" is said by identifying repetition of language, to then examine the broader question of "how is this sayable?" referring to the discourses that need to be present in order for this language to be used (Bacchi & Bonham, 2016). This method requires a scrutiny of the language used, the concepts deployed and the unraveling of the "truth" it creates. To do this, we understand the transcript as discursive practices—how language constructs meaning, regulates behaviour, and establishes societal norms (Schneck, 1987).

The relevant PIA questions for my analysis were:

1. What specific "things said" appear in the text?
2. What underlying assumptions and meanings must be in place for these statements to be intelligible?
3. How have certain "things said" come to be accepted as "truth"?
4. What norms or values are invoked by these "things said"?
5. Are there any statements that challenge dominant, taken-for-granted realities?

Findings

"What" was said?

Approaching abortion discursively opens up key analytic space that prevents the bracketing of the issue as a private, women's matter, but rather urges an expansive exploration of abortion into wider social and political issues (Belfrage, 2024). Firstly, by exploring representations of abortion we can take apart the assumptions at work to expose the impact of historical policy and restrictive knowledge practices. This includes excavating norms about what abortion 'is', how people should behave and how these norms are linked to wider societal taken-for-granted realities.

The initial findings focused on answering the following PIA questions:

1. What specific "things said" appear in the text?
2. What underlying assumptions and meanings must be in place for these statements to be intelligible?
3. What norms or values are invoked by these "things said"?

The following discursive practices were identified and prevalent in the texts of the vox pops.

Medical Talk

There were repeated references to the medical system in the transcripts. Medical talk demonstrates the dominance of the understanding of abortion as a medical "problem" to be solved by medical professionals (El-murr, 2010; Nandagiri & Berro Pizzarossa, 2023). It is interesting to see how the transcripts included an assumption or taken-for-granted reality of the involvement of GPs, public hospitals and clinics in abortion provision. This knowledge situates abortion within a medicalised discourse, positioning individuals seeking abortions as patients to medical provision.

My first step would be to go to a **GP**

I would probably book in with a women's health **clinic**

I would take myself to the **GP**, get advice or referral

then make my way to a public **hospital**

I have a **gynaecologist** on speed dial so would call her

Maybe go to the **hospital** or **GP**

I know that Marie Stopes has an abortion **clinic**

My first thought would be going to a **GP**

The **public health system** or **GP**

"Big Decision" Talk

The repeated use of terms such as "consider", "decision" and "reasons" casts doubt on the legitimacy of the choices made by a pregnant individual, problematising the quality of decisions made by a pregnant person and implying that the decision to undergo an abortion may be a "big decision". This framing implicitly situates abortion as irrational and abnormal. While such assumptions may be perceived as 'normal' within the context of abortion, they would be conspicuously absent in discussions surrounding other forms of healthcare, such as the decision to undergo an IUD procedure. These repetitive discursive practices denote the questioning of one's decision-making capacity, implicitly assuming that opting for an abortion is a "big decision". These discursive practices ultimately govern a pregnant person's reproductive conduct.

It is interesting to note, the vox pops did not ask questions regarding the decision of abortion - rather this discursive practice was used without a relevant question to it, underscoring the

normative nature of questioning one's decision-making capacity when specifically related to abortion.

> Have you **considered** everything because it's a life as well
>
> Their **reasons** to find out causing them to think so
>
> If they really **made a decision**
>
> Explore **their reasons** why they want to have the abortion
>
> Are they **making the decision** in the right headspace?
>
> You can just **make a decision** like you have had an
>
> argument, that's it I'm getting rid of it
>
> What if we did this, do you think you would **reconsider**?
>
> I think it's a big thing to **consider**

Uncertainty Talk

These texts elucidate the lack of knowledge accessible to the public regarding medication abortion availability. It may be seen as the usual way of talking within a vox pop, however, it was the only textual evidence within the vox pops where participants prefaced their answers with uncertainty repeatedly, clearly depicted through phrases of "I don't know", "I think". This situates abortion as an unknown topic, especially regarding the logistics of availability, highlighting the censorship of certain knowledges regarding abortion.

I don't really know

I actually **don't know** anything about the availability or where to get it

I think it's supposed to be freely available but **I don't know**

Before I thought yes, but since you asked I'm going to change my answer to no

I think it's complicated

I think you can get abortions in Australia

I don't think it's freely available but there is a little bit of availability.

Danger Talk

In contrast and similarly notable, there was clarity in the knowledge of medication abortion being "dangerous". Broader research indicates medication abortion problems occur, however, it usually only does so in spaces with restrictive practices and in-access to adequate support (Berer & Hoggart, 2018). It is interesting to note the knowledge being disseminated to the public is that medication abortion is only "dangerous and scary" providing a skewed understanding of medication abortion.

It causes **a lot of health problems** for women

Probably **not the most optimal** thing you want to do to your body

It **makes you quite unwell** for a couple of weeks

It's not like **100% safe**

I **haven't heard the best things** about it

You just go home and it's **very traumatic**

Hard-to-Get talk

Further, similarly, there was circulating knowledge of exclusive accessibility measures for abortion provision. The language use of "privilege", "resources", "expensive" and references to "obstacles" denote the understanding of how hard it is to get an abortion in Australia's current medical system and legislative landscape.

If they don't have **enough resources** it's **not easy**

I think there are **so many obstacles**

Not finding a clinician that can do it

They're **incredibly expensive** to get

A lot of doctors **won't provide them**

It's still **very regulated**

I think it's **very expensive** and **it's a privilege**

Depends on your tax bracket and your **privileges**

For people **with resources,** I think it's pretty accessible

Whilst abortion is situated within the medicalised discourse, collectively these five discursive practices construct the dominant narrative around medication abortion; that it is "exclusive and dangerous healthcare" thereby undermining its viability as a legitimate option. This constellation of discursive practices serves to further restrict agency through also reinforcing the questioning of a pregnant person's decision-making capacity ("big decision" talk) and thereby denying pregnant people their right to safe access to abortion provision. In this way, these discursive practices not only marginalises abortion as a healthcare option but also reinforces structural barriers to reproductive autonomy through restrictive knowledge practices regarding medication abortion.

Discussion

PIA enables a critical examination of how access to abortion—and specifically, medication abortion—is discursively represented, how these representations reflect or resist historical policy narratives, and how such discourses shape what is socially, politically, and institutionally possible. In so, after determining the discursive practices present, the underlying assumption and the norms it invoked, we can begin to piece together the dominant discourse at play. The following section relates the findings back to the research questions.

The remaining PIA questions are answered in this section:

1. How have certain "things said" come to be accepted as "truth"?
2. Are there any statements that challenge dominant, taken-for-granted realities?

The above 5 discursive practices do not exist in isolation, nor are they confined to only specific instances of language use. Rather, they function as communicative tools that actively produce and reproduce a dominant discourse, one that I coin as, abortion as a "big medical decision". This discourse, accepted as the "truth", through its repeated enactment, shapes public perceptions, transforming abortion as an illegitimate option and driving its restrictive access to medication abortion.

The Hybrid Discourse: Abortion as a "big medical decision"

Baird (2015) argues that abortion is frequently framed as a morally contentious decision rather than a legitimate healthcare service, reflecting a hybrid discourse that simultaneously supports pro-choice and anti-abortion positions. This hybrid discourse serves to negate abortion as a healthcare service, framing it as a stigmatised experience rather than a routine medical intervention. In similar fashion, it was evident in these findings, medication abortion was situated as a medical problem within a moralising discourse in governing people's reproductive conduct. This interplay of the

medicalised and moralised discourse produces the boundaried positioning of abortion as an illegitimate decision - a “big medical decision”.

These five discursive practices highlight the dominant narratives surrounding abortion in Australia today. The medical discourse positions abortion as a healthcare issue, while the “big decision” or moralising discourse introduces a moral judgement into the decision-making process. The coalescence of “uncertainty”, “hard-to-get” and “danger” discursive practices create a hybrid discourse that portrays abortion as both medically complicated and fraught with risk.

It is particularly revealing that abortion is situated within a medicalised discourse, framed as a healthcare service to be provided by medical institutions. However, there is a concurrent understanding that abortion is “hard-to-get”, revealing a tension between its status as healthcare and the lived realities of those seeking it. This duality exposes a significant gap in the public dissemination of knowledge about abortion access, where awareness is not only limited but strategically obscured. The prevailing narrative positions abortion as both a medical procedure that is also difficult to access, reinforcing a broader epistemic framework in which knowledge operates as a form of power—shaping public perception and regulating behaviour (Guédon, 1977; Schneck, 1987). Medication abortion presents a significant alternative, yet is similarly subject to discursive constructions that frame it as inherently risky. This stands in stark contrast to the World Health Organisation’s endorsement of its safety and its routine use in many global contexts (*New Clinical Handbook Launched to Support Quality Abortion Care*, n.d.). Through this discourse analysis, it becomes evident that a pervasive “truth” about medication abortion has taken hold—one that exaggerates risk and obscures legitimacy. This discrepancy underscores how the regulation of knowledge can influence public discourse and limit access to reproductive healthcare.

Through a Foucauldian lens we can see how this hybrid discourse exemplifies the relationship between knowledge and power. Power is upheld with the censorship of knowledge, in this case, allowing only certain knowledges about abortion to be disseminated (Bacchi & Goodwin, 2016a; Schneck, 1987). It is evident that, in order to govern reproductive conduct, only specific forms of

knowledge are permitted to circulate as "truths" (Guédon, 1977). This creates a dominant hybrid discourse and it functions as the "truth". In this context, a hybrid discourse emerges that simultaneously frames abortion as a healthcare procedure while subjecting the decision to terminate a pregnancy to intense scrutiny, portraying it as a morally questionable decision. Additionally, this discourse of an alternative - medication abortion, is positioned as inherently dangerous or frightening. Together, these elements consolidate the perception of abortion as a "big medical decision"; a hybrid discourse functioning as an accepted "truth" that shapes public understanding and ultimately governs reproductive decision-making and abortion access (Belfrage, 2024; Berro Pizzarossa & Nandagiri, 2021).

The "big medical decision" dominant discourse presents abortion as a last resort rather than as a legitimate healthcare option. It constrains how people can navigate their reproductive choices, framing it as something to be avoided unless absolutely necessary (Davey & editor, 2024). This discourse functions as a "truth" that limits individual autonomy and reinforces structural barriers to access (Veldhuis et al., 2022). At no point in the transcript was there a reference to an alternative to this taken-for-granted reality, it is simply unthinkable. This discourse analysis clearly highlights the complex boundaries that confine abortion, medication abortion and abortion access - the walls in which we all build to uphold the dominant discourse. Without highlighting these boundaries and situating of abortion, we cannot possibly begin to transgress these boundaries and re-imagine a new world of expansive abortion care.

The impact of the "big medical decision" discourse

The influence of this hybrid discourse is such that it opens up a potential pathway for further restrictions on abortion access, or even the imposition of an outright ban (Belfrage, 2023; Nandagiri & Berro Pizzarossa, 2023). By reinforcing the narrative of abortion as morally dubious, hard-to-get, and dangerous, this discourse lays the groundwork for policies that could further limit reproductive autonomy under the guise of protecting public health or moral integrity. While abortion is decriminalised in Australia, this discourse has already made its impact.

Decriminalisation, while a progressive gesture, may be in reality more of a performative facade of a pro-choice stance rather than a comprehensive commitment to expanding access.

The abortion bans in the United States may appear distant from the Australian situation; however, this discourse analysis suggests abortion bans and restricted access are positioned within the same spectrum of reproductive governance—both are defined by the punitive regulation of reproductive conduct (Yanow et al., 2021). The discursive practices embedded within the hybrid discourse reveals the ways in which reproductive decisions are implicitly governed and scrutinised, restricting autonomy and agency (Belfrage, 2023). It is important to acknowledge that, while these discursive practices are implicit within the data analysed, these knowledges impact marginalised people even more explicitly. When intersecting with other systems of oppression, such as race, gender, and disability, this discourse is actively enforced, directly governing and constraining reproductive autonomy (Ngo et al., 2021). The "big medical decision" hybrid discourse thus functions as a dominant narrative, whereby individuals internalise and reproduce these discursive practices as normative "truths", perpetuating the governance and moralisation of abortion.

It is essential to recognise that these norms are socially constructed and therefore mutable (Bacchi & Goodwin, 2016a). By critically interrogating and challenging this dominant discourse, we can work toward a more expansive and inclusive abortion care as a normalised framework. Post-structuralism offers a powerful lens through which we can examine and critique the ways in which we unknowingly reproduce discourse built upon political monopoly and outdated policy; discourses that perpetuate the framing of abortion as a "big medical decision". By interrogating this discourse, we can begin to re-imagine a world in which abortion care is truly accessible, expansive, and normalised.

Self-problematisation

This analysis represents my contribution to the construction of new "truths" and knowledge within the discourse surrounding abortion. Post-structuralism compels me to critically reflect on the

assumptions and interpretations I bring to the findings and analysis. Had someone else examined the same vox pop texts, they might have identified different patterns or understood the discursive practices in alternative ways. This process of reflection is essential to understanding the power dynamics inherent in knowledge production and the influence of my own positionality in shaping these meanings (Bacchi & Goodwin, 2016b). My lived experience has evidently shaped the interpretation of these discursive practices, ultimately contributing to the construction of the hybrid discourse. Post-structuralism recognises this subjective process, suggesting that all "truths" are not absolute, but rather contingent and shaped by specific contexts and perspectives (Bacchi & Goodwin, 2016b). Through this lens, the meanings I derive from the data are not seen as definitive, but as part of a broader, dynamic process of knowledge production.

Conclusion

This paper has argued that historical medication abortion policy in Australia continues to exert influence not only through formal regulatory mechanisms but also through the discursive frameworks that shape how abortion is understood, accessed, and experienced. By employing Post-structural Interview Analysis, this paper has highlighted how dominant narratives that limit access to medication abortion are underpinned and sustained by restrictive knowledge practices rooted in historical policy. The legacy of the de facto ban on mifepristone in Australia during the 1990s continues to reverberate in the present. Despite subsequent policy reforms that formally permit the provision of medication abortion, prevailing discourses surrounding it remain outdated, stigmatising, and obstructive to equitable access. While legislative reform represents a critical mechanism for expanding reproductive healthcare, its transformative potential is significantly constrained if not accompanied by a parallel effort to dismantle and reconstruct the dominant discourses shaped by historically restrictive policies. Without such discursive reconstruction, policy change risks becoming symbolic rather than substantive. Recognising that policy is not only a matter of governance but also a site of meaning-making, this article emphasises the need to interrogate the epistemological foundations of abortion discourse that cannot be dismantled through policy reform alone.

To meaningfully expand abortion care in Australia, it is essential to render these discourses visible, critically reflect on the knowledge practices that sustain them and the historical policy that breed them; and collectively reimagine abortion beyond the current limitations. As Anna Noonan aptly asserts, abortion should occupy a central place in both public discourse and public health, accessible *"if, when, and where it is needed or desired."* (Noonan, 2024). Crucially, the power to challenge dominant narratives lies not only in institutions but also in the collective agency of individuals to question, resist, and reconstruct them. This paper hopes to contribute to the broader imperative of building expansive abortion care—care that affirms autonomy and is shaped by inclusive and transformative discourses. Such re-imagining is both possible and necessary, and it begins with the conscious effort to unsettle the taken-for-granted and to advocate for discursive and material change.

Acknowledgements

To Sue, the teacher and supervisor that always made me feel as though I belonged in the midst of academic success. I will never be able to thank you enough for the countless hours you've selflessly provided, nevertheless, thank you - you have changed my life.

To Lakshman, thank you, in the greatest sense of the phrase, for the unconditional love, faith and belief in me, especially in times where I did not believe in myself. Words cannot express that which I will spend the rest of my life showing you, and for that this paper is dedicated to you.

Inaccessibility to safe, equitable, expansive abortion care remains a current injustice throughout the world. I hope we continue to fight for a world where abortion is no longer a topic of contestation. This paper is inspired by the countless people who have fought and continue to fight for this, and by those who have or will seek an abortion in their lifetime.

References

Aubusson, K. (2023, March 6). *Women turned away from public hospitals three years after abortion decriminalised in NSW*. The Sydney Morning Herald. https://www.smh.com.au/national/nsw/women-turned-away-from-public-hospitals-three-years-after-abortion-decriminalised-in-nsw-20230303-p5cp5e.html

Bacchi, C., & Bonham, J. (2016). Poststructural interview analysis: Politicizing "personhood." In *Http://www.palgrave.com/gp/book/9781137525444*. Palgrave Macmillan. https://digital.library.adelaide.edu.au/dspace/handle/2440/108061

Bacchi, C., & Goodwin, S. (2016a). Making Politics Visible: The WPR Approach. In C. Bacchi & S. Goodwin (Eds.), *Poststructural Policy Analysis: A Guide to Practice* (pp. 13–26). Palgrave Macmillan US. https://doi.org/10.1057/978-1-137-52546-8_2

Bacchi, C., & Goodwin, S. (2016b). *Poststructural Policy Analysis*. Palgrave Macmillan US. https://doi.org/10.1057/978-1-137-52546-8

Baird, B. (2015). Medical abortion in Australia: A short history. *Reproductive Health Matters*, *23*(46), 169–176. https://doi.org/10.1016/j.rhm.2015.10.002

Baird, B. (2023, October 3). *Abortion Care is Health Care*. Melbourne University Publishing. https://www.mup.com.au/books/abortion-care-is-health-care-paperback-softback

Belfrage, M. (2023). Revolutionary pills? Feminist abortion, pharmaceuticalization, and reproductive governance. *International Feminist Journal of Politics*, *25*(1), 6–29. https://doi.org/10.1080/14616742.2022.2154688

Belfrage, M. (2024). Reclaiming Autonomy: The Changing Landscape of Mexican Abortion Activism. *Signs: Journal of Women in Culture and Society*, *49*(3), 535–556. https://doi.org/10.1086/727986

Berer, M., & Hoggart, L. (2018). Medical abortion pills have the potential to change everything about abortion. *Contraception*, *97*(2), 79–81. https://doi.org/10.1016/j.contraception.2017.12.006

Berro Pizzarossa, L., & Nandagiri, R. (2021). Self-managed abortion: A constellation of actors, a cacophony of laws? *Sexual and Reproductive Health Matters*, *29*(1), 23–30. https://doi.org/10.1080/26410397.2021.1899764

Costa, C. D. (2007). *RU-486: The Abortion Pill*. Boolarong Press.

Davey, M., & editor, M. D. M. (2024, November 4). 'It's kind of whispered in corridors': Women being forced into underground abortion networks in rural NSW, study finds. *The Guardian*. https://www.theguardian.com/world/2024/nov/05/abortion-access-study-rural-new-south-wales-women

Davey, M., Evershed, N., & Lu, D. (2024, December 16). NSW abortion deserts: Just three of 220 public hospitals provide terminations, research finds. The Guardian. https://www.theguardian.com/australia-news/2024/dec/17/nsw-abortion-deserts-just-three-of-220-public-hospitals-provide-terminations-research-finds

El-murr, A. (2010). Representing the Problem of Abortion: Language and the Policy Making Process in the Abortion Law Reform Project in Victoria, 2008. *Australian Feminist Law Journal*, *33*(1), 121–140. https://doi.org/10.1080/13200968.2010.10854447

Ferrer, I., Lorenzetti, L., & Shaw, J. (2020). Podcasting for social justice: Exploring the potential of experiential and transformative teaching and learning through social work podcasts. *Social Work Education*, *39*(7), 849–865. https://doi.org/10.1080/02615479.2019.1680619

Foucault, M. (2008). Power/Knowledge. In The New Social Theory Reader (2nd ed.). Routledge.

Guédon, J. C. (1977). Michel Foucault: The Knowledge of Power and the Power of Knowledge. *Bulletin of the History of Medicine*, *51*(2), 245–277.

LaRoche, K. J., Wynn, L. L., & Foster, A. M. (2020). "We've got rights and yet we don't have access": Exploring patient experiences accessing medication abortion in Australia. *Contraception*, *101*(4), 256–260. https://doi.org/10.1016/j.contraception.2019.12.008

Liu, R., Davey, M., Ball, A., & Evershed, N. (2024, December 16). How hard is it to access an abortion in NSW? These maps show the 'deserts' for care in the state. The

Guardian. https://www.theguardian.com/australia-news/ng-interactive/2024/dec/16/how-hard-is-it-to-access-an-abortion-in-nsw-these-maps-show-the-deserts-for-care-in-the-state

MSI Australia | Abortion, Contraception & Vasectomy Provider. (n.d.). Retrieved November 13, 2024, from https://www.msiaustralia.org.au/

Nandagiri, R., & Berro Pizzarossa, L. (2023). Transgressing biomedical and legal boundaries: The "enticing and hazardous" challenges and promises of a Self-Managed Abortion multiverse. *Women's Studies International Forum*, *100*, 102799. https://doi.org/10.1016/j.wsif.2023.102799

New clinical handbook launched to support quality abortion care. (n.d.). Retrieved November 13, 2024, from https://www.who.int/news/item/12-06-2023-new-clinical-handbook-launched-to-support-quality-abortion-care

Ngo, N. V., Pemunta, N. V., Basil, N., Estella Tembe, F., Eyambe, M. S., Ezra, K., Che Ngwa, H., & Ombugadu Sabo, E. (2021). Reproductive health policy Saga: Restrictive abortion laws in low- and middle-income countries (LMICs), unnecessary cause of maternal mortality. *Health Care for Women International*, 1–19. https://doi.org/10.1080/07399332.2021.1994971

Noonan, A. (2024, March 5). *Abortion is key to women's autonomy. Why are our politicians still so silent about it?* Women's Agenda. https://womensagenda.com.au/latest/abortion-is-key-to-womens-autonomy-why-are-our-politicians-still-so-silent-about-it/

Noonan, A., Black, K. I., Luscombe, G. M., & Tomnay, J. (2023). "Almost like it was really underground": A qualitative study of women's experiences locating services for unintended pregnancy in a rural Australian health system. *Sexual and Reproductive Health Matters*, *31*(1), 2213899. https://doi.org/10.1080/26410397.2023.2213899

Schneck, S. F. (1987). Michel Foucault on Power/Discourse, Theory and Practice. *Human Studies*, *10*(1), 15–33.

Sifris, R. (2023). Chapter 7: Abortion in Australia: law, policy, and the advancement of reproductive rights.

https://www.elgaronline.com/edcollchap/book/9781839108150/book-part-9781839108150-15.xml

Veldhuis, S., Sánchez-Ramírez, G., & Darney, B. G. (2022). Locating Autonomous Abortion Accompanied by Feminist Activists in the Spectrum of Self-Managed Medication Abortion. *Studies in Family Planning*, *53*(2), 377–387. https://doi.org/10.1111/sifp.12194

Yanow, S., Pizzarossa, L. B., & Jelinska, K. (2021). Self-managed abortion: Exploring synergies between institutional medical systems and autonomous health movements. *Contraception*, *104* (3), 219–221.https://doi.org/10.1016/j.contraception.2021.06.006