When Young People Don't Seek Care

How fear, secrecy and misinformation turn treatable adolescent health problems into serious harms, with a case study on concealed pregnancy and unsupported abortion.

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Abstract. What happens when a young person notices something is wrong with their body or mind, and decides not to tell anyone? Across many countries, adolescents delay or avoid health care because they are scared their parents will find out, are unsure whether they are allowed to see a doctor alone, worry about cost, or feel too ashamed to ask. Silence rarely makes a health problem go away. More often, it makes the problem harder and riskier to treat by the time help is finally sought. This report synthesises 30 academic and grey literature sources on the harms that follow when young people conceal or delay health problems. It is organised around three themes: why young people stay silent; a central case study on concealed pregnancy and abortion managed without medical support; and other "silent harms", including untreated sexually transmissible infections (STIs) and delayed mental health care. Throughout, it highlights the Victorian rights and services that make supported care possible.

Keywords: young people; adolescent health; why young people stay silent; concealed pregnancy and unsupported abortion; other silent harms of delayed care

1. Introduction

Adolescence is a time of rapid change, when health problems often first appear and when patterns of using (or avoiding) health services are formed (Patton et al., 2016). Yet young people are also the group most likely to feel that a health worry is something to hide. The four points below explain why this issue is urgent.

1.1 Many young people go without care they need

Research on United States adolescents has found that between about 19% and 27% have gone without medical care they believed they needed, with concern about confidentiality a recurring reason (Lehrer et al., 2007). In Australia, the Royal Australasian College of Physicians has highlighted evidence that about one in five adolescents had skipped care because they worried their parents would find out (Royal Australasian College of Physicians [RACP], 2010). These are not rare cases; they describe an ordinary pattern in adolescent life.

1.2 The problems young people hide are often time-sensitive

The health issues adolescents are most likely to keep secret, such as pregnancy, STIs and mental distress, are also the ones where time matters most. Pregnancy options narrow as gestation increases, untreated infections can spread to reproductive organs, and mental health conditions can deepen without support. In Victoria, early medication abortion is available only up to 9 weeks of pregnancy (Better Health Channel, n.d.; The Royal Women's Hospital, n.d.), so even a few weeks of hiding can change which options remain.

1.3 Online information fills the gap left by silence

When young people avoid clinics, they often turn to search engines and social media instead. The internet can be a useful starting point, but it also connects young people with unregulated sellers and inaccurate advice. One study found that websites selling abortion medicines shipped products without asking for a prescription or any medical history (Murtagh et al., 2018). For a frightened teenager, a website can look like an easier option than a doctor's appointment.

1.4 Rights to confidential care are poorly understood

In Victoria, a young person under 18 may be able to consent to their own treatment, including contraception and abortion, if a clinician judges that they understand the decision (Victoria Legal Aid, n.d.; Sexual Health Victoria, n.d.). Young people can also hold their own Medicare card from age 15 (Services Australia, n.d.). Many young people do not know these rights exist, which means fear is often based on a misunderstanding rather than on how care actually works.

Table 1. Key terms used in this review

Term	Definition
Mature minor	A young person under 18 who a clinician judges is mature enough to understand a treatment and its consequences, and so can legally consent to it themselves.
Gillick competence	A legal test, from a UK court case, used in Australia to decide whether a person under 16 understands a treatment well enough to consent to it.
Concealed pregnancy	A pregnancy that a person knows about but deliberately hides from family, friends or health professionals, often until late in pregnancy or birth.
Medication abortion	Ending an early pregnancy using prescribed medicines, with a health professional checking gestation, giving information and providing follow-up care.
Pelvic inflammatory disease (PID)	An infection of the uterus, fallopian tubes or ovaries, often caused by an untreated STI, which can lead to pain and infertility.

2. Method

This report is a narrative literature review of peer-reviewed and grey literature on the harms that arise when young people conceal or delay health problems. Peer-reviewed sources were identified through PubMed, Google Scholar and publisher databases, and grey literature was drawn from Australian and international government, professional and non-government organisations, including the Australian Bureau of Statistics, the Kirby Institute, the World Health Organization, the Royal Australasian College of Physicians and Victorian health and legal services. The review focused on young people aged approximately 10 to 24, English-language sources, and Australian and international evidence, with priority given to systematic reviews, large cohort and population studies, randomised trials and official reports. Sources were synthesised thematically rather than through formal meta-analysis.

3. Conceptual model: The Concealment Cascade

The Concealment Cascade describes how a hidden health worry can move step by step from a manageable problem to a crisis. Each stage is also an "exit point": a moment where accurate information, a trusted adult or a confidential service can redirect a young person towards safe care. The model is drawn from the evidence

reviewed in this report and is intended to help schools, families and services see where they can intervene.

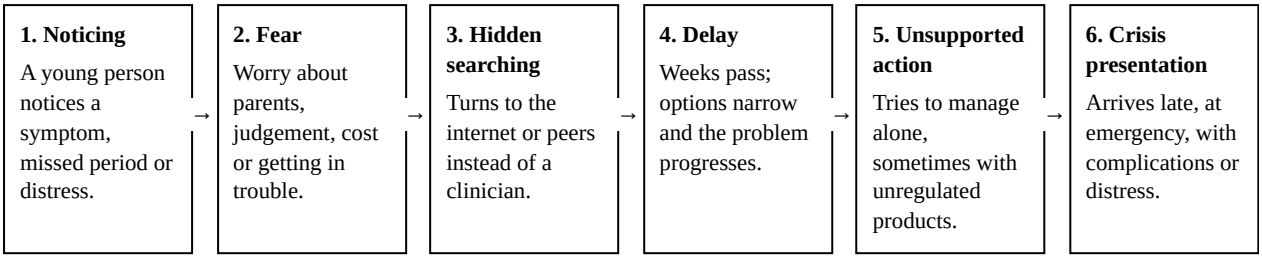


Figure 1. The Concealment Cascade: conceptual model developed from the literature reviewed.

4. Why young people stay silent

Young people rarely avoid care because they do not care about their health. The evidence shows they weigh the health problem against the social risks of seeking help, and fear of disclosure often wins.

4.1 Fear that parents will be told is a powerful barrier

A landmark study of adolescent girls attending family planning clinics in Wisconsin asked what they would do if parents had to be notified about prescribed contraception. Nearly half said they would stop using all sexual health services at the clinic, and around six in ten would stop or delay some care, including STI testing and treatment (Reddy et al., 2002; RACP, 2010). Crucially, almost all of those who would stop care said they would continue to be sexually active. In other words, removing confidentiality did not change sexual behaviour; it only removed the safety net.

International guidance reflects this. The World Health Organization (WHO) recommends that abortion be available without the authorisation of any other person, noting that evidence links third-party authorisation requirements with delays to care, and that mandated parental involvement has been associated with delay, family conflict and fear of violence (World Health Organization [WHO], 2022).

4.2 Simply being told care is confidential changes behaviour

The reverse is also true: reassurance works. In a randomised controlled trial, adolescents who heard a clinician's assurance of confidentiality were more willing to disclose sensitive information about sexuality, substance use and mental health (rising from 39% to 46.5%), and more willing to return for future care (rising from 53% to 67%) (Ford et al., 1997). This suggests that some silence is preventable with a single, clear sentence at the start of a consultation.

Australian guidance encourages clinicians to see young people alone for part of each visit, explain confidentiality and its limits, and tell adolescents they can apply for their own Medicare card from 15 (RACP, 2010). Confidentiality is not absolute: clinicians may need to act if a young person is at risk of serious harm, such as abuse (Sexual Health Victoria, n.d.). Being honest about these limits builds more trust than vague promises.

4.3 Misconceptions about rights and cost keep young people away

Many young people do not know they can consent to their own care or that Medicare is available to them directly. In Victoria, a young person who is judged mature enough can consent to contraception or abortion without a parent's agreement (Victoria Legal Aid, n.d.), and a "Gillick competent" patient under 16 can legally

consent to an abortion (Centre for Excellence in Rural Sexual Health [CERSH], n.d.). From 15, young people can apply for their own Medicare card, and from 14, parents cannot see a young person's My Health Record without their permission (Services Australia, n.d.; Sexual Health Victoria, n.d.).

Cost and navigation also matter. A survey of 1,416 young people aged 12 to 24 in New South Wales found that cost was the most common barrier to health care, reported by 45.8% of participants (Kang et al., 2020). Young people with a regular GP were less likely to report cost, feeling judged, not knowing where to go, or not having their own Medicare card as barriers, showing how a trusted, ongoing relationship with one clinician can dissolve several barriers at once.

4.4 Stigma and self-reliance make silence feel safer

A systematic review of 22 studies found that the barriers young people most often name when it comes to mental health help-seeking are stigma and embarrassment, difficulty recognising symptoms, and a strong preference for dealing with problems on their own (Gulliver et al., 2010). Positive past experiences and encouragement from others were the main facilitators.

These same forces operate around sexual and reproductive health, where taboo is often stronger. For young people from culturally and linguistically diverse families, LGBTQIA+ young people, and those in small or rural communities, the fear of being seen at a clinic or judged by family can be especially intense. When stigma combines with a belief that one "should" cope alone, a young person may hide a problem until it becomes impossible to ignore.

4.5 Implications and recommendations

Make confidentiality visible

- *Say it early.* Clinicians state confidentiality and its limits at the start of every adolescent consultation.
- *Time alone.* Routinely offer young people part of each appointment without a parent present.
- *Youth-friendly signage.* Display "You can see us on your own" messages in clinics, pharmacies and school health spaces.

Teach rights, not just risks

- *Medicare at 15.* Include getting your own Medicare card in school health and careers programs.
- *Consent explained.* Teach what "mature minor" means in plain language in Year 9 and 10 health classes.
- *Know the numbers.* Put 1800 My Options and Kids Helpline on student ID cards and school portals.

Reduce cost and stigma

- *Bulk-billing for young people.* Encourage clinics to bulk-bill under-25s and advertise it clearly.
- *Peer champions.* Train youth ambassadors, including CALD and LGBTQIA+ young people, to normalise help-seeking.

5. Concealed pregnancy and unsupported abortion

Concealed or unreported pregnancy is one of the clearest examples of how silence can turn a manageable situation into a dangerous one. This theme examines the outcomes of concealed pregnancy, the risks of managing an abortion without medical support, and the strong evidence that supported care is safe.

5.1 Concealed pregnancies are more common than many assume

A one-year prospective study in Berlin estimated that about 1 in 475 pregnancies was not recognised or acknowledged until at least 20 weeks, and about 1 in 2,455 was not recognised until delivery (Wessel et al., 2002). Research from an Irish university hospital found roughly one concealed pregnancy for every 148 births (Thynne et al., 2012). Definitions differ between studies, ranging from denial (not knowing) to concealment (knowing but hiding), but both lead to the same result: little or no antenatal care.

The Irish study compared 43 women who concealed a pregnancy with women who experienced a crisis pregnancy but did not conceal it. Those who concealed were, on average, eight years younger than the general birthing population, and 79% reported fearing a negative reaction from their parents, compared with 40% of the comparison group (Thynne et al., 2012).

5.2 Concealment is linked to poorer outcomes for parent and baby

Babies born after concealed pregnancies in the Irish study weighed on average about 400 grams less than the hospital's normal birth weight (Thynne et al., 2012). A review of 31 concealed pregnancies at a Dublin maternity hospital, with mothers aged 15 to 38, recorded ten preterm births, postpartum haemorrhage in 16% of mothers, and admission of a quarter of babies to neonatal intensive care (Stokes et al., 2020).

These outcomes are not caused by pregnancy itself but by the absence of care: no screening, no monitoring and, in some cases, birth without a trained attendant. The same isolation that leads to concealment can also leave young people facing labour alone and in shock. South Australia's perinatal guidelines specifically address concealed and denied pregnancy because late or absent antenatal care carries risks for both the mother and the newborn (SA Health, 2024).

5.3 Delay narrows choices and pushes care later

Hiding a pregnancy does not only affect those who continue it. United States research comparing people who had abortions at or after 20 weeks with those who had first-trimester abortions found that younger age was associated with later abortion, while discovering a pregnancy before eight weeks strongly predicted earlier care (Foster & Kimport, 2013). Later care was also driven by practical delays, such as finding a provider and raising money.

In Victoria, abortion is legal and available up to 24 weeks of pregnancy, and after that with the agreement of a second medical practitioner (Better Health Channel, n.d.). However, the simplest and most private option, early medication abortion, is limited to the first 9 weeks. Every week a young person spends hiding a pregnancy can take a safer, cheaper and less invasive option off the table.

5.4 Supported medical abortion is very safe and can be delivered by telehealth

Australian evidence on supervised early medical abortion is reassuring. A study of 13,345 early medical abortions across 15 Australian clinics reported a treatment failure rate of 3.5%, with very low rates of serious complications: haemorrhage occurred in about 0.1% of cases and confirmed infection in fewer than 0.1% (Goldstone et al., 2012). A direct-to-patient telehealth service in Australia found that, among women with known outcomes, 96% had a complete abortion without surgery, and over half of patients lived outside major cities (Hyland et al., 2018).

Access has also widened. Following a Therapeutic Goods Administration decision, doctors no longer need special certification to prescribe the medical abortion medicine MS-2 Step, and pharmacists no longer need to register to dispense it (Pharmaceutical Society of Australia [PSA], 2023). The WHO notes that deaths from

safe abortion are fewer than 1 per 100,000 procedures (WHO, 2025).

5.5 Unregulated products and unsupported attempts add avoidable risk

When young people believe they cannot access care, some turn to online sellers. In a study that purchased abortion medicines from websites, researchers reported that "No site required a prescription or any relevant medical information" (Murtagh et al., 2018). Delivery took up to 21 business days, and tests showed that one of the medicines in the products often contained less active ingredient than the label stated, in some cases far less. Without a health check, a buyer also has no confirmation of how far along the pregnancy is, and no plan if something goes wrong.

A national United States survey found that people who had tried to end a pregnancy without clinical care used a wide range of methods, many ineffective; only 28% of attempts ended the pregnancy, and around a third of people later sought care at a facility (Ralph et al., 2020). By contrast, a study of people who used an online telemedicine service with an online consultation, structured information and ongoing support found that most had a complete abortion, and that 95% of those advised to seek medical attention did so (Aiken et al., 2017). The lesson is that support, accurate information and follow-up, not secrecy, are what make care safer. Globally, the WHO estimates around 45% of induced abortions are unsafe, and unsafe abortion remains a cause of preventable death (WHO, 2025).

> "No site required a prescription or any relevant medical information." (Murtagh et al., 2018)

Table 2. Summary of evidence discussed in this section

Feature	Supported care (GP, clinic or telehealth)	Unregulated online purchase
Medicine quality	TGA-approved, from a pharmacy	Unknown; may differ from label
Pregnancy check	Gestation confirmed by a clinician	No check
Information	Clear advice on what to expect	Often missing or inaccurate
Follow-up	Planned follow-up and advice if concerned	None
Cost	Medicare and PBS subsidies may apply	Full price, no protection
Evidence	High effectiveness, low complications	Uncertain; failed attempts common

Box 1. Lena's story (composite)

Lena, 16, lives in Melbourne's outer suburbs with her parents, who migrated to Australia before she was born. When her period is three weeks late, she takes a test at a friend's house and it is positive. She is terrified her parents will find out. At night she searches online and finds websites selling pills with no questions asked, and forums full of conflicting advice. She almost places an order. Instead, she mentions her worry to the school nurse, who explains that Lena can see a doctor on her own, that she can apply for her own Medicare card, and that 1800 My Options can help her find a confidential service nearby. Within a week Lena has a telehealth appointment, a referral for an ultrasound and a clear plan with follow-up. Whatever she decides, she now has information, support and a clinician who knows her situation. This vignette is a composite drawn from themes in the literature and does not describe a real person.

5.6 Implications and recommendations

Shorten the time to care

- *Early pregnancy pathways.* Schools and youth services keep a simple, confidential referral list for pregnancy concerns.
- *Promote 1800 My Options.* Advertise this free, confidential Victorian service (Women's Health Victoria, n.d.) where young people are: social media, schools and libraries.
- *Telehealth for young people.* Encourage youth-friendly telehealth options, especially for rural and regional Victorians.

Counter online misinformation

- *Trusted content first.* Health services invest in search-friendly, youth-tested information that outranks unregulated sellers.
- *Teach source-checking.* Health education includes how to spot unsafe health products and sellers online.

Support, don't shame

- *Non-judgemental responses.* Train teachers, coaches and youth workers to respond to disclosure with calm support and referral.
- *Family conversations.* Offer culturally safe resources that help families talk about pregnancy without blame.

6. Other silent harms of delayed care

Pregnancy is not the only health problem young people hide. Untreated STIs and delayed mental health care show the same pattern: problems that are usually simple to treat early become harder to manage when kept secret.

6.1 Untreated STIs can cause lasting reproductive harm

Young people carry the largest share of STIs in Australia. In national surveillance data, around 69% of chlamydia notifications were among people aged 15 to 29 (Kirby Institute, 2023). Chlamydia often has no symptoms, so it is easily ignored, and young people who are afraid of being judged or found out may avoid testing altogether.

When chlamydia is left untreated in women, it can spread and cause pelvic inflammatory disease (PID). A major review found that in high-risk settings, 2% to 5% of untreated women developed PID in the short gap between a positive test and treatment, and that up to 18% of women may develop infertility after symptomatic PID (Haggerty et al., 2010). The study by Reddy et al. (2002) shows how these risks connect: if confidentiality is threatened, STI testing and treatment are among the first services young people say they would delay.

6.2 Many young people with mental health conditions do not get help

Australia's national mental health survey found that 38.8% of people aged 16 to 24 had experienced a mental disorder in the previous 12 months, rising to 45.5% among young women (Australian Bureau of Statistics [ABS], 2023). Yet among people aged 16 to 34 with a recent mental disorder, fewer than half (46.2%) had seen a health professional about their mental health in that time.

The reasons echo Theme 1. Young people report stigma, embarrassment, difficulty recognising symptoms and a wish to handle things alone (Gulliver et al., 2010). Delayed help-seeking can mean distress deepens, school and relationships suffer, and young people reach services only at a point of crisis. Earlier, low-barrier options such as online chat and phone lines can provide a first step for those not ready to see someone in person.

6.3 Delay is a shared pattern, not a personal failing

Across pregnancy, infections and mental health, the evidence points in one direction: young people delay care when the system feels unsafe, expensive or confusing, and they engage when it feels confidential, affordable and respectful (Ford et al., 1997; Kang et al., 2020). Adolescents with a regular GP report fewer barriers of almost every kind (Kang et al., 2020), and global experts argue that health systems must be designed around adolescents' needs rather than expecting young people to adapt to adult services (Patton et al., 2016).

This framing matters. Blaming young people for "leaving it too late" ignores the barriers that pushed them towards silence. Treating delay as a design problem shifts responsibility to clinics, schools, governments and communities, who have the power to make help easier to reach.

6.4 Implications and recommendations

Make testing and help routine

- *Opt-out STI testing.* Offer chlamydia testing as a normal part of youth health checks, without needing to ask.
- *Free youth clinics.* Expand free, walk-in sexual health and mental health services for under-25s.

Build early entry points

- *Low-pressure first steps.* Promote phone, text and online chat services as safe ways to start a conversation.
- *Regular GP for every teen.* Support young people to find a youth-friendly GP they can return to.

Listen to young people

- *Youth co-design.* Involve diverse young people in designing services, signage and health campaigns.
- *Measure forgone care.* Include questions on avoided care and confidentiality fears in Victorian youth health surveys.

7. Conclusion

Six main conclusions emerge from the evidence reviewed:

1. *Fear of disclosure is the root of much silence.* Young people often avoid or delay care because they fear parents will be told. Evidence shows that removing confidentiality does not stop risky situations; it only removes the safety net of care.
2. *Confidentiality reassurance is a simple, effective intervention.* When clinicians clearly explain confidentiality and its limits, adolescents are more willing to share and return. Schools and services can reinforce this message long before a young person needs it.
3. *Concealed pregnancy carries real and preventable risks.* Studies link concealment with younger age, fear of parental reaction, lower birth weight, preterm birth and neonatal intensive care admission. Most of these harms stem from the absence of care, not from pregnancy itself.

4. *Supported medical abortion is safe; unsupported attempts are not.* Australian clinic and telehealth data show high effectiveness and very low complication rates. Unregulated online products offer no health check, uncertain quality and no follow-up, and unsupported attempts frequently fail.
5. *Silent harms extend beyond pregnancy.* Untreated STIs can lead to pelvic inflammatory disease and infertility, and fewer than half of young Australians with a recent mental disorder see a professional. Delay is a shared pattern across health issues.
6. *Victorian young people have more rights than they realise.* Mature minors can consent to their own care, young people can hold their own Medicare card from 15, and 1800 My Options offers free, confidential guidance. Making these rights widely known is one of the most practical ways to prevent harm.

Support services (Australia)

1800 My Options; Free, confidential Victorian information and referral service for contraception, pregnancy options and sexual health (weekdays 9am–5pm); 1800 696 784

Kids Helpline; Free, private counselling for young people aged 5 to 25, 24 hours a day; 1800 55 1800

Lifeline; 24/7 crisis support by phone, text or online chat; 13 11 14 or text 0477 13 11 14

headspace; Online and phone support for young people, including clinician chat; headspace.org.au

Services Australia; How to get your own Medicare card from age 15; servicesaustralia.gov.au

Emergency; If you have heavy bleeding, severe pain, fever or feel unsafe, call Triple Zero; 000

In an emergency, call 000. This article is health education, not medical advice.

Declarations

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References

Aiken, A. R. A., Digol, I., Trussell, J., & Gomperts, R. (2017). Self reported outcomes and adverse events after medical abortion through online telemedicine: Population based study in the Republic of Ireland and Northern Ireland. *BMJ*, *357*, j2011. https://doi.org/10.1136/bmj.j2011

Australian Bureau of Statistics. (2023). *National Study of Mental Health and Wellbeing, 2020–2022*. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release

Better Health Channel. (n.d.). *Abortion in Victoria*. Victorian Department of Health. https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-in-victoria

Centre for Excellence in Rural Sexual Health. (n.d.). *Patients aged 16 and under*. The University of Melbourne. https://medicine.unimelb.edu.au/cersh/resources/health-practitioner-resource-hub/patients-aged-16-and-under

Ford, C. A., Millstein, S. G., Halpern-Felsher, B. L., & Irwin, C. E., Jr. (1997). Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care: A randomized controlled trial. *JAMA, 278*(12), 1029–1034. https://doi.org/10.1001/jama.1997.03550120089044

Foster, D. G., & Kimport, K. (2013). Who seeks abortions at or after 20 weeks? *Perspectives on Sexual and Reproductive Health, 45*(4), 210–218. https://doi.org/10.1363/4521013

Goldstone, P., Michelson, J., & Williamson, E. (2012). Early medical abortion using low-dose mifepristone followed by buccal misoprostol: A large Australian observational study. *Medical Journal of Australia, 197*(5), 282–286. https://doi.org/10.5694/mja12.10297

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10*, 113. https://doi.org/10.1186/1471-244X-10-113

Haggerty, C. L., Gottlieb, S. L., Taylor, B. D., Low, N., Xu, F., & Ness, R. B. (2010). Risk of sequelae after *Chlamydia trachomatis* genital infection in women. *The Journal of Infectious Diseases, 201*(Suppl. 2), S134–S155. https://doi.org/10.1086/652395

Hyland, P., Raymond, E. G., & Chong, E. (2018). A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 58*(3), 335–340. https://doi.org/10.1111/ajo.12800

Kang, M., Robards, F., Luscombe, G., Sanci, L., & Usherwood, T. (2020). The relationship between having a regular general practitioner (GP) and the experience of healthcare barriers: A cross-sectional study among young people in NSW, Australia, with oversampling from marginalised groups. *BMC Family Practice, 21*, 220. https://doi.org/10.1186/s12875-020-01294-8

Kirby Institute. (2023). *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2023 – Sexually transmissible infections*. UNSW Sydney. https://www.kirby.unsw.edu.au/research/reports/asr2023

Lehrer, J. A., Pantell, R., Tebb, K., & Shafer, M.-A. (2007). Forgone health care among U.S. adolescents: Associations between risk characteristics and confidentiality concern. *Journal of Adolescent Health, 40*(3), 218–226. https://doi.org/10.1016/j.jadohealth.2006.09.015

Murtagh, C., Wells, E., Raymond, E. G., Coeytaux, F., & Winikoff, B. (2018). Exploring the feasibility of obtaining mifepristone and misoprostol from the internet. *Contraception, 97*(4), 287–291. https://doi.org/10.1016/j.contraception.2017.11.005

Patton, G. C., Sawyer, S. M., Santelli, J. S., Ross, D. A., Afifi, R., … Viner, R. M. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet, 387*(10036), 2423–2478. https://doi.org/10.1016/S0140-6736(16)00579-1

Pharmaceutical Society of Australia. (2023). *Pharmacists now able to dispense medical terminations medicines across Australia*. https://www.psa.org.au/nation-wide-access-to-medical-terminations/

Ralph, L., Foster, D. G., Raifman, S., Biggs, M. A., Samari, G., Upadhyay, U., Gerdts, C., & Grossman, D. (2020). Prevalence of self-managed abortion among women of reproductive age in the United States. *JAMA Network Open, 3*(12), e2029245. https://doi.org/10.1001/jamanetworkopen.2020.29245

Reddy, D. M., Fleming, R., & Swain, C. (2002). Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA, 288*(6), 710–714. https://doi.org/10.1001/jama.288.6.710

Royal Australasian College of Physicians. (2010). *Confidential health care for adolescents and young people (12–24 years)*. https://www.racp.edu.au/docs/default-source/advocacy-library/confidential-health-care-for-adolescents-and-young-people.pdf

Services Australia. (n.d.). *Getting your own Medicare card at 15 years old*. Australian Government. https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-card/getting-your-own-medicare-card-15-years-old

Sexual Health Victoria. (n.d.). *Accessing health services for people under 18*. https://shvic.org.au/resource/accessing-health-services-for-people-under-18

SA Health. (2024). *Concealed or denied pregnancy: SA perinatal practice guidelines*. Government of South Australia. https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/concealed+or+denied+pregnancy+-+sa+perinatal+practice+guidelines

Stokes, J., Forster, P., & Geary, M. (2020). Concealed pregnancy in the 21st century. *Irish Medical Journal, 113*(10), P204. https://imj.ie/wp-content/uploads/2020/12/Concealed-Pregnancy-in-the-21st-Century.pdf

The Royal Women's Hospital. (n.d.). *Abortion.* https://www.thewomens.org.au/health-information/unplanned-pregnancy-information/abortion

Thynne, C., Gaffney, G., O'Neill, M., Tonge, M., & Sherlock, C. (2012). Concealed pregnancy: Prevalence, perinatal measures and socio-demographics. *Irish Medical Journal, 105*(8). https://pubmed.ncbi.nlm.nih.gov/23155911/

Victoria Legal Aid. (n.d.). *Contraception, pregnancy and abortion*. https://www.legalaid.vic.gov.au/contraception-pregnancy-and-abortion

Wessel, J., Endrikat, J., & Buscher, U. (2002). Frequency of denial of pregnancy: Results and epidemiological significance of a 1-year prospective study in Berlin. *Acta Obstetricia et Gynecologica Scandinavica, 81*(11), 1021–1027. https://doi.org/10.1034/j.1600-0412.2002.811105.x

Women's Health Victoria. (n.d.). *1800 My Options*. https://whv.org.au/our-focus/1800-my-options

World Health Organization. (2022). *Abortion care guideline*. https://www.who.int/publications/i/item/9789240039483

World Health Organization. (2025). *Abortion* [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/abortion