RURAL GPs AND UNINTENDED PREGNANCY IN THE GRAMPIANS PYRENEES AND WIMMERA REGIONS

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This research collaboration between Women's Health Grampians and The University of Melbourne builds evidence to inform advocacy, planning, training and service development in the Grampians region.

Executive Summary

BACKGROUND

In 2012, Victorian rural women's health services conducted a study which indicated that information on the range of options available to women with unintended pregnancies is limited and direct services are scarce. Parts of the Grampians region have teen pregnancy rates that are significantly higher than the state average. Trends over the past five reporting years have seen Ararat, Horsham and Northern Grampians ranked within top 10 highest teenage pregnancy rates in the state.

This study aimed to explore GPs' views on the services in the region and their referral practices when women present with an unintended pregnancy.

The range of options available to women with unintended pregnancies is limited

METHOD

A mixed method study was conducted with GPs and Practice Nurses working in the Grampians Pyrenees and Wimmera regions. All GPs publicly listed as working in one of these regions were mailed a paper survey on unintended pregnancy, and all GP clinics were emailed a link to the same survey online. GPs were also invited to participate in a semi-structured interview about their experience when women present with an unintended pregnancy. In addition, snowball sampling was used to recruit Practice Nurses with an interest and experience in this topic.

RESULTS

23 of the 84 GPs working in the region completed the survey (27% response rate), 5 GPs and 3 Practice Nurses completed a telephone interview. **On average, the GPs saw 3 women per year presenting with an unintended pregnancy** (range 0-25). The majority of GPs were trained overseas (65%).

41% 'always' discuss surgical abortion

27% 'always' discuss medical abortion

0% 'always' discuss tele-abortion

38% 'sometimes' or 'always' refer due to a conscientious objection

41% of GPs reported 'always' discussing surgical abortion with a woman presenting with an unintended pregnancy, and **only 27% would 'always' discuss medical abortion**. **No GPs 'always' discussed tele-abortion** in this instance, with 75% reporting that they 'never' discussed tele-abortion.

38% of GPs 'sometimes' or 'always' referred women to a colleague because they hold a conscientious objection, with the proportion going up to 62% for GPs trained overseas.

Perspectives from conscientious objectors, GPs interested in providing medical termination of pregnancy (MTOP) and Practice Nurses working with the community gathered during the telephone interviews gave rich insights into each of these issues.

CONCLUSIONS

Overall, we identified **limited abortion services** (in Ballarat and/or Melbourne only), **poor knowledge of the options of medical abortion and tele-abortion**, as a well as inconsistencies in both GP and practice nurse awareness of services, including **no clear referral pathways**, and difficulty accessing information.

For those interested in providing MTOP, there were a number of barriers; lack of ultrasound facilities; lack of clarity about back-up hospital services for MTOP and; lack of knowledge as to whether pharmacists would be willing to stock the drugs.

The study highlights a number of positive opportunities: respondents indicated strong support for improvement in sexual and reproductive health services in the region (up until the point termination is needed); at least a small number of GPs are willing to consider providing MTOP; there is evidence that there are conscientious objectors who abide by Section 8 of the Abortion Act and refer to a colleague.

RECOMMENDATIONS

The study results indicate significant scope for improvements to support women with unintended pregnancy in the Grampians region in terms of knowledge, services and referral pathways. Recommendations of this research include:

- Improving referral pathways for medical and surgical abortion
- Improving health care providers knowledge of medical and tele-abortion
- Provision of support to GPs willing to provide medical and/or tele-abortion to set up a trial service, develop clinical protocols and explore support for ultrasound availability, emergency backup and pharmacy medication
- Promoting the provision of accurate and comprehensive information on all available options for women facing unintended pregnancy through government, regional and local community information communication networks.

Contents

Background

Parts of the Grampians region experience teenage pregnancy rates double the national average

Parts of the Grampians region, like other rural and regional areas, experience teenage pregnancy rates double the national average and more than four times that of major cities such as Melbourne (Australian Institute of Health and Welfare, 2017, City of Greater Dandenong, 2017). While in 2015 Australia recorded the lowest teenage fertility rates at 12 per 1,000 (Australian Bureau of Statistics, 2016), these rates have been shown to increase with distance from major cities, and to be almost six times higher in the most remote areas (Australian Institute of Health and Welfare, 2017). According to 2014 ABS data for Victoria (City of Greater Dandenong, 2017), both **Horsham and Northern Grampians had a birth rate amongst 15-19 year-olds of 23 per 1,000**. Melbourne, in contrast, had a birth rate in the age-group of 5 per 1,000. While the reasons for teenage pregnancy are multi-faceted, and a number of pregnancies in this age group will be intended, access to sexual and reproductive health services is considered one important factor in ensuring young women are able to make fully informed choices.

Structural factors relating to rurality limit availability of health services in rural areas more generally and are not confined to sexual and reproductive health services. People in rural areas have poorer health outcomes than their urban counterparts and while there are multiple reasons for this, access to health services plays a key role (Department of Health, 2016). Sexual and reproductive health, including family planning, is considered to be a core primary health care service (Thomas et al., 2015). In an Australian Delphi study of the opinions of rural primary health care experts, Thomas and colleagues (2015) found that this was an area of primary healthcare that experts considered should be provided at population thresholds of 100 in remote communities and at 500 in rural communities.

30-40% of pregnancies in Australia are thought to be unintended

In rural areas women must travel greater distances to access services and often present at a later stage in their pregnancy

Persistent barriers to the provision of adequate sexual and reproductive health services in rural areas exist. 30-40% of pregnancies in Australia are thought to be unintended (Sedgh et al., 2014, Rowe et al., 2016), yet services to support women with unintended pregnancies remain patchy, particularly in rural areas, where women must travel greater distances to access services (Doran and Hornibrook, 2014) and often present at a later stage in their pregnancy (Shankar et al., 2017).

While **equitable access to safe termination of pregnancy (TOP) is considered to be a core component of sexual and reproductive health from public health and human rights perspectives** (World Health Organization, 2012), persistent barriers hamper access. The lack of access to abortion services in rural areas, both in Australia (Kruss and Gridley, 2014, Dawson et al., 2016, Shankar et al., 2017, Doran and Hornibrook, 2014, Doran and Hornibrook, 2016) and in other developed countries (Heller et al., 2016, Doran and Nancarrow, 2015), is commonly reported in the academic literature.

Lack of access to abortion services in rural areas is commonly reported in academic literature

Abortion remains a crime in five of Australia's eight states, and while abortion has been decriminalised in some states, a range of different laws still exist across the country (de Moel-Mandel and Shelley, 2017). Even in states where decriminalisation has been achieved, this has not resulted in universal access for women in those states (Keogh et al., 2017). In a critical review of literature on barriers to abortion access, de Moel and colleagues (2017) considered the question of access through a multi-domain framework. They suggest access needs to be understood not only in terms of the availability of services, but also via structural inhibitors such as legal context and procedural requirements, as well as ideological barriers such as conscientious objection. Young women, as well as socially and economically disadvantaged women have been shown to bear the brunt of shortfalls in abortion services. **Women experiencing unintended pregnancy and seeking abortion in rural areas are faced with greater costs, longer delays and waiting periods, logistical concerns and strains to social support networks compared to women in urban centres** (Doran and Nancarrow, 2015, Nickson et al., 2006)

Women seeking abortion in rural areas are faced with greater costs, longer delays and waiting periods, compared to women in urban centres

Recent improvement in the number of options for abortion in Victoria may not be equally distributed. Medical termination of pregnancy (MTOP) involving the use of the drugs mifepristone and misoprostol to induce abortion up to nine weeks' gestation was made available in Australia in 2012. Along with the possibility of delivery of MTOP via telemedicine services such as those now available through Marie Stopes and the Tabbot Foundation, **MTOP is generally considered to be a good way of increasing access to abortion for women in rural and regional areas** (Newton et al., 2016).

In order to provide MTOP, general practitioners (GPs) are required to undergo a short, online training program provided by Marie Stopes Health (https://www.ms2step.com.au/). Yet, despite the availability of MTOP in Australia since 2012, relatively few GPs are thought to have taken up the option of becoming MTOP providers (Newton et al., 2016). Very little information is publicly available on the location of providers of MTOP. The 'Better Health Channel' sponsored by the Victorian Government provides the most accurate and up-to-date information, and

MTOP is generally considered to be a good way of increasing access to abortion for women in rural and regional areas

MTOP provided via telemedicine has been shown to reduce the cost for women, enable earlier terminations, reduce women's stress, and increase the availability of abortion

lists only two medical abortion providers in regional Victoria – Wangaratta and Wodonga (https://www.betterhealth.vic.gov.au/health/healthyliving/abortion-services-in-victoria).

MTOP provided via telemedicine has been shown to reduce the cost for women, enable earlier terminations, reduce women's stress around abortion, and increase the availability of abortion generally (Dawson et al, 2016). Research indicates that women rate these services favourably (Dawson 2016). Aiken, Gomperts and Trussell (2017) present data from over 1,000 users of online tele-abortion in Ireland and report high rates of satisfaction with the service - 97% of women felt they had made the right choice and 98% would recommend the service to others. A study of tele-abortion services through Planned Parenthood in the US found that both providers and women seeking abortions had favourable attitudes towards the service (Grindlay et al., 2013). These telemedicine appointments were provided at women's local clinics where a physician was not available to provide abortions. The telemedicine option was perceived to have increased the availability of appointments and reduced travel time.

While we know tele-abortion is available in the Grampians region, we do not know whether there is awareness of this option among women or their doctors

While we know tele-abortion is available to women living in the Grampians region, we do not know whether there is awareness of this option among women who experience unintended pregnancies in the Grampians or their doctors. Both international and Australian literature indicate that there are difficulties in obtaining reliable information about abortion services in rural areas (Dawson et al., 2017, Dressler et al., 2013), and reliable statistics on abortion rates in general are not available (Shankar et al., 2017).

A 2008 study of the perspectives of stakeholders in the Grampians region found that health professionals considered women in the region to be faced not only with practical barriers such as cost and transport, but also with the provision of inaccurate information about abortion and concerns about privacy. The health professionals in this study acknowledged that while the availability of services needed to be improved, attitudes towards abortion in the Grampians region would also need to be addressed (Kruss and Gridley (2014). Given the decriminalisation of abortion has occurred in Victoria since this data was collected, it is not known whether there has been an improvement in women's experiences of stigma and access since these data were collected.

Canadian researchers have reported that, in rural and remote communities, abortion services are often delivered in hospitals, while private clinics tend to be located in urban areas (Cano and Foster, 2016). In Canada, they have found that women will often bypass a hospital as they prefer to attend a free standing private service, and

that this option was not available to women in rural and remote areas. Yet a survey of 391 young people in rural Far North Queensland indicated that the attitudes of service providers was the most important factor for young people in accessing sexual and reproductive health (SRH) services, whether at a general service or a dedicated SRH service (Johnston et al., 2015, Matich et al., 2015). While factors such as cost and transport were important for young people, they placed a greater emphasis on the ability of staff to listen, to be easy to talk to, and to have a non-judgmental attitude (Johnston et al., 2015).

Conscientious objection to abortion by health professionals is a known factor that can act to limit access to abortion services worldwide (Boland and Katzive, 2008). High rates of legitimate conscientious objection can reduce access (Bo et al., 2015), and, in addition, refusal to provide abortion care for moral or religious reasons seems to be increasing globally (Chavkin et al., 2013). In addition, our as yet unpublished research, shows doctors may not abide by legal requirements to refer women; those other than doctors may claim a conscientious objection (institutions, cleaning or security staff); doctors may claim a conscientious objection not because of religious or moral conviction, but because of general discomfort or reputational reasons, and; even with appropriate referral, the experience of a health care provider expressing a conscientious objection to the service being sought could increase the sense of shame and stigma for some women, and potentially delay them from accessing services in a timely manner.

Data on the rates of conscientious objection to abortion is often of poor quality. However, a survey of Australian obstetrics and gynaecology fellows and trainees found that 15% of the 740 participants held views that made them totally opposed to abortion (De Costa et al 2010). Data about how health professionals act when they do have a conscientious objection, even in environments were the law clearly states an obligation to refer, is very limited. In one of few studies, Curlin and colleagues (2007) found that of those who objected to abortion, only 60% believed that physicians should be obliged to refer the patient. This suggests that up to 40% of conscientious objectors in this US study may not refer women seeking abortion to a provider able to help them. The question of whether doctors in Victoria who claim a conscientious objection to abortion meet their legal and professional obligation to refer, where this is clearly stipulated in the Victorian *Abortion Law Reform Act 2008*, needs further study. It is conceivable that if only a small proportion of doctors claim a conscientious objection in any location, and, if they abide by their obligation to ensure best possible care for the patient, that conscientious objection could have little impact on access, yet data on this issue is lacking in Victoria.

SETTING FOR THIS STUDY

Doctors coming from overseas to a rural area like the Grampians region will need to familiarise themselves with the legal status of abortion in Victoria

MEDICAL WORKFORCE IN AUSTRALIA

According to a 2013 Department of Health review of health workforce programs funded by the Australian government (Mason, 2013), 25% of practicing medical practitioners in Australia were trained overseas. The review noted that there is a particular focus on attracting overseas doctors to work in areas where there is a workforce shortage (rural and regional Australia) and so the proportion is thought to be higher in these areas (46%). **Given the range of ways women's health services are provided globally, and the varying levels of access to contraception and abortion, it is likely that doctors coming from overseas to a rural area like the Grampians region will need to familiarise themselves with the legal status of abortion in Victoria**, as it remains illegal and inaccessible in many developing countries (Boland and Katzive, 2008).

LEGAL AND POLICY SETTING IN VICTORIA

In 2008, the Victorian Parliament passed the *Abortion Law Reform Act* (Vic). Abortion is now legally permissible for women giving free and informed consent at any stage of gestation and for any reason, with the only proviso that, after 24 weeks, two doctors must agree that "it is appropriate in all the circumstances". In Section 8 of the Act, it states that any health practitioner who is asked to advise a woman about abortion, or to perform, direct, authorise or supervise an abortion, and who has a conscientious objection to abortion must: 1) inform the woman that they have a conscientious objection, and 2) refer the woman to another health practitioner, in the same profession, who the practitioner knows does not have a conscientious objection to abortion. Non-compliance with the guidelines set out in Section 8 may result in charges of professional misconduct administered by the practitioner's registering authority.

Access to sexual and reproductive health services is a fundamental right for every Victorian woman

There is often little or no access to the information, support and services that women require, particularly in rural and regional areas

The Victorian Public Health Plan 2015-2019 outlines the government's key priorities and strategies for improving health and wellbeing. The plan highlights sexual and reproductive health as a key health issue for the state. To support this, the Victorian Government recently released the first Victorian Sexual and Reproductive Health Strategy, 'Women's sexual and reproductive health: key priorities 2017-2020'. The strategy acknowledges that **while access to sexual and reproductive health services is a fundamental right for every Victorian woman, there is often little or no access to the information, support and services that women require, particularly in rural and regional areas**.

The strategy calls for partners across the health system, including primary health, women's health services and local government, to work together to improve access to services to support reproductive choices.

LOCATION OF THIS STUDY

The study focused on the Grampians Pyrenees and Wimmera catchment areas of the Grampians region in Victoria. These are the municipalities to the west of Ballarat, a major regional centre with a population of 100,283 (Department of Health and Human Services, 2017). **The areas included were Ararat and Horsham rural cities, as well as the Pyrenees, North Grampians, Hindmarsh, Yarriambiack and West Wimmera shires.** As of 2014[1], these areas had a total population of 54,372. Horsham and Ararat rural cities are the most populated, with populations of 19,691 and 11,184 respectively. West Wimmera Shire has the lowest population with 3,982 residents.

This study sought to understand the referral practices and attitudes of GPs and Practice Nurses in the Grampians region when women present with unintended pregnancy.

Despite the fact that some abortion services can be accessed without a referral from a GP, for most women, especially in regional and rural areas, GPs and/or nurses are the first port of call when facing an unintended pregnancy. It is therefore the GPs and nurses who provided the data for this study.

[1] All demographic information obtained from Department of Health and Human Services, Victoria website (2017).

Research Question

The research aimed to better understand general practitioners' referral practices for unintended pregnancy options and abortion. The specific aims of this research were to:

- Describe current knowledge held by GPs and nurses in the Grampians region about the options for women with an unintended pregnancy
- Describe the types of services perceived by GPs and nurses to be available for women facing an unintended pregnancy in the Grampians region
- Identify GP and nurse attitudes to the options of medical and surgical abortion and tele-abortion
- Identify GP and nurse attitudes to the provision of medical abortion in primary care in the Grampians region

Method

This was a mixed-method study involving a short questionnaire and a semi-structured qualitative phone interview with both GPs and nurses. A project steering committee with members from various health organisations in the Grampians region oversaw the development and delivery of the survey (see Appendix 1 for a full list of members of the project steering committee). The project steering committee members were familiar with the populations involved, namely GPs and other health professionals, and were knowledgeable about the issues related to unintended pregnancy in the region. They provided important information about the local context and informed both the method of approach and the questions that were explored through questionnaires and interviews.

Ethics approval was granted by the Health Sciences Human Ethics Sub-Committee of the University of Melbourne (ethics number 1748829).

POPULATION AND RECRUITMENT

The population of interest for this study was all 84 GPs working in 33 practices in the Grampians region (described above), and the Practice Nurses working in these clinics. GPs were sent a letter in the mail inviting them to participate, including a paper survey and a reply-paid envelope. A week later, the practice was sent a similar email letter, and a link to an online survey. Practice Managers were asked to forward the email to all doctors working in the practice. A follow up phone call was made to each practice two weeks later to determine whether the email had been forwarded. In several cases, further surveys were mailed to GPs.

In order to recruit for the interview, the letter included an additional page on which the GP could provide a telephone number or email address to indicate their willingness to be contacted for the interview. The researchers (SC or LK) then telephoned or emailed to arrange a convenient time for the interview. Additional snowball sampling occurred at the end of the interview, when participants were asked to provide names of individuals (Practice Nurses or GPs) who might agree to be interviewed.

DATA COLLECTION

A two-step data collection approach was used; first, a short paper-based or online questionnaire (see Appendix 2) was administered and second; a semi-structured telephone interview was conducted (see Appendix 3 for sample interview guide). The questionnaire included both closed-ended questions and open-ended questions and took less than five minutes to complete. GPs were asked how often they discussed pregnancy options counselling, surgical abortion, medical abortion, tele-abortion, sexually transmitted infections and contraception with women presenting with unintended pregnancy. They were also asked how often they referred women to another provider due to having a conscientious objection to abortion. An open-ended question asked GPs about their impression of services in their area supporting women with unintended pregnancy. GPs who agreed to a short telephone interview were asked about these issues in more detail. Specifically, they were asked about the processes they went through when women presented with an unintended pregnancy, what services they were aware of that women could access if they wanted a termination, the referral pathways they followed, their thoughts on what GPs could do to provide greater support to these women, and the impact of the current level of access on women who require a termination.

Practice Nurses who agreed to take part in a telephone interview were asked about the services they knew of in their areas, the processes that doctors at their clinic went through with women who requested an abortion, their perception of the barriers to greater support for these women, the impact this had on patients, as well as their roles in supporting women with unintended pregnancy. Participants were also asked about their knowledge of MTOP and tele-abortion and about the legal status of abortion in Victoria. These semi-structured interviews were conducted from April to August 2017 and ranged between 15 and 45 minutes. Participants were initially invited to take part in an interview of 30 to 45 minutes. This was later adjusted to 15 to 25 minutes in follow-up invitations to encourage more GPs to take part. Interviews covered the same broad themes with the same main questions but questions were covered in less depth. The interviews were audio recorded and transcribed verbatim by a professional transcribing firm.

DATA ANALYSIS

The quantitative survey data was analysed descriptively and the open-ended responses were analysed thematically. In addition, the online word cloud tool 'Wordle' (www.wordle.net) was used to generate a word cloud for the open-ended survey question (GPs impressions of the services in their areas). Participant responses were edited to remove articles, pronouns and conjunctions (e.g. 'the', 'I', 'and') unless they contributed to the meaning of a phrase (e.g. 'to my knowledge' or 'still an issue'). All responses were then uploaded to Wordle indicating words that needed to be grouped together in phrases. Word clouds are a useful tool for providing a visual image of the words written by participants and the more often a word occurs, the larger it is in the word cloud.

Semi-structured interviews were also analysed thematically. Once data collection was complete, two researchers read through interview transcripts and designed a coding framework. Data was then coded. As well as identifying the themes in the interview data, the interviewees were grouped according to the different positions they occupied. Given participants occupied quite different positions in relation to provision of services for unintended pregnancies in the Grampians region, data was more meaningful when considered though these perspectives. Analysis was designed to capture the full range of data collected, but to present these data as succinctly as possible.

ETHICAL CONCERNS

Confidentiality of participants was one of the major ethical concerns in the conduct of this study. Given the sensitive nature of abortion service provision in rural areas and the small number of GPs and Practice Nurses, we undertook several steps to ensure the confidentiality of participants. Survey responses were either presented as summary statistics, or if data from an individual was reported, no demographic details were presented with the data, for example, the presentation of the open ended survey responses. In reporting interview data, pseudonyms were used to refer to participants, and identifying details were disguised. Quotes were often edited to remove natural speech patterns that may identify a particular individual, for example, 'you know' might be removed from a quote, so that the meaning remains, but potentially identifying speech patterns were removed. In addition, reported patient stories were edited to remove details that may identify patients.

Results: Survey

THE PARTICIPANTS

A summary of demographic characteristics is shown in Table 1. Of the 84 GPs who were invited to take part in the study 23 returned the questionnaire (21 completed the paper questionnaire and two completed the online questionnaire), giving a participation fraction of 27%. **There were 12 female participants and 11 male participants; ranged from 27 to 67 years of age; and had been working in the region for nine years on average** (range two months to 30 years).

PRESENTATIONS FOR UNINTENDED PREGNANCY

Participants reported seeing on average 3 women (mean=2.9) presenting with unintended pregnancy each year (range 0-25). Given 1 GP reported seeing 25 women with unintended pregnancy per year, we also calculated the average with this response excluded. The remaining 22 participants reported seeing between zero and six patients, with an average of two women per year (mean=1.9).

Table 1. GP survey participants' demographic characteristics

Variable	Number	Percentage
Gender		
Male	11	48%
Female	12	52%
Age1		
27-45	10	50%
46-67	10	50%
Medical training		
Australia	8	35%
Overseas[3]	15	65%
Time practicing in region[2]		
2 months - 5 years	12	52%
6 years - 30 years	11	48%
Additional women's health training		
Yes	12	52%
No	11	48%
Unintended pregnancy presentations/year		
0	6	26%
1-2	10	43%
3 or more	7	30%
TOTAL	**23**	**100%**

1: 3 participants did not report their age.
2: 1 participant did not report years in region
3: GPs were trained in countries in Africa, Asia, Europe and the Middle East

TRAINING

The majority of participants, 15 of 23 (65%) had received their medical training overseas, higher than the 47% for regional and rural areas reported by Mason in 2013. Of the 15 participants trained overseas, 10 were male and five were female. 12 of 23 participants (52%) reported having additional training in women's health, with 9 of these having formal qualifications (e.g. diploma of obstetrics) and three reported attending women's health seminars, workshops and updates.

GP PRACTICE WHEN WOMEN PRESENT WITH UNINTENDED PREGNANCY

We asked participants what they discussed with patients who presented with unintended pregnancy. **27% reported that they 'rarely' or 'never' discussed surgical abortion, while 36% reported 'rarely' or 'never' discussing medical abortion. The overwhelming majority of survey participants said they 'rarely' or 'never' discussed tele-abortion (90%)**. From the interviews with GPs (discussed further below), it was clear that few GPs had heard of tele-medicine services for termination of pregnancy such as those available via Marie Stopes and the Tabbot Foundation, and that not all were aware of the option of medical abortion.

In contrast, 86% (n=21) of survey participants reported 'sometimes' or 'always' discussing pregnancy options counselling. Our interview data however, suggests that GPs often take 'pregnancy options counselling' to mean their own discussion with patients about the available options for unintended pregnancies.

Table 2. GP practice for women presenting with an unintended pregnancy

Practice	Frequency	Percentage (%)
Future contraception		
Always	20	87%
Sometimes	2	9%
Rarely	1	4%
Never	0	0%
Sexually transmitted infections[1]		
Always	11	50%
Sometimes	8	36%
Rarely	3	14%
Never	0	0%
Pregnancy options counselling[2]		
Always	17	81%
Sometimes	1	5%
Rarely	3	14%
Never	0	0%
Surgical abortion[1]		
Always	9	41%
Sometimes	7	32%
Rarely	1	4%
Never	5	23%
Medical abortion[1]		
Always	6	27%
Sometimes	8	36%
Rarely	3	14%
Never	5	23%
Telehealth medical abortion[3]		
Always	0	0%
Sometimes	2	10%
Rarely	3	15%
Never	15	75%

1: 1 missing value
2: 2 missing values
3: 3 missing values

CONSCIENTIOUS OBJECTION

Of survey participants, **38% reported 'always' or 'sometimes' referring patients to a colleague because they hold a conscientious objection to abortion**. This percentage is high given the estimated rate of conscientious objection among doctors in Australia puts the rate at 15% (De Costa et al., 2013).

Of the eight participants who said they 'always' or 'sometimes' refer due to conscientious objection, all had received their medical training overseas, and six were male (75%). As noted previously, of the overseas-trained doctors, the majority (67%) were male. **61% of overseas trained doctors said they 'always' or 'sometimes' referred women due to holding a conscientious objection** (though there were missing data for two participants). These participants had been trained in other Anglophone countries such as the UK as well as countries in Asia, Africa, and the Middle East.

All Australia-trained participants reported 'sometimes' or 'always' discussing STOP with women with unintended pregnancy, and the majority (88%) also 'sometimes' or 'always' discussing MTOP.

TABLE 3. Participant referral for conscientious objection by country of medical training

How often do GPs refer women to a colleague because they hold a conscientious objection?					
Medical Training	Never	Rarely	Sometimes	Always	Total
Australia (n=8)	7 (88%)	1 (13%)	0 (0%)	0 (0%)	8
Overseas (n=15)	3 (23%)	2 (15%)	2 (15%)	6 (46%)	13*

*2 missing values.

TABLE 4. Participants' discussion of STOP by country of medical training

How often do GPs discuss surgical abortion (STOP)?					
Medical Training	Never	Rarely	Sometimes	Always	Total
Australia (n=8)	0 (0%)	0 (0%)	3 (38%)	5 (63%)	8
Overseas (n=15)	5 (36%)	1 (7%)	4 (29%)	4 (29%)	14*

*1 missing value.

TABLE 5. Participants' discussion of MTOP by country of medical training

How often do GPs discuss medical abortion (MTOP)?					
Medical Training	Never	Rarely	Sometimes	Always	Total
Australia (n=8)	0 (0%)	1 (13%)	4 (50%)	3 (38%)	8
Overseas (n=15)	5 (36%)	2 (14%)	4 (29%)	3 (21%)	14*

*1 missing value.

Most of the participants who reported that they 'never' or 'rarely' refer patients to a colleague because of a conscientious objection to abortion reported that they 'always' or 'sometimes' discuss abortion (either STOP or MTOP).

However, of the participants who said they did not refer patients due to a conscientious objection, two of these participants also reported 'rarely' discussing options counselling, two 'rarely' discussed MTOP, and one 'rarely' discussed STOP.

While our sample is small and numbers need to be interpreted with caution, of particular concern was one participant who reported 'rarely' referring women on due to conscientious objection but also 'rarely' discussing options counselling, STOP or MTOP. This participant was male, overseas trained, was in the over 46 age group and had seen one patient with an unintended pregnancy in the previous 12 months.

All female participants answered the question about conscientious objection (n=12). Of these nine (75%) reported 'never' referring patients on due to conscientious objection, which we assume to mean they do not have a conscientious objection. Nine male participants answered this question (two missing data), and of these, one (11%) reported 'never' referring women on due to conscientious objection with five (56%) always referring women on.

There was no marked difference in conscientious objection by age group.

In line with the higher percentage of conscientious objection among male participants in this sample, while 92% of female participants 'sometimes' or 'always' discussed STOP, only 50% of male participants did so. The equivalent percentages for MTOP for female and male participants were 75% and 50% respectively.

TABLE 6. Participants' referral for conscientious objection question by gender

How often do GPs refer women to a colleague because they hold a conscientious objection?					
Gender	Never	Rarely	Sometimes	Always	Total
Female (n=12)	9 (75%)	1 (8%)	1 (8%)	1 (8%)	12
Male (n=11)	1 (11%)	2 (22%)	1 (11%)	5 (56%)	9*

*2 missing values.

TABLE 7. Participants' discussion of STOP by gender

How often do GPs discuss surgical abortion (STOP)?					
Gender	Never	Rarely	Sometimes	Always	Total
Female (n=12)	1 (11%)	0 (0%)	5 (42%)	6 (50%)	12
Male (n=11)	4 (40%)	1 (10%)	2 (20%)	3 (30%)	10*

*2 missing values.

TABLE 8. Participants' discussion of MTOP by gender

How often do GPs discuss medical abortion (MTOP)?					
Gender	Never	Rarely	Sometimes	Always	Total
Female (n=12)	1 (8%)	2 (17%)	5 (42%)	4 (33%)	12
Male (n=11)	4 (40%)	1 (10%)	3 (30%)	2 (20%)	10*

*2 missing values.

GP IMPRESSIONS OF SERVICES FOR WOMEN WITH UNINTENDED PREGNANCY IN REGION

One open-ended question asked participants to describe their opinion of the services available to support women with unintended pregnancy in their area. All but two participants answered this question. Of the 21 participants who answered the question, 12 described the services as limited or inadequate, five said that they were not aware of what services were available in their area, while one each described the services as adequate, average or improved. Altogether, nine participants said that they referred women out of the area to either Ballarat or Melbourne for terminations. Figure 1 provides a word cloud of participants' responses. After Melbourne and Ballarat, the three most commonly used words/phrases were 'away,' 'not aware' and 'poor.'

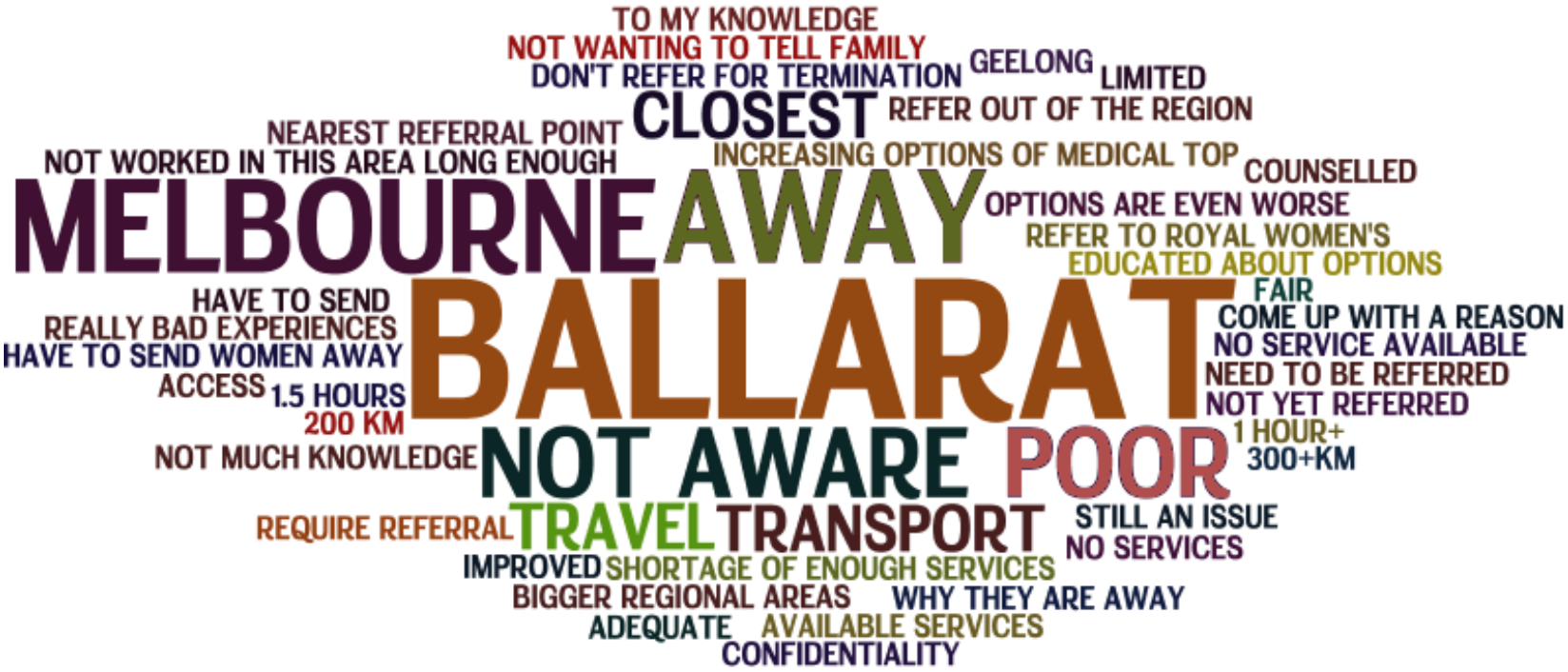

FIGURE 1. Word cloud of participants' impressions of services in their area

HOW WE CODED THEIR RESPONSES

We coded responses that described services as poor, described negative experiences, reported no available services, or said only that they needed to refer women out of region as 'limited or inadequate'. Responses coded 'no knowledge' included a participant who was new to the area and had not yet needed to access services, as well as a conscientious objector who did not refer women for terminations.

Table 9. Participants' opinion of services for women with unintended pregnancy

GPs' opinions of services in their area			
Theme (total number)	**Gender**		**Example quotes**
	Male	Female	
Limited or inadequate services (12)	4	8	*There's shortage of enough services in the region. The nearest referral point is Ballarat which is 1.5 hours away.* *I have to send women away - closest Ballarat 200km away and Melbourne 300+km away.* *I have had really bad experiences - due to patients without transport or not wanting to tell family who can't get to Melbourne because it would involve having to come up with a reason as to why they are away. Even with medical abortion now possible through family planning Ballarat, the transport is still an issue. For women presenting too late for medical abortion, the options are even worse.* *Poor- due to confidentiality. Most patients will travel to centres away from home. Not aware of telehealth medical abortion providers.*
No knowledge of services in area (6)	2	4	*Not much knowledge about available services.* *I am not aware of the services.*
Services were average (1)	1		*Fair. Patients need to be referred to Ballarat Health Services if they choose surgical abortion.*
Services were adequate (1)	1		*Adequate.*
Services had improved (1)	1		*Access via Ballarat has improved in the past 2 years, increasing options of medical TOP.*

Results: Qualitative Interviews

Of the 23 GPs who participated in the survey, five volunteered to take part in a telephone interview. These GP interviews were supplemented by interviews with three Practice Nurses who were able to provide greater context for understanding the setting and the issues facing GPs. We present the data from the qualitative interviews in four groups to capture the different perspectives that these groups of participants provided, and the different issues they were able to shed light on. The groups were positioned differently with respect to unintended pregnancy in the Grampians region. The groups are:

- The conscientious objectors
- The would-be MTOP providers
- The city doctor
- The Practice Nurses

We have assigned pseudonyms to each participant, and have named the conscientious objectors 'Rohan' and 'Robert', they were the only two male participants who agreed to telephone interviews. Rohan and Robert's stories highlight the different ways in which it is possible to be a conscientious objector and the contrasting experiences women presenting for unintended pregnancy could be met with.

'Jennifer' and 'Julie' (pseudonyms) were at opposite ends of the spectrum in terms of their careers and the length of time they had been in the area, and together illustrate the challenges facing GPs who are willing to become MTOP providers. Jennifer's story highlights the difficulty GPs face in accessing reliable information about the services available, while Julie's story highlights how, even for a GP with years of experience, there is much about abortion services in the Grampians region that is unknown.

Lisa, who had recent experience both in Melbourne and at a clinic in the Grampians region, was able to reflect on the unique challenges faced by women in less populated areas in contrast with those residing in Melbourne.

Finally, the Practice Nurses were from three different towns and had significant experience offering pregnancy options counselling, and supporting young and disadvantaged women. They described the challenges they faced and the opportunities for change.

In these interviews, the participants described the available services in a range of ways. As was the case with the open-ended question in the survey, most participants referred to Ballarat as being the main place that women seeking abortion in the region would be referred to.

THE CONSCIENTIOUS OBJECTORS: ROHAN AND ROBERT

Rohan and Robert both expressed some form of conscientious objection. Both participants were male, aged between 40 and 60, and were Christian. Rohan had been working in the region for under 10 years while Robert had been in the region for over 25 years

Though Rohan is a Christian and said that he was not comfortable referring women to abortion services, he was comfortable providing women with contraception, including emergency contraception or the morning after pill. He described emergency contraception as 'prevention,'

> *If somebody comes and sees you within 72 hours and you can prevent it, then that's alright…Prevention is better than having an abortion.*

Robert is a GP who had previously been involved in providing access to terminations in cases of foetal abnormality where it was 'clear the baby wouldn't be surviving anyway', but the hospital had since changed its policy on terminations. He had referred women to Ballarat hospital, to clinics in Melbourne, and had used the Tabbot Foundation's tele-abortion service. Robert was the only participant we interviewed who had made use of a tele-abortion service. He said:

> *I'm Christian and that's my background and I guess that's been both my upbringing and my ethical standpoint for as long as I've been aware of having one.*

Nevertheless, unlike Rohan, Robert said that he felt comfortable referring women on to services where they could get an abortion. Doing so was not something that he '[lost] sleep' over.

As other authors have shown, conscientious objection is not an absolute, and as with both Rohan and Robert, there were things that they were comfortable with (e.g. emergency contraception in the case of Rohan, referring to an abortion service for Robert), and others that they were not.

PRACTICES WHEN WOMEN PRESENT WITH UNINTENDED PREGNANCY

A large proportion of Rohan's caseload was managing elderly patients, and he estimated only about 10% of his work related to sexual and reproductive health, contraception being the most common reason. In the last 12 months, 2 women had been to see Rohan requesting abortions. He described them as 'not married, young girls, and they had unprotected sex without … a plan'. When asked how comfortable he was helping these patients, he said:

> *Because I'm personally not comfortable to refer to an abortion clinic…. I have a chat with them about why it happened and what we can do to prevent those kind of things, and why they are wanting an abortion, and then if they want an abortion, I ask one of my colleagues, so they see someone else.*

Rohan was aware which of his colleagues he could refer the patient on to, and was comfortable that the clinic could accommodate this transfer of the patient from one doctor to another. He knew of other Christians at the practice, but was not aware of any other conscientious objectors. Although he had not received further training in women's health, he felt able to seek advice from more knowledgeable colleagues when necessary.

Before referring the women on, Rohan said he spoke to them about contraception, safe sex, and suggested that they consider having tests for sexually transmitted infections (STIs). He said:

> *I ask them whether they use contraception … And then their sexual health, is it unsafe sex or not?*

The bulk of Robert's caseload involved seeing patients for sexual and reproductive health and he said he was often the 'first port of call for a lot of women' who were presenting with unintended pregnancy. Robert estimated that he would see about six women a year presenting with unintended pregnancy, and he had good knowledge of the available services and supports. He described the process that he went through with patients who wanted an abortion:

> *My usual routine is to see them … confirm their pregnancy. I do a scan … to see how many weeks they are, which sort of leads to which direction, and then I usually like to see them a few days later … Unless people are very clear in their own mind that they want a termination - I usually like to see them a second time to talk it through ... I'll sometimes do a social work referral if they have a bit more complicated social or psychological issues, especially if they want more time to discuss things. And then, depending on their gestation … Ballarat's the nearest surgical service. Ballarat also do medical terminations. Or one of the clinics in Melbourne or if they're a bit more complicated - the Pregnancy Advisory Service at the Women's.*

PREGNANCY OPTIONS COUNSELLING

Rohan said that he did not discuss pregnancy options counselling with these patients as 'when they come for abortion, they don't want to talk about anything else'. He did not know of any services in his area that he could refer women on to for pregnancy options counselling, but was aware of a Christian service in Ballarat. He thought this service could provide women with information about alternatives to abortion that they could consider as 'some people don't have any idea whether they can get any support to continue the pregnancy'.

Robert, likewise, said that he was not aware of any specific pregnancy options counselling services in his area, but that if the patient needed further counselling to make a decision, he could write them a mental health plan that would give the patient five to six sessions with a counsellor. Robert said that, most of the time, women did not require further pregnancy options counselling:

> *Probably ninety per cent of the time I would say that I feel able to give enough time and see them. [As] I said, I'd always see them twice before I'd embark on a referral just so that we cover it, and then cover it [again] on the second visit.*

OPINION OF AVAILABLE SERVICES

We asked participants what GPs could be doing better for women with unintended pregnancy. Both Rohan and Robert talked in terms of improving contraceptive education and services. From Rohan's perspective, nothing could be done for women who experienced unintended pregnancies, but GPs could focus on 'people who are sexually active'. He said: 'We can advise them to use some sort of contraception, and more safe sex practices.' Robert also talked about '[getting] better at contraceptive service', though he thought the clinic at which he was based did contraception quite well,

> *From time to time we've done talks at local schools and that sort of thing about contraception … there's no sort of family planning clinic locally. Specifically, it's all done by the GPs but we tend to do the Mirenas and Implanons and Depo and the range of things here.*

Rohan said that the closest abortion service was in Ballarat. He thought it was a surgical abortion service, and he was not aware of any medical abortion services. Rohan said that he knew 'there's a thing called medical abortion'. He did not know 'if Ballarat are doing that, they usually go for surgical'. When asked how much he knew about medical abortion, Rohan said that he knew 'they can do it with medication', but that was the extent of his knowledge, and he did not know where the closest service for medical abortion would be for women in his town. Rohan perceived that Ballarat was close enough for women who wanted an abortion, being an hour away by car. Since the population in the area he worked was relatively small, he reasoned that it was unlikely that women from his area who wanted an abortion would not be able to get an appointment with the service. Robert, similarly, noted that women who wanted abortions usually attended the clinic 'fairly early on in pregnancy' and he had not experienced any difficulties with patients accessing relevant services. He thought that 'it would be nice for [patients] if they didn't have to travel' to Ballarat, but as there was no one locally willing to do terminations, this was not possible.

Interviewer:	*So, what would it be that's preventing these services from being provided locally?*
Robert*:*	*… it's more of an ethical thing that we don't do them … not that I couldn't … provide medical termination, it's probably more an ethical thing for me ...*
	So, both myself and the hospital obstetrician have an ethical issue with termination of pregnancy … so it's an ethical issue, not a procedural issue if you know what I mean?

THE WOULD-BE MTOP PROVIDERS: JENNIFER AND JULIE

Jennifer had been working in the area for less than a year, while Julie had worked for almost 30 years in the region. Both Jennifer and Julie had in the past or were now considering providing MTOP themselves and both had additional women's health qualifications. One was aware of telemedicine, one was not. They identified waiting times for ultrasound and absence of local back up surgical as key barriers to offering MTOP, and both described difficulty getting access to information about services and options for women experiencing unintended pregnancy in the region.

REFERRAL PRACTICES

In contrast to Julie, who had been in the region for a long time and who saw about six women a year who presented with unintended pregnancy, at the time of interview, Jennifer had just had her first presentation for unintended pregnancy. Since she had not previously referred a patient to an abortion service in the Grampians region, Jennifer had to research the options that were available to her patient, a 16 year old girl. She described the process of working out what services were available in the region:

> *I actually found it really hard. I didn't know where to refer and, even when I spoke to GPs in my clinic, no one knew if we could prescribe medications for a medical termination - because we manage miscarriage which is essentially a similar thing - but no one in my clinic even knew the answer to that. I called the rooms of an obstetrician/gynaecologist and the* [person] *in the rooms found out where should we send them to and they said the Choices Clinic at Ballarat Hospital. So then I called … the Hospital and* [they] *took the referral and* [were] *happy to see her and gave me some advice on where to go from there. But yes, it was really a matter of calling around and trying to find out exactly what to do as I didn't know the options.*

In researching the available options, Jennifer found that Ballarat was the closest service. While larger towns that were closer to her had obstetric services, these did not provide terminations. For Julie, Ballarat was also the closest option, but was a longer drive for her patients. Having been in the area for a long time, Julie was able to describe the changes that had happened in the provision of services. In the town she worked in, she said there had been a gynaecologist who had been willing to do terminations. The current gynaecologist at the local hospital was a conscientious objector and did not provide terminations. Julie currently refers her patients to a range of services in both Ballarat and Melbourne. Julie had previously found it difficult to get women into the service at the Ballarat hospital as she said the clinic would only take patients on certain days and had a quota of how many women they could see. Reiterating the dependence of GPs on their professional contacts in order to access information and services, she said she now has a good contact at the hospital and has found that she has been able to get her patients into the service much more easily. She had been able to refer the three women who had presented in the six months prior to the interview to Ballarat for both surgical and medical terminations.

Both Julie and Jennifer had been able to get their patients seen at the Ballarat service without difficultly in the last six months prior to the interview. Given it was Jennifer's first referral to Ballarat and because it had been a 16 year old

girl (who might have been considered high priority in terms of clinic admissions), she remained unsure about how easily she might navigate referral for an older patient. Julie had her most recent three patients seen easily, the youngest of whom was 18 years old.

Though Jennifer had not had trouble referring the 16 year old girl on to Ballarat hospital, she described how access affected the options for termination:

> *She presented with her ex-partner and her ex-partner's mum so it was quite an interesting situation but they thought she was still quite early on in her pregnancy and so had requested medical termination rather than surgical termination.*
>
> *The challenge is getting them in in time because they only run the clinic twice a week and it was over a long weekend so the next available clinic was going to be the following week when I saw the patient and we had to organise ultrasound. The limiting factor for us was that all of the ultrasounds around our area were fully booked and so I couldn't get an urgent ultrasound here. I had to send her up to Ballarat anyway for her ultrasound dating scan.*

WHEN WOMEN PRESENT WITH UNINTENDED PREGNANCY

Julie did not refer women for pregnancy options counselling (though as Jennifer indicated, this would be provided as part of the process before a termination at the Ballarat hospital). She felt comfortable and able to discuss the options with women and said that in the case of the last three women she had sent for terminations, all had presented saying that 'It's not an option':

> *I'm comfortable to discuss the options. I think that girls normally come with very fixed ideas. They either have a wanted pregnancy that they want to continue, or an unwanted pregnancy that they don't. You don't normally have to discuss very much with them, but I do. I'm happy to do that. I feel comfortable enough to discuss it with my patients, rather than send them away for a discussion.*

Jennifer said that she would refer women on to Ballarat knowing there was 'pregnancy counselling associated with [terminations]' there. She 'would always do an initial options counselling before [the patient] decides whether or not they want to go onto termination or not.' Jennifer described herself as 'quite comfortable' having these discussions with women, and having done a diploma of obstetrics, felt equipped with the knowledge needed to help women presenting with unintended pregnancy. She described the process that she goes through with these patients:

> *Counselling about the intention for the pregnancy now that they've found that they are pregnant and trying to figure out exactly what their thoughts are. Step one is always just information, so providing information, valid information and resources … just facts rather than - a lot of people do a lot of internet research beforehand and have a lot of different ideas about options. So I guess just counselling about the different options at that point - and continuing through to parenthood versus adoption versus termination and then the different termination options. It's also information collecting about their history and how far along they might be - makes a big difference as well.*

BARRIERS TO MTOP PROVISION

Julie had considered providing MTOP in the past but said the requirement for local surgical backup was a barrier. She said:

> *I had wanted to learn about RU486. For GPs, there is an education about that, but it does ask you to have a backup, what would happen if something doesn't work for, like curettes and so on. I did ask [the] obstetrician, gynaecologist who is here in [our town] whether [they'd] be happy if I learnt about RU486, would [they would] be my back up and the answer was 'no. I'm not doing it.'*

Julie was not sure if Ballarat would accept patients for whom medical abortion had not worked. Even if they would, she said, 'to travel a long distance' when the women were 'in a lot of pain and bleeding' was not ideal. Julie described an experience with a patient who she had sent to Ballarat for MTOP and who had 'some retained product'. She said:

> *I did an ultrasound, but I said, 'Miscarriage'. I didn't say, 'Termination'. She ended up taking herself to the emergency department and she was dealt with here.*

Being new to the region, and only recently realising the paucity of services in the area, Jennifer said that 'ideally, someone at [her] clinic' would provide MTOP. For Jennifer, being closer to Ballarat than Julie, having Ballarat as a backup surgical option was more feasible. She said that she would probably learn to provide MTOP 'at some stage', but needed to work out whether it would be possible. She said that she would first have to look into the available support. For example, would the local pharmacy be willing to supply the drugs that women would need for a medical termination? And based on her experience with the 16 year old patient, it seemed that accessing timely ultrasounds could also prove to be a potential barrier. Jennifer said:

> *So when we saw this patient there wasn't any feasibility that she could get an ultrasound locally for a couple of weeks. So we were going to have to send her to Ballarat anyway so it kind of defeats the purpose if you're trying to provide a service here but they'd have to go to Ballarat anyway.*

THE CITY DOCTOR: LISA

Lisa was a GP who had recent experience both in Melbourne and at a clinic in a small town in the Grampians region. While the number of women she saw with unintended pregnancy was limited, Lisa's perspective provides important information about the unique challenges facing women in smaller rural towns.

THE SMALLER THE TOWN, THE MORE CHALLENGES THERE ARE

Lisa said that in an average year, she might see one or two women in rural towns because of an unintended pregnancy. The procedure that she followed when women saw her with an unintended pregnancy was to first discuss their thoughts on continuing the pregnancy and then running through the options with them if they wanted a termination. For the women she saw in rural towns, this always meant referring them elsewhere to clinics (both private and public) in Ballarat or Melbourne. As the other researchers have discussed, Lisa described rural women as being prepared to travel. She said:

> *Rural women don't like to go where people know them. So, they'll often be happy to travel to Ballarat or Melbourne for a termination. These women travel anywhere, anytime. They don't think twice about it.*

Confidentiality was a considerable barrier in these small towns in terms of the provision of abortion services. These smaller towns had only one or two GPs, and Lisa noted that even if these GPs were willing to provide MTOP, women would be unlikely to see them for terminations anyway. The same issue would arise with the use of tele-abortion services since the support of a GP was necessary. Lisa had found that women in these towns were even 'reluctant to come to get treatment for an STI' as they would have to 'get through the reception staff that know their history'. Concerns about confidentiality would override issues to do with travel:

> *It's much more important that they have confidentiality in a small town. They travel for hours for their appointments just for confidentiality, they don't think twice about it. Comes with the territory.*

Lisa suggested that women's drop-in family planning clinics would be a suitable solution to some of these issues.

THE PRACTICE NURSES: LEAH, ERIN AND KIRSTY

To supplement the interviews with GPs, we also interviewed three Practice Nurses who were able to shed light on the bigger picture and describe in greater detail the impact of some of the inadequacies in service provision in the area. The nurses worked in a combination of community health and medical centres. All three women had undergone additional women's health training and ran women-specific clinics as part of their work. Education was a large part of their roles, during these women's health clinics, through referrals from the GPs they worked with, as well as referrals from the local schools where they were involved in education.

The Practice Nurses worked in three different towns in the Grampians region. **All three said that, as far as they were aware, women who needed an abortion were sent to Melbourne. Trips to Melbourne involved journeys of between two to four hours**. They had different perspectives on the availability of TOP services in Ballarat. Erin said that women had been able to go to Melbourne 'in the past', while Kirsty thought that Ballarat was a possibility 'from time to time'. Leah had the impression that while surgical termination was available through the Ballarat hospital, this service was not 'favourable' and that doctors were more inclined to send patients to Melbourne.

EXPERIENCE WORKING WITH YOUNG (DISADVANTAGED) WOMEN

While Kirsty thought that tele-medicine was a good option, she expressed concerns about the cost, and noted that since many of the women she saw were 'socially disadvantaged', they tended to be referred to Melbourne so that they would be able to access a termination through the public system. Kirsty described the GPs at this service as 'non-judgemental and supportive'. Kirsty estimated that she would encounter between four and five unintended pregnancies each year. Like Jennifer, who noted the challenges with timely access to ultrasound, Kirsty had found that even when women had the resources to access tele-abortion, delays in access to the necessary tests locally meant that they had to travel to Melbourne anyway, which could involve a four-hour journey. Kirsty described the experience with a patient who had to access a termination service in December:

> *It was a young woman and she was under twenty-one, had three children and was pregnant and couldn't get organised enough to do the telehealth so ended up having to go down to Melbourne for a surgical termination.*

While patients attending the clinic that Erin worked at did not have to travel as far, it was nevertheless a considerable distance for young women with unintended pregnancies. Erin said: 'It's very tricky if they're young kids and if they don't want anyone to know and if they don't want to talk to a parent or something.' She described an encounter with a young 16 year old patient, who, because of a complicated family situation, was not able to tell her parents about the pregnancy:

> *It was really hard for that young girl to say, I'm not going to school today and I'm going to Melbourne, she was down on a farm. She came into school by bus, so she had limited access to getting here at any other time. A very tricky situation respecting her needs and what she felt the needs of her family were.*

Erin said: 'we have a lot of young mums coming through, young pregnant girls coming through looking for advice'. The most common sexual health presentation was 'intended pregnancies'. Erin was reluctant to describe many of the pregnancies in young women she encountered as 'unintended'. She said that very few of the young women who came through seeking support around pregnancy testing could be considered genuinely 'unintended.'

> *We do find that a lot of the young girls coming through have had previous terminations. They are sexually active, so there is that chance that a young girl hadn't … realised that she could get pregnant, or hadn't wanted to…Even the ones that are saying I'm not sure if I'm pregnant or not and I didn't want to have a baby often aren't shocked because when you discuss with them - they have been sexually active without using any precautions, or anything.*

Erin described the process for women presenting to her clinic wondering if they were pregnant. She described GPs who were interested in women's health and who saw large caseloads of female patients. She thought that in terms of support for women with unintended pregnancy, the doctors at the clinic 'do it very well'. Additionally, young women who presented wanting a pregnancy test were often seen first by a nurse who could ascertain, depending on what the young woman was worried about, if emergency contraception was a possibility. The young girls who showed up wondering if they were pregnant were considered a 'priority because of their mental health':

> *Our role mainly is the support, number one to … help them find out if they are or not, and diagnose by doing a pregnancy test. Also, just by having a chat with them. Sometimes if we find that the pregnancy test is negative, we can … take a history as to why they think they may be. Because it may be it's just very early stages, or that they know that last night they had unprotected sex and therefore they were anxious, or the condom broke the night before or something. We can then assist them … having the morning after pill, or whichever it may be.*

Kirsty said she was able to provide pregnancy options counselling, having done a course on this topic several years ago. Most of the referrals for pregnancy-related counselling would come through the local schools rather than GPs, though the doctors at the clinics she worked at sometimes referred women on to her for contraceptive education. Kirsty was not aware of other pregnancy options counselling services that GPs were referring women on to. She said:

Kirsty:	*it's a service that I really don't think I've ever had a doctor refer a patient to me.*
Interviewer:	*For pregnancy options counselling you mean?*
Kirsty:	*Yes. It's one of those areas that we don't really advertise... But no, it's not something that's taken up and I guess doctors, realistically, if they are referring a woman for a termination of a pregnancy they know that counselling's going to happen. I guess a lot of the women have already made their choice anyway*

Because she ran education sessions in the local community, Kirsty was 'well known', and teachers would sometimes bring in young women for pregnancy options counselling. Kirsty was 'upfront' with these young women, explaining that she was 'not a counsellor', but was 'able to talk to women about their options and to assist them to make that decision and certainly explore some of their beliefs'. Kirsty described young girls who had unintended pregnancies who would say 'I can't kill the baby' or 'I couldn't do that':

> *I'm able to very gently explain that not everybody feels that way and help so that they've got some information. And I provide the Royal Women's handouts for them…. Because if we don't help them with that then how can they really be making the choice that's best for them?*

Leah also regularly provided education in her local community and like Kirsty, was the first port of call for schools when a student needed support around an unintended pregnancy. While Leah had not done a formal course on pregnancy counselling, she had professional resources that she followed. **In her education sessions at the school, Leah had found that students were not well-versed in the options open to them in the case of unintended pregnancies:**

> *I was doing … a talk on contraception, and I had one young girl .. she said, 'Oh, I'd just get something and stick up there', if she was pregnant, and I said, 'No, termination's legal, and you can do it safely.' I had to reinforce that. You don't have to do that sort of thing anymore.*

KNOWLEDGE OF LOCAL GPS

Kirsty said that she knew a GP who had previously worked in her town who performed terminations and who had said that he did not 'want to be known as the abortion doctor'. She acknowledged, as other authors have suggested is often the case in small towns, that there is a reluctance to publicise services even when these are available:

> *I guess in a small country town it's more difficult to be anonymous. Anonymity is a huge thing. Again, why don't more people know about my service* [pregnancy options counselling]? *… People can be very opinionated. Rural areas are traditionally more conservative in their thinking.*

Kirsty's sense of providers' reluctance to advertise termination services provides a context for Jennifer's experience of the difficulty in accessing information about available services. At the time of interviewing though, Kirsty said that 'there [are] no services'.

Similarly, while Leah thought that having local GPs who could provide MTOP would improve access, she thought that a major barrier was that there was 'still that taboo thing' around abortion. Leah also thought that GPs were reluctant to be seen as 'that doctor':

> *"You're going to that doctor – you must be having that done." Maybe they're worried about that … And, also – there's the people in the community … that are very pro-life. We live in a small community.*

With the support of the GPs with whom Kirsty and Erin worked as well as the support provided by all three nurses, it is clear that young women have good support until the point of requiring a termination. At that point, it 'sort of falls away' as Erin found in the case of the young girl who could not tell her family; and as Kirsty found with her 21 year old patient with three children who had to organise to go to Melbourne, a journey that took four hours. **Erin described the frustration for the health professionals involved in supporting these women: '…you can give all this and then all of a sudden they're just left trying to get themselves to Melbourne and because there's only limited [services] - you can only do so much.'**

Discussion: Challenges and Opportunities

Overall, the results reported here represent a number of positive improvements in attitudes and practices affecting women facing an unintended pregnancy in the Grampians region compared with 2012, while also presenting opportunities for further improvements. We have not focused here on the experiences for women who proceed with an unintended pregnancy and go ahead to have a child, but have instead focused on the options for the roughly 50% of women with an unintended pregnancy who will seek to an abortion.

Key factors found to reduce the options available to women seeking an abortion fall broadly into the following; the willingness of the health workforce to support women seeking abortion, the availability of services, health providers' knowledge of services and appropriateness of services, and patient related factors. Each will be discussed in turn.

We focused in this study on the GP population and on Practice Nurses. **We found a higher than average proportion of GPs in the region were trained overseas** (from a range on countries including Asia, Africa and the Middle East). **Within the group of GPs who were trained overseas, we found very high rates of conscientious objection to abortion (65%)**, and a further two participants who neither refer women, nor discuss MTOP or STOP. It is possible that these additional two doctors hold a conscientious objection, but do not refer women to a colleague (an obligation that is enshrined in law in Victoria). Many of the countries in which these doctors were trained are likely to have restrictive abortion laws, and/or policies that do not support women's access (although this is not true for all countries in which GPs were trained). It is not known how GPs trained overseas become accustomed to different laws and practices, nor the best methods for achieving accurate knowledge and acceptance of abortion law for overseas trained doctors.

In addition, **we found a large amount of variation in knowledge held by GPs and Practice Nurses about services and options for women, from highly knowledgeable through to holding very limited knowledge**. Knowledge seemed to be reliant on knowing who to call, GPs peer networks and previous job experience, rather than due to easy to access, accurate and impartial advice. Those GPs with recent experience in Melbourne were unsurprisingly more aware of the range of public and private services operating in Melbourne, with many others mentioning only the Women's Hospital's Pregnancy Advisory Service.

We found overall that the range of abortion services in the Grampians was extremely limited with the only services GPs and Practice Nurses spoke of being located outside the region, in either Ballarat or Melbourne. In towns with hospitals, it was common to hear that nobody in the hospital would provide surgical abortion services and these hospitals and specialists were often seen not to be sharing the load with regard to provision of abortion services. In hindsight, it would have been beneficial to have interviewed doctors working in hospitals as they play a key role in determining what services are available to women. There were reports that in at least one town, the reason that the hospital did not provide abortion was due to conscientious objections held by key staff.

Knowledge of MTOP was suboptimal, with some GPs unaware that it was an option, and there was a general lack of clarity about whether it was available, and through which services. Some had good experiences referring women to Ballarat, others did not know that Ballarat offered MTOP. A positive finding was the willingness of at least two GP participants to complete the training in the future and begin to offer MTOP themselves. However, a number of conditions need to be met for this to occur. The GPs would need to be assured that women could access surgical back-up should MTOP fail, they would need access to timely and affordable ultrasound and they would require access to pharmacists willing to stock the medication.

Conscientious objection encompasses a large range of attitudes, and a narrow definition should not be assumed to apply in all situations. Some with a conscientious objection may be comfortable referring women to an abortion service in a limited range of situations, and still refer to themselves as conscientious objectors because they do not themselves perform abortions. Others will refer to a colleague for discussion of abortion options. Others still may refuse to discuss abortion with women, but also refuse to refer women to somebody who can inform them of their options. This final instance is not lawful in Victoria, but the authors are not aware of situations where sanctions have been applied to doctors for not abiding by Section 8 of the *Abortion Law Reform Act* (Vic). **It is imperative that doctors in the Grampians region are aware of the law regarding abortion and their obligations. Overseas trained doctors may require targeted information on legal status of abortion, community acceptance of services and their obligation to refer**.

Knowledge of the option of tele-abortion, which has been favourably evaluated by women and providers, was inconsistent and only two discussed having offered it to women during interviews. Very few participants in the survey regularly discuss tele-abortion with women. In addition, even those who had discussed the option with women were often not able to use it due to lack of ultrasound facilities. It is likely the promise of tele-abortion is far from fulfilled in Grampians region.

A number of features of patients were reported by GPs and Practice Nurses. Practice Nurses in particular reported evidence of a sub-group of disadvantaged young women, with poor knowledge of sexual and reproductive health. One reported that some patients are not aware that abortion is legal and accessible, and others reported that young women exposed to the risk of pregnancy are not all using contraception. It is unclear whether the reason for non-use of contraception is due to poor knowledge, poor access, or indifference to the possibility of falling pregnant. **It is clear that there is an opportunity to improve knowledge and practices among young women, especially those facing social disadvantage**.

Compared to earlier studies conducted in the Grampians, we found less evidence that highly conservative views dominate all areas of practice. While conservative views remain in pockets, and patient concerns about confidentiality continue to hamper use of services, there is also evidence that slow change might be occurring and there is an opportunity to further breakdown stigmatising and limiting attitudes towards women's control of their fertility.

Overall, there is a need to improve knowledge, services and adherence to legal and professional obligations, and there are clear opportunities to achieve this, with all interview participants expressing strong support for prevention of unintended pregnancy, and many highlighting the need for good support up until the point of termination. Practice Nurses and some doctors have good links with schools, meaning there are opportunities to disseminate information to the community of young people in the region through these active and committed health professionals.

Limitations

This research is limited by the sample size for both the survey and the interviews. While the response rate was only 27% this is equivalent to similar surveys with health professionals. Ideally further work will need to be conducted with hospital staff, gynecologists, pharmacists, who did not form part of the population of interest for this study. In addition, we did not reach saturation for the interview component of the study, so there are likely to be issues and attitudes present in the population that are not reported in this study.

Recommendations

This research has highlighted several opportunities to address gaps and barriers to services access for women dealing with unintended pregnancy in the Grampians region. Overall there is a need to increase knowledge on referral pathways and services both among professionals and in the community more broadly. The recommendations in this report align with priority actions to improve women's reproductive choices as stated in the **Victorian Government's Women's Sexual and Reproductive Health: Key Priorities 2017-2020.**

As the key providers of primary care in rural communities, it is vital that GPs have access to accurate, comprehensive and current information on all the options for women facing unintended pregnancy. Priority should be given to the **development of GP referral pathways for surgical, medical and tele-abortion** in order to ensure women have access to health services as close as possible to where they live or work (*Women's Sexual and Reproductive Health: Key Priorities 2017-2020 – page 15*).

Despite being legally available and approved under the Pharmaceutical Benefits Scheme in Australia since early 2013, **knowledge about the option of MTOP** in the Grampian is patchy and it is widely unavailable and poorly understood among health care providers and the community generally**.** It is vital to address the provision of accurate and comprehensive information on all available options for women facing unintended pregnancy through government, regional and local community information communication networks (*Women's Sexual and Reproductive Health: Key Priorities 2017-2020 – page 15*)

The availability of MTOP should be enabled through strategies to increase the number of community and primary care providers who are trained and offer this option. This will involve:

a. Working with GPs willing to provide medical and/or tele-abortion to set up a trial service
b. Addressing issues with services required to support medical and/or tele-abortion

- local ultrasound availability
- surgical emergency backup
- pharmacy support to supply medication

(*Women's Sexual and Reproductive Health: Key Priorities 2017-2020 – page 15*)

Federal and state governments alongside regional and local partnerships must engage in supporting Primary Health Networks and public hospitals to **develop clinical health pathways** for reproductive choices by:

- Developing clinical protocols to assist advanced practitioners in their roles
- Advocating for appropriate service provider training to ensure services are in the best interests of the woman
- Advocating for developing networked models of care to provide abortion services early, closer to the woman's home

(*Women's Sexual and Reproductive Health: Key Priorities 2017-2020 – page 15*)

This report will inform and guide initiatives to ensure all Grampians women can exercise their right to access services to ensure positive sexual and reproductive health outcomes.

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Appendices

APPENDIX 1: PROJECT SPONSORS

Research Team:
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Project Lead:
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In Partnership with:
Western Victoria Primary Health Network

Project Steering Group:
East Grampians Health Service
Stawell Regional Health Service
Wimmera Health Care Group
Grampians Community Health
Grampians Pyrenees Primary Care Partnership

Funded by:
Victorian Women's Benevolent Trust

APPENDIX 2: INVITATION LETTER AND QUESTIONNAIRE

INVITATION TO PARTICIPATE IN RESEARCH ON RURAL GPs KNOWLEDGE AND REFERRAL PRACTICES FOR WOMEN PRESENTING WITH UNINTENDED PREGNANCY

As a General Practitioner (GP) listed as working in the Grampians Pyrenees or Wimmera regions in Victoria, we invite you to tell us about your knowledge, practice and experience with women presenting to you with an unintended pregnancy.

The Grampians Pyrenees and Wimmera regions experience higher rates of teenage pregnancy than the average for Victoria, and there is poor understanding of the options available to support GPs when women present with unintended pregnancy. The University of Melbourne, in partnership with Women's Health Grampians, have been funded by The Victorian Women's Benevolent Trust to study the challenges and opportunities involved in managing unintended pregnancy in the Grampians region. The findings will be used to inform future training and health promotion activities in the region.

The project has been approved by the University of Melbourne Human Research Ethics Committee (project number 1748829.1).

You have been identified as someone, who, in his/her professional role, is likely to have some experience of this issue, and we would value your participation. We invite you to complete a short, 5-minute survey on the attached page, and in addition, to indicate your willingness to take part in a telephone interview with a researcher from the University of Melbourne, on the attached form. You can choose to complete the survey only, the interview only, or you can choose to do both. If you indicate you are willing to take part in the interview, we will contact you by your preferred method to arrange a suitable time. The interview will be conducted over the telephone, and we anticipate that the interview will take between 30 and 45 minutes. Participation in this study is voluntary and even if you agree to be interviewed, you are free to withdraw at any stage until the data has been analysed.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored at the University of Melbourne. It will be disclosed only with your permission, or as required by law. The audio-recording of the telephone interview which may contain identifiable data and the transcripts will be stored securely for 5 years from the date of publication, after which time they will be destroyed.

A summary of the project findings will be made available on the Women's Health Grampians website in July 2017. The results of the study may be presented at academic conferences and published in peer-reviewed journals. In any publication and/or presentation, a pseudonym will be used.

Please find attached the short survey and a form on which you can indicate whether you would be willing to take part in a telephone interview. Please return this form to us in the reply paid envelope, even if you do not wish to take part.

If you would like to discuss the study, please feel free to contact the research team by email or telephone. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on (03) 8344 2073, or fax: (03) 9347 6739.

Sincerely,

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Tell us about you

Gender: Male ☐ Female ☐ Other/Undisclosed ☐ Age:_____

How many years have you been working as a GP in the region? _____

Country in which you completed your medical degree; _____ Year completed;_____

Have you had any additional training in Women's Health? Yes ☐ No ☐ Describe_____

The following questions relate to your experience of patients presenting to you with an unintended pregnancy while you have been working as a GP in the Grampians.

In the last 12 months, can you estimate how many times a patient has presented to you with an unintended pregnancy? _____

Any comment on this rate_____

If a woman presents with an unintended pregnancy, which of the following things would you discuss with the patient?

OPTIONS	Never	Rarely	Sometimes	Always
Pregnancy options counselling	☐	☐	☐	☐
Medical abortion	☐	☐	☐	☐
Telehealth medical abortion	☐	☐	☐	☐
Surgical abortion	☐	☐	☐	☐
Future Contraception	☐	☐	☐	☐
Sexually transmitted infections	☐	☐	☐	☐
Refer to a colleague due to conscientious objection	☐	☐	☐	☐

Other / comment_____

Overall, what is your impression of the services available to support women facing an unintended pregnancy in your area?

I am willing to be contacted by a researcher from the University of Melbourne to take part in a 30-45 minute telephone interview Yes ☐ No ☐

If yes, my preferred contact details are:

Telephone n^{o}: _____ AND/OR email address: _____

If you have agreed to participate in a telephone interview, a member of the research team will be in touch shortly to arrange a suitable time to conduct the interview. Thank you.

APPENDIX 3: INTERVIEW GUIDE (GPS)

Broad themes	Main Questions	Follow up prompts (if not raised)
Health service and training	Tell me about where you are working currently. How long have you been at the service/clinic? Are you working full-time or part-time? Where did you work previously? Do you have any additional training or expertise in Women's Health? If so, please describe. Can you tell me a bit about the patients who attend your service?	Bulk billing clinic? Diversity of patients - SES, age, common presentations, etc. Do you have another specialty? Are there particular challenges for patient group?
Practice for patients with an unintended pregnancy	Roughly what proportion of your consultations would be concerned with sexual or reproductive health? Can you tell me about the most common sexual and reproductive health presentations? What about women presenting for unintended pregnancy? How often would this occur? How comfortable are you helping these patients? Can you tell me the steps you would go through with a woman presenting with an unintended pregnancy? Do you offer to refer patients for pregnancy options counselling? Why? Why not? Is it accessible? Do your patients take up this offer? Do many women request abortion? What do you do in this instance?	Do you have access to information/advice on SRH? Where do you go for information? Do you feel you need additional resources for SRH? Do you discuss future contraception for patients with an unintended pregnancy? When? What do you recommend? Do you know if many patients know about emergency contraception?
Referral for STOP in the Grampians	Do you know of any services providing surgical termination of pregnancy in your region? How often would you refer a women to this (or another) service? Are you satisfied with the treatment your patients receive at the service you refer to? How late in the pregnancy can you refer a woman for abortion? Are most women you see eligible? (if not referring) Do you think it would be better for women if there were a service you could refer to? How do you think this would improve things for women? In your view, what is preventing this type of service from being provided? What would it take for a service like this to be set up?	What is the cost for women? How far away is the service? Is there transport? Have you had patients who were unable to access an abortion when desired? What have been the consequences for these patients? Do you follow up your patients after abortion?
Referral for MTOP in Grampians	Do you know of any services providing medical abortion in your region? How often would you refer a women to this service? How late in the pregnancy can they be? Do women ask you for advice about medical abortion? Do you think women know about it? Do you think there are enough services providing medical abortion in your region? Why? Why not?	Have you heard of medical abortion? Do you know of any tele-abortion services? Do you ever tell women about this option? Do you have any concerns about medical abortion?
Expanded role for General Practice	In your opinion, is there anything GPs could be do better to help patients with unintended pregnancy? Could GPs offer early medical abortion? Have you ever considered this in your service/clinic? If yes, what factors did you weigh up? Do you think it is something you would still consider doing in the future? What would need to happen for you to go ahead? If not, can you tell me about the reasons for not considering this? What might lead you to consider providing this type of service? What is the major factor that prevents you? Do you have other concerns?	What support/resources would be required to support you getting more involved in medical abortion service provision? Discuss role of practice nurse Discuss role of pharmacist Discuss role of hospital
Abortion Law (if not mentioned up to this point)	What is your understanding of the legal status of abortion in Victoria? What is your understanding of your obligation to patients requesting advice about abortion? Are you comfortable with the current legal status of abortion in Victoria?	Do you know if your colleagues share these views?

APPENDIX 4: INTERVIEW GUIDE (PRACTICE NURSES)

Broad themes	Main Questions	Follow up prompts (if not raised)
Health service and training	Tell me about where you are working currently. How long have you been at the service/clinic? Are you working full-time or part-time? What is your role? What kind of tasks do you do? Can you tell me a bit about the patients that attend your service?	Diversity of patients - SES, age, common presentations, etc. Do you have specialty/area of interest? Are there particular challenges for patient group?
Practice for patients with an unintended pregnancy	Roughly what proportion of your time would be spent on tasks related to sexual or reproductive health? What do you think the most common sexual and reproductive health presentations might be? What about women presenting for unintended pregnancy? How often do you think this would occur? How comfortable do you think the doctors in your practice are helping these patients? Do you have a role when women present with an unintended pregnancy? If so, what role? Do you think patients are offered pregnancy options counselling? How/where? Do you know if patients take up this offer? Do you have a role in discussing contraception with patients?	Do you feel you GPs have adequate resources for SRH? Do you know if many patients/doctors know about emergency contraception?
Abortion services in the Grampians	Do you know of any services providing abortion in your region? (Get a full list of known services) Do know which services GPs at your clinic refer women to? (if so) Why do GPs refer to one service or another? (if GPs not referring) Do you know why GPs do not refer women to this service? In your view, are the services adequate to meet women's needs? Do you think there are enough services providing medical abortion in your region? Why? Why not? Do you think women know about the full range of services? Know where to go/who to call? Have you had patients who were unable to access an abortion when desired? What have been the consequences for these patients?	What is the cost for women? How far away is the service? Is there transport? Do you know if doctors follow up patients after abortion?
If no knowledge of MTOP	Have you heard of medical abortion? Do you know of any tele-abortion services? Do you think these services would benefit women in your region?	
Expanded role for General Practice	In your opinion, is there anything GPs could be do better to help patients with unintended pregnancy? Could GPs themselves offer early medical abortion? Has your clinic ever considered this? If yes, what factors were weighed up? Do you think it is something you would still consider doing in the future? What would need to happen for you to go ahead? If not, can you tell me about the reasons for not considering this? What might lead your clinic to consider providing this type of service? What is the major factor that prevents you? Do you have other concerns?	What support/resources would be required to support your clinic getting more involved in medical abortion service provision? Discuss role of practice nurse Discuss role of pharmacist Discuss role of hospital
Abortion Law (if not mentioned up to this point)	What is your understanding of the legal status of abortion in Victoria? What is your understanding of doctor's obligation to patients requesting advice about abortion? Do you think there are many conscientious objectors in your clinic? Surrounding clinics? Do they all refer women to someone they know is not a conscientious objector? (if a problem identified) Do you think further education would help? Any other recommendations?	