INCREASING REPRODUCTIVE CHOICES IN THE GRAMPIANS PYRENEES AND WIMMERA REGIONS

A FOLLOW-UP STUDY TO RURAL GPs AND UNINTENDED PREGNANCY IN THE GRAMPIANS PYRENEES AND WIMMERA REGIONS

Louise Keogh[1], Casey Haining[1], Marieke Dam[2], Marianne Hendron[2]

1: Centre for Health Equity, Melbourne School of Population and Global Health, The University of Melbourne

2: Women's Health Grampians

KEY CONTACTS:

Associate Professor Louise Keogh
Centre for Health Equity
The University of Melbourne
Phone: (03) 8344 0692
Email: l.keogh@unimelb.edu.au

Marianne Hendron
CEO
Women's Health Grampians
Phone: (03) 5322 4100
Email: marianne@whg.org.au

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.

The project has been approved by the University of Melbourne Human Research Ethics Committee (1748829.2).

We acknowledge the guidance and advice of our project steering committee members: Ballarat Health Services, Ballarat Community Health, Wimmera Health Care Group, Hamilton Street Medical Clinic, Department of Health and Human Services.

Acknowledgement of Country

University of Melbourne and Women's Health Grampians acknowledge the traditional owners of the lands across the region which is the focus of this report. We pay respects to Aboriginal and Torres Strait Islander elders past, present, and future, and in particular we acknowledge the wisdom, history and knowledge of the Aboriginal women of these lands and their unique connection to country.

The project was supported by the Victorian Government.

VICTORIA
State Government

EXECUTIVE SUMMARY

BACKGROUND

In 2017, a baseline survey was conducted in the Grampians Pyrenees and Wimmera regions to better understand general practitioners' referral practices for unintended pregnancy options and abortion. **The survey revealed limited services, high rates of conscientious objection, and a lack of clarity about options for women and referral pathways.**

In response to the report, the Increasing Reproductive Choices Project (IRCP), funded by the Department of Health and Human Services, was designed to lead change in the Grampians Pyrenees and Wimmera regions. **It was intended that the project would help ensure women had access to reproductive health services in the region where they reside and work.** This report adopts a mixed methods approach to evaluate the effectiveness of IRCP since 2017.

METHODS

Methods to evaluate the Increasing Reproductive Choices Project include:

1. formal documentation of the activity of the project;
2. summary of stakeholders' views of the project's achievements;
3. case studies of service change in the region;
4. reflection on local service usage; and
5. comparison of survey data collected from GPs in 2019 with 2017 baseline data.

Methods include surveys, structured questionnaires, facilitated stakeholder discussions and inviting services to provide any reflections on usage of local services. Analysis methods were designed to document the impact, outcomes and changes that have occurred in the region since 2017 following the introduction of the IRCP.

RESULTS AND DISCUSSION

The IRCP has contributed to the delivery of new reproductive health services in the Grampians Pyrenees and Wimmera region. The IRCP provided administrative support to health services; increased awareness of medical abortion; and facilitated closer working relationships between experts like Dr Moore and Gateway Health in Wodonga, Victoria and local providers.

Reflection of the IRCP reveals that whilst progress has been made, obstacles remain. For example, there continues to be a low interest in supporting women to access abortion services close to home from a large proportion of health providers. This may be a result of a poor understanding of the factors that contribute to unintended pregnancies, few incentives, and ongoing stigma.

Participation in the 2019 survey was 27% (the same as 2017) yet the sample was slightly larger (n=28) due to the inclusion of nurses in the sampling frame. Respondents reported seeing on average 5 women with an unintended pregnancy each year (increased from 3 in 2017). This is likely to be due to the new services in the region offering medical abortion and the inclusion of the nurses involved in these services in the sample.

There was an increase in the proportion of participants who would 'always' discuss medical abortion (from 27% to 43%) with patients presenting with an unintended pregnancy. One quarter of participants failed to answer the question about referring their patients due to a conscientious objection. It is possible this was influenced by the perception of negative publicity relating to the high rates of CO identified in the 2017 Report.

Open-ended questions indicated that **participants in the survey believed that there were improved services and more awareness of options for women**. However, 43% of participants still felt services were inadequate (down from 52% in 2017), and **there was a strong interest amongst survey participants for further improvements in medical abortion services.**

CONCLUSIONS

The IRCP seems to have had the biggest impact on the availability of medical abortion services and medical professionals' knowledge and awareness of medical abortion as an option for women. However, this study also indicates that this is the area in which participants would like to see the most improvements. This indicates that in order to fully capitalise on the gains made so far, work must continue.

RECOMMENDATIONS

The study results indicate that there is a need to further improve the support for women with unintended pregnancy in the Grampians region.

The following recommendations are made:

- The ICRP Reference Group is retained in order to continue to sustain the focus on this important issue and to lead work on the identified recommendations.
- Capacity is maintained in the Grampians Pyrenees and Wimmera regions to advocate, liaise and promote communication and partnership with the Department of Health and Human Services (regionally and centrally in context of the SRH strategy), Western Victorian Primary Health Network and other key providers.
- Sexual and reproductive health service provision in Grampians Pyrenees and Wimmera is continually monitored by ICRP Reference Group in conjunction with 1800 My Options.
- A suitably trained and sustainable workforce is promoted through the provision and exploration of workplace and professional development opportunities, including MTOP and supporting regional providers.
- Rural and regional expertise, knowledge and advocacy is provided to relevant peak bodies, statewide entities and networks working towards improved reproductive choices for women.
- Local education is provided through the provision of workshops that are not limited to health professionals.

TABLE OF CONTENTS

BACKGROUND

Parts of the Grampians region, like other rural and regional areas, experience a greater number of teenage pregnancies than metropolitan cities (Women's Health Atlas, 2017). Structural factors relating to rurality limit the availability of health services in rural and remote areas leading to poorer health outcomes amongst rural communities when compared to their urban counterparts. Sexual and reproductive health, including family planning, is considered to be a core part of primary health care services (Thomas et al., 2015). Persistent barriers to the provision of adequate sexual and reproductive health services have been found in rural areas, and women are typically required to travel greater distances to access services (Doran and Hornibrook, 2014) and often present to a health professional during a later stage in their pregnancy (Shanker et al., 2017).

Whilst equitable access to safe termination of pregnancy is considered a core component of sexual and reproductive health from a public health perspective and a fundamental woman's right from a human rights perspective,[1] poor access to abortions services in rural areas, both in Australia (Kruss and Gridley, 2014; Dawson et al., 2016; Shankar et al., 2017; Doran and Hornibook 2014; Doran and Hornibrook 2016; Keogh et al., 2019) and in other developed countries (Heller et al., 2016, Doran and Nancarrow, 2015), continues to be reported.

Despite decriminalisation of abortion in most states, universal access to abortion for women has not been achieved (Keogh et al., 2017). Access is impeded in rural areas, due to greater costs, longer delays and waiting periods, logistical concerns, strains to social support networks and high rates of conscientious objection when compared to urban areas (Doran and Nancarrow, 2015; Nickson et al., 2006; Keogh et al., 2019). Medical termination of pregnancy (MTOP), has been available in Australia since 2012, and is thought to be generally a good way of increasing access to abortion for women in rural and regional areas (Newton et al., 2016). Despite such availability, relatively few GPs are thought to have taken up the option of becoming an MTOP provider (Newton et al., 2016).

In 2017, a baseline survey was conducted in the Grampians Pyrenees and Wimmera regions to better understand general practitioners' referral practices for unintended pregnancy options and abortion.[2] The survey revealed that GPs saw 3 women per year presenting with an unintended pregnancy and that the majority of GPs were trained overseas (65%). Survey responses suggest 41% of GPs 'always' discussed surgical abortion with a woman presenting with an unintended pregnancy, but only 27% would 'always' discuss medical abortion. No GPs 'always' discussed tele-abortion and 38% of GPs 'sometimes' or 'always' referred women to a colleague because they held a conscientious objection, with the proportion going up to 62% for GPs trained overseas. A key finding was the need for clarity around 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 reside and work.

In response to the report, the Increasing Reproductive Choices Project (IRCP), funded by the Department of Health and Human Services, was designed to lead change in the Grampians Pyrenees and Wimmera region in order to improve access to reproductive choices for women.

[1] Relevant human rights include: right to health; right to privacy and autonomy; and right to be free from violence, discrimination, and torture or cruel, inhuman and degrading treatment.

[2] Copy of the 2017 report available here: https://whg.org.au/wp-content/uploads/2019/08/Unintended-Pregnancy-Grampians_2017_-Final.pdf

The project commenced in July 2018 for 12 months (extended to December 2019). A project worker, who was based in Women's Health Grampians' Horsham office, was appointed to manage the project. The IRCP was intended to support the establishment of the Ballarat Sexual Health Hub based at Ballarat Community Health, which is expected to have a strong outreach focus, helping to address the access issues in the Grampians Pyrenees and Wimmera regions identified in the first study.

The project was led by Women's Health Grampians in partnership with Ballarat Community Health, Ballarat Health Services, Wimmera Health Care Group, Western Victoria Primary Health Network and the Department of Health as well as other local service providers.

The aims of the project were to:

- Identify, strengthen and improve awareness of referral pathways;
- Improve general knowledge in the region with respect to abortion services and legal obligations; and
- Develop an evaluation framework to measure the outcomes of the project and share findings with other rural regions.

This study has been designed to evaluate the impact of the IRCP, by collecting and analysing available data, determining how stakeholders view the achievements of the project and by comparing the current knowledge of GPs in the region with the 2017 Baseline study.

SETTING FOR THIS STUDY

LEGAL AND POLICY SETTING IN VICTORIA

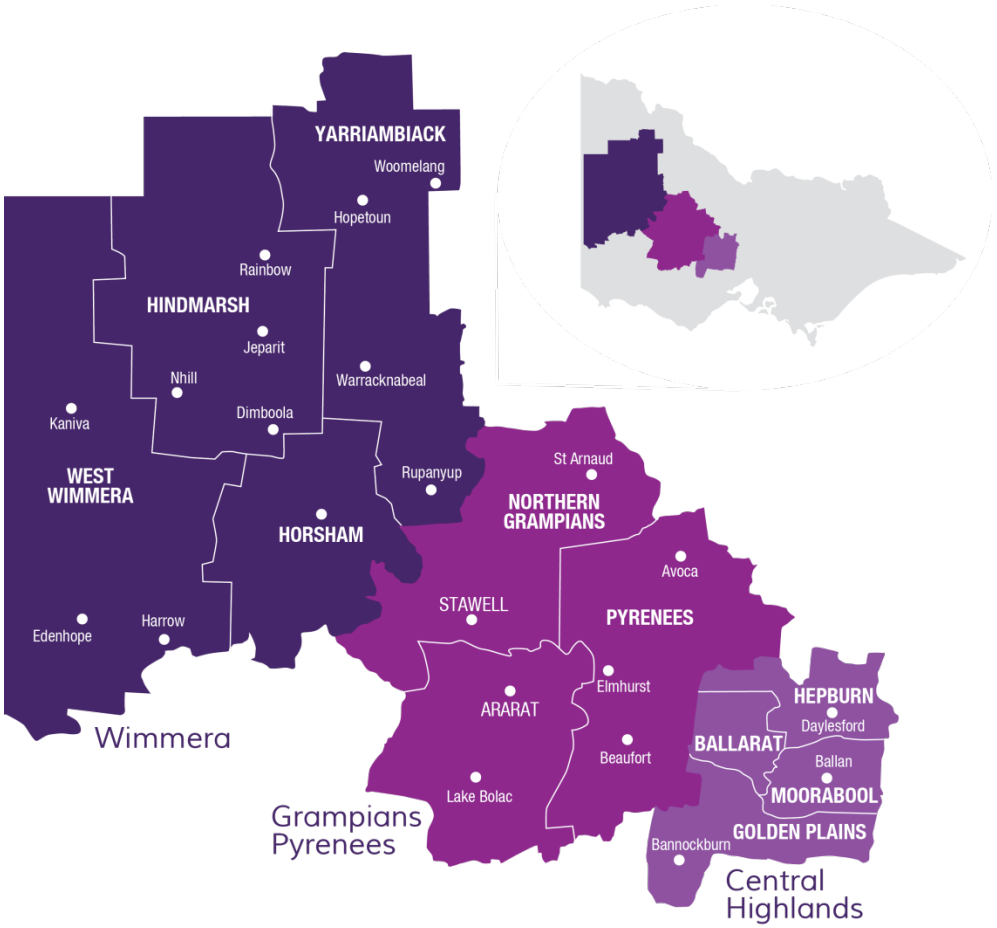
The *Abortion Law Reform Act 2008* (Vic) permits women to obtain an abortion within 24 weeks of gestation.[3] Women are still able to obtain abortions after 24 weeks, upon approval from two registered medical practitioners, who both reasonably believe that the abortion is appropriate in the women's circumstances, taking into consideration the women's current and future, medical, physical, psychological and social circumstances.[4] Section 8 of the Act, states that any registered health professional who is asked to advise a woman about abortion, or to perform, direct, authorise or supervise an abortion, and who has a conscientious objection must: (a) inform the woman that they have a conscientious objection; and (b) refer the woman on to another health practitioner in the same regulated health professional, who the health professional knows does not have a conscientious objection to abortion. Non-compliance with the legislation may result in disciplinary action administered from the Australian Health Practitioner Regulation Agency.

The **Victorian Public Health and Wellbeing Plan 2019-2023** outlined the government's key priorities and strategies for improving health and wellbeing. The plan highlights sexual and reproductive health as a key issue for the State. This is consistent with the Victoria government's 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 settings. The strategy asks for partners across the health system, including primary health, women's health services and local governments, to work together to improve access to services to support women's reproductive choices.

[3] *Abortion Law Reform Act 2008* (Vic), s 4
[4] *Abortion Law Reform Act 2008* (Vic), s 5

LOCATION OF THIS STUDY

This study focused on the Grampians Pyrenees and Wimmera catchment areas of the Grampians region in Victoria. These are municipalities to the west of Ballarat, a major regional centre. The areas in the study included Ararat, Horsham, Pyrenees, North Grampians, Hindmarsh, Yarriambiack and West Wimmera shires.



This study sought to compare the range of services available in the region now, and the referral practices and attitudes of health professionals when women present with unintended pregnancy in 2019, with data collected in 2017.

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

AIMS AND OBJECTIVES

The overall aim of this study was to evaluate the impact of the IRCP.
This was achieved by:

1. Documenting the activity of the project
2. Summarising stakeholder views of the project's achievements
3. Providing case studies of service change
4. Seeking reflections from the local service on any trends or patterns in use
5. Comparing survey data collected from GPs in 2019 with baseline data from 2017 in the following areas:
    a) Health professional knowledge of services available to patients with unintended pregnancy (pregnancy options counselling, contraception and abortion services).
    b) The type and range of services perceived by health professionals to be available for women facing unintended pregnancy in the region
    c) Health professionals' attitudes to the options of abortion available (including medical, surgical and tele-abortion options).
    d) The challenges and opportunities health professionals describe in managing unintended pregnancy in the region.

METHOD

OBJECTIVE 1: DOCUMENTING THE ACTIVITY OF THE PROJECT

The project worker from Women's Health Grampians documented the achievements of the Increasing Reproductive Choices Project over the funding period.

OBJECTIVE 2: SUMMARISING STAKEHOLDER VIEWS OF ACHIEVEMENTS OF THE PROJECT

Reference Group members were sent the summary document prepared by the project worker, and invited a week later to a facilitated discussion of the achievements of the project. The Reference Group members were asked a series of open-ended questions about the IRCP (appendix 1) and were invited to reflect on the questions and offer their views. The discussion lasted for 75 minutes and was audio-recorded. The transcript was then analysed thematically. Broadly participants were asked to reflect on the following:

- What worked well.
- Challenges and barriers.
- Sustainability of the project.
- Future directions of the project.

OBJECTIVE 3: PROVIDING CASE STUDIES OF SERVICE CHANGE

In order to learn from the experiences of providers in the region, as they attempt to increase options for women seeking reproductive choices, case studies were sought. The project worker invited health practitioners who had been active in the IRCP to answer a structured questionnaire about their experience. Their answers were then summarised individually to present a case study of each of their experiences.

OBJECTIVE 4: SEEKING REFLECTIONS FROM LOCAL SERVICE ON ANY TRENDS OR PATTERNS IN USE

In order to understand how current services were being used in the region, the project worker collaborated with medical abortion providers to determine if there were any noticeable trends in use of MTOP over the last 12-18 months.

OBJECTIVE 5: COMPARING SURVEY DATA COLLECTED FROM GPS IN 2019 WITH BASELINE DATA FROM 2017

A follow up study was conducted with very similar methodology to the baseline study conducted in 2017. This part of the study utilised a short questionnaire that asked both closed and open-ended questions of GPs, sexual health nurses and practice nurses. A project steering committee with members from various health organisations in the Grampians region oversaw the development and delivery of the follow-up survey. 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 and with the activity of the IRCP. 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.
An ethics amendment was made to the original ethics approval granted for the 2017 survey (granted by the Health Sciences Human Ethics Sub-Committee of the University of Melbourne, ethics number 1748829.2)

POPULATION AND RECRUITMENT

The population of interest for this study were GPs, sexual health nurses and practice nurses in the Grampians Pyrenees and Wimmera regions. Health professionals in the area were initially emailed a Survey Monkey link and a digital document copy of the survey and asked to complete the survey in one of the formats (appendix 2) Two weeks after the email survey was distributed, a list was generated of all the health professionals in Grampians Pyrenees and Wimmera, and a paper-based version of the survey was sent out to each GP, practice nurse and sexual health nurse at one of the practices in which they work (as some health professionals worked at multiple practices).

DATA COLLECTION

The questionnaire featured both open-questions and closed-ended questions. Participants were asked to reflect on their experiences of patients presenting to their practice with unintended pregnancies whilst they were working in the region, including what options they would discuss with their patients and their impressions on such options. Some questions were identical to the survey questions in the 2017 baseline study, to enable direct comparison. In addition, the survey included questions that explicitly required participants to reflect on any changes they observed in the previous 12-18 months with respect to: the range and number of services available; referral pathways; and training options available. A copy of the survey is found in appendix 2.

ETHICAL CONCERNS

Confidentiality of participants was one of the major ethical concerns in this study. Given the sensitive nature of abortion service provision in regional areas and the small number of participants who took part in this study, several steps were undertaken to ensure that the confidentiality of participants was preserved as much as practicable. Survey responses were either presented as summary statistics, or if data from an individual was reported, no demographic details were presented with the data, pseudonyms were used to refer to participants, and any identifying details were removed or disguised.

RESULTS

OBJECTIVE 1: DOCUMENTING THE ACTIVITY OF THE PROJECT

The IRCP has enjoyed strong support from regional partners.
The key outcomes of the project include:

- **Establishment of Grampians Increasing Reproductive Choices Project Reference Group** comprising of:
    - Ballarat Health Services
    - Melbourne University
    - Department of Health and Human Services
    - Ballarat Community Health
    - Wimmera Health Care Group
    - Hamilton Street Medical Clinic
    - Women's Health Grampians

  Western Victoria Primary Health Network has engaged with the group from time to time. The group met monthly in 2018 and bi-monthly in 2019. Participants have indicated a commitment to continue to meet beyond the life of the project.

- **Establishment of strong and enduring working relationships with key stakeholders** and local health service providers supportive of the project both locally in the Grampians Pyrenees and Wimmera area and with state-wide Increasing Reproductive Choices stakeholders.

- **Establishment of local medical abortion services**:
    - Engagement with a Wimmera based Medical Clinic developing a medical abortion provision model, nurse led with GP prescribing. Service commenced March 2019, with the Medical Clinic advertising publicly on 1800 My Options. The project worker has assisted with administrative processes and recommendations to their Board.
    - A pharmacy in Horsham is a registered provider of MS2Step needed for medical abortion and is now publicly advertising their services on 1800 My Options.
    - Ballarat Community Health has established an outreach service with a sexual health nurse attending Ararat on a weekly basis supported by a GP on telehealth for prescribing of MS2Step.

- **Creation of Best Practice Guidelines and mentoring relationships** with Gateway Health Centre in Wodonga and with the expertise of the Royal Women's Hospital's Clinical Head of Abortion and Contraception Services and the Sexual & Reproductive Health Clinical Champion Project.

- **Addressing the lack of local services and the need to establish good referral pathways** through targeted communication with local Health Professionals interested in improved sexual and reproductive health and choices.

- **Delivery of medical abortion information sessions** to gynaecologists, obstetricians and primary health care professionals in partnership with the Royal Women's Hospital Clinical Champion's Project, Women's Health Grampians, Ballarat Community Health, Western Victoria Primary Health Network in Horsham, Ararat and Ballarat in February 2019. Continuing professional development points were attached to the workshop. The Clinical Head of Abortion and Contraception Services at the Royal Women's Hospital shared her expertise on training requirements for providing medical abortion and an update on medical abortion procedures, practice experiences, support and referral pathways for GPs who provide medical abortion.

A total of 66 people attended. After the event 90% of participants felt entirely comfortable describing the clinical management of abortion, while 84% of participants felt the training was relevant to their practice. 85% of participants felt the overall quality of the event was excellent.

- **Identification of health pathways for abortion services**, which are now accessible online, by collaborating with Western Victoria Primary Health Network.

- **Increased registrations of local women's health services, including abortion options, on 1800 My Options**.

- Providing relevant information to Health Professionals attending the Medical Abortion Education and Information sessions via two newsletters (June & October 2019) containing information about medical abortion, referral pathways, clinical facts and risk mitigation, and other websites and links, etc.

- Providing support to Wimmera Southern Mallee Regional Partnership Early Years Trails (Uniting Wimmera, Murdoch Children's Research Institute, Horsham Rural City Council) by providing relevant information about contraception and abortion services.

OBJECTIVE 2: SUMMARISING STAKEHOLDER VIEWS OF ACHIEVEMENTS OF THE PROJECT

OVERVIEW OF REFLECTION

The Reference Group reflection included 11 people representing Women's Health Grampians, Ballarat Health Services, Department of Health and Human Services, Ballarat Community Health, Wimmera Health Care Group and the University of Melbourne. The evaluation was facilitated by the University of Melbourne.

THINGS THAT HAVE WORKED WELL

SESSIONS WITH CLINICAL HEAD OF ABORTION AND CONTRACEPTION SERVICES:

The majority of the reference group felt that the workshop sessions given by Dr Moore were incredibly valuable. According to a Reference Group member, the workshops proved to be the turning point for the project. The workshops were held at the right time and helped to capture the work occurring in the region.

Moreover, the sessions appeared to attract a culturally diverse range of health professionals. The Primary Health Network providing attendees with certificates proved to be a good incentive and such a strategy could be adopted in the future to encourage health professionals to attend further education workshops.

Dr Moore's session was thought to be useful in debunking myths related to abortion (specifically medical abortion) and raising awareness amongst health professionals. It was particularly helpful in pointing out that, even if a health professional was not willing to be a prescriber, there were still other options available to allow them to assist patients that presented to them, such as 1800 My Options.

> *"Even if [health professionals] do not come on board as prescribers, it is to educate them that there are actually options out there. The number of GPs I talk to that do not even know about 1800 My Options. We're all busy and cannot read everything that gets in front of us, but we just need to be able to educate them that they do have that facility."*

Furthermore, Dr Moore's explanation of the boundaries and requirements of a health professional under Section 8 (conscientious objection provision) of the Abortion Law Reform Act 2008 (Vic) proved to be particularly valuable. She was able to convey the boundaries of Section 8 naturally without sounding too prescriptive. Such an approach could prove to be valuable in future abortion educational opportunities directed at health professionals in the region. Finding the right approach is imperative given that it was previously found that some health professionals in this region tended to be unfamiliar with their legal obligations.

> *"Paddy Moore covered legal obligations in terms of referral in those sessions in a way that worked well to cover the audience that were present. We need to do more on that for health professionals in the region, given that it was a strong finding in the research."*

THE REFERENCE GROUP

Members thought that the establishment of the Reference Group, comprising individuals who are passionate about sexual and reproductive health and providing women with choices, was a huge strength of the project. The consistent commitment and contribution from the various stakeholders proved to be very beneficial. The regular meetings that were held and attended by members of the Reference Group encouraged information sharing between different parties which proved to be invaluable.

> *"There has been a value in the information sharing. It has caused me to reflect that there has been a great generosity in sharing information; there has not been any preciousness."*

Information sharing enabled members of the Reference Group to capitalise on each other's relationships, networks, and knowledge. This was particularly helpful in ascertaining information about different health professionals in the region and assisted in building up knowledge about which health professionals would be willing to be providers and would be supportive of the project's aims and which ones would not. Having such knowledge assisted in establishing referral pathways and avenues for the region.

> *"The strength for me is the collaboration around the table, by using our local relationships, we can try and get better intelligence about what places do have the emergency options and if they don't, how we can advocate for those* ***…I think with our local relationships … we can feel quite informed about real avenues and pathways."***

FUNDING

Funding was able to give the project momentum. The funding encouraged and permitted 'out of the box' thinking. It was felt that a lot of innovation had resulted from relatively limited resources.

> *"Having the opportunity for the funding does help you think outside the box about how you can deliver services."*

Moreover, funding permitted the employment of a project worker at Women's Health Grampians, who was viewed as being instrumental to the project's success thus far. Her ongoing support and encouragement throughout the project proved to be invaluable.

> *"(She) has been so instrumental in us setting up our clinic. She has provided us with so much support administratively."*

Furthermore, it was acknowledged that without the funding, the training sessions that were offered would not have been possible.

Challenges and barriers of the project

GP Failure to follow up after workshops

At the time of the reference group reflection there were only three 'dots' indicating service providers in the Horsham area on the 1800 My Options website. This was considered to be a disappointing number of service providers given the previously expressed interest. Specifically, at the Horsham workshop a number of health professionals indicated that they were willing to register with 1800 My Options, but failed to do so.

> *"At the GP session in Horsham they all nod their heads and say well 'we're going to look into that.' They say they're going to register on 1800 My Options … but then nothing."*

Health professional obstacles

Misconceptions

Misconceptions that existed amongst health professionals were believed to act as a barrier against access to sexual and reproductive services in the region. Reference group members suggested that health professionals in the area typically thought that the females predominantly seeking access to abortions were adolescents, despite 33 being the average age of termination. Moreover, it was believed that health professionals generally failed to consider the range of different reasons behind a woman seeking a termination such as sexual coercion, rape, problems with condoms (e.g. breakage, slippage), stealthing (non-consensual removal of the condom during sexual intercourse) and failure of the contraceptive pill.

Local practice barriers

Reference group members highlighted that the nature of the practices of some of the local medical clinics/hospitals were impeding a woman's ability to access sexual and reproductive services. For instance, obtaining ultrasounds was perceived to be generally very difficult. Additionally, whether or not a referral for an ultrasound was successful was ultimately contingent upon the messaging and content contained in a referral form. Moreover, the refusal of some of the local pharmacies to stock MS2Step, and failure of some local pharmacies to even offer contraceptive options were identified as being further barriers.

Inability to set up substantive pathways

It was raised that there are difficulties with obtaining enough prescribers. It was noted that nurses in the region seemed to be ready and willing to execute all the preparatory work and follow up work, but because of the lack of general practitioners willing to become prescribers, referral pathways are hard to establish.

Although 1800 My Options is a valuable resource, there are clinics unable to register because they currently do not have established pathways. From a project perspective, there was a deliberate hold back on 1800 My Options because there "were not enough dots on the map" and hence 1800 My Options had limited utility to women.

> *"From a project perspective, we deliberately held back on 1800 My Options because we had no dots on the map. There was no point pushing 1800 My Options when there was no local use to women. So, we have a need to now use project time to get those numbers on the map."*

SUSTAINABILITY OF THE PROJECT

Concerns were raised about the longevity of the project, given that the funding will eventually cease.

> *"We would not have been able to have those opportunities without the funding. I'm conscious of the sustainability of the service going forward as well. Once you start developing expectations it is hard to go back … there are limited resources."*

The importance of empowering the nursing workforce during the project and ensuring that they remain active even beyond the project's timeline was highlighted.

> *"I think we do need to do something to ensure that we do still have nurses active in this service. Because we are working in a region, we do not have a sufficient workforce to be able to provide a broad scope of care, usually. "*

Following the cessation of funding, members of the Reference Group agreed that they would still be willing to attend meetings on a quarterly basis.

FUTURE DIRECTIONS OF THE PROJECT

- **Provision of more workshops**
  Given the identified success of the previously held workshops it was suggested that workshops of a similar nature should be held in the future. However, future workshops should not only target individual health professionals, but also practice managers who have the potential to 'sway' GPs.

- **Continuation of advocacy to improve access to abortion service provision across all parts of the region**

- **Potential to establish a telehealth service**
  The IRCP project aimed to complement the Ballarat Community Health Sexual Health Hub and the outreach components of SRH services, including MTOP, into the Grampians Pyrenees and Wimmera regions.

  At the endpoint of the project, there has been an outreach service established to Ararat, but there is room for other outreach services into other parts of the region. This could take the form of a Nurse Led Service, with a GP on telehealth, if local prescribers are not available in a town. Women would be referred by the nurse having obtained the scan, reports and blood tests and then a telehealth appointment would be conducted from the patient's own home and medication posted to the woman.

OBJECTIVE 3: PROVIDING CASE STUDIES OF SERVICE CHANGE

Three case studies were collected, one from a Sexual Health Nurse, one from a GP and one from a Pharmacist. The case studies were used to summarise the enablers to setting up a new MTOP service and to compare the anti-abortion backlash expected with the backlash actually experienced.

CASE STUDY 1: SEXUAL HEALTH NURSE

Delivering a new medical abortion service in a particular regional area with no existing abortion services. Model is a nurse led service with GP prescribing.

ENABLERS:

Having a successful model on which to base service (Gateway Health Service); support from Dr Moore; practical support from the project worker; expert reception staff; supportive and non-judgemental ultrasound, pharmacy, emergency department and pathology services locally; open and positive communication with stakeholders and partners.

EXPECTED VERSUS EXPERIENCED BACKLASH:

Expected some backlash, however, there was no public or online backlash. Minor personal judgement from other health professionals was experienced.

OVERALL VIEW:

Positive and empowering for women, however more prescribers needed in the region. There is evidence that suggests that other local GPs are referring women to the service, which is a positive step. 65% of women leave with contraception.

CASE STUDY 2: GP

The GP had been offering a medical abortion service in addition to the services provided to their usual patient list.

ENABLERS:

High quality nursing support; information and resources shared by Gateway Health Service; 'MTOP Providers Downunder' - private Facebook group an excellent resource for collegial support and information; supportive ultrasound, pathology and emergency department services.

EXPECTED VERSUS EXPERIENCED BACKLASH:

Delayed publicly listing on 1800 My Options for fear of backlash, but since being listed, have had no backlash.

OVERALL VIEW:

It is quite an expensive service to deliver, so even where there is no conscientious objection, some clinics may find it does not suit their business model.

CASE STUDY 3: PHARMACIST

The pharmacy felt that a local service was needed by women in their region, so went ahead with training to become a MS2Step dispenser. It has had very little impact on the service overall, but makes a huge difference for women.

ENABLERS:

High quality counselling provided by GP service prior to women presenting at pharmacy.

EXPECTED VERSUS EXPERIENCED BACKLASH:

Were not expecting a backlash and none has been experienced.

OVERALL VIEW:

Dispensing MS2Step through a local pharmacy service provides women a less expensive option and reduced stress at an already difficult time.

OBJECTIVE 4: ANALYSING SERVICE USAGE

To analyse medical abortion services in the Ballarat, Grampians Pyrenees and Wimmera areas the Increasing Reproductive Choices project gathered perspectives from the Ballarat and newly established Horsham and Ararat providers of medical abortion services. Positive improvements to support women to access local services have been observed. After the establishment of the Horsham medical abortion service in March 2019, there has been a decline in women from the Wimmera catchment accessing services in Ballarat. This highlights the potential for this trend to continue in the Grampians Pyrenees region, with the medical abortion service being established in Ararat in June 2019. This is a positive step forward in increasing reproductive choices within the region.

OBJECTIVE 5: COMPARING SURVEY DATA COLLECTED FROM GPS IN 2019 WITH BASELINE DATA FROM 2017

THE PARTICIPANTS

A summary of demographic characteristics is shown in table 1.

- Of the 103 health professionals who were invited to take part in the study, 28 returned the survey, giving a participation fraction of 27% (the same response rate as in 2017).
- There were 15 females and 13 male participants ranging from 24 to 72 years of age, and they had been practicing in the region for 13 years on average, ranging from 0 to 42 years (calculated based on n=25).
- There was a slightly higher proportion of older respondents in 2019 compared to 2017 (74% compared to 50%). A major difference between 2017 and 2019 was the inclusion of nurses in the sample.

Table 1: Health professional demographic characteristics

	2017 Data (n=23)		2019 Data (n=28)	
Variable	**Number**	**Percentage**	**Number**	**Percentage**
Gender				
Male	11	48%	13	46%
Female	12	52%	15	54%
Age				
45 years and under	10	50%	7	26%
Older than 45	10	50%	20	74%
Declined to answer	3		1	
Role in General Practice				
Doctor	23	100%	19	70%
Practice Nurse			3	11%
Sexual Health Nurse			1	4%
Nurse Practitioner			1	4%
Other			3	11%
Declined to answer			1	
Medical Training				
Australia	8	35%	12	48%
Overseas	15	65%	13	52%
Declined to answer/ not applicable			3	
Time practising in region				
0- 5 years	12	52%	7	27%
6 years or more	11	48%	18	69%
Has not practised as a heath professional			1	4%
Declined to answer			2	
Additional women's health training				
Yes	12	52%	15	54%
No	11	48%	13	46%
Unintended pregnancy presentations in past year				
0	6	26%	6	21%
1-2	10	43%	10	36%
3 or more	7	30%	12	43%

Percentages are calculated on the basis of the participants who responded to the particular question. Percentages have been rounded to the nearest whole number.

THE RESULTS

PRESENTATIONS FOR UNINTENDED PREGNANCY

Participants reported on average seeing 5 women (mean=4.5) presenting with unintended pregnancy each year (range= 0-20). In comparison to the 2017 baseline data (mean: 2.9; range: 0-25) this is an average increase of 2 women per year, however the range of the 2019 data is less variable (0-20 compared to 0-25).

Furthermore, it should be noted that 7/28 participants indicated that the reported value may be underrepresented. The underrepresentation was thought to be a product of the health professional's low clinical hours (n=4), the health professionals older age and tendency to see less patients as a result (n=2), local presence of a health clinic for individuals seeking termination (n=1) and the gender of the health professional (with suggestion that women were more likely to present to female colleagues).

Some participants, who indicated they had seen 10-11 patients with an unintended pregnancy, acknowledged that they worked at a clinic known to provide medical abortion and accepted referrals, which explained the higher number of presentations.

TRAINING

As was found with the baseline data, there was a large proportion of participants in the follow-up survey who obtained their medical education overseas. However, whilst the proportion of overseas trained doctors in the baseline study was 65% this study found a lesser proportion of overseas trained health professionals (52%). Of the 17 doctors that answered the question, 9 indicated they obtained their medical training overseas (53%).

HEALTH PROFESSIONAL PRACTICE WHEN WOMEN PRESENT WITH UNINTENDED PREGNANCY

Participants were asked what they discussed with patients who presented with unintended pregnancy.

- 26% reported that they rarely or never discussed surgical abortion, which was comparable to the 2017 data (27%).
- Whilst 30% participants reported that they 'rarely' or 'never' discussed medical abortion, this proportion is slightly smaller than that found in the 2017 data (36%).
- Significantly, the number of health professionals that always spoke to their patients about medical abortion had increased 16% from the 2017 data.
- Whilst most participants did not discuss tele abortion, 79% of participants indicating they rarely or never did, this proportion was smaller than the 2017 data (90%). Notably, unlike in 2017 where no patient indicated that they would always talk to their patients about tele abortion, in the 2019 data two participants (8%) indicated that they always discuss tele abortion with their patients.
- In contrast, 88% indicated they would sometimes or always discuss pregnancy options counseling, this was similar to the 2017 baseline data that indicated 86%. Most participants indicated that they 'always' or 'sometimes' discuss sexually transmitted infections (83%) this percentage has slightly decreased from the 2017 baseline data (86%).
- Moreover, there was a decrease in the proportion of individuals who would always/sometimes discuss future contraceptive options with women who presented with unintended pregnancies (87% compared to 96%).

CONSCIENTIOUS OBJECTION

Of the survey participants who responded to the question, 24% indicated they 'always' or 'sometimes' referred on patients due to a conscientious objection, whilst most participants indicated they 'never' referred (76%). These percentages have decreased and increased respectively in comparison to the 2017 data (38%; 48%).

However, these values should be interpreted with caution as it is not known whether those who indicated that they never or rarely referred had a conscientious objection, or if they "never" or "rarely" referred because they were medical abortion providers. The ambiguity in the question was deliberate, given that Section 8 of the Abortion Law Reform Act 2008 (Vic) mandates that health professionals, who have a conscientious objection to abortion must refer and failure to do so is in contravention of the Act. Moreover, it should be noted that 7 participants (including 3 doctors) declined to answer the question, which represents a substantial proportion of the participants (25%). Of those participants who did answer the question, 24% indicated that they refer women seeking an abortion, 'always' or 'sometimes,' due to a conscientious objection. In relation to doctor participants, this accounted for 31% of doctors, who answered the question (compared to 38% in 2017). Each of the doctors, who would 'always' or 'sometimes' refer, were trained overseas.

Table 2: Health professional practice for women presenting with an unintended pregnancy

	2017 Data (n-23)		2019 Data (n=28)		Difference (+/-%)
Practice	**Frequency**	**Percentage**	**Frequency**	**Percentage**	
Future contraception					
Always	20	87%	14	61%	-26%
Sometimes	2	9%	6	26%	+17%
Rarely	1	4%	1	4%	0
Never	0	0%	2	9%	+9%
Declined to answer	0		5		
Sexually transmitted infections					
Always	11	50%	14	58%	+8%
Sometimes	8	36%	6	25%	-11%
Rarely	3	14%	3	13%	-1%
Never	0	0%	1	4%	+4%
Declined to answer	1		4		
Pregnancy options counselling					
Always	17	81%	18	75%	-6%
Sometimes	1	5%	3	13%	+8%
Rarely	3	14%	2	8%	-6%
Never	0	0%	1	4%	+4%
Declined to answer	2		4		
Medical Abortion					
Always	6	27%	10	43%	+16%
Sometimes	8	36%	6	26%	-10%
Rarely	3	14%	3	13%	-1%
Never	5	23%	4	17%	-6%
Declined to answer	1		5		
Surgical Abortion					
Always	9	41%	11	48%	+7%
Sometimes	7	32%	6	26%	-6%
Rarely	1	4%	2	9%	+5%
Never	5	23%	4	17%	-6%
Declined to answer	1		5		
Telehealth medical abortion					
Always	0	0%	2	8%	+ 8%
Sometimes	2	10%	3	13%	+3%
Rarely	3	15%	6	25%	+10%
Never	15	75%	13	54%	-21%
Declined to answer	3		4		
Referral due to CO					
Always	6	28%	4	19%	-9%
Sometimes	2	10%	1	5%	-5%
Rarely	3	14%	0	0	-14%
Never	10	48%	16	76%	+28%
Declined to answer	2		7		

Note percentages are calculated using the proportion of participants who elected to answer the question. Percentage values are rounded to the nearest whole number percentage.

Table 3: Comparison of referral for conscientious objectors by doctors

	2017 data (n= 23)		2019 data (n=19)		Difference (+/- %)
	Frequency	Percentage	Frequency	Percentage	
Always	6	28%	4	25%	-3%
Sometimes	2	10%	1	6 %	-4%
Rarely	3	14%	0	0	-14%
Never	10	48%	11	69%	+21%
Declined to answer	2		3		

Note percentages are calculated using the proportion of participants who elected to answer the question. Percentages have been rounded to the nearest whole number.

Table 4: Comparison of doctors with conscientious objection referral by country of medical training (n= 17)*

Medical Training	Never	Rarely	Sometimes	Always	Declined to answer
Australia (n=8)	6 (100%)	0 (0%)	0 (0%)	0(0%)	2
Overseas (n=9)	4 (44%)	0 (0%)	1 (11%)	4 (44%)	0

.* 2 doctors declined to answer where they got their medical training
Note percentages are calculated using the proportion of participants who elected to answer the question. Percentages have been rounded to the nearest whole number

OPEN-ENDED QUESTIONS

Participants were asked a number of open-ended questions to provide them with the opportunity to reflect on: their overall impression of the services available to women in the region; changes observed in the past 12-18 months following the implementation of the Increasing Reproductive Choices Project; and to provide comment on the changes they would most like to see with respect to the services and training options.

GP IMPRESSIONS OF SERVICES

Coding of responses for this question followed the same coding framework as the 2017 baseline study, so a comparison could be drawn. However, an additional "good" code was added. This code was added to capture some of the responses that indicate the current services offered in the region were in fact "good." Such responses were only represented in the 2019 data and were not reflected in the 2017 baseline.

The following codes were used to describe the quality of the services in the region:

- Limited/inadequate
- Average
- Adequate
- Improved
- Good
- Limited knowledge/Unsure

The responses reflect a decline in the number of responses indicating that the services available are inadequate or limited (43% compared to 52%), and increase in the number of responses that indicate the services have improved (29% compared to 4%) or are good (a category previously found not to exist).

For those who indicated that the services had improved, the improvement was attributed to an increase in medical abortion providers (n=4), improved referral options (n=2) and increased accessibility of services (n=2).

There is also decrease in the number of participants who indicate they are unaware or have limited knowledge of the services available in the region.

Table 5: Health professionals' opinions of services in their area

Code	Number (%) of participants		Example quote(s) for the 2019 data
	2017 (n=21)	**2019 (n=28)**	
Limited or inadequate	12 (57%)	12 (43%)	"*Services are available, but access is difficult due to distance/transport availability/lack of individual support."* *"Very poor, as the local base hospital refuses to take patients unless we have fully worked up, which is not taking the patient really."* *"Can be a problem if very young and if you are not able to travel. Also, if you [are] needing surgical or if you have no Medicare, which has been an issue cost wise for our women."* *"Limited, but better than before."**
Average/Adequate	2(10%)	2 (7%)	"*OK*"
Improved	1 (5%)	8 (29%)	"*Previously I sent all to Ballarat base at a particular clinic, now if I have a lady with such a problem, I would refer to my colleague in another practice*." "*Becoming available in the region after [a now available] option [of] medical termination offered by a GP in town*." "*Improved. More accessible*."
Good	N/A	5 (18%)	"*Very good support"* *"There are clinics in the area to support patients who presented early and [are] eligible for medical abortion."*
Limited knowledge/ unsure	6 (29%)	2 (7%)	"*Local O & G not keen on terminations, not aware of other local options, I usually refer."*

Note percentages were rounded to the nearest whole number.

*Response coded twice to reflect the limited, yet improved service described by the participant.

REFLECTION ON THE LAST 12-18 MONTHS

Participants were asked to reflect on changes in the last 12-18 months with respect to:

- The range and number of services available;
- Referral pathways; and
- Training options available for Doctors/Nurses/ Practice managers.

Data was coded according to three categories namely whether there was improvement; no apparent change; or unsure. None of the participants indicated a decline in service quality/availability and hence such a code was excluded from analysis.

Table 6: The range and number of services (n=25)

Code	Number	Quote
Improved	15	"*Increased options and range of services available."* *"Improved women's preventative health, DISS clinic with lots of contraceptive consultations and the local women's clinic has improved access to preventative care for women in the community."* *"Increased locally accessible medical termination.* *"… an increase in some of the larger rural cities"*
No change	10	"*Same problem."* *"Remained unchanged to the best of my knowledge."* *"Now one MTOP provider, still no change from STOP, as far as I am aware."**

*Response coded under improved and no change to reflect the improvement in MTOP provision and the stagnant STOP provision.
3 participants declined to answer this question.

Table 7: Referral pathways (n=23[#])

Code	Number	Quote
Improved	14	"*More options due to local availability of MTOP."* *"Increase via PHN."* *"None via 1800 My Options but several from other GP and social media."* *"Referral pathways improved and education provided to our services."* *"Health pathways helpful*" *"1800 Choices."*
No change (*)	9	*"Still too slow for some."* *"Not available unless you are prepared to do it their way."* *"Similar as before."*

*****Note 4 of the responses that were coded in the "no change code" featured participants describing their current referral pathway rather than reflecting on the changes. The pathways described by these participants made mention of Ballarat, Marie Stopes, Royal Women's Hospital. Given all of which were referral options 18 months ago, such responses were coded under no change.
5 Participants declined to answer this question.

Table 8: Training options for doctors/nurses/ practice managers (n= 22[#])

Code	Number	Quote
Improved/ available	8	*"More easily accessible"* *"I attend all PHN events on offer and recently attended IUD training in Perth."*
No change	5	*"Not significantly different"*
Unsure	9	*"None that I am aware of."* *"Unsure regarding this."* *"Random."*

6 participants decline to answer this question.

41% of participants were unsure of the training options that were available to them. There was also a large proportion of participants noting training options were available or had improved. Of these participants, 2 participants indicated that whilst there were training options available to them, they did not feel the need to undergo such training. Moreover, another participant captured by this code indicated that whilst there were several training options on offer to health professionals, they were too hard to get to.

AREAS WHERE CHANGES TO AVAILABLE SERVICES AND TRAINING OPTIONS IN THE REGION WERE MOST DECIDED

Participants were also asked what area of the region they would most like to see changes to services or training in the region. 23/28 participants answered this question.

A word cloud was created to of participants' responses (figure 1). The most common responses were MTOP, education/training and STOP.

Figure 1: word cloud of participants' responses with respect to areas which the most improvement is desired.

Nine participants indicated they wanted to see improvement in medical abortion (MTOP) in the region, whether that be with respect to an increase in provision, willing providers, or clinics willing to provide MTOP.

Eight participants identified education/ training as being areas in which improvement was most preferable. Many participants wanted to see more local training being provided, one participant even requesting online education to become available. Whilst the majority of participants wanted improvements in education and training more generally, other participants wanted a specific type of education and training. Two participants indicated that they would like training and education with respect to referral pathways, so they can refer their patients to a willing provider without causing delay. Two other participants wanted education tailored towards the preventive side of things with one participant wanting training with respect to domestic violence and another participant wanting to see more education in schools with respect to contraception and sexual health.

Three participants viewed STOP provision as an area in need of improvement.

There were other areas of improvement noted, but such areas were each only identified by one participant each.

These improvements included:

- increase in telehealth services;
- increasing level of support to public hospitals;
- the introduction of self-referral systems;
- cheaper contraceptive options available;
- provision of more options for allied health professionals (including dieticians, physiotherapists, counsellors and psychologists);
- increased access to sexual health services in small rural townships:
- improvement in sexual health services at Horsham Hospital;
- community acceptance of procedures.

One participant noted that there were no areas of the region in which they would like to see changes to the services or training in the region.

DISCUSSION AND CONCLUSION

Overall, the IRCP has had a significant effect on both knowledge and services related to reproductive choice in the Grampians Pyrenees and Wimmera regions; however there is still further work to do. Most of the progress seems to have been made in the area of the provision of medical abortion services, which was extremely limited in 2017.

The 2019 survey, group reflections and case studies all indicate green shoots, as services test the waters with providing a medical abortion service, and are able to report a positive experience. There appears to have been a slight increase in knowledge of the availability of medical abortion and about access to training and information. However, the majority of GPs working in this region have not themselves undertaken the training to become a provider, nor do they indicate a preparedness to do so. Reasons behind this could be personal conscientious objections, the absence of a financial incentive, workload, support from local providers, and a perception that access to abortion providers in larger centres is sufficient.

Case studies show that the perceived barriers (from the 2017 study) of difficulty accessing ultrasound, and support from emergency department can be overcome, and that the support of champions like Dr Moore and Gateway Health, facilitated by local champions, make a big difference to both the practicalities and the less tangible aspects of setting up a new service.

RECOMMENDATIONS

Upon reflecting on the results obtained from this study, the IRCP Reference Group prescribed a number of recommendations that are believed to assist in continuing to improve the access and availability of sexual and reproductive health services in the Grampians Pyrenees and Wimmera region.

The recommendations are as follows:

- The IRCP Reference Group is retained in order to continue to sustain the focus on this important issue and to lead work on the identified recommendations. The reference group is supported by Women's Health Grampians and meets on a quarterly basis. Reference Group membership is strategically increased through approaching 1800 My Options and representatives across the Western end of the region, eg West Wimmera Health Service.

- Maintain capacity in the Grampians Pyrenees and Wimmera regions to advocate, liaise and promote communication and partnership work with the Department of Health and Human Services (regionally and centrally in the context of the SRH strategy), Western Victoria Primary Health Network and other key providers, with a particular focus on the Ararat/Grampians Pyrenees region.

- The reference group, in conjunction with 1800 My Options, monitor sexual and reproductive health service provision in the Grampians Pyrenees and Wimmera regions through mapping and appropriate/agreed data collection.

- Promote a sustainable workforce through:
    - facilitating access to relevant workforce development opportunities.
    - supporting emerging medical abortion providers through clinical champions.
    - advocating for incentives to ensure financial viability of medical abortion provision, eg MBS Billing Code for long consultations.
    - exploring opportunities for the development of a nurse practitioner model.
    - explore MBS Billing Code for Nurse time attending to taking a patient history, arranging any necessary investigation and implementing a management plan.
    - telehealth for GP's (currently requires a specialist only for telehealth).

- Provide rural and regional expertise, knowledge and advocacy to relevant peak bodies, statewide entities and networks with an interest in women's reproductive choices.

- Provide local education through the provision of workshops, that are not limited to health professionals, but also extend to practice managers and any other health administration/executive staff, who have the potential to influence the practice of health professionals.

REFERENCES

Abortion Law Reform Act 2008 (Vic)

Dawson, A. J., Nicolls, R., Bateson, D., Doab, A., Estoesta, J., Brassil, A. & Sullivan, E. A. 2017. Medical termination of pregnancy in general practice in Australia: A descriptive-interpretive qualitative study. Reproductive Health, 14.

Doran, F. & Hornibrook, J. 2014. Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study. The Australian Journal of Rural Health, 22, 121-126.

Doran, F. & Nancarrow, S. 2015. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. The Journal of Family Planning And Reproductive Health Care, 41, 170-180.

Heller, R., Purcell, C., Mackay, L., Caird, L. & Cameron, S. T. 2016. Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study. Bjog-an International Journal of Obstetrics and Gynaecology, 123, 1684-1691.

Keogh, L.A., Croy, S., Newton,D.,Hendron.,M, Hill, S. 2017. Rural GPs and Unintended Pregnancy in the Grampians Pyrenees and Wimmera Regions. Available at: https://whg.org.au/wp-content/uploads/2019/08/Unintended-Pregnancy-Grampians_2017_-Final.pdf

Keogh, L.A., Gillam, L., Bismark, M.,McNamee, K., Webster.,A, Bayly, C & Newton, D. 2019. Conscientious objection to abortion, the law and its implementations in Victoria, Australia: perspectives of abortion service providers. BMC Medical Ethics, 20, 11.

Keogh, L. A., Newton, D., Bayly, C., Mcnamee, K., Hardiman, A., Webster, A. & Bismark, M. 2017. Intended and unintended consequences of abortion law reform: Perspectives of abortion experts in Victoria, Australia. Journal of Family Planning and Reproductive Health Care, 43, 18-24.

Kruss, J. & Gridley, H. 2014. 'Country women are resilient but....': Family planning access in rural Victoria. Australian Journal of Rural Health, 22, 300-305.

Newton, D., Bayly, C., Mcnamee, K., Bismark, M., Hardiman, A., Webster, A. & Keogh, L. 2016. '…a one stop shop in their own community': Medical abortion and the role of general practice. Australian and New Zealand Journal of Obstetrics and Gynaecology, 56, 648-654.

Nickson, C., Smith, A. M. A. & Shelley, J. M. 2006. Travel undertaken by women accessing private Victorian pregnancy termination services. Australian & New Zealand Journal of Public Health, 30, 329-333.

Shankar, M., Black, K. I., Goldstone, P., Hussainy, S., Mazza, D., Petersen, K., Lucke, J. & Taft, A. 2017. Access, equity and costs of induced abortion services in Australia: a cross-sectional study. Australian and New Zealand Journal of Public Health, 41, 309-314.

Thomas, S. L., Wakerman, J. & Humphreys, J. S. 2015. Ensuring equity of access to primary health care in rural and remote Australia - what core services should be locally available? International Journal for Equity in Health, 14.

Victorian Public Health and Wellbeing Plan 2019-2023. Available at: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-public-health-wellbeing-plan-2019-2023

Woman's Health Atlas. Sexual and reproductive Health: Teenage Birth- Aggregate 2 year rate (per 1000).2017. Available at: https://victorianwomenshealthatlas.net.au/#!/atlas/Sexual%20and%20Reproductive%20Health/SRH/Teenage%20Birth/SRH_06/2017%20Aggregate%202%20year%20rate%20(per%201,000)/235/F/state/all/false

Women's sexual and reproductive health: key priorities 2017-2020. Available at: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities

APPENDICES

APPENDIX 1: REFERENCE GROUP REFLECTION INTERVIEW GUIDE

REFERENCE GROUP REFLECTION

1. What aspects of the Reproductive Choices Project have worked well so far?
   - Why do you think the aspects you identified worked well?
   - Were the aims of the project achieved?

2. What aspects of the project did not work well?
   - How do you think the project could have been improved?

3. What have been the identified challenges or barriers with executing the Reproductive Choices Project in the Region? What are your thoughts on the project's sustainability?
   - What can be done to ensure the project is sustained?

4. What do you identify the goals of the project to be going forward?

APPENDIX 2: INDIVIDUAL HEALTH PROFESSIONALS INVITATION TO PARTICIPATE AND SURVEY

INVITATION TO PARTICIPATE IN FOLLOW-UP SURVEY ON RURAL GP KNOWLEDGE AND REFERRAL PRACTICES FOR WOMEN PRESENTING WITH UNINTENDED PREGNANCY

As someone working in a General Practice (GP) listed in the Grampians Pyrenees or Wimmera regions in Victoria, we previously (in 2017) invited you to tell us about your knowledge, practice and experience with women presenting to you with an unintended pregnancy. We are now interested to determine whether there have been any changes in your views or experiences since that time.

The Grampians Pyrenees and Wimmera regions experience higher rates of teenage pregnancy than the average for Victoria, and in the previous survey we found limited services for supporting women with an unintended pregnancy. Subsequently, the Department of Health and Human Services funded the Reproductive Choices project, which has been conducted by Women's Health Grampians, in part to improve knowledge in general practice of abortion services and referral pathways. This survey is designed to determine if there has been any changes in knowledge or attitudes since the baseline survey. 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 1748829.2).

You have been identified as someone, who, in your 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 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 it will take between 15 and 20 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 August 2019. 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,

Associate Professor Louise Keogh
Centre for Health Equity; The University of Melbourne
Phone: (03) 8344 0692
Email: l.keogh@unimelb.edu.au

Marianne Hendron
Women's Health Grampians;
Phone: (03) 5322 4100;
Email: marianne@whg.org.au

Tell us about you

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

How many years have you been working in General Practice in the region? _____

What is your role in general practice?

- Doctor ☐
- Practice Nurse ☐
- Sexual Health Nurse ☐
- Other ☐_____

Country in which you completed your medical or nursing degree; _____ Year: _____

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

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

In the last 12 months, can you estimate how many times a patient has presented 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? _____

_____

_____

In the last 12-18 months what changes have you observed in:
The range and number of services available?

_____
_____

Referral pathways

_____
_____

Training options for Doctors/Nurses/Practice Managers?

_____
_____
_____

What is the area you would most like to see changes to services or training in the region?

_____
_____
_____

Name_____

I am willing to be contacted by a researcher from the University of Melbourne to take part in a 15-20 minute telephone interview to further discuss these issues; Yes ☐ No ☐

If yes, my preferred contact details are:

Telephone n°: _____ 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.