Women's Health Vic

Knowledge Paper 6

Realising access: Abortion and contraception inequities and enablers in Victoria

October 2024

Women's Health Victoria is a statewide, feminist, not-for-profit leading the pursuit of gender equity in health.

We work with government, the health sector and the community to create better health outcomes for women (cis and trans inclusive) and gender diverse people.

We deliver vital support services to the community and empowering health information. We share evidence and recommendations to challenge bias in the health system. We build capacity in the health sector to achieve equitable health outcomes.

Women's Health Victoria is transforming the health system – doing whatever it takes to reach gender equity in health.

Realising access: Abortion and contraception inequities and enablers in Victoria

October 2024

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Women's Health Vic

Knowledge Paper 6

Acknowledgement of Country

Women's Health Victoria (WHV) acknowledges the Traditional Owners of the land we work on, the Wurundjeri people of the Kulin Nation. We pay our respects to their Elders past and present and acknowledge their continued custodianship of these lands and waters.

As a statewide organisation, we also acknowledge and pay our respects to the past and present Elders and Traditional Owners of the lands and waters across Victoria.

We recognise that sovereignty was never ceded and that we are the beneficiaries of stolen land and dispossession, which began over 230 years ago and continues today.

Our Commitment to Gender Diversity

Women's Health Victoria's focus is women (cis and trans inclusive) and gender diverse people. We address gendered health issues and are committed to supporting all people impacted by gender inequity who can benefit from our work.

As a proud intersectional feminist organisation, Women's Health Victoria is working towards meaningful inclusivity, guided by and supporting people who identify as women, trans, intersex and gender diverse. We will seek and value feedback and be accountable to our partners and stakeholders from diverse communities.

Suggested Citation
Sarder M, Mogharbel C, Kalman T (2024) Realising access: abortion and contraception inequities and enablers in Victoria. Women's Health Victoria. Melbourne. (Women's Health Victoria Knowledge Paper; 6).

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Published October 2024
ISSN 2209-3672 (Online)

Abstract

This report analyses trends in sexual and reproductive health service seeking across Victoria with a focus on abortion and long-acting reversible contraception (LARC). It draws on previously unpublished data from 1800 My Options, a service of Women's Health Victoria. Analysis of over 30,000 calls received by the service from 2018 to 2023 highlights differences in service seeking according to geographic location, population characteristics, and measures of socioeconomic disadvantage. Further insights are drawn from Victorian Women's Health Atlas mapping of medication abortion and LARC access by local government area, and from a qualitative survey of nine Victorian women's health services. The report discusses barriers and enablers to accessing abortion and contraception services throughout Victoria. Challenges facing service seekers, particularly those seeking abortions, are often complex and reflect deeper social, safety, economic and health challenges in the community. Detailed recommendations are provided to inform Victorian and Australian needs-based health policy and service provision, and 1800 My Options service planning.

Acknowledgements

Women's Health Victoria would like to acknowledge the valuable contributions of the Advisory Group, whose guidance and expertise enhanced the depth and quality of this research. Members included:

Dr Anisa Assifi, Research Fellow, SPHERE NHMRC Centre of Research Excellence, ALLIANCE Trial Project Manager, Monash University

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Professor Jane Tomnay, Director, Centre of Excellence in Rural Sexual Health, Department of Rural Health, University of Melbourne

Special thanks to VACCHO for their thoughtful review and feedback on findings related to Aboriginal and Torres Strait Islander service seekers.

We would also like to extend sincere thanks to Emily Dang and Carolyn Mogharbel for their detailed input into the data analysis, and to Dr Kate Johnston-Ataata, Jenny Ward and Dr Sianan Healy for their meticulous review of and insightful feedback on the final report.

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Executive Summary

Abortion and contraception are fundamental human rights and pillars of women's health and gender equity. In Victoria these services are safe, legal, and protected by authorising policy and legislative frameworks, achieved through decades of advocacy and collaboration between healthcare providers, women's health services, advocates and people with lived experience.

Yet, histories of criminalisation, stigma and shame have impeded access to reliable population level data relating to service access, barriers and care seeking. This report clearly demonstrates that the "postcode lottery" of sexual and reproductive health (SRH) access is persistent, consistent and highly inequitable. It disproportionately affects disadvantaged and under-served populations, and those living in socioeconomically disadvantaged areas.

While abortion and contraception are basic healthcare rights, they are not accessible for all.

Through analysis of previously unpublished data from the 1800 My Options service, examining de-identified data from over 30,000 calls and 725 SRH providers, alongside indicators from the Victorian Women's Health Atlas, population and socioeconomic data from the Australian Bureau of Statistics (ABS), and service seeker needs and trends, this report identifies service access gaps and population-related barriers.

To achieve true gender equity in health and ensure that abortion and contraception care is accessible to all, we must understand the data – by examining service seeker trends, service provision and gaps, service user experiences, and barriers to access.

This report is a significant step towards building this understanding, providing critical insights and recommendations that can drive better access and inform planning, policy reform, and monitoring and evaluation of both the Victorian SRH service system and service seeker needs.

Women's Health Victoria is steadfast in our commitment to supporting improved access to abortion and contraception in Victoria and is proud to lead and communicate this essential policy advocacy.

Datasets and methodology

This report draws on the following datasets:

- 1800 My Options de-identified caller data (March 2018 – December 2023);
- 1800 My Options provider data (March 2018 – December 2023);
- Victorian Women's Health Atlas data (2017 – 2022) – medication abortion (PBS), intra-uterine device (IUD) insertion (MBS) and hormonal implant device insertion (MBS);
- ABS Census of Population and Housing data (2021)
- ABS Socio-Economic Indexes for Areas (SEIFA) data (2021);
- Women's Health Services Network qualitative survey responses.

Datasets were analysed and described using the R language for statistical computing.

Major findings

- Abortion seekers who called 1800 My Options over nine weeks gestation were likely to be from more disadvantaged backgrounds and under-served communities.
- Long-acting reversible contraception (LARC) seekers who called 1800 My Options were likely to be from more advantaged backgrounds and better-served communities.
- SRH service 'deserts' demonstrated by registrations on the 1800 My Options service provider database were common in regional LGAs, particularly the most disadvantaged half by SEIFA ranking. Of these 24 LGAs:
    - 67% did not have any listed surgical abortion providers,
    - 45% did not have any listed medication abortion providers,
    - 29% did not have any listed IUD providers,
    - 25% did not have an STI or cervical screening provider, and
    - 60% did not have any listed medication abortion dispensing pharmacies.
- There is a misalignment between the high number of abortion seekers who will require surgical abortions due to advanced gestation and the low level of registered surgical abortion providers available to them, particularly in regional areas.
- The registration of at least one visible medication abortion provider or dispenser with 1800 My Options increases abortion access in a local area.

1800 My Options callers

- Between March 2018 and 31 December 2023, 1800 My Options received 30,344 calls.
- 87% of callers were seeking abortion services.
- Service seekers were overwhelmingly female and more likely to be aged 15-44, with ages ranging from 12 to in their 80s.
- 3% of callers identified as Aboriginal or Torres Strait Islander.
- 39% of callers were born overseas; 12.5% of all callers were temporary residents or asylum seekers.
- Metropolitan callers were concentrated in outer growth areas of the west and north. 70% more calls were received from metropolitan high disadvantage LGAs compared to metropolitan low disadvantage LGAs.
- More rural callers were from under-serviced regions, with 16% more calls received from rural high disadvantage LGAs compared to rural low disadvantage LGAs.

SRH providers registered with 1800 My Options

As at 31 December 2023,

- 725 service providers were registered with 1800 My Options.
- 67% of LGAs had no listed surgical abortion providers, 39% had no medication abortion dispensing pharmacies, and 19% had no medication abortion providers.
- of the 24 high disadvantage regional and rural LGAs:
  - 67% did not have a registered surgical abortion provider;
  - 60% did not have a registered medication abortion dispensing pharmacy;
  - 45% did not have a registered medication abortion provider.

Challenges facing SRH service seekers

Between 2018 and 2023, callers described barriers to access at the following rates (averaged):

- Financial insecurity 27%
- Mental illness 11%
- Complex medical issues 8%
- Family violence 6%
- Caring responsibilities 5%
- Advanced gestation 5%

30,344

calls received

by 1800 My Options between March 2018 and 31 December 2023

The COVID pandemic exacerbated these access barriers in early 2020. Certain population groups, including people under 18 years of age, overseas-born citizens and residents, Aboriginal and Torres Strait Islander people, and regional and rural residents, were more likely to report additional hardships and barriers to care when calling 1800 My Options.

Abortion access

- Abortion access in Victoria is largely determined by gestational age, with a narrowing of options as gestational age increases.
- While access to medication abortion increased between 2017 – 2022, it remains limited - in mid-2023 only 17% of GPs were providing this service and only 19% of pharmacists were dispensing medication.
- Surgical abortion is even more limited with only 35 providers in Victoria in December 2023, of which only 15 offered abortions after 12 weeks gestation.
- Key barriers to abortion access are conscientious objection and lack of referrals to alternative providers, lack of timely access to supporting services (pathology and ultrasound) still required by many providers, lack of provision in regional and rural areas, and limited public provision.
- Enablers of improved access include Victoria's SRH hubs, telehealth consultations, and the existence of 1800 My Options to support service navigation.

LARC access

- MBS claims for both hormonal implant and IUD insertions were significantly higher in regional and rural areas compared with metropolitan areas, on a population-adjusted basis.
- LARC seekers calling 1800 My Options were more likely to be living in a metropolitan area, living in a less disadvantaged area, over 35 years, from a non-Aboriginal or Torres Strait Islander background, and if born overseas, be from an Anglosphere country.
- More than a quarter of regional and rural high disadvantage LGAs did not have any IUD or hormonal implant service providers listed, and only about half of all regional and rural LGAs had any LARC dispensing pharmacies listed.

Recommendations

Chapter 1: Datasets

For Government

Victorian Government

1.1 Provide broader recognition of and support for collection and reporting of 1800 My Options data as a critical evidence resource to inform needs-based SRH health planning in Victoria.

1.2 Explicitly recognise the compounding effects of disadvantage and geographical location, particularly for non-metropolitan regions, in SRH service planning and provision.

1.3 Incorporate consultation with place-based women's health services into SRH service planning at the regional level.

Australian Government

1.4 Create stand-alone MBS items for surgical abortion procedures, so that needs-based health planning can occur at state and Federal levels for these essential health services.

For 1800 My Options

1.5 Institute real-time monitoring of de-identified SRH service-seeker data to allow evidence to be provided, upon request, to researchers, government agencies and community organisations working in the sector.

Chapter 2: 1800 My Options service seeker overview

For Government

Victorian and Australian Governments

2.1 Expand access to low- and no-cost abortion and LARC services in areas with greater socio-economic disadvantage, urban growth areas, and regional and rural areas, in line with evidence of greater demand.

Victorian Government

2.2 Provide ongoing support for 1800 My Options to continue to bridge SRH information and service referrals gaps across Victoria.

Australian Government

2.3 Expand access to low- and no-cost abortion and LARC services to all people regardless of visa status, recognising that sexual and reproductive health rights are fundamental human rights (UN OHCHR 2024).

For 1800 My Options

2.4 Identify opportunities for closer co-operation between 1800 My Options and Aboriginal-led health services to enable the service to continue to deliver and improve on its function as a useful and culturally safe resource for Aboriginal and Torres Strait Islander service seekers.

2.5 Identify additional avenues to raise awareness of 1800 My Options among migrant and asylum seeker communities.

Chapter 3: 1800 My Options service provider availability

For Government

Victorian Government

3.1 Extend support under the Victorian Patient Transport Assistance Scheme (VPTAS) scheme to include all SRH service-related travel, in recognition of the low level of SRH service provision in primary care settings in regional and rural areas.

3.2 Ensure that initiatives to support additional service provision are informed by real time service provider data from 1800 My Options.

Chapter 4: Challenges facing service seekers

For Government

Victorian and Australian Governments

4.1 Support data collection on a range of factors affecting SRH equity of overseas-born service seekers so that appropriate tailored information is available. This must include moving beyond monolithic categories such as 'CALD' (Culturally and Linguistically Diverse).

Victorian Government

4.2 Ensure that plans for future pandemic management incorporate innovations that will ensure the continuity of SRH care and mitigate wellbeing risks to women and gender diverse people.

4.3 Evaluate whether cost-of-living pressures have impacted access to SRH services, and consider additional supports based on evidence.

4.4 Continue to provide appropriate SRH education for young people, including in relation to consent, and include information and promotion of 1800 My Options in education initiatives.

4.5 Continue to support expanded health service provision in regional and rural areas, and identify innovations that will result in greater capacity building and sustainable attraction and retention of health providers, such as the SRH Clinical Champions Project.

4.6 Fund development of cultural SRH resources to improve access to care and mandate cultural safety training for all workforce delivering SRH care in Victoria.

4.7 Develop and fund strategies to address the barriers to accessing care that have been highlighted in this report.

For 1800 My Options

4.8 Establish a mechanism for consultation and feedback from 1800 My Options service users to better understand the context in which service needs arise, and to enable continuous improvement (such as a user reference group).

4.9 Continue to identify opportunities to work with organisations advocating for the health needs of young people, older people, migrants, Aboriginal and Torres Strait Islander people, LGBTQI+ people and people with disabilities, to raise awareness of 1800 My Options and to improve tailoring of the service.

4.10 Progress accreditation under the Victorian Aboriginal Research Accord Project (VARAP).

4.11 Continue to advocate with and on behalf of women's health services in regional and rural areas to ensure that service provision is responsive to changes at the local level.

Chapter 5: Access to abortion in Victoria

For Government

Victorian and Australian Governments

5.1 Fund research that increases understanding of drivers of abortion seeking in the second trimester and beyond, so that impactful solutions can be identified to facilitate earlier access for priority populations.

Victorian Government

5.2 Expand surgical abortion provision in publicly funded hospitals, to close gaps in service provision across Victoria, particularly for abortions over 12 weeks' gestation.

5.3 Develop an evidence base that evaluates demand for abortions, considering gestational age at which abortion seekers are likely to access services, against supply of abortion providers by gestational limits, to enable a meaningful evaluation of service provision against need.

5.4 Support abortion providers in primary care settings to co-locate with ultrasound services, or to have capacity for bedside ultrasound.

5.5 Support SRH hubs to provide consistency of services, taking into account hours of operation, staffing, co-location of ultrasound and pathology services and willingness to deliver low- or no-cost services.

5.6 Expand SRH hubs to locations with the greatest demonstrated need, based on comprehensive data analysis, and consulting with women's health services and existing SRH providers.

5.7 Develop meaningful oversight and complaint processes to understand the extent to which:

- 5.7.1 healthcare practitioners conscientiously object to abortion care, and
- 5.7.2 healthcare practitioners are breaking the law by failing to refer abortion seekers to another practitioner who does not conscientiously object.

Chapter 6: Access to LARC in Victoria

For Government

Victorian and Australian Governments

6.1 Make a range of contraceptive options, including LARC options, available at low or no cost to people at risk of pregnancy, regardless of visa status.

6.2 Fund research into factors influencing contraceptive decision making, so that avenues for providing information, and combatting disinformation can be better identified, particularly in relation to priority populations.

Victorian Government

6.3 Develop information tools that can assist practitioners in providing information about contraceptive options, including LARC, in a comprehensive manner, and which fully address patient concerns about the risk of pelvic pain.

6.4 Provide incentives for practitioners to provide LARC information to patients alongside information about the oral contraceptive pill.

6.5 Increase availability of skills-based training in community settings to enable more health practitioners – nurse practitioners, GPs and trainees – to train in LARC insertion and removal.

6.6 Expand financial support and provide incentives for health providers to attend training and travel for LARC insertion and removal.

Australian Government

6.7 Increase MBS payments for LARC insertion and removal, in line with any recommendations that emerge from the gender audit of the MBS.

Introduction

Decades of stigma have hampered the collection and publication of reliable data indicating the need for key sexual and reproductive healthcare (SRH) services in Victoria, and the availability and accessibility of existing providers to meet those needs. Such evidence is required for needs-based health planning and service provision.

This report is intended to help close the evidence gap, bringing together new insights drawing on data published for the first time from 1800 My Options and the Victorian Women's Health Atlas (the Atlas).

1800 My Options is a statewide phoneline and internet-based information service, supported by the Victorian Government and operated by Women's Health Victoria. 1800 My Options was established in March 2018 to address gaps in health information and referral pathways for SRH services.

The Victorian Women's Health Atlas is an interactive online platform developed by Women's Health Victoria in 2015 that allows users to explore quantitative, sex-disaggregated datasets by Local Government Area (LGA). It includes over 70 datasets across 8 priority areas.

The report includes analysis of 1800 My Options (de-identified) data from 2018 – 2023 to report on:

- trends in SRH service seeking,
- characteristics of service seekers challenges faced by different populations, and
- the availability of health providers in different areas to meet local population health needs.

Service seeking and provision trends are discussed in the context of Victoria-wide medication abortion and LARC service access data from the Atlas from 2017 – 2022. These datasets from the Atlas are included both to explain the impact of service visibility on access, as well as to advance understanding of reproductive equity in Victoria across different geographical areas.

The report also explores differences in SRH service seeking among different groups including service seekers who are:

- under 18 years of age,
- Aboriginal and Torres Strait Islander,
- overseas-born,
- short-term residents,
- living in metropolitan areas compared with regional and rural areas, and
- residing in socio-economically disadvantaged areas.

As insufficient data was available to evaluate service challenges for older service seekers, service seekers living with disability or LGBTIQ+ service seekers, specific data findings relating to these groups were not able to be included in this report. Women's Health Victoria recognises that these groups face distinct and significant challenges in meeting SRH needs and supports further quantitative and qualitative research to inform appropriate and accessible service provision for all women and gender diverse people.

A note on language

Throughout this report, a mix of the terms 'women', 'females', 'gender diverse people' and 'people' is used, reflecting the focus of and terminology used in the various datasets and research on sexual and reproductive health analysed and cited in the report as well as WHV's Commitment to Gender Diversity (a living statement) outlined at left. It should be noted that the use of the term 'females' often occurs because of age considerations – when people under 18 are included in the data.

While research and data collection on sexual and reproductive health in relation to trans, gender diverse and intersex communities is slowly growing, it has started from a very limited base. In line with WHV's support for the NHMRC-MRFF 2024 Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research, we recognise that more research and better data collection are urgently needed on sexual and reproductive health, including that which is inclusive of and sensitive to the nuances of the experiences of people with all gender identities – cisgender women and girls as well as trans and gender diverse people – and intersex people.

Datasets and methodology

1800 My Options data

Every service seeker who contacts the 1800 My Options service seeking a referral is given the details of three listed health services that most align with their needs and preferences. Alternatively, service seekers can search the service's online health provider database using personalised search criteria. Some services are only available over the phone – in the case of health providers who do not wish their details to be widely available to the public.

Service seeker dataset

The (de-identified) dataset for this analysis relates to over 30,000 phone calls received by 1800 My Options between 1 March 2018 and 31 December 2023. Phoneline staff work through service scripts that are designed to assist them to understand and respond to individual service seeker needs. The following information is captured for each call, as far as possible.

- Service seeker details:
  - age
  - Aboriginal and Torres Strait Islander background
  - country of birth
  - Medicare and Health Care Card availability

- Service specific factors:
  - SRH service/s sought
  - area or postcode of residence
  - area or postcode where the service is sought

- If abortion is sought, the following abortion service-specific factors:
  - type of abortion sought
  - gestational age
  - ultrasound results availability
  - pathology results availability

- If raised in the course of conversation, additional challenges identified (e.g., family violence, financial insecurity, mental illness, etc.)

- Service details provided, both clinical and non-clinical

All callers are informed that information collected may be used for service improvement and research in a de-identified way.

Service provider dataset

As at 31 December 2023, 725 health providers were registered on the 1800 My Options database. 1800 My Options engages proactively with clinics, allied health providers, hospitals and pharmacies to ensure that its database of SRH providers is up to date and comprehensive.

The health provider dataset includes information relating to all services listed between 1 March 2018 to 31 December 2023. The following information was included in this analysis:

- postcode
- provider type (e.g., clinic, hospital, imaging, etc.)
- SRH service/s available
- abortion provider gestation limits (where relevant)

1800 My Options also captures information such as whether a provider is publicly or privately registered on its geomap, whether a female doctor is available, what languages are spoken at the service, etc. However, as these additional fields were discretionary, and therefore incomplete, they were not included in the analysis.

Victorian Women's Health Atlas data

Service uptake data for medication abortion and LARC were extracted from the Atlas for the period 2017–2022. These are summarised in Table 1(a).

Data limitations relating to surgical abortion

A major data limitation is the lack of available data on surgical abortion numbers, the service most frequently sought by 1800 My Options callers. Currently, there are no stand-alone items for either medical or surgical abortion under the MBS – medication abortion consultations are claimed as a time-based sexual and reproductive health item, and surgical abortion procedures have the same reporting as miscarriage-related procedures. This is largely for historical reasons: abortion was not decriminalised in all Australian states and territories until March 2024. As a result of this data limitation the number of abortions in Australia remains unknown, and this data gap is a significant barrier to needs-based health planning.

Table 1(a): Victorian Women's Health Atlas datasets

Subject	Dataset	Source
Medication abortion access	Total PBS Item 10211K claims – Mifepristone and misoprostol	Services Australia, PBS
Contraceptive IUD access	Total MBS Item 35503 claims – Intra-uterine contraceptive device	Services Australia, MBS
Hormonal contraceptive implant access	Total MBS Item 14206 claims – Hormone or living tissue implantation by cannula	Services Australia, MBS

Supplementary Data

ABS Australian Census of Population and Housing data

Population data from the ABS 2021 census was used to adjust LGA and region-level service counts. The census date represents a mid-point within the seven years of data included in this report (2018 to 2023 for 1800 My Options, and 2017 to 2022 for Atlas data).

The figure relied upon to adjust SRH service figures is the number of females of reproductive age, 15-44, for a given LGA. This age range is in line with the definition of 'women of reproductive age' used by the Australian Institute of Health and Welfare (AIHW 2023). Although the actual age at which women may be able to become pregnant and bear children is wider and depends on a range of individual factors, a narrower age range is used for population adjustment, so that data indicators are most effectively adjusted for probable, rather than possible, potential service users.

ABS Socio-Economic Indexes for Areas (SEIFA) data

Both spatial and socio-economic disadvantage were considered in this analysis with reference to the Index of Relative Socio-Economic Disadvantage (IRSD). Spatial inequality in service provision was a major challenge identified by the Senate Standing Committee Report into universal access to reproductive healthcare, *'Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia'* (Australia Senate CARC 2023). The report described the compounding effect of spatial and socio-economic disadvantage as follows:

> Groups who are already experiencing disadvantage are amongst the worst affected, including people with low incomes and those in rural and remote areas, Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds.

To better understand the effect of spatial disadvantage on SRH service supply and demand, LGAs were grouped into one of four categories:

- Metropolitan low disadvantage LGAs
- Metropolitan high disadvantage LGAs
- Regional low disadvantage LGAs
- Regional high disadvantage LGAs

LGAs were allocated into groupings based on whether they fell within metropolitan or regional and rural geographies, and whether they fell into the top half or bottom half of LGAs within those two groupings, based on their IRSD score.[1]

1 The IRSD index is a measure of the relative disadvantage, comprising components such as low income, low educational attainment, low English proficiency, low bedroom to resident ratio (overcrowding), etc.

The application of these groupings in the analysis allows for a closer understanding of the different and compounding effects of living in a regional or rural area and living in a socio-economically disadvantaged area. See Appendix 2 for a table of spatial disadvantage grouping allocations for LGAs, along with the IRSD score for 2021.

Statewide Health Services

Women's Health Victoria
Multicultural Centre for Women's Health
Women with Disabilities Victoria

Place-based Health Services

- Women's Health Loddon Mallee
- Women's Health Goulburn North East
- Gippsland Women's Health
- Women's Health Grampians
- Women's Health and Wellbeing Barwon South West
- GenWest
- Women's Health in the North
- Women's Health East
- Women's Health in the South East

Figure 1(a): Women's Health Services Network

A table of LGAs within each region appears in Appendix 2.

Women's Health Services Network qualitative survey responses

The Women's Health Services Network (WHSN) is a collective of Victorian Government-funded women's health services that lead and coordinate local and state-wide health promotion activities to advance women's health and equality. The WHSN includes three statewide services and nine place-based services (Figure 1(a)).

In May 2024, a qualitative survey was sent to representatives of the nine place-based women's health services to identify and understand the impact of barriers and enablers to service access and provision. The survey questions are available in Appendix 1.

Survey responses were received from all nine place-based providers and are woven throughout this report. Where responses are included, reference is made only to the region type – metropolitan or regional and rural – to protect survey respondent anonymity.

Methodology for data analytics

Datasets were analysed and described using the R language for statistical computing.

For the analysis reported in Chapter 5, binomial linear regression was used to identify characteristics predictive of abortion seeking over nine weeks gestation among 1800 My Options service seekers.

A linear fixed effects regression model was used to test the hypothesis that at least one visible medication abortion provider in a given LGA improves medication abortion access. The plm package was relied upon for modelling.

For the analysis reported in Chapter 6, binomial linear regression modelling was applied to identifying characteristics predictive of seeking a LARC referral among 1800 My Options service seekers. The stats package was relied upon for modelling.

Recommendations

For Government

Victorian Government

1.1 Provide broader recognition of and support for collection and reporting of 1800 My Options data as a critical evidence resource to inform needs-based SRH health planning in Victoria.

1.2 Explicitly recognise the compounding effects of disadvantage and geographical location, particularly for non-metropolitan regions, in SRH service planning and provision.

1.3 Incorporate consultation with place-based women's health services into SRH service planning at the regional level.

Australian Government

1.4 Create stand-alone MBS items for surgical abortion procedures, so that needs-based health planning can occur at state and Federal levels for these essential health services.

For 1800 My Options

1.5 Institute real-time monitoring of de-identified SRH service-seeker data to allow evidence to be provided, upon request, to researchers, government agencies and community organisations working in the sector.

1800 My Options service seeker overview

Chapter Summary

Women and gender diverse people living in Victoria face several challenges in accessing SRH services. The Victorian Government supported the creation of 1800 My Options in recognition of the limited information and referral pathways for people seeking these services. This chapter provides an overview of 1800 calls during the service's first six years of operation, in relation to call volume and focus, and demographic characteristics of callers. It provides a critical insight into the profile of SRH service seekers who are facing informational or service provision barriers.

Call volume and service focus:

- Between March 2018 and 31 December 2023, 1800 My Options received 30,344 calls (an average of 433 calls per month).
- The vast majority (87%) of service seekers were calling to find, or learn more about, abortion services. The next most enquired about service was long-acting reversible contraceptives (LARC) (4%).

Service seeker demographics:

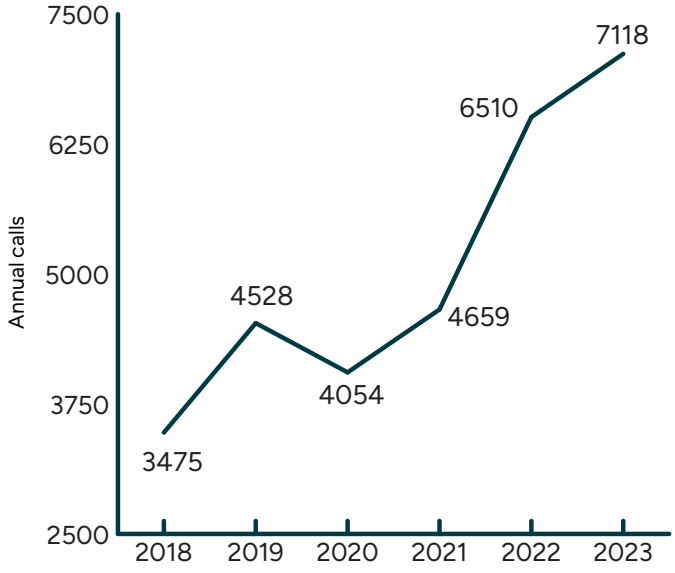
- Most callers were female (99%) and aged 15–44 years (95%).
- Around 40% of callers were born overseas, with many from Central and Southern Asia or East Asia. While interpreter services are available, few have used them, suggesting potential barriers in reaching non-English speakers.
- Approximately 12.5% of callers were temporary residents or asylum seekers. These groups often face significant barriers, such as high costs and limited access to Medicare, complicating their ability to obtain abortion and LARC services.
- 3% of service seekers were Aboriginal or Torres Strait Islander people. Between 2022 and 2023 the proportion of Aboriginal and Torres Strait Islander service seekers increased by 50%.
- Calls were concentrated in outer metropolitan areas like Wyndham and Hume, and in non-metropolitan place-based regions such as Grampians and Gippsland. On a population-adjusted basis, there were also 70% more calls received from service seekers residing in high disadvantage LGAs, compared with low disadvantage LGAs (lowest half and highest half for IRSD score).
- Many service seekers were economically vulnerable, with 48% holding Health Care Cards, compared to just 6% of the general Victorian female population. Additionally, only 16% had private health cover, highlighting financial challenges in accessing LARC and abortion services.

Analysis and Discussion

1800 My Options callers and trends

Women and gender diverse people living in Victoria face several challenges in accessing SRH services. The Victorian Government supported the creation of 1800 My Options in 2018 in recognition of the limited information and referral pathways for service seekers. To increase service accessibility to Aboriginal and Torres Strait Islander people, 1800 My Options staff have completed cultural safety training (a commitment under Women's Health Victoria's Reconciliation Action Plan). Between 1 March 2018 and 31 December 2023, 1800 My Options received 30,344 calls from service seekers or another person calling on their behalf (an average of 433 calls per month).

Figure 2(a): Annual calls to 1800 My Options — 1 March 2018 to 31 December 2023



During this period, calls to 1800 My Options increased every year except for 2020, as shown in Figure 2(a). This is likely a result of pandemic restrictions, which resulted in a decline in sexual contact between individuals and in people seeking preventive health services (Coombe et al. 2021; Tsirtsakis 2020). Call levels subsequently rebounded with the ending of restrictions, with the sharpest year-on-year jump in 2022 after restrictions were eased.

SRH services sought by callers

Calls received by 1800 My Options are categorised by the health service being enquired about, with some callers enquiring about multiple services (Table 2(a)). The vast majority of callers to 1800 My Options were enquiring about abortion services (87%). The next most frequent enquiries were about LARC (4%) and pregnancy options counselling (4%). The concentration of caller interest in abortion, and to a lesser degree LARC, suggests service seekers are making their way to 1800 My Options due to challenges accessing services through their ordinary primary care pathway. If this were not the case, there would be greater numbers of enquiries about ubiquitous SRH services such as oral contraceptive pill provision. This indicates that 1800 My Options is filling gaps in information and referral pathways as intended.

Service seeker demographics

As 1800 My Options does not collect personally identifying information, it could not be determined whether each record represented a unique service seeker, or whether some service seekers made multiple calls. As 1800 My Options staff advised that most callers contact the service once per referral, each call was treated as a unique service seeker.
While most service seekers (85.6%) were calling on their own behalf, a small number of calls were from a health professional, partner, friend, or family member. Only service-seeker characteristics are recorded.

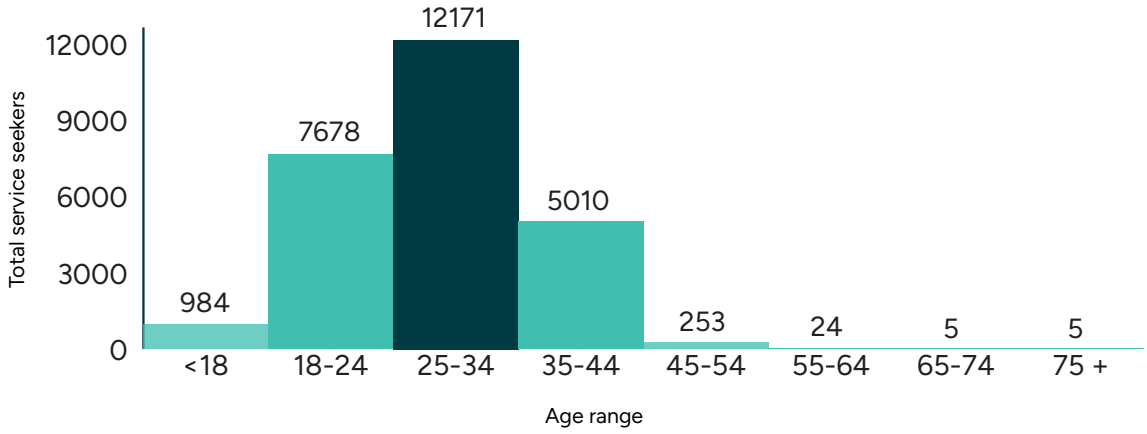
Gender

1800 My Options is open to service seekers of all genders and is committed to delivering a safe and inclusive service for trans and gender diverse people. Of the service seekers who indicated their gender, 30,089 were female (99%), 154 were male, fewer than five were transgender female, and fewer than five were transgender male.

Table 2(a): Services sought 1 March 2018 to 31 December 2023 by residential area

Reason	Metro	Regional	Residence unknown	Total
Abortion	20211 (92%)	3448 (92%)	2597 (57%)	26256 (87 %)
LARC	989 (4%)	88 (2%)	154 (3%)	1231 (4%)
Pregnancy options counselling	812 (4%)	173 (5%)	145 (3%)	1130 (4%)
Imaging/ultrasound	576 (3%)	38 (1%)	21 (<1%)	635 (2%)
STI testing/treatment	144 (1%)	31 (1%)	104 (2%)	279 (1%)
Emergency contraceptive pill	130 (1%)	26 (1%)	102 (2%)	258 (1%)
Oral contraceptive pill	119 (1%)	16 (1%)	81 (2%)	216 (1%)
Pregnancy genetics testing	48 (<1%)	8 (<1%)	49 (1%)	104 (<1%)
Permanent sterilisation (salpingectomy/tubal ligation)	26 (<1%)	13 (<1%)	9 (<1%)	48 (<1%)
Contraceptive injection	12 (<1%)	0 (<1%)	10 (<1%)	22 (<1%)
Polycystic ovary syndrome	8 (<1%)	<5 (<1%)	8 (<1%)	17 (<1%)
Endometriosis	9 (<1%)	<5 (<1%)	<5 (<1%)	14 (<1%)
Permanent sterilisation (vasectomy)	8 (<1%)	<5 (<1%)	<5 (<1%)	14 (<1%)
Fertility / Conception	<5 (<1%)	<5 (<1%)	7 (<1%)	12 (<1%)
Menopause	5 (<1%)	<5 (<1%)	<5 (<1%)	8 (<1%)
Cervical screening	<5 (<1%)	<5 (<1%)	0 (<1%)	5 (<1%)
Total callers	**22069 (100%)**	**3753 (100%)**	**4522 (100%)**	

Figure 2(b): Age distribution of service seekers — 1 March 2018 to 31 December 2023



Age

Of the 26,125 service seekers who indicated their age, the age distribution was:

- 12,171 (46.6 %) aged 25-34
- 7,678 (29.4%) aged 18-24
- 5,010 (19.2%) aged 35-44
- 984 (3.8%) aged under 18
- 253 (1.0%) aged 45-54
- 34 (0.1%) aged 55 and over

Over 95 percent of callers were aged between 15 and 54 years (Figure 2(b)). The youngest service seekers were 12 and the oldest service seekers were in their 80s.

Aboriginal and Torres Strait Islander service seekers

Of the 20,159 service seekers who indicated their cultural background, 557 (2.8%) identified as Aboriginal and/or Torres Strait Islander. Among these service seekers:

- 529 (2.6%) identified as Aboriginal,
- 15 (0.07%) identified as Torres Strait Islander, and
- 13 (0.06%) identified as both Aboriginal and Torres Strait islander.

Between 2022 and 2023 the proportion of Aboriginal and Torres Strait Islander service seekers increased by 50 percent.

The percentage of Aboriginal and Torres Strait Islander service seekers is significantly higher than the percentage of Aboriginal and Torres Strait Islander people in Victoria, which was 1.0 percent in 2021 (ABS 2022).

Country of birth

Of the 20,159 service seekers who indicated their country of birth, 38 percent (7,632) were born overseas. The percentage of overseas-born service seekers is higher than the percentage of overseas-born Victorian residents, which was 30 percent in 2021 (ABS 2022). This suggests that people born overseas are also overrepresented as service seekers, relative to their share of the Victorian resident population. This may be due to the younger age profile of both service seekers and overseas-born Victorian residents.

Figure 2(c) shows a breakdown of regions of birth countries for overseas-born service seekers. Of the 7,632 overseas-born service seekers, 23 percent were born in Southern and Central Asia or Southeast Asia and 14 percent were born in a core Anglosphere country other than Australia (the United Kingdom, Canada, New Zealand, Ireland or the United States).

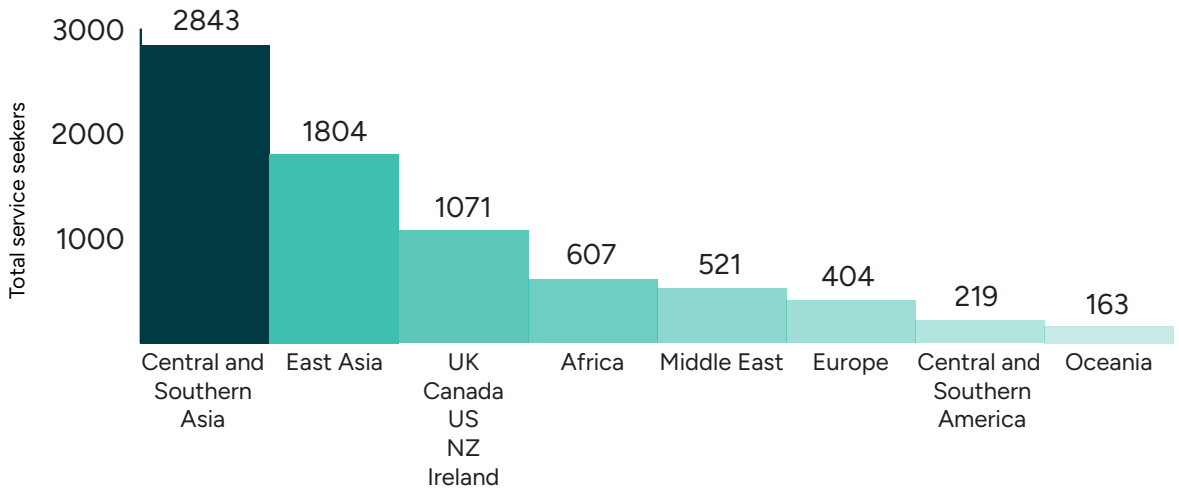
Linguistic diversity

1800 My Options presents information in multiple languages on the website, and an interpreter option is available. Table 2(b) indicates that the most requested languages were Chinese, Arabic, Punjabi and Farsi.

Overall, the actual number of service seekers who requested an interpreter was very low (148) considering the number of service seekers who were born overseas.

One possible explanation for the low level of interpreter requests may be that migrant and refugee service seekers with low English proficiency lack pathways to find out about 1800 My Options in the first place. A recent study indicated that migrant and refugee women face language barriers navigating SRH information, including online resources (Hawkey et al 2021). The study emphasised the importance of culturally appropriate, in-language information, for example through

Figure 2(c): Region of birth of service seekers born overseas — 1 March 2018 to 31 December 2023



making health education brochures in target languages available via GPs, health clinics and/or online. While 1800 My Options provides a translated version of the online web page, as well as hard copy brochures to providers who request them, there may be opportunities for further targeted promotion.

Temporary residents and asylum seekers

Medicare eligibility in Australia is restricted to citizens, permanent residents and a limited number of visa classes (such as some humanitarian visas). Of the 23,788 service seekers that indicated their Medicare eligibility, 11.5 percent had no access. Of the group with no Medicare access:

- 60% were student visa holders,
- 24% were employment visa holders,
- 5% were tourist visa holders,
- 2% were asylum seekers,
- 10% were on a visa class unlisted in the database.

Student visa class holders were the largest group of temporary resident service seekers. Although international students are required to have Overseas Student Health Cover (OSHC), most insurers specify a 12-month waiting period for abortion claims, meaning students will not have access to any financial assistance for abortion services during a particularly vulnerable transitional period (WHIN 2020).

Table 2(b): Number of service seekers by language requesting interpreter — 1 March 2018 to 31 December 2023

Language	Total requested	Language	Total requested
Chinese	23	Malay	<5
Arabic	14	Amharic	<5
Farsi	8	Italian	<5
Punjabi	8	Korean	<5
Spanish	6	Turkish	<5
Thai	6	Urdu	<5
Vietnamese	6	Japanese	<5
Tamil	<5	Kurdish	<5
Burmese	<5	Nepali	<5
Cambodian	<5	Tigrinya	<5
Hindi	<5		

According to research, only 20 percent of asylum seekers in Australia have access to Medicare (Arora 2022), and many short-term employment visa holders, such as seasonal workers under the Pacific Islander Labour Mobility scheme, have no access to Medicare. For these temporary residents, a surgical or medication abortion will cost more than $1000, and LARC insertion will cost between $450 and $1000.

The high number of service seekers who are likely ineligible for financial assistance in relation to SRH services, particularly abortion, highlights the importance of ensuring that these services can be accessed at low or no cost for temporary residents, regardless of Medicare eligibility.

Health Care Card and private health insurance cover

A high proportion of service seekers who contact 1800 My Options are from economically vulnerable segments of the community. Of the service seekers who indicated that they had a Medicare Card, 48 percent also held a Health Care Card. This is significantly higher than the 6 percent of Victorian females who hold a Health Care Card (DSS 2023). Only 16 percent of service seekers had private health insurance cover, which is significantly lower than the 60 percent of Australian females in Australia who have private health insurance cover (AIHW 2023).

Service seeker location

Of the service seekers who indicated their place of residence and lived within Victoria, a total of 22,069 were from metropolitan LGAs and 3,753 were from regional and rural LGAs. On a population adjusted basis, there were fewer service seekers from regional and rural LGAs (13.2 per 1,000 females aged 15-44) compared with metropolitan LGAs (21.1 per 1000 females aged 15-44).

The lower number of regional and rural service seekers is surprising given the lower level of service provision in regional and rural areas. It may be that regional and rural service seekers have a more streamlined referral pathway to SRH services through the women's health services in their region. Alternatively, regional and rural service seekers may assume that SRH services will not be available locally, so they do not contact 1800 My Options to find them.

Service seekers living in metropolitan LGAs

Figure 2(d) shows the number of service seekers living across metropolitan LGAs on a population adjusted basis. There was a clear concentration of service seekers in outer growth areas in the west and north such as Hume and Melton.

The number of callers in metropolitan LGAs was analysed by spatial disadvantage grouping (Table 2(c)). There were 70 percent more calls received from service seekers residing in high disadvantage LGAs, compared with low disadvantage LGAs.

Figure 2(d): Service seekers per 1,000 women aged 15-44 in metropolitan LGAs — 1 March 2018 to 31 December 2023

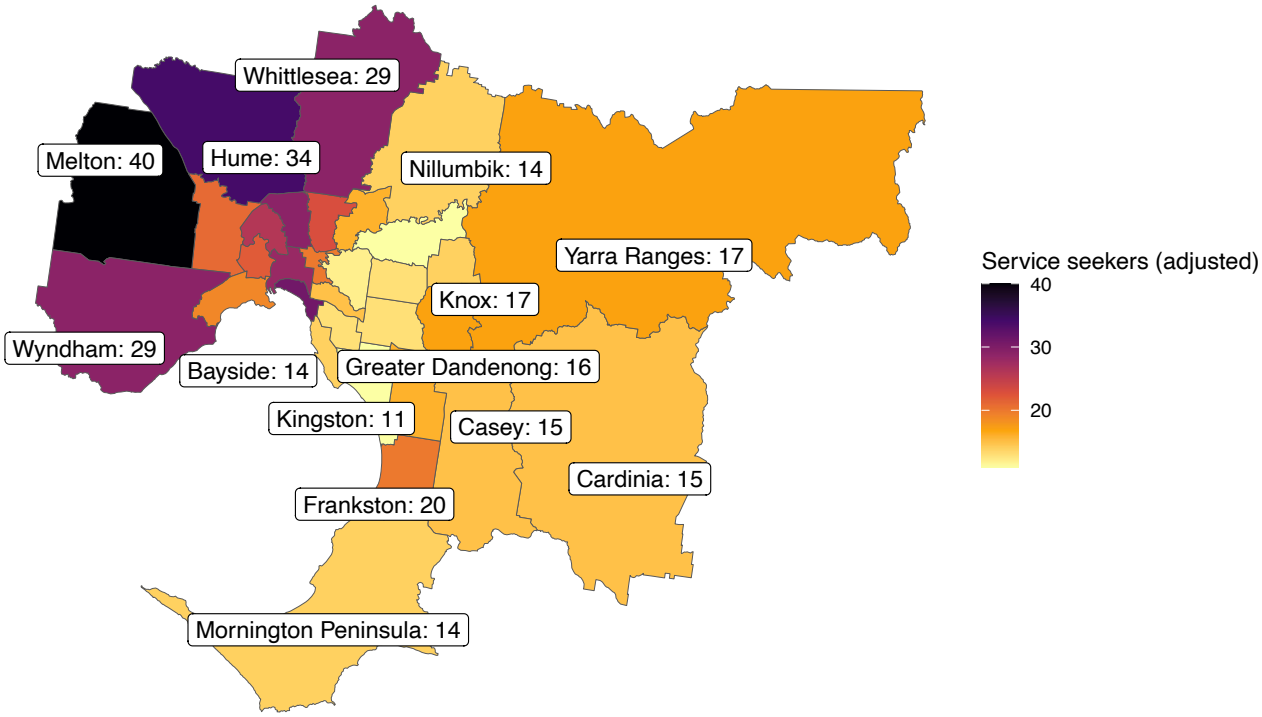


Table 2(c): Metropolitan service seekers per 1,000 females aged 15-44, by spatial disadvantage group — 1 March 2018 to 31 December 2023

Socio-spatial group	Total service seekers	Total females aged 15-44 in group	Total service seekers per 1000 females aged 15-44
Metro – high disadvantage LGAs	15,855	643,552	26.4
Metro – low disadvantage LGAs	6,214	403,558	15.4

Service seekers living in regional and rural areas

Figure 2(e) shows the number of service seekers living across regional and rural LGAs on a population adjusted basis. There appear to be higher levels of calls from LGAs that are known to be under-serviced such as the Northern Grampians, or that were under-serviced until recently, such as Gippsland (Sanders & Jeuniewic 2024; Davis 2022).

LGAs adjacent to metropolitan areas, such as Mitchell and Morwell, had higher numbers of service seekers, with numbers more in line with metropolitan areas.

There were 16 percent more calls received from service seekers residing in high disadvantage LGAs, compared with low disadvantage LGAs. This is likely due to the lower availability of service providers in more disadvantaged regions (Table 2(d)).

Figure 2(e): Service seekers per 1,000 women aged 15-44 in regional and rural LGAs — 1 March 2018 to 31 December 2023

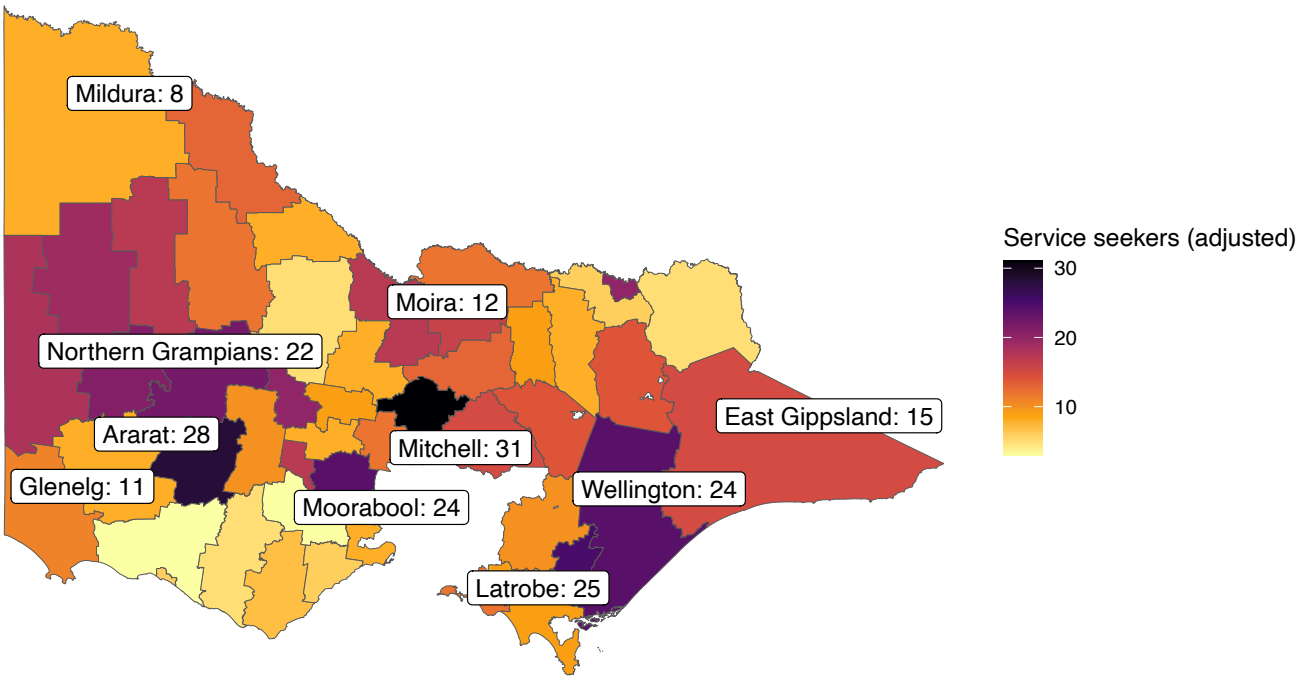


Table 2(d): Regional service seekers per females aged 15-44 per 1,000 by spatial disadvantage group — 1 March 2018 to 31 December 2023

Spatial disadvantage group	Total service seekers	Total females aged 15-44 in group	Total service seekers per 1000 females aged 15-44
Regional and rural high disadvantage LGAs	1,746	120,049	14.5
Regional and rural low disadvantage LGAs	2,007	165,451	12.5

Recommendations

For Government

Victorian and Australian Governments

2.1 Expand access to low- and no-cost abortion and LARC services in areas with greater socio-economic disadvantage, urban growth areas, and regional and rural areas, in line with evidence of greater demand.

Victorian Government

2.2 Provide ongoing support for 1800 My Options to continue to bridge SRH information and service referrals gaps across Victoria.

Australian Government

2.3 Expand access to low- and no-cost abortion and LARC services to all people regardless of visa status, recognising that sexual and reproductive health rights are fundamental human rights (UN OHCHR 2024).

For 1800 My Options

2.4 Identify opportunities for closer co-operation between 1800 My Options and Aboriginal-led health services to enable the service to continue to deliver and improve on its function as a useful and culturally safe resource for Aboriginal and Torres Strait Islander service seekers.

2.5 Identify additional avenues to raise awareness of 1800 My Options among migrant and asylum seeker communities.

1800 My Options service provider availability

Chapter Summary

1800 My Options proactively engages with SRH service providers to maintain up-to-date service listings. As at 31 December 2023, there were 725 SRH service providers listed on the platform. This chapter provides an analysis of 1800 My Options service provider availability, with the following key findings:

- **Service provision gaps:** Less than 70% of listed practitioners and hospitals provided intra-uterine devices (IUDs), less than 50% provided medication abortion services, and only 6% provided surgical abortion procedures.
- **Service deserts:** Significant gaps exist, with 67% of LGAs in the provider dataset lacking any surgical abortion providers, 39% lacking any medication abortion dispensing pharmacies, and 19% without medication abortion providers. Service deserts were more acute in regional and rural LGAs compared with metropolitan LGAs.
- **Impact of service deserts:** Service deserts can significantly limit sexual and reproductive health choices. Service seekers who cannot access SRH services locally may be required to travel long distances, take significant time away from work and caring responsibilities and stay overnight away from home. Travel for SRH services is not an option for some service seekers, particularly those who are socio-economically disadvantaged or under 18 years of age.

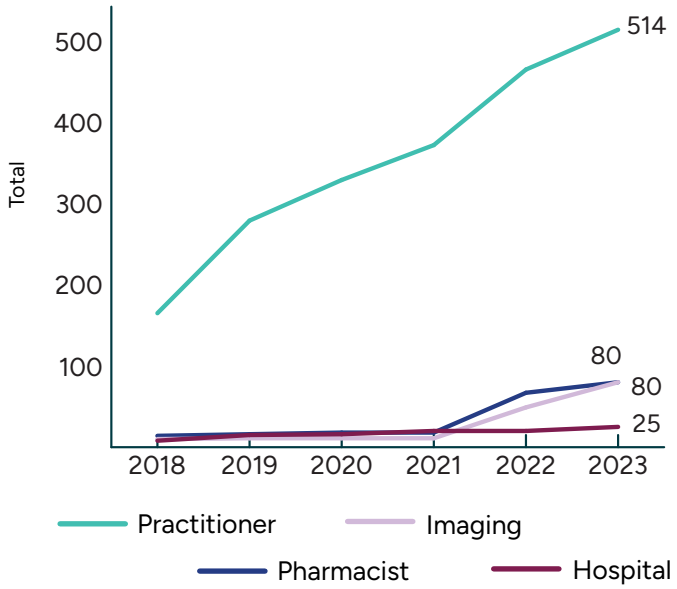
Analysis and Discussion

Services overview and listing trend

As at 31 December 2023, there were 725 service providers listed on 1800 My Options, categorised across the five different provider types (see Table 3(a)). While not all providers of SRH services are listed in the 1800 My Options database, every effort is made to grow and maintain the accuracy of listings.

Practitioner listings have grown steadily over time (Figure 3(a)). Listings of pharmacies and medical imaging services have significantly increased in the past two years due to a targeted campaign to increase the visibility of these services on the database.

Figure 3(a): Total number of services listed on 1800 My Options by provider type — 2018 to 2023



** Non-directive pregnancy counselling has not been included in this visualisation as listings have remained constant*

Services listed on 1800 My Options

The percentage of providers listed on the 1800 My Options database that offer various types of services does not reflect actual availability of services across Victoria. These listings reflect a subset of health providers that proactively offer SRH services, often as a result of one or more champions within the organisation with a dedication to reproductive health equity.

Some service listings were more common than others. As at 31 December 2023, of the practitioners and hospitals listed on 1800 My Options, four in five (over 85%) provided oral contraceptive pill prescriptions, cervical screening and sexually transmitted infection (STI) screening. However, less than two thirds (63%) provided IUD insertion and less than half (49%) provided medication abortions (Table 3(b)). Only 35 services, or 6 percent, provided surgical abortions.

Of 80 pharmacies listed on 1800 My Options, all indicated that they dispensed the oral contraceptive pill and emergency contraceptive pill. Ninety percent of pharmacies listed also dispensed medical abortion medication, hormonal IUDs, and hormonal implants (Table 3(b)).

As at 30 June 2023, only 17 percent of GPs in Victoria provided medication abortions and only 19 percent of pharmacies dispensed medication abortion medications (MS Health 2023; Australia DHAC 2024).

Table 3(a): 1800 My Options listed providers by type as at 31 December 2023

Provider type	Total
Practitioners (includes GPs, Gynaecologists, Obstetricians, specialists, nurses)	514
Hospitals	25
Pharmacies	80
Imaging	80
Non-directive pregnancy options counselling	26
Total providers listed	**725**

Table 3(b): Services listed on 1800 My Options by provider type as at 31 December 2023

Provider type	Listed services	Total
Practitioners and hospitals	Hormonal and emergency contraceptive pill	490 (91%)
	Cervical screening	475 (88%)
	STI screening	464 (86%)
	Hormonal implant	462 (86%)
	IUD	341 (63%)
	Generalist counselling	314 (58%)
	Hormonal injection	288 (53%)
	Pathology	279 (52%)
	Medication abortion	263 (49%)
	Non-directive pregnancy options counselling	134 (25%)
	Vasectomy	37 (7%)
	Surgical abortion	35 (6%)
	Tubal ligation	32 (6%)
Specialist services	Pathology	279 (NA)
	Ultrasound	166 (NA)
	Non-directive pregnancy options counselling (counselling only)	26 (NA)
Pharmacies	Hormonal and emergency contraceptive pill	80 (100%)
	Medication abortion	73 (91%)
	Hormonal implant	73 (91%)
	Hormonal IUD device	72 (90%)
	Hormonal injection	49 (61%)

** A single service provider can provide multiple services*

SRH service deserts in Victoria

A gap analysis was conducted on service availability. 'Service deserts' at the LGA level can significantly limit sexual and reproductive health choices. Service seekers who cannot access SRH services locally may be required to travel long distances and stay overnight away from home for some procedures, as well as take significant time away from work and caring responsibilities. While there is some support for Victorians to travel for health procedures under the Victorian Patient Transport Assistance Scheme (VPTAS), this scheme is limited to rural areas and does not extend to GP appointments. Travel to access medication abortion or LARC appointments in primary care settings is therefore excluded. Consequently, travelling for SRH care may prove too difficult for some service seekers, particularly those who are socio-economically disadvantaged or under 18 years of age.

The additional financial and practical impact of service deserts was highlighted in a recent landmark research report, *Tell Your Story*, compiled by Women's Health Grampians. *Tell Your Story* brings together the experiences of 110 women in the Grampians, sharing their experiences of trying to access SRH services (WHG 2024):

"I ended up getting an appointment for a medical abortion in Melbourne. I had to take four days off work, pay for travel, three nights' accommodation and $1200 of medical expenses."

– *Tell Her Story* participant from Grampians

"I had to go to a women's health clinic in Melbourne for an abortion because I couldn't get a local appointment in time. I am very fortunate I was able to afford the costs of travelling, accommodation and the procedure itself."

– *Tell Her Story* participant from Northern Grampians

"I have had to travel from Horsham to Melbourne for a surgical abortion. I was lucky that I could access VPTAS (Victorian Patient Transport Assistance Scheme)."

– *Tell Her Story* participant from Horsham

The number and percentage of LGAs in each spatial disadvantage group that did not have a service listed on 1800 My Options as at 31 December 2023 appears in Table 3(c).
Of the 79 LGAs in Victoria, 53 (67%) did not have any listed surgical abortion providers, 31 (39%) did not have any listed medication abortion dispensing pharmacies, and 15 (19%) did not have any listed medication abortion providers (practitioners or hospitals).

Service deserts were more acute in regional and rural LGAs compared with metropolitan LGAs. High disadvantage LGAs – those in the bottom half by IRSD score ranking – were the most under-served. Of the 24 LGAs in the regional and rural high disadvantage group:

- 16 (67%) did not have any listed surgical abortion providers,
- 14 (60%) did not have any listed medication abortion dispensing pharmacies,
- 11 (45%) did not have any listed medication abortion providers,
- 7 (29%) did not have any listed IUD providers, and
- 6 (25%) did not have an STI or cervical screening provider.

Table 3(c): Number and percentage of LGAs without 1800 My Options listed SRH service by spatial disadvantage group as at 31 December 2023

Total LGAs in group	Metro – low disadvantage LGAs	Metro – high disadvantage LGAs	Regional – low disadvantage LGAs	Regional – high disadvantage LGAs	Total LGAs without listed service
Provider and hospital gaps					
Surgical abortion	9 (60%)	11 (69%)	17 (70%)	16 (67%)	53 (67%)
Ultrasound	2 (13%)	-	2 (8%)	13 (54%)	24 (30%)
Hormonal injection	-	-	7 (9%)	10 (42%)	17 (35%)
Medication abortion	-	-	4 (16%)	11 (45%)	15 (19%)
IUD insertion	-	-	2 (8%)	7 (29%)	9 (11%)
STI screening	-	-	2 (8%)	6 (25%)	8 (10%)
Hormonal implant insertion	-	-	2 (8%)	6 (25%)	8 (10%)
Emergency & hormonal contraception	-	-	2 (8%)	6 (25%)	8 (10%)
Cervical screening	-	-	1 (4%)	6 (25%)	7 (9%)
Pharmacy gaps					
Hormonal injection	5 (33%)	7 (44%)	14 (58%)	15 (63%)	41 (52%)
Medication abortion	4 (26%)	3 (19%)	10 (42%)	14 (60%)	31 (39%)
IUD device	2 (13%)	3 (19%)	11 (46%)	12 (50%)	28 (35%)
Hormonal implant	2 (13%)	3 (19%)	11 (46%)	12 (50%)	28 (35%)
Emergency & hormonal contraception	2 (13%)	3 (19%)	9 (38%)	12 (50%)	26 (33%)
Total LGAs in socio-spatial group	**15**	**16**	**24**	**24**	**79**

Recommendations

For Government

Victorian Government

3.1 Extend support under the Victorian Patient Transport Assistance Scheme (VPTAS) scheme to include all SRH service-related travel, in recognition of the low level of SRH service provision in primary care settings in regional and rural areas.

3.2 Ensure that initiatives to support additional service provision are informed by real time service provider data from 1800 My Options.

Challenges facing service seekers

Chapter Summary

Challenges facing SRH service seekers, particularly those seeking abortions, are often complex and reflect deeper social, safety, economic and health challenges in the community. 1800 My Options phone staff capture data fields relating to specific challenges that are raised over the phone for additional support referral purposes. This chapter provides an analysis of common challenges reported over time and by the following demographic and cultural groups: people under 18 years of age, overseas-born citizens and permanent residents, Aboriginal and Torres Strait Islander people and people living in regional and rural areas.

- **Common challenges:** From March 2018 to December 2023, financial insecurity (27%) was the most cited challenge among SRH service seekers, followed by mental illness (11%) and complex medical factors (8%). It is possible that not all callers feel comfortable describing personal circumstances, so actual prevalence of challenges may be higher.
- **Trends over time:** In 2020, mental illness, complex medical factors, family violence, housing insecurity and alcohol and other drug (AOD) challenges were at peak levels. Since 2021, reports of these challenges have decreased, however financial insecurity remains high. The percentage of service seekers experiencing geographic access and advanced gestation issues has generally increased over time.
- **People under 18 years of age:** Service seekers under 18 years of age raised advanced gestation, mental illness, financial insecurity and geographic access more frequently than service seekers aged 18 and over. They also report higher rates of sexual assault.
- **Overseas-born citizens:** Overseas-born citizens tended to raise challenges less frequently than those born in Australia, with the exception of advanced gestation (6% compared with 4.6%).
- **Aboriginal and Torres Strait Islander people:** Many Aboriginal and Torres Strait Islander callers raised one or more of the challenges discussed in this section, reflecting service barriers resulting from institutional racism, lack of cultural safety, and the intergenerational impacts of colonisation and dispossession.
- **Regional and rural areas:** 20.7% of service seekers living in a regional or rural area indicated that geographic access was a challenge, and this group brought up advanced gestation as a challenge twice as often as metropolitan service seekers. Other challenges such as complex medical factors, mental illness and family violence were also raised more frequently by these service seekers, highlighting the need for improved health services and support in these regions.

Analysis and Discussion

Challenges facing SRH service seekers

1800 My Options phone staff select specific fields in the online database according to challenges that are raised in a phone call to better tailor support referrals. The categories of challenges appear in Table 4(a).

Communication and categorisation of challenges is influenced by several factors, particularly how much additional context the service seeker is comfortable providing. However, this identification of challenges across more than 30,000 phone calls provides a unique equity lens through which to understand the social context of SRH service seeking, and particularly abortion seeking.

The most frequently cited challenges were financial insecurity (27.2%), mental illness (11.1%), complex medical factors (7.6%), international/ temporary resident status (7%), family violence (6.1%), caring responsibilities (5.3%), advanced gestation (4.7%), geographic access (3.1%), housing insecurity (2.9%) and alcohol and other drugs (AOD) (2.6%) (Table 4(a)). These percentages likely underrepresent the actual prevalence of challenges as not all callers may feel comfortable describing personal circumstances when seeking information or a referral.

Table 4(a): Number and percentage of phone calls where challenge was identified by service seekers between 1 March 2018 and 31 December 2023

Challenging context	Service seekers
Financial insecurity	8251 (27.2%)
Mental illness	3371 (11.1%)
Complex medical	2316 (7.6%)
International/Temporary resident	2114 (7%)
Family violence	1853 (6.1%)
Caring responsibilities	731 (5.3%)*
Advanced gestation	1425 (4.7%)
Geographic access	943 (3.1%)
Housing insecurity	867 (2.9 %)
Alcohol and other drugs	783 (2.6%)
Caring responsibilities	731 (2.4%)
No supports	339 (2.5%)
Child protection	258 (<1%)
Reproductive coercion to continue pregnancy	234 (<1%)
Interstate	233 (<1%)
Sexual assault	200 (<1%)
Reproductive coercion to abort	196 (<1%)
Disability – intellectual/cognitive/learning	136 (<1%)
Foetal abnormality	67 (<1%)*
Disability – physical	62 (<1%)

** Category was introduced in August 2022 – percentages were calculated only on call numbers from that date.*

Changes in challenges over time

Financial insecurity, mental illness, complex medical factors, family violence, housing insecurity and AOD challenges peaked in 2020 at the start of the COVID-19 pandemic. (Figure 4(a)).

From 2021, the percentage of service seekers citing mental illness, AOD challenges, housing insecurity and family violence declined, though in most cases in 2023 were still above pre-pandemic levels. However, financial insecurity has persisted at high levels and was raised by around a third of service seekers over the past four years (Figure 4(a)).

The percentage of service seekers indicating that they faced both geographic access and advanced gestation – defined as gestational age of 16 weeks and over – has generally increased over time (Figure 4(a)).

Figure 4(a): Percentage of service seekers who raised selected challenges — 2018 to 2023

The percentage of service seekers facing challenges due to temporary residency status has followed the rate of international arrivals as borders reopened.

Challenges by cultural and demographic group

The percentage of service seekers who raised specific challenges in relation to SRH service seeking was further analysed for the following demographic groups:

- people under 18 years of age
- overseas-born citizens and permanent residents
- short-term residents
- Aboriginal and Torres Strait Islander people
- people living in regional and rural areas

Service seekers under 18 years of age

1800 My Options was contacted by 984 service seekers under 18 years of age. Service seekers in this group indicated the following challenges and contexts more frequently than service seekers aged 18 and above:

- financial insecurity (33.8% compared with 30.4%)
- mental illness (14.4% compared with 12.4%)
- advanced gestation (6.6% compared with 3.3%)
- geographic access (5.6% compared with 3.3%)
- sexual assault (3.5% compared with 0.6%)

It is concerning that the rate of sexual assault was five times higher for service seekers aged under 18 years than for service seekers aged 18 and above. It is consistent with recent figures from the Australian Child Maltreatment study which found that peer-on-peer sexual assault is on the rise with nearly one in five young people aged 16 to 24 having been sexually assaulted by another teen (Mathews et al. 2024). These statistics underscore the importance of sexuality and consent education in schools.

Overseas-born citizens and permanent residents

Overseas-born citizens and permanent residents comprised 5,080 service seekers. These service seekers indicated the following challenges and contexts less frequently than Australian-born service seekers:

- financial insecurity (32.1% compared with 40.1%)
- complex medical issues (9.3% compared with 11.3%)
- mental illness (6.2% compared with 18.5%)
- family violence (4.8% compared with 8.8%)

There are several possible explanations for this difference. In the past twenty years Australia has shifted the bulk of migration to the Skilled Migration visa stream, which requires applicants to meet a minimum health threshold. As a result, on average overseas-born citizens and permanent residents have a better health status than Australian-born citizens (Jatrana et al. 2014). Alternatively, cultural differences in communication styles and language among this group may have resulted in fewer challenges being disclosed during conversations with 1800 My Options support staff.

Conversely, service seekers who were overseas-born citizens indicated that advanced gestation was a challenge more often than Australian-born citizens (6% compared with 4.6%). This is consistent with research findings that migrant and refugee women access health services at a later point, and at lower levels than the rest of the population (AIHW 2020).

It is important to highlight that migrants and temporary residents are not a homogenous group. Factors such as visa/residency status, migration stream, year of arrival, ethnic identity, language proficiency and income may all affect the likelihood that different challenges will arise. Better data informing the influence of the above factors on health will lead to more appropriate understanding of barriers to SRH health at the policy level.

At the community level, organisations such as the Multicultural Centre for Women's Health (MCWH 2022) have advocated for:

> "community-led, tailored preventative sexual and reproductive health education run by migrant women's organisations and delivered to migrant women and gender diverse people by trained bilingual workers, on key sexual and reproductive health topics, including in FGM/C and reproductive coercion."

Aboriginal and Torres Strait Islander people

At least 557 Aboriginal and Torres Strait Islander service seekers contacted 1800 My Options since the service commenced operations. The fact that many raised one or more of the challenges discussed in this section reflects the institutional racism across all facets of Australian society and the intergenerational legacy of colonisation and dispossession, which combine to make mainstream health services culturally unsafe and hence challenging to access for Aboriginal and Torres Strait Islander people.

Findings from this data are consistent with the Victorian Aboriginal Community Controlled Health Organisation's (VACCHO) submission to the Yoorook Justice Commission into Health and Healthcare. VACCHO (2024) highlighted the social, political and historical determinants of health influencing these current health outcomes and related factors which are:

"intrinsically linked to underlying factors such as discrimination; racism; grief and loss; child removals and unresolved trauma; life stress; social exclusion; economic and social disadvantage; disproportionate rates of incarceration and child removal by care and protection orders; abuse and violence, including family violence; substance use issues; physical and mental health problems; family breakdown; and cultural dislocation."

VACCHO has highlighted the importance of centring social and emotional wellbeing (SEWB) – a complex, multidimensional concept encompassing connections to land, culture, spirituality, ancestry, family, and community – in service provision in order to address health disparities. VACCHO has also indicated that making these models of care accessible will require support and resourcing of Aboriginal-led training initiatives, expanding the Aboriginal and Torres Strait Islander health and wellbeing workforce, and ensuring health providers generally undertake cultural safety training (VACCHO 2024). Women's Health Victoria supports these initiatives.

Service seekers living in regional and rural areas

3,753 service seekers were living in regional and rural areas. Service seekers in this group indicated the following challenges and contexts more frequently than service seekers residing in metropolitan areas:

- geographic access (20.7% compared with 0.3%)
- advanced gestation (6.3% compared with 3.9%)
- mental illness (14.8% compared with 11.6%)
- complex medical issues (9.2% compared with 8.3%)
- family violence (7.9% compared with 6.3%)

Given the service gaps that have been identified in regional areas, it is not surprising that both geographic access and advanced gestation are frequently indicated by this group. Accessing general practitioners and specialist health care services has been a perennial problem in regional areas, leading to poorer health outcomes (Victoria DHHS 2017). The reported incidence of family violence is also higher in these areas – regional and rural Victorians have been considered a priority population in Victoria's strategy for ending family violence (Campo & Tayton 2015; Victoria DPC 2016). Women's Health Victoria supports programs aimed at increasing health capacity in regional and rural areas, such as health workforce attraction and retention programs and capacity building initiatives.

Recommendations

For Government

Victorian and Australian Governments

4.1 Support data collection on a range of factors affecting SRH equity of overseas-born service seekers so that appropriate tailored information is available. This must include moving beyond monolithic categories such as 'CALD' (Culturally and Linguistically Diverse).

Victorian Government

4.2 Ensure that plans for future pandemic management incorporate innovations that will ensure the continuity of SRH care and mitigate wellbeing risks to women and gender diverse people.

4.3 Evaluate whether cost-of-living pressures have impacted access to SRH services, and consider additional supports based on evidence.

4.4 Continue to provide appropriate SRH education for young people, including in relation to consent, and include information and promotion of 1800 My Options in education initiatives.

4.5 Continue to support expanded health service provision in regional and rural areas, and identify innovations that will result in greater capacity building and sustainable attraction and retention of health providers, such as the SRH Clinical Champions Project.

4.6 Fund development of cultural SRH resources to improve access to care and mandate cultural safety training for all workforce delivering SRH care in Victoria.

4.7 Develop and fund strategies to address the barriers to accessing care that have been highlighted in this report.

For 1800 My Options

4.8 Establish a mechanism for consultation and feedback from 1800 My Options service users to better understand the context in which service needs arise, and to enable continuous improvement (such as a user reference group).

4.9 Continue to identify opportunities to work with organisations advocating for the health needs of young people, older people, migrants, Aboriginal and Torres Strait Islander people, LGBTQI+ people and people with disabilities, to raise awareness of 1800 My Options and to improve tailoring of the service.

4.10 Progress accreditation under the Victorian Aboriginal Research Accord Project (VARAP).

4.11 Continue to advocate with and on behalf of women's health services in regional and rural areas to ensure that service provision is responsive to changes at the local level.

Access to abortion in Victoria

Chapter Summary

In Victoria, abortions are legally permitted up to 24 weeks gestation, with medication abortions available up to 9 weeks and surgical abortions up to 24 weeks. This chapter analyses data from 1800 My Options, the Victorian Women's Health Atlas (the Atlas) and a qualitative survey of place-based women's health services to describe abortion service availability, including trends over time and barriers and enablers to accessing abortion services in Victoria. Key findings include:

Abortion service availability and trends:

- Access to abortion in Victoria is largely determined by gestational age, with a narrowing of options and higher risk of missing out on abortion care as gestational age increases:

    - medication abortions can be safely provided in a primary care setting up to 9 weeks gestation, and as at June 2023 1,345 of 8,141 (around 17%) GPs in Victoria provided this service. As at July 2023, only 19% of pharmacists in Victoria dispensed medical abortion medication (MS Health 2023; Australia DHAC 2024; National Health Workforce Dataset 2024).[2]
    - surgical abortions using 'suction curettage' methods are usually available up to 12 weeks gestation and are offered by 35 providers.
    - surgical abortions after 12 weeks gestation, using a range of techniques due to increased complexity, are only offered by 15 providers.
- The likelihood of an abortion seeker contacting 1800 My Options over nine weeks' gestation is higher for individuals who are living in a regional or rural area, living in a more disadvantaged area, under 18 years of age, and born overseas.
- Between 2017 and 2022:
    - medication abortions increased across Victoria (by 120% in metropolitan areas and by 84% in rural and regional areas).
    - medication abortion rates were higher in regional and rural areas, with an average of 7.1 medication abortions per year per 1,000 females aged 15 to 44, compared with 4.6 in metropolitan areas.

Key barriers to abortion access:

- Conscientious objection and a lack of referrals by objecting providers complicate access to abortion services.
- Requirements from practitioners for service seekers to obtain pathology and ultrasound test results can prove a significant barrier to abortion access, particularly for medication abortion. While under the most recent current clinical guidelines, pathology and ultrasound results are no longer necessary, most practitioners still ask for both sets of results before providing a medication abortion (RANZCOG 2024).
- Abortion seekers in regional and rural areas, especially those over 12 weeks gestation, face significant challenges due to fewer providers and longer wait times for required tests like ultrasounds. Of 263 medication abortion providers listed on 1800 My Options, less than one-third were in regional and rural areas. This contributes to higher rates of later stage abortion seekers in these areas.

Key enablers of abortion access:

- Improvements in SRH access include the establishment of SRH hubs, telehealth consultations, and a centralised referral system through 1800 My Options.
- Despite these advances, service provision remains inadequate compared to demand, particularly for later stage abortions and disadvantaged groups.

2 At the time this information was collected, general practitioners and pharmacists were required to formally register and undertake training to be accredited to provide medical abortions. It is unclear whether the removal of this restriction, which occurred on 1 August 2023, has resulted in an increase in the number of health providers supplying this service.

Analysis and Discussion

Abortion in Victoria

Abortion was decriminalised in Victoria in 2008, and medical abortion medication has been available on the Pharmaceutical Benefits Scheme (PBS) since 2013. In practical terms, however, access to abortion in Victoria is determined by geographical location and gestational age, with a narrowing of options as gestational age increases. Specifically:

- medication abortions can be safely provided in a primary care setting up to 9 weeks gestation, and around 1,345 general practitioners (around 17%) are trained to provide this service (it is unknown how many provide the services post-training).
- surgical abortions using 'suction curettage' methods are usually available up to 12 weeks gestation and are offered by 35 providers.
- surgical abortions after 12 weeks gestation, using a range of techniques due to increased complexity, are only offered by 15 providers.

While exact numbers of surgical abortions are not known, data collected between 2015 and 2022 indicated that there were four times as many abortions carried out in hospitals (most likely surgical abortions) as there were medication abortions in primary care settings. On an average monthly basis, there were 300 medication abortions and 1,287 hospital abortions per month over this period (Marzan et al. 2024).

In recent years the Victorian Government has sought to expand access to medication abortion, as this is a more accessible option that can be delivered in a primary care setting and requires fewer health resources compared with surgical abortion (Victoria DH 2022). In the years 2012–2022 there was an overall decrease in the number of abortions in hospitals, and an increase in the number of medication abortions outside hospitals (Marzan et al. 2024).

Surgical abortion remains an indispensable part of the SRH service mix. Abortion seekers opt for this procedure for a range of reasons, such as personal preference, medical contraindications, or failure of medication abortion (in 3–5% of instances). Alternatively, surgical abortion may be the only remaining option because gestational age is at or over 9 weeks.

Table 5(a): Cost of abortion by type in a private clinic

Abortion type	Health Care Card	Medicare card	No Medicare
Medication abortion	$580	$620	$1,280
Surgical abortion	$740	$775	$1,185

Source: MSI Australia 2024

Table 5(b): Average annual PBS medication abortion prescriptions per 1,000 females aged 15-44 years, by patient spatial disadvantage group, 2017–2022

Regional – high disadvantage	5,747	8.0
Metro – high disadvantage	18,928	4.9

For Medicare and Health Care Card holders, medication abortion is a cheaper option compared with surgical abortion. Cost estimates for both abortion types in a private setting are provided in Table 5(a). Note, however, that some public hospitals, community health services such as government-supported SRH hubs (discussed below) and some GP clinics will have lower fees or will fully bulk bill.

Geographical distribution of medication abortions

The Victorian Women's Health Atlas includes Medicare Benefits Schedule (MBS) claim data for all medication abortion prescription claims made on the PBS between 2017 and 2022 inclusive, by Local Government Area (LGA) of residence. An analysis of this dataset showed that the number of medication abortions, adjusted for population, is higher in regional and rural areas compared with metropolitan areas.

The number of medication abortions also varied by spatial disadvantage. Over the six-year period, women and gender diverse people living in regional and rural high-disadvantage areas had 20 percent more medication abortions than their counterparts in regional and rural low-disadvantage areas (Table 5(b)).

Medication abortion trends – 2017 to 2022

Between 2017 and 2022 the rate of increase of medication abortions was higher for metropolitan areas (120%) compared with regional areas (84%) (Figure 5(a)). This is likely due to regional and rural health practitioners incorporating medication abortion care into their professional practice at a slower pace than metropolitan health practitioners. While medication abortion service provision in Victoria is increasing, as at July 2023, only 17 percent of practitioners and 19 percent of pharmacists in Victoria either provided medication abortion care or dispensed medication abortion medication (MS Health 2023; Australia DHAC 2024).[3]

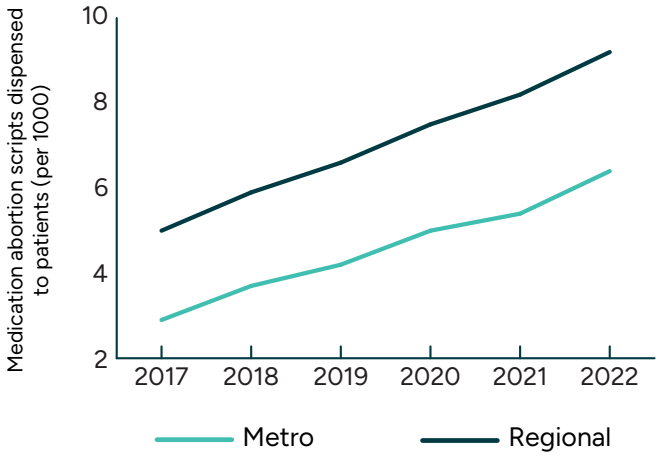
3 At the time this information was collected, the requirement that GPs and pharmacists formally register and undertake training to be accredited to provide medical abortions has been removed. It is unclear whether the removal of this restriction, which occurred on 1 August 2023, has resulted in an increase in the number of health providers supplying this service.

One potential driver for the relatively low level of provision of medication abortion services across Victoria is the existence of a legally protected right for health practitioners to 'conscientiously object' to patient requests for medication abortion services. It has been argued that as the *Abortion Law Reform Act 2008* (Vic) frames abortion as a personal moral stance on the part of the practitioner, rather than an essential health service, many GPs and pharmacists see provision as discretionary (Dawson et al. 2017).

The challenge of conscientious objection was raised by multiple respondents to the SRH service demand and provision survey. Respondents also indicated that some conscientious objectors were failing to exercise their statutory obligation to refer abortion seekers to an alternative provider:

> "We are hearing that there are a number of GPs across community health services who are not willing to provide medication abortion due to culture and faith. While this is understandable, it is making it difficult for practice managers and nurses who are eager to provide the service, to cope with requests."
>
> – Metropolitan women's health service region

Figure 5(a): Number of PBS medication abortion prescriptions per 1,000 females aged 15-44 years, by patient residential area, 2017–2022



> "There are issues around conscientious objection to medication abortion and not referring to another provider or referring to maternity services."
>
> – Regional women's health service region

Another flow-on effect of the conscientious objection provision is that practitioners who do want to offer the service may be hesitant to do so due to the potential for backlash from conservative community members who see them as making the 'wrong choice'. This is especially the case for health practitioners operating in small communities in regional and rural areas (Keogh et al. 2019; Dawson et al. 2017).

Table 5(c): Abortion type referral sought by gestational age — 1 March 2018 to 31 December 2023

Abortion type	Under 9 weeks	Over 9 weeks	Gestational age unknown	Total
Surgical only	28.4% (4,712)	97.9% (7,223)	41.6% (346)	49.5% (12,281)
Medication only	54.2% (9,000)	0.4% (30)	35.5% (295)	37.6% (9,325)
Both	17.4% (2,882)	1.7% (128)	23.0% (191)	12.9% (3,201)
Total	100.0% (16,594)	100.0% (7,381)	100.0% (832)	100.0% (24,807)

1800 My Options abortion seekers

Between 1 March 2018 and 31 December 2023, 1800 My Options received 24,807 calls from abortion seekers. Of these:

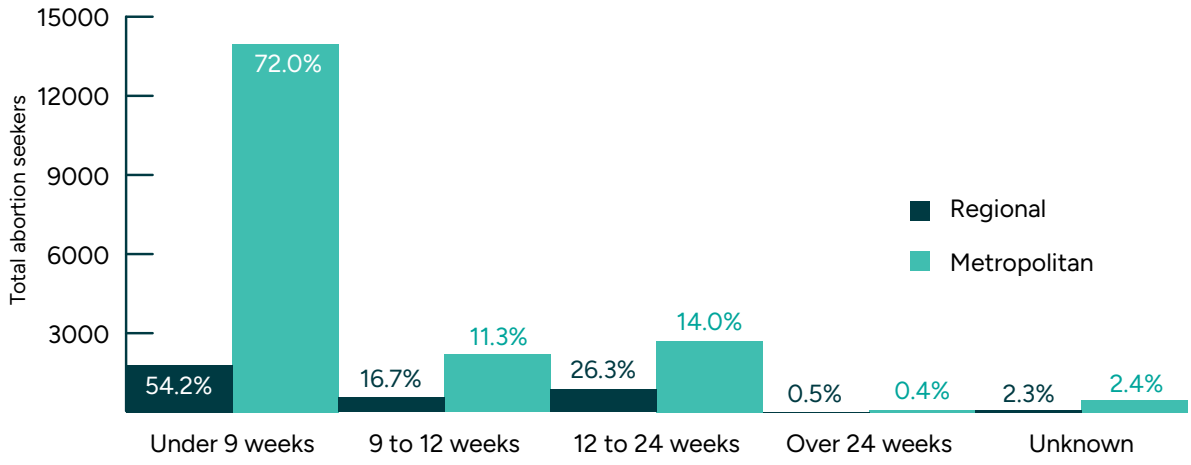
- around half were interested in referrals for surgical abortion services only,
- 38% were interested in referrals for medication abortion services only, and
- 12% were interested in referrals for both types of abortion service.

Gestational age and abortion type sought

For those 16,954 abortion seekers who were below nine weeks gestation, medication abortion was the most frequently sought abortion type (Table 5(c)). This suggests that most abortion seekers who meet current requirements for medication abortion choose to exercise this option.

The distribution of gestational ages for abortion seekers contacting the service appears in Figure 5(b). The percentage of regional and rural abortion seekers contacting 1800 My Options (27%) was almost double the percentage of metropolitan abortion seekers, indicating that the demand for surgical abortions is likely to be higher in regional and rural areas.

Figure 5(b): Gestational age of abortion seekers between 1 March 2018 and 31 December 2023, by area type



1800 My Options abortion providers

As at 31 December 2023, 273 abortion providers were listed on 1800 My Options. Of these, only 35 provided surgical abortions. Growth in listings over time and by provider type appear in Figure 5(c).

Of the 35 surgical abortion providers listed, only 15 provide surgical abortions beyond 12 weeks gestational age, of which five are in regional areas (Table 5(d)). Only the Royal Women's Hospital offers surgical abortions after 16 weeks gestation.

One of the most significant challenges to equitable access for surgical abortion seekers is the reluctance of many publicly funded hospitals to provide these services, despite having capacity, with most surgical abortions occurring in private settings. In Victoria between 2012 and 2022, 75 percent of births were in public hospitals, but only 21 percent of hospital-based abortions were provided in public hospitals (Marzan et al. 2024). While some smaller regional hospitals may not have capacity to provide these services, in many cases the reasons are historical or religious.

Figure 5(c): Growth in listings of abortion providers on 1800 My Options, 2018–2023

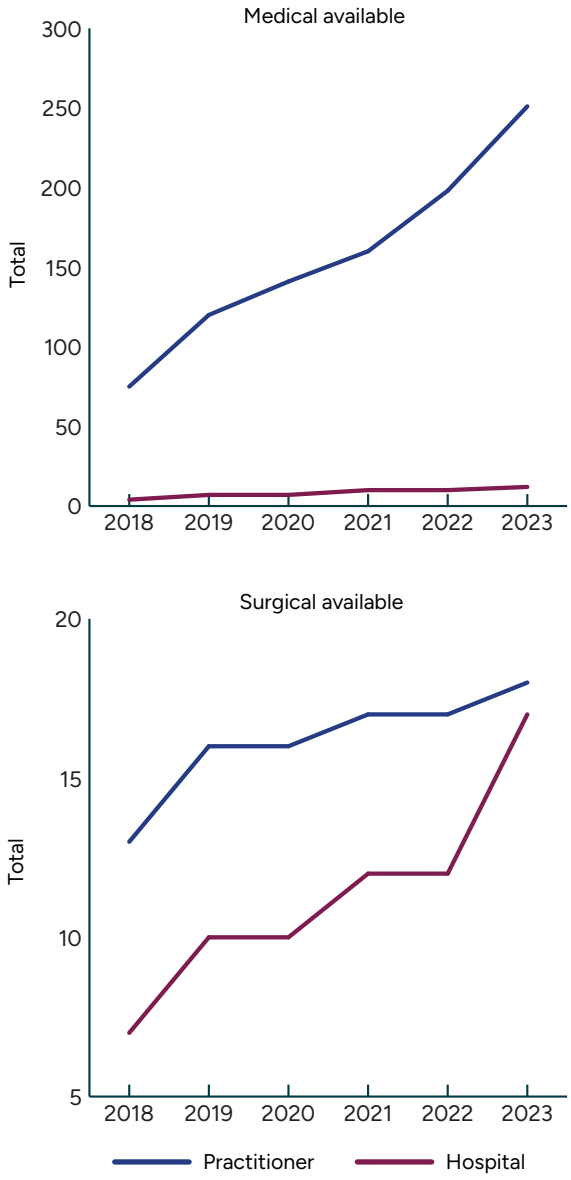


Table 5(d): Abortion services by gestational limit and geographical area as at 31 December 2023

Gestational limit	Under 9 weeks	Under 12 weeks	Under 13 weeks	Under 14 weeks	Under 16 weeks	Under 24 weeks
Metro	179	4	1	6	2	1
Regional	59	16	2	2	1	0
Total	238	20	3	8	3	1

This issue was raised by two of four regional respondents to the SRH service demand and provision survey. One respondent indicated that their local hospital was only just starting to offer surgical abortion after "having been hesitant for many years due to concern of 'protests'."

Another respondent from a regional women's health service provider indicated that during the pandemic, "gynaecological services were contracted to the local Catholic hospital, impacting service provision of contraception and abortion."

The gap in abortion service provision by publicly funded hospitals was recognised as a major barrier to universal access to reproductive care in the recent Senate Committee Report (Australia Senate CARC 2023):

> "Recommendation 15: The committee recommends that all public hospitals within Australia be equipped to provide surgical pregnancy terminations, or timely and affordable pathways to other local providers. This will improve equality of access, particularly in rural and regional areas and provide workforce development opportunities."

Abortion barriers: timely access to supporting services

A secondary barrier to obtaining an abortion, particularly a medication abortion, is the need to obtain pathology and ultrasound test results. Under the current clinical guidelines, pathology and ultrasound results are no longer required as clinical examination has been deemed sufficient to determine gestation and assess for other risks. However, most practitioners still ask for them (RANZCOG 2024).

Ultrasound services can have long wait lists, and typically cost around $150 out-of-pocket (with varying rebates depending on Medicare and Health Care Card eligibility). Therefore, testing requirements, and the delays they impose, can pose a significant challenge to accessing abortion. Among 1800 My Options abortion seekers, less than half had already obtained ultrasound results when they contacted the service.

The impact of secondary barriers was raised by several respondents to the SRH service demand and provision survey:

> "Access to ultrasound appointments is problematic for timely early medical abortion pre-tests – we have heard multiple reports of people travelling significant distances to obtain a scan."
>
> - Regional Women's Health Service

> "In regional centres there is no funded ultrasound to confirm pregnancy in utero (many providers are still wanting this, so women have to travel a large distance)."
>
> - Regional Women's Health Service

Personal experiences of women in the Grampians captured in the *Tell Your Story* report reflected the compounding delays resulting from the need to book ultrasound, pathology and practitioner appointments in different locations (WHG 2024):

> "I wasn't sure I could access the medical abortion option. By the time I had seen my GP, had a scan at radiology, and then went to another GP who would see me for the medical abortion, I think I was within days of the cut off limit."
>
> – Participant from Horsham

From a practical standpoint, co-location of testing services can greatly assist in overcoming abortion access hurdles. Around one-in-five 1800 My Options abortion providers as at 31 December 2023 had co-located ultrasound premises, and more than half were located alongside pathologists (Table 5(e)).

Equity and demographic characteristics of abortion seekers over nine weeks gestation

Understanding the characteristics of abortion seekers who were over nine weeks gestation when they contacted 1800 My Options is important as this group can only access surgical abortions, regardless of preference or provider availability. These abortion seekers are at greater risk of missing out on abortion care.

A binomial logistic regression analysis was performed to see how the characteristics recorded for 1800 My Options abortion seekers described in Chapter 2 impacted the likelihood that they were over nine weeks gestational age when they contacted the service.

The results of the model indicated that being born overseas, being under 18 years of age, living in a regional or rural area or living in a more socio-economically disadvantaged area all increase the likelihood of an abortion seeker calling the service over nine weeks gestation (Table 5(f)).

Table 5(e): Abortion practitioner co-location with pathology and ultrasound services as at 31 December 2023

Co-located service	Medication abortion practitioner	Surgical abortion practitioner
Pathology	156 (59.3%)	21 (60%)
Ultrasound	52 (19.8%)	21 (60%)

Specifically:

- abortion seekers under 18 years of age are 38% *more* likely to be over nine weeks gestational age than abortion seekers aged 18 and over,
- abortion seekers born overseas (permanent residents and citizens) are 10% *more* likely to be over nine weeks gestational age compared with abortion seekers born in Australia, and
- abortion seekers who are short-term residents are 28% *less* likely to be over nine weeks gestational age compared with abortion seekers born in Australia.

Also, compared with abortion seekers living in a metropolitan low disadvantage LGA,

- abortion seekers living in a metropolitan high disadvantage LGA are 17% more likely to be over nine weeks gestational age,
- abortion seekers living in a regional or rural low disadvantage LGA are twice as likely to be over nine weeks gestational age, and
- abortion seekers living in a regional or rural high disadvantage LGA are 300% more likely to be over nine weeks gestational age.

The cumulative and compounding effects of individual and cultural characteristics as well as postcode disadvantage on abortion seeker gestational age highlight the fact that service provision is an equity issue.

A range of factors influence gestational age at which abortion seekers access services, including financial barriers, a lack of providers that are trusted and culturally safe, a lack of any local providers and service waitlists. A closer understanding of the factors leading to delays in abortion service seeking is needed to address these factors so that all women and gender diverse people in Victoria can exercise their reproductive rights.

Table 5(f): Relative likelihood of having a gestational age over nine weeks when contacting 1800 My Options for selected characteristics – 1 March 2018 to 31 December 2023

Characteristic	Odds ratio	95% CI	P-value
Under 18 compared with 18 and over	1.38	1.12 - 1.68	<0.05
Overseas-born citizen compared with Australian-born citizen	1.10	1.02 - 1.20	<0.05
Short-term resident compared with Australian-born citizen	0.72	0.64 - 0.81	<0.05
Metro high disadvantage compared with metro low disadvantage	1.17	1.07 - 1.28	<0.05
Regional low disadvantage compared with metro low disadvantage	2.05	1.79 - 2.36	<0.05
Regional high disadvantage compared with metro low disadvantage	2.93	2.54 - 3.38	<0.05

Effects of abortion provider on access

An additional investigation was carried out to establish whether the presence of a visible local medication abortion provider (practitioner or pharmacist) in an LGA has a positive effect on medication abortion access.

To carry out this investigation, annual medication abortion data at LGA level from 2018 to 2022 was extracted from the Atlas and joined with annual 1800 My Options service provider data over the same five-year period. At the beginning of this period, several of the LGAs in the linked dataset had no practitioners or pharmacies.

A fixed effects regression model was used for this investigation. This type of model controls for the trend increases in medication abortion over the period, as well as (time-invariant) characteristics that differ between LGAs. The model results showed that:

- on average, the presence of at least one medication abortion provider listed on 1800 My Options in an LGA increases the number of annual medication abortions by 1.9 per 1,000 females aged 15-44.
- on average, the presence of at least one medication abortion medication-dispensing pharmacy listed on 1800 My Options in an LGA increases the number of annual medication abortions by 1.7 per 1,000 females aged 15-44.

The average annual rate of medication abortions for an LGA in Victoria was 6.3 per 1,000 females of reproductive age. We can say with confidence that the presence of at least one visible practitioner or at least one pharmacist listed on 1800 My Options is associated with a significant increase in access in an LGA, meaning that more women who need medication abortions can get them locally.

This result reinforces the importance of expanding medication abortion provision, service visibility and referral pathways as a means of achieving reproductive equity.

Abortion enablers – survey responses

As part of the SRH service demand and provision survey, respondents from across nine women's health place-based services were asked about SRH service provision enablers in their local areas. This section provides an overview of the initiatives that respondents indicated had a positive impact on access.

Telehealth medication abortions

Since 2020, a new MBS telehealth item for SRH consultations, including medication abortion provision, has been available. This item removed the restriction on SRH consultations that required patients to have had at least one in-person appointment with the prescribing practitioner in the previous year. The change was introduced by the Federal Government to ensure that access to abortion was not interrupted by the pandemic.

Under the new rules, medication abortion has become far more accessible, as abortion seekers are able to choose from practitioners

around the country to obtain a prescription, and to receive this medication from a pharmacy via post. One major provider indicated that telehealth abortions increased 30 percent between 2019 and 2020 because of the change (Marie Stopes 2021a).

While respondents to the survey overwhelmingly cited the MBS item for telehealth abortions as an enabler, some respondents also expressed concerns that residents in regional and rural areas with poor internet connectivity were not able to benefit from this change at the same level as their metropolitan counterparts.

SRH hubs

Since 2018, the Victorian Government has sought to address barriers to SRH services by funding the establishment of 20 SRH hubs – 8 in metropolitan areas and 12 in regional areas – that are based in community health services. To receive funding as an SRH hub providers must:

- offer clinical services for women who opt for medication abortion,
- develop referral pathways for women who require surgical abortion,
- provide information for all forms of contraception and abortion options,
- offer clinical services to women who opt for long-acting reversible contraception,
- provide sexual health testing, treatment and support.

Respondents indicated that the SRH hubs are a welcome development. It was also pointed out that staffing levels and integration of services are not consistent across the hubs, with widely varying levels of service even in the same area:

> "[One SRH hub] … is located inside a multidisciplinary medical centre. If the hub GP is not available there are other trained GPs in the clinic that can assist. They also have an ultrasound machine onsite and can offer a wraparound service for patients.
>
> In contrast … [the second SRH hub] is stand alone and if on the day the one GP is not available the patient will have to return again the following day. The hub is also only open 3 days a week, limiting access."
>
> – Regional women's health service

> "While at present we have a SRH hub, there is a single GP providing EMA [early medical abortion] at that service. Reliance on one person presents concerns in case of staff turnover, that person taking annual leave, or sick leave, as that will mean that service provision will stop."
>
> – Metropolitan women's health service

Some respondents also indicated that the level of service provision was still not keeping pace with the need for no-cost or low-cost services in their regions.

> "Fast growing outer regions of Melbourne have created a rapid increase in the need for service provision, particularly low cost and in language. Unfortunately, we know that this service provision isn't meeting community need which is largely made up of refugee and migrant communities."
>
> – Metropolitan women's health service

1800 My Options

Since the establishment of 1800 My Options in 2018 to address the statewide gaps in SRH information and referral pathways, both calls and website visits have grown rapidly. In 2022 there were over 10,000 website views per month, with 'Abortion: what to do' and 'Find a service' the most viewed pages after the home page (VAGO 2023).

The importance of this service was raised by several participants in the Women's Health Grampians' *Tell Your Story* report:

> "I was so stressed out, I knew I needed to have an abortion but I had no idea how any of it worked. The woman I spoke to on the phone was so kind and patient. She gave me names and numbers of places to call, and a counsellor I could talk to as well. I felt so much better once I knew what the steps were."
>
> – *Tell your Story* participant from Ballarat

Additional public hospitals providing surgical abortion services

The announcement in November 2023 of three additional public hospitals offering surgical abortion services in Victoria will go some way to providing equitable access to abortion services and supporting women who require surgical abortions (Victorian Minister for Health 2023). This was raised by several service seekers who had seen hospital provision enabled in their regions.

However, more providers need to be established to ensure that surgical providers effectively complement the work being done in primary care settings (Subasinghe & Seema 2024).

Communities of Practice (CoP)

Given the stigma, lack of support and isolation some practitioners may feel in making the decision to incorporate medication abortion into their practice, clinical Communities of Practice (CoPs) have been identified as an essential resource for abortion care providers (Mazza 2023).

State-wide groups, such as the Victorian Clinical Network for Abortion and Contraception (VCNACC), established in partnership with the Royal Women's Hospital and the Centre for Excellence in Rural Sexual Health (CERSH), provide peer support, opportunities for peer learning and information on best practice to providers, as well as providing support to smaller CoPs at the local level.

Local clinical communities of practice care are augmented with online communities such as the *Australian Contraception and Abortion Primary Care Practitioner Support Network* (AusCAPPS), a multidisciplinary online community supporting primary care providers to deliver contraception and abortion care.

Several survey respondents identified the above-mentioned CoPs as an enabler of abortion access. One respondent detailed the importance of their local area CoP in assisting in local SRH planning and advocacy as well as providing a network of support for practitioners.

Recommendations

For Government

Victorian and Australian Governments

5.1 Fund research that increases understanding of drivers of abortion seeking in the second trimester and beyond, so that impactful solutions can be identified to facilitate earlier access for priority populations.

Victorian Government

5.2 Expand surgical abortion provision in publicly funded hospitals, to close gaps in service provision across Victoria, particularly for abortions over 12 weeks' gestation.

5.3 Develop an evidence base that evaluates demand for abortions, considering gestational age at which abortion seekers are likely to access services, against supply of abortion providers by gestational limits, to enable a meaningful evaluation of service provision against need.

5.4 Support abortion providers in primary care settings to co-locate with ultrasound services, or to have capacity for bedside ultrasound.

5.5 Support SRH hubs to provide consistency of services, taking into account hours of operation, staffing, co-location of ultrasound and pathology services and willingness to deliver low- or no-cost services.

5.6 Expand SRH hubs to locations with the greatest demonstrated need, based on comprehensive data analysis, and consulting with women's health services and existing SRH providers.

5.7 Develop meaningful oversight and complaint processes to understand the extent to which:

- 5.7.1 healthcare practitioners conscientiously object to abortion care, and
- 5.7.2 healthcare practitioners are breaking the law by failing to refer abortion seekers to another practitioner who does not conscientiously object.

Access to LARC in Victoria

Chapter Summary

Long-acting reversible contraceptives (LARCs), including intra-uterine devices (IUDs) and hormonal implants, are recommended as first-line contraception by professional bodies and the World Health Organization. Despite this, only 11 percent of Australian women use LARCs, with IUDs being more common (6.3%) than hormonal implants (4.5%). This chapter analyses data from the Victorian Women's Health Atlas (the Atlas) and 1800 My Options to describe LARC uptake trends by area and demographic characteristics, and barriers to LARC access in Victoria. Key findings are detailed over the page.

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LARC uptake trends by area, time and demographic

- **Geographic trends:** Analysis of Medicare Benefits Schedule (MBS) claims and 1800 My Options data reveals that regional and rural areas have a higher proportion of LARC use compared to metropolitan areas. Within regional and rural areas, hormonal implant use is more prevalent in high disadvantage areas, suggesting it is a more financially accessible option compared to IUDs, which are more common in less disadvantaged areas.
- **Trends over time:** Analysis of the number of MBS claims made between 2017 and 2022 shows that the number of IUD insertions has gradually increased over time, whereas the number of hormonal implants has decreased.
- **Demographic characteristics:** Data from 1800 My Options indicates that LARC seekers are typically from less disadvantaged metropolitan areas, over 35 years old, and from Anglosphere countries (e.g., UK, Canada). Younger individuals, Aboriginal and Torres Strait Islander people, and non-Anglosphere migrants are less represented among LARC seekers.

Barriers to LARC access

- **Provider distribution:** LARC services are unevenly distributed, with significant gaps in regional and rural high disadvantage areas. More than a quarter of these areas lack IUD or hormonal implant providers, and about half do not have LARC dispensing pharmacies, highlighting disparities in service availability.
- **Upfront costs:** High initial costs of LARCs present a barrier, particularly for economically vulnerable individuals who might benefit most from the long-term cost savings associated with these forms of contraception.
- **Training and provision:** Limited availability of training for practitioners on LARC insertion and removal, especially in regional and rural areas, along with insufficient Medicare rebates, restricts service provision.
- **Misinformation:** A lack of comprehensive community education and misinformation about LARC costs and benefits hinder informed choices. Many primary care providers still recommend oral contraceptives over LARCs due to being less familiar with the latter.
- **Cultural and access barriers:** Aboriginal and Torres Strait Islander populations and non-Anglosphere migrants face additional obstacles, including insufficient culturally appropriate information, which affects their LARC access.

Analysis and Discussion

LARC use in Victoria and Australia

Long-acting reversible contraceptives (LARCs) are widely recommended by professional bodies and the World Health Organization as first-line contraception, and increasing access to and uptake of LARCs is a priority in the *2022-30 Women's sexual and reproductive health plan* (WHO 2015; Victoria DH 2022). Barriers to LARC uptake are extensive, however, and include low number of providers, high upfront costs, and a variable quality of health information available to Victorian women and gender diverse people to make fully informed choices about contraception.

A recent survey of contraceptive preferences of Australian women of reproductive age indicated that 11 percent use LARCs. The most common LARC type used was the IUD (6.3%) followed by the hormonal implant (4.5%). Less than 2 percent of women use the contraceptive injection (Wright et al. 2018; Grzeskowiak 2020). While Australia generally lags behind other developed countries in terms of IUD use, use of hormonal implants in Australia is one of the highest in the world (UN 2019).

The dominant forms of contraception in Australia at present are the oral contraceptive pill (OCP) (28%) and the male condom (24%). Both these methods require active management by the user and have lower effectiveness rates than LARCs (Wright et al. 2018; RWH 2022).

LARC types and cost and maintenance interval

Compared with the OCP, LARCs have a higher upfront cost, but are more cost-effective (Table 6(a)). For example, for a typical Medicare card holder (MSI 2024; Sexual Health Victoria 2024):

Table 6(a): Maintenance interval and cost estimates of LARC options for Medicare card holders

LARC type	Maintenance interval	Medicare out-of-pocket cost	Device or medicine cost (with PBS)	Total upfront cost	Average total annual cost
Hormonal IUD	Up to 8 years	$170	$30.60	$200.60	$25.10
Copper IUD	Up to 10 years	$170	$100	$270	$27.10
Hormonal implant	Up to 3 years	$120	$30.60	$150.60	$50.20
Hormonal injection	Up to 12 weeks	$40	$26	$66	$264
Oral contraceptive pill (for comparison)	1 day (112 pills per box)	$40	$15	$55	$174.35

Sources: MSI 2024, Sexual Health Victoria 2024

- a hormonal IUD costs around $170 out-of-pocket, but at $25.10 a year over eight years, is a sixth of the price of the OCP,
- a hormonal implant costs $120 out-of-pocket, but at $50.20 a year over three years, is a third of the price of the OCP.

The high upfront cost of LARCs, however, means that many of the most economically vulnerable contraceptive users – those who would benefit most in terms of financial costs and time saved – may not be able to pay for insertion.

Hormonal implant and IUD uptake and trends in the Victorian Women's Health Atlas

The Atlas includes both patient and provider LGA level data on the number of MBS claims made for hormonal implant and IUD insertions, from 2017 to 2022. This data was analysed to understand the differences in LARC uptake across locations and over time.

LARC use by region and spatial disadvantage

The number of claims made for hormonal implant and IUD insertion per 1,000 women of reproductive age (15-44 years) were significantly higher in regional and rural areas compared with metropolitan areas (Table 6(b)). It has been suggested that LARCs are preferred by many users living in regional and rural areas due to their multi-year 'set-and-forget' nature, making them a more sustainable option for users who face significant travel and wait times to access health provider appointments (Bingham et al. 2018).

Within both metropolitan and regional and rural areas, the level of uptake of IUDs was higher in relatively less socio-economically disadvantaged areas. However, hormonal implant uptake was higher in regional and rural high disadvantage areas compared with low disadvantage areas (Table 6(b)), suggesting that lower income users may consider them a more financially accessible LARC option compared with IUDs.

Table 6(b): Uptake of LARC in regional and metropolitan areas by level of disadvantage — 2017 to 2022

Economic group	Hormonal implants per 1,000 females aged 15-44	IUDs per 1000 females aged 15-44
Regional – low disadvantage	26.2	20.2
Regional – high disadvantage	30.4	19.2
Metro – low disadvantage	16.1	14.1
Metro – high disadvantage	16.1	9.8

Changes in trend for hormonal implant and hormonal IUD uptake

The change in patient level prescriptions was analysed for both hormonal implants and IUDs (Figure 6(a)):

- Hormonal implant uptake increased slightly between 2017 and 2019 but has subsequently decreased year-on-year.
- IUD use increased between 2017 and 2021 but appears to have plateaued between 2021 and 2022.

Patient claim locations compared with provider claim locations

Further equity disparities were identified by analysing the differences between locations of LARC patients, compared to the locations of LARC providers.

Table 6(c) shows the average number of LARCs received by patient location divided by the average number of LARCs supplied by provider location, by regional disadvantage area type. The greater the patient-provider

Figure 6(a): Hormonal implant and IUD insertions 2017 to 2022 — by area type

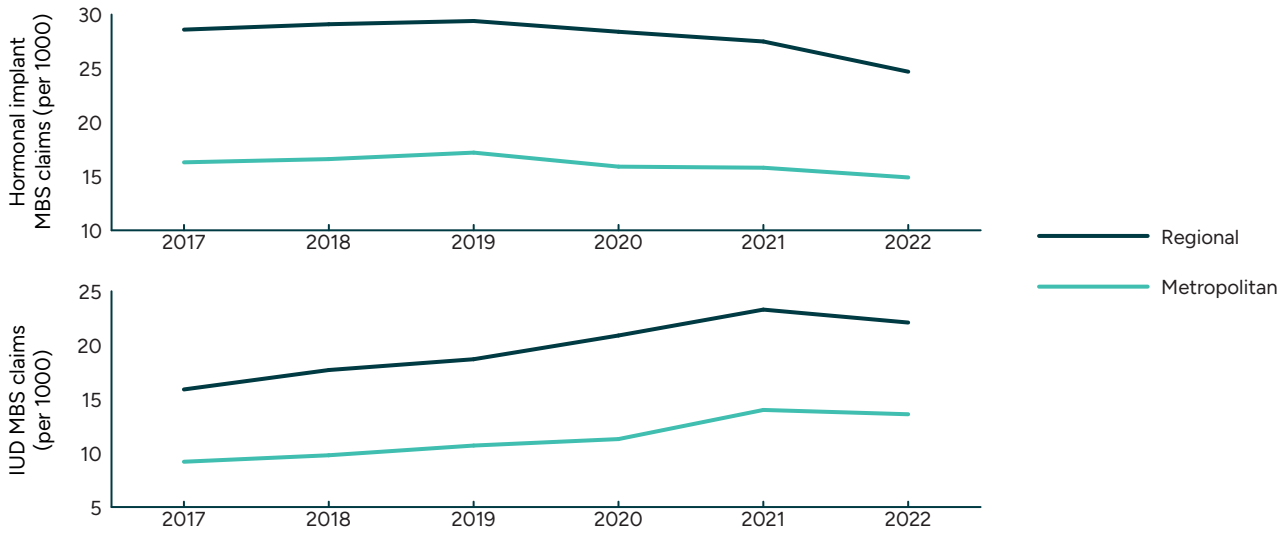

Table 6(c): LARC patient-provider location ratio in regional and metropolitan areas by level of disadvantage — 2017 to 2022 annual average

Economic group	IUD ratio	Implant ratio
Regional - low disadvantage	3.7	1.7
Regional - high disadvantage	2.6	1.7
Metro - low disadvantage	1.8	1
Metro - high disadvantage	1.7	1.1

location ratio, the higher the number of LARCs that could not be accessed in the local LGA.

For example, the Northern Grampians, which is a regional and rural high disadvantage area, has an IUD ratio of 6.7. This means that there were almost 6.7 times more IUDs received by patients living in the Northern Grampians, compared with the number provided by local doctors. Most patients living in this region who had IUDs inserted travelled to other LGAs to have the procedure. In contrast, Yarra, which is a metropolitan low disadvantage area, has an IUD ratio of 0.4. This means that most of the provider claims for this procedure were for provision to patients who travelled within the LGA to obtain this service.

The patient-provider ratio for regional and rural areas was consistently much higher than 1. This indicates that patients often have to travel outside of their local areas for hormonal implant and IUD insertion. This occurs more often for regional and rural high disadvantage LGAs where the number of patient claims exceeds the number of provider claims for IUD insertion by a ratio of almost 4:1.

Characteristics of 1800 My Options LARC seekers

Between 1 March 2018 and 31 December 2023, 1800 My Options received 993 calls from LARC seekers who were explicitly seeking referrals to services (as opposed to health information only). The most common LARC referral requests were for hormonal IUDs, followed by copper IUDs and hormonal implants.

Table 6(d): Average annual LARC referrals 1800 My Options — 2022 and 2023

Contraception type – LARC and other	Average annual referral requests
Hormonal IUD	85
Copper IUD	44
Hormonal implant	30
Contraceptive injection	11

1800 My Options contraception types

1800 My Options collected detailed information regarding specific contraceptive methods sought from 1 January 2022. Over 2022 and 2023, the LARC service most sought by callers was IUD insertion. Table 6(d) summarises the average number of referral requests for each LARC type per year. Note that a single service seeker may obtain a referral for multiple services.

LARC seekers compared with other 1800 My Options service seekers

A statistical analysis was carried out to identify the characteristics of 1800 My Options LARC seekers, to develop a better understanding of barriers in and equity implications of the current state of service provision.

A binomial logistic regression analysis was performed on the dataset of referral seekers to identify and understand whether characteristics of LARC seekers differed from those of service seekers who were seeking referrals to other SRH services. Note that 30 percent of LARC seekers were seeking both abortion and LARC services. These callers were also treated as LARC seekers.

The results of the model indicated that LARC seekers were more likely to be older, non-indigenous, and live in a more advantaged metropolitan area. Also, migrants from a core Anglosphere country (United Kingdom, Canada, New Zealand and the United States) were more likely to be seeking a LARC than Australian-born service seekers.

The relative likelihoods (Table 6(e)) are as follows:

- overseas-born service seekers who were permanent residents or citizens from an Anglosphere country are 42% *more* likely to be enquiring after a LARC referral compared with service seekers born in Australia,
- overseas-born service seekers who were permanent residents or citizens not from an Anglosphere country are 36% *less* likely to be enquiring after a LARC referral compared with service seekers born in Australia,
- service seekers who are short-term residents were 27% *less* likely to be enquiring after a LARC referral compared with service seekers born in Australia,
- service seekers under 35 years of age are 19% *less* likely to be enquiring after a LARC referral compared with service seekers 35 years and over,
- service seekers living in a metropolitan high disadvantage LGA are 23% *less* likely to be enquiring after a LARC referral compared with service seekers in low disadvantage metropolitan LGAs,
- service seekers living in a regional or rural low disadvantage LGA are 54% *less* likely to be enquiring after a LARC referral compared with service seekers in low disadvantage metropolitan LGAs, and
- service seekers living in a regional or rural high disadvantage LGA are 67% *less* likely to be enquiring after a LARC referral compared with service seekers in low disadvantage metropolitan LGAs.

Table 6(e): Relative likelihood that a service seeker is enquiring after a LARC referral from 1800 My Options for selected characteristics — 1 March 2018 to 31 December 2023

Service Seeker Characteristic	Odds ratio	95% CI	P-value
Overseas-born citizen (Anglosphere) compared with Australian-born citizen	1.42	1.01 – 1.91	<0.05
Overseas-born citizen (non-Anglosphere) compared with Australian-born citizen	0.64	0.51 – 0.78	<0.05
Short-term resident compared with Australian-born citizen	0.72	0.55 – 0.93	<0.05
Under 35 compared with 35 and over	0.81	0.68 – 0.98	<0.05
Metro high disadvantage compared with metro low disadvantage	0.77	0.65 – 0.91	<0.05
Regional low disadvantage compared with metro low disadvantage	0.46	0.31 – 0.65	<0.05
Regional high disadvantage compared with metro low disadvantage	0.33	0.20 – 0.51	<0.05

Overseas-born service seekers

Anglosphere countries have higher IUD use than Australia as well as more supportive policies to remove barriers to access. For example, the United Kingdom provides primary care incentives to provide LARC information (Mazza 2017). Consequently, it is not surprising that service seekers from Anglosphere countries were more likely to be contacting the service about LARC referrals compared with Australian-born service seekers. Presumably migrants to Australia will prefer to continue the contraception method they used in their home country.

In contrast, service seekers born in non-Anglosphere countries were less likely to be contacting 1800 My Options about LARCs compared with service seekers born in Australia. The Multicultural Centre for Women's Health (MCWH) has previously cited a lack of culturally appropriate in-language information, a lack of guidelines for health practitioners on culturally safe practice, and the upfront cost as major barriers to LARC uptake (MCWH 2022).

A recent research study conducted by the SPHERE Centre for Research and Excellence at Monash University showed that informational resources such as an online in-language video, co-designed with young, non-Anglosphere women, was effective at increasing contraceptive knowledge, preference for and uptake of LARCs among women from this group (Mazza 2024).

Short term residents

LARC access is likely to be particularly challenging for short-term residents who cannot access Medicare to assist with LARC insertion fees or the PBS to assist with device costs. MCWH has called for "access to free or lower cost contraception, and a wider range of contraceptive options to be widely available to everyone, regardless of visa category" (MCWH 2022).

Younger service seekers

Over the past ten years the highest rates of increase of IUD uptake in Australia have been among the 35- to 44-year age group. Given the majority of 1800 My Options LARC seekers were interested in IUDs, it makes sense that service seekers over 35 years of age had a higher likelihood of calling to enquire about LARC referrals (Grzeskowiak 2024).

Living in a regional and rural or high disadvantage area

The combined challenges of provider access in regional and rural areas, and high upfront costs have been addressed elsewhere in this report.

1800 My Options LARC providers

Of providers listed on 31 December 2023, 461 practitioners, 73 pharmacies and 15 hospitals listed at least one LARC service with 1800 My Options.

Table 6(f) provides a breakdown by service type and provision. Hormonal implants were the most commonly listed LARC service.

An analysis of service gaps – those LGAs with no listed LARC providers – was also undertaken (Table 6(g)). Only about half of all regional and rural LGAs had any LARC dispensing pharmacies listed on 1800 My Options. More than a quarter of regional and rural high disadvantage LGAs did not have IUD or hormonal implant service providers listed.

Supply-side challenges to LARC service provision: a lack of trained professionals

In Victoria, both doctors and nurse practitioners can prescribe and insert hormonal implants and IUDs, where they have undertaken additional training to do so. However, a lack of incentives to undertake training has resulted in a low number of providers, and hence of service availability.

There are limited number of places available for skills-based training in IUD and hormonal implant provision in community settings (RACGP 2022). While there are no-cost training programs for hormonal implant training at the Royal Women's Hospital, this is not the case for IUD insertion, and training to become an IUD provider can prove expensive.

Table 6(f): LARC providers registered with 1800 My Options by area and provider type as at 31 December 2023

Provider description	Listed services	Metro	Regional	Total
Practitioner and hospital	Hormonal implant	328	134	462
	IUD	237	114	341
	Contraceptive injection	213	75	288
Pharmacist	Hormonal implant	42	31	73
	IUD	41	31	72
	Contraceptive injection	26	23	49

It has also been suggested that MBS rebates for LARC insertion and removal, particularly for IUD insertion and removal, are insufficient to cover the costs of the service (Heaney 2024). The Federal Government has recognised this challenge and is currently undertaking a gender bias audit into rebates for insertion and removal of LARCs, diagnostic imaging and ultrasounds, to better understand these barriers.

Demand -side challenges to LARC service provision

Several demand-side drivers have been identified that are likely to influence decisions around LARC options.

Primary care provider influence

Many primary care providers still recommend the oral contraceptive pill as first-line contraception. This is likely more common among providers who are not trained in LARC insertion and removal and are less familiar with these methods. Some providers may also have misconceptions about LARCs.

The *Tell Your Story* report (WHG 2024) sheds light on how GP influence shapes decisions. For example, one participant who was interested in an IUD was warned off by her provider:

Table 6(g): Number of LGAs without service by spatial disadvantage grouping as at 31 December 2023

LGA group without service	Metropolitan low disadvantage LGAs	Metropolitan high disadvantage LGAs	Regional low disadvantage LGAs	Regional high disadvantage LGAs	Total LGAs without service
Provider and hospital gaps					
Hormonal implant	-	-	2 (8%)	6 (25%)	8 (10%)
IUD insertion	-	-	2 (8%)	7 (29%)	9 (11%)
Contraceptive injection	-	-	7 (9%)	10 (42%)	17 (35%)
Pharmacy gaps					
Hormonal injection	2 (13%)	3 (19%)	11 (46%)	12 (50%)	28 (35%)
IUD device	2 (13%)	3 (19%)	11 (46%)	12 (50%)	28 (35%)
Hormonal implant	5 (33%)	7 (44%)	14 (58%)	15 (63%)	41 (52%)
Total LGAs in socio-spatial group	15	16	24	24	79

"Recently I inquired about going off the pill and getting an IUD inserted. My GP was very dismissive and said it's risky. He suggested I just go off contraception all together (this is not an option for me, as I do not want to risk an unplanned pregnancy). He did not provide any other contraceptive options or advice."

– *Tell Your Story* participant from Ballarat

Concerns about pain

Many people have concerns around pain associated with LARCs, particularly IUD insertion. Two participants in the *Tell Your Story* study indicated that their providers either minimised or did not cater to their concerns about possible pelvic pain.

"I didn't go ahead with getting an IUD. I was worried about the pain, my doctor doesn't offer anaesthetic for IUD insertion."

– *Tell Your Story* participant from Ballarat

High upfront costs and lack of provider appointments

The high upfront cost of LARC options, and challenges associated with finding local providers and travelling to providers remain major practical barriers.

"After my last child I wanted an IUD ASAP, but the waitlist at Bendigo hospital was over a year. With little faith in my local GP I decided I would have to access it privately in Melbourne. I've had the initial consultation but getting back to Melbourne for the procedure has been really difficult to schedule."

– *Tell Your Story* participant from Bendigo

Lack of tailored education and information

There is generally low community awareness of LARC options, coupled with poor information or misinformation about costs and benefits. Education and information provision across a range of traditional and technology-based platforms is important to addressing this information gap. Such information will need to be tailored to the needs of different ages and communities.

Recommendations

For Government

Victorian and Australian Governments

6.1 Make a range of contraceptive options, including LARC options, available at low or no cost to people at risk of pregnancy, regardless of visa status.

6.2 Fund research into factors influencing contraceptive decision making, so that avenues for providing information, and combatting disinformation can be better identified, particularly in relation to priority populations.

Victorian Government

6.3 Develop information tools that can assist practitioners in providing information about contraceptive options, including LARC, in a comprehensive manner, and which fully address patient concerns about the risk of pelvic pain.

6.4 Provide incentives for practitioners to provide LARC information to patients alongside information about the oral contraceptive pill.

6.5 Increase availability of skills-based training in community settings to enable more health practitioners – nurse practitioners, GPs and trainees – to train in LARC insertion and removal.

6.6 Expand financial support and provide incentives for health providers to attend training and travel for LARC insertion and removal.

Australian Government

6.7 Increase MBS payments for LARC insertion and removal, in line with any recommendations that emerge from the gender audit of the MBS.

Appendices

Appendix 1

Women's Health Services qualitative survey – Understanding SRH service demand and provision in Victoria's WHS regions: 2017 – present

1. Name

2. WHS

3. Position

4. Email address

5. Does your WHS have a SRH plan? If yes, please provide a copy via email.

6. Have there been any major shifts in SRH services sought by different cohorts in your region since 2017? If yes, please describe.

7. Have there been any major shifts in SRH services being provided in your region since 2017? If yes, please describe.

8. What are the barriers to SRH provision in your region? Please note any that are unique to your region.

9. To the best of your knowledge, are there any service-specific barriers / vulnerabilities as per the services listed below? Please describe.

- Surgical abortion
- Medical abortion
- Hormonal IUD
- Hormonal Implant

10. What are the enablers of SRH provision in your region? Please note any that are unique to your region.

11. Are there any changes to policies that have enabled or hindered service access in your region, particularly as they related to changes implemented during the COVID-19 pandemic?

12. Are there any clinical communities of practice in your region?

Appendix 2

Victorian Local Government Areas by region and spatial-disadvantage group

LGA	Regional / Metro	WHSN region	IRSD Score	Spatial disadvantage group
Alpine	Regional	Hume	1028	Regional – low disadvantage
Ararat	Regional	Grampians	955	Regional – high disadvantage
Ballarat	Regional	Grampians	986	Regional – low disadvantage
Banyule	Metro	Metro North	1058	Metro – low disadvantage
Bass Coast	Regional	Gippsland	993	Regional – low disadvantage
Baw Baw	Regional	Gippsland	1003	Regional – low disadvantage
Bayside	Metro	Metro South East	1090	Metro – low disadvantage
Benalla	Regional	Hume	968	Regional – high disadvantage
Boroondara	Metro	Metro East	1090	Metro – low disadvantage
Brimbank	Metro	Metro West	912	Metro – high disadvantage
Buloke	Regional	Loddon Mallee	975	Regional – high disadvantage
Campaspe	Regional	Loddon Mallee	965	Regional – high disadvantage
Cardinia	Metro	Metro South East	1021	Metro – high disadvantage
Casey	Metro	Metro South East	995	Metro – high disadvantage
Central Goldfields	Regional	Loddon Mallee	898	Regional – high disadvantage
Colac-Otway	Regional	Barwon South West	973	Regional – high disadvantage
Corangamite	Regional	Barwon South West	985	Regional – high disadvantage
Darebin	Metro	Metro North	1018	Metro – high disadvantage
East Gippsland	Regional	Gippsland	963	Regional – high disadvantage
Frankston	Metro	Metro South East	1003	Metro – high disadvantage
Gannawarra	Regional	Loddon Mallee	952	Regional – high disadvantage
Glen Eira	Metro	Metro South East	1075	Metro – low disadvantage
Glenelg	Regional	Barwon South West	952	Regional – high disadvantage
Golden Plains	Regional	Grampians	1040	Regional – low disadvantage
Greater Bendigo	Regional	Loddon Mallee	985	Regional – high disadvantage
Greater Dandenong	Metro	Metro South East	887	Metro – high disadvantage
Greater Geelong	Regional	Barwon South West	1007	Regional – low disadvantage
Greater Shepparton	Regional	Hume	944	Regional – high disadvantage

LGA	Regional / Metro	WHSN region	IRSD Score	Spatial disadvantage group
Hepburn	Regional	Grampians	1006	Regional – low disadvantage
Hindmarsh	Regional	Grampians	940	Regional – high disadvantage
Hobsons Bay	Metro	Metro West	1021	Metro – high disadvantage
Horsham	Regional	Grampians	990	Regional – low disadvantage
Hume	Metro	Metro North	941	Metro – high disadvantage
Indigo	Regional	Hume	1029	Regional – low disadvantage
Kingston	Metro	Metro South East	1044	Metro – low disadvantage
Knox	Metro	Metro East	1042	Metro – low disadvantage
Latrobe	Regional	Gippsland	931	Regional – high disadvantage
Loddon	Regional	Loddon Mallee	948	Regional – high disadvantage
Macedon Ranges	Regional	Loddon Mallee	1063	Regional – low disadvantage
Manningham	Metro	Metro East	1056	Metro – low disadvantage
Mansfield	Regional	Hume	1028	Regional – low disadvantage
Maribyrnong	Metro	Metro West	1010	Metro – high disadvantage
Maroondah	Metro	Metro East	1041	Metro – low disadvantage
Melbourne	Metro	Metro West	1017	Metro – high disadvantage
Melton	Metro	Metro West	985	Metro – high disadvantage
Merri-bek	Metro	Metro North	1027	Metro – high disadvantage
Mildura	Regional	Loddon Mallee	940	Regional – high disadvantage
Mitchell	Regional	Hume	1000	Regional – low disadvantage
Moira	Regional	Hume	958	Regional – high disadvantage
Monash	Metro	Metro East	1042	Metro – low disadvantage
Moonee Valley	Metro	Metro West	1041	Metro – high disadvantage
Moorabool	Regional	Grampians	1017	Regional – low disadvantage
Mornington Peninsula	Metro	Metro South East	1038	Metro – high disadvantage
Mount Alexander	Regional	Loddon Mallee	1007	Regional – low disadvantage
Moyne	Regional	Barwon South West	1029	Regional – low disadvantage
Murrindindi	Regional	Hume	1005	Regional – low disadvantage
Nillumbik	Metro	Metro North	1093	Metro – low disadvantage
Northern Grampians	Regional	Grampians	951	Regional – high disadvantage
Port Phillip	Metro	Metro South East	1061	Metro – low disadvantage
Pyrenees	Regional	Grampians	959	Regional – high disadvantage
Queenscliff	Regional	Barwon South West	1082	Regional – low disadvantage
South Gippsland	Regional	Gippsland	1003	Regional – low disadvantage

LGA	Regional / Metro	WHSN region	IRSD Score	Spatial disadvantage group
Southern Grampians	Regional	Barwon South West	994	Regional – low disadvantage
Stonnington	Metro	Metro South East	1084	Metro – low disadvantage
Strathbogie	Regional	Hume	982	Regional – high disadvantage
Surf Coast	Regional	Barwon South West	1086	Regional – low disadvantage
Swan Hill	Regional	Loddon Mallee	941	Regional – high disadvantage
Towong	Regional	Hume	1001	Regional – low disadvantage
Wangaratta	Regional	Hume	988	Regional – low disadvantage
Warrnambool	Regional	Barwon South West	995	Regional – low disadvantage
Wellington	Regional	Gippsland	973	Regional – high disadvantage
West Wimmera	Regional	Grampians	991	Regional – low disadvantage
Whitehorse	Metro	Metro East	1043	Metro – low disadvantage
Whittlesea	Metro	Metro North	990	Metro – high disadvantage
Wodonga	Regional	Hume	973	Regional – high disadvantage
Wyndham	Metro	Metro West	1006	Metro – high disadvantage
Yarra	Metro	Metro North	1046	Metro – low disadvantage
Yarra Ranges	Metro	Metro East	1041	Metro – low disadvantage
Yarriambiack	Regional	Grampians	946	Regional – high disadvantage

Appendix 3

Service seeker challenges by population group

Table 3.1 Challenges raised by regional vs metropolitan service seekers

Challenge	Regional	Metro	Unknown	Total
Financial insecurity	29% (1088)	30.7% (6775)	8.6% (388)	27.2% (8251)
Geographic access	20.7% (776)	0.3% (69)	2.2% (98)	3.1% (943)
Mental illness	14.8% (554)	11.6% (2567)	5.5% (250)	11.1% (3371)
Complex medical	9.2% (347)	8.3% (1821)	3.3% (148)	7.6% (2316)
Family violence	7.9% (296)	6.3% (1393)	3.6% (164)	6.1% (1853)
Advanced gestation	6.3% (237)	3.9% (854)	7.4% (334)	4.7% (1425)
Sexual assault	0.8% (30)	0.6% (138)	0.7% (32)	0.7% (200)

Table 3.2 Challenges raised by service seekers aged under 18 vs over 18 years

Challenge/ context	Under 18	18 and over	Unknown	Total
Financial insecurity	33.8% (333)	30.4% (7649)	6.4% (269)	27.2% (8251)
Mental illness	14.4% (142)	12.4% (3106)	2.9% (123)	11.1% (3371)
Advanced gestation	6.6% (65)	4.7% (1188)	4.1% (172)	4.7% (1425)
Family violence	6.3% (62)	6.7% (1692)	2.3% (99)	6.1% (1853)
Geographic access	5.6% (55)	3.3% (825)	1.5% (63)	3.1% (943)
Sexual assault	3.5% (34)	0.6% (151)	0.4% (15)	0.7% (200)
Complex medical	2.6% (26)	8.7% (2196)	2.2% (94)	7.6% (2316)

Table 3.3 Challenges raised by service seekers according to country of birth and residency status

Challenge	Overseas-born citizen or resident	Temporary resident	Australian-born citizen or resident	Unknown	Total
Financial insecurity	32.1% (1629)	13.3% (363)	40.1% (5025)	12.3% (1234)	27.2% (8251)
Complex medical	9.3% (474)	1.8% (48)	11.3% (1416)	3.8% (378)	7.6% (2316)
Mental illness	6.2% (313)	1.2% (32)	18.5% (2313)	7.1% (713)	11.1% (3371)
Advanced gestation	6% (304)	3.1% (85)	4.6% (570)	4.7% (466)	4.7% (1425)
Family violence	4.8% (242)	1.4% (38)	8.8% (1106)	4.7% (467)	6.1% (1853)
Geographic access	1.1% (57)	1.1% (29)	5.6% (702)	1.5% (155)	3.1% (943)
Sexual assault	0.3% (15)	0.2% (6)	0.8% (97)	0.8% (82)	0.7% (200)

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WHV acknowledges the
support of the Victorian Government

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