Sexual & Reproductive Healthcare 15 (2018) 23–27

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

Australian women's experiences of a rural medical termination of pregnancy service: A qualitative study

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Introduction

Medical termination of pregnancy (MToP) has been shown to be safe, highly effective and acceptable to women [1]. It involves the use of two medications, mifepristone and misoprostol, to induce an abortion in women within the first and second trimesters of pregnancy [2,3]. This abortion option is becoming increasingly used globally, particularly as it can be safely and effectively administered by mid-level non-physician healthcare providers including nurses, midwives, and physician assistants [4,5].

In the Australian context, MToP has been available since 2012 for use within the first 63 days of pregnancy [6]. Despite medication availability, ease of administration, and women's acceptance of MToP, service provision is limited [1,7]. Currently, abortion is legal in three jurisdictions in Australia with inconsistent abortion legislation nationwide [8]. In 2015 there were only 663 certified prescribers of mifepristone in Australia, not all of whom may be actively prescribing [6]. MToP delivered through public services is limited to a small number of facilities, with few of these outside urban locations [9]. As a result, most women rely on private providers, incurring substantial out-of-pocket costs, despite the process being less invasive than surgical abortion and able to be completed in a home environment [9].

From the rural service system perspective, abortion provision is hindered by providers' professional and personal concerns about stigma, limited trained personnel, and suitable locum replacements [7,10,11]. From the rural service user perspective, access to abortion is affected by a lack of local services, long travel distances, and stigma [12–16]. There are few qualitative studies that explore MToP service system processes from the perspectives of rural women who already experience inequity in relation to reproductive healthcare service access [15–18].

In light of calls for understanding and utilising effective models of abortion provision [7], this study was undertaken to explore which aspects of a rural MToP service system, from seeking advice to abortion completion, worked well, and what could be improved. The aim of better understanding rural women's experiences in obtaining a MToP was to produce pragmatic evidence that could help to improve current rural MToP service provision.

Methods

Study setting

Gateway Health is a public sector primary healthcare service, employing over 300 staff, located in northeast Victoria, Australia. The service provides a range of medical, social and health promotion services to people with highest risk of poor health outcomes. Gateway Health established a sexual health clinic in 2010. The model of care implemented to provide MToP at the clinic is nurse-led with general practitioner (GP) support. In 2014, the clinic began providing MToP for the cost of a single Pharmaceutical Benefits Scheme (PBS) prescription. The GP appointments are bulk-billed, meaning there are no out-of-pocket expenses apart from the ultrasound scan and the medication. The MToP provider at Gateway Health made this decision to ensure that access to MToP is not restricted by extraneous costs. The clinic has adopted a two-appointment policy for women seeking MToP, however there are situations where medication for MToP is prescribed in a single consultation. This is usually when the woman needs to travel a significant distance or the pregnancy is close to 63 days gestation. In such cases women undertake a telephone consultation with the nurse and complete all required investigations prior to attending the clinic. Appointments occur with the nurse and are double-booked as a consultation with the prescribing GP. At the time that the study was conducted, Gateway Health was the only service providing bulk-billed MToP in northeast Victoria.

Participant recruitment, interviews, and data analysis

Women aged 16 years and over who attended the clinic between February 2016 and 2017 for an appointment related to MToP were

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https://doi.org/10.1016/j.srhc.2017.11.008
Received 27 July 2017; Received in revised form 10 November 2017; Accepted 20 November 2017

invited to participate in the study by a clinic nurse. Participants were provided with information about the research and asked if they agreed to be contacted by a member of the research team six weeks or later from the date of the abortion. Details for women who agreed to be contacted were provided to the research team.

The interview guide questions focused on women's experiences throughout the process of pregnancy confirmation to MToP including experiences at the clinic; having an ultrasound and obtaining medication; easy and difficult aspects of accessing MToP including cost, transport, travel distance, support from family, friends or partner; confidentiality or privacy concerns; experiences of stigma; most important aspects regarding the services available, and suggestions for improvement. Some demographic data about participants was also collected.

Interviews were conducted by AHC who holds a doctor of philosophy and is not connected to service provision at Gateway Health. Interviews were audio recorded and transcribed. Whilst Gateway Health is identified with permission in this paper, participants are not identified in any research outputs.

Data analysis was iterative and commenced upon completion of the first interview. QSR NVivo (version 10) qualitative software was used to organise and code data using an inductive analysis approach [19]. The interview schedule formed a framework by which initial themes were identified; however new themes that emerged within this framework were also captured. Related themes were then allocated to broader categories involving either aspects of MToP service system delivery or personal details of participants' life circumstances. When the number of interview participants reached 16, one third of interview transcripts were randomly selected and coded separately by JT and MTS. At this point the team agreed that data saturation had been reached, however a further two women were interviewed as they had already agreed to participate. These interviews reflected themes already identified and no new themes emerged. The research team then notified the clinic to cease inviting potential participants. Themes and interpretations were compared and discussed with some categories refined by AHC in terms of language or wording. All authors agreed upon final interpretations of the data. Ethical approval for the study was obtained from The University of Melbourne (1646750).

In total, 59 women agreed to be contacted. Upon contact, 19 declined to participate, 22 did not respond to a maximum three episodes of contact, and 18 agreed to participate in a telephone interview lasting between 15 and 25 min. Telephone interviews were chosen based on the experience of previous researchers who found that women discussing abortion preferred telephone interviews because they provided a degree of anonymity [20]. Further, it has been noted that it may be easier to disclose sensitive information when not having to speak with a stranger in person [21].

Results

Semi-structured interviews were conducted with 18 women between November 2016 and April 2017. All participants lived in a rural location in Australia and ranged in age from 16 to 36 years, with the median age being 25 years. Self-reported gestation at time of termination ranged from five to nine weeks. Distances travelled to the clinic ranged from 10 to 468 km return trips. Table 1 provides further detail about interview participants.

Overall, our study found that women were very satisfied with care received from clinic staff in terms of accessing MToP. However, care from other professionals associated with the MToP process, such as GPs, sonographers, and pharmacy staff, varied from being helpful to distressing experiences. The study results are presented in relation to the four key components of accessing MToP that were described by women: (i) finding a rural MToP service and making an appointment; (ii) interactions with clinic staff; (iii) interactions with health professionals at services associated with the MToP process; and (iv) most important aspects of the MToP service system and suggestions for service improvements.

Finding a rural MToP service and making an appointment

All women interviewed had thought considerably about abortion and were confident in their decision. A number of women commented, unprompted, on how the decision was based on family circumstances or readiness for children:

> *…it's a very hard decision, but it was best for what I've got at home at the moment.* (Participant #2, age 25)

Most women reported limited knowledge of MToP before seeking abortion options and many women learned about MToP through searching the internet:

> *I hadn't really heard anything about it [MToP], but I obviously turned to the internet like most people do and Googled what my options were and thought that was more fitting for me.* (Participant #10, age 26)

Many women had not heard about the clinic prior to attending for MToP. Most said they received the contact details when they went to a GP to confirm the pregnancy or to seek referral to an abortion service. Others reported making numerous phone calls to a range of services, including surgical abortion clinics, before finding the clinic. A small number of women found the clinic themselves via the internet, however some of these women said it took quite a lot of searching. Most women who called Gateway Health reported that it was a straightforward experience to obtain an appointment. Other women reported that their GP made the appointment for them:

> *…she [GP] called up Gateway and booked an appointment and then just let me know what time it was and I just attended that appointment.* (Participant #9, age 21)

Almost all women said they were able to obtain an appointment with the clinic within a week. No one felt this was too long to wait. Most reported that clinic reception staff were helpful and no one described experiencing any stigma in asking for an appointment related to MToP.

Women's reasons for choosing MToP in preference to surgical termination varied greatly but the most common responses highlighted the convenience and flexibility of MToP and the ability to time it around work and life commitments; the less invasive nature of the process; and that the clinic was the closest location providing MToP outside of urban areas. Although surgical termination was available close by in the neighbouring regional city, women's reasons for not using this service included cost, limited appointment availability, and avoiding protestors who picketed the facility.

Interactions with clinic staff

All women described very positive experiences with the clinic nurses. Women said that their questions about the MToP process, particularly in relation to the differences between MToP and surgical termination, were answered. The nurses were described as non-judgmental, approachable and friendly. Information provided in the consultation was described as informative, realistic and, for a number of women who had anticipated feeling stigmatised, the experience not as distressing as expected.

> *To be honest I was a bit concerned that I was going to be judged…So I was panicking…[clinic nurse] was actually really good. I didn't even have any questions; she answered everything and then went back over everything for me…It was already a hard-enough decision and I was thinking I was going to make it worse going in there, but no, when I came out I was a lot more relieved with the decision coming out than when I was going in.* (Participant #12, age 28)