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Providing accessible medical abortion services in a Victorian rural community: A description and audit of service delivery and contraception follow up

Jane E. Tomnay[a,*], Lauren Coelli[b], Ange Davidson[b], Alana Hulme-Chambers[a], Catherine Orr[b], Jane S. Hocking[c]

[a] Centre for Excellence in Rural Sexual Health (CERSH), University of Melbourne, Department of Rural Health, 49 Graham Street, Shepparton, VIC 3630, Australia
[b] Clinic 35, Gateway Health Wodonga, 155 High Street, Wodonga, VIC 3690, Australia
[c] University of Melbourne, School of Global and Population Health, 235 Bouverie Street, Carlton, VIC 3053, Australia

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ABSTRACT

Objective: To describe how a nurse led, MToP service is run in primary care in regional Victoria and investigate the characteristics and contraceptive choices of the women who have attended.
Study design: Descriptive study of the development and implementation of a rural MToP service and a retrospective chart audit of patients attending between January 2015 and September 2016.
Main outcome measures: Characteristics and clinical outcomes for women attending an MToP service in a primary care setting in rural Victoria.

Contraceptive usage pre and post attending a rural service for MToP.
Results: There were 229 presentations, representing 223 women, of which 172 women (75.1%; 95%CI: 69.0%, 80.6%) had a successful MToP and for two further women, MToP failed, requiring a surgical termination (0.9%; 95%CI: 0.1%, 3.1%). At the time of presentation, the mean age of women was 25 years, the median length of gestation was 49 days and 171 (75%) had not had a previous termination. Data about contraceptive use was available for 195 women, 143 (73.3%) reported no contraception, 2 reported emergency contraceptive pill (1.0%), 10 used condoms (2.1%) and 39 (20.0%) reported hormonal contraception. Among the 156 women using no contraception, condoms or emergency contraception at the time of pregnancy, 113 (72.4%) initiated a reliable form of contraception post presentation to the MToP service.
Conclusion: Provision of accessible, affordable MToP through an integrated primary health service is one strategy to address access inequity in regional areas.

Introduction

Access to abortion services is an important health issue for Australian women. In 2008, abortion was removed from the crimes act in Victoria and the Abortion Law Reform Act was passed to ensure that the choice to have an abortion, up to 24-weeks' gestation, became the decision of the woman in consultation with a health professional [1]. The combination of medications mifepristone and misoprostol have been used for medical termination of pregnancy (MToP) in over 46 countries, including the United Kingdom, United States, New Zealand, China and Europe [3] since 1988. However, these medications have only been approved for use in Australia since 2012 for termination of early pregnancy (initially up to 49 days then revised up to 63 days gestation) [2]. They were added to the Commonwealth Pharmaceutical Benefits Scheme as a subsidized medicine in 2013, thereby allowing widespread use.

Women living in rural areas of Australia have been at considerable disadvantage with respect to access to pregnancy termination services [4–6]. Given the extensive use of MToP throughout the developed world, the lack of affordable access to abortion services for rural Australian women deserves particular attention [4], specifically issues related to geographical [5] and financial access [6]. Doran and Hornibrook (2014) found that the main barrier rural Australian women experienced in accessing abortion services was travelling relatively long distances because of lack of services in their local area. Also, rural women who were experiencing financial restraints needed to borrow

* Corresponding author at: Centre for Excellence in Rural Sexual Health, Department of Rural Health, University of Melbourne, 49 Graham Street, Shepparton, Victoria 3055, Australia.
E-mail addresses: jtomnay@unimelb.edu.au (J.E. Tomnay), Lauren.Coelli@gatewayhealth.org.au (L. Coelli), Andrea.Davidson@gatewayhealth.org.au (A. Davidson), alana.hulme@unimelb.edu.au (A. Hulme-Chambers), Catherine.Orr@gatewayhealth.org.au (C. Orr), j.hocking@unimelb.edu.au (J.S. Hocking).

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money for the procedure and associated costs of travel and accommodation [4]. A review by Dawson and colleagues in 2016, aimed at improving access to abortion services in Australia, found that the key elements for improving access were the establishment of standards, provision of choice of procedure, improved provider education and training and the expansion of telemedicine for medical abortion [7]. With these factors in mind, a group of Victorian regional health professionals, in partnership with the Early Pregnancy Service at the Royal Women's Hospital Melbourne, planned and subsequently delivered an affordable, accessible MToP service in regional Victoria, through an existing sexual health service.

The sexual health clinic at Gateway Health Wodonga uses an integrated service model and is located in a large rural primary healthcare setting. It provides flexible access to free clinical service delivery five days a week that is targeted towards young people, and priority populations; including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, sex workers, men who have sex with men, travellers and mobile workforce and people in custodial settings. An MToP service was planned throughout 2014 and established in January 2015, with particular emphasis on ensuring flexibility, affordability, and an integrated approach.

Objective

We describe here how this clinic was set up and present data obtained through a clinical audit of patient's charts of the first 19 months of operation, including describing the patients consulted and the outcome of their consultations including uptake of MToP and contraception use before and after attending the service.

Methods

Description of the MToP clinical service

For the twelve months leading up to the commencement of the MToP service, Gateway Health, in partnership with the Centre for Excellence in Rural Sexual Health (CERSH), undertook extensive local stakeholder engagement. Stakeholders included local radiology providers, local pharmacies, specialist gynaecologists, local emergency department staff, and the Primary Health Network (PHN). The engagement process included meeting to discuss Gateway's intention to provide an MToP service and to seek input into the development and establishment of local MToP procedures and protocols. This ensured women experiencing unplanned pregnancy would receive a consistent message during every step of MToP provision in this rural community. These relationships are ongoing and have proved important to the evolution of the MToP Model. Prior to commencing the MToP service in 2015, Gateway Health provided referral for women to a local New South Wales (private) and metropolitan based (public and private) services, for surgical or medical termination of pregnancies.

The MToP service at Gateway Health uses a nurse-led with general practitioner (GP) support integrated model of care. Women enter the service by self-referral or GP referral. Women contact the service either via telephone or in person to the reception of Gateway Health. Reception staff at Gateway Health undertook specific training to ensure an understanding of the sensitive and time critical nature of the MToP booking process. Reception staff provide women with necessary information related to appointments, and investigations that may be undertaken prior to attending Gateway Health. Reception staff do not discuss the MToP itself, and if prompted for more information, the nurse is asked to contact the woman directly via the phone. Gateway Health have adopted a two appointment policy for women seeking MToP, however, there are situations where MToP is prescribed in a single consultation, particularly if the woman is travelling a long distance to attend the service. In this instance, the women will undertake a telephone consultation with the nurse, and complete all required investigations prior to attending the clinic.

All appointments take place with the nurse, and are double booked with the prescribing GP. The GP appointments are bulk-billed, thus there are no 'out of pocket' costs to the woman unless the woman isn't eligible for Medicare, in which circumstance she will pay approximately 500 AUD in total. At the first consultation, the nurse initiates a non-directive pregnancy options discussion; makes an assessment to determine MToP eligibility; organises investigations to be ordered by the prescribing GP if not already undertaken; provides information regarding post termination contraceptive options; and provides information about MToP both verbally and in writing. Investigations that may be required depending on history and circumstances include a pelvic ultrasound to confirm intrauterine pregnancy; self-collected high vaginal swabs for microscopy, culture and sensitivity, and Chlamydia testing; venepuncture for full blood count, iron studies, blood group and antibodies and a quantitative human chorionic gonadotropin (QBHCG). At the conclusion of the initial consultation, the nurse will schedule one further appointment, double booked with the prescribing GP, at a time when all pathology and ultrasound results are available.

At the second consultation, the nurse reviews investigations, and confirms that the woman still wants to go ahead with MToP. If the woman declines MToP, further non-directive pregnancy options counselling is undertaken and appropriate referrals are made. If the decision is made to pursue MToP and no ambivalence is noted, the nurse fully explains the two-step MToP procedure again, and a consent form is signed. At the conclusion of the second consultation, the nurse informs the prescribing GP that the woman is ready to be prescribed MToP. The GP then confirms the woman's eligibility, including whether she is providing informed voluntary consent, that the pregnancy is intrauterine and no more than 9 weeks (63 days) gestation, that there are no medical contra-indications to MToP, and finally that she is able to access a hospital emergency department should urgent medical attention be required. If these criteria are fulfilled, the GP provides the woman with a single PBS prescription for MToP, and further scripts for contraception of her choice, analgesia, and an anti-emetic. The GP explains the MToP process once more to the woman and provides medical certificates if required.

The woman then takes the script to be filled at a local pharmacy, where the first dose of Mifepristone 200 mg is taken, witnessed by the pharmacist. The pharmacy dispenses the second dose, Misoprostol 800mcg, to be taken at home 36–48 h later. The nurse also provides the woman with a letter to the dispensing pharmacy that includes a 'do not dispense after this date' (the 63 day gestation date) and a fax-back form alerting Gateway Health when the first step of MToP is completed. The nurse also provides a letter to the emergency department to be used should urgent medical attention be required; and if Rhesus negative, another letter is provided and the woman is asked to present to the local emergency department for anti-D immunoglobulin administration within 72 h of bleeding. If the woman does not live close to Gateway Health, the nurse phones their closest local emergency department to confirm anti-D availability and the process involved for administration. The woman is also provided with contact details for both Gateway Health and the MS Health 24 h Nurse After-care Telephone Service.

While cramping and bleeding are expected as part of ending a pregnancy, rarely serious and potentially life threatening adverse effects can occur following an MToP. Gateway Health staff encourage patients to seek urgent medical attention for any of the following circumstances:

- Heavy vaginal bleeding (soaking two or more sanitary pads per hour for two consecutive hours or have large fist sized clots).
- Prolonged heavy bleeding or severe cramping. It is expected that, on average, bleeding will occur for 10–16 days.
- Cramping which is not improved by pain relief medication.
- Fever, chills or malaise lasting six hours or more.
- Any abnormal vaginal discharge.