Too Much Hush Hush! Rural women tell their stories about access to abortion services

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Introduction

Little is known about Australian rural women's overall experiences of accessing an abortion service and the barriers they encounter despite the fact that around one in three Australian women (1) seek an abortion at some stage in their lives: approximately 80,000 women per year. Both surgial and medication abortion are both low risk medical procedures (2). Most abortions are performed in private clinics (3), not public hospitals. Women pay a fee for a service with a complicated Medicare and medical rebate structure (1).

Often rural women need to travel long distances, sometimes interstate (3, 4) away from home (5) to access private clinics. As there is a higher proportion of rural women on low incomes compared to their city counterparts, rural women have additional financial burdens to access essential reproductive health care.

Barriers to women's access to abortion include legal, social, religious barriers as well as stigma. Despite women's rights to access essential reproductive care, abortion remains a contentious topic, under-researched and under discussed. Until 2008 abortion was located within criminal law in all states and territories, except the Australian Capital Territory. Abortion was removed from the Crimes Act in Victoria in 2008 and in 2013 the Tasmania decriminalised abortion (6). Negatives attitudes and practices of doctors create obstacles for women seeking abortion and seem to persist despite Australian and international guidelines to not impede medical treatments because of personal moral objections. (The World Health Organization, 2012 Medical Board of Australia, 2010).

The medication abortion drug, Mifepristone was added to the Pharmaceutical Benefits Scheme (Australian Government: Department of Health and Ageing, 2013) in 2013, Despite hope that this would translate to a significant reduction in cost of medical abortions, increased availability and a way to reduce inequities in access to health care for rural women, this has not been achived. Mifepristone is limted in further limted because providers must become registered prescribers and pharmacies must be willing to dispense (7).

Whilst there are clear barriers such as geographical distance and lack of services in the local community, there is a paucity of research that explores women's experiences when they seek access to health care or of the barriers to care at a time of life crisis. A study was undertaken to begin to fill this knowledge gap. The aim was to identify factors that rural NSW women experience in accessing abortion services. To our knowledge this is the first study of its kind undertaken in Australia. It was part of a broader exploratory qualitative study that also aimed to identify the role of non-government community based women's health centres (WHC) in supporting rural women's access to abortion. A snapshot of key findings and methodology have been reported (5). Another article which reports women's stories in greater detail has been submitted for publication and is currently under review in the *Journal of Rural and Remote Health*. Consequently, only key points relevant to the presentation are discussed in this Paper in order to prevent overlap of publication content.

Methods

The research was approved by the Southern Cross University Human Ethics Committee, Ethics Consent Number 13-060, 2013. Rural women living in NSW, who had an abortion in the previous 15 years were eligible to participate in in-depth interviews undertaken either by phone or in person. Different recruitment strategies were used and interested women contacted the researcher. Informed consent was gained. Interviews lasted on average one hour explored women's experiences of seeking access to an abortion service.

Interviews were audio-recorded and transcribed. Thematic analysis was undertaken. Pseudonyms are used to report findings.

Results

Thirteen women participated in the study. Sixteen women contacted the researcher. Two were ineligible to participate as they were not from rural NSW and follow-up was not possible for another. Twelve women were interviewed via phone and one face-to-face. Women had an abortion five months to 15 years prior to interview, when aged between 18-46 years. Most women had one abortion. [See Doran & Hornibrook (2014) where demographics of all participants have been published (5)]. All women had a surgical abortion and many were unclear about choices for medical abortion.

Abortion clinics in Queensland, NSW and the Australian Capital Territory were accessed. All women had a surgical abortion in trimester one. Participants travelled between two to nine hours one-way to reach a clinic. Three women required overnight accommodation and five women required early morning child care. All except one woman used private transport to travel to the clinic. Five women borrowed money.

Themes

Five main themes emerged as indicated below. A summary of key points is presented for each theme with specific quotes selected to represent the women's stories.

1. Self-referral and doctors referrals
2. Stigma and silence
3. Logistics to access services
4. Medical/surgical abortions
5. More affordable, local and mainstream services

Self-referral and doctors referrals

Women found information about the abortion clinic by contacting the clinic directly after finding their own information or seeking a referral and information from their local doctor. Barriers included long waiting lists to see some GP's with a 3-6 weeks wait for appointments and some GP's close books on new patients. One doctor required 2 visits and 2 ultrasounds before referring. Some doctors were unwilling to refer but did not offer information that women could self-refer. One doctor advised a woman to have amniocentesis, even though she stated she wanted to have an abortion. One woman saw 5 doctors in a rural town, then had to take her husband with her to insist on a referral. One woman had good experience with woman GP.

- Kelly – doctor required her to have ultrasound before referring - "it was horrible - bizarre– they zoomed in and showed me (the ultrasound pictures). I had to wait for something to get bigger before I could terminate".
- Skye – went through the phone book to find a GP 'ticked them off, becoming more depressed with each rejection about a referral'. On the fifth appointment she asked her husband to accompany her, a big strappy man. She described her ordeal as "horrendous" and could not believe the "conservative" approach of GP's, particularly "Baptists" in her rural area
- June – didn't go to doctor and said "they'd probably give me a lecture anyway."

Stigma and silence

All women commented on the stigma surrounding abortion. Shame, fear and silence were other barriers women mentioned.

- Zilah – ''Out bush – there is still a lot of stigma about getting information in the first place and certainly something that is not talked about''.

- Clara – ''I think if women were really respected as free thinking individuals – people who were allowed to make decisions for themselves, then that stigma would not be as strong''.
- Fern – ''It was an eye opener when everyone I had disclosed to had also disclosed. It's not a general topic of conversation: it's all a bit hush though everybody does it, so to speak''.
- Clara – ''I thought it was wrong, it's hard to explain. I am absolutely pro-choice".

Logistics to access services

Logistics and expenses involved organising early morning departure, childcare, borrowing a car, seeking finance, asking a support person to drive to and from the clinic, overnight accommodation, petrol/train/airfare costs and taking time off work (for a woman and their support person).

- Elaine commented that for her, "money was already a problem".
- Mary commented that the abortion fee in itself "wasn't that much but it's all the associated costs".
- Clara who had previously an abortion in the city compared the city/ regional experience as "chalk and cheese" and was "gobsmacked" she had to travel "all that way to another state" where she felt "isolated" and "horrible" driving over that border.

Medical/surgical abortions

For some women medical abortion was not a feasible option because of logistics of returning to the clinic. Five women were unaware of an option for medical abortion. Two women did not want a surgical abortion and tried to induce their own abortions; one by taking herbs and another taking an increased dose of her contraceptive pill. Neither attempt was successful.

- Kelly stated "it was too hard to return to the clinic" (and) "I wanted it over and done with on one day".
- June - "no-one explained medical abortion," (she had 3 previous abortions)
- Kelly - found out about medical abortion by the "man on the phone at the abortion clinic, not the doctor".
- Zilah- ''I figured out if I had a whole sheet of a month's worth of the pill then it would be equal... so once or twice I've self-medicated to perform my own medical abortion."

More affordable, local and mainstream services

The main suggestions on how to improve women's access to an abortion service were for more affordable, local and mainstream services to reduce travel and cost. However, some women spoke of broader social barriers that need to be removed.

- Eliza expressed a need for "more broad public awareness and communication, rather than a taboo, 'under the carpet' topic".
- Fern – I don't think it's about women's welfare and women's rights and women's health that we have to do it the hard way – it's about moral, ethical, religious pressure that forces those things.

Discussion

The results of this study highlight how complicated it is for rural women to access essential reproductive health care.

Women in this study point to non-integrated health systems, as evidenced by sub-standard primary care where doctors do not readily refer, or do not provide accurate information about self-referral options. Doctors must follow the guidelines to practice as set out in the Medical Board of Australia Good Medical Practice Guide. The views of the minority of providers who object to abortion are out of

sync with the majority of the Australian community (8-10) who are pro-choice and support decriminalisation of abortion (11).

For women in this study access to medical abortion was hindered because it was too hard to return for a follow-up appointment and lack of knowledge of abortion options. Policies are needed to ensure that Mifepristone has the potential to be accessed by rural women at a significant cost reduction compared to surgical abortion. Tele-health and tele-medicine provide opportunities to increase the availability of service provision for rural women which need to be considered (12-14).

Abortion stigma is a complex issue that complicates initiatives aimed at improving access to abortion services. As stressed in the Australian Women's Health Network's ''Women and Sexual and Reproductive Health Position Paper'', a "rights based approach recognises women as the experts in their own lives" (2012). Abortion is a safe medical proceedure and rural women have a right to access appopropriate care, to information and referrals and to make decisions about their health care. These rights are recognised in international and national guidelines. Women's health care needs supportive and multi-disciplinary care to assist in good outcomes through significant life changes.

Recommendations

We support the following broad recommendations outlined within the Australian Women's Health Network Women and Sexual and Reproductive Health Position Paper (2012)(1).

- Abortion be decriminalised through law reform and laws that protect women's health and their human rights.
- Safe and legal abortion be accessible to all Australian women through the public health system and licensed private providers, based on health needs and human rights of women.
- Federal, state and territory governments address inequities in abortion service delivery to ensure women living in regional, rural and remote areas have timely access to affordable services.

In practice the following recommendations for health care provision and costs of medication are needed:

- Tele-health for information and awareness raising for rural health professionals;
- Tele-medicine to be developed to prescribe Mifepristone to rural women in a multi-disciplinary approach with nurses on site;
- Reduce cost of Mifepristone; more doctors to become prescribers; more pharmacies to become dispensers and to ensure training of providers for good quality care.

Conclusion

Rural women in this study experienced many barriers to accessing an essential health service for their unanticpated pregnancy. Women who are already isolated should not feel more isolated by barriers to medical care and attitudes that may affect real access.

Despite welcome legal and pharmaceutical reform in Australia, results from this study induicate that there is a long way to go "remove the hoops" and let go the "hush hush" on issues rural women experience in their process of accessing reproductive health care. Continued advocacy for policies that support women's reproductive health are needed to ensure rural women have access to appropriate, affordable, available and acceptable health care. They need services closer to home and non-judgemental care by health professionals at a time of crisis.

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Presenters

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