

“Country women are resilient but....”

Family Planning Access in Rural Victoria

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Abstract

Most women use family planning services during their reproductive lifetime, but many lack ready access to such services, particularly in a rural area. The aim of this study was to document and thus develop an understanding of the facilitators and barriers to accessing three types of family planning services (emergency contraception, termination of pregnancy, and options counselling) within a particular rural area of Victoria, Australia, and how these might affect women's psychosocial health and their ability to make timely decisions about continuation of a pregnancy. A feminist framework was adopted throughout the study, and qualitative methods were employed in the design. Eleven professionals whose current employment was connected to family planning service provision participated in semi-structured interviews that focussed on their perceptions and experiences of women's access to family planning services in the Grampians Region of Victoria. Findings from a thematic analysis confirmed that rural women face many barriers identified in past Australian and international research, including lack of local services, distance from metropolitan services, anonymity and confidentiality issues, and judgemental service providers. Further issues raised included the legal status of pregnancy termination, rural culture, gender relations, and family planning myths and misinformation. Women confronting these barriers were seen to experience negative psychosocial effects which can compromise timely decision-making. This study highlights the complexity of women's reproductive "choices", and includes recommendations for the design of plausible interventions and reproductive health promotion strategies to address the barriers identified and facilitate women's access to family planning services as a human right.

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Declaration

I, Julie Kruss declare that the Doctor of Applied Psychology (Community and Health) thesis entitled “Country women are resilient but...” Family Planning Access in Rural Victoria is no more than 40,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes.

This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma.

Except where otherwise indicated, this thesis is my own work.

Signature: [Insert signature]

Date: [Insert date]

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Chapter 1: Overview

The motivation for this research developed from when I became a volunteer phone support worker for the Victorian Women's Information and Referral Exchange (WIRE). It was there that I was first introduced to and had all my negative stereotypes of feminism challenged. What struck me about the work was that although "we" had claimed to have come so far in the fight for gender equality, we still had much more work to do; so few people (including myself) were aware of the gendered nature of many issues that arose in the course of our work on the phone lines. I knew that I had to find a way to incorporate these feminist frameworks and issues into my journey to becoming a psychologist. I started with the aim of researching a women's health issue, and the present study evolved through a process of consultation with professionals from Women's Health Victoria and Women's Health Grampians about what might be useful to Victorian women. When the opportunity to research rural women's experiences of family planning options was proposed to me I felt immediately drawn to it, given my rural upbringing. In Australia, 34% of the population live in rural and remote areas (Australian Institute of Health & Welfare, 2006). Generally, the further a rural community is from a metropolitan centre, the poorer the health outcomes and service accessibility (Wainer, Strasser, Harvey, & Kelly, 1996). Australian rural populations have often been described as resilient, proud, and self sufficient as they have to survive in a tough environment, facing droughts and recessions, coupled with threatened/frequent closures of key medical, educational, employment, transport services, and the subsequent fight to regain these services (Humphreys, 1998). It was these findings and my own relationship with the rural context that continued to motivate me in this research process.

Approximately one in three Victorian women will have an unwanted pregnancy and obtain a termination in their lifetime (Bayly, 2007, November) and up to 50% of Australian women may have an unintended pregnancy, although these pregnancies are not necessarily

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unwanted¹ (Marie Stopes International, 2008). Emergency Contraception (EC), terminations of pregnancy (TOP), and options counselling continue to be an important part of family planning because not all contraceptive methods are failsafe. In a sample of 9,134 Australian women and 10,173 men, it was found that fewer than 50% used failsafe contraceptive methods such as hysterectomies or vasectomies (Rissel, Richers, Grulich, De Visser, & Smith, 2003). Furthermore, in a one year period, 23.8% of women from the same sample reported experiencing failed condom use, such as breakage (De Visser, Smith, Rissel, Ritcher, & Grulich, 2003). A further study of 2,000 women found half had experienced an unplanned pregnancy, despite 60% of these having been using contraception at the time, with 21% using more than one type (Marie Stopes International, 2008). Such findings demonstrate that there is a need for further family planning options beyond contraceptive methods.

Ryan, Ripper, and Buttfield (1994) noted that there is an assumption that because of the advances in contraceptive methods, fertility is controllable and that “contraception and sex are equally negotiated” (p. 196). They argued that there is a difference between knowing about contraception and subsequent behaviour to use it, and that the notion of controllability ignores coercive relationships, power differences in relationship, gender identities (including stereotypes of men as initiators and women as responders to sex). In addition, many women choose not to use contraception; as South Australia’s Pregnancy Advisory Centre (n.d.) noted “technology and education are not the sole determinants of sexual practices” (p. 23).

¹ The terms unwanted and unplanned pregnancy are often used interchangeably throughout this report. However, it is important to note that not all unplanned pregnancies are unwanted nor are all planned pregnancies wanted (e.g., a woman may have planned a pregnancy, however the pregnancy may become unwanted due to the possibility of birth defects).

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Accessing family planning services may not just be a matter of physical access, nor of having the relevant information. Reproductive choices may be influenced by a multitude of factors, including gender roles in Australian society.

Australian women have always made decisions about the timing, number, and spacing of children, although these decisions have been compounded by social, cultural, and class systems. An early example of such systems was when the lower class women arriving on the First Fleet (such as the unmarried female convicts) were expected to have a termination if they became pregnant either during the journey or once in Australia (Siedlecky & Wyndham, 1990). Ironically, they were also sometimes sent to Australia because they either had a termination illegally or were involved in performing them (Siedlecky & Wyndham, 1990). From the time of the First Fleet, men outnumbered women (Australian Government, 2008) in Australian white settler society, and consequently, almost 100 years after this arrival there was great concern for the declining birth rate in Australia, with the responsibility located squarely with women (Gilding, 2001).

What is Family Planning?

Family planning is the planning and use of various methods to control the number, timing, and spacing of children (World Health Organisation [WHO], 2010). Family planning services are services that provide these methods (e.g., a pharmacist providing contraception). Family planning methods may be subdivided into those used before, during, and after (post-coital) sexual intercourse. As the focus of this study is on post-coital methods, methods that are not considered here in detail include natural or rhythm methods (where a woman tracks her ovulation), the contraceptive pill, male and female condoms, female use of a diaphragm or an intra-uterine device (IUD), spermicides, hormonal injections and implants, withdrawal method, sterilisation, and abstinence (WHO, 2007). In addition, WHO also lists family planning services not related to contraception such as Sexually Transmitted Infection (STI)

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prevention, testing and treatment, pre-conception and infertility counselling, and fertility treatment, none of which are considered here although they may affect fertility. The three main post-coital family planning methods or services are EC, TOP, and options counselling which are considered in further detail here.

Emergency contraception (EC).

Emergency contraception (EC) is a hormonal contraceptive that operates to prevent a possible pregnancy, post intercourse. Family Planning Victoria (2007) noted that EC can work in three different ways, through preventing or delaying ovulation, preventing a fertilised egg from implanting in the uterine wall and through interrupting the hormonal process required for a pregnancy to continue. They also list three methods of EC available to women in Australia: progesterone only method, combined (yuzpe) pill method containing oestrogen and progesterone, and IUD insertion. Since “progesterone only” is now the most commonly used method in Australia, this is the method that will be referred to when using the term EC in this thesis.² In this method, two pills of EC (Postinor-2 or Levonelle-2) containing a dose of a female hormone are taken. The doses are either taken as a single dose of two tablets or two doses of a single tablet taken about 12 hours apart. “Alternatively, the minipill can be used to make up the dose by taking 25 tablets and repeating this dose in 12 hours time, although this is the least popular” (Family Planning Victoria, 2006, p. 4).

EC is more effective the sooner it is taken after unprotected sex (when no contraception is used or the “withdrawal” method is used), or when other methods fail such as when condoms have broken or slipped off, diaphragms have dislodged, or the contraceptive pill has been misused (e.g., through missed pills or antibiotic use). It is estimated that EC is about 85% effective, although the sooner it is taken after unprotected sex

² It is also assumed throughout this thesis that when interviewees spoke about EC they were referring to the progesterone only method, unless otherwise stated.

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the more effective it is (Family Planning Victoria, 2007). EC should be taken within 120 hours of unprotected sex, although effectiveness is greatly reduced after 72 hours and as such any barriers that decrease the ability to access EC in a timely manner need to be identified and reduced. Women no longer require a doctor's prescription to access EC. After 20 years of being available on prescription only in Australia, EC was made available over-the-counter in pharmacies in 2004 (Family Planning Victoria, 2006). EC is also still available from some doctors, hospital emergency departments, community health and family planning clinics and this may be free or at a reduced cost compared to pharmacy access. As EC is not on the Pharmaceutical Benefits Scheme there is no legal requirement for pharmacists to stock it (Martin, 2004).

Termination of pregnancy (TOP).

There are two types of abortions, spontaneous and induced. Spontaneous abortion, or a miscarriage, is the result of accidental or natural causes. This thesis focuses on induced abortions or TOP, that is, pregnancies that are intentionally ended (The Royal Australian and New Zealand College of Obstetrics and Gynaecologists [RANZCOG], 2005). It has been suggested that the term "abortion" can be ambiguous as it can refer to a spontaneous abortion (miscarriage) as well as a therapeutic abortion (where the abortion is induced). The terms termination of pregnancy (TOP) and abortion are often used interchangeably in the literature. When the term abortion is used in this study, it refers to induced abortions unless otherwise specified.

There are two methods of TOP currently practised in Australia, surgical and medical. A medical TOP is one where drugs are used to induce the termination (RANZCOG, 2005). One drug commonly used for a medical termination, mifepristone³ (also referred to as

³ Other drugs licensed for uses other than TOP (e.g., Methotrexate and Misoprostol) have also been used "off-label" by medical practitioners for TOP (De Costa & Carrette, 2009)

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RU486) was legalised in Australia in 2006.⁴ At the time of writing, some TOP providers have started to use this drug for medical TOP, although this is limited to pregnancies under nine weeks gestation (Better Health Channel, 2009). Surgical TOP is most commonly performed under general or local anaesthetic (often to the woman's choosing), using a suction curettage (the cervix is expanded manually using metal dilators, and then a small suction curette is applied to the uterus). This method is appropriate for pregnancies up to about 15 week's gestation (RANZCOG, 2005). Late term TOP refers to induced abortions after 20 weeks gestation. After about 14 to 15 weeks a dilation and evacuation procedure is used, where a pharmacological agent or dilator is used prior to the procedure (from several hours to a day) to open up the cervix (RANZCOG, 2005).

In Australia, TOP is regulated by state laws rather than federal laws. Prior to 2008, Victorian law was primarily based on the Menhennitt Ruling of 1969. This ruling deemed induced TOP lawful if it was necessary to protect a woman from serious danger to her life or physical and mental health, beyond the normal dangers in pregnancy and childbirth (Victorian Law Reform Commission, 2008). This context changed in mid-2008, when terminations were legalised up to 24 weeks, after which point two doctors need to agree that the termination is appropriate for the woman's physical and mental health (Women's Health Victoria, 2010). The law reform also clarified the protocol that must be followed if a practitioner has a conscientious objection to TOP and although "there is no penalty for non-compliance with this section, health practitioners may be liable for charges of professional misconduct by their registering authority" (Women's Health Victoria, 2009, p. 1). These changes require doctors to "tell women seeking information about TOP services of their

⁴ Despite RU486 being legalised nationally, in states where the legality of TOP is contentious (e.g., Queensland) there still may be risks to women/practitioners who use RU486. For example, in 2009 a Queensland couple was taken to court for obtaining RU486 with the intention of terminating; subsequently at least two gynaecologists stopped offering RU486 because of legal fears (De Costa & Carrette, 2009).

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objection and refer them to another doctor who does not hold such an objection. It is not a referral directly to an abortion service provider and the woman may or may not go on to terminate her pregnancy” (p. 1).

TOPs are provided through the private health system in private and public hospitals, day surgery clinics, and private practitioners. It is important to note that in Australia there is no indication that illegal TOPs are still widely provided (National Health and Medical Research Council [NH&MRC], 1996). Within the public system, TOPs are available only in some public hospitals. The public hospital system in Victoria does not have the capacity to meet all the TOP needs; for example, the Pregnancy Advisory Service at the Royal Women’s Hospital, which is the largest public TOP service provider in Victoria (meaning the TOP is free), is said to only meet 33% of its demand for the service (Calcutt, 2007). Because of the public system’s lack of capacity, the vast majority of TOPs are provided within the private system (Victorian Law Reform Commission, 2008). Providers also specify differing gestation limits and there are few late term termination providers.

It is not clear or widely advertised which hospitals in Victorian regional centres perform terminations; however the regional city of Bendigo established a public clinic in 2008. Some funding for various items relating to a termination (such as a suction and curette procedure, different types of anaesthetic) is provided with a Medicare rebate. The Medicare rebate does not cover theatre fees and therefore is often less than the total cost involved (NH&MRC, 1996). Some private insurance funds may cover the cost for the entire procedure. Some services provide discounts for women on a low income, students, and pensioners, and some private clinics will also try to make arrangements for women who have difficulty meeting the costs (Victorian Law Reform Commission, 2008). Women’s Health Victoria (2010) estimated that out-of-pocket expenses with private providers may range from \$200 to \$400.

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Family planning and the TOP debate.

It is important to acknowledge the controversy surrounding whether TOP should be included under the gamut of family planning methods. There is no set Australian or international consensus on whether TOP is a family planning method. The debate seems to be defined by those who see family planning through a “contraception only” definition and those who see it as encompassing more than just contraception. Whichever definition is used has an influence on women’s general and reproductive health. For example, under the Howard Government’s family planning definition, the use of foreign aid towards services that advised about or provided TOP was banned. The overturning of this ban by the Rudd Government in 2009 expanded access for women in developing countries where unsafe TOP is often conducted. To make matters more confusing, several contradictions occur in the international literature. It was stated at the United Nations (UN) International Conference on Population and Development that “abortion should in no case be promoted as a method of family planning” (UN Population Fund, 1995, chapter 7, para. 8.25), yet this conference also went on to state “but in circumstances where abortion is not against the law, such abortion should be safe” (para. 8.25). The UN avoids promoting TOP as a family planning method yet at the same time advocates for safe TOP and the empowerment of women through asserting their right to determine the number, timing, and spacing of their children.

A possible solution to this debate lies in the suggestion that the term “fertility regulation” be used as a more appropriate term, as it is often considered to be a broader term, encompassing TOP as well as methods of family planning. Fertility regulation was described by the WHO as “family planning, delayed childbearing, the use of contraception, treatment of fertility, interruption of unwanted pregnancy and breastfeeding” (Earth Negotiations Bulletin, n.d., para. 2). However, there was still an objection to using “interruption of unwanted pregnancy” in the definition of fertility regulation in the UN documents, from those countries

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where TOP was strongly opposed (Eriksson, 2000). This fluctuating debate demonstrates that whether TOP is included as a family planning service is entrenched in political, cultural, social, and religious contexts. While the inclusion of TOP as a family planning method is fraught with controversy, the term “family planning” has been preferred to “fertility regulation” (or “control”) because it is used more widely in Australia. I acknowledge that the reasons for focusing on post-coital methods in this study are, like other definitions, also influenced by my own political, social, and cultural contexts. These contexts will be discussed in the reflexivity section of Chapter Two.

Options counselling.

There is no set definition of options counselling, however at its very basic level the term is used to describe a service that explores options regarding an unplanned pregnancy (Better Health Channel, 2010). Women’s Health Victoria (2010) noted that although options counselling is not covered by legislation, it should be provided as part of best practice guidelines.

Allanson (2007) examined some of the guidelines set out for counselling women facing an unwanted pregnancy. She noted that many of the definitions set by reputable organisations or organisations providing terminations have commonalities such as respect for a woman’s autonomy, values, beliefs, individual history, and circumstances throughout the decision-making process, and an expectation to be unbiased and non-judgemental, free from coercion, and non-directive. One such guideline, the Australian Psychological Society’s (APS) “Ethical Guidelines for Psychological Practice with Women” (2008) also “recognises and supports a woman’s capacity to define her own problems”, (p. 168) and states that psychologists should “act in a way that is free from overt or covert prejudice or impropriety” (p. 170). These guidelines also make recommendations regarding working with sexual issues, adding that “implementation involves psychologists respecting women as self-

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determining in their sexual behaviour...sensitive to the possibility of power imbalances that can disadvantage women in sexual relationships” (p. 169). In a statement regarding Pregnancy Counselling Services, the APS (APS President, 2007) also noted that “non-directive” counselling does not exclude providing a woman with information about options or services.

Mandatory counselling (where women are required to have counselling before they can have a TOP, regardless of whether they feel sure or uncoerced in their decision) is often discussed in the development of TOP laws and policies, although this clause was not included in the Victorian TOP laws. Mandatory counselling appears to violate the APS principle that women have the capacity to define their own problems and participate in counselling voluntarily.

There is no set professional background required for someone to practice options counselling, except in the context of the Medicare Pregnancy Support Counselling item which is limited to specific professions. It is not a legal requirement in Victoria that TOP services provide women with pre-TOP options counselling; however because it is a medical procedure and therefore information must be provided detailing the risks, benefits, and alternatives, most of the Melbourne clinics offer counselling if a woman feels she needs it (Allanson, 2007).

The National Pregnancy Support initiative

Despite termination statistics not being well kept in Australia, in response to “concern” for the “rising” number of TOPs, a National Pregnancy Support Hotline was established by the Australian Government in 2006, available for support from the moment of conception to 12 months post birth. It was said that the hotline would offer women “unbiased advice” on anything concerning their pregnancy (“Pregnancy Helpline to Start Amid Fears,” 2007). However, there was controversy over the implementation of the hotline and concern

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from pro-choice organisations that it was biased, did not provide information about all three options, and anti-choice (Metilikovek & McRae, 2007). In July 2010, the Rudd government replaced this hotline with the Pregnancy, Birth, and Baby Helpline, which aimed to provide a “broader range of information, advice, and referrals” (Parnell, 2010, para. 7).

In addition, in 2006, the Australian Government introduced the Pregnancy Support Counselling Medicare item, where psychologists, GPs, social workers, and mental health nurses who had completed specific training modules could offer up to three face-to-face 30 minute sessions. This item defines pregnancy support counselling as a non-directive form of counselling, where “the counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them” (Australian Government, 2006, para. 3).

A number of services purporting to offer pregnancy counselling do not provide information on the full range of options available. These services are managed by anti-choice organisations and have been described by the NH&MRC (1995) as “false providers” because they deliberately mislead a woman into thinking she is accessing a counselling service that discusses = all options, but really attempt to persuade a woman to continue her pregnancy. Allanson (2007) argued that such services “violate the most basic and central ethical and professional tenets of counselling” (p. 6) because they are “directive”, biased and often provide false or misleading information (e.g., that TOP will cause infertility). The Pregnancy Counselling (Truth in Advertising) Bill was introduced in 2005 to stop such false providers from advertising “misleading and deceptive pregnancy counselling services; promote transparency and full choice in the notification and advertising of pregnancy counselling services; and minimise the difficulties associated with obtaining advice to deal with

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unplanned pregnancy” (Stott Despoja, 2005, p. 6). An APS statement issued at the time supported the upfront Pregnancy Counselling (Truth in Advertising) Bill as being consistent with the society’s code of ethics (APS President, 2007). Although this Bill was not passed, it did raise public awareness that false providers reduce a woman’s timely access to support and appropriate services when making decisions about a pregnancy (Women’s Health Victoria, 2010).

Framework for Research on Family Planning

This research project was informed by community and health psychology frameworks, discussed here through their common links. Reproductive health goes beyond the biological; “it is not merely the absence of disease or infirmity” (UN Population Fund, 1995, chapter 7, para. 7.2). It includes social, cultural, political, gender, and religious contexts. Both community and health psychology also work from such a philosophy. Health psychology adopts a biopsychosocial model of health; it assumes that health problems and behaviours such as family planning are influenced by biological (fertility), psychological or behavioural (beliefs about contraception), and social (e.g., relationship contexts, rural culture) factors. Similarly, community psychology takes an ecological systems perspective approach, where behaviour cannot be considered without taking into account the different contexts within which one lives. These philosophies were central to the study, especially when considering barriers to access.

Community and health psychology also take a public health approach that focuses on prevention as a means to solve problems ahead of treatment. In line with this wider lens on behaviour, community and health psychology both encompasses first and second order change. First order change is when an attempt is made to change an individual to fit a setting, while second order change is an attempt to change the environment, such as systems and structures that affect a person (Watzlawick, Weakland, & Fisch, 1974). Addressing

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situational barriers to women's sexual and reproductive health necessarily involves attention to second order change.

Principles of particular relevance to community psychology are empowerment, social justice, and diversity, all of which note the importance of empowering, giving voice to, and including those from minority or marginalised groups. People living in rural communities in general are a marginalised group whose voices are often left out of key decisions that may impact on them (Wainer, 1998). The starting point of exploring issues faced by rural women, who are a minority of women and arguably a marginalised group, was consistent with community psychology, while the focus on the psychological aspects of reproductive health behaviour places the study in a health psychology domain as well.

When viewed through a community psychology lens, access to family planning services does not just imply the physical availability of the methods of one's choice. It also includes the right to make decisions concerning reproduction “free of discrimination, coercion, and violence” (UN Population Fund, 1995, chapter 7, para. 7.2). In other words accessing family planning methods should be free from barriers such as excessive costs, judgments from medical professionals and coercion from partners or family members. Access also includes freedom from social, political, and religious influences on the decision-making process. For example, while a woman may be physically able to access a safe and legal TOP from a local service provider, her ability to access the service may be confounded by social norms in her community.

This study particularly focuses on exploring barriers to family planning services that provide post-intercourse options, specifically, EC, TOP, and pregnancy options counselling. These services can be deemed semi-urgent. TOP is a semi-urgent procedure because later gestation dates pose greater health and psychological risks for women and because few service providers are willing to undertake later term TOP (Henshaw, 1995). Similarly, EC is

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a semi-urgent issue because if left longer than 48 hours after unprotected sex it becomes void. Pregnancy options counselling, incorporating any type of counselling that provides information and support about the choices regarding a pregnancy, is a service that can assist a woman in making the best decision for her, and as such also needs to be conducted within a limited time frame. Accessing these services is time limited, and any barriers add to this urgency.

The literature review that follows in Chapter Two addresses four areas relating to family planning: a brief historical context of family planning and policy in Australia, the importance of family planning, research conducted on rural health in general, and research conducted in a rural context on family planning and reproductive health. Chapter Three outlines the research process which was conducted in collaboration with Women's health Grampians, who also received a copy of the findings. Chapter Four presents the findings from individual interviews with professionals whose current employment was in some way connected to the issue of family planning. The implications for women, particularly women in the Grampians region, as well as policy and service provision, are discussed in the final chapter.

Chapter 2: Literature Review

The first section of this chapter explores the contexts in which Australian women have made decisions about the timing, number, and spacing of children. It begins with a brief exploration into Australian history through the lens of population policies. It looks at how women have been placed at the centre of political and moral concerns about fluctuating birth rates and population numbers. It also highlights how women's choices around contraception and termination of pregnancy (TOP) have been influenced by these same concerns. From here, the discussion moves to explore how social, cultural, and class systems have been contributors to childbearing decisions, such that who can (or is expected to) access different types of contraception and TOP has largely been shaped by a woman's place in society. The section is completed with reference to a more public health and human rights conceptualisation of childbearing decisions that underpins present day policy developments.

Shaping the Australian Family 1788-2011

Gregory (2006) provided an examination of the legal history of TOP in Victoria, noting that throughout Australia's history there has been concern regarding birth rates. The discourse on this issue has located women as centrally responsible for any decline in birth rates, with little consideration paid to women's rights or the health and safety of women obtaining illegal TOPs. The Australian Government held a Royal Commission in 1904 which found that women were deliberately limiting their number of children. In investigating the changing structure of families since Federation, Gilding (2001) observed that all but one of the Commission members were male, who then determined population decline was due to the "selfishness" of women, and initiated a campaign warning women of the "dangers" of birth control. Beyond warnings against the physical dangers of birth control, the Government also played upon national pride and patriotism, warning that the use of birth control would lead to the declining sovereignty of Australia and the family morals. This warning has been revisited

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several times during Australia's history. Despite the birth rate actually increasing, a 1994 report still expressed concern for Australia's future population because women were deliberately practising family planning through birth control and abortion (Cass, 1983). By the Cold War, the Government again became concerned that Australia would be vulnerable because of its small population, to the point where immigration was increased due to the decreasing birth rate (Gregory, 2006). This concern came full circle in 2004 with the Howard Government's urge to combat the declining birth rate and ageing population. Again the campaign was directed towards women's responsibility to have "one for the father...the mother and for the country" (Faroque, 2004, para. 1). However, Gregory (2006) stressed that despite examples of moral and political fear-mongering throughout Australia's history, and the consequent legal restrictions placed on contraception and TOP, many women have still found ways to stay in control of the timing, number, and spacing of their children, even if those means are illegal and unsafe.

A woman's class and social status could also influence what family planning methods she could access. The focus has often been on whether the "right" women were having enough children (e.g., white, middle, or upper class, and married) while reducing the fertility rate of other women (e.g., Indigenous, women with disabilities). Gregory (2006) noted that "white, middle class" women in the 1960s could afford contraception or safe terminations, while "low income white women" and "non-white" women who could not access these options were having larger families, or resorting to unsafe methods. Yet, as Gregory also commented, it was these groups that governments continuously wanted to discourage from having more children. Moreton-Robinson (2002) noted cultural and racial oppression was experienced by Indigenous women who were discouraged from having children and were subsequently forced to have sterilisations, terminations, and were even coerced into using Depo Provera (a hormonal contraception received through an injection every three months)

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before it had been approved for general use in Australia. These significant differences between classes, social divisions, and cultures shows how TOP, contraception and the ability to decide on the timing, number, and spacing of children all have different meanings for different groups of Australian women. For some “family planning” is seen as a form of freedom, for others a form of oppression.

Towards a human rights perspective.

According to Baker’s 2005 review of the “globalisation” of family planning, the 1960s marked a time when human rights started to become more embedded into family planning discourses. The feminist movement labelled population control policies as “coercive, unethical and subjecting women’s bodies to the attainment of an abstract and quantitative societal goal” (Baker, 2005, p. 6). Baker concluded that perhaps because of this movement, there was a shift towards a focus on women’s reproductive rights and empowerment alongside a corresponding focus internationally. The International Conference of Human Rights asserted that “parents have a basic human right to determine freely and responsibly the number and spacing of their children” (United Nations [UN], 1968, para. 16). This was reiterated at the 1994 UN International Conference on Population and Development, where reproductive health was located within the human rights paradigm:

Reproductive health...implies that people...have the freedom to decide if, when and how often to reproduce. Implicit in this last condition are the right...to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of choice...for regulation of fertility... (UN Population Fund, 1995, chapter 7, para. 7.2).

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The catalyst for this shift was an increase in available contraceptive methods for women and hence greater reproductive freedom. The contraceptive pill was first introduced in Australia in 1961, but yet again, the moral and social concerns of the time influenced who could be “permitted” to use it. For many years only married women were permitted the contraceptive pill. Since then, there has been widespread use of contraception throughout the world, most notably in developed countries, in addition to increasingly open policy support for modern contraception for all women (UN, 2003).

With the shift to a human rights and feminist perspective came an emphasis on women’s choice. However, the “right to choose” if and when to have children has to be, as Gregory (2006) put it, “real choice” (p. 68). Real choice is not simply having greater, safer and easier access to family planning methods, it also includes a wide range of related issues that affect a woman’s decision if and when to have children. Gregory listed campaigns such as equal pay, improvements to socio-economic status, greater access to childcare, government financial support, and sex education as all contributing to increasing real choice.

While Australian society has changed since the First Fleet, present day Australian women are still making family planning decisions bound by governmental decisions, while also living in a more sexually free world where contraception options and TOPs are the most freely and legally available they have ever been. The next section of this chapter takes a brief but critical look into current sexual and reproductive policies and Victoria’s sexual health system.

Australia and Victoria: Sexual and reproductive health policies and systems.

Sexual and reproductive health policies have now progressed from a human rights perspective to increasingly taking on a public health, gendered, and socio-determinant approach to health, acknowledging that men and women have different health contexts as well as recognising that health is influenced by social, cultural, and environmental contexts.

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Despite many other countries having a unified strategy (e.g., England and New Zealand), Australia currently has no national sexual and reproductive health strategy (O'Rourke, 2008). O'Rourke (2008) noted that calls for a national strategy from 2000 continue to be made on a Victorian level. Instead, facets of sexual and reproductive health are often addressed as an action area through various broader federal and state policies. This call for a national strategy was also part of the 2010-2012 Victorian Women's Health Services 10 point plan and the 2009 Women's Health Grampians Action Plan. O'Rourke summarised some of the common problems with this approach:

- sexual and reproductive health often being subsumed under the banner of women's health in general and being low on the agenda (e.g., sexual and reproductive health is seventh on the 2007-2012 Health Promotion Priorities in Victoria);
- the individually focused nature of strategies (e.g., the 2004 Federal Government pregnancy counselling initiative);
- being overly focused on Sexually Transmitted Infections (STIs);
- may only focus on women without including the important role of men;
- many do not recognise connections between other areas such as mental health and alcohol and other drug use.

Of specific relevance to the present study, is that many of the strategies fail to address the contexts of unwanted pregnancy, and its prevention, or the social determinants of sexual and reproductive health, and prevention models for unwanted pregnancy (O'Rourke, 2009).

One such state policy in which sexual and reproductive health is addressed is the Victorian Women's Health and Wellbeing Strategy 2010-2014 (Victorian Government, 2010). This strategy does provide a public health, gendered, and socio-determinants approach to health, recognising sexual and reproductive health as one of four key priority areas. This broader framework acknowledges that strategies must move beyond the

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individual to include family and community, and that different life spans, migrant or non-English speaking backgrounds, sexual preferences, and contexts will affect sexual and reproductive health outcomes, service delivery, prevention, and treatment. It also makes an effort to link sexual and reproductive health and other health issues such as smoking, weight, and chronic disease. While the family planning approaches considered in this study are not specifically mentioned, the strategy is linked to them through action areas such as “improving access to services that provide options in pregnancy choices...in locations where choice of provider is limited, including rural Victoria” (p. 43).

Victoria has six state funded sexual health clinics located in Melbourne and the Ballarat, Barwon, La Trobe, Wodonga, and Bendigo regions. These services cover the five regional Department of Human Services catchments and the three metropolitan catchments. Other services that may provide sexual and reproductive health services include private clinics, community health centres, GPs and nurses, hospitals, family planning services, Indigenous specific services, and youth health services. In a review of Victorian clinical sexual health services involved in the prevention, diagnosis, and treatment of sexually transmitted infections, Poljski, Atkins, and Williams (n.d.) reported that regional services vary in terms of funding and service provision, and that they often feel isolated, underfunded, and unsupported. Expecting these services to provide for the entire region can be problematic considering how large these regions are, especially when a service may not be located centrally. Dixon (2003) was also critical of the current system’s separation of TOP from other maternal and family health services and that more should be done to increase its acceptance within these systems. Service providers and women interviewed by Ryan et al. (1994) had also previously recommended that TOP be normalised and mainstreamed into health service delivery and be considered “as an adjunct to other contraceptive strategies because fertility is not controllable” (p. 154).

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Benefits of Family Planning

Access to family planning methods has extensive benefits from an ecological systems perspective. Dixon-Mueller (1993) asserted that not only does it affect individual women's health, but also their relationships, children, and the wider community through economic and social benefits. She provided a summary of the possible individual benefits to family planning using a rights-based framework. For example, in countries where women's rights are supported, it increases a woman's right to define her life, increasing her self-esteem and capacity to self actualise while decreasing the patriarchal control on women. Furthermore, in societies where premarital sex is common, or where pregnancy may signal the need to marry, family planning methods increase a woman's ability to delay marriage, to find a more suitable partner, or to not marry at all. She may be more prepared for the emotional and stressful side to motherhood. This control may also give the woman space to be in a better financial position to start a family, which in turn would give the child a more secure life and also act as a role model for her children to continue this cycle. The World Health Organisation (WHO) (1995) reiterates this point and also includes increased emotional support for children in smaller families as a benefit. In summary, in societies where family planning is supported, the right to education, and stable employment, relationships and economic futures are increased, as affirmed by Astbury (2008). Dixon-Mueller (1993) completes her framework by recognising that family planning access also supports a woman's right to a safe and healthy sex life and relationship because she may have less anxiety over becoming pregnant. Wulf and Donovan (2002) explain that women who can control the number and timing of their children experience an increased opportunity to complete schooling and find paid employment, thus improving their own and their family's economic and social wellbeing in addition to contributing to the economic future of their community, thus rounding off the ecological perspective to family planning benefits.

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The WHO (1995) also recognises that for certain groups of women, pregnancy can pose certain risks to their health. Young women are at particular risk of developing pre-eclampsia and eclampsia (which is life threatening to the woman and foetus), obstructed labour, and anaemia. On the other side of the life cycle, the risks of child disabilities, low birth weight, and complications for the older mother can increase. Accessing family planning methods gives these groups of women the freedom to delay or to decrease the chances of pregnancy and the associated risks.

Specific post-coital family planning services.

Trussell, Stewart, Guest, and Hatcher (1992) argued that the most obvious benefit of emergency contraception (EC) is the possible reduction in the number of unwanted pregnancies and in TOPs, given the large number of women who experience pregnancies due to contraceptive failure. Trussell and Calabretto (2005) analysed Australian pregnancy, termination and delivery data to determine the financial costs and savings of EC and found it reduced the medical costs associated with unintended pregnancy, which outweighed the costs of EC. Some EC researchers suggest that EC does not reduce unwanted pregnancy rates. It is difficult to determine the validity of these research claims because of the lack of control of external variables in studies (including that EC is not 100% effective). A review of eight studies of more than 6,000 women from the USA, India, and China found that those who received an advance supply of EC were equally likely to become pregnant as those who did not (Polis et al., 2007). However, the review also stressed the complex nature of family planning use, for example, it is not just about having access to EC, but the education and capacity to use it. Trussell et al. (1992) made this same point, noting that EC would not address all unintended pregnancies given that some women are unaware of contraceptive failure until it is too late.

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At a very basic level, termination of pregnancy (TOP) has been described as beneficial to the community because it decreases the number of unwanted children (Wulf & Donovan, 2002). There are many reasons unwanted pregnancy may occur, even in couples using contraception correctly. For example, contraception may fail as it is not 100% reliable; women who have reached peri-menopausal age may think that they can no longer become pregnant; and women also become pregnant through rape. Benefits are of course only benefits when TOP is legal and safe. It is recognised that unsafe and illegal TOP carries many negative physical and social risks, however, since this study focuses on access to safe and legal TOP in Australia these aspects will not be discussed.

Specific research into the benefits of options counselling is limited, and is mainly provided anecdotally by counsellors working in TOP settings (Singer, 2004). Allanson (2007) argued that options counselling is more pertinent for those women expressing ambivalence about the pregnancy, however even for women who have made their decision it may also be an opportunity to receive education and information (e.g., on future contraceptive options). As senior nurse educator at Family Planning Victoria, Brown (2006) noted that options counselling can validate a woman's thoughts, feelings, and decisions; provide further advocacy, referral, and risk assessment; and be an opportunity for a woman to receive "factual and non biased information regarding outcomes and options" (p. 2). Singer (2004) suggested that options counselling may benefit an ambivalent women because it allows her to clarify her feelings and make decisions about whether to continue with pregnancy (subsequently keeping or having the baby adopted) or terminating. Finally, service providers interviewed by Ryan et al. (1994) perceived counselling as having the "potential to lower stress and minimise the risk of harm by intervening to dispel the myths and concerns about abortion" (p. 185).

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Risks in Family Planning Methods

It should be acknowledged that there is much debate about the effects of TOP on women's physical and psychological health, much of which focuses on whether TOP has any negative effects (e.g., Fergusson, Horwood, & Ridder, 2006). Post Abortion Syndrome is a term used by anti-choice proponents to describe the supposed psychological stress and trauma that women who undertake a termination face (Speckhard & Rue, 1992). However this "syndrome" is not recognised by the American Psychiatric Association, nor is it listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Research into the effects of TOP is beyond the scope of this study, however the most recent review conducted by the American Psychological Association (Major et al., 2009) evaluated 58 peer reviewed empirical research papers published between 1989 and 2008 that measured mental health outcome following an induced TOP, either in USA or international samples. This evaluation revealed that much research in this area is fraught with methodological issues including inadequate control for co-occurring risk factors, sampling biases, and interpretational problems. The authors summarised that the psychological effects of TOP may be influenced by "women's personal characteristics, relationships, reasons for, type, and timing of the termination, events and conditions occurring in their lives during and subsequent to a termination and the larger socio-political context" (p. 866), many of which are difficult to control in research.

Consideration of any negative effects of TOP needs to be balanced with consideration of possible effects if TOP is denied. Research in this area is also limited and difficult to assess because of the lack of control groups and difficulty in controlling for external sequelae. It is important to note that an unwanted pregnancy may not always result in an unwanted child, however as the National Health and Medical Research Council (NH&MRC) (1996) summarised from six termination "denied" studies, "negative effects may occur for

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the mother and the child if mandatory motherhood occurs” (p. 26). In what may be the largest review of the literature, Dagg (1991) reviewed 225 studies of the psychological effects on mother and child when termination is denied and found possible negative effects on children, especially if the parents tried desperately to avoid the pregnancy. Such effects might include unstable childhood, home, self-esteem, and relationships as well as poorer educational attainment, subsequent employment, and financial stability. Dagg found that mothers might also be adversely affected and experience more guilt and anxiety than those who terminated.

While the expansion in family planning methods has benefited women in many ways, there are some risks involved that must be acknowledged in any balanced discussion. For example, with the contraceptive pill, women are often concerned about increased weight, decreased sex drive, and the increased risk for stroke and blood clots (especially in smokers); moreover, many risks such as breast cancer are still uncertain (Better Health Victoria, 2010). It is often not the method of family planning that poses high risks in itself, but risks are increased and women's health is decreased when only unsafe and unreliable methods are available (Australian Public Health Association, 2005). Ryan et al. (1994), after interviewing women who had had terminations and service providers in regional and metropolitan Queensland, South Australia, and Tasmania, argued that it is not TOP that causes women to have emotional problems but the service delivery and legislations involved around the procedure. The American Psychological Association's most recent review of the effects of TOP noted that “perceived social stigma can influence...how they [women] feel about their decision” (Major et al., 2009, p. 886). In an overview of literature on contraceptive use and mental health effects, Astbury (2008) concluded that often it was not an actual procedure that induced mental health problems but the limited fulfilment of reproductive rights such as not being given correct health information nor giving free and informed consent for a procedure.

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Beyond any physical risk in family planning methods, Dixon-Mueller (1993) suggested that there may be at least two areas where negative social implications may occur. She argued that forcing or coercing women into using particular family planning methods strengthens patriarchal control over their sexuality and reproduction. Coercion can occur on many levels, for example on an individual level from a partner through to a political level when governments restrict access. In other words, there need to be real options. Secondly, Dixon-Mueller raises the possibility that greater reproductive freedom for women has also meant that increasingly; women have sole responsibility for family planning, especially with such a focus on female-only contraception. There is concern that men benefit more from the greater sexual freedom that family planning methods bring, without the responsibility to implement the actual methods, especially in the case of EC or TOP.

Determinants of Sexual and Reproductive Health

In calling for a national sexual and reproductive health strategy in Australia, O'Rourke (2008) summarized the Australian research into the social determinants of sexual and reproductive health, noting the same social determinants also influence a person's overall health and wellbeing. The general prediction that the lower a person is on the social scale, the lower their health status and access to resources, also applies to sexual and reproductive health. O'Rourke also considered evidence suggesting that social determinants of sexual and reproductive health are often coupled with the influence of social attitudes. For example, it has been found the best sexual and reproductive health outcomes occur in countries that have more open sexual and reproductive health policies, laws, attitudes, and services. Among the determinants listed by O'Rourke that may be relevant to the present study are rural and remote locations, age, culture, and ethnicity.

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The following section of this chapter examines overall use of EC and TOP within the Australian context, before moving on to issues affecting rural women's general health. Although this exploration is brief, it is considered important because many issues affecting rural women's health in general may also have an effect on access to family planning services. The discussion then considers research exploring the barriers rural women face when accessing general family planning services and the specific family planning methods in this study, EC and TOP, as well as counselling.

Many studies have been conducted to determine the use of EC in Australia, all with varied results. The largest sexual and reproductive health survey found that from a random sample of 9,134 women aged 16-59 years, an estimated 19.2% of Australian women have used EC at some point (Smith, Rissel, Richters, Grulich, & De Visser, 2003). A similar pattern was found in a New South Wales TOP clinic where only 10% of the sample had considered using EC, despite some 70% knowing about it (Weisber & Fraser, 1997). In another random sample taken from a women's health clinic in Melbourne, only 9% of clients had used EC, despite 80% having knowledge of it (McDonald & Amir, 1999). The authors found that 74% of the women did not understand the time frame available to take EC. Calabretto (2009) replicated these findings in a sample of university students, where it was found that there was general confusion about when to take EC, with a belief that it could only be taken the "morning after". Confusion also surrounded the nature of how EC worked, with half of the students believing that EC was an abortion pill (Calabretto, 2009). What the varied results of these studies do indicate is that there may be barriers preventing Australian women from accessing EC.

Accurate data detailing rates of TOP in Australia are limited. There is no official data collection except in South Australia. Data in other states is often inferred from the South Australian data, statistics from individual clinics and Medicare data. Medicare data presents

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specific limitations as a TOP is listed under the same code as for a miscarriage, essentially combining figures for induced and spontaneous abortions. Medicare data also does not represent those women who do not make a Medicare claim (as they may be concerned about confidentiality), women who have a TOP later than 24 weeks, or public hospital patients (Australian Public Health Association, 2005). According to Medicare data, an estimated 70,000 to 80,000 TOPs were provided nationally in 2004 (Pratt, Biggs, & Buckmaster, 2005). It has been estimated that Victoria's TOP rate is around 18,000 annually (Bayly, 2007, November).

Contextuality: Rural Health

Family planning decisions cannot be considered out of context. The context of women's lives determines exposure to risks, access to technology, information, resources, economical stability, health care, and the fulfilment of rights, all of which influence their reproductive health (WHO, 1998). One such context is the rural environment. The following small sample of research conducted on rural women's health in general, gives a picture of rural women's health issues as differing from those of metropolitan women and therefore warranting separate exploration.

Possibly the largest study in rural women's health lies within the Australian Longitudinal Study in Women's Health (ALSWH), which has examined the health of over 40,000 women since 1996, providing a summary report of rural and remote health (Warner-Smith & Lee, 2006). Findings from this summary include that rural women marry and start having children younger, and are less likely to have completed secondary or post secondary schooling than their metropolitan counterparts. While there were relatively few differences between rural and metropolitan women's ratings of physical health and quality of life, rural women still had poorer access to health services including GPs and hospitals, and also reported having to travel long distances or lack of transport to access these services. They

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were also less satisfied with access to after-hours care, waiting times, and lack of choice of GP. Access to female GPs is also an issue for rural women. Data gathered from 8,869 surveys from the younger cohort of the longitudinal study (aged 28 to 33 years in 2006) found access to a female GP was considered poor for 12.4% of women from a large rural area, 16.2% from a small rural area and 20.4% from other rural or remote areas compared to 6.5% of metropolitan or capital city women (Women's Health Australia, 2007). The ALSWH also indicated that rural and remote women have less access to counsellors, women's health centres and mental health services (Warner-Smith & Lee, 2006).

Privacy, anonymity, and confidentiality are common issues for rural women when seeking health services in general. The close-knit nature of rural life means that rural people are often suspicious of metro services and will need to know who a local service provider is before trust can be developed (Wainer, 1998). Further data analysed from the ALSWH Project indicated that younger rural women in particular are more concerned about confidentiality and trust, especially when they might know a GP or receptionist socially (Warner-Smith & Lee, 2006).

In summarising the outcome of research with rural women, Wainer (1998) listed other common issues that affect rural women's health, including the cost and availability of transport (public and private), and a lack of education and counselling around health issues. She also argued that rural cultures may present a limited view of what are considered acceptable gender roles, where women often have little time to focus on their own health and are instead expected to be the "manager" of their family and community's health.

As noted, rural communities have poorer access to GPs. A strategy employed to reduce this shortage has been to increase overseas-trained GPs to rural areas, with an increase of 80% by 2004 in overseas-trained GPs as compared to 8.8% for Australian doctors trained in rural areas (Department of Health and Ageing, 2005). However, problems reported with

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this scheme include GPs having difficulties adjusting to rural life and relationships with colleagues and the Australian health system (Australian Medical Workforce Advisory Committee, 2004), and it is also possible they experience racism themselves. Studies have also demonstrated that recruitment and retention problems are not just limited to GPs but also include other health professionals such as pharmacists and nurses (Khalil & Leversha, 2003; Lea & Cruickshank, 2005).

Critiques of rural research have been focused on the assumption of homogeneity of rural populations, that is, assuming that research results apply to anyone living in a rural area. Roufeil, Battye, Lipzker (2007) reminds researchers that within the rural context there may also be enormous variations within and between geographical boundaries and between women's experiences. Indeed throughout Victoria different rural geographical areas are affected by different distances from Melbourne.

Family planning in rural communities.

Despite rural women having the same family planning needs as their urban counterparts, actual use of services can be less because of reduced access (Dobie, Gober, & Rosenblatt, 1998). Research from the USA indicates that rural women often have to travel to access family planning clinics, not just because rural towns lack services but because of issues such as a concern for anonymity and privacy in small town environments, increased financial costs of services in rural areas, and because facilities are so stretched that they have no available appointments (Dobie et al., 1998; Henshaw, 1995). A USA survey of TOP providers also concluded that rural women may be further disadvantaged by TOP facilities that require multiple visits (Henshaw, 1995).

In regards to family planning services in Australia, retrospective data analyses of the seven state/territory family planning organisations (excluding South Australia) found that between July 1998 and June 1999, 29.1% of the 146,157 clients were from rural areas (Mirza,

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Kovacs, & Kinfu, 2001). The rural women in this study were more likely to request EC compared to their metro counterparts, and of the counselling services data available, rural women were more likely to seek counselling on contraceptives, pregnancy and menopause, suggesting they may lack timely access to such information in the course of their reproductive lives. With 1/3 of Australian women living in rural areas, 29% is less than might be expected according to relative populations.

Rural teenagers are a particular group of interest. The South Australian Department of Human Services (2001) conducted a literature review on unplanned teenage pregnancy, which found that more rural young people are sexually active compared to metropolitan youth, also noting that “rural recession, and lack of educational and employment opportunities for youth may reduce alternatives to pregnancy” (p. 4). There is some evidence of higher teenage birth rates in rural Victoria; an example given by Family Planning Victoria and the Royal Women's Hospital Centre for Adolescent Health (2005) indicated that in some rural areas 6% of births were to teenagers compared to 1.4% in the Eastern Metropolitan area of Melbourne. Specifically, the Grampians region in 2005 and 2006 had the third highest birth rate for under 20s, at 4.4% (Davey, Taylor, Oats, & Riley 2008).

As Warner-Smith and Lee (2001) noted, early motherhood may have several repercussions. These include less chance of further education, having a career, and finding subsequent employment, which may in turn result in greater chance of long term socio-economic disadvantage. These repercussions impact on the longer term health and wellbeing of these young mothers and their families. Warner-Smith and Lee point to the need for “more supportive policies which will help to bridge the growing divide among Australian women by enabling all young women, regardless of where they live, to choose how they wish to achieve their aspirations for both motherhood and employment” (p. 9).

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Confidentiality, anonymity, and privacy may be a particular concern for young rural women wanting to access family planning services. This group (age 18-22) in the ALSWH reported being especially sensitive to speaking to a GP about sexual and reproductive health issues, and were concerned about confidentiality, privacy and the lack of support and education around such issues (Bryson & Warner-Smith, 1998). Warr and Hillier (1997) found similar results through surveys and focus groups of 1,168 year 8 and 10 students in rural communities throughout Australia, with the young women expressing even more concern about their privacy when accessing doctors and pharmacies, especially regarding their public reputations if seen accessing these services

Rural access to emergency contraception (EC).

Research in the USA identified barriers for some women in accessing EC, despite it being made available over-the-counter in 2006. Chuang and Shank (2006) surveyed 93 rural and 93 urban pharmacies located in the north eastern region of Pennsylvania, finding that only 60% had EC currently in stock; this finding was consistent across rural and urban areas as was the cost. When asked why they did not currently have EC in stock, 61% believed there was no need to stock it, 12% did not know why; moral objections either because it was against store policy (9%), or against personal beliefs (8%) were also cited. Although there was no significant difference between rural and urban environments stocking EC, rural pharmacies were found to have shorter opening hours compared to their urban counterparts, for example, 93% of urban pharmacies were open later than 6pm compared to 63% rural, and 63% of urban pharmacies were open over the weekend compared to only 44% rural. The authors suggested that this would have further implications for rural women, given that the lack of alternative options in a rural setting, travelling to access another service or travelling restrictions for those without licences or cars would all compromise timely access. Bigbee et al. (2007) studied a sample of 34 Californian rural or frontier pharmacies, and found that

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reasons cited for not stocking EC were related to perceived lack of interest and need as well as lack of training. The authors suggested education should be provided to pharmacists on reproductive health needs.

Dunn, Brown, and Alldred (2008) compared results from 188 pharmacists from Ontario, Canada who returned a survey one month before the change to over-the-counter status and 167 who returned a follow up survey, 14 to 17 months after these changes. EC availability did seem to increase after the regulation changes, and there were no significant differences between rural and urban areas. It was difficult to ascertain if cost was an issue because many pharmacists did not complete this section. Rural pharmacies in this study also reported reduced opening hours, with 15% closed for the entire weekend and 79% closed on Sundays compared to only one urban pharmacy being closed over an entire weekend. The authors suggested that while changing the status of EC to over-the-counter had increased availability, access in rural communities goes beyond physical availability, and that the effects of the cost of EC and pharmacist attitudes must be studied. In comparison to the findings from the Chuang and Shank (2006) study, the increase in availability post over-the-counter regulation was greater in this Canadian study. The authors hypothesised that this may be due to increased promotion and awareness of EC in Canada or increased acceptance and status of the drug.

In Australia, Martin (2004) interviewed the national President of the Pharmaceutical Society of Australia, pharmacists, lawyers, and researchers in the field three months into changing to over-the-counter status. A concern expressed by one interviewee was that rural access could be limited if pharmacists refuse to dispense since there might be few other pharmacies nearby.

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The ALSWH (Women's Health Australia, 2007) also questioned women on their access to EC since it was made available over-the-counter. When asked if they had tried to obtain EC, 7.6% of the sample of women from large rural areas, 5.8% from small rural areas and 5.6% from other rural or remote areas reported finding it readily available compared to 10.2% of the metropolitan and capital city sample.

Young women have been found to be particularly vulnerable when accessing EC, although none of the research has specifically examined rural areas. For example, when interviewing 13 Australian women aged 14 to 24 who had used EC at least once, Calabretto (2004) found issues relating to negative attitudes by professionals who made moral judgements on the young women. The women also reported having to wait for a long time in emergency departments and feeling ignored. While young women likely face these same issues, as Martin (2004) noted it might be difficult to find alternatives in rural regions if they are discouraged from seeing a particular practitioner to access EC.

Rural access to termination of pregnancy (TOP).

Many of the studies exploring the effects of having to travel to another town, city, or state for a TOP come from the USA, mainly because TOP laws differ between the USA and many women are forced to travel to obtain a legal termination. Shelton, Brann, and Schulz (1976) analysed the data from legal certificates that were required by women obtaining a TOP according to Georgia (USA) law, and hypothesised that the further a rural woman had to travel for an TOP, the less likely she would go ahead and obtain one. In addition, it was hypothesised that it is not only financial barriers that limit rural women from travelling to access TOP services, but also knowing where a service might be found outside their town. Moreover, in areas where family planning clinics were available, many did not include a TOP provider. Dobie et al. (1999) compared pregnancy termination reports from 1983-1984 and 1993-1994 in Washington State, finding a significant drop in termination rates for both urban

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and rural women, and more so for rural women. However, this was coupled with an increase in rural Washington State women travelling interstate for a termination, and travelling further to obtain a termination than in 1983-1984. The researchers hypothesised that these figures might be due to a decline in termination services in Washington State, rural women wanting to travel for anonymity (especially teenagers), personal and community attitudes, economics, and other factors influencing the decision-making process; whatever the reason, rural women were travelling for a termination and thus their care and timeliness was compromised.

When all 31 Family Planning clinics in rural Washington State were surveyed, of which only one provided TOP, none listed it as a service they would like to provide (Dobie et al., 1998). Two of the most common reasons for not providing termination services were local community opposition (71%) and the lack of a trained provider (55%). Staff moral concerns were rated as the least important reason for not including TOP services. The authors acknowledged that while rural women face specific barriers in accessing family planning services, little was known about the impacts this might have on the health and wellbeing of women, and on their ability to make timely decisions about pregnancy, or the best means to reduce these barriers.

When 138 of the 251 physicians in rural Idaho were surveyed, the most important reason family planning physicians gave for not administering terminations were their own moral/religious objection (82%) followed by the community's objection to TOP (77%) (Rosenblatt, Mattis, & Hart, 1995). TOP law is a state rather than federal matter in the USA and research such as the above suggests that reasons behind the decision not to provide a TOP service may differ between states.

New Zealand women may have to travel long distances to obtain a TOP. Using population and TOP data, Silva and McNeill (2008) determined that women were travelling an average 221 kilometres one way and 5.5 hours in total to obtain a TOP if a service was not

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available locally. Their research did not assess any other issues surrounding why TOP was not provided to women locally.

In South Australia, where termination statistics must be reported, in 2006, 835 (17.1% of all TOP) rural women received a TOP, of which only 280 (5.7%) were in rural hospitals (Pregnancy Outcome Unit, South Australia, 2006). This suggested that rural women were disproportionately accessing terminations in metropolitan regions or travelling interstate. Reasons why this was occurring were not discussed.

De Costa (2005) spoke with a number of practitioners from rural Queensland involved in terminations to gather opinions of the barriers rural women face in that state. The practitioners reported seeing women who experienced difficulties with travel, cost of transport, concerns family and the community would find out, and isolation, to the effect that many would continue with the pregnancy although they wanted a termination. One doctor reported seeing more young rural women in particular presenting for late term terminations because of lack of awareness and shame about the pregnancy. It was also reported that many rural women lack both the means and the skills to find information about a service (yellow pages, internet etc). Another practitioner believed that more pregnancies resulted from of failure to use contraceptives than from contraceptive failure. Some interviewees in De Costa's study expressed the opinion that medical termination could be a cost effective way to reduce access barriers for rural women. One practitioner provided the following case study demonstrating that not all women who require access to a TOP service are in a position to travel, and that this decision may have lasting effects on the woman, her family, and the community.

A young woman in a rural community had gone to a doctor in a small country hospital to request an abortion. She had two children under three; both delivered prematurely because of severe pre-eclampsia, one of the most dangerous complications of

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pregnancy. She was eight weeks pregnant; her partner was unsupportive. The doctor was sympathetic but unable to arrange a termination. She would need to travel by bus, at her expense, to the nearest large town, several hundred kilometres away. An abortion could be performed in a private clinic there. It would cost her more than \$700 in all - completely beyond her resources. At 26 weeks pregnant, the woman returned to the hospital, severely ill with pre-eclampsia. She was flown to the town where she could have had the abortion. The baby died after an emergency caesarean. Taxpayers paid for the flight and the intensive nursing she needed (p. 58).

The Melbourne Pregnancy Advisory Service conducted an audit from January to March 1996, finding that 5.4% of the 1,088 women attending the clinic requesting a TOP were from rural Victoria (Black, Fisher, & Grover, 1999). Figures obtained from eight private TOP clinics in Melbourne between November 2002 and June 2003 show that of 1,244 Victorian women, 9.3% were travelling more than 100 kilometres to access TOP services (Nickson, Smith, & Shelley, 2006). The researchers also asked participants why they chose a particular clinic, with rural women reporting similar results to the US studies: no services in the local area reportedly because no one will perform the procedure; increased costs of local services; and women wanting to be anonymous or concerned about privacy.

Publications by Women's Health Victoria (2007, 2010) have summarised the experiences of rural women through the accounts provided by health professionals working at termination clinics in Melbourne. Barriers listed included geographical isolation, financial concerns, lack of providers, conscientious objections from GPs who refuse to refer to another GP, pharmacists, hospitals and the community, increased cost of services, issues of confidentiality, and concerns about privacy/anonymity. Women's Health Victoria's (2009) also noted that since the 2008 Victorian Abortion Law Reform, "a refusal to provide accurate and timely information and services for informed decision-making is not legal" (p. 2). They

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suggested that refusal to refer puts rural women at particular disadvantage in terms of timeliness as they might have to travel further distance at a greater cost to reach appropriate services. Women's Health Victoria cited reports that rural women were travelling to metropolitan TOP services to ensure privacy and confidentiality, and would experience increased stress associated with travel, increased pressure to organise childcare and accommodation, plus the financial cost of childcare, accommodation and travel. These women might have limited skills to navigate an unknown and larger city, and difficulty accessing correct information about metropolitan service providers. One professional reported an account of a woman leaving her children with strangers at the clinic as she had been unable to organise childcare. Women's Health Victoria (2007) stressed the complex nature of such accounts.

Furthermore, the Women's Health Victoria (2007) accounts described disincentives for doctors to provide TOPs in rural areas, such as experiencing harassment from anti-choice supporters to the point where terminations are often hidden under the term curettage. Prior to the 2008 law reform, legal concerns were another deterrent to doctors considering providing or training to provide terminations in Victoria. However, at the 2007 "Abortion in Victoria: Where are we now? Where do we want to go?" Conference, intensive care specialist and acting CEO at Bendigo Health, Dr. John Edington, discussed the importance of accurate information and not making assumptions when it comes to determining barriers to TOP services (2007, November). He noted that the lack of TOP services in Bendigo is often attributed to the high Catholic population, lack of gynaecologists prepared to perform terminations, lack of resources such as theatres because of the anti-choice sentiment, and because women would rather travel for privacy reasons. Dr. Edington stated that he had found no evidence that this was the case; rather, he pointed out that Melbourne and Sydney both have higher Catholic populations than the Bendigo region, at least one gynaecologist

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was prepared to perform terminations, and theatres were available. He questioned the belief that women prefer to travel, given that cost of travel and accommodation overrides the need for privacy. Interestingly, after this presentation, in April 2008, a termination clinic was set up in Bendigo.

In an audit conducted by the Melbourne Pregnancy Advisory Service, more than one in ten of the participants came from rural or interstate areas (Rosenthal, Rowe, Mallett, Hardiman, & Kirkman, 2009). The Pregnancy Advisory Service extended their findings on rural women by interviewing 60 of the 432 women audited. When asked what services should be available for other women experiencing an unwanted pregnancy, many interviewees felt unable to answer, or recommended more publicity about services. The researchers suggested that TOP was a matter most women did not think about until the situation arose. Most of the rural women interviewed commended the service for its information and support; however, many felt it had been difficult to get through to the Advisory Service phone line. Issues important to those women interviewed were the desire for counselling and TOP services locally, waiting lists, privacy and confidentiality issues, negative attitudes and responses from local GPs, and the time and cost of travelling to Melbourne. Those who had made the decision to terminate their pregnancy also spoke of the emotional stress they experienced during the waiting period for an appointment.

Finally, although not a rural study, it is important to mention some of the findings of Ryan et al. (1994), because theirs is one of the few studies which interviewed both women and TOP service providers. While they did not specifically ask about barriers to accessing TOP they found several issues that would definitely have an effect on a woman making decisions regarding a pregnancy. The first issue they found was that women experienced judgements and pressure not only to continue a pregnancy but also to terminate. They were surprised that this pressure was experienced by both young women and women in their 40s as

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well. Secondly, there were reports of practitioners performing TOP but only agreeing to do so conditionally. Conditions placed on women included the threat that they would only be “allowed” one TOP, and that they must promise to use contraception in future. Ryan et al described these “judgements that a woman should have to pay in some way for becoming pregnant and be punished for careless or immoral behaviour” (p. 117). Finally, myths about TOP (e.g., that it causes infertility) as perpetuated by practitioners and anti-choice followers were anxiety provoking for women; an example was even given of a woman who thought she could die from the procedure, despite it being performed at a safe, reputable clinic.

Access to options counselling.

Limited research has been conducted in the options counselling sphere, let alone for rural Australian women seeking counselling in relation to an unplanned pregnancy. The following is a sample of studies into such counselling on an international and local level.

Options counselling is not just provided by TOP services. GPs, family planning organisations, women’s health organisations may also offer counselling and information (NH&MRC, 1996). Romans-Clarkson (1989) reviewed 18 articles which researched the psychosocial effects of TOP, and most were in agreement that “the counsellor need not be medically trained” and “psychiatric referral was not necessarily desirable or sensible, although it could be useful when ambivalence occurs” (p. 562). As Ryan et al. (1994) found when researching the experiences of women seeking a termination in Queensland, South Australia, and Tasmania, it was not so much the setting of the counselling that mattered to women, but its quality, and thus social workers, psychologists, nurses, and community health centres may all be well placed to provide this service.

The implementation of the Australian National Pregnancy Support initiative drew mixed responses. After the National Pregnancy Support Hotline was established in 2006, uptake failed to reach the Government’s estimates, with only 1,438 calls received over a 10

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month period (Parnell, 2010). In 2010 it was replaced by the broader Pregnancy, Birth, and Baby Helpline, which in its first four months received three times as many calls as the original service, with women aged between 25 and 34 the most frequent callers, and information about hospitals, mother and baby facilities, family welfare, and crisis intervention the most requested issues (Burton, 2010).

Matthews and Lindner (2008) conducted an analysis of the uptake of the 2006 Medicare Pregnancy Support Item as well as an online survey of psychologists' experiences of this item. They found that uptake was slow for psychologists, with 233 psychologists completing the online training provided for the item, but only 68 pregnancy support counselling sessions having been claimed in 2008. Yet there had been 6,613 sessions claimed by GPs. From the survey of 102 psychologists, possible termination of pregnancy was the second most common concern (77%) experienced by the women counselled (relationship issues being first), and 69% of the psychologists believed that the counselling was helpful (Lindner & Sciacchitano, 2008). The psychologists surveyed suggested that the major reason for the limited uptake of the counselling item was that GPs assumed it was only meant for women considering a TOP, which resulted in low rates of referral to and service delivery by psychologists. However, in comparison to this low uptake of the Medicare Pregnancy Support Item, there has been a massive uptake of the broader mental health items under Better Access (Department of Health and Ageing, 2008), which suggests Australian women are not rushing to counselling in order to make a decision about managing their fertility.

Much of the options counselling research has explored what options counselling is and what women want when accessing it. At the Melbourne Pregnancy Advisory Service women reported desiring a service that was in line with many of the options counselling principles: non-directive, supportive, counselling and information giving for all three options,

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and a safe environment where they could talk openly (Rosenthal et al., 2009). The findings of the Marie Stopes International (2006) web survey of 1,022 Australian women who had experienced an unplanned pregnancy, affirmed these principles. For women who did obtain counselling, 46% felt that being non-judgemental was the most important quality of the counsellor and 24% believed that lack of bias was the most helpful component.

Ryan et al. (1994) asked the women they interviewed what they considered helpful and unhelpful aspects of counselling. Aspects that women felt were positive were “receiving information about options and services that were available to support them and receiving information about abortion procedures, costs, risks, availability, and on pre and post operative care” (p. 123). However, the researchers found that it was often these aspects that were frequently lacking in the women’s experiences despite being essential to informed consent. Advice-giving and making judgements were the two aspects that women felt were not helpful or necessary to the counselling process, while information about contraception and post termination counselling were considered appropriate for some women but should not be enforced. Ryan et al. concluded that while counselling services are needed, they should also be optional and woman-centred. In contrast, when service providers were interviewed, Ryan et al. found they lacked a consistent definition of the term “counselling”, and their definition sometimes included offering advice. Regarding barriers to accessing counselling, Ryan et al. found that women sometimes tried to avoid counselling because they believed the counsellor would place pressure on them to make a specific choice.

Women’s experiences of accessing options counselling were documented in a sample of antenatal and TOP clinics in Ireland and England (Conlon, 2005). In this study, 400 women facing a “crisis pregnancy” at these clinics were surveyed. Common beliefs that reduced the likelihood of a woman seeking options counselling included that it aimed to change a woman’s choice; women would have to give reasons why the pregnancy occurred

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and reasons for their decisions. This barrier was particularly reported by rural women. Other barriers included geographical isolation from a counselling service, limited opening hours, privacy and confidentiality concerns (especially regarding being recognised at a clinic).

Women expressed preference for services that were flexible, low cost or free, discrete, and provided via outreach or telephone.

Anti-choice organisations may also purport to offer pregnancy counselling, however these services do not offer women information and referral on TOP and as such also constitute a barrier. Although research on the effects of such “counselling” is limited, Allanson (2007) documented anecdotal evidence from her work at Melbourne’s Fertility Control Clinic which demonstrated the negative psychosocial effects (e.g., feeling anxious, guilty and hopeless, job loss, and relationship stress) of such providers on women and their families. She noted that the “consequences can be severe for women, their families, and the community” (p. 7).

Mandatory counselling is favoured by anti-choice groups; however the Marie Stopes International (2006) study found that 75% of women sampled said they had not wanted to speak to a counsellor before deciding whether or not to terminate an unplanned pregnancy. As Allanson (2007) argued, any discussion of adoption or continuation of a pregnancy should not be required if the woman has made a clear decision to terminate or she feels she does not require counselling.

Research Gaps and Aims

It could be suggested that there are many gaps in the current literature on access to family planning services in rural areas. In particular, evidence of gaps in at least four areas can be identified.

- In general, research which has examined family planning, EC, TOP, and options counselling access in a rural context is limited in scope. While it is generally

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acknowledged that rural women face specific barriers in accessing family planning services, little is known about the impacts this has on their health and wellbeing, how it affects their ability to make timely decisions about pregnancy, or the best means to reduce these barriers.

- Much debate and research (especially psychological) has focused on the effects of accessing these services (especially TOP); however the research needs to expand to consider the psychosocial effects for women who cannot access these services.
- Existing Victorian literature generally considers rural Victoria as a whole. Specific regions in rural Victoria (such as the Grampians region) have not been considered as a possible separate research domain. Varying distances from a metropolitan region may mean different rural areas present different services, experiences, and barriers for women. In addition, each rural area may also come with its own set of “standards” and cultures regarding family planning issues, and stereotypes (e.g., some rural areas are “known” for their “high” teen pregnancy rate and some may be considered as “retirement” areas).
- Research specifically targeting professionals whose work encompasses the area of family planning (e.g., GPs, nurses, politicians, health promotion, managerial, and policy level workers) is limited, particularly in rural contexts. Professionals working in this area may be seen as “gatekeepers of information”. That is, they not only hold the experiences of the women service users but the experiences and knowledge they hold may be relevant to wider service, system, and policy structures. Professionals can offer opinions about a broad range of issues, and may suggest possible means of reducing any identified barriers.

In light of these gaps, the overall aim of this research was to document and thus develop an understanding of the facilitators and barriers to accessing family planning services

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in a particular region of rural Victoria, and how these might affect the psychosocial health of women and their ability to make timely decisions about continuation of a pregnancy.

Chapter 3: Method

The aim of this chapter is to provide a detailed account of the methodology used to explore the barriers for women in the Grampians region accessing family planning services. The first section examines the methodological approach to the inquiry. A qualitative methodology was used to guide this study, specifically a feminist framework, with some departure points such as the choice to initially interview professionals rather than women. Professionals with medical, nursing, social work, political and counselling backgrounds were chosen to be interviewed because they might be able to provide a broader view of issues (e.g., the reproductive health systems in Victoria). In line with the application of qualitative research methods within a feminist framework, this chapter also includes a short section situating myself as the researcher, where the concepts of insider/outsider are used to clarify how the researcher's experiences and values necessarily infuse the research and what strategies might elucidate and manage their impact. The second section provides an account of the methods and procedures employed in the study, including the pertinent ethical considerations. The chapter concludes with a section exploring trustworthiness in qualitative research and the strategies used to increase trustworthiness in this study.

Methodological Approach to Inquiry

Qualitative research.

This study used a qualitative methodology to document and thus develop an understanding of the facilitators and barriers to accessing family planning services. Smith and Dunsworth (2003) noted that qualitative research aims to uncover meanings or views relating to a phenomenon, typically involves verbal or written accounts (e.g., interviews and transcripts), and may be appropriate with a small sample of participants. This is in contrast with quantitative methodology, where a numerical value is often used to describe a

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phenomenon. Consistent with a qualitative research methodology is the feminist framework adapted for this study.

Feminist framework.

Brayton (1997) described a feminist framework as using three principles to guide methodology: it involves the examining and removing of power imbalances within the research; it aims to change social inequality; and third, it focuses on women's voices and experiences. The following is a discussion of the extent to which the present study was informed by these three principles.

Power imbalances.

Efforts were made to increase the involvement of the participants throughout the research process, an approach often used by feminist researchers to give more power to those being researched (Brayton, 1997), for example by giving participants the opportunity to check the accuracy of their interview transcripts, or to assist with the development of the interview questions.

Reducing power imbalances in research includes recognising the role a researcher may play in the research process (Brayton, 1997). Feminist researchers have often been critical of traditional quantitative and qualitative research in its portrayal of research as clean and orderly (Letherby, 2003), whereby the results have to be free from the researcher's own biases and history in order to be considered legitimate. Reflexivity, "where researchers turn the critical gaze towards themselves, examining how the researcher and intersubjective elements impact on and transform research" (Finlay, 2003, p. 3-4), is a critical concept in feminist research. A feminist framework takes the stance that openness about a researcher's history and biases is an important contribution to the research undertaken. In fact feminist researchers would go further to argue that bias is a "misplaced term" (Olesen, 1994, p. 165). Olesen argues for biases not to be considered as a negative but as a potential resource to the

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research, in that being reflexive can lend itself to recognising possible influences on the research question and data gathering as well as the interpretation of the results. The issue for feminist researchers is not whether research should be bias-free but on gaining sufficient reflexivity so that unconscious biases can become exposed (Olesen, 1994). In keeping with the feminist framework I have examined my own background and its likely influence on the present study, as discussed in the section “Reflexivity”.

Another aspect of power imbalances that informs feminist research is the consideration that gender is only one source of inequality (Letherby, 2003). Letherby writes that we cannot assume that all women face the same levels and types of oppression, nor can one assume that women cannot exert power over other women. An example of this is Indigenous women. Moreton-Robinson (2007) points out that white middle class feminists often have the power to define what is considered normal, that is, they “constitute what is the norm” (p. xxv), while Indigenous women are often left out of the discourse, despite having different histories and experiences of oppression. Within the family planning sphere, Moreton-Robinson points out that Indigenous women were often sterilised, forced into terminations or had their children forcefully removed from their care under the White Australia policy, while at the same time white middle class women were fighting for their rights to terminate, access contraception and to choose if and when to have children. So the notion of choice in family planning would have a very different context and meaning for Indigenous women.

Not all rural women share the same identity, class or ethnicity, and access to services will also be influenced by different distances from city services. It was thus important to consider whether women from different areas of the Grampians region, classes, and cultures might have different experiences, and this was raised in the interview questions.

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It is acknowledged, however, that this study also departed from the usual way of addressing power imbalances. Firstly, while efforts were made to reduce the power imbalances between the researcher and participants (such as offering the participants opportunities to check the transcribed interviews), to truly address any imbalance, participants needed to be included at every stage of the research (Brayton, 1997). For example, participants would have been given the final interpretations of the interviews to consider for accuracy. Attempts to reduce power imbalances were limited by time constraints of both the student research context and the participants themselves. In addition, power within this research process was less of an issue because I was a student and the interviewees were the “gatekeepers”. As professionals they could be considered to have more power in the interactions than myself (Johnson, Gridley, & Moore, 2003). Another possible departure point was that, although the feminist principle that gender is only one source of inequality was acknowledged throughout the research process, no specific strategies were employed to include women from different classes and cultures.

Changing social inequality.

Feminist researchers also argue that research should not just be conducted for the sake of research (Brayton, 1997). In line with the feminist mantra “the personal is political”, research informed by feminist frameworks must be directed towards change not only on an individual level but on a social level as well (Letherby, 2003). The choice of topic was initiated by discussions with women’s health policy developers who needed better documentation of perceived problems in order to lobby for change. Sharing the results with Women’s Health Grampians (WHG) is intended so the organisation can address inequalities by expanding women’s reproductive health choices in the region.

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Focusing on women's voices and experiences.

A central focus of feminism is on centring women's voices and experiences (Olesen, 1994), which have historically been absent in two areas relating to this study: psychological research and family planning issues. Letherby (2003) noted that women's voices have traditionally been left out of psychological research and when included have often been considered as the "other". In the discussion in Chapter Two the influence of population policies, class, social divisions and culture on women's family planning choices, it noted that women's voices are often ignored and replaced with concerns for Australia's population as a whole. Given the focus on access to family planning services as primarily a women's health issue, the study demanded a feminist approach that placed women's experiences and needs at the centre. Of the 11 participants, nine were female professionals and the questions placed women's experiences at the centre of the research, even though they were not directly accessed.

The most obvious limitation of the current research from a feminist perspective was the absence of the direct voices of women as service users or community members facing family planning decision. Ethical issues limited the ability to recruit women as did time constraints, and possible issues relating to the context of the rural environment, the issue being investigated and the multiple pressures of women's lives. These issues are discussed in more detail in Chapter Five.

Situating the researcher: Reflexivity.

As previously mentioned, an important component to a feminist framework is the influence of the researcher's own history and biases. The choice of topic, methodology, relationship with stakeholders and participants, analysis and presentation of findings can all be influenced by a researcher's individual biography or what Letherby (2003) calls the "importance of our own intellectual biography" (p. 9). Written from the first person stance,

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the following section uses the insider/outsider framework to describe my own relationship with the study.

As a means of conceptualising reflexivity, qualitative researchers often locate themselves as either an insider or an outsider to their research (Bonner & Tolhurst, 2002). Insider researchers are usually researchers who are researching a particular group they “belong” to or a phenomenon they have experienced. On the other hand outsider researchers usually do not identify with the group or phenomena they are researching (Breen, 2007). Insider and outsider perspectives both have advantages and disadvantages. In this study, I considered myself neither an insider nor an outsider researcher, but one who was placed in the middle of these dichotomies. I believe this unique position meant that I could take on the positive aspects of both positions and hopefully minimise any negative aspects.

Insider components.

I am a late 20-something, white Australian woman. I grew up in the Grampians region of Victoria, living there until I was 18. I moved to Melbourne to attend university. My family of origin still live in the same town I grew up in, which led me to reflect on the influence of my upbringing in the rural setting under investigation. My upbringing in this setting could mean that I carry certain stereotypes, biases and values about rural settings, women, and pregnancy that may influence my research decisions. A motivating factor for choosing this particular research setting was my prior experience and history because it might allow the participants to have greater trust in me.

In the second year of conducting this research I completed a placement at a Melbourne Termination of Pregnancy (TOP) clinic, providing counselling to women faced with an unwanted pregnancy, some of whom were from rural regions in Victoria. These experiences may also have assisted me during the interview process. Positive aspects of being an insider researcher that can benefit a study include not being seen as a stranger and

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gaining trust from the group under investigation (Bonner & Tolhurst, 2002). Being an insider researcher might decrease the distance between the researcher and the participants, in keeping with the study's feminist framework (Matsumoto, 1996).

My motivations for researching this topic began before I started the Doctorate program. As a white Australian woman, my "whiteness" gives me privileges in society that other groups may not experience (e.g., other cultures). However, as a woman, I belong to a group that has often been "silenced" in psychological research and society, where their voice has often been assumed by men. This silence was first brought to my attention through volunteering for a women's phone support agency. Thus began my development as a feminist and the realisation that I wanted to research an issue of importance to women and feminism. When the opportunity to research rural women's experiences was proposed to me I felt immediately drawn to it given my rural upbringing and still close connections to this area. My interest in this research opportunity was further generated by my mother who had faced fertility issues prior to my birth, but who nevertheless had been resolutely pro-choice. This vivid memory jumped into my head and resonated with me when the research topic was first proposed. I would also consider myself to be a pro-choice feminist, and thus the values I hold influenced the present study.

Outsider components.

My status as an outsider related to the fact that I have never been in the situation of needing emergency contraception (EC), TOP, or options counselling while living in a rural setting, which was the focus of the research. I was thus not a complete insider, nor was I completely embedded in the research phenomena, and as such, the research may have also benefited from my being an outsider researcher, in terms of being able to adopt a degree of critical distance from the "edge" rather than the "centre" of the research. Not having

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accessed the family planning services that were the focus of the research, I would be less likely to assume that my own experiences applied to everyone else in a similar situation

Research Setting

Although there are many different ways of defining rural, the Australian Institute of Health and Welfare (2006) defines rural as a population under 250,000. As such the Grampians region covers an estimated 48,112 kilometres and is located in the western region of Victoria. It is probably best described as covering the area from “Bacchus Marsh in the east to the South Australian border in the west, and from Patchewollock in the north to Lake Bolac in the south” (DHS, 2008). Within this area, there are 11 local government areas (as shown in figure 1 and 2), Golden Plains, Yarriambiack, Pyrenees, Northern Grampians, West Wimmera, Moorabool, Hindmarsh and Hepburn, the Rural Cities of Horsham and Ararat, and the City of Ballarat. The Cities of Ballarat and Horsham could be described as the two major cities located in the Grampians region, Ballarat with a distance of 113 kilometres from Melbourne and population of approximately 85,000, and Horsham, 299 kilometres and 18,000 respectively. At the last census, the Grampians region had a population of 211, 638, of whom 51.22% were female (Australian Bureau of Statistics, 2006).

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Figure 1. Map of Local Government Areas and Department of Human Services (DHS) Regions in Victoria. Grampians region shown in dark pink (DHS, 2004).

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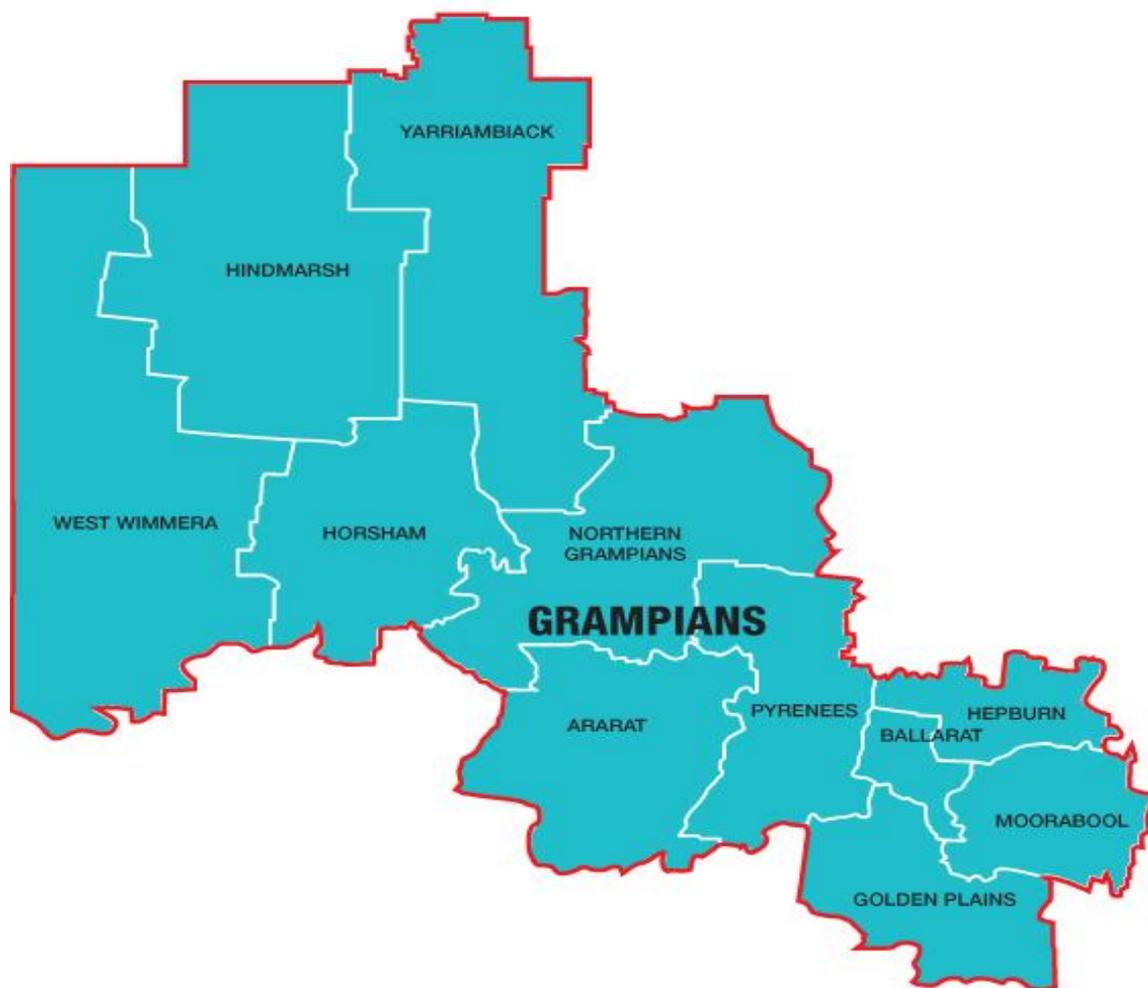


Figure 2. Map of Grampians Region Divided into Local Government Areas (State Government of Victoria, 2010).

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Methods Employed in the Study

Semi-structured individual interviews were adopted for this study as they allowed participants time to reflect, develop, and expand on their views. Individual interviews rather than focus groups were preferred because of the sensitive nature of the topic, to give the participants a more private space to talk about their experiences (Fontana & Frey, 1994).

Interviewing as a method was in line with a feminist framework as the conversational format can decrease the space between researchers (Gumbrium & Holstein, 2002). The interview technique allowed me to move beyond just gathering “the facts” about family planning service accessibility in the Grampians region to co-construct and interpret what this means to professionals working and thus indirectly to women living in the region. Burman (1994) lists three ways an interview technique can benefit research: it allows flexibility and openness that other techniques may not offer to a new research topic; interviews also allow exploration of possible gaps or notions that challenge the prevailing view more than questionnaires or surveys can do. Finally, the flexibility of interviewing can be empowering to groups often “silenced” in research, such as women service users or professionals who work in the “front line” of rural women’s health, and can be driven by what they consider important to discuss.

Because the research topic was largely unexplored and there was an associated need for flexibility, the interview schedule was semi-structured (see Appendix A). In a semi-structured interview, questions are largely open ended and broad enough to avoid limiting participants’ responses (Fontana & Frey, 1994). Interviews were stopped once data saturation was reached, that is, no new information was being delivered after several interviews had been conducted.

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Accessing the setting.

A pertinent issue for many qualitative researchers is how to access a particular setting, or as Fontana and Frey (1994, p. 366) describe, how do we “get in?” This was particularly relevant to the present study as rural communities are close-knit and are often apprehensive of new or metropolitan services and professionals (Wainer, 1998). This was confirmed in two areas of the research process: gaining access to WHG and their networks, and the interview process itself. Gaining access to WHG and their subsequent knowledge and contacts regarding the issue was assisted by the research supervisor’s prior history conducting research with regional women’s health organisations. My own history living in the Grampians rural area also made access easier.

Two important elements of interviews are trust and rapport and the more successful interviews will be those where trust has been gained (Fontana & Frey, 1994). Strategies used to increase trust and rapport with the participants was as follows. The very fact that WHG, a prominent and respected organisation in the region, was willing to assist and have their name included in the study, began the process of developing trust with possible participants when they were being contacted. The interviews themselves followed protocols as described by Fontana and Frey, where the interviewer may begin with broad questions to “break the ice” (p. 371), then progress to more specific questions. Interviews often started with factual questions such as enquiring about the participant’s job description and length of employment. However, the most valuable method to gain the participant’s trust was sharing my own background of living in the rural area, as explained earlier. Other methods used to increase trust and rapport also involved sharing the women-centred nature of my own work history, including working at women’s telephone support and referral agency, sexual assault clinic, and finally a TOP clinic. I found that whenever I mentioned these personal experiences, a

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productive and effortless interview environment developed between myself and the participants.

Ethical considerations.

Approval for the study was granted from the Victoria University Faculty of Arts, Education & Human Development Human Research Ethics Committee in September 2007 (see Appendix B). The Australian Psychological Society's (APS) Code of Ethics (2007) was initially used as a framework for the present study, with the General Principle A: Respecting the rights and dignity of people (which included informed consent and confidentiality) deemed most relevant to this research. Another ethical principle that guided this research, non-maleficance (or do no harm), related not only to the participants but to the researchers and the wider community as well. The following is a description of these ethical concerns and how they were addressed in the present study.

General Principle A: Respect for the rights and dignity of people.

Respecting the rights and dignity of people includes respecting a research participant's autonomy or informed consent, confidentiality, and privacy, all of which were relevant to the present study. Informed consent implies that the research participants are fully informed of the research aims and method before they participate in the research. Confidentiality was considered to be a particular issue for this study because participants might be concerned about disclosure of their opinions affecting their professional reputation. Participants may have felt vulnerable in exposing their views in a rural environment with a limited field of health workers.

In addition, although women service users themselves were not interviewed during this study, their confidentiality was also considered as participants were often describing the experiences of clients during the interview. Therefore, it was also made clear that they were not being asked to breach client confidentiality, and that they should be careful to de-identify

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any examples of client experiences. Privacy issues were particularly relevant when the contact details of the three potential participants were obtained, for example when a phone call was answered by a message bank.

“Ground rules” are an important part of recruitment because they reduce the likelihood of being perceived as harassing a potential participant who is no longer interested (Shephard, 2003). Our ground rules included that potential participants would not be re-contacted after a certain time period and it would be deemed that they were no longer interested in participating. This was explained in the emails to potential participants.

Non-maleficence: Do no harm.

Non-maleficence was also a concern throughout the research. Non-maleficence refers to the notion, “do no harm”, referring to reducing the risks for the researchers and participants. Participants may have felt uncomfortable taking part in individual interviews, disclosing and discussing their professional experiences and opinions. Participants may have had strong moral or political views about the use of such family planning methods such as TOP. Since all participants were professionals working in connection with family planning issues, this was assumed to make them less vulnerable than the general population, and more familiar with research procedures; however a conscious effort was made to be attuned to and respectful of the sensitive nature of this research.

Given the sensitive nature of the subject matter, it was also a concern that the research might attract unfavourable publicity for myself and my family who live in the region under investigation. Potential risks were minimised by not including my full name on documents that would be posted publicly. Frequent consultations with my supervisor also took place to discuss potential risks and solutions throughout the course of the research.

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Participants.

Seeking the perceptions and experiences of professionals such as GPs, nurses and social workers was seen as a worthwhile first step in the process of exploring sensitive issues such as family planning and TOP, because their responses may assist in clarifying the nature of what facilitates or hinders service provision, before women in the community were approached. Within their professional roles they see many women seeking access to family planning services, and the research is less likely to cause them discomfort or distress than might be the case for the service users themselves. Professionals were also considered because they could not only provide information about service users experiences but also a broader view of issues relevant to the systems and structures (e.g., the sexual and reproductive service system structure in Victoria) that might affect women, which service users might not be aware of themselves.

A snowballing sampling technique was used for this study. According to Peterson and Valdez (2005), snowballing uses initial participants to provide recommendations for possible future participants and is often used to find and recruit hidden populations, that is, groups not easily accessible to researchers, or with a specific range of experiences. Professionals who encounter women wanting to access family planning services are considered to be a hidden population because many do not have job titles that indicate they specifically deal with this group, but rather, cover a wide range of areas, for example, GPs and health promotion workers. These professionals may also encounter women in an “ad hoc” way, that is, their role may not be specifically titled or aimed at family planning services, yet they are providing the service on an informal basis because within a rural setting there is a limited range of health professionals. The only selection criteria applied to the participants were that they would have encountered women from the Grampians region who were making decisions about family planning, specifically through the use of EC, TOP, and

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options counselling, and/or were considered to have expertise in the area through their involvement with the policy and political aspects of these family planning services.

The first step in snowballing is to identify what is known as “gatekeepers”, potential participants through whom access to other participants may be gained (Patton, 2002). In identifying possible gatekeepers, Patton (2002) suggests a researcher should begin by asking “who knows a lot about...?” In this case, I asked “who would be well situated to know a lot about family planning services in the Grampians region?” The gatekeeper was thus WHG because they specialise in women’s health issues. Moreover, WHG operates offices in both Ballarat and Horsham (considered to be the two main “hubs” of the Grampians region), and were well placed to be considered gatekeepers to a wide range of potential participants from the entire region. Initially, potential participants were contacted via email from a list of WHG contacts (although the agency had no access to final participant’s details and participation remained voluntary). Potential participants were also sourced through media interviews and seminars that I viewed and attended.

One threat to the trustworthiness of the research was the potential for the snowballing effect to produce a potentially narrow network of acquaintances and thus skew the results. Efforts were taken to counteract this limitation as interviews did not just address possible barriers to family planning service access but also possible facilitators so as to elicit a more comprehensive and less negative picture.

I interviewed eleven professionals whose current employment was in some way connected to the issue of family planning decision-making (specifically EC, TOP, and options counselling), either through direct encounters with women making these decisions, or through secondary involvement from a policy and political level.

It is estimated that the participants’ ages ranged from 25-60 years. Nine of the 11 participants were female. Participants were drawn from a range of professions including

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politics, social work (clinical and managerial level), general practice, counselling, and nursing (community health nursing, family planning nursing, health promotion, and managerial roles). Two of the participants were from a Melbourne service, one participant currently worked in both the Grampians region and Melbourne. Although ethnicity was not enquired about it is assumed the participants were all born in Australia. Participants had extensive experience (ranging from three to 18 years) in the field and the service providers saw women from a range of age groups, from teenagers through to menopausal women. Four of the interviews were conducted after the 2008 change in TOP law in Victoria.

Accessing women service users.

As previously noted, one of the departure points from the feminist framework was not including women service users in this study. We were conscious from the outset of the importance of including women service users as research has often ignored or silenced women (see section on “Feminism”). Efforts were made throughout this research process to invite women service users to be interviewed, but this proved to be difficult and ultimately we were unsuccessful.

The process of attempting to recruit women service users began after the interviews with professionals were completed and ethics approval was obtained from Victoria University. For this next step, advertisements similar to those used for recruiting professionals were placed in major newspapers in the Grampians region, in WHG Newsletters and in a Melbourne TOP clinic. The professionals who were interviewed also attempted to recruit women service users as potential participants through their own client base or workplace, without applying undue pressure.

Three potential participants were accessed via one professional. I was only given their email addresses; this was the women’s choice. All three were sent an information sheet. Two did not respond to the emails inviting them to participate in the research. One woman

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emailed her phone contact, however, when I called this number the voicemail referred to someone else, and to protect the woman's privacy, no messages were left. Reasons why these three women chose not to participate remain unknown; it may be that after reading the information (see Appendix C for an example information sheet) supplied they realised their stories were not applicable to the study, or perhaps for various reasons (see Chapter Five), they chose not to participate even if they had accessed a EC, TOP, options counselling service.

Materials.

The study used semi-structured interviews. A list of the questions guiding the interview is attached in Appendix A. Interview questions were formulated in consultation with WHG and were intended to be focused enough to guide the interviews and provide data on specific areas, as well as being flexible so that participants could elaborate on their own experiences. To get "used to" the interview process, I completed a community research placement prior to conducting the first interview. This placement provided valuable practice and also assisted in decreasing my anxiety about conducting interviews, which in turn enabled the current research process to flow more smoothly. Regular discussion with my supervisor enabled reflection on the research process, for example in limiting the use of "leading" questions. It also became clear throughout the interview process that other issues were relevant to the topic under study, which led me to keep a list of "topic areas" similar to that suggested by Burman (1994). Examples included the period of the Victorian Abortion Law Reform and the influence of rural culture on family planning issues. The interviews were reflexive, with emerging questions and comments being added to subsequent interviews based on prior interviews, so as not to limit the perspective of the participant, for example "what effect do you think the law reform (or the rural culture) will have on any barriers you have mentioned?"

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Procedure.

The research process began when I contacted WHG to discuss the research topic and possible design. After the study received ethics approval data collection began. Potential participants were initially contacted via email where an information sheet (Appendix D) was provided.

If after receiving the email a professional was interested in being interviewed they contacted the researcher via email or phone. The date, time, and place of the interview were then made at the convenience of the participant. All interviews were conducted face to face and all but two were conducted at the participant's place of employment (one interview being conducted at the participant's home, and one at a cafe). One interview was conducted with two participants from the same organisation. Interviews ranged from 30 to 120 minutes in duration.

Before beginning the interview, participants were provided with a statement explaining the purpose of the interview and what type of questions they could expect to be asked (Appendix E). They were also provided again with the plain language information sheet which contained contact numbers if they felt they needed further support or information (Appendix D). They then signed an informed consent form (Appendix F). Participants were then invited to consider their experiences and perceptions of the facilitators and barriers faced by women from the Grampians region when accessing family planning services, and how these affect the psychosocial health of women and their ability to make timely decisions about continuation of a pregnancy. They were also invited to consider what they thought could be done to reduce any barriers they identified.

At the end of each interview I explained to participants that their transcribed interview would be forwarded to them via their personal email to allow them to determine if it was a true and accurate account of the interview. Participants could choose not to receive the

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transcribed interview, or not to receive it via email, but all participants consented to this step. To assist with memory recall and to allow the interviews to run smoothly, all interviews were tape recorded via a digital recorder and transcribed soon after the interviews were conducted. Each transcribed interview was then numerically coded (e.g., #53621) to ensure confidentiality, and emailed to the participant's individual email address, marked "confidential". This process is a form of member checking. Each coded transcribed interview was also given to the research supervisor for review of the interview process. She was consulted frequently to reflect on my interviewing techniques, to discuss any possible issues or problems that might be occurring during the interviews and ways of adapting my interview technique accordingly. Supervision also ensured that the interviews were kept ethically sound throughout the study.

Data Analysis.

The transcribed interviews were analysed using thematic analysis. Braun and Clarke (2006) described this as a common method used for analysing interview data, which aims to identify, analyse and report on a set of patterns found within the data set. However, the main problem with thematic analysis is the lack of a synchronised method to apply it, thus many researchers will report having used "thematic analysis" and such themes "emerged" from the data. Braun and Clarke argue that this sort of language over simplifies the research process, and that the lack of detail on the analysis decreases the ability for the research to be replicated, compared and evaluated. For this reason, the analysis of the transcribed interviews followed a condensed version of the thematic analysis process set out by Braun and Clarke (2006). This process consisted of six stages, outlined with examples below.

Step 1. Familiarising yourself with your data.

The first step involved repeated reading of the data, noting down any significant words or ideas as well as getting an initial impression of significant patterns. Transcribed

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interviews were read at least twice throughout a six month period. An example of this initial notation is provided in Appendix G, Box G1.

Step 2. Generating initial codes.

After familiarisation with the transcribed interviews, the coding process began. Codes are the most rudimentary pieces of data, and have narrow and limited meaning, as opposed to themes which are broad (Boyatzis, 1998). An example of how each transcript was methodically worked through and coded is shown in Appendix G, Box G2. A separate document was also kept that detailed each code, and its corresponding definition and colour (Appendix G, Box G3). Braun and Clarke (2006) recommended coding for as many extracts and patterns as possible as they may become important later. After each transcript was coded, I included a file for extracts that were not initially coded as well. A file was also kept for particular case examples presented by the participants.

Step 3. Searching for themes.

The aim of this step is to collate all the codes into potential themes. As each code and its associated extracts were printed out, similar codes or codes that appeared to be connected were collated into a pile. Once all the codes were collated into potential themes, a summary of the details of these potential themes was made (See Appendix G, Box G3 for an example). This summary also included a set of themes labelled “miscellaneous” that did not seem to fit anywhere. At this stage these potential themes were discussed with my supervisor. The previously mentioned uncoded extracts were also reassessed; many were re-coded and placed into potential themes, while those remaining were deemed not relevant to the study and were discarded (see Appendix G, Box G4).

Step 4. Reviewing themes.

The purpose of this stage is to continue to refine the themes, much like a drafting and redrafting. One part of the process included checking if the themes worked in relation to the

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coded extracts (level one) and the entire data set (level two), generating a thematic “map” or a visual representation of the relationship between the themes (see Appendix G, Box G5). Level one reviewing (asking if the coded extracts fit the themes) required examining all the collated data extracts for a particular theme and considering if they formed a coherent pattern, refining them if not. Level two reviewing (asking if the themes fit the data) included developing a thematic map of the entire data set and considering whether it reflected the meaning of the data set as a whole. Several aspects were considered throughout this stage, including whether some potential themes might not be themes (not enough data to support them or the data is too vast); other themes might collapse into each other or need to be broken down further. Internal homogeneity (“data within themes should cohere meaningfully”) and external heterogeneity (“there should be clear and definable distinctions between themes”) was also considered (Braun & Clarke, 2006, p. 91). At the end of this stage, a clear idea of what the different themes were, how they fitted together and the overall story they were telling about the data was available.

Step 5 and 6. Defining and naming themes and producing the final report.

The fifth step in the analysis continued the process of refining the specifics of each theme and generating clear definitions and names for each theme. The final stage included the write up of each theme and the selection of extracts to demonstrate them.

Trustworthiness.

Both quantitative and qualitative researchers need to test and demonstrate that their research is credible. For quantitative research this is commonly known as demonstrating the validity and reliability of the research. However, finding the qualitative version of reliability and validity has always been a challenge, with some researchers even suggesting that the terms were not applicable to qualitative research, thus leaving it open for criticisms about credibility. Quantitative research assumes a universal standard, which qualitative does not;

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preferring the notion of reference points. Various solutions to this dilemma have been explored, one of the most common being the suggestion that the qualitative equivalent of reliability and validity be “trustworthiness” (Lincoln & Guba, 1985). Lincoln and Guba described four criteria for increasing trustworthiness: credibility, transferability, dependability and conformability. Credibility, similar to internal validity in quantitative research, considers whether the research is investigating what it was intended to investigate. Transferability, or external validity, is the extent to which the findings can be generalised to a wider population. Transferability is a contentious issue with qualitative work as one could argue that since qualitative research is confined to a specific environment or situation, one cannot apply the results to other populations. Lincoln and Guba suggested that while qualitative researchers can make no guarantees about the applicability of the findings to other environments and situations, they can provide sufficient information about the study’s context to assist readers to develop their own opinion. Dependability (or reliability in quantitative terms), is the use of methods to increase the likelihood that if the research was to be repeated in the exact same way then the results would be similar. Again, this is a problematic issue in qualitative research for much the same reasons as for transferability. Finally, conformability relates to the objectivity of the findings. It asks to what degree the research reflects the experiences and meanings of the participants rather than the researcher. Shenton (2004) subsequently summarised these criteria and related strategies, some of which informed the present study. Table 1 draws on Shenton’s summary to describe each strategy under the four criteria and how it was applied in the present study.

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Table 1

Summary of strategies used to demonstrate the four trustworthiness criteria and their application to the present study; adapted from Shenton (2004).

Criterion	Strategy employed	Description (if required)	Application in present study
Credibility	Triangulation	The use of different data sources to confirm credibility (e.g., examining “documents created corporately by participating organisation”) (p. 66)	The use of WHG documents when reflecting on the findings
	Tactics to ensure honesty in informants	Involve only those who are genuinely willing to take part and prepared to offer data freely” (p. 66)	Participants assured of voluntary, confidential participation
	Frequent debriefing with supervisors	Discussion may bring forth other perceptions and alternative approaches, and draw attention to any flaws in the research process	The researcher regularly met with supervisor and a peer supervision group
	Peer scrutiny of the research project	Opportunities to receive feedback enables discussion of other approaches and flaws in the research process	The preliminary findings were presented and discussed at three conferences as well as two university presentation sessions
	Member checks.	Participants given the opportunity to check the accuracy of their data	Participants were given the opportunity to read and amend their interview transcripts

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Criterion	Strategy employed	Description (if required)	Application in present study
Transferability	Detailed description of background data to establish context of study		Descriptions of the research context provided (see Chapter 1 and 2)
Dependability	In depth methodology description to allow study to be repeated or compared		See “Methods Employed in this Study” section
Conformability	Admission of researcher’s biases		Research report includes a section discussing possible biases (reflexivity). These biases were also discussed with supervisor throughout the research process
	Recognition of study’s shortcomings		Research report devotes a section to recognising possible limitations to the research
	In depth methodology description to allow it to be scrutinised		See “Methods Employed in this Study” section
	Use diagram to scrutinise “data trail”		Development of a theme map during data analysis

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Chapter 4: Findings

In this chapter, the findings from the study are presented. In interviewing the eleven professionals who participated in this study, the aim was to document their experiences and perceptions of the barriers Grampians women face when accessing family planning services (specifically Emergency Contraception [EC], Termination of Pregnancy [TOP], and options counselling). The seven themes that were drawn from these interviews are described, with quotes from participants to illustrate each theme.

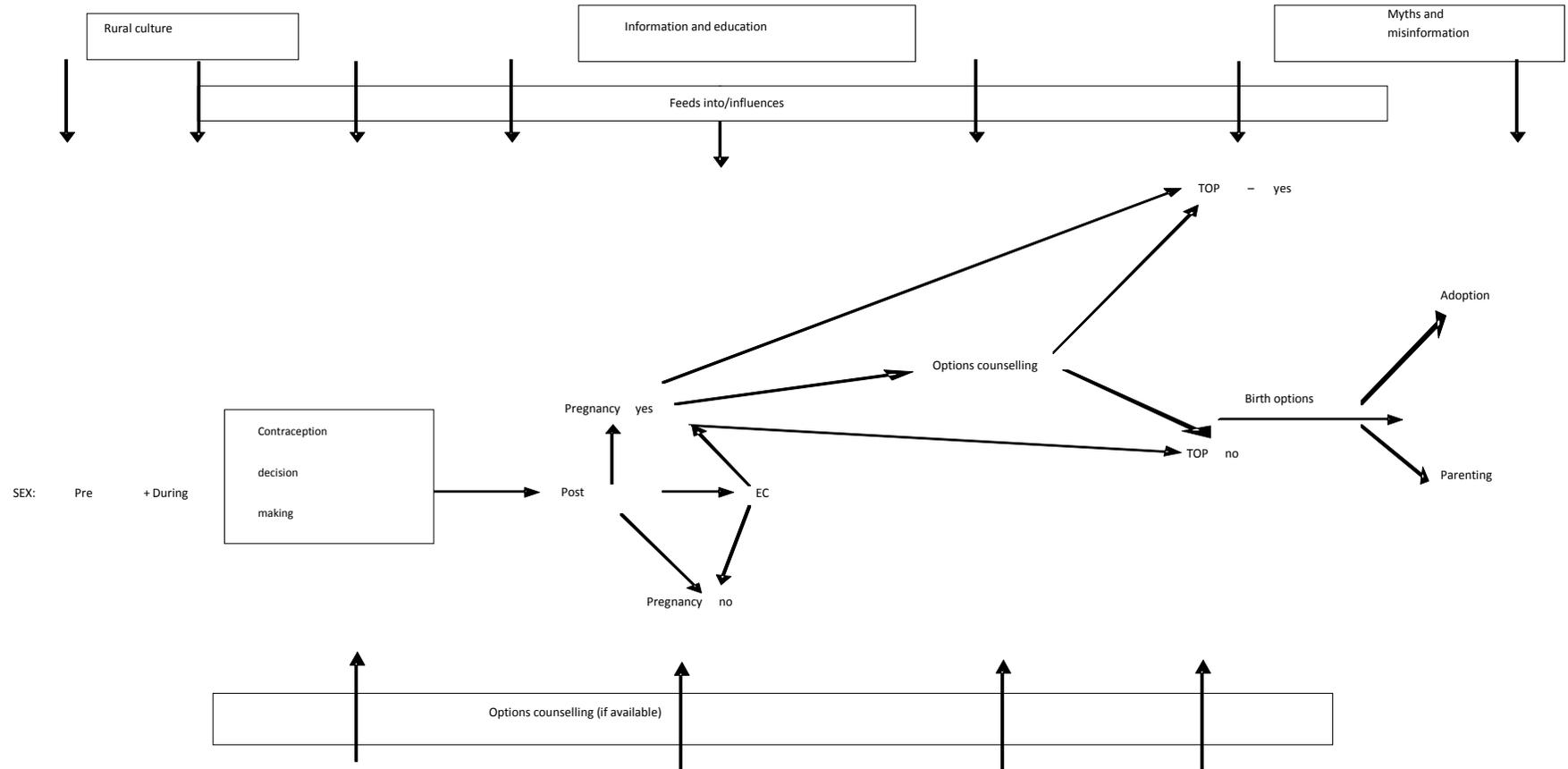
Theme One: Emergency Contraception, Termination of Pregnancy, and Options Counselling are Only Part of the “Story”.

“It’s probably partially about role models and aspirations as much as...well that’s part of the big picture as well as assisting services.”

It became evident throughout the course of the interviews that the post-coital family planning services under investigation (Emergency Contraception [EC], Termination of Pregnancy [TOP], and options counselling) could not be spoken about in isolation from other family planning services and methods (e.g., hormonal contraception) and sexual and reproductive health in general. These family planning services form part of a bigger process; a woman does not just “decide” that she needs to use a service and is then faced with barriers; a woman’s decision to use any family planning methods or services is a process that may begin before sexual intercourse and may continue at many points throughout her sexual and reproductive life (e.g., after sexual intercourse, when she visits a GP for contraception advice). Many different phenomena are part of this process (e.g., exposure to information, rural culture, family history) and continue to feed into and influence her sexual and reproductive health life at these various points and as such can represent barriers. Figure 3 demonstrates the diagram that was developed to summarise this “process”.

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Figure 3. Schematic diagram of EC, TOP, and options counselling within overall family planning process. Barriers can be encountered at any point throughout this process.



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Theme Two: Information and Education.

Participants frequently referred to the role of information and education at two levels: relating to the specific family planning approaches being considered (EC, TOP, and options counselling), and relating more broadly to sexual and reproductive health. These issues are considered here at the broader level except where specific reference to a family planning service is required.

This theme is divided into two subthemes. The first examines the role of information and education in the lives of rural women, including where and when they receive their information. The second relates to one specific barrier women face in relation to obtaining information that became more salient in the course of the interviews.

How rural women find and obtain information and education.

Four participants noted that women “operate in a void”, that is they often do not think about an unwanted pregnancy or termination until they experience it; “[they] are very much driven by information about [their] needs at the time”.

Participants, particularly nurses and those working in health promotion roles, considered that information and education play an important role in women’s lives because of their immediate as well as significant long-term effects. Moreover, women may come to a health service seeking information about a sexual and reproductive health issue and learn about or be linked into another services later on.

You are building that bridge to get there anyway but it’s also another health opportunity to opportunistically give health information, opportunistically link them to someone else, it might not be related to reproductive health...might be able to actually say, “hey look I know that program really is doing great things around your diet.”

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It was suggested that women living in Melbourne might have greater and easier access to sexual and reproductive health information than their Grampians counterparts. And within this region, it was also suggested that the further a woman lives from a main city (e.g., Ballarat) the more disadvantaged she is likely to be when it comes to information and education about sexual and reproductive health as well as information about TOP services.

I think that there is a world of difference for someone who lives in the Wimmera on a farm as there is for a professional woman in her 30s working in Melbourne.

If that is the situation then you see the ads in the paper, you know people who have been...you can go to the place in East Melbourne or you can go to Richmond...I imagine if you are a school girl in the bush it could not be harder.

Participants also reiterated the dissemination of information and education. “Points of information” connecting Grampians women with Metropolitan services are located in the major regional centres (e.g., Women’s Health Grampians in Ballarat and Horsham and the Sexual Health Centre in Ballarat).

I think having a service like this is a bridge, a pathway, that makes it easier...we have a lot of medical services in Ballarat but as you go further out it would be more difficult, but even networking regionally women from up the other end of the region seem to hear about us too so I think we are like a conduit into the metro services so we are a bit of a resource pathway...having services out in the regions is then like a tentacle to network it further.

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Several other methods used by Grampians women for finding out about sexual and reproductive health were mentioned across the interviews; two of the most salient were word of mouth, and networking: “someone told me that you knew how to help me...”. There was general agreement, especially by those who had worked in both rural and metropolitan environments, that these two methods were important to rural areas. Other ways Grampians women find out information included: the local child and maternal health nurse, phone or internet, women’s magazines, advertisements and articles in the local and metropolitan papers, outreach to the more regional areas.

Participants discussed various barriers to obtaining information and education from these means for rural women, such as:

- Isolation on a financial, medical, and social level. For example, rural women with limited phone or internet access might struggle to access information and social isolation would limit the effects of word of mouth.
- Magazine information might be issue-based rather than service-based so a woman might still not know where to access a service.
- Newspaper and magazine advertising might not reach all women, especially those further out.
- The maternal and child health nurse might only visit the area one to two days a week.
- The changing nature of health promotion where large health promotion strategies are now encouraged rather than one-off talks. This may result in women not realising that they can approach a nurse or service provider for other issues.
- It is not just about receiving information; women have to have “the context and capacity to use the information they are given”.

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- Marketing of such issues may be difficult because family planning, especially TOP, is an emotive issue.

...if you put a pamphlet up, “pregnancy choices,” some women will never go and pick that pamphlet up because it’s got unplanned pregnancy and because it’s unplanned does not always mean it’s unwanted...The drug companies have beautiful fancy pamphlets with pretty middle class women that may not be relevant to someone who is struggling, who might not relate to that... but that might be the best contraception choice for them in terms of what’s going to be affective.

Specific barriers with family planning information provision: Myths and misinformation.

Participants spoke often about the major role of myths and misinformation as a barrier to accessing services, and in negatively affecting a person’s sexual life:

I’ve seen young people who have come in and said you know I can’t have sex again because I have got herpes,” that’s been got off a medical practitioner that obviously hasn’t kept abreast with things, and you know that can be devastating for a person.

Myths about contraception (e.g., the pill makes you gain weight), fertility (women experiencing the early stages of menopause may believe they cannot get pregnant) and over relying on the withdrawal method, may feed into whether a woman will become a candidate for EC or TOP. In turn, assumptions and misinformation about EC, TOP, and options counselling can influence whether a woman wants or tries to access these services and even how she feels about using them. The following examples were provided:

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- The term “morning after pill” sometimes perpetuates a myth that you have to use EC literally the morning after intercourse, and although it does lose effectiveness the later it is taken, it is still effective up to 72 hours later. A woman may not consider using EC as she may think it is too late.
- While there were no reports of pharmacists refusing to supply EC, an example was given of a pharmacist who would give out written misinformation (not evidence-based).

It clearly was opposed to the use of the drug, it had a passage about how you could potentially cause an abortion...so if people weren't used to reading between the lines or reading critically then you wouldn't know that that sort of information is really misleading then they could possibly be frightened out of using it again.

- One particular myth mentioned regarding TOP is that it may affect a woman's ability to have children later in life.

It's almost been like a light bulb going off for them that it's an option for them to terminate and be healthy afterwards and be ok and go on to lead a happy life...and to be able to have children later...so we are a really useful contact in terms of phone counselling, we are actually delivering accurate information. Possibly the first accurate information that they have ever had.

- Misinformation through advertisements in the Yellow Pages was also an issue for rural women who had no option but to source potential services there.⁵

⁵The 2005 Pregnancy Counselling (Truth in Advertising) Bill was cited as something that had helped rectify this as it pressured organisations to state if they were anti-choice (although this Bill was not passed, it appeared at least three participants assumed it either was passed or had made a difference by promoting the issue of false providers in advertising).

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- The participants who provided counselling services reported that women were sometimes reluctant to access “formal” counselling because “the assumption is that counselling means that we are going to be trying to change your mind” and they “hate seeing counsellors”. However, often women received counselling in a “quasi” way, that is, it was not formally called counselling but the practitioner would still be using the same skills. Women were also reported as often being surprised and more open to counselling once they realised its purpose was to be “reaffirming, to talk about your decision and how you are and what sort of support you have and if you don't then we can support you”.

- Myths may go beyond affecting the individual, as in the following example:

I don't know why but the west is completely not on the list, whether it's because it is relatively further from Melbourne than a lot of those other areas or whether it just hasn't had good advocacy it's just not seen as an area where youth is important.

When I looked for funding to do that sort of work in this area people thought it was an ageing population therefore “we don't need to worry about contraception and sexual health services that much” but there is still quite a lot of young people here...

Myths and misinformation were thought to be particularly harmful in a rural environment, whether coming from the internet, service providers, health professionals, peers, or relatives.

I find that staggeringly different to rural women - the reframing of myths. Because they get caught up in a culture, a complete community culture about what is right and what is wrong and everyone around them believes the same thing or is led to believe that they think the same thing.

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Theme Three: Service Provision and Access.

While information and education may influence a woman at many stages throughout her sexual and reproductive health journey, the next theme to come out of the interviews related specifically to service provision. This theme has been divided into two subthemes: access points for each service, and barriers to service provision.

Access points for each service.

Emergency Contraception is mainly available to women in the Grampians region over-the-counter at pharmacies, which many participants felt had to some degree opened up access for women. While it can still be provided by a GP, over-the-counter access had reduced the amount of times the GPs interviewed saw women seeking EC. EC is also available at some community and sexual health centres and emergency departments, which could mean reduced or no costs.

In the Grampians region, pregnancy termination used to be available from one doctor in the Horsham region; however this is no longer the case. There was some indication that TOP could be provided on a limited basis at some hospitals within the region, however, a number of participants noted that this process can be extremely difficult to organise (see next subtheme, geographical barriers). Grampians women may also travel to other rural areas (e.g., Bendigo) or Melbourne for a TOP.

Options counselling is provided to Grampians women through “formal” and “informal” means. More often than not it was described as an informal service, where it may not be provided by someone whose job is to provide, or has been trained in, options counselling, but by other professionals who take on “multi-hatted” and ad hoc roles, for example, a community health nurse, or a GP. There was some concern that women might also see health professionals who might claim to be offering counselling, but who in fact might not be as supportive or operate feminist/pro-choice perspectives.

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Because of its informal nature, women might not necessarily make a decision to use options counselling, but might come across a health professional who uses basic counselling principles such as options giving, sharing of accurate, up to date and evidence-based information, and being non-judgemental and supportive.

Barriers to service provision and access: “It’s a wonder people make it to us...there are so many barriers...”

A teenage girl - threatening suicide if she wasn’t able to access [TOP] - she was over 20 weeks so obviously it couldn’t be done in the regional context. All of the issues that we have talked about came into play, low socio-economic situation, poor family support, lack of education, no money, other kids to think about, violence - the whole denial thing had happened, she had tried to access services but had trouble, she had gone away and come back over the 20 weeks. Because she was over 20 weeks she had to stay overnight, so we had to access overnight childcare and she couldn’t ask any family members because she didn’t want any of them to know...the cost of going to a private clinic which is the only place we could get her into really quickly was massive...so we had to raise that money together for her in a really short amount of time and transport out to the other side of Melbourne...You need to stay around for a couple of days to make sure nothing was wrong and then you had accommodation issues...it was just huge. Every barrier that could have been thrown up we had.

The above example provided by a social worker illustrates the point made by many participants that barriers to accessing EC, TOP, and options counselling were all “interrelated”. More often than not, the women they spoke about had met more than one such barrier. The barriers to service provision have been divided up into four areas, financial,

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geographical, relating to confidentiality/anonymity/privacy, and negative attitudes and judgements.

Financial barriers.

The financial costs incurred by women wanting to use EC were particularly prominent, involving three key issues:

- The cost of EC since it has been made available over-the-counter may be out of reach for most women, especially those groups that may need it most such as women of low socio-economic status, or with children already to support, “it’s just not affordable”.
- There are wide cost variations between pharmacies because EC is not on the Pharmaceutical Benefits Scheme, coupled with the limited number of pharmacies in rural areas.

...now you can pay up to \$36...if you were a young teen or even a struggling married woman that is on a limited financial resources and doesn’t have access to money it’s a definite access issue...across-the-counter was going to be easier access, I beg to differ in terms of affordability...I think in Melbourne you can go down the road an hour and there is someone selling it for \$10 under what you will get it here.

- Although EC is sometimes available free from hospital emergency departments and community health centres, some participants mentioned that many do not want this widely advertised, “because the hospital doesn’t want to give it away for free for everyone”.

The financial costs (and ways to reduce them) incurred by women seeking TOP locally and from metropolitan services are summarised in Table 2.

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Table 2

Summary of the financial costs and assistance experienced by women accessing TOP, locally and from metropolitan services.

Costs	Financial assistance through
<ul style="list-style-type: none"> • The procedure • Associated services for example, ultrasound, antibiotics, and contraception post-procedure 	<ul style="list-style-type: none"> • Subsidies by clinics, bulk billing, private health insurance
<ul style="list-style-type: none"> • Calling a metropolitan service to arrange termination 	<ul style="list-style-type: none"> • Minimised if services offer to call the woman back
<ul style="list-style-type: none"> • Transportation • Petrol • Parking • Public transport • Accommodation 	<ul style="list-style-type: none"> • Services, community organisations and the government; however this may be limited and not always available
<ul style="list-style-type: none"> • Lost wages • Childcare 	

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Geographical barriers.

Again, participants took a wider angle and often did not limit their discussions on geographical barriers to those services which are the focus of this study. The limited local availability of gynaecological and general health services was considered important because they feed through to services required for TOP such as a GP referral. The following were issues noted for Grampians women:

- General gynaecological services are limited.
- Low cervical screening rate for the region.
- Long waiting lists to see GPs.
- “Continuity of care” issues such as:
 - less chance of seeing a GP of choice
 - high turnover of practitioners
 - women may not want to see a male GP when “dealing with emotional issues and don't feel like they want to go to 'pink bits' ”
 - yet there is less chance of seeing a female GP.

Recruiting overseas-trained GPs to rural areas was a welcomed strategy to ease shortages in the area, but there were particular concerns regarding overseas-trained GPs such as:

- religious or cultural implication when interacting with clients.
- they may not understand either the Australian medical system (where they are expected to refer out if uncomfortable) or family planning services available in the region and state.
- difficulties in retention as GPs may stay only for their traineeship because:
 - rural life has less religious and cultural opportunities;

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- family, friends, and community may be in Melbourne; with a lack of money to move family to the rural area they can be very unsupported.

There was some conflict between responses as to why local hospitals in the Grampians region may not offer TOP, ranging from waiting lists and surgical times to the “real reason” being religious objections. TOP may be hidden under other services possibly due to its legal status prior to the law reform, so barriers may be difficult to identify. As one social worker put it:

...The unofficial answer is we will send you back to your GP and they will bring you in on the day patients list. So the unofficial answer is yes and the official answer is no...

Another was under the impression that even if a termination could be organised in a local hospital it was a “shit place to do so...” It was clear that regardless of the reasons, the process of organising a TOP in a local hospital was not easy or pleasant! Table 3 lists other geographical issues for women and service providers assisting women having a termination locally or travelling to Melbourne.

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Table 3

Geographical issues for Grampians women and professionals trying to access TOP locally or in Melbourne.

Issue	Quote
<ul style="list-style-type: none"> • Confusion around: <ul style="list-style-type: none"> ○ Locating a service ○ Navigating your way through the service system 	<p>I did once try to refer someone to Ballarat and that ended up being a bit of a shemozzle because I thought I was doing the right thing, I rang one of the clerks and they said this is the process, if you send us the referral tomorrow then we can get her in by next week. So I did all that and did it through the GP where I work and got in trouble for not sending an ultrasound and a blood group and then they said we don't want to take referrals from Horsham for abortion...</p> <p>So I think that sort of barrier in terms of, what do I know about the city and who do I call and how do I get there and possibly don't even make that call because they possibly just can't figure it out. So that sort of degree of isolation is a big one.</p>
<ul style="list-style-type: none"> • Services may be hard to reach • Long waiting periods between initial contact and appointment 	<p>I saw a girl today that could be 20 weeks pregnant and wants to have an abortion and so I rang the Women's switch because...that was the number I knew and the only appropriate option...I spoke to someone there and she said we can make a referral or we can give health professionals a direct number to the pregnancy advisory service and I know...that you can't get through to that number, like it's really hard to get through.</p>
<ul style="list-style-type: none"> • Leaving your support network 	<p>...you have to leave your social support networks; you are not where you normally are, your friends can't come and visit you, [you are] potentially unsupported, stay overnight, have a procedure, come home, that's all pretty wrong.</p>

Issue	Quote
<ul style="list-style-type: none"> Emotional side to travelling for such a procedure 	<p>...She went down to Melbourne and didn't have an ultrasound until she got to Melbourne and when she had the ultrasound they found out she was having twins and felt thrown on a complete tailspin, didn't want to have an abortion because somehow with having twins it seemed more special...just didn't know what to do about it...</p>
<ul style="list-style-type: none"> Safety and vulnerability concerns with travelling to the city 	<p>I had a woman who came in from New South Wales and she had to travel overnight to get to her appointment at 8.45 on the morning and there was absolutely no flexibility...so she spent the day and the overnight travelling and who knows where she was staying or what...or maybe safety concerns as well along the journey that, you know they're in a strange town without resources potentially. So what does that mean? Staying overnight in a bus shelter so you can get to your abortion, you know, appointment in the morning. That's pretty full on</p>
<ul style="list-style-type: none"> Navigating public transport Navigating the city, transport and hospital 	<p>Not expecting that there is going to be rush hour traffic or what rush hour traffic in the country compared to what rush hour traffic in the city, is completely different and I think that can be really anxiety provoking...and it's a big hospital and it's easy to get lost in the system and you know even for someone who lives in the city it's like that but I sort of imagine that for women who live in the country it's an extra challenge.</p>

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Other issues mentioned that affect access to TOP were:

- changes in services provision in a metro area (e.g., when the Royal Women's Hospital was being remodelled)
- where the services are located in Melbourne, for example some are on the opposite side to the Grampians region
- access to accommodation
- may have to travel twice if they require counselling or a later term TOP
- childcare issues, such as limited services in the region
- getting time off work
- limited opening hours of services
- lack of counselling (all types of counselling) in rural regions and waiting lists for counselling.

Geographical issues were also found regarding EC. Many of the nurses and GPs reported that gender and the age of pharmacists in the region is an issue “there was research done to suggest...the average age of pharmacists in the Wimmera was 65 and they are almost all men...they weren't that comfortable either because they could see the young women weren't that comfortable...” Restricted opening hours of pharmacies and community health centres as well as emergency department waiting times were also cited as reducing access to EC, particularly because their might be only one source available to women in rural towns to access EC from.

One nurse felt that teenagers did not care about the age of the pharmacist when accessing EC, “...there is a different generation between them and the health care workers but it depends on who is there and who they run into”.

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Confidentiality/privacy/anonymity: “They come from a rural town...they can't tell anyone what is happening...they are so nervous about somebody in the town finding out...”

The issues of confidentiality, privacy, and anonymity as barriers ran across TOP and EC. These three terms were all used seemingly interchangeably; participants were particularly concerned about the lack of private space in pharmacies, and noted that women in rural communities may fear that someone they know will find out they are accessing EC. This fear may affect women to the extent that “people will go to other towns to get ultrasounds”.

Women may have little choice but to see someone (when accessing EC or TOP) with whom they have a dual relationship, that is, someone she knows or might see socially. One participant mentioned that rural women sometimes make the choice to travel for a TOP so as to remain anonymous within their own community and might not ask relatives to look after children because of privacy concerns.

Service providers working in a rural area may also have their privacy affected because they also may have a dual relationship with a client or as one GP noted, may have “some level of interaction with the relative in future circumstances since the community is small”. One participant gave the example of a relative finding out about the client’s TOP “and the subsequent confrontation with the service provider”.

Negative attitudes and judgements.

Women may experience negative attitudes and judgements from health professionals (e.g., GPs) which may not only affect their present situation but any future issues and may also be relayed to others, “they might tell their friend and a friend and a friend....” thus having a secondary effect on other people if they eventually face a similar issue. Many of the

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judgements were based on certain morals and values held and appeared to be one of the most significant barriers...”they will know straight away if you are making a judgement of them, there are no two ways about that, you know they will pick up, you won’t see them again...”

...when I used to work in the emergency department some of the nurses were very judgemental about emergency contraception so it wasn’t a very pleasant process for women to come and go through.

I have had kids who say they can’t go to the pharmacists and get the morning after pill...they make it so uncomfortable that...you know if you’re judged in any way, you’re not going to come back. Worse thing is if that person leaves and doesn’t take that opportunity, then they are dealing with a bigger decision than filling in a piece of paper, so it’s pretty useless to be cruel and judgemental to someone...what’s that servicing?

Not only were there reports of GPs refusing to refer out for a TOP, but there were examples of GPs deliberately delaying the access to a termination by “doing harm by withholding [information]...” and people finding their way to services by accident rather than being given timely information:

I know a woman who went to a doctor for a referral and got mucked around and ended up getting delayed for so long that it was too late and she ended up having a baby which she is having now as a single mum which she intended on having an abortion and this doctor effectively prevented it by referring really inappropriately, making her come back in 3 weeks and she was 12 weeks by then.

We have become suspicious that GPs are actually delaying them accessing a service because of their own views on abortion so they are sending them off to get

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multiple ultrasounds...then we have to wait for that test result and now I need to organise an ultrasound for that test result and that's three weeks away so they get them further along with the pregnancy before they actually contact us and by then women are often completely furious that it has taken that long and they have had to have all those tests before they come and they don't need to have all those tests...

Young women are often the recipients of particular judgements from health professionals about their age and in the form of threats and intimidation: "I'll give it to them this time but if they come back again I'll ring their parents". Young women may also experience pressure to abort a pregnancy because "you are only a teenager". Similar attitudes were also reported within the school context:

...one of the girls was pregnant...at school and I remember a teacher saying to her "are you sure you are feeling comfortable in that uniform?" But it was him feeling uncomfortable because she was pregnant, the girl was quite happy, she was proud of her body.

Participants were also asked whether they themselves or other professionals had encountered negative attitudes or judgements from the community level. Some participants felt that there was a negative community attitude (particularly if the region has a Catholic presence) towards TOP. However, one participant, a GP reported "I don't think that's an issue here".

Most of the participants who believed that these negative attitudes did exist also believed that they *do not* pressure clinicians against performing terminations locally if they are trained to do so. They felt that insurance premiums were a greater deterrent to GPs who want to train to do TOP as they would not recuperate costs in a rural context

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Negative community attitudes sometimes followed women who travelled to Melbourne to access termination. The protesters outside city services were reported as particularly distressing to women.

...it's just as bad if you are on a footpath... you don't need that, it's actually abusive and it's just an infringement of your personal freedom and space. Women who have made that journey and made a decision to get there, they have gone through enough....

Theme Four: The Impact of the Victorian Abortion Law Reform: “A Lot of My Peers Didn't Know it was in the Crimes Act and Were Horrified When They Found Out...”

The fourth theme to come from the interviews centred on the 2008 Victorian Abortion Law Reform which legalised TOP in Victoria and removed it from the criminal domain. At least three participants made references to the “changing legislation” and were then invited to further comment on the impact on the law reform. The law reform was deemed to have a possible impact in three areas: on women and the wider community, on doctors who refuse to provide or refer for a TOP, and on unwanted pregnancies or TOP rates.

The impact on women and the wider community.

There were three key positive impacts the participants felt may come from the law reform:

- The law reform brings the legal aspect of TOP in line with current practice, and because TOP was made legal until 24 weeks it may even have the effect of broadening rural services to be more flexible with late term TOP.
- The change in legal status may improve data collection on TOP in Victoria (which is currently not recorded). Subsequently, there may be an opportunity to feed this information into the development of prevention strategies.

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- Taking TOP out of the Crimes Act and the accompanying publicity might increase conversations about unwanted pregnancies and TOPs and begin to open up a topic that has long been hidden. This might result in decreasing stigma and negative ideology sometimes surrounding the topic.

...people I know who had had abortions were really relieved and felt that it was an - affirmation...they found that the debate had brought up a lot of reasonably unpleasant memories and to turn on the radio or looking in the paper...was a constant assault on their memory of their own experience but they were just incredibly grateful that it had been decriminalised.

Although participants were not sure if this legal change would result in practical changes there was some suggestion that with this increased publicity, TOP “would become more visible in the world and possibly with greater visibility would come greater access...”

The influence on doctors: “It’s more than just telling [them] they have to refer.”

There were mixed reactions concerning the influence the law change would have on doctors who refused to refer a woman for a TOP. Some participants noted that in Victoria, medical students are taught that they must refer out regardless of their beliefs about TOP, however, many still do not and some participants felt it was up to the Medical Board to begin to address this rather than rely on the law reform. The following comment reveals the uncertainty of some participants as to whether the law reform would have any effect on doctors who refuse to refer: “even though guidelines change or rules change sometimes it takes time for it [practice] to catch up...”

Because what it would need to take is a societal...if the legalisation of abortion means that they are going to talk more about it in schools or in sex education then maybe the doctors of the future are the ones who the seed will be planted...maybe it's

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a long term benefit but - I think for the now - that people have the way they do things and they have their opinions and unless it affects them directly it's pretty much the way it is, unfortunately.

One interviewee who believed the reform would change the referral process suggested that those who previously did not refer out might begin to do so because they would no longer be afraid of the law, "I have had off the record discussions with people in a few health services...and it would be their intention to change that practice if we decriminalised abortion..."

While participants spoke mostly of the positive side to the law reform, there was some concern doctors who are morally opposed to TOP might feel forced to refer for the procedure but would do so with a negative attitude; one nurse was concerned that "they [women] are going to get a difficult compliance rather than no compliance" such as "I will give you the referral...but...."

The impact on unwanted pregnancies or TOPs: "No one is expecting it to change the behaviours that lead to unplanned pregnancies but it's a really important step."

There were also mixed responses regarding whether the law change would increase the numbers of unwanted pregnancies or TOPs. One participant reported that "people will be surprised to find out that actually nothing had changed accessibility or the way services are run..." However, two participants who worked at a TOP clinic reported that they had noticed during the law reform debate a possible reduction in calls and contacts to the service, perhaps because negative publicity might have prevented women from calling. Immediately following the law changes, they noticed an increase in women contacting the services for late term TOPs, assuming that because the law change allowed for TOP up to 24 weeks, all

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services would provide terminations up to this date, which is not necessarily the case. “There was a woman who lived in a rural area with an intellectual disability and was 24 weeks, and the doctor was calling on her behalf and that's just...we can't do anything, you know. And the doctor was saying, ‘but I thought that you could...’ ”

Theme Five: The Role of Social/Cultural Issues.

Throughout the interviews it became clear that belonging to certain social and cultural groups could influence a woman on many levels including the accessibility of the family planning services under investigation, and on a broader level, the decision-making processes behind contraception use and termination as well as the meaning of a pregnancy. Age, being Indigenous, or from a migrant or non-English speaking background, experiencing family violence, having mental health issues and specific aspects of the rural culture were dimensions of diversity the participants mentioned.

Life stage.

Participants noted the importance of recognising that there are different family planning issues for women at different ages. Two life stages were particularly prominent:

Women with children already/Menopausal women.

These are women who may already consider their family complete and do not want more children. Women experiencing menopause may fall pregnant because they do not use any contraception, instead assuming that they are safe. These women are likely to be particularly disadvantaged financially and yet they are the women who really need these services.

...She was an older woman, like 40 or so, with teenage children about to experience the independence and she had an unexpected pregnancy just when she thought it was no longer an issue at all...

Teenagers.

If teenagers come to a GP pregnant and want a termination, it's not going to happen – it's as simple as that. Teenagers are probably the group who face the most barriers such as being able to afford the service and subsequent costs with travelling to Melbourne, limited ability to travel for the service, limited support in making the decision and finding out about and accessing a service etc.

Rural teenage women are at particular disadvantage when it comes to accessing EC, TOP, or other family planning services. Table 4 details the particular and interconnected issues raised.

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Table 4

Issues faced by rural teenagers when accessing EC, TOP, or other family planning services.

Issue	Quote
Financial and transportation barriers are greater because they have less chance of having a separate income to their parents and cannot drive	For a school age kid often there is only school buses and there are limited hours and then if you miss the bus or can't catch the bus...
Greater concern for privacy (e.g., may be concerned parents will open a medical bill or access Medicare records)	The younger ones are more concerned about privacy and less confident...you know a 30 year old woman could go to the doctor for any number of reasons but a kid will always go because they are sick with a parent and so they just don't go in without their parents...
Consent issues (although parental consent is not a legal requirement for EC and TOP some practitioners still require this because of their own moral concerns)	Young women - particularly in rural areas who have double disadvantage of sometimes needing guardian or parental consent if they are younger than 16.
It is common for pharmacists to refer the teenager to a family planning clinic for EC because of judgements about their age	It's really complicated even if you are 17 and a little bit older you still depend on your parents so it's just not going to be that easy to sneak off and do it without having a story about it.
Teenagers may have less support and be less able to or likely to tell someone if they need contraception, are pregnant or need to access EC or a TOP. Participants noted that having supportive parents a teenager can talk openly with can make a difference.	...for me to have to tell them to be there and to be a support for their daughter...it's not always there and I know that a couple of conversations I have had have been around at least your daughter has been able to come to you about this issue...can you be a support, but for me to have to tell them, it saddens me that that support base, that someone, a total stranger on a phone...
Being in denial about a pregnancy may also be common among teenagers	...denial is probably a really big factor for people, it's just a really hard thing to deal with, for whatever reason and that could be to do with all sorts of things in terms of how and why they conceived. For young people just not wanting to go there because it's too hard to acknowledge the fact that they are pregnant and the reality is that some people are a long way into their pregnancy before they actually deal with the fact...

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School nurses are an important source of health information and support for some teenage women, and “often they are the only one”. However, school nurses have restricted roles and services they are allowed to provide, “they can't provide pregnancy tests, they can't access emergency contraception, they don't want to go to local services to get those sorts of things supplied because they feel that even though there should be confidentiality, there's a breach in that [the nurse and subsequent student accessing EC will not remain confidential].”

Information and knowledge about health services were also mentioned, with participants noting that younger rural women may have received some common knowledge about how to access Ballarat's Community and Sexual Health Services from their school's health promotion. However there are implications for those who drop out of the school system as they may miss out on this information.

Participants were concerned that while “the age of sexual activity is dropping...there hasn't been a corresponding [change] in services to respond to that population”. Service delivery needs to reflect the above issues faced by teenagers; some of the suggestions of flexible service delivery for teenagers included SMS communications and free EC.

Other groups of women facing particular barriers.

Participants acknowledged that within the rural context there were other groups of women (see table 5) who meet additional barriers as well as attributing different meanings to unplanned pregnancy. Such barriers compound the stress and complexity of their cases “whether that's mental health or some sort of medical issue or all those things, that can be really, you know, just triple, because of that distance to get through as well”.

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Table 5

Issues faced by other groups of women from the Grampians region accessing sexual and reproductive health services.

Group	Quote
Migrant or non-English speaking background women	Do you know I don't think I have ever had a CALD [culturally and linguistically diverse] woman from a rural region...Which makes you go, what's happening, what is happening to those women if we are not, if they are not part of my memory of working with them...and so what happens to them?
Refugees	Something that is emerging in the region for us is a whole lot of resettlement programs so we are getting overseas refugees...we have got access to interpreters over the phone, but we haven't got a lot of language printed things...so somewhere along the line we need to catch up with how to access that information as well and just learning culturally, we have actually had some sessions on the cultural appropriateness of issues to do with sexual health because it's actually a whole new learning curve for a lot of us in that area....
Indigenous Australians	<p>...very poor literacy, poverty and limited skills to kind of negotiate the world...you really do have to be there to try and help them but despite that they often end up in really crappy situations.</p> <p>...children and unplanned pregnancies is a cultural thing and children were so valued and unplanned early pregnancies were so normal that an abortion was really kind of unacceptable....</p>
Women who experience family violence	They can absolutely believe that they will come to the city and be found.
Women experiencing mental health issues	<p>...That woman who was agoraphobic...So she has this really big journey and fear of leaving the house and she had to be able to get out of her house and get here. And she lives...a long way and severe physical responses to that experience of leaving and the humiliation, I suppose, of having to be away from what holds you together...She did end up getting here... it was with a lot of support, a lot of check in with her throughout the day...and actually going into the day surgery with her until she has had an anaesthetic and then seeing her in the recovery centre and affirming how well she has done throughout the whole process...limiting the number of people that have contact with her or sometimes the advocate part of our job is to help facilitate making things like that as smooth as possible.</p>

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In summary, some subsets of rural women face extra barriers on top of distance to access family planning services. Rural teenagers are one subset of the population who meet significant disadvantages when accessing TOP, such as limited financial access, increased privacy concerns, less support, and service providers who require parental consent before providing EC or TOP. Despite these barriers, many of the participants noted that supportive parents, school nurses and flexible service delivery can be facilitators to overcoming these barriers. Refugees are increasingly settling in rural areas, meaning service providers need to be culturally sensitive. Women experiencing family violence and mental health issues may require extra emotional and practical support when accessing TOP. Case studies provided by the participants illustrated that advocacy skills and professional development were particularly important for service providers working with these subgroups.

Rural cultural implications: “It’s not just the physical barriers; I think the social barriers would affect the physical.”

Specific aspects of what some of the participants deemed “the rural culture” were raised as having an influence on at least three different levels: on becoming pregnant in the first place and family planning methods compliance and use, on the decision-making process once pregnant, and on service delivery. The following case example demonstrates that motivation to use family planning methods is more than a matter of physical access.

... she was 21, not that young...so she was going to have an abortion so we went and had the ultrasound, she saw the little beating heart and decided not to... I think she is a little bit typical of that fantasy that country girls can have...”I haven’t got any other alternative,” she had some crap job...so life is boring, so why wouldn’t she want to have a baby in quite bad circumstances, you know an unstable relationship with a guy who is not committed so she is just in denial about it....

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...my belief is that really the motivation to use family planning services really comes from a deeper level, it's about having aspirations and self respect, perhaps not being too inclined to fantasise about how great your life would be if you became a mother...

Each of the following subsections describes further aspects of a rural culture that may have implications for women in need of sexual, reproductive, and family planning services.

Rural cultures may be more conservative, judgemental, and less open to talk about sexual health issues.

Having moved here from Melbourne I would say that women here are much more reluctant to talk about sexual issues... people are much more reluctant to open up to a stranger who is often someone in the community...

Participants noted that in a rural community “everyone knows everyone”, including the health professionals providing the services and as such rural communities can be more conservative when it comes to discussing sexual health issues. This conservative nature needs to be considered if developing a new service or when a new service provider comes to a region: “I think it would take time...they are suspicious of new things...people who stand out tend to be judged very negatively and somehow that could play out...”

If you put a building how long would it take before people began to use it, how would you make it appropriate, if you put sexual health out the front...everyone will have a bag on their head in the waiting room, it would be really difficult...

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Rural culture and gender: “Role models for teenagers validate teenage pregnancy as acceptable.”

There may be specific gender roles played out within a rural context that affect the choices women make, as seen in the Table 6. It should be noted that not all these examples denote negative outcomes; as can be seen in the first issue, some aspects of gender roles can support women from rural areas to make positive family planning choices.

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Table 6

Issues around rural gender roles and sexual and reproductive health.

Issue	Quote
<p>Mother/daughter relationships:</p> <ul style="list-style-type: none"> • may stay connected for longer • may be more likely to go and see a GP together 	<p>...young women seem to stay very connected to and related to their mothers longer than they would and are much more likely up until their 20s even to present with their mothers for the whole consult and want the mother there...and are really keen for their mother to know all about their pill use and their sexual activity.</p> <p>...Because mum has come in for a pap smear and will say “look my daughter’s having sex and you know, I’m a bit worried and she might come with me next time.” Sometimes you see the young people with the boyfriend’s mother, if mothers not in the picture, you will get a female figure like that or an auntie, or I’ve even had grandmas with really young women come in.</p>
<p>The influence of role models and early pregnancy:</p> <ul style="list-style-type: none"> • normalise and validate • continue the cycle 	<p>One of the things I think is interesting about working in the country and challenged me when I first moved here, cause I grew up in the city...was the discovery that some country women having an unplanned pregnancy and going through with it is not always that bad, it doesn’t seem to be as bad a thing as it was in the social circles I was in the city and I think that is because of community and cultural expectations and support.</p>
<p>Gender identity in rural areas:</p> <ul style="list-style-type: none"> • may influence contraception use • may influence sexual health • a woman’s role may be more about motherhood 	<p>Could also be the “blokey” culture - because there is a lot of men out here, I know they are everywhere but you know, it’s a real macho, bloke culture and we know that men’s interest in contraception is a huge factor in compliance...</p> <p>I just think it’s the culture...you know hard working, put your family and your work, the survival of the farm first, your sexual needs are really low down...your role as a woman is more defined in your contribution in certain ways than through your sexual relationship with your husband....</p>

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Issue	Quote
Rural teenagers and women may have fewer opportunities (employment and education), may be disengaged, isolated and marginalised. This has an effect on motivations to use family planning services, early pregnancies and continuing unplanned pregnancies	A lot of welfare dependent families because of the culture I suppose, if they could find a way to inspire those women and those people with some sense of the future... [There is] more incentive to continue with a pregnancy because there is nothing else to do.
Non-traditional gender roles have effects. For example, childrearing may be seen as incompatible with non-traditional gender roles	One example is of a woman who had a termination because she had to work on the farm in a non-traditional role for a woman.

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Whether because of gender roles or the lack of opportunities present in rural areas, one interviewee felt that women might be more likely to continue with their pregnancy in rural areas. Another suspected that rural women are more ambivalent when making decisions about an unwanted pregnancy.

They seem to be much more ambivalent about abortion, it's much more complicated...when I worked in Melbourne the only pregnant women I saw were looking for an abortion so they were further down the decision path way and maybe the ones who I see come to me because they really are ambivalent.

One participant provided a positive case of a rural teenager who decided to continue a pregnancy, which turned her life around. The case highlights the need for good supports for women regardless of the decision they make:

There was one patient I had who was about 19...she had left school and she wasn't doing much...hanging out with a fairly dodgy crowd with her boyfriend and she'd got pregnant unexpectedly and broke up with him almost immediately and decided to have the baby and move back in the small town with her mum...when she had moved away from home and got involved with him or whatever, she had had a falling out with her mum...it was such an amazing and positive experience for her which really surprised me...it reconnected her with her family in a good way, it gave her a focus for life which was really positive...because she wasn't really going anywhere and she didn't really have any plans, she didn't want to study, she didn't have any career ambitions...but in some ways in deciding to become a mother and putting all her energies just into that was really positive and that wasn't sort of the stereotype that you have about early unexpected pregnancies!

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Rural women have many different voices.

Despite some of the rural cultural issues mentioned, some participants also cautioned against “lumping” all rural women into one group. It became apparent that although rural women are often talked about as though there is only one voice to be heard, there is a multitude of voices and power differentials that need to be considered and have implications for the barriers experienced. It became evident that rural Victorian women faced some different issues from those in other states, and that within the Grampians region here may be differences between the major centres Ballarat and Horsham (e.g., Ballarat may have a TOP provider, Horsham is also further away from Melbourne). Within the Grampians region there are class divides where different groups of women see themselves as holding, or see others as holding, certain values. For example, one group may be seen as having more early pregnancies, another not. One’s group identity is likely to have an effect on whether one is proactive about family planning or how one sees an early or unplanned pregnancy, “there are multiple social circles that don’t have that much to do with each other and wouldn’t all share information or beliefs by any means”.

Less choice of services and the influence of the smaller population.

The most significant part of living in a rural town was that there is less choice in services, which adds barriers that can increase the psychosocial effects. A GP noted that even if there is a TOP provider in the area, women may be reluctant to see them for reasons such as the providers’ poor interpersonal skills. Other professionals may refer away from this clinician or prefer to send certain groups of vulnerable women to a metropolitan service, thus making the process more negative or difficult for the woman.

A couple of women who had later abortions and had prostin [a hormone like substance used to induce TOP] some of them had absolute nightmares with him because he was a difficult personality, brisk...sometimes inappropriate...so it wasn’t

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ideal and some of the women were quite traumatised by that and we would never, would certainly never have a procedure with him again or go here again so you're limited.

In addition, some of the barriers are more likely to “stick” and last longer in a rural setting because the “pool” of people a woman may know is smaller. However, this also means health promotion can have a positive effect in just the same way:

...I think there is potential for a good or bad influence to have a big impact because of that small [community]...for example, when I was talking before about family planning nurses down here take a lot of good sex education locally or the teacher...has done good sex education we can see a direct impact of that individual's action....small communities are very vulnerable to that, it's one of the attractive things as a rural professional in that your impact makes a big difference.

Theme Six: Psychosocial Effects of the Barriers to Access.

There is a greater psychosocial impact [for women living in rural communities] and there are two reasons why. One is there is less anonymity than being able to access a service like that and there is less option depending on how far you go out.

The psychosocial impact is huge with barriers, it really is because they just don't need that at that time when they are making this incredibly difficult decision if you add even one barrier it can absolutely tip them over the edge, yeah ok you have made your decision but now we can't get you into the clinic or you are going to have to go to Melbourne because you're actually 12 weeks and 3 days and it can just be the thing

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that makes it all too hard. I think barriers can make a really tough decision exceptionally tough.

Participants described a number of impacts for rural women who experience the previously mentioned barriers. These in turn may contribute to a woman struggling with or delaying a decision, and may increase the emotional effects to an overwhelming extent. While many of the barriers impacted on women themselves, participants moved beyond this individual perspective to note relationship and social implications as well. Rural women were described as resilient; and one participant reported that many rural women see barriers to health services as the “norm”, so they just “get on with life”. However, the barriers were also described as a “huge distraction for women...in their lives, organising all that”. They may feel disempowered and their self worth and self-esteem may be diminished when meeting these barriers. Table 7 lists some of the psychosocial effects participants described in the course of the interviews:

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Table 7

The psychosocial effects of barriers to accessing family planning services.

Effects	Quote
Guilt	It's how you feel in yourself, if you are feeling vulnerable with these life making decisions, your vulnerability, your hormonal levels, or your support levels, or how life is travelling in general...then you're very open to misrepresentation and being taken advantage of and people just don't need that when they are dealing with a whole heap of challenging...they don't need those other obstacles put up in their way because they are doing the best they can with what they have got at that time...guilt is a big wasted emotion, because it actually weighs you down and you can't move, you're just sort of floundering...
The emotional stress of waiting	We often have to call women back whether that appointment has been approved or not, so I am sort of wondering, you know waiting to find out if that appointment is a possibility can be anxiety provoking as well. I have seen women who have really become quite beside themselves in that two and half/three weeks that we are trying to slot them in.
The emotional stress of travelling	I am just kind of thinking about coming into the city and the anxiety associated with or the experience of coming to the big smoke.
May be less likely to seek help for future sexual and reproductive health problems or access family planning services	Well it certainly would not be conducive to going back to that person, and I think for younger women they are going to get more dejected easily, so all the women who are more grounded or more sure of their feelings are more likely to go in there and seek help somewhere else in the future but possibly the younger women mightn't. They would definitely be affected adversely by that experience.
Relationship stress	To the relationship, to the family dysfunction, relationship, you know the whole thing's under pressure and so that's what I'm saying, you don't need all these other obstacles on top of all the obstacles you may already face...
Social effects	[There are] social consequences when faced with an unplanned pregnancy, for example, less education, work opportunities.

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Effects on timeliness.

A problem looked at and shared can be worked on but if they keep getting knocked down with these types of barriers, it affects their ability to seek help about these issues in a timely manner.

There were mixed responses relating to the effects of timely decision-making about a pregnancy or using EC. Some participants believed that these barriers affected women to the point where they miss the cut-off for a TOP or will not access EC: "I have certainly come across people who have got to the point where it's too late because they just haven't known where to go." Another noted "we know that with teenagers, if they don't have timely access to a service at the moment they want it then they won't use it, that's part of the problem."

On the other hand, some participants suggested that "women rarely run out of time and that if a woman, in particular wants a TOP, she will find a way to do it". The following quote, from a social worker, illustrates the barriers might not stop a woman from accessing a service she wants, but will certainly serve to delay and prolong the process, increasing the psychosocial effects and perhaps even contributing to a later term TOP.

Stretching it out really makes it more traumatic. I haven't seen a case where it's actually been beneficial...other than for people who are ambivalent, than sure you have got to give them time and you know you see them again and do all those sorts of things to make sure they are in the best frame of mind that they can be in terms of decision-making. But if they have made a decision then they have to wait it's not a good thing.

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Theme Seven: What Is Being and Can Be Done?

The final theme came from asking participants to consider what could be done to reduce any barriers they identified. Many participants took this opportunity to point out some of what is currently being done in the region to make the process and access easier for women. This comprises the first subtheme of this section, with the second subtheme, being the future possibilities for family planning in the Grampians region.

What is currently being done: Facilitators to access.

Participants gave examples of the importance of good services from health professionals: “the most common response is that they talk to us and they can't believe how thorough we are with helping them come and have a service”. Numerous descriptors were used throughout the interview process for what makes a “good” professional in this area, including: non-judgemental, has facilitation skills, is supportive, has connections with other relevant health professionals or support services, knows the sexual health system, is aware of judgemental professionals in the area, understands the metro services (e.g., their referral and intake system, how many weeks they provide abortions up to).

Participants put together a composite picture of good practice in tackling barriers and facilitating access, as summarised in Table 8. It is important to note that counselling was considered an important service that incorporates most of these good practice guidelines.

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Table 8

Summary of good practice guidelines for decreasing barriers and facilitating access to services.

Good practice	Quote
Option and information giving, being a gateway to other services	I've seen people go down and have a procedure and then maybe they have come back and they are pregnant and they are doing a different choice this time...that's a credit that they come back to a service that might hold memories of them...that's a positive health experience that they will come back...so they are tapping back...
Getting a sense of what is going in the whole picture for a woman (e.g., her relationships)	Letting them know that it's ok if they come with their partner to find out, that's often an enlightening experience because you get to see a bit of the dynamic, what's happening in the relationship, you can usually get a bit of a snapshot...
Facilitating and organising the process for a TOP to make it as smooth as possible	In that time I could have gone to the GP, got the ultrasound, got the dates sorted, get to gyno clinic and then book them into the next gyno time...
Liaise and organising aspects of the process with other services	<p>...in trying to get money, we don't have access to funds like at the acute hospital so we had to go to external services and so then of course I was dealing with church services or church affiliated services...I had to give them a reason why they had to give this woman a substantial amount of money and name her medical dilemma then. Which we then had to work through that ethical dilemma....</p> <p>...it's kind of like one of these things where you have to jump into being a social worker and I guess with this particular issue you get more involved in trying to organise everything for the woman than I do for I don't know, back surgery or something.</p>

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Good practice	Quote
Navigating around the barriers	They would see me and I guess I would try to facilitate it without her having to hit that barrier [judgemental service providers]. I see that as part of my role to try and ease her way through the health system.
Supporting the woman emotionally	It was with a lot of support, a lot of check in with her throughout the day that she was here and actually going into the day surgery with her until she has had an anaesthetic and then seeing her in the recovery centre and affirming how well she has done throughout the whole process...
Advocating and negotiating for the woman	...the advocate part of our job is to help facilitate making things like that as smooth as possible so, I don't know if she had a room to herself but maybe that's something that we might have been able to negotiate, trying to advocate for...
Having knowledge of rural issues, especially if they are a metro service	I found the pregnancy advisory service were quite facilitative about that which was good and they had an awareness of rural issues which was good...
Post termination support. While this service is limited in rural areas, it is also difficult to know if women need support post TOP given that they may not contact a service afterwards	...it's also looking at their other reproductive health needs, it's looking at future planning, it's making sure that, because these days medically things are a lot safer but you still want to make sure everything is going well for them, and it's also tapping in to see how they are travelling post procedure, and we would often link back to a counsellor if need be.
Support and referrals if it is too late for a TOP	You hook in with this person and make sure this is where they are at, they have decided to carry on with the pregnancy but at 20 weeks...It's similar to what we do to them in terms of I would often refer people who were considering terminations to community health. So that would be, that sort of cross referring, happens all the time.

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Two of the GPs and one nurse specifically spoke about the role nurses can play in reducing pressure on GP services. They noted that “there are a lot more general practice nurses in the area now”. While they noted that a nurse’s role can be “a bit ad hoc” it can include the following benefits to women:

- nurses may operate using a triage system, therefore decreasing the workload of GPs
- they may provide information and education
- they may have longer appointment times than GPs so “they tend to be able to talk about a whole range of things, include preconception, general health and contraception generally”
- “a lot of them have sexual and reproductive health training and do pap smears”
- prevention: “she [a family planning nurse at a hospital] also has a role and I think other nurses do in education in schools and in young people which is relatively new, it’s only been happening over the last two or three years and that’s a good thing.”

Participants also mentioned flexible service delivery (especially for youth) as something already occurring in the Grampians region. Such methods included:

- Metro services prioritising rural women:
 ...for rural women we always book them ahead so we try to bridge those sorts of access issues with opportunities...we won't give to a local woman. So if a woman calls up from a rural region and she was 16 weeks, 16 years old and she just goes on the next available no matter what.
- Using SMS as a means of communication
- Drop in centres with flexible times

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- Modifying the way information is given so that it is more understandable to the lay person:

We have got one [nurse] in particular who draws a lot, so she will actually draw things out, I love that because if their understanding of the medical lingo isn't quite good she will actually do a picture, we have done it with our pill pamphlet...

What could be done in the future.

In considering what might be done in the future to reduce the barriers, interviewees stressed the importance of consulting with those within the rural community:

The best people that know are people that live in the regions and the areas, it can't be made in a 13th floor building without knowing the infrastructure of how that community works so there are really keyed up people in different regions who have an idea of what works for them and the same for the cultural works you know there are people in those communities that know what works...

Prevention.

To decrease misinformation and also promote what services are available, the participants spoke of the importance of education for women and professionals so that they have up to date information about family planning methods and services. Education was described as an “empowering tool that can change a lot of decisions, you know poor decisions...”

Rather than facing a crisis, if you can get there and do all the preventative stuff, people have access to STI [sexually transmitted infection testing], contraceptives, they know about facilitating choices, with pregnancy, all of that needs to happen

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early, and I think that goes back to almost when people are pregnant, the learning about themselves...

Participants believed that continuing to open up discussions and research in the area will also start to dispel myths and stigma associated with family planning methods, who uses it, who doesn't, why and also that the Grampians region is not just an ageing population but one that requires these services.

I just think talking about this whole area is a good thing, sometimes there is not enough research in these difficult areas, or these tricky areas or the areas that are a bit clandestine, it's not spoken about, its secretive, I mean you have to open up the dialogue so that progress can be made, we are in 2008 but some of our views are right back there...

Participants had seen the benefits of school based prevention work in that it enhanced the decision-making capabilities of young women before they found themselves in such situations, and educated them on their rights so they had the confidence to speak to someone or keep trying if they met any of the barriers or experienced negative reactions from health professionals. One participant considered that men need to also be involved in any education strategies, "often you will get partners of women ringing up very distressed - wanting to know what to do to help...because they are often left out of the whole thing".

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Changes to service delivery: “Melbourne services are amazing, a complete flagship and the others are really poor cousins and there is nothing further out.”

Participants reported sexual health services in Victoria were centralised and almost based entirely in Melbourne; rural services were described as “piggy backing” off them and not being “appropriately resourced”. Support offered to doctors and nurses in rural areas is on the phone primarily and there is not really any other outreach or no clinical services. Whereas, in rural New South Wales they have clinical services spotted all over the place, there are more regional sexual health services, nurses are based there permanently and doctors visit out and provide consultancy support. When comparing the Melbourne and Ballarat sexual health services, participants felt that Ballarat was “resource and knowledge poor”. One participant also hoped that the recent addition of a Bendigo TOP service and the rivalry between Bendigo and Ballarat would pressure Ballarat to do the same: “they are doing it, why aren’t Ballarat doing it.”

Comparisons were also made between overseas models such as France, United Kingdom, and Sweden, where TOP was considered “normalised and all options could be openly discussed” and it was hoped that Victoria could model some aspects of the sexual health service delivery in these countries. One participant thought that countries such as France “were far more progressive” since they had access to EC in schools. “A phone line or web site that provides information about [all options] services for women wanting to continue and not continue with the pregnancy” was also suggested.

It was suggested by a GP who had previously worked interstate that the difference between the rural Queensland and Victorian models included a stronger feminist support service in Queensland. Because TOP was not as illegal in Victoria, sometimes this support was lacking because it was assumed it was not needed.

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Participants believed that to decrease any of the barriers, sexual and reproductive health must become or continue to be a priority on health plans and agendas at an organisational, primary care partnership, regional, state and national level. “If not it's a disincentive for organisations to maintain sexual and reproductive health. If you don't have it as key priority then there is less likely to be a commitment to training.” It was noted that the family planning nurse position in Horsham was created because someone moved to the area with an interest in sexual health rather than being part of the systematic service delivery, which would be a more sustainable option.

Two GPs in particular also referred to the issue of trainee doctors and doctors from overseas coming to rural areas, suggesting that there should be more incentives for migrant doctors to not only come but to stay in rural communities; the barriers to their retention should be addressed, as well as their knowledge about Australian sexual health systems. Incentives also need to be offered to increase the number of appropriately trained gynaecologists practicing in rural areas.

Participants suggested two ways to manage the lack of TOP providers in the Grampians region; one was using a visiting model, where doctors who provide TOP could visit rural areas on certain days. Second, they pointed to the need for incentives to train or to provide TOP in rural regions, especially by reducing high insurance premiums.

Because increasing services in rural areas is not always an option, funding could particularly be provided for services and programs in general health because they provide a conduit between other services “if there was funding if women needed to get an appointment then someone can pick them up from their house and take them to their appointment here and then take them home...” Any funding needs to be appropriate and sustainable for rural areas.

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Finally, recommendations specific to EC were also mentioned. Placing EC on the Pharmaceutical Benefits Scheme so that the cost is reduced was a constant suggestion made by participants as was increasing private waiting areas in pharmacies.

Summary of Themes

The participants provided a comprehensive view of family planning services in the Grampians region that were eventually developed into the above seven themes. It was clear from the beginning that EC, TOP, and options counselling were only going to form part of the discussion, and participants indicated that they could not be considered in isolation from other family planning and sexual and reproductive health issues, as discussed in Theme one. There were some barriers that could be found across both rural and metropolitan women wanting to access family planning services (e.g., judgemental professionals). However, what was apparent across EC, TOP, and options counselling and what makes many of these barriers different for rural women, and is that they have less choices and options. The GPs interviewed also tended to emphasise different aspects of the barriers compared to the nurses and social workers. For example, GPs focused more so on gaps in service provision such as insurance, while the nurses and social workers focused more on health promotion issues and barriers for women themselves (e.g., financial). These findings were also balanced with an exploration into the facilitators of access to family planning services, and a positive side was the finding that within the Grampians region many professionals are already doing things to try and make women's access easier. The psychosocial effects of any barriers were also explored and it was evident to some that barriers meant a woman might not make a timely decision about family planning. However, it was also argued that these barriers sometimes did not stop women from accessing EC or TOP, none the less these women were still left feeling disempowered and the negative effects were felt not only for women but for their families as well. As one participant reported:

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Country women are resilient but there is only so much [they can take], especially if they are not feeling ok about themselves, you know their esteem, their whole body, their being, they are not getting lots of messages about their [being] worthwhile...you are giving people really black messages of not a lot of hope...

Finally, participants provided examples of future initiatives to reduce identified barriers, with the focus mainly on prevention strategies and changes to the service system. It became evident that these participants wanted these family planning services to become a more “normalised” part of Victoria’s sexual and reproductive health system. In light of these seven themes, the next chapter considers the original research questions and findings in relation to the previous literature and the possible implications of such findings for women and for rural women’s health policy and practice.

Chapter 5: Discussion and Conclusion

There are three sections to this chapter. The original research questions considered: the barriers for women in the Grampians region accessing family planning services as well as what makes it easier, the psychosocial effects of these barriers and their effects on timely decision-making, and finally what can be done to make it easier for women to access family planning services? The first section discusses the five research questions and the findings in relation to the Literature Review. The second and third sections consider the limitations and implications of the present study.

The eleven professionals interviewed in this study provided rich accounts of their experiences and perceptions of family planning services (specifically Emergency Contraception [EC], Termination of Pregnancy [TOP], and options counselling) in the Grampians region. The study began as an exploration into the facilitators and barriers to accessing these services in a rural area, what effects these barriers might have on women's wellbeing and what might be done to remove them. But the reach of the study broadened into an exploration of a much wider process that operates before and throughout a woman's sexual and reproductive health life. In other words, the barriers to access were not just a matter of physical availability or travelling to Melbourne for a service; the story that unfolds is much more complex, encompassing subtle barriers such as the legal status of TOP, rural cultural constraints, gender relations, and myths about family planning options, much of which is beyond the scope of this study. The following section examines these findings in relation to the five original research questions and the existing literature.

The Barriers to Accessing Family Planning Services in the Grampians Region

Participants were initially asked to consider: what barriers do women in rural Victoria experience in accessing family planning services? In identifying the barriers to accessing family planning services in general, it became clear that the overall state of health services in

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a rural area must also be considered. The Australian Longitudinal Study on Women's Health (ALSWH) found that rural women had poorer access and choice in GPs, hospitals, counsellors, women's health services and specialists, and reported lack of transport, greater waiting times, and/or having to travel long distances to access these services (Warner-Smith & Lee, 2006). These issues were also borne out in the Grampians region. In line with the data from Women's Health Australia (2007), Grampians women were also reported as having less choice to see a female GP. While some of the participants reiterated the benefits of recruiting overseas-trained GPs to rural areas to reduce this shortage, they also pointed to retention issues because these GPs may experience difficulties with rural life and have less understanding of the Australian medical system (in this case specifically family planning issues), as noted by the Australian Medical Workforce Advisory Committee (2004). All these issues feed into women's access to family planning because they delay access and reduce choice.

Barriers to accessing termination of pregnancy (TOP).

Many of the present findings regarding geographical, financial, and confidentiality/anonymity/privacy barriers to TOP access were similar to findings from previous international and local studies. Similarities with the international literature (e.g., Dobie et al., 1998; Dobie et al., 1999; Silva & McNeill, 2008) included lack of local services, travelling for confidentiality and privacy, increased costs, travelling overnight or for more than one visit, and knowing where a service is located. Again, many of the issues presented in the Australian literature (e.g., De Costa, 2005; Nickson et al., 2006; Rosenthal et al., 2009; Women's Health Victoria, 2007, 2010) such as distance, cost, logistics, confidentiality, childcare, and difficulties in getting through to metropolitan services were reiterated in the present study. Women's Health Victoria (2007) previously noted the complexity of the accounts they had heard from women; the same can most certainly be said for the accounts

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relayed here. Many of the examples relayed by participants demonstrated that women seeking TOP do not meet with just one but are usually faced with multiple barriers. These barriers are often interconnected; for example if a woman must find care for her children while she is having a TOP, usually she will struggle to find the money to do so, which then means she may have to unwillingly confide in friends and family, all while taking time off work...which again leads her to be short of money.

Women's Health Victoria (2009) reported that practitioners who refused to refer women for TOP particularly disadvantaged rural women who have limited choices to see someone else, and most of the participants also confirmed this concern for women in the Grampians region. Moreover, some participants provided examples of delaying tactics being used by those with moral objections (e.g., by ordering multiple ultrasounds or omitting important details about how to access TOP). Such reports suggest that despite the 2008 Victorian Abortion Law Reform, which included the responsibility to refer on, some health professionals will deliberately delay the process, and as such the "work" is still not complete in this area.

The specific reasons why TOP was not conducted or was difficult to access in this rural region were hard to ascertain. There is a definite lack of trained TOP providers in the Grampians region. It was also suggested that terminations are often hidden under other medical services (possibly due the legal status prior to the law reform) as was found by Dobie et al. (1998), Rosenblatt et al. (1995), and Women's Health Victoria (2007). The very fact that terminations are not always recorded as such makes it very difficult to ascertain if they are indeed performed in local hospitals. Some participants had been told that TOP was difficult to obtain at the local level because of waiting lists for surgical times, while others believed that underlying this excuse were moral/religious objections. Perhaps the reality is quite complex and more than one issue is at play: for example there may be limited surgical

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times available and because of religious objections TOP is placed at the end of the list. When Eddington (2007) presented a paper on the adjacent Loddon-Mallee region at the “Abortion in Victoria: Where are we now? Where do we want to go?” Conference, he questioned the belief waiting lists and religious objections were used as reasons” not to provide a service, stating that a closer examination of the local situation did not support this view. Soon after this conference a TOP clinic was established in Bendigo. It is uncertain whether Dr Eddington’s observation of the Loddon-Mallee region would apply to the Grampians region. Regardless of whether these are “real” reasons or just excuses, despite being a procedure that is based on timeliness, TOP is difficult to obtain at the local level. One of the most frequently mentioned reasons in this study that was not raised in the previous literature is that rural doctors would not perform enough terminations to recover the associated costs such as insurance. This is another disincentive to train to provide the service. The question is then raised as to whether a visiting model for TOP provision might be more appropriate to rural regions rather than lobbying for a full time service.

Barriers to accessing emergency contraception (EC).

While the concerns mentioned in the previous studies (e.g., Dunn et al., 2008; Martin, 2004) regarding access to EC related mainly to pharmacists’ refusal, or not seeing a need to stock it, as well as pharmacy opening times, these were not the most pressing issues cited for Grampians women. While EC may be available within the region to Grampians women over-the-counter, in emergency departments, and community and sexual health centres, the biggest issue raised was the harm done by misinformation (non-evidence based warnings about the “risks” of EC) provided by one local pharmacy, even though they dispensed the medicine. This resonates somewhat with government campaigns such as the Royal Commission of 1904 into declining birth rates that resulted in the Australian Government warning women of the physical dangers of birth control (Gilding 2001). Although there was

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only one example of a pharmacist providing misinformation, more than one participant bought this case up, suggesting that the effects of just one practitioner providing misinformation were wide because of the small community.

Myths about EC and TOP.

Myths about general contraception (such as “all contraceptive pill types make you gain weight”) continue to be an issue for women in both rural and metropolitan areas. The myth that “a TOP can make you infertile” is also still a pertinent issue, as it was 20 years ago (Ryan et al., 1994). Myths were particularly pertinent for EC because of the use of the term “the morning after pill”. The reported confusion this term caused about the time frame to take EC was also noted in studies conducted by McDonald and Amir (1999) and Calabretto (2009). While myths and misinformation also exist in metropolitan areas, it could be suggested that the effects in a rural environment may be more significant because the limited pool of people a woman knows and the conservative nature of rural culture mean the myths travel faster and “stick” more in the absence of disconfirming information/conversations. These myths are damaging because they may stop a woman from accessing a service that she would otherwise consider using. These issues need to be taken into consideration when developing health promotion for family planning services.

EC and TOP: Negative attitudes and judgements.

The issue of providers judging women who access EC and TOP (raised in earlier studies, e.g., Calabretto, 2004; Rosenthal et al., 2009) also applied in the current study. Even in cases where a local service is provided, fear of such judgements may lead rural women to still feel they have to travel to the city, or lead health professionals to refer them out of town, which further limits choice and the timeliness of the process. Negative judgemental attitudes also operate on multiple fronts, not just towards TOP. Much like the findings of the Ryan et al.’s (1994) study, there was evidence to suggest that some women also experienced pressure

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to terminate a pregnancy, based on judgements that they were too young to have a child, or other practitioners would provide a termination or EC but placed conditions and threats on providing this service to women. Findings such as these give new insight into the nature of choice as more than just a matter of service access.

Barriers to accessing options counselling.

The ALSWH Project found that rural and remote women have less access to counsellors (Warner-Smith & Lee, 2006), and participants also noted this was the case in the Grampians region. However, unlike Conlon (2005), none of the participants in this study raised concerns about limited opening hours or privacy/confidentiality issues for rural women. Barriers to options counselling were not mentioned in the interviews as often as barriers to EC and TOP, however this does not necessarily mean that barriers do not exist. A number of participants described options counselling as an ad hoc part of their work. One could make the assumption that options counselling is not considered a discrete service but is embedded in holistic care and be part of service and information provision.

Barriers to options counselling were mostly discussed in relation to anti-choice organisations and “false providers”. Since the 2006 “Pregnancy Counselling (Truth in Advertising) Bill” was not passed, advertisements by false providers are still an ongoing barrier particularly for rural women who may have no other way of finding out about a service but to search in the Yellow Pages or internet. Interestingly some of the participants believed that this Bill had been passed. Possibly due to the false providers, participants reported that many women perceived counselling as a way of trying to get them to change their minds about a termination. This barrier was consistent with the Conlon (2005) and Ryan et al. (1994) studies which reported this belief as a common barrier that limited women from Irish, English, and Australian samples accessing counselling. This type of finding is not surprising given that many organisations purport to provide “counselling” despite not

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necessarily discussing TOP, the most recent example being the implementation of the National Pregnancy Support Hotline by the Howard Government in 2006. Examples such as this confirm the importance of educating women about the services that do and do not provide counselling on all options for an unplanned pregnancy, and of empowering and supporting women who have accessed these false providers.

Life stage.

While it is acknowledged that teenagers are generally more disadvantaged than adult women, this study also provided insight into the different issues women face at different life stages. Perhaps what is most central to this insight is that there are many reasons why a woman at a particular life stage may find herself pregnant or decide to terminate. This is something lacking in previous research but important to explore when devising reproductive health promotion strategies.

As in previous research, rural teenage women were noted as being at particular disadvantage, possibly more concerned than adult women about anonymity and privacy, and lacking the ability pay for services (Bryson & Warner-Smith, 1998; Warner-Smith & Lee, 2006; Warr & Hillier, 1997). Our findings expanded on these concerns, with participants noting that teenagers are also constrained more than other women regarding transportation to a service, service providers who have moral opinions and want consent from parents, denial about a pregnancy, and restrictions placed on the services that can be provided by school nurses. Given that a young woman is at the start of her sexual and reproductive health life, these disadvantages may have profound effects on her ability to seek help for such issues later in life.

Young women may be particularly disadvantaged by the view that rural communities are an ageing population that does not require family planning services. This results in limited family planning service provision, and thus the younger section of the population

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being underserved. Indeed, participants believed that family planning service provision for rural youth was lacking despite rural youth being more sexually active than their metropolitan counterparts (South Australian Department of Human Services, 2001) and young motherhood rates in rural areas being higher than in urban areas (Family Planning Victoria and the Royal Women's Hospital Centre for Adolescent Health, 2005). These findings have implications for obtaining funding for such services and demonstrate the need to break down this misconception that an ageing population does not need family planning services.

Barriers for other groups of women.

Participants noted that women from certain minority groups such as those from migrant or non-English speaking backgrounds, Indigenous women, or those with family violence or mental health issues face additional challenges to their reproductive rights, as well as living rurally. For example as Moreton-Robinson (2002) described, Indigenous women were often coerced into terminations and contraception, and so family planning and TOP may have a different meaning for these women. Often women in family violence situations or with mental health issues required different and extra support and resources when seeking a TOP, and there were some positive examples provided of practitioners and clinics addressing this need. However, two counsellors noted that they did not see migrant or non-English speaking background women from rural areas in their day to day practice, but could not explain why; further research into this gap could expand and explore family planning from the perspective of cultural minorities.

Impact of rural culture.

While much of the previous research has focused on financial and geographical barriers to family planning access, this research provides additional understanding of some more subtle and hidden influences within a rural culture. Wainer (1998) described the close-knit and suspicious nature of rural culture; in this study rural communities were similarly

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described as conservative, judgemental, and less likely to be open about sexual issues.

Findings such as these give support to the argument put forth by Ryan et al. (1994) that part of the reason fertility is not controllable (despite advances in technology) is that gender identities and stereotypes mean there is a difference between information, access and behaviour. While the present study reiterated that a woman's role may be more confined to motherhood and families in the rural context, it also suggested that the cycle of early motherhood plus limited education and employment opportunities might influence decisions made by rural women. There are two issues within these findings. One is that previous research by Warner-Smith and Lee (2001) showed that early motherhood may lead to long term socio-economic disadvantage which in turn affects the long term health of women and their children. Second, making a choice because "there is nothing better to do" is not "real" choice. This leads to the other argument by Warner-Smith and Lee that more supportive policies need to be developed to offer women real choices about motherhood, employment, and education regardless of where they live. Such policies are not confined to family planning services but are part of a wider picture that includes equal pay, improvements to socio-economic status, greater access to childcare and government financial support, and sex education (Gregory, 2006).

Roufeil et al. (2007) noted that within the rural context there may also be wide variations between the experiences of women in a particular region. The participants, particularly those working further away from Melbourne, similarly reminded us that within the Grampians region there may be variation between such places as Ballarat (a regional city) and Horsham (a smaller, regional hub) as well as class divides within towns. So, while there may be some overall barriers all women face within the Grampians region (e.g., lack of services) it is important not to assume all women will face the same barriers, with some being more problematic to some women than others. Findings such as these provide evidence that

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policies need to move beyond an individual focus as was acknowledged in the “Victorian Women’s Health and Wellbeing Strategy 2010-2014” (Victorian Government, 2010).

Different life stages, cultural backgrounds, contexts, and rural cultures all affect sexual and reproductive health outcomes, service delivery, and health promotion. For example, there would be no point in putting a termination or sexual and reproductive health clinic in a rural area without first considering how service users might approach the service. People living in a relatively small community might be tentative and too embarrassed to use a sexual health service with an entrance that is not private because of concerns that other people might judge them for using the service.

Facilitators to Family Planning Service Access in the Grampians Region

Participants were asked what they believed made it easier for women from the Grampians region to access the family planning services under question. In answering this question, the participants identified many facilitators to access, some of which they try to implement themselves in their work within the region. These facilitators included points of information or gateways to information, access to a “good” health professional, best practice guidelines, the increasingly multifaceted role of nurses, flexible service delivery, and the 2008 decriminalisation of abortion in Victoria. Given that major barriers they identified for women were the lack of services and practitioners in the region, judgemental practitioners, and privacy/confidentiality/anonymity issues, many of these facilitators involve circumnavigating barriers that may be difficult to remove. For example, if changing the opinion of a judgemental service provider is improbable other practitioners may need to make sure they steer women away from this person, assuming other options are available.

Two of the adjectives used by the participants to describe a good health professional (non-judgemental and supportive) were also used by women in the studies conducted by Marie Stopes International (2006) and Rosenthal et al. (2009) to describe what they desired

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from options counselling or what was not desired, as in the case of Ryan et al. (1994) study. In these studies women indicated they wanted options and information, which the professionals in this study also listed among “good practice guidelines” that facilitated access to services. Ryan et al. found that the definition of counselling from the point of view of service providers lacked consistency and sometimes included offering advice. This did not seem to be the case among the professionals interviewed in this study, as advice-giving was not mentioned as good practice.

Flexible service delivery was also listed as a facilitator to access, in line with the UK study conducted by Conlon (2005) which explored what women desired from a TOP service. However, that study also reported that women wanted a telephone counselling service, which was not mentioned here. In fact, none of the participants mentioned the Australian Government’s National Pregnancy Support Hotline, developed to reduce the TOP rate, although the phone and internet were mentioned as ways women access information, in general. A phone line was also mentioned by one participant as a possible future direction *if* it provided information on all options. There was also no mention by the participants that options counselling should be made mandatory.

Many practitioners (e.g., nurses, social workers, health promotion workers) in rural settings take on multiple roles as a means of reducing the shortage of workers in the region. Counselling is one such role that may be adopted by these practitioners. This accords with Ryan et al.’s (1994) finding that it is not so much the setting of the counselling that mattered to women, but the quality of the counselling, which is why although these ad hoc roles were described as facilitating access, some participants cautioned that “in the wrong hands” it could also be a barrier. It may be less important that a specific options counselling service be set up, than that all service providers interacting with women and family planning issue have the basic skills required. In Chapter Two it was observed that while there had been a massive

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uptake of the Medicare Better Access mental health items (Department of Health and Ageing, 2008), the same could not be said for the pregnancy counselling item (Matthews & Lindner, 2008) and perhaps it is worth considering that many women do not feel they need counselling to make a decision regarding a TOP, or perhaps they are accessing it already in the above mentioned integrated ways. Further research into the area would be required to substantiate these hypotheses.

Effects on Women's Psychosocial Health and Reproductive Choices

Participants were asked about the psychosocial effects of the barriers on rural women and how barriers affect their ability to make timely decisions about family planning and the continuation of a pregnancy. In terms of the effects on timeliness, the present findings suggest that, for some women, time does run out and they have to proceed with a pregnancy, as De Costa (2005) also concluded. But there was also another story told by participants, of women not being stopped but being delayed in their access of a termination. These women may experience increased risk to a late term termination along with negative psychosocial effects.

In the case examples presented by participants, there was no consistent outcome for women who made choices regarding continuing a pregnancy (where choice was not removed because they could not access a termination in time). There were positive experiences reported for women who chose to terminate, and also for one who chose not to, and for another who chose adoption. Conversely, one participant described a negative outcome for a woman who chose termination, while another mentioned a distressing situation for a woman who didn't. These cases all emphasise that women need good, realistic choices, support and services whatever their eventual decisions.

As in previous research with rural women (Humphreys, 1998), Grampians women were frequently described as resilient. In Chapter Two the benefits to family planning

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discussed included increased self-esteem, self actualisation, stability and opportunities in relationships, employment, and education (Astbury, 2008; Dixon-Mueller, 1993; Wulf & Donovan, 2002). Consequently, many of the reported effects of meeting barriers to family planning were the reverse of these, such as guilt, disempowerment, distraction, reduced self-esteem, relationship dysfunction, diminished education and work opportunities.

Addressing the Barriers

Little research has considered what can be done to reduce barriers to family planning access; participants were therefore invited to consider what could be done to reduce the barriers they described. Participants offered many ideas which went beyond increased services and funding. Possible actions were examined on two levels: prevention of unwanted pregnancy (through education) and changes to current service delivery models. A key aspect of prevention was opening up the topic for discussion, especially regarding TOP.

Termination of pregnancy is often thought of as a clandestine issue, and participants discussed the positive implications of more open discussion. As previous research by Rosenthal et al. (2009) indicated, and as reiterated here, most women do not think about TOP until faced with an unwanted pregnancy. If this is indeed the case, more opportunity for information-sharing would increase women's knowledge and options before they are placed in the decision-making situation.

While the most obvious way to reduce many of the barriers associated with lack of local services is to increase these services (e.g., using a visiting model, increasing incentives to train in TOP, reducing the cost of EC through the Pharmaceutical Benefits Scheme), our findings seem to indicate that this may not always be possible or sufficient, and consideration needs to be also given to increasing access to metropolitan services (e.g., financial assistance for women travelling from rural areas). Despite suggestions from rural Queensland practitioners (De Costa, 2005) that RU486 (medical TOP) be used to expand rural women's

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TOP access, none of the participants suggested this as a potential option for Grampians women.

Previously discussed criticisms of the current sexual and reproductive health system (Poljski et al., n.d.) in Victoria were also raised by the participants, including the need to increase resources for rural services. Comparisons were made with models from other more “progressive” countries. Participants noted the links between the best health outcomes and countries that have more open sexual and reproductive health policies, laws, community attitudes and services (O’Rourke, 2008). Even using the Bendigo and Ballarat “rivalry” was suggested as a way of getting a TOP clinic to Ballarat, since Bendigo now has one. Dixon’s (2003) suggestion that more should be done to include TOP within maternal and family health services rather than as a separate service was also supported by participants. Participants agreed (similar to the health professionals in Ryan et al.’s [1994] study) that TOP should be normalised within the system, and that all options should be openly discussed, issues prioritised in health plans, and key service provider roles be an explicit part of service delivery.

Limitations to the Current Study

This place-based study of access to services within a particular region cannot be assumed to apply to other regions, nor was it designed to do so. The diversity of rural areas (e.g., different distances from metropolitan centres, demographics) has been recognised (Roufeil et al., 2007), and so confining the focus to the Grampians region may actually be a strength of this study.

Interviewing participants more than once might have assisted in clarifying ambiguities or contradictions and also clarified or tested further suggestions from previous participants. Using triangulation (multiple forms of data gathering, such as focus groups and questionnaires) and member checks (giving participants a copy of the draft findings to

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confirm) may also have enhanced confirmability; however there is no certainty that these steps would have shed more light on the findings, and the scope of the project did not permit their inclusion.

Recruitment issues.

The original intention was that professionals would be interviewed prior to interviews with women service users. Clearly, with more resources, the inclusion of women service users would have provided a more comprehensive view, especially on the psychosocial effects of any barriers.

However, the health professionals afforded a range of views (such as those relating to the wider health system) that might not have emerged from interviews with service users. Although we will never know the exact reason why women did not participate in this study, or how many women with relevant stories saw the advertisements and chose not to respond, the challenges in recruiting service user participants warrant consideration. The following are potential areas worth considering as barriers to the recruitment of women service users.

Ethical issues in service user recruitment.

The recruitment of women service users was largely confined to the public arena such as newspapers or noticeboards in waiting rooms. It is possible that recruiting from within private clinics or community health settings, that is, having GPs and other health professionals speak directly to women accessing a family planning service, could have reduced any reservations or misunderstandings a woman might have about the study. But, because such a recruitment method would require ethical approval from the health facilities which is often a long and difficult process, the decision was made not to follow this path as the research was time limited. Recruiting participants while they are in a vulnerable situation also presents risks of perceived pressure or exploitation.

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Ground rules were set regarding how much to pursue potential participants. However, it is difficult to gauge the appropriateness of these ground rules given that the contact was via email, which might not be read frequently or might be lost in junk boxes. It is possible that a more assertive strategy, such as emailing or calling more than once, would have resulted in more women agreeing to participate.

Ethical issues: Privacy and risks to the researcher.

The decision not to include the researcher's name on advertisements was made for safety reasons in a climate of potential hostility to the subject area. However, this may have depersonalised the advertisements and deterred potential participants. They may also have been reluctant to participate because they saw the researcher as an outsider. Rural communities are close-knit and people are often apprehensive of new or metro-based services and professionals who try to gain access to the setting (Wainer, 1998). Women may have assumed the researcher was from the city and perceived her as "someone who does not know about rural life, yet again coming to 'do' research on us". The sensitivity of this study required the researchers to balance the desire to recruit women service users against the need to prioritise the safety of the researcher and her family, who actually live in the region.

The nature of the rural community and the phenomena under investigation.

The very nature of rural communities may have proved an obstacle to recruiting women service users. In exploring another sensitive issue (domestic violence) in a rural setting, Cox, Cash, Hanna, D'Arcy-Tehan and Adams (2001) noted that a rural community presents specific recruitment problems especially around disclosing sensitive or controversial material. Although we stressed that the interviews would be confidential, women may still have been reluctant to discuss topics such as TOP and EC, because of fears they might be identified.

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Another consideration, one that became evident following the analysis of the interviews with professionals, is that rural women may see the barriers they experience regarding family planning services, or health care in general, as “the norm” or “just something you have to do”. Following this line of thinking, potential participants may not have realised the importance or relevance of their experiences to the research project.

The nature of women’s lives.

Although they were referring to research with women from developing countries, two points made by Scheyven and Storey (2003) may also be applicable to the problems experienced in recruiting women in the present study. They noted that women may lead busy lives involving multiple roles, and the times they can sit down and talk to a researcher are limited. Although our advertisements noted that the research interview would take place at a time and place convenient to the woman, they may not have felt this was possible. While women do read newspapers, the context of when they read them may have an effect on whether they notice a particular advertisement (e.g., getting the children ready for school at the same time). Written advertisements also assume a level of literacy that may exclude some service users.

In addition, Scheyven and Storey (2003) noted that women have to believe they have something worth saying before they decide to contribute to research. At least three issues may have contributed to potential participants feeling they would not be heard, or that what they had to say had no value. These issues include the sensitive nature of the research topic, the historical “silencing” of women in research, and the fear that women experiencing an unplanned pregnancy might be judged or “put down”. However, all of the above is speculation and it could also be argued that the issue of family planning access is not as salient to rural women as we had expected.

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Reflections on the Insider/Outsider Experience

As discussed in the Method section, my identification as an insider/outsider researcher may have assisted me throughout the interview process. It became apparent when I started interviewing the participants that the small piece of information that I was from the region, in addition to sharing my experiences from a placement in the field, was enough to bring on noticeable changes in my relationship with the participant. Participants who began with a “reserved” attitude became more “open” to me once this was shared. In this study there was a very clear link between my establishing trust with a participant and the ensuing increase in rapport and apparent success of an interview, as suggested by Bonner and Tolhurst (2002). The influence of my background on the present study was summed up in a comment made “you can take the woman out of the country but not the country out of a woman” (personal communication, 2009) when I was discussing the preliminary results and research process at a conference. As Matsumoto (1996) suggested, this insider position appeared to decrease the space between myself as the researcher and the participants. In addition, as an outsider who had not had to access any of these family planning services, and was not a service provider (except in the case of options counselling) I was able to have a degree of openness and genuine curiosity and thus not assume that my experiences of accessing or providing these services were the same as my participants. In some sense, this shifting between the insider and outsider roles was used when appropriate to enhance communications.

Implications of the Current Study

Empowerment, social justice, giving voice to and including those from minority or marginalised groups, are all important to the ethos of community, health, and feminist psychology. Rural people in general are a marginalised group whose voices are often left out of key decisions that have impact on them (Wainer, 1998). The application of a qualitative methodology has given voice to those working in rural communities who encounter women

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experiencing unplanned pregnancy. Examining this issue from a rural perspective also advances research because it recognises that the decision-making process is influenced by contexts, and expands the research lens from an individual level towards an ecological perspective favoured within a community psychology paradigm. This perspective also recognises that not all rural communities nor all women within these communities experience the same issues in the same way. This study furthers our understanding of the context and diversity of rural women's experiences, rather than just identifying them as a homogenous group.

It was continually stressed that governments and organisations need to consult with women service users before they decide to implement any strategy. For example, previous research highlights that women want a non-judgemental service that can provide information on all options available, and the participants in this study also believe this is what makes a good health professional. Yet there was concern that the National Pregnancy Support Hotline implemented by the Howard Government in 2006 was flawed and did not provide information on all the family planning options (Metilikovek & McRae, 2007). In addition, there needs to be consideration given to what is already occurring in the regions. While the introduction of a Medicare item and associated training for pregnancy counselling may have been well intended, it did not take into consideration the counselling already available and embedded within other services (e.g., through GPs, women's health services, school nurses). Provision for adequate training might address the variability in health professionals' knowledge and attitudes but this is difficult to mandate.

Exploring barriers to service provision is seen to have a collective benefit for women in that the results can contribute to the design of plausible intervention and health promotion strategies as well as providing detailed information for funding bodies. This study brings us closer to the experiences of rural women service users; the research is expected to be used by

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Women's Health Grampians as a means of decreasing service gaps. A key aspect of community and health psychology is second order change, attempting to change the environment rather than the individual. The criminalisation of TOP, EC not being available on the Pharmaceutical Benefit Scheme, the Victorian sexual and reproductive health service model, limited incentives for training, recruitment and retention of health professionals to rural communities, are all examples of policies that result in the marginalisation, reduced access, and disempowerment of rural women. By focussing on service systems this study reflects second order change, rather than attempting to manipulate women's behaviour in a policy vacuum.

Access to family planning services benefits women and their families, including an increased opportunity for young women to complete schooling and find paid employment, thus improving their own and their family's economic and social wellbeing (Wulf & Donovan, 2002). Any increase in their ability to freely make choices and have control over family planning decreases the equality gap between men and women and between women from different backgrounds.

The community psychology strengths based approach provided a particularly useful frame for analysis. The study provides insight into some of the work professionals in and beyond the region are already doing to support women through (or around!) any barriers to family planning access (e.g., professionals making an effort to be aware of other judgemental service providers). Such initiatives need to be acknowledged and incorporated in future service planning.

An issue that was not expected to be so prominent in the study was the 2008 Victorian Abortion Law Reform. Taking TOP out of the Crimes Act may have begun to "normalise" the procedure as part of the health system rather than as a separate domain, which was one of the criticisms participants raised around the current sexual and reproductive health system in

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Victoria. While this reform brings the law into line with current practice, there were conflicting views as to whether it would actually facilitate access which could be a topic for future research. At the very least, the reform debates initiated conversations and dialogue on a “taboo” topic, which could facilitate data collection and thus prevention and intervention measures. Perhaps the next step after the law reform is to educate the community about current services. The law reform may even motivate some services to increase termination timeframes. If the best health outcomes occur in countries that have more open sexual and reproductive health policies, laws, attitudes, and services (O’Rourke, 2008), then legalising termination options will bring Victoria closer to this ideal.

It was also noted throughout the interview process that many of the professionals had to be reminded that the specific focus of the study was EC, TOP, and options counselling. Many seemed to assume that family planning meant general contraceptive methods (e.g., the pill, condoms or the withdrawal method). In addition, Sexually Transmitted Infections (STIs) were also frequently mentioned. The fact that the participants wanted to raise other issues suggests that general contraception methods and STIs are also important issues that this study did not cover.

Conclusion

Most women use family planning services during their reproductive lifetime, but many lack ready access to such services, particularly in a rural area. This study was undertaken after at least four gaps in the existing research base concerning the provision of family planning services in rural contexts were identified. Previous research had not focused on the impact of the rural context on women’s health and decision making process. Nor had specific Australian rural contexts such as the Grampians been considered, despite the likelihood that women from different rural areas and different cultures face different barriers. In addition, while much of the previous research had focused on the value of family planning

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services, there was limited research considering the effects of not being able to access such services. Another departure point from previous research was the decision to focus in this study on professionals as “gatekeepers” who not only hold the experiences of a range of women service users, but would also be aware of wider service systems, and policy contexts.

The research took a feminist theoretical orientation and employed a qualitative methodology. In addressing the challenges faced by geographically marginalised women, this study contributes to feminist research in the field of family planning. It contributes by providing further understanding of limits to women’s agency within the cultural, social, and political contexts of family planning and reproductive health. Feminist research also focuses on producing change rather than just researching issues. The findings presented in this thesis can inform and assist efforts by organisations such as Women’s Health Grampians to produce change within the reproductive health and family planning spheres.

Eleven professionals whose employment in some way connected them with women accessing family planning services were interviewed regarding the provision of three post-coital family planning methods or services (emergency contraception - EC, termination of pregnancy -TOP, and options counselling) in one region of rural Victoria. The professionals were recruited using a snowballing methodology and were from various backgrounds including nursing, politics, social work and general medical practice. Their interview transcripts were examined using Braun and Clarke’s (2006) approach to thematic analysis, which aims to identify, interpret and report any themes emerging from the data that shed light on the research questions. Seven key themes were drawn out from this analysis.

Participants indicated from early on in the interviews that EC, TOP and options could not be considered separately from other reproductive health issues, reiterating that strategies should not be developed in isolation (O’Rourke, 2008). In addition to reinforcing that many women (rural and metropolitan) face similar barriers to family planning access, such as

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judgmental service providers, this research revealed that many of these barriers for rural women are extenuated because there is less choice of provider and fewer options to seek further assistance. Interviewees also had the opportunity to speak about what facilitates access to family planning services, and the study's community psychology strengths-based approach highlighted real examples of how professionals can, and some already do, make it easier for women to access such services.

The psychosocial effects of barriers to access were also explored, and it was indicated that these barriers prevented some women from making a timely decision about their pregnancy. However participants also suggested that many women would find a way to access these services despite any barriers, but would often be left with negative psychosocial effects and feelings of disempowerment.

Finally, this research contributes to the body of reproductive health and family planning knowledge by providing insight into the barriers to service access in rural areas like the Grampians Region. Further, the study provides examples of strategies that could be used to reduce such barriers, facilitate access and improve the service system overall. The findings highlight a number of issues warranting future research within the family planning and reproductive health areas, and illustrate that such research needs be multi-faceted, rather than focusing on particular aspects in isolation. Women's choices and decisions are complex and a challenge of future research is to continue to open up sensitive topics for discussion. Future research may be constrained by the medicalisation of such topics, but reproductive health research is likely to benefit from community and health psychology perspectives that consider socio-cultural and political contexts as well as behavioural and biomedical factors. A further challenge to future research may also be to ensure that it is strategy focused, and that the voices of women service users are foregrounded in the devising and development of any such strategies.

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Family planning is important for maintaining reproductive health, and most women require access to these services at some point in their lives. Contraception is not failsafe and as such EC may be needed by some women who experience contraceptive failure. In addition, there are many other influences feeding into contraception use (such as gender relations) which necessitate that EC, TOP, and options counselling form part of comprehensive sexual and reproductive health service provision. The findings in this study demonstrate the complexity of women's choices leading up to and around the use of these services; their story has already begun before they have sexual intercourse. Moreover, family planning and reproductive health affect many other areas of women's lives such as their relationships, employment and education status. By opening up the topic for conversation and conducting research in a particular region, this study may have eroded the secrecy and negativity that sometimes surrounds EC, TOP, and the choices women make. In a political climate where the supposed high rates of TOPs are debated, research on women's access to family planning services can contribute to initiatives that decrease both the number of unwanted pregnancies and the rates of TOP. Now that TOP has been legalised in Victoria, perhaps the next step is to develop strategies to ensure *all* Victorian women have real choice when it comes to determining the timing, number and spacing of children or deciding if they will indeed have children. Appropriately the last words of this study come from one of the participants:

I think our next challenge is to support people in a variety of ways in making choices, choices to keep their baby and choices to not keep their baby now that this big elephant in the room has been done away with!

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Appendix A: Semi-Structured Interview Questions for Health Professionals

1. Can you tell me a bit about your role as a health professional (e.g., what do you do?) How long have you been employed in this position? How does your role relate to family planning?
2. What are some things that make it easier for women in rural Victoria to access family planning services?
3. What barriers do women in rural Victoria experience in accessing family planning services?
4. How often do you estimate women experience these barriers?
5. Why do you think these barriers occur?
6. How does this affect women's ability to make timely decisions about family planning?
7. How does this affect their ability to make timely decisions about continuation of a pregnancy?
8. How does this affect their psychosocial health?
9. Would you be able to tell me some examples of any specific situations that clients have experienced? I don't want you to mention names or breach anyone's confidentiality here. Any information you give will be treated as confidential, and no identifying information about you or your clients will be used in the final report. If we use any of these experiences, we will turn them into composite case examples drawn from more than one woman's story.
10. What can be done to make it easier for women to access these services? / What future initiatives do you think would assist in reducing the kinds of barriers you've described?
11. Is there anything else you would like to add?

Appendix B: Victoria University Ethics Approval**MEMO****VICTORIA
UNIVERSITY****A NEW
SCHOOL OF
THOUGHT**

TO Ms. Heather Gridley
School of Psychology
Footscray Park Campus

DATE 10/09/2007

FROM Dr. Denise Charman
Chair
Faculty of Arts, Education & Human Development
Human Research Ethics Committee

SUBJECT Ethics Application – HRETH 07/196

Dear Ms. Gridley,

Thank you for resubmitting this application for ethical approval of the project:

HRETH07/196 Family Planning Service Provision in Rural Victoria: Perceptions and Experiences'

The proposed research project has been accepted by the Chair, Arts, Education & Human Development Human Research Ethics Committee. Approval for this application has been granted from 10 September 2007 to 10 September 2009.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious or unexpected adverse effects on participants, and unforeseen events that may effect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date (by **10 September 2008**) or upon the completion of the project (if earlier). A report proforma may be downloaded from the VUHREC web site at: <http://research.vu.edu.au/hrec.php>

If you have any queries, please do not hesitate to contact me on 9919 2536.

On behalf of the Committee, I wish you all the best for the conduct of the project.

Dr. Denise Charman

Chair

Faculty of Arts, Education & Human Development Human Research Ethics Committee

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Appendix C: Plain Language Information Sheet: Women Service Users**SCHOOL OF SOCIAL SCIENCES AND PSYCHOLOGY****Invitation to Participate in a Research Study*****Family Planning Service Provision in Rural Victoria: Women's Perceptions and Experiences***

My name is Julie Kruss, I am a Psychology Doctorate Student, supervised by Heather Gridley, School of Social Sciences and Psychology, Victoria University.

I am undertaking research in the area of family planning service provision in rural Victoria, in particular the Grampians region. The research aims to document women's experiences and perceptions of these services and how any barriers to accessing them might affect women's psychosocial health, and their ability to make timely decisions about the continuation of a pregnancy.

What do we mean by family planning services?

Family planning in this study is defined as the ability for a woman to freely determine the number, timing and spacing of her children. Family planning services are those services that assist women to make such decisions, for example, emergency contraception providers, pregnancy options counselling, and abortion services.

We would like to know about your experiences of accessing family planning services in your area and how these experiences have affected you and your family.

As part of this study, we are asking you to take part in an interview to be conducted at a time and place convenient to you. Interviews are expected to take no more than an hour, and will be audio taped with your consent. I recognise that many demands are made on your time and energy. Your response will contribute to an overall picture of family planning service provision in rural Victoria.

Information from the interviews will be treated as confidential by the researchers; no details that could identify any participants will appear in the report. The final report of the research will be made available to any participants wishing to see it.

We do not expect that anyone who agrees to be interviewed for this project will find it distressing, but if anyone does, they may request that the tape recording be stopped, and leave the room. If necessary, we can discuss support and referral options. We are aware of the sensitive nature of this topic, which can arouse strong feelings and opinions within the community and for individual women. You are not obliged to participate in this study but we would appreciate your assistance. If you would like further support or information about family planning services in Victoria, you may find the information on the back of this form helpful.

Any queries about your participation in this project may be directed to Heather Gridley (9919 5224) or Julie Kruss (0438 51 66 99). If you have any concerns or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 Melbourne, 8001 (telephone no: 03-9919 4710).

Yours sincerely,

Julie Kruss

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Appendix D: Plain Language Information Sheet: Professionals**SCHOOL OF PSYCHOLOGY*****Invitation to Participate in a Research Study******Family Planning Service Provision in Rural Victoria: Perceptions and Experiences***

My name is Julie Kruss; I am a Community Psychology Doctorate Student, supervised by Heather Gridley, School of Psychology, Victoria University, Footscray Campus.

I am doing research in the area of family planning service provision in rural Victoria, in particular in the Grampians region. This research is being undertaken with the support of and in collaboration with Women's Health Grampians.

What do we mean by family planning services?

Family planning in this study is defined as the ability for a woman to freely determine the number, timing and spacing of her children. Family planning services are those services that assist women to make such decisions, for example, contraception providers, pregnancy options counselling, adoption services, and abortion services.

The research aims to document experiences and perceptions of the facilitators and barriers to accessing family planning services and how any barriers affect the psychosocial health of women, and the ability to make timely decisions about the continuation of a pregnancy. This study is important because so many women need to access family planning services during their lives, and they need to do so in a timely manner.

We would like to know about your experiences and feelings as a rural health professional in dealing with women who may need to access family planning services. We would also like to ask your opinion on what can be done to reduce any barriers.

As part of this study, we are asking you to attend an individual interview to be conducted at a time and place convenient to you. Interviews are expected to take no more than an hour, and will be audio taped with your consent. I recognise that many demands are made on your time and energy. Your response will contribute to an overall picture of family planning service provision in rural Victoria.

Information from the interviews will be treated as confidential by the researchers; no identifying details of either participants or their clients will appear in the report. Women's Health Grampians will only have access to collated findings which will also be stripped of any identifying information. The final report of the research will be made available to any participants wishing to see it.

If you are willing to be interviewed, please complete the 'willing to be interviewed', section below and return it in the reply paid envelope to the address provided. We will then contact you to arrange an interview in the next few months. Alternatively you can also contact me (Julie Kruss: 0438 51 66 99) to express your interest in participating in the project, or to ask any questions you may have about the research.

We do not anticipate that anyone who agrees to be interviewed for this project will find it distressing, but if anyone does, they may request that the tape recording be stopped, and to leave the room. If necessary, we can discuss support and referral options. We are aware of the sensitive nature of this topic, which can arouse strong feelings and opinions within the community and for individual women and health professionals who work with them. You are not obliged to participate in this study but we would appreciate your assistance. If you would like further support or information about family planning services in Victoria, you may find the information on the back of this form helpful.

Any queries about your participation in this project may be directed to Heather Gridley (9919 5224) or Julie Kruss (0438 51 66 99). If you have any concerns or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 Melbourne, 8001 (telephone no: 03-9919 4710).

Thanking you in anticipation

Yours sincerely,

Julie Kruss

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 Willing to be interviewed?

NAME:.....

PHONE NUMBER (DAYTIME).....(EVENING).....

**TEAR OFF THIS SECTION FROM THE INFORMATION SHEET AND SEND IT TO US IN THE REPLY PAID ENVELOPE (OR VIA
 EMAIL ON JULIE.KRUSS@LIVE.VU.EDU.AU),**

OR CALL JULIE KRUSS (0438 51 66 99) TO EXPRESS YOUR INTEREST

Contact numbers if you would like further support or information about family planning services in Victoria:

**Women's Health Grampians: 5322 4100
 Australia's National Pregnancy Helpline: 1800 422 213
 Family Planning Victoria: 1800 013 952
 WIRE Women's Information: 1300 134 130**

If you are feeling uncomfortable or upset following this interview, and would like further support, or if you would simply like further information about family planning services available to Victorian women, the above contact numbers may be helpful.

Here is a guide to the various levels of pregnancy counselling currently available to women in Victoria.

- (i) The recently-launched Federal Government telephone counselling National Pregnancy Support Helpline is staffed by paid counsellors whose brief is to offer "non-directive counselling" but not to provide concrete information or referrals – Australia's National Pregnancy Helpline: 1800 422 213.
- (ii) The new Medicare item for face-to-face Pregnancy Counselling is available to women expressing concerns about any aspect of a current or recent pregnancy. Accredited providers can be psychologists, social workers or mental health nurses.
- (iii) A number of other family planning and pregnancy advice services run by hospitals and community health agencies offer reputable professional training programs and information/counselling services – for details contact Family Planning Victoria:1800 013 952 or WIRE Women's Information: 1300 134 130
- (iv) For local advice or support on any women's health matter, contact Women's Health Grampians: 5322 4100

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Appendix E: Letter to Service Providers who Agree to be Interviewed

TO SERVICE PROVIDERS WHO AGREE TO BE INTERVIEWED

Thank you very much for agreeing to be interviewed.

Questions asked throughout the course of the interview relate to your experiences and feelings as a rural health service provider and your experiences in dealing with women who have attempted to access family planning services when accessing family planning services. The focus will be on any barriers that you may know about and know women have experienced when accessing these services and how this has affected their psychosocial health and their ability to make timely decisions about their reproductive health and the continuation of a pregnancy.

However, if you should become distressed or unwell during the course of this research, I propose that we discuss, and contact an appropriate support person. I will take responsibility for facilitating this process.

I do not anticipate that professionals who agree to be interviewed will become distressed by the process. However, it is important that we take precautions to ensure the psychological safety of people consenting to involvement in this study. Professionals are free to request that the interview and the recording of the interview be stopped at anytime.

Should you have any questions about this, or any other aspect of the study, please contact:

Julie Kruss

0438 51 66 99

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Appendix F: Informed Consent Form**CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH
INFORMATION TO PARTICIPANTS:**

We would like to invite you to be a part of a study into family planning service provision in rural Victoria, in particular the Grampians region. The research aims to document experiences and perceptions of the facilitators and barriers to accessing these services and how these barriers affect the psychosocial health of women, and the ability to make timely decisions about continuation of a pregnancy. We would like to know about your experiences and perceptions as a rural health professional who works with women who may need to access family planning services.

CERTIFICATION BY SUBJECT

I, _____

of _____

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study:

“Family Planning Service Provision in Rural Victoria: Perceptions and Experiences”

being conducted at Victoria University by: Heather Gridley and Julie Kruss,

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by: Julie Kruss, and that I freely consent to participation involving the use on me of these procedures:

- To take part in an individual semi structured, audio taped interview of approximately one hour, at a time and place convenient to me, about my experiences and perceptions as a health professional in working with women who may need access family planning services.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed: _____

Date: _____

Any queries about your participation in this project may be directed to the researchers

Heather Gridley (9919 5224) or Julie Kruss (0438 51 66 99).

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4710.

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Appendix G: Data Analysis: Procedural Examples**Box G1, stage 1: Writing initial notes on the transcript**

Transcript	Initial Notes
<p>T (1083): Working in a different way here because like I said people are more...adults are more...women are more private about what they will say about sexuality or sexual issues, there are still a lot of women who are worried about unplanned pregnancy or the stigma of it and they seem to be much more ambivalent about abortion, it's much more complicated. but you know when I worked in Melbourne the only pregnant women I saw were looking for an abortion so they were further down the decision path way and maybe the ones who I see come to me because they really are ambivalent. I know generally the culture I have seen here is much more conservative and people are much less tolerant about differences and I'm not sure how much that relates to their sexual and reproductive health. I know people out here are really judgemental and there is that sort of class divide which because it's a small town and it's a bit of melting pot, people are thrown together more, you know there's not sort of a shopping mall in that suburb for those people and there's another one over here for those people, people have to mingle so there is a bit us and them culture and there could be certain values that people use to distinguish themselves, you know it's our fate to have children when we are teenagers...</p>	<p>Rural culture more private about sexual health etc.</p> <p>This culture is related to concern for stigma about unplanned pregnancy and TOP</p> <p>Rural women may be more ambivalent about TOP</p> <p>Decision-making process for TOP may be more complicated for rural women</p> <p>Rural culture more conservative</p> <p>Judgemental culture</p> <p>Class divides occur but they have to mix more in rural towns</p> <p>"Us and them" divides who may be seen to have unplanned pregnancies etc</p> <p>People see is at their "fate" to have teen pregnancies</p>

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Box G2, stage 2: Example of individual transcript being coded

Transcript	Coding
T (1083): Working in a different way here because like I said people are more...adults are more...women are more private about what they will say about sexuality or sexual issues, there are still a lot of women who are worried about unplanned pregnancy or the stigma of it and they seem to be much more ambivalent about abortion, it's much more complicated. but you know when I worked in Melbourne the only pregnant women I saw were looking for an abortion so they were further down the decision path way and maybe the ones who I see come to me because they really are ambivalent. I know generally the culture I have seen here is much more conservative and people are much less tolerant about differences and I'm not sure how much that relates to their sexual and reproductive health. I know people out here are really judgemental and there is that sort of class divide which because it's a small town and it's a bit of melting pot, people are thrown together more, you know there's not sort of a shopping mall in that suburb for those people and there's another one over here for those people, people have to mingle so there is a bit us and them culture and there could be certain values that people use to distinguish themselves, you know it's our fate to have children when we are teenagers...	Code: RCSI, T: 1083, P: 6, L: 333-5 Code: RCMA, T: 1083, P: 6, L: 335-8 Code: RCSI, T: 1083, P: 6, L: 338-40 Code: RCJ, T: 1083, P: 6, L: 341 Code: RCCD, T: 1083, P: 6-7, L: 341-4 Code: RMCE, T: 1083, P: 7, L: 344-56

Box G3, stage 2: Example of code names and definitions

Code Name	Definition
RCSI	Rural culture –reluctant to talk about sex issues and more conservative
RCMA	Rural culture more ambivalent about
RCJ	Rural culture – judgemental
RMCE	Role models and cycle's of early motherhood in rural communities
RCCD	Rural culture – class divides and melting pots

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Box G4, stage 3: Example of a potential themes

1. What makes it easier (for rural women to access these services?) – General
2. What makes it easier – health professionals role
3. Barriers – Abortion rurally
4. Barriers - EC
5. Barriers - Counselling
6. Barriers - GPs
7. Barriers – if they do decide to travel for abortions
8. The Effects of barriers on rural women’s psychosocial health.
9. How do they barriers affect timely decisions about pregnancy and family planning?
10. What can be done to decrease the barriers (or to improve rural women’s sexual and reproductive health)?
11. Rural cultural implications on:
 - a. Influence on becoming pregnant in the first place / family planning methods compliance and use
 - b. On the decision-making process once pregnant
 - c. Service delivery
 - More conservative and judgemental, less open to talk about sexual health issues
 - Because everyone knows everyone, including the health professionals if they live in the town
 - Need to consider this when providing a service (1 on 1 and at a community level)
 - Need to consider this when setting up a new service
 - Mother / daughter relationships
 - May stay connected longer?
 - Examples of mothers taking a teenage daughter to see the family GP to go on the pill
 - Role models and cycles of early pregnancy (this may be linked to 2)
 - Normalise and validate early pregnancy in rural areas as acceptable
12. Sexual / reproductive health information provision
13. Law Reform
14. Misc / yet to be assigned:
 - Rural women experiencing mental health issues a barrier to getting to Melbourne
 - Migrant or non-English speaking background/aboriginal communities
 - Issues are different at different ages for abortion and this can be challenging
 - Teenagers have greater disadvantage etc
 - Women with children already
 - Menopausal women
 - Religion in the community and abortion
 - Limited response
 - Some say not really an issue in Grampians others say it is

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Box G5, stage 3: Example of discarded extracts and codes

Extract	Code
T (2856): They seem to come along and be surprised we fit marinas...they are led to believe it is a specialist area...	Code: Z, T: 2856, P: 5, L: 274-90 Marina's not relevant to the study
T (1083): It's a pretty diverse community [regarding other contraceptive use]. So I'd say it's like any other community just that everyone is a little bit closer here, so there are women who know a fair bit and then women who don't know anything. I don't think you can really generalise	Code: Z, T: 1083, P: 4, L: 215-20 More about other contraceptive types not part of this study

Box G6, stage 4: Thematic map example

