

ORIGINAL RESEARCH

Barriers around access to abortion experienced by rural women in New South Wales, Australia

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ABSTRACT

Introduction: Little is known about Australian rural women's overall experiences of accessing an abortion service and the barriers they encounter. Approximately one in three Australian women access an abortion at some time in their lives. Most abortions are undertaken during the first trimester of pregnancy in private clinics. Although both medical and surgical abortions are uncomplicated medical procedures, abortion remains a contentious area of women's health. Whilst it is clear that rural women experience disparities in relation to access to health care, there is a gap in the evidence on rural women's experiences of accessing an abortion. The aim of the present study was to identify factors that women in rural New South Wales (NSW) experience in accessing abortion services and suggestions about how rural women could be better supported when seeking access to an abortion service.

Methods: In-depth qualitative interviews were undertaken with rural women living in NSW who had had an abortion in the previous 15 years. Participants self-selected for a phone or face-to-face interview, in response to promotion of the study through women's services, community flyers and press releases.

Results: Rural women in this study experienced many barriers to accessing an abortion. Women travelled 1–9 hours one way to access an abortion in clinics. Several women borrowed money for the abortion fee. Five themes were identified: finding information about the provider; stigma, shame and secrecy; logistics involved in accessing the clinic related to travel, money and support; medical and surgical abortion; and ways rural women could be better supported in this process. Suggestions to improve rural women's access to abortion services included more affordable services that were 'closer to home' as a way to reduce travel and cost, and to normalise abortion as a women's health rights issue.

Conclusions: Despite welcome legal and pharmaceutical reform in Australia, results from this small study indicate that there is a long way to go remove barriers on issues rural women experience in their process of accessing reproductive care, including the



pervasiveness of abortion stigma. Services closer to home may help reduce inequities in access to health care experienced by rural women. Strategies such as broader use of tele-health and willingness of general practitioners to become authorised prescribers for medical abortions could help to reduce long distances to travel to services and the financial burden experienced by rural women.

Key words: access to services, Australia, primary care, stigma, women's health.

Introduction

Abortion is a contentious issue as reflected in inconsistent laws across Australia. Until 2008 abortion was located within criminal law in all states and territories, except the Australian Capital Territory. Abortion was removed from the *Crimes Act* in Victoria in 2008, and in 2013 Tasmania decriminalised abortion^{1,2}. Tasmania has taken decisive legal action to ensure women's right to care is not impeded by protestors when they seek access to an abortion clinic³. Laws that remain within the criminal code influence the availability of abortions in both public hospitals and private clinics.

Abortion is a common women's reproductive experience⁴ with estimates that one in three Australian women seek an abortion at some stage in their lives¹. Globally, one in five pregnancies is estimated to end in abortion⁵. In 2008, more than 43 million abortions were performed worldwide, an abortion rate of 28 per 1000 women aged 15–44 years⁶. Abortion is an uncomplicated and low risk intervention whether performed as a surgical procedure requiring anaesthetic or a medical intervention requiring medication⁵. Most abortions occur in the first trimester of pregnancy¹.

Despite global and national guidelines that set out obligations for health professionals to care for women seeking an abortion⁵, negative attitudes of doctors and nurses create obstacles for women⁷⁻⁹. The Medical Board of Australia instructs doctors who conscientiously object to abortion to inform patients of their objections, not to impede access and not to allow influence of their own moral or religious views to deny patients access to medical care¹⁰. A recent systematic

literature review on barriers to first trimester abortion in resource rich countries, including two Australian studies¹¹, documented barriers experienced by women, which included negative attitudes of staff, lack of access to services, protestors and the associated costs of an abortion¹¹. For rural women, these barriers are often compounded.

A study conducted by the Key Centre for Women's Health in Society (Melbourne University; now the Centre for Gender and Women's Health in Society), in collaboration with the Pregnancy Advisory Service (PAS) of the Royal Women's Hospital and VicHealth, provides some insight into rural women's experiences of unplanned pregnancy and abortion¹². An audit of 3827 electronic records of women who contacted PAS found more than 90% of these women requested an abortion and of these one in ten lived in rural areas¹³. Almost one in five women experienced difficulties in gaining access to services, including geographical isolation, lack of transport and child care, and financial problems¹³.

Rural women generally have lower incomes than urban women, yet they bear higher costs for access to health care. Distance to services and lack of primary health services in rural areas have been suggested as contributing factors to the poorer health experienced by rural dwellers¹⁴. A study exploring mental health services through a secondary analysis of national data for Medicare, Australia's public healthcare scheme, found increasing remoteness was clearly associated with lower access to health services, which is often accompanied by higher socio-economic disadvantage¹⁵. Results of a study in which 820 women in rural Australia were interviewed about their access to health care led the authors to describe the lack of rural women's access as 'brutal neglect.'¹⁶ Specific to women's access to an abortion



provider, a recent editorial in the *Medical Journal of Australia* reports that women in the Northern Territory are experiencing diminishing access to abortions within hospitals and may need to fly interstate to access an abortion¹⁷.

Whilst it is clear that rural women experience disparities in relation to their access to health care beyond travel, distance and lack of services, there is a gap in the evidence on rural women's experiences of accessing an abortion within Australia. A study was undertaken by the authors with rural women in New South Wales (NSW) to address this knowledge deficit. It was part of a broader study that aimed to explore the role of non-government community based women's health centres in supporting rural women's access to abortion. Whilst key findings, including a snapshot of access issues, have been reported¹⁸, a separate paper was needed to present women's stories in more detail. The specific aim of the research and analysis reported in this article is to identify factors that impact the experience of rural NSW women in accessing abortions and suggestions about how rural women could be better supported when seeking an abortion.

Methods

Eligibility criteria for women to participate in the study were that access to an abortion was sought in the previous 15 years whilst living in a rural area of NSW, women were older than 18 years and able to converse in English for an interview. Confidential in-depth interviews were considered to be the most suitable method¹⁹. Strategies to recruit women for interview included flyers displayed on local community noticeboards and on the back of toilet doors in public places, media releases, word of mouth and through women's services. Interested women self-selected and contacted the researcher. Informed consent was gained with permission to record the interviews. The interview explored four broad questions designed to facilitate a conversation about women's experiences of accessing an abortion.

At the beginning of the interview, the women were asked how they found out about the abortion clinic. The next two questions related to logistics involved in getting to the clinic (question 2), and follow-up care was explored in question 3. In the final question the women were asked to suggest how rural women could be better supported to access an abortion provider and in an ideal world what this service might be. Interviews were transcribed verbatim by the primary author. The de-identified transcripts were read by both authors to gain familiarity with content, and thematic analysis was undertaken. Transcripts were reviewed in relation to the set questions but also sought to capture unexpected themes. In line with the thematic analysis described by Braun and Clark (2006) the process was reiterative and rigorous²⁰. A thematic scheme was developed, with both authors using the answer to decide on five themes that comprehensively and accurately represented women's experiences. The themes were identified by significance of results and diversity rather than number of responses²¹. Selective quotes highlight points meaningful to the main findings, pseudonyms are used and demographics are reported separately to the themes.

Ethics approval

This research was approved by the Southern Cross University Ethics Committee (Ethics Consent Number 13-060, 2013).

Results

Sixteen women contacted the researcher. Two women did not live in rural NSW when they accessed an abortion, so they were ineligible to participate. Follow-up contact was not possible for another woman. Thirteen women were interviewed, 12 by phone and one face-to-face, with interview duration of on average 1 hour. Nine women reported learning about the study from flyers posted on the back of toilet doors of public venues in their local area. Women had had an abortion 5 months to 15 years prior to interview, when aged between 18 years and 46 years, with an average age of 27.5 years. All women except two had had one abortion. June had three abortions and Zilah four



abortions. Women accessed abortions from clinics located in Queensland, NSW and the Australian Capital Territory (ACT). At the time women sought an abortion they lived in rural areas across NSW with populations ranging from 500 to 50 000. All women interviewed had a surgical abortion in trimester one.

Five main themes emerged, which are discussed below.

Getting to the clinic: self-referral, doctors referrals and 'jumping through hoops'

This theme incorporates answers to the first question women were asked, designed to explore women's experiences of how they found information about the abortion provider. Five women accessed a general practitioner (GP) for a referral, three contacted a women's service for information (and later self-referred) and five women directly self-referred to the clinic after finding information, mainly by an internet search.

Women's experiences of the GP process varied from being easy and supported (one participant) to very challenging. Challenges related to delays in seeing a rural GP, lack of willingness of GPs to refer, lack of information provided about the procedure or the clinic, lack of information about medical abortion and the required follow-up visit, delays caused by the need for blood tests or ultrasounds and negative GP attitudes.

Elaine consulted a GP initially who 'gave her a pamphlet' and advised her she needed a blood test but provided no information about a clinic. For Kelly, it took 3 weeks to get to the abortion clinic as her doctor required two visits and two ultrasounds before he was willing to refer.

Skye likened her experience of getting to the clinic to 'jumping through hoops' in relation to acquiring a doctor's referral, which was not needed, but she didn't know. Skye accessed five GPs before she found a doctor to provide a referral. The first doctor advised Skye she needed a referral, but was unwilling to refer and did not talk about options for

self-referral. The doctor knew Skye personally and advised her to have amniocentesis, despite her stated decision to have an abortion. She described her ordeal as 'horrendous' and could not believe the 'conservative' approach of GPs, particularly 'Baptists', in her rural area.

In contrast, one woman who had an established relationship with her GP commented on her positive experience accessing her GP. Zilah stated how 'lucky' she was to have a supportive female GP whom she saw before and after having an abortion in a town where there was not only a shortage of female GPs, but where some GPs had closed their books on new patients.

Three women contacted a non-government women's health service for information. All reported being provided with helpful information. Fern further commented that the abortion clinic required her to find out her blood group, which was problematic because of time constraints, lack of available doctors and lack of money. In her local area there was a 3-week wait to see a doctor who bulk billed.

In relation to self-referral, women cited various reasons for choosing to directly contact the clinic or for deciding not to see a GP. Some women knew that a GP referral was not required, some were confident they could find the information themselves on the internet, one woman was conscious of the uncertain legal climate and one woman wanted to avoid seeing a GP because of fear of being judged.

Stigma, shame and secrecy

An emergent theme was of women's experiences of stigma, shame and secrecy. All women commented on the stigma they experienced surrounding abortion, which for some was particularly apparent in small rural towns. External stigma was exacerbated by protestors, and internalised stigma was linked to feelings of shame and secrecy. Some women discussed the consequences of stigma and the lack of respect for women to make reproductive decisions concerning their own bodies.



Out bush – there is still a lot of stigma about getting information in the first place and certainly something that is not talked about ... and I reckon there's a higher rate of teenagers having births because of the stigma. (Zilah)

Stigma is linked to the expectation of society for a woman to be loving and nurturing and to think of others. When a woman chooses to have an abortion, she is making that decision for herself. I think if women were really respected as free thinking individuals, people who are allowed to make decisions for themselves, then that stigma wouldn't be as strong. (Clara)

Two women specifically commented on protestors and the obvious link to a stigmatised procedure. Molly discussed her experience of protestors at the clinic and the associated public stigma of being confronted by this.

While strangers are still waving placards, telling me what to do with my body there is stigma. Well, can you buy RU486 [for medical abortion]? Can you get it from your GP? I think there's lots of stigma. (Fern)

Many women discussed stigma surrounding abortion as being intertwined with secrecy and shame. Stigma, which contributed to secrecy, permeated all women's experiences of accessing an abortion. Glenda's comment that abortion is 'still a taboo topic' underpins the sentiment of secrecy. Some women who required overnight or early morning child care either did not disclose the 'real' reason for travel or child care or disclosed reluctantly. Molly suggested the carer 'may have twigged' and Zilah stated, 'it's not something you explain to people, you just kind of have this mysterious absence'.

Parallel to this experience of secrecy where abortion was a common yet hidden experience was the belief of all women in the importance of abortions in supporting women's life choices. For some, when they shared their experience it became evident how many other women had not only had an abortion but had kept it secret.

It was an eye opener when everyone I had disclosed to had also told me they've had at least one, so why is it so difficult? It's not a general topic of conversation: it's all a bit hush hush though everybody does it, so to speak. (Fern)

Not surprisingly, closely linked to secrecy was shame, which for some women caused some internal conflict with their belief in women's rights to access an abortion. Moira felt a 'bucket load of shame, told no-one, felt isolated and alone'. Clara struggled with having more than one abortion, felt guilt and was judging herself: 'I thought it was wrong, it's hard to explain even though I am absolutely pro-choice'.

Logistics to access services

This theme incorporates responses from question 2, in which women were asked about their experience of accessing an abortion provider. Arrangements varied but commonly logistics included managing expenses related to organising early morning departure, child care, borrowing a car, seeking finance, asking a support person to drive them to and from the clinic, overnight accommodation, petrol/train/airfare costs and taking time off work for the woman or the support person. As Molly stated, accessing an abortion was further complicated by 'all those logistics that I had to organise' to access the clinic.

Money: Not all women mentioned problems with money but several did. Some women's partners paid the abortion fee, even if they were separated. Some women commented that the abortion cost, whilst expensive in the short term, was not as expensive as raising a child. Many women borrowed money to help with petrol, abortion fees or accommodation. Moira borrowed \$300 to subsidise her friend's travel to accompany her to the clinic, and four women borrowed between \$500 and \$700 to help pay the abortion fee. Molly commented that the fee in itself 'wasn't that much but it's all the associated costs' of getting to the clinic. Several women struggled financially although they did not borrow money. Eliza commented that 'finances were thin, so the unanticipated financial expenses were hard'. Eliza and her partner had to take a day off work and finance costly



child care as they were away from early morning until late in the evening.

Travel: Participants travelled 1–9 hours one way to reach a clinic and five women required overnight accommodation. All except one woman used private transport to travel to the clinic. Moira travelled on an overnight train to Brisbane. For Fern it was a 'harrowing day', requiring a 6-hour journey to the clinic and then the return journey home, all in one day. Clara, who had previously had an abortion in the city, compared the city/regional experience as 'chalk and cheese' and was 'gobsmacked' she had to travel 'all that way to another state' where she felt 'isolated and horrible driving over that border'. Clara stated her experiences enhanced her empathy for women in Ireland who also had to travel over a border to another country to access an abortion.

Support: Support was discussed in relation to child care or a support person. Five women required early morning child care, which was provided by either a formal childcare provider or by friends or family. The clinic requirements were for someone to drive them home. Moira suggested this could have been particularly challenging for young women, for women who had no one to accompany them and for women without a licence. Skye also wondered how challenging this could be for women with few social or personal resources to negotiate loans and deal with the stigma and challenges.

Follow-up: medical/surgical abortions

This theme relating to medical/surgical abortions was unexpected. Although it was somewhat linked to question 3, responses extended beyond follow-up care to factors related to medical/surgical abortion. All women commented that medical abortion was not a feasible option because of logistical factors that prevented them from returning for the required follow-up appointment. Some women did see their GP for recommended follow-up care whilst some did not see the need for it. Some viewed the care as disjointed, describing feeling isolated. June, who had already had several abortions, commented there was no point in seeing a doctor

before (or after) the abortion as the doctor would 'probably give me a lecture anyway and that's when they find out you have [had] an abortion'. June had seen the GP after her first abortion but not for subsequent abortions.

Women discussed the perceived advantages of either a medical or surgical abortion related to safety, risk, complications and the need for anaesthetic. Surgical abortion was reported as the preferred, safest and easiest option by most women. For Tillie, surgical abortion was seen as the 'less complicated procedure'. Elaine thought it was 'much nicer to be put to sleep' with a general anaesthetic (GA) used in a surgical abortion. Kelly was concerned that medical abortion was 'more drawn out' and that it would involve severe cramping and haemorrhaging. 'Going under' was not ideal for June who 'didn't handle the GA very well' and would have preferred to 'take a drug and not go through all this'. Fern would have much preferred the option of a medical abortion 'with RU486' as a way to simplify the process: 'just even having to go under GA and the need for blood groups, doesn't have to be that heavy duty full on surgical procedure'.

Whilst almost half of those interviewed were unaware of medical abortion, one participant who was aware suggested that knowledge of medical abortion was constrained by the media and community attitudes. Clara commented on 'moralistic ideology and judgement' around abortion and the propaganda about RU486 in the media. June commented, 'nobody ever explained medical abortion to me', despite having had three previous abortions, and she commented that she had never been asked about contraception. Kelly found out about medical abortion by the 'man on the phone at the abortion clinic, not the doctor'.

All women except two wanted to access an abortion from a medical provider but for Glenda and Zilah surgical abortion was a last resort after trying other ways to end their pregnancies. Glenda tried to medically abort her pregnancy through herbal mixtures whilst Zilah tried acupuncture to 'release the baby' as well as self-medication. Zilah asked her doctor what was in the 'morning after' pill and 'figured out



that if I had a whole sheet of a month's worth of the pill then it would be equal ... so once or twice I've self-medicated' to perform her own medical abortion: 'you just learn to look after yourself'. Zilah discussed the lack of local doctors and the not-uncommon 6-week wait for an appointment or lack of access when GPs stop taking on new patients.

More affordable, local and mainstream services

This theme relates most closely to responses to the final question (question 4) in relation to better support and the ideal service. Fern stated the system should 'make the whole process easier', a sentiment reflecting the views of all participants. Common suggestions on ways to improve rural women's access were for more affordable, local and mainstream services to reduce travel and cost. However, having local services in a small rural town also raised issues around lack of confidentiality and privacy for some women, who thought travelling outside of the area had advantages. Some thought access to medical abortion was a way to reduce a complicated process: 'If RU486 was prescribed by my doctor, I wouldn't have had to go through all that', commented June.

Moira, like all the participants who accessed a private abortion clinic, pondered why she could not access an abortion at her local hospital, which was 20 km away: 'I wouldn't have had to travel and it would have been free'. Financial considerations underpinned some suggested strategies to improve access to local services. Molly suggested some women might be willing to pay for a local service to avoid the travel: 'even if it was in a private hospital I think women would rather pay for it here locally', which would mean it would be 'less disruptive if it could be done locally'.

For women who are more remote than I am there should be some sort of financial support for people who are in difficult financial situations who could be considered on a case-by-case basis. (Eliza)

Different models including more integrated women's health care were suggested. Moira's idea was a 'one-stop shop where

women could go for help to get pregnant or if they want to end their pregnancy', which could also potentially increase privacy and deter protestors. Fern proposed that abortion services needed to be 'part of proper women's health care: it still needs to be dragged out of the back alley'.

The whole process is messed up and it should not be like that: the process, the questioning and not trusting women's own decision making. I'm pro-choice. The ideal service would be free, safe with abortion on demand. (Clara)

Women commented on social barriers linked to women's rights and overly complicated systems that if addressed could improve access to abortion services for all women.

Come on, really – reproductive rights – it's not rocket science. I don't think the issues around simplifying the process are medically based – I don't think it's about women's welfare and women's rights and women's health that we have to do it the hard way – it's about moral, ethical, religious pressures that force those things. (Fern)

Women should be respected to make decisions about their own bodies and lives. Let's normalise the fact that women get pregnant and want to end their pregnancy – stop putting so much moralistic ideology around it – let's have access to these services and not be silent about it. (Clara)

Discussion

The results of this research provide insights to challenges faced by women aged 22–46 years living in rural NSW in the process of accessing an abortion, highlighting how complicated it can be for rural women to access essential reproductive health care. For women in this study, stigma was real and associated with shame and secrecy.

Stigma and negative characteristics linked to abortion are perpetuated by social and political processes including media portrayals, which in turn influence women's experiences, examples of which have been reported by women in this



study. A qualitative analysis of print media in Great Britain in 2010 found abortion to be portrayed as negative, risky and associated with 'discredited' social practices²². Goffman's early work (1963) described stigma as a discrediting attribute that can reduce the possessor from a whole person to a tainted, discounted one²³. Goffman suggested stigma is both externalised through a dominant discourse linked to disgrace and internalized so that an individual's negative perception of themselves becomes linked to a 'spoiled identity'²³. In relation to abortion and surrounding stigma, others have described the way abortion stigma is felt and perpetuated at multiple levels – including individually, with internalised, perceived, and experienced stigma, and more externally, within communities and at service delivery and policy levels²⁴.

Kumar et al argue that although abortion stigma is widely acknowledged it is poorly theorised, and they extend Goffman's description of 'spoiled identity' to notions of 'spoiled womanhood'²⁵. They propose a definition of abortion stigma as a 'negative attribute ascribed to women who seek to terminate a pregnancy that makes them externally or internally, as inferior to ideals of womanhood'(p. 4). They suggest that women seeking abortion inadvertently challenge widely held assumptions about feminine ideals and 'essential nature of women'²⁵. As noted by the Australian Women's Health Network, a 'rights based approach recognises women as experts in their own lives'¹, a perspective shared by some of the participants in the present study.

Women in this study linked stigma to secrecy, also reflected in the broader literature. Abortion stigma has been described as 'concealable stigma', which is unknown to others unless disclosed²⁶. Concealing abortion can be part of a vicious cycle that reinforces and perpetuates stigma²⁶. Whilst not telling anyone about having an abortion may be a strategy to reduce external stigma, concealed stigma can lead to internalised stigma, as revealed by some participants²⁶. Understanding abortion stigma will help inform strategies to reduce it, and to improve care for those who are stigmatised²⁵.

WHO recommendations for health systems are that, to the full extent of the law, abortion services should be readily

available to all women⁵. Australia is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women²⁷ and has an obligation to take action to ensure women have access to sexual and reproductive healthcare services. Continued advocacy for abortion to be removed from criminal codes in all Australian states and territories is needed to locate abortion within women's health system care. In Australia there is a high reliance on private abortion providers with associated travel and high out-of-pocket costs for women. If abortions were provided through local public hospitals, costs for women would be reduced as services could be accessed via the system of universal health care in Australia²⁸. All participants in this study bypassed local GPs and hospitals to travel to private clinics because this was the only option.

It is of concern that women in this study who could not easily access an abortion tried potentially unsafe and unregulated ways to self-abort. Unsafe abortions are usually associated with women in resource-poor countries²⁹. The implications of lack of access to abortions in Australia are not well documented but could potentially have negative health consequences. These concerns, however, extend beyond the scope of this exploratory investigation.

Non-integrated health systems and lack of services in rural areas hinder access to abortion²⁴. Women in this study point to non-integrated health systems, as evidenced by their experience of sub-standard primary care where doctors did not readily refer, did not provide accurate information about self-referral options and expressed judgemental attitudes reflective of their moral objections. Doctors who have a conscientious objection to abortion are required to follow the guidelines to practice set by the Medical Board of Australia³⁰. The profession's standards are at risk of being lowered to support individual provider's moral views³¹. The views of the minority of providers who object to abortion are out of sync with the majority of the Australian community^{4,32}, and GPs³³ who are pro-choice and support decriminalisation of abortion³⁴.



The medical abortion drug mifepristone (RU486), listed as an essential drug by WHO since 2005³⁵, is not readily available in Australia, despite being added to the Pharmaceutical Benefits Scheme in 2013³⁶. It has the potential to significantly reduce the cost of medical abortions and reduce inequities for rural women but it is limited in the time period it can be used, the willingness of providers to become authorised prescribers and pharmacies to make it available. As more doctors take a lead to become registered providers this may help to improve access¹⁷. Not surprisingly, having services closer to home, including medical abortion, was suggested by study participants as a way to improve access and reduce cost. Other ways to improve access to services for rural women could be through tele-health.

Tele-health equipment is readily available in many rural hospitals and could be better harnessed for tele-medicine (which enables provision of a clinical service remotely) for medical abortions³⁷. In the USA, the effectiveness and acceptability of medical abortion using tele-medicine was compared with standard, face-to-face care with women who had accessed both settings^{38,39}. Both models had comparable clinical outcomes and satisfaction. A desire for a medical termination (71%), as early as possible (94%) and close to home (69%) were factors that facilitated access to care and influenced women's decisions for a medical abortion using tele-medicine^{38,39}. Tele-medicine as a model of care is consistent with the strategic direction of the NSW Rural Health Plan as a way to support people who are otherwise required to travel⁴⁰. Tele-medicine could increase women's access to GPs, expand the services provided and address some of the problems posed by chronic shortages of GPs in rural areas⁴¹.

Limitations

It was anticipated that recruitment of participants for the research could be difficult, so the voices of 13 women make a significant contribution to understanding some of the barriers experienced by rural women in NSW. Although women commented on experiences that occurred up to 15 years prior to interview, the barriers seem to be consistent over

time and across the clinics accessed in NSW, Queensland and the ACT. Flyers on the back of toilet doors proved to be part of a successful recruitment strategy. Further research is needed to explore experiences of younger women, women on low incomes, living in remote areas, women with disabilities, from minority and vulnerable groups and Aboriginal and Torres Strait Islander women^{42,43}.

Conclusions

Despite welcome legal and pharmaceutical reform in Australia, results from this study indicate that there is a long way to go to remove barriers rural women experience in accessing abortions. Services closer to home would help reduce inequities in access to health care experienced by rural women. Strategies such as broader use of tele-health and willingness of GPs to become authorised prescribers for medical abortions could help reduce long distances to travel to services and the financial burden experienced. Abortion is a common women's health experience and further research is needed to identify ways to reduce barriers rural women experience when they seek to access essential women's health care.

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