
Charles Darwin University

'I didn't feel judged'

Exploring women's access to telemedicine abortion in rural Australia

Ireland, Sarah; Belton, Suzanne; Doran, Frances

Published in:
Journal of Primary Health Care

DOI:
[10.1071/HC19050](https://doi.org/10.1071/HC19050)

Published: 24/03/2020

Document Version
Publisher's PDF, also known as Version of record

[Link to publication](#)

Citation for published version (APA):

Ireland, S., Belton, S., & Doran, F. (2020). 'I didn't feel judged': Exploring women's access to telemedicine abortion in rural Australia. *Journal of Primary Health Care*, 12(1), 49-56. <https://doi.org/10.1071/HC19050>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.



'I didn't feel judged': exploring women's access to telemedicine abortion in rural Australia

Sarah Ireland RN, RM, BSs, Grad Dip Mid, PhD;^{1,4} Suzanne Belton BSc(Hons 1), PhD;² Frances Doran PhD³

¹ Charles Darwin University, Ellengowan Drive, Casuarina, NT, Australia

² Menzies School of Health Research, Ellengowan Drive, Casuarina, NT, Australia

³ Southern Cross University, Military Road, East Lismore, NSW, Australia

⁴ Corresponding author. Email: Sarah.ireland@cdu.edu.au

ABSTRACT

INTRODUCTION: Regardless of geographical location, safe and legal abortion is an essential reproductive health service. Accessing an abortion is problematic for women in rural areas. Although telemedicine is globally established as safe and effective for medical abortion in urban settings, there is a paucity of research exploring access to telemedicine abortion for women in rural locations.

AIM: The aim of this qualitative research is to explore and better understand women's access to telemedicine abortion in Australian rural areas.

METHODS: Structured interviews were conducted with women ($n = 11$) living in rural areas who had experienced a telemedicine abortion within the last 6 months. Phone interviews were recorded and transcribed verbatim. Data underwent a Patient-Centred Access framework analysis and were coded according to the domain categories of approachability/ability to perceive, acceptability/ability to seek, availability/ability to reach, affordability/ability to pay, and appropriateness/ability to engage.

RESULTS: Rural women had severely limited access to abortion care. The five domains of the Patient-Centred Access model demonstrated that when women with the prerequisite personal skills and circumstances are offered a low-cost service with compassionate staff and technical competence, telemedicine can innovate to ensure rural communities have access to essential reproductive health services.

DISCUSSION: Telemedicine offers an innovative model for ensuring women's access to medical abortion services in rural areas of Australia and likely has similar applicability to international non-urban contexts. Strategies are needed to ensure women with lower literacy and less favourable situational contexts, can equitably access abortion services through telemedicine.

KEYWORDS: telemedicine; remote health; abortion; reproductive health; health-care access

Introduction

In Australia and other parts of the world, provision of telemedicine in rural areas is considered to increase access to health and medical services.¹⁻⁴ Telemedicine may be beneficial to rural populations by eliminating the spatial distance between people and the health services they need.⁵ Certainly,

geographical remoteness is an important health determinant,⁶ with widening disparities in health outcomes and behaviours between urban and rural dwelling populations.⁷ This means that telemedicine is a promising approach to improving the health outcomes of rural populations and that successful provision models are worthy of scrutiny.

J PRIM HEALTH CARE

2020;12(1):49-56.

doi:10.1071/HC19050

Received 6 June 2019

Accepted 27 January 2020

Published 24 March 2020

WHAT GAP THIS FILLS

What is already known: Access to abortion services is problematic for women living in rural areas. Although telemedicine is safe and effective for medical abortion in urban settings, there is a paucity of research exploring access to telemedicine abortion by women in rural locations.

What this study adds: Despite medical abortion being within the scope of rural primary health-care services, our study provides evidence that women in rural areas continue to have limited access to abortion. Telemedicine abortion bridges this access gap to essential reproductive health-care services for rural communities. Specific strategies are needed to ensure that vulnerable population subgroups can equitably access telemedicine in rural areas.

The World Health Organization recognises that access to safe and legal abortion is an essential reproductive health service, yet access to abortion services, even in developed wealthy Western countries, remains problematic.⁸ There is an established track-record of medical abortion safely provided by telemedicine in numerous countries including Brazil, the United States, Finland, Norway, Ireland and Canada.^{9–13} Some research notes the likely utility of telemedicine to extend abortion access into rural settings,¹¹ but none specifically explores non-urban women's access and perceptions around abortion by telemedicine.

Although Australia is a wealthy and developed country, women living in rural areas find access to abortions difficult and would likely benefit from innovative telemedicine services to address their unmet needs.^{14,15} The current research explores women's access to telemedicine abortion in rural areas of Australia. In this paper, we define 'rural' as areas with greatly limited access to service centres, including outer regional, remote and very remote Australia. These remoteness classifications are determined through the Australian Statistical Geography Standard (ASGS) remoteness structure that uses the Accessibility Remoteness Index of Australia to define distance to service centres.¹⁶

Australian abortion health services are primarily found in urban centres and are largely outsourced to private providers; it is a profit-driven item of health care.^{17,18} Medical abortion has had a

convoluted access entry point and, although being within their scope of practice, is not widely used in primary health care by general practitioners (GPs).¹⁹ There is no Medicare- (universal health insurance) specific reimbursement for a medical abortion performed in primary care. Similar to New Zealand,²⁰ Australia has a complex legal environment that has inhibited abortion provision, but there are an estimated 19 legal abortions performed per 1000 women aged 14–45 years.²¹ Unlike some countries, there is not an underbelly of unsafe, illegal abortions in Australia. Australian telecommunication infrastructure (mobile and landline networks) supports the delivery of telemedicine in both urban and rural areas, but Medicare rules limit doctors' ability to fund this practice. In the telemedicine service from which we recruited our participants, the service used the telecommunication mobile and landline networks and charged women AUD\$250 for a medical abortion.

Methods

Methodology

We used a qualitative feminist methodology to explore women's experience of using an Australian telemedicine medical abortion service in rural areas of Australia. Liamputtong states that 'in feminist methodology women and their concerns are the focus of the investigation'.²² Our qualitative feminist approach explicitly sought to privilege the lived experiences of women and to understand the meanings of their experiences. Our research had ethics approval from Menzies School of Health Research (#2016–2624) and all women gave their informed verbal consent before participation.

Participants and recruitment

As part of standard medical abortion care, a nationally practicing Australian telemedicine service sought permission from clients to be contacted after their abortion for the purposes of research and evaluation. After applying the research participant selection criteria (Box 1), telemedicine staff provided three female researchers with a list of potential participants. To seek interest in participating in the research, these potential participants were then privately contacted by researchers using phone, email or text message. Women were invited to

contact researchers if they wished to participate in ‘women’s health research’.

A much lower number of women responded to participation requests than were contacted. Due to the sensitivity of the research topic and to ensure participant privacy and safety, only two contact attempts were made to recruit. We were mindful that some women may be living in family violence situations and would not have control over their mobile phone or email accounts. Our first priority was to ensure women’s privacy and safety. The final number of participants recruited was guided by the concept of data saturation and limited by the project’s time constraints. Monitoring of saturation occurred throughout data collection and was deemed achieved when few different experiences were collected from participant interviews.²²

Processes

We undertook structured interviews over the phone with women using an interview schedule. The schedule contained social demographic questions including Indigenous Australian (Aboriginal and Torres Strait Islander) self-identification, alongside questions about accessing and choosing the service, perception and experiences about the abortion service and staff, reasons for choosing telehealth and preferences regarding face-to-face or telemedicine. Women were also asked to describe how they managed their abortion, the effort expended to find the service, their supports and if they faced any types of barriers or harassment. Finally, women were asked to comment on whether they would refer a friend to the telemedicine service. The interview questions were tested and modified to ensure flow. Interviews were digitally recorded and transcribed verbatim. Identifying features were removed from transcripts and names replaced with pseudonyms.

Data analysis

We used an adapted framework analysis to interpret the transcribed interview data, as this approach has been useful in similar applied health research settings.^{23,24} The framework analysis involved the five-stepped process of: data familiarisation, thematic framework identification, indexing, charting, and then mapping and interpretation.²³ The adapted

Box 1. Research participant inclusion criteria

Participant inclusion criteria

- Agrees to be contacted for research purposes
- Abortion not more than 6 months before interview
- Aged ≥ 18 years at the time of interview
- Living in a rural area (Australian Statistical Geography Standard outer-regional, remote and very remote)
- Any ethnicity including self-identification as Indigenous Australian (Aboriginal and/or Torres Strait Islander), but should speak and understand English
- Nulliparous and multiparous women
- All States and Territories*

* Except Australian Capital Territory and South Australia due to legal restrictions preventing telemedicine abortion at time of research.

thematic framework used to analyse the data was the integrated Patient-Centred Access to health-care model.²⁵ This model demonstrates five necessary dimensions to health-care access, alongside associated supply (system-based) and demand (personal and situational) determinants (Table 1). The conceptual model permits a nuanced gaze on health-care systems and delivery, which allows a comprehensive understanding of the complex human skills, situational context and service qualities that determine successful access to health care.

Results

Participants

In total, 11 women participated in phone interviews. Participants’ ages ranged from 23 to 38 years. All women spoke and understood English well, despite English not being a first language for three participants. All the women lived in rural areas of Australia (ASGS outer-regional, remote and very remote), in New South Wales (seven women), Queensland (two women), the Northern Territory (one woman) and Tasmania (one woman). The women were all in secure housing, either renting (five women) or owning (four women), except one young woman who was a tourist visiting from the UK. Many (eight women) had college or university-level education. Nearly all were employed, but often part-time, as they were also parenting children or studying. One woman had no income independently from her partner. Four women had no children and seven were already mothers, caring for

Table 1. Patient-centred access to health-care dimensions and determinants²⁶

Access dimension	Supply dimension	Supply determinants (system-based)	Demand dimension	Demand determinants (personal and situational)
1	Approachability	Transparency; outreach; information; screening	Ability to perceive	Health literacy; health beliefs; trust and expectations
2	Acceptability	Professional values, norms, culture and gender	Ability to seek	Personal and social values; culture, gender, autonomy
3	Availability and Accommodation	Geographic location; accommodation; hours of opening; appointment mechanisms	Ability to reach	Living environments; transport; mobility; social support
4	Affordability	Direct costs; indirect costs; opportunity costs	Ability to pay	Income; assets; social capital; health insurance
5	Appropriateness	Technical and interpersonal quality; adequacy; coordination and continuity	Ability to engage	Empowerment; information; adherence; caregiver support

children. Women had one to five children in their family. No women identifying as Indigenous Australian participated in the study.

Patient-centred access model analysis

Approachability and ability to perceive

When confronted with an unplanned pregnancy, participants all had difficulty accessing health information and community-based services related to abortion services. The exception was access to Internet-sourced material. Initially, all the women required high-level English and digital literacy skills to research and identify the telemedicine service, using the Internet and web search engines. This level of skill was apparent, even for the three participants from culturally and linguistically diverse backgrounds, which are contextualised by these women's explanations:

'On Google basically, I did a bit of research because being around here, there was you know not much choice.' [Dell]

'I suppose I could have discussed it with the GP but didn't really feel comfortable and so I found the service on the internet'. [Kellie]

'Google gave me my options of either going to Newcastle to have a surgical abortion or of doing it this way, like I've done it'. [Fiona]

'Google pretty much, to be honest. Just searching for answers - how to go about terminations...'. [Karen]

'Yeah, I was on Google and looking at all my options, because I have never been in that

situation before. And I came across, and I read through some of the feedback about the service. I contacted them and went from there.' [Lucy]

While women's reproductive health literacy levels were variable, all had the required foundational knowledge, competence and motivation that Sorensen *et al.*²⁶ suggest are needed to access, understand, appraise and apply health information. The women reported being given adequate and appropriate information about their care options after contact had been established with the telemedicine service. The initial screening process that involved blood and ultrasound tests was timely and smooth. Both the service and staff were trusted by women and were able to meet their expectations.

'Within, I think 24 hours I think, I was given the referrals for the blood tests and the ultrasounds, and within I think 2 days I'd spoken to both the doctor and the mental health person. And then within the week, I had the medications.' [Lucy]

Acceptability and ability to seek

Many of the women interviewed had initial face-to-face contact with GPs in their remote and regional home town. Although medical abortion is within the practice scope and knowledge domain of GPs in Australia, women reported that none of the doctors they attended were helpful or familiar with providing this essential health care; and nor were they able to offer alternative services to women. Some women were referred from one health service to

another, before using their own initiative and skills to identify and access the telehealth service. Two women reported returning to their GPs and educating them about telehealth and medical abortion services. Some women incorrectly reasoned that medical abortion could not be provided by their town's GP because of their non-urban location. These women explained their experiences with GPs:

'My GP is regional, so they do not do abortions or anything like that. So, they put me onto Family Planning [Organisation] and Family Planning was the one who turned around and said 'we don't actually do abortions' but finally they told me about the [telemedicine service].'
[Maddie]

'I came across the [telemedicine service] like that, did some research. We spoke with a GP in the meantime and she didn't really help me much further and I thought that this was the best solution for me.'
[Karen]

'I also went to my own doctor anyway, the week after, just to update her: she was really supportive. She didn't even know about the [telemedicine service] so I let her know about it and she's now letting all her clients know. Because we haven't got anything in town and she said she has so many people coming to her asking her and she just has no idea, because we just haven't got anything.'
[Lucy]

Although the women in this study perceived abortion as an acceptable choice, they experienced a normative cultural positioning of abortion as shameful, stigmatised and negative.²⁷ Some reported not discussing the need for an abortion with their GP for fear of stigmatisation and the lack of confidentiality in a small town. When women accessed the telemedicine service, they were pleasantly surprised by the staff's professional values. This was highlighted by two women separately stating 'I didn't feel judged'. The sex of telehealth staff was noted by participants, with some women showing a preference for female nurses and psychologists. The care provided by women was perceived as warmer and more compassionate. Maddie said on this topic:

'I don't mean to be a feminist or sound sexist but I think when women deal with women's issues like termination they have slightly more understanding than a man.'

Availability and ability to reach

All the women, bar one, reported very poor geographical access to standard abortion services in their remote location. Only one woman reported being a 15 minute distance to an abortion service, whereas all the remaining women lived 1–16 h away from a physical site providing abortions. While telemedicine was available, women still remained burdened by distance and excessive travel to obtain the necessary screening checks. All the women had access to personal transport and most relied on road and private motor vehicle travel for attending screening tests. One woman described having to attend multiple appointments squeezed between school drop-offs and pick-ups for her two children. This amounted, in total, to at least 8 hours of driving time and she explained it as 'simply hectic'. Women generally reported social isolation and low levels of support, meaning that they had to juggle their abortion care around work and childcare commitments.

Affordability and ability to pay

Women reported that the telemedicine service was affordable and overwhelmingly the cheapest option available to them. They reported costs of \$AUD250–350. One woman reported that her alternative option for a surgical abortion was \$AUD1500. Affordability was a crucial determinant for these women, many of whom had a low income and dependants to support. Indirect costs such as time away from work, childcare and transport were absorbed by the woman, but were perceived as having far less impact than either travelling away for a surgical abortion or the alternative of going through with an unwanted pregnancy. All the women accessed some sort of social capital by disclosing their decision to stop the pregnancy to either a trusted friend or family member. Some of the screening tests incurred an additional fee, but this was outside the control of the telemedicine service. Most women were able to undertake these screening tests free-of-charge under the universal Medicare insurance scheme. No women reported using private health insurance to pay for screening tests or the service fees.

Appropriateness and ability to engage

All study women highly valued the technical care offered by telemedicine staff and found no fault with

the adequacy, coordination and continuity of the care they experienced. Even for the two women who experienced uncommon side-effects requiring tertiary care, they reported that the telemedicine staff met their care needs. The process of transitioning between the telemedicine service, primary and tertiary levels of care generated some difficulty, and women reported situations where many services were unprepared. One tertiary service struggled to provide appropriate care to a woman who was experiencing excessive bleeding and, as above, GPs performed poorly in offering abortion care or alternative abortion services.

The telemedicine staff, particularly the female nurses, were highly regarded by the women for their support and interpersonal communication skills. All the women were happy and confident to recommend the telemedicine service to a friend. While women often referred to the transactional nature of the care, telemedicine was desirable because of the privacy and control it afforded. These women who accessed the telemedicine service were empowered, skilled and had high levels of self-efficacy.

The role of support persons was recognised by all the women, although their levels of actual support during the telemedicine abortion process were mixed. Support ranged from physical companionship, phone-only support and then a commitment to being on-call if needed. For example, one woman explained that her friend who had agreed to support her lived too far away, but committed to staying on the phone with her for several hours during the abortion. Another woman had her partner on stand-by at work ready to attend if needed, and a further participant in the study explained that she recruited her in-laws to look after her children while she aborted in the room next-door. Two women reported being obstructed in their choice by their nominated support person. This included an abusive ex-partner and a sister with devout religious beliefs.

Discussion

This qualitative exploration of rural women's access and perceptions around abortion by telemedicine addresses an identified knowledge gap in international literature. The five domains of the Patient-Centred Access model demonstrated that when

women with the prerequisite personal skills and circumstances are offered a low-cost service with compassionate and technically competent staff, telemedicine can innovate to ensure rural communities have access to essential reproductive health services. The rural women who participated in our research were able to access telemedicine abortion without a referral, but they reported many difficulties in gaining abortion information and services from local GPs. The reasons for this are likely due to a complex interplay of systemic and personal factors including financial Medicare disincentives, health provider abortion stigma and burdens from the additional administrative and training prerequisites required to legally prescribe Australian abortion medication.^{28,29} Similar barriers have been reported by Dawson *et al.* who explored reasons for the low uptake of medical abortion provision by Australian GPs.¹⁹ Although none of these service provision barriers are specifically related to the challenges of geography, they disproportionately affect rural women who have either fewer choices or often no home town abortion service at all, and thus contribute heavily to the inequity of rural abortion access. In our research, access to the telemedicine service required women to have high digital literacy and self-efficacy, alongside other favourable situational personal circumstances such as transport.

This research is limited by the small sample, which is typical of qualitative research, but may resonate with other similar rural contexts. While not specifically excluded, no Indigenous Australian women participated in the study, which is also a limitation. The reason for this is likely due to our small qualitative research sample size and perhaps confounded by more frequent late presentations and thus ineligibility for medical abortion. Recent Australian research indicated that women who identified as Indigenous were more likely to present for abortion care at greater than nine weeks' gestation.¹⁸

Further research using representative sampling and survey methods would also be useful to better understand the context and challenges of rural abortion service provision. Despite these limitations, the PCA²⁵ framework analysis enabled a rich understanding of how telemedicine is able to meet the needs of rural women by providing access to abortion services outside urban areas of Australia.

Although our analysis offers cause for celebrating the innovations of telemedicine in meeting reproductive health challenges, it may also inadvertently perpetuate known health inequities for certain rural population cohorts, especially minority, Indigenous, marginalised or socially vulnerable women, who may be in the greatest need for access to reproductive health services but who lack the personal skills and favourable circumstances to access telemedicine. Addressing telemedicine's 'paradoxical inequity' is therefore a crucial challenge, especially in the current global context where many nations' health inequities are widening.³⁰ Our findings suggest the need for further scrutiny over how to safeguard access to telemedicine for marginalised and vulnerable populations, particularly those with low digital literacy.

Competing interests

The authors have no competing interests to declare.

Acknowledgements

The Australian telemedicine service we collaborated with was the Tabbot Foundation. The Tabbot Foundation provided approximately 6000 early medical abortions via telephone between 2015 to 2019. We would like to thank Dr Paul Hyland and the staff who supported this research and note that the service funded the transcription of interviews, but was otherwise not involved in the data collection, analysis or writing this article.

References

- Bradford NK, Caffery LJ, Smith AC. Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. *Rural Remote Health*. 2016;16(4):3808.
- Goodini A, Torabi M, Goodarzi M, et al. The simulation model of teleradiology in telemedicine project. *Health Care Manag*. 2015;34(1):69. doi:10.1097/HCM.0000000000000049
- Mendez I, Jong M, Keays-White D, Turner G. The use of remote presence for health care delivery in a northern Inuit community: a feasibility study. *Int J Circumpolar Health*. 2013;72(1):21112. doi:10.3402/ijch.v72i0.21112
- Wesson JB, Kupperschmidt B. Rural trauma telemedicine. *J Trauma Nurs*. 2013;20(4):199–202. doi:10.1097/JTN.000000000000012
- Neville CW. Telehealth: a balanced look at incorporating this technology into practice. *SAGE Open Nurs*. 2018;4:1–5. doi:10.1177/2377960818786504
- Smith JD. Australia's rural and remote health: a social justice perspective [Internet]. 2nd ed. Croydon, Vic.: Tertiary Press; 2007 [cited 2019 February 27]. Available from: <https://trove.nla.gov.au/version/44717596>
- Australian Institute of Health and Welfare. Australia's Health 2018: in brief. Canberra: Australian Institute of Health and Welfare; 2018. Report No.: Cat. no. AUS 222.
- Doran F, Nancarrow S. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. *J Fam Plann Reprod Health Care*. 2015;41(3):170–80. doi:10.1136/jfprhc-2013-100862
- Endler M, Lavelanet A, Cleeve A, et al. Telemedicine for medical abortion: a systematic review. *Br J Obstet Gynaecol*. 2019;126(9):1094–102. doi:10.1111/1471-0528.15684
- Gomperts RJ, Jelinska K, Davies S, et al. Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. *Br J Obstet Gynaecol*. 2008;115(9):1171–8. doi:10.1111/j.1471-0528.2008.01787.x
- Grindlay K, Lane K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. *Women's Health Issues*. 2013;23(2):e117–22. doi:10.1016/j.whi.2012.12.002
- Grossman D, Grindlay K. Safety of medical abortion provided through telemedicine compared with in person. *Obstet Gynecol*. 2017;130(4):778. doi:10.1097/AOG.0000000000002212
- Wiebe ER. Use of telemedicine for providing medical abortion. *Int J Gynaecol Obstet*. 2014;124(2):177–8. doi:10.1016/j.ijgo.2013.07.038
- Doran F, Hornibrook J. Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study. *Aust J Rural Health*. 2014;22(3):121–6. doi:10.1111/ajr.12096
- Doran FM, Hornibrook J. Barriers around access to abortion experienced by rural women in New South Wales, Australia. *Rural Remote Health*. 2016;16(3538):1–12.
- Australian Bureau of Statistics. The Australian Statistical Geography Standard (ASGS) Remoteness Structure. Remoteness Structure Australian Bureau of Statistics. ABS; 2019 [cited 2019 November 13]. Available from: <https://www.abs.gov.au/websitedbs/D3310114.nsf/home/remoteness+structure>
- Dawson A, Bateson D, Estoesta J, Sullivan E. Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. *BMC Health Serv Res*. 2016;16(1):612. doi:10.1186/s12913-016-1846-z
- Shankar M, Black KI, Goldstone P, et al. Access, equity and costs of induced abortion services in Australia: a cross-sectional study. *Aust N Z J Public Health*. 2017;41(3):309–14. doi:10.1111/1753-6405.12641
- Dawson AJ, Nicolls R, Bateson D, et al. Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study. *Reprod Health*. 2017;14(1):39. doi:10.1186/s12978-017-0303-8
- Macfarlane E. Abortion law reform – what it means for primary care. *J Prim Health Care*. 2019;11(3):191–2. doi:10.1071/HCV11n3_ED2
- Newan P, Morrell S, Black M, et al. Reproductive and sexual health in New South Wales and Australia: differentials, trends and assessment of data source. Sydney: Family Planning NSW; 2011.
- Liamputtong P. *Qualitative Research Methods*. 4th ed. South Melbourne: Oxford University Press; 2013.
- Srivastava A, Thomson SB. Framework analysis: a qualitative methodology for applied policy research. *JOAAG* 2009;4(2):72–9.
- Ward DJ, Furber C, Tierney S, Swallow V. Using Framework Analysis in nursing research: a worked example. *J Adv Nurs*. 2013;69:2423–31. doi:10.1111/jan.12127

25. Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(1):18. doi:10.1186/1475-9276-12-18
26. Sørensen K, Van den Broucke S, Fullam J, et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*. 2012;12(1):80. doi:10.1186/1471-2458-12-80
27. Kumar A, Hessini L, Mitchell EMH. Conceptualising abortion stigma. *Cult Health Sex*. 2009;11(6):625–39. doi:10.1080/13691050902842741
28. Children By Choice. Becoming a medical abortion provider - Children by Choice [Internet]. Children by Choice Association Incorporated; 2019 [cited 2019 November 13]. Available from: <https://www.childrenbychoice.org.au/forprofessionals/becoming-a-medical-abortion-provider>
29. MSHHealth. ms2step - This site is intended for healthcare professionals only. [Internet]. 2019 [cited 2019 November 13]. Available from: <https://www.ms2step.com.au/>
30. Marmot M. *The Health Gap: The Challenge of an Unequal World*. London: Bloomsbury Publishing; 2015. 292 p.