Submission to the Senate Standing Committees on Community Affairs Inquiry on Universal Access to Reproductive Healthcare

28 December 2022

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1.Preamble

The National Rural Women's Coalition

The National Rural Women's Coalition (the NRWC) is a grass roots organisation, established in 2002, that works to support and grow vibrant rural, remote, and regional communities throughout Australia. We are a coalition of six rural alliances - the Australian Local Government Women's Association, Australian Women in Agriculture, Country Women's Association, National Rural Health Alliance, Women in Seafood Australasia and Transport Women Australia Limited.

For over twenty years, we have worked to ensure better social, economic, and environmental outcomes for women in rural townships, in rural communities and in primary production throughout Australia. The NRWC provides a collaborative, powerful national voice for women living in rural, regional, and remote (RRR) Australia through:

- Representing the diverse views and voices of women in rural, regional, and remote Australia
- Providing advice to the Australian Government on policy issues relevant to the views, circumstances and needs of rural women
- Contributing to building a positive profile of rural women, their achievements, and their issues.

We believe it is important that the unique views of rural women who reside in the numerous rural, remote, and regional communities throughout Australia as farmers, businesswomen, community leaders and volunteers, have substantial input into consultations about their communities, industries, needs and issues, including any matters relating to women's rights, gender equality and discrimination.

2.Introduction

A key focus area in the National Women's Health Strategy 2020-2030 is to address inequities in health care, between and within population groups. Women in RRR areas are recognised as a priority group because of the inequalities in health outcomes, greater health risk factors and poorer access to, and use of, health services compared to women and girls in major cities.

Compared to women in major cities, rural women have a lower life expectancy that can be as much as a 15 year gap, with women in major cities having a life expectancy of 84 years compared to women in very remote areas with a life expectancy of 70 years[1]. Health inequities increase the further away women are from a major city. For example, in remote and very remote areas there are higher rates of unintended pregnancy[2], domestic violence,[3] cervical cancer (up to 49% higher[4]), and lower rates of women participating in cervical screening[5] than in major cities.

Rural women face multiple interrelated social, economic and environmental challenges such as lower incomes, under employment and lack of access to transport, lower education attainment, access to health care and gender inequalities. Rural women earn 21% less per week and report higher levels of cash flow problems (for example when they could not pay an essential services bill on time (i.e., gas, electricity, or phone) [6].

Added to this is the fact that each rural place has its own unique culture, networks, relationships and social norms. This results in a complex interplay of determinants that enable and constrain health behaviour in rural communities, particularly when accessing sexual or reproductive healthcare. This

means that 'Metrocentric' assumptions about health care design and delivery (as stated in the National Women's Health Strategy) often do not work or are not sustainable in rural places.

The focus of this inquiry is about *universal access* to reproductive health care. The concept of 'universal' means that there should be healthcare coverage for everyone i.e. that all people have *access* to the *full range of quality health services they need, when and where they need them, without financial hardship*[7]. Access to healthcare has several dimensions and includes availability, geographically accessible[*], affordable, accommodating[†], timely, acceptable (taking into account age, gender, religion, ethnicity, and culture) and awareness[‡8]. Access to sexual and reproductive healthcare has been identified as core primary health care services. This means that when making decisions about what services should be available for rural and remote communities, (even communities with very small population sizes), sexual and reproductive healthcare must be a priority[9]. Unfortunately, when it comes to describing access to sexual and reproductive healthcare for women and girls in RRR, universal access is not one of them.

Finally, women and girl's reproductive health and wellbeing is so much more than the absence of disease. It incorporates physical, mental and social wellbeing at all stages of women's reproductive lives[10]. We realise that we have outlined many deficits that exist in RRR areas. But the reality is that our rural places have many strengths, with high levels of community participation, social capital and sense of place, that can and do promote a sense of wellbeing that goes beyond what a health service can provide. We urge the Australian Government to look beyond the deficit paradigm[11] and move to a strengths-based place approach that takes into account the complex interplay of the social-ecological issues and applies a holistic comprehensive approach to women's health and wellbeing.

The NRWC welcomes the opportunity to provide comments to the Senate Standing Committee on Community Affairs on this important inquiry into universal access to reproductive healthcare. Our feedback is based on comments and information sourced from rural women, health practitioners and researchers. We would be very happy to provide more information should you require it.

3.NRWC Response to the Inquiry Terms of Reference

Many barriers exist for women and girls in RRR Australia in having universal access to sexual and reproductive health information, treatment and services. This deficit significantly impacts on their sense of empowerment and choice and control about their bodies. Some of the issues are outlined below.

3.1 Cost and accessibility of contraceptives

Providing that they are appropriately assessed through the TGA process, the NRWC believes that for true universal access, the full range of contraceptive medication and devices, including medical abortion care, must be accessible i.e., that all the dimensions of access are met, as outlined above, for women in RRR areas.

The oral contraceptive pill is the most frequently used form of contraception. However, some women and girls are taking the oral contraceptive pill to regulate their menstrual cycle, decrease hormonal imbalance, to decrease acne, treat hirsutism, reduce period pain, or take it as part of

[*] Geography refers to the ability and ease with which people get to a service and the distance between their location and that of the services needed (Russell et.al 2013).

[†] Accommodation refers to consumer ability to contact, gain entry to and navigate the system at times of need. This can include the physical environment of the health service itself, meeting eligibility criteria or navigating appointment systems (Russell et.al 2013).

[‡] Awareness refers to health literacy and level of understanding of a health issues and awareness of the services available to assist (Russell et.al 2013).

treatment for polycystic ovarian syndrome and endometriosis. The NRWC believe that as this medication is important to so many women for a range of reasons, women should be able to access the oral contraceptive pill, free of charge, as demonstrated in countries like New Zealand, the UK and Iran. Access to free long acting reversible contraception has also been trialled in Finland (since 2013) and is showing decreased rates of abortion.

Although long acting reversible contraception (LARCs) has been proven to be safe and a highly effective as a 'set-and-forget' contraception, there has been a slow uptake in Australia. Of note research has shown that women in outer regional or remote areas are more likely than women living in cities to use long acting or permanent contraceptive methods[12]. It follows then that women in RRR should be able to access more providers who can provide this service. Yet, there are additional barriers that women face in RRR have to access this service. One example is that the insertion of an Intra Uterine Device (IUD) can require multiple visits to see a GP for pre-insertion advice and screening, the insertion of the device and post insertion checks. We understand that these consultations are all necessary to meet safety and quality standards. However, the consultation fees to see the GP, the logistics of purchasing / ordering a device and the cost of any screening tests, time and travel, all add up. We have heard that for some women that if a GP practice, or health service provider does not provide bulk billing the cost of having an IUD inserted is in excess of $500. This cost does not include the cost of fuel , accommodation costs or time away from home.

In RRR there are often long waiting times to see a GP. If it is the woman's preference to see a female GP, the woman may need to travel a long distance to access female GP/ health practitioner services. There are some areas where a mobile primary care service visits a region. But these services are available infrequently and might only visit a region once fortnight or even on a monthly basis, often with a rotating team. This means that in addition to waiting for the device to arrive, getting an appointment and waiting for the service to come to town, a couple of months could have gone by before the woman can access reproductive health care or even get advice. It also means that the idea of having a consistent GP who knows you and your medical history is often not a reality.

Feedback from rural GPs also indicates that providing a service to insert an IUD is not sufficiently covered by the current MBS items. Feedback indicates GPs need more education and support, more time to discuss option with their patient, and more funding to cover costs of equipment (for example, one GP suggested that all GPs should be given funding for a quality gynaecological examination bed).

The NRWC notes that there is some opposition by some medical peak body organizations to changes to the PBS to allow pharmacists to provide over the counter contraception. In situations where a woman has been taking an oral contraceptive pill for some time and has had no side effects; and given that there can be a long wait time to see a GP in RRR (and for a Nurse Practitioners even more so), the NRWC supports changes to the PBS to enable pharmacist to issue repeat prescriptions. The NRWC would also recommend that should a pharmacist reissue a prescription that the woman's GP is notified so that they are kept in the loop with their patient's sexual and reproductive healthcare.

3.2 Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas

Access to safe abortion care either medical or surgical termination of pregnancy services are time sensitive, especially for access to a medical abortion by 9 weeks gestation. Women in RRR are disproportionately burdened by the sheer logistics of accessing abortion care, surgical or medical. For some women the only option available to them if they do not want to proceed with the pregnancy is to access Early Medical Abortion (EMA), a surgical abortion is simply not an option

available to them. Figure 1 is a snapshot taken from the Victoria 1800 My Options interactive Map. It shows that in Victoria for those services that are listed there are very few surgical services available to women outside of a major city. Research undertaken by Subasinghe et.al[13] showed that the rate of medical abortion is higher than in major cities, but that there are many areas where MS-2 Step had not been prescribed by GPs or dispensed by community pharmacists. This means that women in these areas had to access the service. Either by travelling or by telehealth.

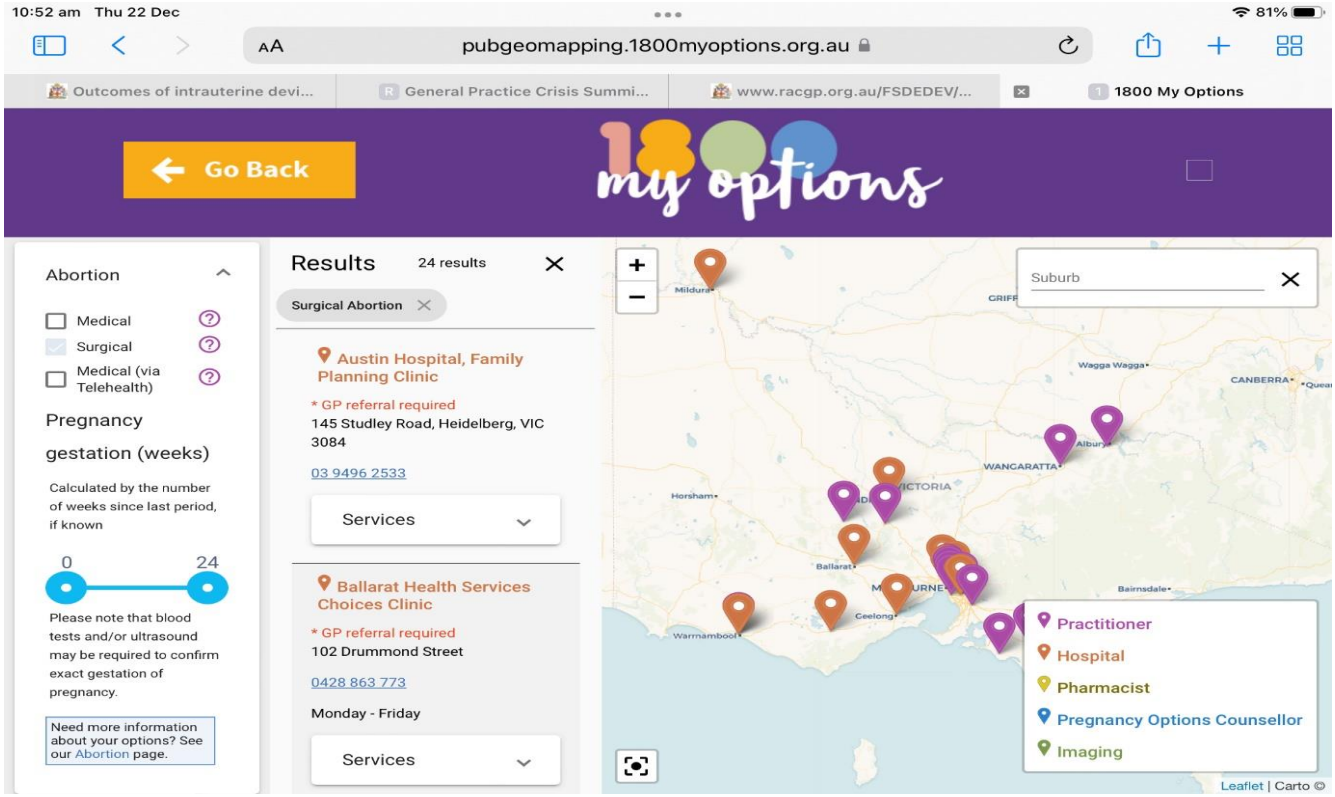

Figure 1 Snapshot Surgical Abortion Services Available in Victoria. https://www.1800myoptions.org.au/information/where-to-go

Although the process of getting an abortion is the same for urban women and rural women, for women in RRR to access abortion services comes with its own additional access issues. Feedback from our contacts indicates that some pharmacists and medical practitioners are conscientious objectors. In towns where there might be only one pharmacist and one GP this is already a barrier before you can even get the medication or a referral to surgical service. However, we have also heard that women's privacy, and confidentiality is threatened when standing in line to access the medication in a small rural town pharmacy. In addition, even if a woman accesses telehealth consultations and has the medication posted, as opposed to waiting in a pharmacy to get the medication, a postal delivery can take over 5 days to arrive. And for people who live in remote properties this will require another trip to the mailbox. All of this is time sensitive.

Access to medical abortion is equally problematic for women in RRR areas. Figure 2. is a snapshot from the Interactive 1800 My Options map showing how many practitioners are available, note there is a concentration of service closest to Melbourne and Geelong but get less and less the further away from the cities you are.

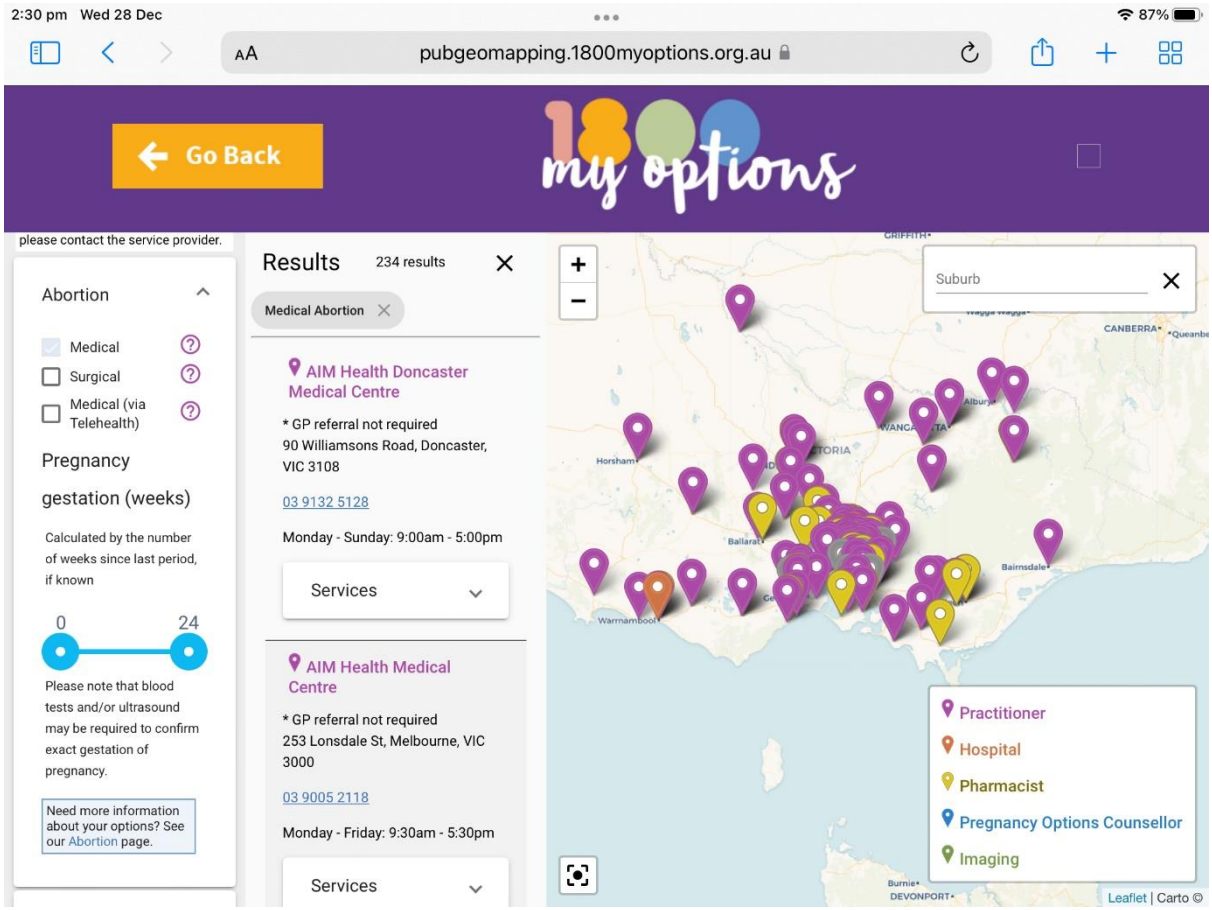

Figure 2 Snapshot Medical Abortions in Victoria 1800MyOptions Map. https://www.1800myoptions.org.au/information/where-to-go

In addition to this, the woman will still need to access a pathology service to get a serum beta-hCG blood test (required to confirm the pregnancy) and radiology service to get an ultrasound to confirm gestation and to rule out other issues such ectopic pregnancy before the medication can be administered. An ultrasound and serum beta-hCG blood test will need to be repeated at least seven days after taking the medication to confirm that the pregnancy has ended. Follow-up may be face to face, via telehealth or via telephone consultation.

Research undertaken in rural Queensland revealed that women who access an abortion service had to travel 1-9hrs to access the abortion clinic with some having to borrow money for fee. Participants also identified following barriers to accessing abortion care: finding information about provider; stigma, shame, secrecy; logistics involved in accessing clinic with travel, money, support; and lack of awareness about medical and surgical abortion[14].

Feedback from rural GPs indicates that although they might provide access to abortion services, it is not something they want to advertise for fear of being overwhelmed with an increased demand and having no capacity to meet this demand. For some GPs, they perceive that as there are so few GPs providing this service, the increased demand could also mean “it is the only thing I do”. Another reason is that GPs feel they need more support and education on reproductive health care generally. Some GPs are concerned about the safety of medical abortion at home and are reporting seeing complications after the woman has taken the medication that has required surgical removal of retained products of conception. Which in effect is a double whammy for the woman who in effect has two types of abortion services that could have been avoided if the woman had been able to

access a safe surgical abortion in the first place. This feedback indicates that although emergency medical abortion can be available there does need to be additional safety and quality checks in place to assist the woman particularly if complications such as this arise.

Research undertaken in western New South Wales exploring what women want from local primary care services for unintended pregnancy in rural Australia found that although the women who participated in the study were very aware of the access limitations of rural health services in their area, they had an expectation that their all of their reproductive health needs would be meet in a timely and efficient way[15]. In addition to delays in getting access to a medical practitioner, some participants commented on feeling shocked and dismayed that the care they did receive failed to meet their needs, with medical practitioners being unprepared or seemingly unwilling to provide information or advice, particularly pregnancy decision-making support or advice about available abortion services[16].

Some participants discuss that the lack of options for pregnancy care and for contraception more broadly were also not available[17]. The researchers conclude that the primary care community of GPs and women's health nurses are the crucial first point of contact for the time sensitive pregnancy decision-making support and abortion services for women managing unintended pregnancy in rural areas. A lack of woman centred care in their local rural health setting, choice, time efficiency, and aftercare were identified as gaps[18].

As accessing abortion services is problematic for rural women, this means that for some an unintended and unwanted pregnancy might have to go ahead. This creates additional stress and health and wellbeing burdens, not only for the woman but for her family and future child. Therefore, only looking at access abortion services as a measure means that the needs of those who could not access and went through with the pregnancy are missed. Researchers are suggesting that data needs to be captured to measure this issue[§].

Due to severe lack of access to surgical abortion services in RRR areas the NRWC call on the government to develop a national approach to abortion care and work towards mandating that every public hospital service must provide abortion medical and surgical and offer the full range of contraceptive care.

3.3 Workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals

The NRWC supports a broader range of options of accredited service providers to increase access in rural areas so that to choose from, and the health professionals are credentialed to meet professional standards. Abortion is not in the medical training curriculum. For medical practitioners who will be working in RRR areas this must be a core topic requiring applied skills and knowledge. In addition, medical practitioners and women's health nurses should be required as part of their professional development to upskill and update on sexual and reproductive healthcare. We have heard from researchers and RRR women that some medical practitioners are working on outdated evidence for example that IUDs are only safe and easier to insert for multiparous women. We have also heard that some women's health nurses are limited by their health service policy and scope of practice and are unable to provide a wide range of services beyond providing advice and referral.

[§] Information provided by Rural Health Researcher from SPHERE.

Due to lack of services for medical abortion in RRR Areas there is a need for more education and support fort for doctors about early medical abortion and referral pathways are required to ensure that women have access to abortion services[19]. Peer support networks that include other prescribing GPs, as well as a pharmacist, sonographer, and the MS-2 Step 24-hour nurse hotline, can also assist with interdisciplinary knowledge exchange and dissemination[20]. The NRWC would also like to see more investment in the Rural Generalist role (eg, GP with advanced skill in obstetrics) to increase their scope of practice and increase access to these services.

A peer group model that is showing some positive responses is the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) for example is an NHMRC funded online community of practice. It is developed in partnership with the RACGP, RANZCOG, APNA, the PSA, and other key stakeholders for primary health care providers who are interested in increasing women's access to long acting reversible contraceptives (LARC) and medical abortion[21].

Research currently being undertaken in RRR Australia is testing out a practice nurse early medical abortion service model with the sim of increasing accessibility and confidentiality and decreasing stigma. The model is showing some positive outcomes, but researchers have highlighted some barriers to address before this model can be implemented more broadly. One of the main barriers is legislation[22]. Each State and Territory has its own abortion regulation. This can cause confusion amongst practitioners and women as well as create unnecessary barriers. An analysis undertaken by Marie Stopes Australia also showed that on current abortion legislation alone, nurse-led EMA would not be possible in New South Wales, South Australia, Tasmania or Western Australia[23]. Changes are also required to state-based legislation to enable nurse practitioners and endorsed midwives to prescribe MS-2Step, and for appropriately trained and qualified nurses and midwives to obtain and administer mifepristone and misoprostol under relevant scheduled medical authorisation or state-approved Drug Therapy Protocol[24]. This indicates the need for a national approach to abortion service care.

3.4 Best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

The NRWC was unable to find enough information on trauma informed care to include here. Feedback from a remote Domestic Violence Worker indicates that culturally informed and trauma informed care is a mandatory form of practice in their health service. Anecdotally, there is a view that as there are higher numbers of Aboriginal and Torres Strait Islander people accessing remote and very remote health services, trauma informed care is also commonly used in child/family welfare services, mental health and drug and alcohol services. However, training is not formalised and is at the discretion of the health organisation.

3.5 Sexual and reproductive health literacy.

The NRWC has received feedback that there is a general lack of awareness about the sexual health and reproductive healthcare in RRR areas indicating the need for a comprehensive public health social marketing strategy. The general lack of awareness means that RRR women, particularly young women are not aware of the options available to them. There is a lack of confidence in practitioners in rural areas who don't perform procedures regularly, the cost and transport to travel to IUD clinic for rural women, (especially if they do not want their parents to be aware) and the social stigma with contraception[25].

One suggestion from our Young Rural Regional and Remote Advisory Panel is to investigate the expansion of the school nurse role as way of increasing access to health promotion sexual health and

reproductive care. This model has been successful used in the UK to increase awareness in young adults and provide access to health advice by a trusted source.

A suggestion by rural health researchers is to expand the Interactive map for contraception and abortion services such as the My Options interactive map. Maps like this are available in Victoria, Queensland, Tasmania but not in NSW, WA, NT,SA. This map is useful in showing women where there are services located, who requires a referral from a GP and distances to the service.

Feedback from researchers looking into sexual and reproductive health in rural Australia have noted that there is little promotion or advertising of contraception and abortion services- and have raised the question are adverts to MS1 being banned? If so under whose authority?

3.6 Experiences of people with a disability accessing sexual and reproductive healthcare and 3.7 Experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare

For 3.6 and 3.7 the NRWC were unable to gain any relevant information that may assist the inquiry. Again, we identify this as a significant gap that require additional research and investment.

3.8 Availability of reproductive health leave for employees

The NRWC has not made a determination on this point, we would like to see more detail before making any recommendations.

3.9 Any other related matter.

Nothing further to add.

NRWC Summary of Recommendations

In summary, the NRWC recommends that the Senate Standing Committee on Community Affairs consider the following:

1. For true universal access the full range of contraceptive medication and devices, including medical and surgical abortion care, must be accessible, for women in RRR areas.
2. Due to severe lack of access to surgical abortion services in RRR areas the NRWC call on the government to develop a national approach to abortion care and work towards mandating that every public hospital service must provide abortion medical and surgical and offer the full range of contraceptive care.
3. Increase the number and frequency of sexual and reproductive healthcare services in remote and very remote areas delivered as holistic women's wellness model encompassing the range of prevention, treatment diagnostic services.
4. Make oral contraception and condoms available for free at sexual and reproductive health services in RRR areas.
5. As a minimum, increase the patient Medicare rebate to reduce out of pocket costs for the insertion of long acting reversible contraception. For women in RRR areas to access this care, service should be bulk billed with travel subsidies available. The NRWC would like to see that there are no out of pocket costs for this service.
6. Increase funding to support General Practices in being able to provide long acting reversible contraception services to cover the costs of time for the consultations, for the insertion of the devices, for the purchase of equipment needed for the procedure, and the requirement for a nurse to be present.

7. Make changes to the PBS to allow pharmacists to reissue repeat oral contraception prescriptions for women who have been taking the pill for some time with no side effects.
8. Increase access to training and support for health professionals in sexual and reproductive health care and peer support networks.
9. Invest in new innovative models such as practice nurse led sexual and reproductive health clinics and school nurse programs.
10. Mandate the inclusion of trauma informed practice and culturally appropriate health care in all health professional training curriculum.
11. Invest in research to determine the specific needs of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare.
12. Invest in more research and development of service models to meet the needs of women with disability and access to sexual and reproductive health care.
13. Expand the My Options Interactive map and make it a national tool to enable women to find contraception, abortion and other reproductive health care services; and
14. Develop a national social marketing campaign to raise awareness of sexual and reproductive health care issues

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